The NHS's National Programme for Information Technology

(NPfIT)

A Dossier of Concerns

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Extracted from the online dossier at http://nhs-it.info/

(A PDF version of this document is available for download at http://homepages.cs.ncl.ac.uk/brian.randell/Concerns.pdf)

Executive Summary

This dossier has been put together by the group of twenty-three academics who, in April 2006, became concerned by what they had learned of the plans, progress, reported difficulties and controversies surrounding the UK National Health Service's " National Programme for Information Technology". It brings together a host of evidence, covering a very wide range of issues that in combination suggest the project is in serious trouble.

Given the scale of the project, one of the largest ever attempted, the past track record of large public sector IT projects, and the mounting evidence of serious concerns from health and IT professionals and from the media, the risk to the NHS and the public of significant failures reinforces the need for a careful, open, honest and independent examination of the situation.

The first main section of the dossier documents interactions with the Health Committee and the NHS. The single biggest section (Section 4) consists of quotations from published reports and articles reporting on problems or expressing various types of concern over the National Programme for Information Technology (NPfIT), whenever possible accompanied by the Internet address at which an on-line version of the full text of the original article or report can be found. However this is preceded by a section containing the full texts of a number of unpublished expressions of concern.

Other sections include ones that are to devoted to material emanating from or about various organisations, such as the Public Accounts Committee, Parliament, the Department of Heath, the British Computer Society, etc., together with two that attempt to document all the Parliamentary Questions and contributions to Parliamentary Debates relating to NPfIT and concerns about its progress during the early years of the Programme. (These questions and contributions are from forty-eight Members of Parliament and from seven Members of the House of Lords.)

Updating of this dossier continued until September 2010, when a Department of Health review "concluded that a centralised, national approach is no longer required, and that a more locally-led plural system of procurement should operate".

CONTENTS

1. The Health Select Committee

This dossier of information relates to concerns over the current progress and direction of NHS Connecting for Health's National Programme for Information Technology (NPfIT) [http://www.connectingforhealth.nhs.uk/]. It is based on the on-line dossier, at http://nhs-it.info/, that has been compiled over recent months by the set of signatories to open letters to the Health Select Committee calling for an independent inquiry into and detailed technical review of NPfIT.

1.1. The First Open Letter to the Select Committee

This Open Letter (whose full text is at Appendix 1) to the Health Select Committee, signed by twenty-three academics, was sent on 10 April 2006 and read as follows:

> THE NATIONAL PROGRAMME FOR IT IN THE NHS
>
> The Select Committee may be aware of the concerns of health professionals, technologists and professional organisations about the £6bn NHS National Programme for Information Technology (NPfIT):
> - The NHS Confederation has said " The IT changes being proposed are individually technically feasible but they have not been integrated, so as to provide comprehensive solutions, anywhere else in the world" .
> - Two of NPfIT's largest suppliers have issued warnings about profits in relation to their work and a third has been fined for inadequate performance.
> - The British Computer Society has expressed concern that NPfIT may show a shortfall of billions of pounds.
> - Various independent surveys show that support from healthcare staff is not assured.
> - There have been delays in the delivery of core software for NPfIT.
>
> Concrete, objective information about NPfIT's progress is not available to external observers. Reliable sources within NPfIT have raised concerns about the technology itself. The National Audit Office report about NPfIT is delayed until this summer, at earliest; the report is not expected to address major technical issues. As computer scientists, engineers and informaticians, we question the wisdom of continuing NPfIT without an independent assessment of its basic technical viability. We suggest an assessment should ask challenging questions and issue concrete recommendations where appropriate, e.g.:
> - Does NPfIT have a comprehensive, robust:
> - Technical architecture?
> - Project plan?
> - Detailed design?
>
> Have these documents been reviewed by experts of calibre appropriate to the scope of NPfIT?
> - Are the architecture and components of NPfIT likely to:
> - Meet the current and future needs of stakeholders?
> - Support the need for continuous (i.e., 24/7) healthcare IT support and fully address patient safety and organisational continuity issues?
> - Conform to guidance from the Information Commissioner in respect to patient confidentiality and the Data Protection Act?
> - Have realistic assessments been carried out about the:
> - Volumes of data and traffic that a fully functioning NPfIT will have to support across the 1000s of healthcare organisations in England?
> - Need for responsiveness, reliability, resilience and recovery under routine and full system load?
>
> We propose that the Health Select Committee help resolve uncertainty about NPfIT by asking the Government to commission an independent technical assessment with all possible speed. The assessment would cost a tiny proportion of the proposed minimum £6bn spend on NPfIT and could save many times its cost.

One of the immediate consequences was that the signatories all received invitations from the Director-General of NPfIT to discuss the concerns expressed. Following a meeting at NHS attended by representatives of the signatories on 20 April 2006 the following Agreed Statement was issued, and placed on the NHS Connecting for Health web-site,

Meeting held with academics 20 April 2006

At the meeting on 20 April between the six representatives of the 23 signatories and NHS Connecting for Health a constructive and fruitful dialogue occurred.

The representatives expressed their agreement with and support for the overall goals of the programme as expressed in the meeting. There was agreement that a constructive and pragmatic independent review of the programme could be valuable. The parties agreed to meet again to consider further details of how such a review might best be conducted and its terms of reference.

To be exact an initial incorrect version of the statement [text in Appendix 2] was first placed on the Connecting for Health web-site, shortly after meeting, but replaced by the above corrected version once we had pointed out a small but significant error. The Agreed Statement is in fact no longer on the CfH web-site. (The replacement text provided on the CfH web-site as of 12 Oct 2006, is also given in Appendix 2.)

Following receipt of our Open Letter the House Select Committee requested from us, and were provided with, a memorandum [Appendix 3] containing a more detailed proposal and with the following suggestions for the terms of reference for an independent technical assessment of NPfIT.

Proposed Terms of Reference for an Inquiry into NPfIT

The Review should be pragmatic and constructive, and is intended to assist the NHS to achieve its overall aims. As a contribution to establishing confidence in both NPfIT and in the review itself, the review will be an open one. The final report and any interim reports will be published, and evidence given to the review will be made publicly available as far as possible. The review will be guided by an international expert advisory board. The review will undertake the following tasks.

1. Determine the detailed specifications that presently define the technical goals of the NPfIT systems, and examine the processes through which these specifications have been shown to meet the needs of all the users of the systems.
2. Consider the architectural approach that has been adopted to meet these specifications, in particular regarding the decisions made concerning centralised versus federated approaches to system construction, and the replacement or reuse of existing applications.
3. Assess the mechanisms used to control system evolution and manage change, assess the gap remaining between user requirements and system specification, and establish whether the rate of specification change is increasing or decreasing.
4. Assess whether the detailed technical architecture and application designs will deliver systems that match both the required functional aspects of those specifications and the required dependability aspects (safety, privacy, availability, reliability, accuracy, performance, usability, fault tolerance, and modifiability); if appropriate suggest necessary improvements.
5. Review the programme's plans and budgets to assess whether appropriate resources are available for development, process prototyping, pilot studies, modifications, interfacing with existing systems, roll-out, training, data cleansing and maintenance.
6. Review NPfIT risk management and consult with stakeholders to uncover major obstacles that could jeopardise the successful implementation of the new system and associated work practices; where appropriate, suggest possible ways to overcome these obstacles.

Notes

1. The Review should encompass the work of both National and Local Service Providers.
2. In order to perform its functions, the review team should have access to all information available to the Secretary of State.
3. It shall include a formal public consultation conducted under Cabinet Office guidelines.

(The Memorandum and Terms of Reference were sent to the Health Select Committee 14 May 2004, together with an initial version of the Bibliography of Published Concerns.)

1.2. Media Commentary on the Open Letter and the Agreed Statement

1.2.1. CfH says it has 'no objection' to a review (21 Apr 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=1841

" Connecting for Health has agreed with its academic critics that " a constructive and pragmatic" independent review of the National Programme for IT could be valuable, according to a statement issued today. A CfH official meanwhile told EHI that the meeting " was extremely cordial" , and said that " CfH had no objection to an independent taking place" . The statement issued today follows on from a meeting held yesterday between Connecting for Health's chief executive, Richard Granger, and six representatives from the 23 UK-based academics who wrote an open letter calling for an independent technical review of the national programme. Describing the meeting as a " constructive and fruitful dialogue" , the CfH statement continued: " The representatives expressed their agreement with and support for the overall goals of the programme in the meeting. There was agreement that a constructive and pragmatic independent review of the programme could be valuable. The parties agreed to meet again to consider further details of how such a review might best be conducted and its terms of reference." The academics had said in their letter, addressed to the House of Commons health select committee: " Concrete, objective information about NPfIT's [National Programme for IT] progress is not available to external observers. Reliable sources within NPfIT have raised concerns about the technology itself. " The National Audit Office report about NPfIT is delayed until this summer, at the earliest; the report is not expected to address major technical issues. As computer scientists, engineers and informaticians, we question the wisdom of continuing NPfIT without an independent assessment of its basic technical viability." As the academics acknowledged, the national programme is already under scrutiny by the National Audit Office and, in addition, Richard Jeavons, CFH's director of service implementation has said a " refresh" of the programme is underway, though this would appear to be a review of the programme's alignment with central policy for the NHS.

1.2.2. Controversial NHS IT system 'under review' (21 Apr 2006)

24Dash.com

http://www.24dash.com/content/news/viewNews.php?navID=3&newsID=5032

" An independent review of the controversial NHS IT system appears more likely today as question marks grow over the current scheme designed to link together over 30,000 GPs and 300 hospitals across the UK. Earlier this month, 23 computer experts wrote an open letter to MPs calling for an independent audit of the £6.2 billion system which was targetted for installation by 2012. It involves an online booking system, a centralised medical records system for 50 million patients, e-prescriptions and fast computer network links between NHS organisations. The open letter asked if " realistic assessments" had been carried out of how much data the system will have to cope with. It said: " Concrete, objective information about NPfIT's progress is not available to external observers. " As computer scientists, engineers and informaticians, we question the wisdom of continuing NPfIT without an independent assessment of its basic technical viability." 24dash reported the comments of South Norfolk MP Richard Bacon last month as he urged the National Audit Office to investigate the matter, saying the project had " many of the hallmarks of a classic IT fiasco" . Yesterday, six representatives of those who signed the letter met with NHS Connecting for Health (NHS CFH), which is responsible for the programme. The NHS CFH released a statement today suggesting an independent audit could happen. It said: " At the meeting on 20 April between the six representatives of the 23 signatories and NHS Connecting for Health a constructive and fruitful dialogue occurred. " The representatives expressed their agreement with and support for the overall goals of the programme in the meeting. " There was agreement that a constructive and pragmatic independent review of the programme could be valuable. " The parties agreed to meet again to consider further details of how such a review might best be conducted and its terms of reference." The magazine, Computer Weekly, which has campaigned for an audit of the system, said it welcomed the announcement.

1.2.3. Computer experts' anxieties force review of NHS system (22 Apr 2006)

Daily Telegraph

http://www.ixdata.com/imgs/telegraph22iv2006.jpg

" The Government bowed to pressure yesterday to conduct an independent review of the £6.2 billion computerized online booking system for the National Health Service. . . After meeting representatives of the letter's signatories NHS Connecting for Health, which is responsible for the programme, suggested yesterday that an independent audit could happen. It added: " The parties agreed to meet again to consider further details of how such a review might best be conducted and its terms of reference." "

1.2.4. National programme accepts value of IT audit (25 Apr 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/04/25/215532/NationalprogrammeacceptsvalueofITaudit.htm

" Connecting for Health, the agency that runs the national programme for IT in the NHS, has agreed with 23 leading academics that an independent audit of the scheme could be valuable. The agency's agreement came when Richard Granger, director general of NHS IT, met academics last week at Richmond House, the headquarters of the Department of Health. The meeting was arranged at short notice after Computer Weekly revealed that the 23 experts in computer-related sciences had written an open letter to the House of Commons Health Committee asking for an independent audit of the national programme. In a statement, Connecting for Health said that at the meeting on 20 April " there was agreement that a constructive and pragmatic independent review of the programme could be valuable" . Both parties " agreed to meet again to consider further details of how such a review might best be conducted and its terms of reference" . The agreement was in contrast to the initial hostile reaction to the audit call by health minister Caroline Flint. . ."

1.2.5. Why IT is not like building bridges (26 Apr 2006)

Computing

http://www.computing.co.uk/computing/comment/2154832/why-building-bridges

" Once again public sector IT is in the news, and not in a good way. A group of academics say the £6bn National Programme for NHS IT (NPfIT), now two years into its 10-year lifespan, is fundamentally flawed and should be paused for an independent review. Computing is by no means universally forgiving of government technology. Clearly if problems are irremediable, good money should not be thrown after bad. But it is becoming too easy to dismiss every challenge as a crisis. That the phrase 'government IT programme' has become synonymous with disaster is a disaster in itself. After all, what is the alternative? Stick with paper and pens? . . . NPfIT is undoubtedly slower and more difficult than expected. But NHS sources say the problems are not flaws in the design, but management errors and an almost irresponsibly optimistic timetable. As one senior source puts it: 'The strategy is right, they just over-egged the expectations.' This is indeed a lesson that should have been learned. But to sacrifice the whole scheme is equally irresponsible. The issue is not just public relations, it is about understanding. Technology is still seen as just another form of engineering. But IT systems are not like bridges – they are a tool, not an entity. Arguably, giving NPfIT a name, a set of dates and a separate organisation was setting it up as a target for failure. Technology is a process, with no clear start, no clear end and ever-shifting goalposts. And as fast as IT itself evolves, the potential uses of it morph and multiply. There is no end date. The bridge is never built. But that does not mean it is a disaster. That is simply how it should be."

1.2.6. iSoft user group pushing for review of NPfIT (13 Jun 2006)

e-Health Insider

http://www.ehiprimarycare.com/news/item.cfm?ID=1939

" A primary care IT user group has backed calls for an independent review of the National Programme for IT (NPfIT), accusing the project of being unnecessarily secretive, failing to consult its members and producing systems that are not fit for purpose."

1.2.7. The Continuing Saga of NHS IT Folk (Jun 2006)

Symantec

http://www.symantec.com/en/uk/enterprise/Custom/nhs-itfolk.jsp

" In April 2006, in an open letter to the House of Commons Health Select Committee of the UK Parliament with a great deal of press fanfare, 23 UK academics called for an audit of the NHS Programme for IT (NPfIT). . . So what next? The academics were right to question the technical aspects, and the NAO the finances – although there is a House of Commons Public Accounts Committee which will be discussing the report as this OpinionWire is published, and they may be more critical than the NAO. . ."

1.3. Second Open Letter to the Health Select Committee

A further letter, by the same signatories, was sent to the Health Select Committee on October 6, 2006.

> Dear Mr. Barron
>
> In April this year, we wrote to you to express our concern that the National Programme for IT in the Heath Service is displaying many of the symptoms that we have observed in previous major IT projects that have subsequently failed. We suggested that your committee could resolve uncertainty about the NPfIT by commissioning an independent technical assessment with all possible speed. Your Second Clerk, Eliot Wilson, subsequently asked us to provide more detail of the sort of review that we believed was needed, and we sent proposed Terms of Reference on May 14th, along with further details of the issues that led to our letter. Since then a steady stream of reports have increased our alarm about NPfIT. We support Connecting for Health in their commitment to ensure that the NHS has cost-effective, modern IT systems, and we strongly believe that an independent and constructive technical review in the form that we proposed is an essential step in helping the project to succeed. As a review will take several months to organise, conduct and report, we believe that there is a compelling case for your committee to conduct an immediate Inquiry: to establish the scale of the risks facing NPfIT; to initiate the technical review; and to identify appropriate shorter-term measures to protect the programme's objectives. If your committee would like more detail of our concerns, we should be very happy to answer any questions orally or in writing.

1.4. Media Commentary on the Second Open Letter

1.4.1. Hold immediate NHS IT probe, experts tell MPs (10 Oct 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/10/10/219030/Hold+immediate+NHS+IT+probe%2c+experts+tell+MPs.htm

A group of leading computing academics has written a new open letter to MPs calling for an immediate inquiry into the NHS's £12.4bn National Programme for IT (NPfIT). The academics say a report on the programme in June by the National Audit Office did not answer any of their concerns. They are increasingly worried that the systems being built may not work adequately - and that even if they do work they may not meet the needs of many NHS trusts. In a new open letter to Kevin Barron, chairman of the House of Commons' Health Committee, the group says its members strongly believe that an independent technical review is an essential first step in helping the project to succeed. The letter says: " As a review will take several months to organise, conduct and report, we believe there is a compelling case for your committee to conduct an immediate inquiry to establish the scale of the risks facing the NPfIT." The group also wants the committee to help " identify appropriate shorter-term measures to protect the programme's objectives" . Plans for the NPfIT include systems to allow summary electronic medical records on 50 million patients to be shared, and also systems to enable hospital appointments to be booked online. Since the group's first open letter to the Health Committee in April, Accenture has announced it is withdrawing from its original £2bn NPfIT deal. The main software supplier to the programme, Isoft, has reported losses of £383m, and the Financial Services Authority has launched an investigation into the company. The chairman of the British Computer Society's Health Informatics Forum, Glyn Hayes, has questioned whether a centralised approach will work within the complex organisational structure of the NHS, and Computer Weekly has reported that some NHS trusts have been hit by more than 110 major incidents in four months."

1.4.2. Query over £12bn NHS IT upgrade (10 Oct 2006)

BBC News

http://news.bbc.co.uk/2/hi/uk_news/6035135.stm

Scientists who doubt a £12bn NHS computer upgrade will " work adequately" have urged MPs to launch an inquiry. Experts have signed an open letter to the Commons health select committee calling for the National Programme for IT to be probed. The upgrade includes electronic prescriptions and centralised medical records for 50 million patients. Computer Weekly magazine said 23 scientists signed the letter, addressed to committee chairman Kevin Barron. . . The letter states: " As a review will take several months to organise, conduct and report, we believe there is a compelling case for your committee to conduct an immediate inquiry to establish the scale of the risks facing NPfIT." Martyn Thomas, visiting professor of software engineering at Oxford University, and Ross Anderson, professor of security engineering at Cambridge University, are believed to be the lead signatories. A spokesman for NHS Connecting for Health said it was " open to scrutiny and recognises that other parties - from a range of backgrounds, not just computer science - may be able to offer helpful perspectives. " NHS Connecting for Health continues to be ready to engage with independent and appropriately experienced, apolitical experts and NHS Connecting for Health is currently exploring the possibility of creating a reference panel made up of a mix of academic and non-academic disciplines." Last month, it emerged there had been more than 110 major glitches with the system over the past four months. The failures were reported to have affected a number of hospitals in England, which have begun using parts of the new programme."

1.4.3. Call for NHS computer upgrade probe (10 Oct 2006)

The Guardian

http://www.guardian.co.uk/uklatest/story/0,,-6136744,00.html

" Scientists have called for an urgent inquiry into a controversial £12.4 billion IT upgrade for the NHS. Experts signed an open letter to the Commons Health Select Committee urging MPs to review the National Programme for IT (NPfIT). The scheme includes an online booking system, centralised medical records for 50 million patients and electronic prescriptions. But the 23 signatories of the letter, seen by Computer Weekly magazine, said they were not convinced that the programme would work adequately. Last month it emerged there had already been more than 110 major glitches with the technology over the past four months. . ."

1.4.4. Experts Warn NHS Computer System May Be £20BN Flop (10 Oct 2006)

Daily Mail

" THE £20billion NHS computer system may not work, Britain's leading computer scientists warned last night. The experts called for an urgent inquiry into the crisis- hit scheme - the biggest civilian IT project in the world. It is already three years late and over budget. In an open letter to MPs on the Commons Health Select Committee, 23 eminent scientists from universities such as Oxford and Cambridge have raised major doubts about the Connecting For Health project. The letter, addressed to committee chairman Kevin Barron, states: 'As a review will take several months to organise, conduct and report, we believe there is a compelling case for your committee to conduct an immediate inquiry to establish the scale of the risks facing the National Programme for IT (NPfIT).' Its lead signatories are Martyn Thomas, visiting professor of software engineering at Oxford University, and Ross Anderson, professor of security engineering at Cambridge University. The 23 academics - mostly respected professors - say they are not convinced the project will work at all. They also fear the systems will be redundant by the time they come fully into use. The comments are another blow to the project, which includes an online booking system, centralised medical records for 50million patients and the facility to draw up electronic prescriptions. . . The British Medical Association has also warned that doctors have lost faith in the new system as they have not been properly consulted over it. . . The academics, who are independent of the NHS, feel they are able to express their concerns more freely. This is the first time that scientists have called for an urgent inquiry of this kind. In a previous letter, they warned: 'We question the wisdom of continuing the national programme for IT without an independent assessment of its basic technical viability.'"

1.4.5. Academics demand NHS IT review (10 Oct 2006)

ZDNet UK

http://news.zdnet.co.uk/itmanagement/0,1000000308,39283996,00.htm

" Experts are worried that the NHS National Programme for IT will fail, and are demanding an independent technical review. A group of leading UK-based academics have again called on the

Government to undertake an immediate and independent review of the NHS' multi-billion pound IT programme, NPfIT. The group, which comprises 23 computing experts from a wide array of British universities, say urgent action is necessary to prevent the National Programme for IT from failing. They are angered by a lack of action following a succession of project disasters over the summer. . . " The programme is exhibiting more and more indications that it could fail. There are more reasons that an independent review should be held," said Martyn Thomas, a lecturer in IT at the University of Oxford, speaking to ZDNet UK on Tuesday. . . In April, they met with programme director general Richard Granger following an earlier letter, but they are not satisfied with the progress made since. " We were given the political runaround first time," said Ross Anderson, a security expert at the University of Cambridge. " But it is not a happy project, and ministers have to face up to that fact." Anderson said that the independent review the group is demanding should utilise sufficient expertise in IT projects, but he warned that it " might be turned by government into another review from the NAO" . The National Audit Office reviewed the programme in a report released in June, but the content of the report came under fire after several criticisms were removed. . . Asked by ZDNet UK about the consequences of a continued lack of action on the programme, Anderson added: " One possibility is that it would be the end of the NHS. Eventually it [the programme] may face systematic failure." The NHS distanced itself from the academics' letter, saying in a statement that it was a matter for the Health Committee. " Connecting for Health [the part of the NHS which runs NPfIT] is open to scrutiny and recognises that other parties — from a range of backgrounds, not just computer science — may be able to offer helpful perspectives," said the NHS. The statement continued: " Connecting for Health [CfH] is currently exploring the possibility of creating a reference panel made up of a mix of academic and non-academic disciplines. [A] constructive and pragmatic independent review of the programme could be valuable." ZDNet UK contacted CfH, to confirm whether it would undertake the independent review, and for a response to the academics' comments, but it refused to comment. . ."

1.4.6. Call for NHS computer upgrade probe (10 Oct 2006)

Haber Saglık, Turkey

http://www.habersaglik.com/default.asp?Act=Dt&CatId=1&NwId=75421

" Scientists have called for an urgent inquiry into a controversial £12.4 billion IT upgrade for the NHS. Experts signed an open letter to the Commons Health Select Committee urging MPs to review the National Programme for IT (NPfIT). The scheme includes an online booking system, centralised medical records for 50 million patients and electronic prescriptions. But the 23 signatories of the letter, seen by Computer Weekly magazine, said they were not convinced that the programme would work adequately. Last month it emerged there had already been more than 110 major glitches with the technology over the past four months. The failures were said to have affected dozens of hospitals in England which have started using parts of the new programme. . ."

1.4.7. Warner rejects call for CfH architecture review (27 Oct 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2224

" Health minister Lord Warner has rejected calls from leading computer academics for an independent review of the technical architecture of the NHS national programme for IT. Speaking at a conference in London yesterday he said: " ...I do not support at the call by 23 academics to the House of Commons Health Select Committee to commission a review of NPfITs technical architecture. I want the programme's management and suppliers to concentrate on implementation, and not be diverted by attending to another review." The 23 academics earlier this month wrote an open letter to the Commons Health Select Committee calling for an independent review of the £12bn NHS IT programme. In their letter the group urgently called for an independent technical review, describing it as an essential step to help ensure the project succeeds. The group urged the Health Select Committee to carry out " an immediate inquiry to establish the scale of the risks facing the NPfIT" . The 23 leading computer sciences related academics first wrote to the Health Select Committee in April this year expressing their concerns about the technical feasibility and risks associated with the £12bn NHS IT programme, currently running two years behind schedule. They were subsequently invited to meet with NHS IT director Richard Granger who subsequently invited briefing. CfH and the academics issued a joint statement saying " a constructive and pragmatic independent review of the programme could be valuable" . No such review has since occurred. Warner said the CfH programme was central to the government's NHS modernization agenda and had already been vindicated by July's National

Audit Office report. " A positive report was received from the National Audit Office this summer despite subsequent attempts to undermine the objectivity of that report." . . . Notable by its absence though was any mention of the delays to the systems at the heart of the programme: the national summary and local detailed Care Record Service applications that are meant to deliver detailed integrated electronic medical records for everyone in England. To date in the secondary care sector the programme, through its prime contractors, has delivered just over a dozen replacement patient administration systems, and a handful of very few clinical systems. Key suppliers have either been sacked or replaced, creating further delays. Warner acknowledged that not all had gone smoothly: " Given its size and ambition it is not surprising that there are glitches. But overall we are well advanced with delivering the infrastructure of Connecting for Health." He, however, restated the government's commitment for the programme: " " Let me be clear and unequivocal: the Government is committed to ensuring that NPfIT is fully implemented and delivered. We are not going to be deflected by naysayers from any quarter. We recognise that more needs to be done on articulating the benefits that the programme will bring to patients and also to NHS staff." "

1.5. Media Commentary on our NHS IT Info Dossier

1.5.1. Compute this (12 Oct 2006)

Daniel Finkelstein's Rolling Guide to the Best Opinion on the Web, Times Online

http://www.timesonline.typepad.com/comment/

" http://editthis.info/nhs_it_info/Main_Page NHS 23 is a fascinating and horrifying site. It provides an account of the repeated warnings given to Parliament by 23 of the UK's most respected IT academics about the multi-billion pound NHS computer project. They basically warned from the beginning that a fiasco loomed. Take this: " As experts in complex systems, we are concerned that the NHS National Program for IT (NPfIT) is starting to show many of the symptoms displayed by large IT and business change projects that have failed in the past. We have a wide range of IT backgrounds and experience, and have studied many failed projects, as well as many that succeeded. Our professional opinion is that a constructive, independent review is urgently needed." It was written to the Commons' Health Committee in May 2004. Last week, they had to send the same letter again. Anyway, you can pretty much stop anywhere on the site and read about an unfolding multi-billion pound scandal."

1.5.2. Academics set up wiki to monitor NHS IT (18 Oct 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2204

" The 23 academics who wrote to Parliament outlining their concerns about the progress of the National Programme for IT have set-up a wiki to track media reports and act as a resource for NHS IT. The NHS 23 wiki, available at http://editthis.info/nhs_it_info/, features links to articles tracking problems with various suppliers and coverage of the academics' open letter and the agreed statement. It was developed over the past few months as a resource and reference tool for those interested in the progress of National Programme for IT (NPfIT). Ross Anderson, professor of security engineering at the Computer Laboratory at the University of Cambridge and one of the 23 academics, told E-Health Insider: " This is something that we have developed for our own use over the last few months. We have finally decided to make it publicly visible." The wiki contains links to articles by E-Health Insider and other publications collected under themes, as well as primary sources such as relevant official records of Parliament, NPfIT specifications and policies and reports relating to the National Audit Office and Public Accounts Committee investigations. . .

The wiki seeks to clarify the academics' own position on the progress of CfH and the call for a review. According to Professor Anderson, the agreement which CfH and the experts arrived at in the meeting that followed their letter was posted on the agency's site with a small but crucial omission, which he argues changed the meaning. After the first edit, Anderson explained that the agreement was once again altered and republished at a later, unknown date. The academics' wiki contains all three versions of the statement including the one that they say was the original agreed by the two parties. Professor Anderson stressed that the wiki was intended to be a reference point and not a campaigning platform, and was similar to the links and articles posted on the Foundation for Information Policy Research site. . ."

1.5.3. Main Page - NHS It Info (19 Oct 2006)

Informaticopia

http://www.rodspace.co.uk/blog/blogger.html

" This site (set up as a wiki but without public editing rights) has been created by the 23 academics who wrote to Parliament outlining their concerns about the progress of the National Programme for IT, under the banner of NHS 23. It provides a access to a range of documents relating to the NHS NPfIT. These range from the original and subsequent letters addressed to the House of Commons Health Select Committee to media items and documents detailing supplier issues. The site does provide some useful insights and promises to offer more - but it might be worthwhile enabling some degree of public editing rights. Although I'm sure there would be some vandalism - the potential benefit of mobilising " group think" or a " community of practice" would outweigh the risks."

1.5.4. University scientists share their dossier on NPfIT concerns (23 Oct 2006)

British Journal of Healthcare Computing & Information Management

http://www.bjhc.co.uk/news/1/2006/n610012.htm

" NHS 23 wiki (http://editthis.info/nhs_it_info/) is a dossier of documents, reports, letters and press coverage about concerns with the direction and progress of England's National Programme for IT in the NHS. It is compiled by the group of 23 computer scientists from universities in the UK urging the Government to undertake an independent and detailed technical review of the NPfIT, originally for their own reference but now available to general readership. (A 'wiki' is a collation of information about a particular subject published on a dedicated website for reference. It can be added to, updated and edited, either by any visitor to the site or, as in this case, only by specified contributors.)"

1.5.5. The new 100 most useful sites (21 Dec 2006)

The Guardian

http://technology.guardian.co.uk/weekly/story/0,,1975939,00.html

" . . . Politics: The MySociety team remains unbeatable for turning Hansard inside out with [http://theyworkforyou.com Theyworkforyou] and [http://publicwhip.org.uk Publicwhip], but bloggers have begun to expose the unwritten workings of politicians to greater public scrutiny too. Guido Fawkes' [http://5thnovember.blogspot.com blog] has the inside gossip from Westminster, while [http://no2id.net NO2ID] agitates on arguably the most important political and technological issue around, while [http://editthis.info/nhs_it_info NHS 23] is a wiki outlining the problems with the political, technological and medical drama of the NHS computerisation programme. . ."

1.5.6. Academics express NPfIT concerns (23 Jan 2007)

Kable's Government Computing

http://www.kablenet.com/kd.nsf/Frontpage/CF40FCF7D3179EDC8025726B005A04C5?OpenDocument

"A group of academics have issued a 'dossier of concerns' called for a technical review of the NHS National Programme for IT (NPfIT). Brian Randell, Emeritus professor of Computing Science at Newcastle University, told GC News on 22 January 2007 that the 200 page dossier containing "everything said about the NPfIT over the last few years" will help Parliament's Health Select Committee with its pending inquiry. The committee is due to start its inquiry into the progress of the NPfIT this month, Randell said, and the dossier, containing a selection of media reports, select committee responses and supplier issues from the past few years, is to be used as an "encyclopaedia" of concerns. However, the 23 academics' ultimate campaign is for the government to instigate a wider review of the programme's objectives, technical architecture and implementation. Randell said: "We are pleased that the committee has recently stated that our dossier will prove helpful in their planned inquiry, as well as to the detailed technical review, which we hope will ensue." The dossier states: "It (the dossier) brings together a host of evidence, covering a very wide range of issues that in combination suggest the project is in serious trouble. Given the scale of the project, one of the largest ever attempted…reinforces the need for a careful, open, honest and independent examination of the situation." The dossier follows the released late last year of the British Computer Society Health Informatics Forum (BCS HIF) report, The Way Forward for NHS Health Informatics. It acknowledges

the successes of the programme, but says Connecting for Health has placed too much emphasis on central decision making. Its forward refers to the "top down nature" of the programme and lack of local ownership, and says this is one reason why many NHS staff have yet to see its potential for positive change. The Department of Health is reportedly holding a meeting on 26 January 2007 to discuss, among other things, the progression of the programme."

(Repeated on the Register, under the title "Academics compile 'encyclopaedia of concerns' about NPfIT" at http://www.theregister.co.uk/2007/01/23/academics_complile_npfit_dossier/.)

1.5.7. Academics air 'concerns' over NPfIT (24 Jan 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/01/24/221376/academics-air-concerns-over-npfit.htm

"A group of academics have published a "dossier of concerns" about the NHS National Programme for IT (NPfIT) and have called for a technical review of the programme. The NPfIT has run into a variety of problems over the last two years and leading suppliers to the programme, such as Accenture, have pulled out from the project or others, like BT, have got behind in their contracted work. Brian Randell, Emeritus professor of Computing Science at Newcastle University, has led the dossier initiative, and was among the academics who first expressed their concerns as a group about the NPfIT last year. The dossier is designed to help Parliament's Health Select Committee with its pending inquiry on the NPfIT project. This inquiry is expected to start later this month. The 212 page dossier includes a variety of media reports on the NPfIT - including a number from Computer Weekly - and information on supplier issues from recent years. The academics wider aim is to instigate a review of the programme's objectives and implementation."

1.6. Health Select Committee Inquiry

In late November the Health Select Committee reversed their earlier decisions, and announced that they would hold an inquiry into NPfIT.

1.6.1. Future Work Programme of the Health Committee (22 Nov 2006)

UK Parliament

http://www.parliament.uk/parliamentary_committees/health_committee/hcpn061122.cfm

"The Committee has decided to undertake the following additional inquiries in 2007: Aspects of IT in the NHS. . . . Further details, including terms of reference, will be announced in due course."

1.6.2. MPs will hold inquiry into £12bn NHS IT plan (28 Nov 2006)

Computer Weekly

http://www.computerweekly.com/Home/Articles/2006/11/28/220206/MPs+will+hold+inquiry+into+%C2%A312bn+NHS+IT+plan.htm

"The House of Commons' Health Committee has agreed to hold an inquiry into key facets of the £12.4bn NHS National Programme for IT (NPfIT) after some MPs expressed concerns that the scheme may be foundering. The decision reverses a resolution taken by the parliamentary committee only weeks ago not to hold an inquiry, and vindicates a campaign led by leading academics, Computer Weekly and MPs. The inquiry, the terms of reference for which will be announced shortly, is expected to involve the committee's members questioning ministers and officials at a series of hearings. MPs on the committee can take in evidence from trust executives who are concerned about the lack of progress in the delivery of core patient systems for hospitals, and from GPs about whether centralised electronic health records will be secure. The committee in October rejected an inquiry partly because some members believed the programme was too complicated to be investigated by non-expert MPs. Its change of heart comes after Computer Weekly provided some committee members with new evidence - including a confidential briefing paper on the NPfIT from directors of informatics at a large NHS trust. The paper expressed profound concerns about some aspects of the NPfIT. Computer Weekly has also learned that strong support for an inquiry came from Dr Richard Taylor, a former hospital consultant and the only independent MP in the House of Commons. Taylor told Computer Weekly that he was originally not in favour of an inquiry, but changed his mind after an informal briefing by BT, one of the main suppliers to the NPfIT. He said BT's briefing had been so unremittingly positive about

the programme that he found it lacked credibility, and this made him wonder whether the programme was as successful as the supplier claimed. It is seven months since 23 academics, supported by this magazine, wrote an open letter to the committee calling on its members to ask the government to commission an independent audit into the national programme. Martyn Thomas, one of the 23 academics who wrote the open letter to the health committee, said, " Speaking on behalf of the 23, we welcome the news that the Health Committee intends to hold an inquiry early in the new year. We intend to submit evidence to the inquiry further supporting our call for a full, independent and open review of the NPfIT."

1.6.3. Opportunity for clarity (28 Nov 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/11/28/220171/Opportunity+for+clarity.htm

"We are delighted that the House of Commons Health Committee is going to hold an inquiry into the NHS's £12.4bn National Programme for IT. We have campaigned hard for an inquiry, as have 23 leading academics who wrote an open letter to the committee. At first the committee's members seemed none too enthusiastic about the idea of an inquiry. They were put off a little by the programme's complexity. Since then Computer Weekly has provided information to some of the members on the concerns at trust board level about the way things are going. Now the committee members have realised that they can see the programme from the perspective of doctors and nurses and if the scheme is too difficult for clinicians to understand, then there is something fundamentally wrong with it. Senior IT executives in trusts who have not been able to express opinions publicly will have the opportunity to write to the committee, requesting anonymity, and raising questions they think MPs should ask. The committee will also be taking in papers from specialists. The inquiry will provide a chance for officials to say that the NHS has moved on since the programme was first announced, and concede that it needs to change. The committee could then be a stage to announce changes. We hope that MPs will consider the project's strengths and weaknesses with an open mind, and not be critical or defensive according to party alignments. This is also a chance for officials and ministers to explain how patients will benefit from the enormous public investment in this project, and what lessons have been learned so far. They will, we hope, answer questions clearly and openly - for clarity and openness have been largely missing so far."

1.6.4. We must stop pandering to the NPfIT cash cow (28 Nov 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/11/27/220120/Your+shout+No+high+risk%2c+training+issues%2c+NPfIT+failure.htm

"The missed NHS IT deadline has come as no surprise to those in the IT sector. The NPfIT will never get back on track, and was never on track originally. It breaks every rule of project management, from scoping right through to delivery, and is completely failing to address the requirements of NHS clinicians. The project management team has approached the matter as if they are dealing with a nation of identikits, not individual idiosyncratic patients. No right-thinking manager would attempt to deploy systems on a national basis like this - it makes no sense and simply cannot be achieved. Over £20bn of taxpayers' money has been wasted on a system that was destined to fail. The concept is undoubtedly laudable, but it has been approached from the wrong angle from the outset. Smaller software companies already serving the NHS were not permitted to tender for NPfIT contracts, and those that were awarded them had no healthcare experience. In the event, the larger IT firms actually outsourced to the very companies who had been refused contracts. Further, integrating all the regional systems that were created to comprise the final NPfIT was always going to be an uphill struggle to say the least. The NPfIT is five years overdue - how many more casualties are going to be caused by IT industry fat cats pandering to the cash cow the NPfIT has become?" [Richard Barker, Sovereign Business Integration]

1.6.5. Health select committee to investigate NPfIT (28 Nov 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2299

"An inquiry into the National Programme for IT (NPfIT) will be held by the House of Commons' health select committee, according to a report in Computer Weekly. The committee originally decided

not to hold such an inquiry, but are reported to have changed their minds after they were provided with documents from the magazine, including a confidential briefing paper on the NPfIT from directors of informatics at a large NHS trust, which expressed 'profound concerns about some aspects of the NPfIT'. Dr Richard Taylor, a former hospital consultant and independent MP for Wyre Forest, also gave the inquiry strong support after he had an informal briefing with BT, which 'had been so unremittingly positive about the programme that he found it lacked credibility, and this made him wonder whether the programme was as successful as the supplier claimed.' MPs on the committee will now be able to take evidence from trust executives concerned about the lack of progress in the delivery of patient administration systems in hospitals, and from GPs about whether centralised electronic health records will be secure. Martyn Thomas, one of the 23 academics who called for such an inquiry in April, said: " Speaking on behalf of the 23, we welcome the news that the health committee intends to hold an inquiry early in the new year. We intend to submit evidence to the inquiry further supporting our call for a full, independent and open review of the NPfIT." Richard Granger, chief executive of Connecting for Health, told the Financial Times yesterday that a combination of the NHS's financial troubles and problems with software means that the installation of new patient administration systems in hospitals is likely to be further delayed."

1.6.6. Health Select Committee Inquiry into "The Electronic Patient Record and its use" (5 Feb 2007)

United Kingdom Parliament

http://www.parliament.uk/parliamentary_committees/health_committee/hcpn070205.cfm

"The inquiry will focus particularly on the following areas:

- What patient information will be held on the new local and national electronic record systems, including whether patients may prevent their personal data being placed on systems;
- Who will have access to locally and nationally held information and under what circumstances;
- Whether patient confidentiality can be adequately protected;
- How data held on the new systems can and should be used for purposes other than the delivery of care e.g. clinical research; and
- Current progress on the development of the NHS Care Records Service and the National Data Spine and why delivery of the new systems is up to 2 years behind schedule."

1.6.7. MPs' health committee confirms terms of NHS IT inquiry (7 Feb 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/02/07/221679/mps-health-committee-confirms-terms-of-nhs-it-inquiry.htm

"The House of Commons Health Committee has published its terms of reference for an inquiry it will hold into facets of the NHS National Programme for IT (NPfIT). The committee decided to undertake an inquiry last November, following a campaign led by leading academics, Computer Weekly and MPs. This week, the committee said the inquiry will focus on current progress on the development of the NHS care records service and the national data spine – and why delivery of the new systems is up to two years behind schedule. The care records service and data spine are cornerstones of the NPfIT, a £12.4bn project to refresh NHS IT systems and create 50 million electronic patient records. . . In May 2006, 23 academics wrote an open letter to the committee, calling on its members to ask the government to commission an independent audit into the national programme, voicing concerns over its technical feasibility and engagement with clinicians. They also published a dossier of their concerns over the programme last week."

1.6.8. Health Select Committee outlines NPfIT inquiry (9 Feb 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2471

"The House of Commons Health Committee has announced details of what it intends to look into as part of its inquiry into the NHS National Programme of IT. As EHI reported in November, the Health Select Committee announced in November its intention to undertake an inquiry. At a meeting this week, the committee said that the NPfIT inquiry will focus on current progress on the development of

the NHS care records service and the national data spine - and why delivery of the new systems is up to two years behind schedule. Included in the committee's agenda will be what patient information will be held on the new local and national electronic record systems, including whether patients may prevent their personal data being placed on systems and who will have access to locally and nationally held information and under what circumstances. It will also look at whether patient confidentiality can be adequately protected and how data held on the new systems can and should be used for purposes other than the delivery of care, such as clinical research. . ."

1.6.9. MPs to hold NHS IT inquiry (14 Feb 2007)

Computing

http://www.computing.co.uk/computing/news/2183202/mps-hold-nhs-inquiry

"The House of Commons Health Committee is to hold an inquiry into the electronic patient records system at the heart of the £6bn National Programme for NHS IT (NPfIT). According to terms of reference published last week, MPs will focus on patient data issues such as where information will be held, who will have access to it and how confidentiality can be protected. The committee will also consider implementation issues affecting the programme, which is about two years behind schedule. The inquiry is one of a series of reviews of the programme in the past 12 months. In June, public spending watchdog the National Audit Office published a report on the progress, and since the appointment of NHS chief executive David Nicholson in July there have been at least two further internal reviews, according to health service insiders. At a conference this month, Nicholson reiterated his support for NPfIT and, while acknowledging the need for more engagement with NHS users, he rebutted calls for an independent review. Progress on the National Programme is patchy. The N3 broadband network is now fully rolled out more than two months ahead of schedule, and implementation of electronic X-ray systems is considered broadly successful. But installation of complex hospital administration software has all but ground to a halt, and NHS staff buy-in issues are still not resolved. One result of Nicholson's reviews is December's creation of the NPfIT Local Ownership Programme (Nlop), which aims to give local health communities a greater role in the technology programme. But NHS IT staff are not convinced the plan will go far enough. 'If it actually happened, Nlop would be helpful, but it seems there is not going to be any money or contract management – and supplier discussions are to remain central – so it just looks like responsibility without authority,' said a senior source. The deadline for submissions to the health committee inquiry is 16 March."

1.6.10. The Electronic Patient Record: Written Evidence (25 Apr 2007)

House of Commons Health Committee

http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/422/422ii.pdf

(A 196-page compilation.)

1.6.11. The Electronic Patient Record: Uncorrected Oral Evidence (26 Apr 2007)

House of Commons Health Committee'

http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/uc422-i/uc42202.htm

1.6.12. The Electronic Patient Record: Uncorrected Oral Evidence (10 May 2007)

House of Commons Health Committee

http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/uc422-ii/uc42202.htm

1.6.13. Our Submission to the EPR Inquiry (15 Mar 2007)

"Executive Summary: This submission addresses the issue: "Current progress on the development of the NHS Care Records Service and the National Data Spine and why delivery of the new systems is up to 2 years behind schedule". It draws on the Dossier of Concerns regarding NPfIT that we have assembled from a variety of sources, and recently made available to Members of the Select Committee. Despite the difficulty of assessing NPfIT's plans and progress, caused by the Programme's size and complexity, the secrecy regarding detailed system specifications, and the atmosphere of fear that prevents many NHS staff from expressing criticisms, our Dossier contains extensive evidence, some

but by no means all anecdotal, that supports our assessment that the Programme is in serious danger. The huge range of problems, covering technical matters, methods of procurement, the lack of buy-in from stakeholders, privacy and security questions, delivery delays and spiralling costs, greatly complicate the task of correctly identifying the fundamental causes and most effective remedies. Hence our recommendation that a detailed technical review of the Programme be commissioned, a review that must be open and manifestly independent if public confidence in NPfIT is to be regained."

(See Appendix 8.)

1.6.14. Supplementary Evidence on Independent Reviews

"At the Committee's second evidence session, Dr Richard Taylor asked Professor Brian Randell to provide a short note describing where independent technical reviews had previously helped major projects to succeed. This supplementary evidence has been prepared in response to that request."

(See Appendix 11.)

1.6.15. The Electronic Patient Record: Uncorrected Oral Evidence (7 Jun 2007)

House of Commons Health Committee

http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/uc422-iii/uc42202.htm

1.6.16. The Electronic Patient Record: Uncorrected Oral Evidence (14 Jun 2007)

House of Commons Health Committee

http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/uc422-iv/uc42202.htm

1.6.17. Director general defends IT plan and blasts critics of the electronic patient record (3 May 2007)

Health Service Journal

http://www.hsj.co.uk/healthservicejournal/pages/N1/p13/070503

"Critics of the electronic patient record have been branded 'privacy fascists' by the Department of Health director general of IT. Richard Granger launched the attack at the first hearing of a Commons health select committee inquiry into the controversial project. 'People think they can assess the programme after researching it on Google,' he complained. 'A number of people are whipping up anxiety - privacy fascists - who want to dictate that no-one has a right to information anywhere.' But he admitted: 'No system is ever going to be totally secure.' Mr Granger compared concerns over patient confidentiality to an 1834 editorial in The Times, which had argued against the adoption of the stethoscope. The project will be largely implemented by 2010, although some parts of it are running roughly two years behind schedule, he told the committee. This is due to the specifications changing and a lack of consensus from doctors as to how the project should work, he said. He vigorously denied a suggestion by Labour MP Jim Dowd that this meant the original plan had been flawed. 'It would be a fantasy to imagine that halfway through a 10-year programme we would only be doing the same things we set out to do five years ago. . ."

1.6.18. Commons' Health Committee cannot agree unanimous report on key aspects of the NHS National Programme for IT (11 Sep 2007)

Computer Weekly - Tony Collins' Blog

http://www.computerweekly.com/blogs/tony_collins/2007/09/commons-health-committee-canno-1.html

"The Health Committee of the House of Commons is to publish a report on aspects of the NHS's £12.4bn National Programme for IT [NPfIT] without the contents of the document being agreed by all of the MPs on the committee. The contents of the report "Electronic Patient Record" will not be known publicly until it is published on Thursday 13 September 2007 but I understand that MPs on the committee were unable to agree parts of it without specific sections being put to a vote. And when voting over the contents was completed, the final report was not signed by all members. It is rare for the Labour-dominated Health Committee to publish a report without the unanimous support of its MPs. It may show the extent to which the NPfIT has become politcised. This sensitivity is due in part to the

scale of the financial commitment to the programme: it is the government's biggest investment in IT. . . Now the Health Committee, which comprises mainly Labour MPs under a Labour loyalist chairman Kevin Barron, is expected to follow the government's line in rejecting calls for any published independent review of the NPfIT. Twenty-three academics had written an open letter to the committee to ask that it call on the government to commission an independent review. But during hearings of the committee earlier this year Barron had expressed little enthusiasm for too much questioning of the NPfIT. He said: "If you go back in years in medical history, into some of the things that doctors were doing at the time, which made major breakthroughs, people were sceptical about [these]. People were questioning even what their peer groups were doing in terms of whether it was the right thing to do." He said that life expectancy has been extended to an "incredible" extent largely because of the "people doing things for the first time." In what seemed to be a criticism of the 23 academics who had called for an independent review of the NPfIT Barron added: "Quite frankly if people were questioning [medical breakthroughs in history] on the basis of 'we don't think it will work' or 'it might not be manageable' and everything else, we may not have made the progress through the centuries that we have done, in society in general and throughout the world. This sort of questioning every little minutiae, or potential every little minutiae, is something that is non-progressive, for what of a better expression." The Health Committee had launched an inquiry into NHS IT with an initial reluctance. When some MPs on the committee sought to have an inquiry, Barron was reluctant to do so, in part because of the complexity of the subject. When the committee subsequently agreed to an inquiry it was held with narrow terms of reference which did not include scrutiny of the whole programme. Thursday's report is expected to include some criticisms, particularly over the lack of consultation of medical professions." The Electronic Patient Record (13 Sep 2007)

1.6.19. The Electronic Patient Record (13 Sep 2007)

House of Commons Health Committee

http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/422/422.pdf

Summary:

"Electronic patient record (EPR) systems have the potential to bring huge benefits to patients and are being implemented in health systems across the developed world. Storing and sharing health information electronically can speed up clinical communication, reduce the number of errors, and assist doctors in diagnosis and treatment. Patients can have more control of their own healthcare. Electronic data also have vast potential to improve the quality of healthcare audit and research. However, increasing access to data through EPR systems also brings new risks to the privacy and security of health records. In England, implementing EPR systems is one of the main aims of the 10-year National Programme for Information Technology (NPfIT), which was launched in 2002, building on earlier initiatives. The main plank of the NPfIT programme is the NHS Care Records Service (NCRS) which will create two separate EPR systems: a national Summary Care Record (SCR), containing basic information, and local Detailed Care Records (DCRs), containing more comprehensive clinical information. NCRS will also include a Secondary Uses Service (SUS) which will provide access to aggregated data for management, research and other 'secondary' purposes. . . Maintaining the security of the SCR and other NCRS systems is a significant challenge. Each SCR will be potentially available across the country to a wide range of different users, making operational security especially problematic. Connecting for Health, the organisation responsible for delivering NPfIT, has taken significant steps to protect operational security, including strong access controls and audit systems. However, the impact of these measures in the complex environment of the NHS is difficult to predict. We recommend a thorough evaluation of operational security systems and security training for all staff with access to the SCR. DCR systems, which will allow local organisations to share detailed clinical information, are the "holy grail" for NPfIT. Such systems can improve safety and efficiency, support key activities such as prescribing, and vastly increase the effectiveness of clinical communication. In particular, DCR systems offer improvements to the care of patients with multiple or long-term conditions. It is on NPfIT's success in delivering DCR systems that the programme's effectiveness should ultimately be judged. In order to deliver DCR systems, Connecting for Health has set out to replace local IT systems across the NHS, as well as building the capacity to link these systems together. The new national broadband network has now been completed, but progress in other areas has been disappointing. In particular, the introduction of new basic hospital Patient Administration Systems (PAS) has been seriously delayed. One of the two main hospital PAS products, Lorenzo, will not be trialled in the NHS until 2008. As a result of these and other delays, it is not clear when joined-up DCR systems will be widely available. In addition, we found it difficult to ascertain either the level of

information sharing that will be possible when DCR systems are delivered, or how sophisticated local IT applications will be. In its original specification documents in 2003, NPfIT established a clear vision for local electronic records systems. Four years later, however, the descriptions of the scope and capability of planned DCR systems offered by officials and suppliers were vague and inconsistent. Some witnesses suggested that parts of the original vision have been abandoned because of the difficulties of implementing new systems at a local level. We recommend that Connecting for Health publish clear, updated plans for the DCR, indicating whether and how the project has changed since 2003. We also recommend that timetables for completing DCR systems are published by all suppliers. An important cause of the delays to DCR systems has been the lack of local involvement in delivering the project. Hospitals have often been left out of negotiations between Connecting for Health and its suppliers, and found themselves, as one witness put it, at "the bottom of the food chain". As a result, they have lacked the incentives or enthusiasm to take charge of deployments. Increasing local ownership is now a key priority for the programme. The NPfIT Local Ownership Programme is an important first step but does not go far enough. We make a number of detailed recommendations for increasing local ownership, including giving local organisations responsibility for negotiating with suppliers and for contract management, and offering users a choice of systems wherever possible. We recommend that Connecting for Health switch as soon as possible to focus on setting and ensuring compliance with technical and clinical standards for NHS IT systems, rather than presiding over local implementation. . . The development of the SCR and DCR will offer the SUS access to clinical data which are more timely, better integrated and of a significantly higher quality than those currently available. This is likely to transform the SUS and offers significant benefits, most notably for health research. However, researchers told us that more should be done to ensure that these opportunities are maximised. We make several recommendations for improving access to data for research purposes, including not only the single unique identifier, but also developing better linkage between new and existing databases. Increasing access to patient data also brings new challenges for safeguarding patient privacy, however. There is a difficult balance to be struck between the need to protect privacy and the opportunities for research, between safeguarding individual rights and promoting the public good. There are also a number of weaknesses within current access and governance systems. In particular, during the inquiry questions were raised about the extent to which pseudonymisation of data should be relied upon to protect privacy. We recommend that the Department of Health conduct a full review of both national and local procedures for controlling access to electronic health data for ‘secondary uses'. Despite some notable successes, the delivery of NCRS has in general been hampered by unclear communication and a worrying lack of progress on implementing local systems. Although Connecting for Health's centralised approach has brought important benefits, it will increasingly need to be modified, particularly if the crucial DCR programme is to succeed. By clearly restating its aims, providing timetables and indicating how they will be met, and ensuring local organisations take charge of deployment, Connecting for Health can still ensure that NCRS is a success."

1.6.20. MPs says EPRs essential but delivery in doubt (13 Sep 2007)

e-Health Insider

http://www.e-health-insider.com/news/3024/mps_says_eprs_essential_but_delivery_in_doubt

"Electronic patient record systems are vital to the future of healthcare in England, but there remain big questions and concerns over how and when they will be delivered by the NHS National Programme for IT. This is the central conclusion of a detailed report on electronic patient records systems published today by the Commons Health Select Committee. It states that the delivery of the NHS Care Records Service (NCRS) has "been hampered by unclear communications and a worrying lack of progress on implementing local systems". While work has begun on the first trials of the summary care record component of NCRS the report states that this is of secondary importance to the delivery of the local detailed EPR systems – the so-called Detailed Care Record (DCR) of NCRS - delivery of which has barely begun. The Committee recommends that the Government ensures that regional Local Service Providers publish clear plans and a timetable for the completion of Detailed Care Record systems and sets a final deadline for the successful completion of the Lorenzo system. The report also calls for more involvement by local NHS organisations and clinical groups in the implementation of DCR systems – due to be supplied by iSoft and Cerner – and more choice for users about what systems they will receive. The Patient Administration System (PAS) replacement strategy being pursued in England by NPfIT is contrasted with other approaches to EPR development underway internationally. The Chairman of the Health Committee, Kevin Barron MP, said: "Whilst the Government is getting the framework in place they still have some way to go before patients and the profession can see tangible benefits of the new system." The report spells out the huge potential benefits to patients of EPRs,

which are being created under NCRS, but says that delivery of the project remains uncertain with elements delayed by up to two years. While there have been successes such as PACS and the N3 network the report says that NPfIT's overall progress in other areas "has been disappointing". In particular it says CfH has largely failed to deliver on its core objective of clinically rich shared local DCR systems. "It is on NPfIT's success in delivering DCR systems that the programme's ultimate effectiveness should be judged," says the report. The Committee calls for a more localised approach by NHS Connecting for Health, the DH agency responsible for NPfIT, to speed up implementation of the programme. In particular the Committee singles out delays in the delivery of local Detailed Care Records – the rich local clinical component of NCRS – as a concern. The Committee describes such systems as the 'holy grail' for the EPR programme, but according to the report it is "not clear when they will become widely available". . . The report's recommendations include giving local organisations responsibility for negotiating with suppliers and for contract management, "and offering users a choice of systems wherever possible". The GP Systems of Choice (GPSoC) model is recommended as a template for the wider programme. The report also makes clear that it believes root and branch reform of CfH is needed if NPfIT in general, and DCR systems in particular, are to be successfully delivered. "We recommend that Connecting for Health switch as soon as possible to focus on setting and ensuring compliance with technical and clinical standards, rather than presiding over local implementation." Elsewhere the report states CfH's centralised approach "will increasingly need to be modified, particularly if the DCR programme is succeed". . ."

1.6.21. Health Committee MP criticises report on NPfIT electronic patient record (13 Sep 2007)

Computer Weekly - Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2007/09/health-committee-mp-criticises.html

Mike Penning, an MP on the Commons' Health Committee, has criticised a report by his colleagues on aspects of the National Programme for IT (NPfIT). He said the report of the Health Committee on the Electronic Patient Record - a central part of the NPFIT - was "very weak and a golden opportunity missed". Mike Penning, a Conservative MP, played a key role in persuading the committee to hold an inquiry into aspects of the NHS NPfIT. He told Computer Weekly that he has been a strong supporter of the committee's work. He said that his colleagues on the committee had produced some strong reports that did not back off being critical sometimes of government policy. But he said the committee's report on the Electronic Patient Record, which was published on 12 September 2007, missed a golden opportunity to "produce something meaningful". He said it became "bogged down in minutiae" and failed to call for an independent review of the programme. Twenty-three senior computer scientists, including several heads of computing at various universities, had written an open letter to the Health Committee calling a review of the programme. Derek Wanless, a founding father of the NPfIT, also called for a review of the NPfIT in a report on the NHS published on 11 September 2007. He said there was an "apparent reluctance to audit and evaluate the [NPfIT] programme". The Health Committee has taken the government's position that an independent review is unnecessary. Its report said, "Officials and suppliers both denied the need for an independent, external review. Richard Granger [Director General of NHS IT] argued that the programme had already been heavily scrutinised, for example by the National Audit Office, and that ministers had therefore concluded that a further review was not necessary. Guy Hains - representing CSC, one of the main suppliers to the NPfIT - pointed out that suppliers were subject to regular reviews, both technical and commercial, and stated that elements of the programme were in effect reviewed every two months. The committee concluded that it understood why some witnesses had called for an independent review of the NPfIT but said, "We do not agree that a comprehensive review is the best way forward." It said that "many of the questions raised by the supporters of a review would be addressed if Connecting for Health [which runs part of the NPfIT] provided the additional information and independent evaluation [of specific aspects of the NPfIT] which we recommend in this report". Penning acknowledged that the report contained some potent and constructive criticisms of the programme. The report was particularly critical of a lack of information - five years since the programme was launched - on the security of systems and the detailed electronic health record. The report said, "Serious concerns were expressed regarding the lack of information both about how security systems will work and about the outcomes of security testing. We agree with these concerns and recommend that Connecting for Health ensure that BT's planned security systems for its national applications are subject to independent evaluation and that the outcomes of this are made public. "There is a perplexing lack of clarity about exactly what NPfIT will now deliver." The report also said that there was a explanatory vacuum surrounding

detailed care records systems. Three Conservative MPs on the Health Committee, David Amess, Mike Penning and Lee Scott, refused to sign the report.

1.6.22. MPs go easy on care record plans (13 Sep 2007)

Pulse

http://www.pulsetoday.co.uk/story.asp?storyCode=4114502&sectioncode=35

"The health select committee's long-awaited report into the electronic patient record appears to have largely let Connecting for Health off the hook, while expressing some concerns over data security. The report from MPs, published today, backs the current 'opt-out' consent model for the creation of the Summary Care Record, and rejects calls for an independent review of the National Programme for IT. But the committee does call for Connecting for Health to review its plans to protect the security of patient data passed to the Secondary Uses Service. It also calls for better communication with patients and greater clarity over the content of summary and detailed care records. The committee's chair, Kevin Barron MP, had earlier told Pulse he believed 'most of the comments you hear in the media at the moment in my view, particularly about the electronic patient record, are comments that are quite ill-informed'. The committee's backing for opt-out consent is at odds with the BMA's opposition, and evidence from international legal experts that it could break European law. The report concludes that using implied consent to create the Summary Care Record, and explicit consent to add detailed clinical information, is a 'satisfactory model, but one which has not been well communicated to patients or clinicians'. It adds that including prescribing information in Summary Care Records may remain 'problematic'. 'Much of the controversy over privacy and consent arrangements for the Summary Care Record would have been avoided if Connecting for Health had communicated its plans more clearly to patients.' But the report raises questions over how data would be used with the Secondary Uses Service, and whether pseudonymisation can effectively protect patient privacy. It warns 'there is an urgent need to address these problems', calling for Connecting for Health to review its procedures. GPs were disappointed at the committee's general support for the current rollout of care records. Dr Trefor Roscoe, a GP in Sheffield and outgoing member of the joint GPC/RCGP IT committee, said he was 'extremely concerned' MPs had not heeded the BMA's call for opt-in consent. 'They have agreed that what is being done for pragmatic, making-it-easy reasons is fine by them,' he said. 'It's not fine by the BMA. We can't foresee what uses the record will be put to – and the report's concerns about the Secondary Uses Service is very pertinent to that.' Dr Paul Thornton, a GP in Kingsbury in Warwickshire and long-term critic of the National Programme for IT, said MPs had underestimated the threat to patient confidentiality. 'It would appear that Connecting for Health's confusion with regard to its complexities and consent models has bamboozled the health select committee,' he said. Dr Gillian Braunold, GP clinical lead for Connecting for Health, who is taking on a role as clinical director for the Summary Care Record and Healthspace, welcomed the report. . ."

1.6.23. NHS IT system 'maximises' security risk (14 Sep 2007)

Contractor UK

http://www.contractoruk.com/news/003447.html

The current architecture of a showpiece NHS IT system "maximises" the risk of patients' confidential details being leaked, stolen or breached. Rather than minimising the security risk, the Spine provides "both a bigger target and a larger number points of attack" than if the NHS used a group of smaller systems. Plans for the future of the Summary Care Records, a single database of patient data accessible by all NHS staff nationwide, will also make the system "more difficult to use." Delivering these damning verdicts on the system, due to store the data of 50m patients, the Commons Health Select Committee called for all staff with access to be security trained. Security applications for healthcare systems provided by IT contractors, such as BT, should be independently evaluated, with the results to be made public. The committee said such measures would install confidence in the £12bn computerisation of the NHS, and reduce the risk of security breaches, which are "problematic" and "challenging". It also poured scorn over delays to the SCR, which in some parts is two years behind schedule, saying rollout across the UK is being prolonged by confusion over its content. Health officials gave different answers on different occasions to questions about which types of patient information will be included in the SCR and what it will be used for. "The committee was told at various times that the SCR will be used for the delivery of unscheduled care, for the care of patients with long-term conditions, and to exchange information between primary and secondary care. "It is little wonder that patient groups expressed confusion about the purpose and content of the SCR," the

committee wrote in its report into the e-health record. The report warns of "serious concerns" over the lack of information both about how security systems will work and about the outcomes of security testing. This is despite a series of checks, audits and smartcards put in place to secure the SCR, which, overall, will brings benefits to patients, the committee said. "Many of these measures are new and untested on the scale that they will be used in the NHS," it said in its report, published yesterday. "As a result, their impact and vulnerabilities are difficult to predict." To bolster the security of the Spine and the DCR, the local e-record of a patient's full medical history, the committee says custodial sentences should be drawn up to deter would-be data snoopers. Reflecting on the DCR, the cross-party group of MPs said while local control over DCR is a desirable goal; it is "surprising that the architects of the DCR were not able to provide a clearer vision of what is planned." The committee said: "There is an explanatory vacuum surrounding DCR systems and this must be addressed if duplication of effort at a local level is to be avoided." The successful delivery of DCR systems, they said, depends upon the ability of Connecting for Health to harness the benefits from local as well as national input, "something which it has not achieved so far." Among recommendations for the DCR, the committee said an independent technical standards body should be set up to set requirements for interoperability, which all NHS IT suppliers should conform to. Technical standards should cover system security and reliability but the focus should be on ensuring systems supplied by contractors are fully-interoperable, to help the NHS in its goal of seamless data exchange between systems. The committee also recommended that British health executives should follow their counterparts in France, where patients will own their own national summary record. Such an approach is widely accepted as giving patients more control over who can access their record and more opportunity to influence and take control of their own medical care.

1.6.24. MPs clash over Summary Care Record (14 Sep 2007)

Pulse

http://www.pulsetoday.co.uk/story.asp?storyCode=4114520&sectioncode=23

"A furious political row erupted yesterday following the publication of the Health Select Committee's report into the electronic patient record. In an extraordinary outburst at the press conference held to launch the report, MPs shouted each other down and traded insults in front of bemused journalists. The bust up came after the three Conservative MPs on the committee voted against the whole report, in protest at an alleged breach of parliamentary etiquette. Tory MP David Amess said a number of committee members had broken a long-standing parliamentary convention by taking part in a party political debate on NHS IT while the committee's inquiry was ongoing. Several committee members, including the Labour chairman Kevin Barron and Tory member Stewart Jackson, took part in a debate on NHS IT in June. The clerk of the House of Commons had confirmed that the convention existed, Mr Amess added. 'He gave me the advice that it was fine if I and my colleagues felt minded not to continue to attend the rest of the evidence sessions, which we didn't do, and that when it came to the consideration of the report to vote against,' he said. However, Liberal Democrat MP Sandra Gidley said: 'I'm very disappointed with the way this has divided along party lines, because that's not the way we work.I think there was a deliberate attempt to scupper the result.' In a heated exchange, Kevin Barron, Labour MP and chair of the committee, angrily denied that the parliamentary convention existed. 'I think this is about people who didn't like what was said on the floor of the House,' he told Mr Amess. 'Quite frankly I think your opposition is party political.' But Mr Amess, the longest serving member of the committee, replied: 'I take it entirely personally what you've said. 'I'm not going to be called a liar,' he added. 'We're not going to air our dirty linen in public.' Mr Barron retorted: 'You started it.' A spokesperson for the House of Commons said: 'There's no hard and fast rule that members on a committee wouldn't engage in a debate on the topic that their committee was investigating.' 'There is a rule that proceedings in committee are confidential, so they wouldn't be able to divulge any of the committee's views or what it had been deciding.'"

1.6.25. The Government response to the Health Committee report on the Electronic Patient Record (12 Nov 2007)

Department of Health

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080238

From the introduction: "The Government welcomes the report's conclusions on the potential of electronic patient records to improve healthcare services and patient safety. In particular, it agrees with

the Committee's view that the implementation of electronic patient records is a 'long journey best managed by a staged and piloted development not a big bang approach'. The Government reaffirms its view that solid progress has been made on the delivery of the National Programme for IT in the NHS (the National Programme), though it accepts that delays have occurred to the delivery of some parts of the Programme. These delays are in many instances the consequences of taking longer over consultation and stakeholder engagement rather than simply delays in the production of software. In any event, the robustness of the contracts with suppliers means that the costs of any IT system delays have not been borne by the taxpayer. The Government recognises that continuing effort is needed to engage with frontline NHS staff and to communicate the Programme plans to the public."

1.6.26. Government ignores Personal Medical Security (14 Nov 2007)

Security Research, Computer Laboratory, University of Cambridge

http://www.lightbluetouchpaper.org/2007/11/14/government-ignores-personal-medical-security/

The Government has just published their response to the Health Committee's report on The Electronic Patient Record. This response is shocking but not surprising. For example, on pages 6-7 the Department reject the committee's recommendation that sealed-envelope data should be kept out of the secondary uses service (SUS). Sealed-envelope data is the stuff you don't want shared, and SUS is the database that lets civil servants, medical researchers others access to masses of health data. The Department's justification (para 4 page 6) is not just an evasion but is simply untruthful: they claim that the design of SUS 'ensures that patient confidentiality is protected' when in fact it doesn't. The data there are not pseudonymised (though the government says it's setting up a research programme to look at this - report p 23). Already many organisations have access. The Department also refuses to publish information about security evaluations, test results and breaches (p9) and reliability failures (p19). Their faith in security-by-obscurity is touching. The biggest existing security problem in the NHS - that many staff carelessly give out data on the phone to anyone who asks for it - will be subject to 'assessment', which 'will feed into the further implementation'. Yeah, I'm sure. But as for the recommendation that the NHS provide a substantial audit resource - as there is to detect careless and abusive disclosure from the police national computer - we just get a long-winded evasion (pp 10-11). Finally, the fundamental changes to the NPfIT business process that would be needed to make the project work, are rejected (p14-15): Sir Humphrey will maintain central control of IT and there will be no 'catalogue' of approved systems from which trusts can choose. And the proposals that the UK participate in open standards, along the lines of the more successful Swedish or Dutch model, draw just a long evasion (p16). I fear the whole project will just continue on its slow slide towards becoming the biggest IT disaster ever.

1.6.27. Government says no plans to devolve CfH power (15 Nov 2007)

e-Health Insider

http://www.e-health-insider.com/news/3220/government_says_no_plans_to_devolve_cfh_power

"The government has rejected calls by the Commons Health Select Committee for NHS Connecting for Health to hand over greater contractual power to trusts and strategic health authorities as part of the NPfIT local ownership programme. The government's stance appears at odds with the far-reaching contract renegotiations currently underway with the local service providers, to redefine how and when the core clinical systems can be delivered by the late-running Â£12bn IT programme. Charlotte Atkins, Labour MP for Staffordshire Moorlands, a member of the Health Select Committee, told E-Health Insider that the greater moves to local ownership and responsibility must be accompanied by decision making powers: "Local ownership and local buy-in are very important, but responsibility without power has little benefits." . . . The Health Committee recommended in its September report that CfH's role should switch as soon as possible to focus on setting and ensuring compliance with technical and clinical standards for NHS IT systems, rather than presiding over local implementation. They called for a stop to SHAs, PCTs and hospital trusts holding responsibility for NHS IT without power to change the centrally negotiated contracts inherited from CfH. However, in its written response to the Health Committee, the government made it clear that this will not happen: "There is no intention to change the contractual arrangements". . ."

2. Unpublished Concerns Regarding NPfIT

This section of the dossier contains previously-unpublished expressions of concern that we have received from people who have extensive knowledge of issues of direct relevance to NPfIT. These expressions are made publicly available here with the explicit permission of their respective authors.

Other individuals who also feel that they can make informative and constructive contributions to this dossier are welcome to contact us by email at **confidential AT nhs.it.info** (replace " AT " by "@"). It is essential that any such contribution include clear identification of its author. Although it is preferable that authors be identified, we will if so requested protect your identity and/or that of your organisation in the published contribution. It is essential, however, that we are able to verify (i) that you are who you say you are and (ii) that the contribution is from you.

2.1. Clinical Records System (CRS): Some Allegorical Stories (16 Oct 2006)

By Dr Gordon Caldwell FRCP, a senior Consultant in the NHS with considerable clinical and IT experience.

Doctors and nurses can find it hard to make other people understand what they want and need from IT systems to help them in their work. This results in confusion, and delivery of unsuitable or unusable software. I believe this has happened with the National Programme for Information Technology (NPfIT) Clinical Records System (CRS) in the programme " Connecting for Health" . I think our basic needs are simple: who are our patients, where are our patients, what problems and diagnoses do they have, what are we treating them with, some space for free text, and an ability to print the information. Anything else is a major luxury once these requirements are met. I have written three stories as allegories or parables to help to shed some light on the problems.

I like stories, so here are some brief ones to have in mind as everyone tries to address these issues.

2.1.1. The Armed Forces and IT

The Minister of Defence decided to computerise all the armed forces, to make them more effective in their vital roles of defending the country and maintaining democratic processes. The process started by installing new software for Human Resources, Payroll and Logistics for the forces supermarket chain, the NAAFI. This generally went well, with the usual small number of objections and hiccups. Then the Minister decided to computerise the SAS, because it was recognised to be a key force. The SAS already had an amazing record of confidentiality and secrecy, even after a member left the forces. This was based on an ethical tradition and also backed up with a very specific contract of employment. The SAS were introduced to the new computer system 6 weeks before go live. They had been too busy in Afghanistan and Iraq to attend training earlier. After 5 minutes the commanding officer said " This will not work, it does not fit with our modus operandi!" and the developers said " We go live in 6 weeks, it has cost a fortune, it has to work, you will have to find workarounds, or new ways of working." . The officer pointed out that his team often worked in the rain, ice, and the dark. The new laptop computers were not even waterproof and he had found this out after he spilled his coffee on the keyboard. A major concern was that at night the screen would light up their position to the enemy. He said his men could not even enter a password, whilst wearing gloves and climbing a slippery hill in the dark and rain. The project went ahead, and the SAS team were sent out on a reconnaissance mission in enemy territory at night in the wet and cold. Dutifully they raised the " workaround" blackout umbrella over the laptop and opened communications. Unfortunately it was also a windy night, so the umbrella blew away. The enemy immediately fired a mortar, taking out half the team, including the soldier logged on at that moment. One of the survivors knew it was vital to get the mission data back to HQ, and without logging off the dead soldier, hit return and sent the data back. Miraculously the well trained squad completed the mission and returned to HQ. Of course the soldier who used the dead soldier's logon was called to court martial and convicted of this disciplinary offence, and dismissed from the army. The HQ staff were proved right – front line staff always resist new ways of working, and cannot be trusted to follow even the most simple of commands. The moral of this story is that the computer system must match the working environment and practices of the skilled expert for whom it is intended.

2.1.2. The House of Commons and IT

The Speaker of the House decided that too much valuable time in the Commons was taken up after the division bell, in the lobbies and counting the votes. He asked for a top notch IT company to come in to computerise the voting. He worked out that on average there were 150 members in the chamber at any one time, so that 200 laptops would suffice. The IT Company suggested that speeches and question time were unruly and devised a system in which anyone who wanted to interrupt a speech to raise a point or ask a question had to logon to his laptop and join a queue visible on the Speaker's laptop. The Speaker could then logon, ask the Member who held the floor to logoff, the Speaker then had to logoff and allow the next Member to logon, using his ID and eight character password (so many forgot this, it was embarrassing) and ask his question. That Member then had to logoff, to allow the Speaker to logon to ask the first Member to logon to answer the question and so forth. The system was a limited success. Uninteresting debates lasted only a few minutes, because no one could be bothered to interrupt, and there was no problem with access to the laptops for voting. In major debates the MPs became increasingly frustrated and wrote letters to the papers on their laptops, rather than the usual animated and amusing repartee of the House of Commons. Sadly the improvement in voting time was not realised in popular debates because of the shortage of PCs in relation to Members and the logon and logoff process was too slow. Some saw this as an advantage that the House of Commons could no longer carry on its business, whereas others worried where the Members might now wreak havoc. The moral of this story is that computer systems must make processes more efficient and not interrupt the business of an organisation.

2.1.3. The Prime Minister and His Resignation

This is a more fanciful story. At the Party Conference the Prime Minister decided that he would announce his resignation to the country the next morning at 08:10 on " Today" on Radio 4. He felt it a duty of honour to inform his party faithful in person by letter that night before the announcement. He had absolute faith in those at the conference that they would not leak the story to the press. He wanted to write to each attendee personally, so he quickly drafted a letter, which his secretary printed using a mailmerge. He signed every letter personally and went peacefully to bed at 10 p.m., asking finally that each letter be put under the door of each delegate by midnight. His secretary then realised that she did not have a list of the delegates by hotel and contacted the accommodation officer. Fortunately he had a list of hotels and delegates by room number. The mailmerge had been printed off alphabetically. It took hours to match the letters to the correct hotel, and then the letters were organised by hotel and alphabetically. Sadly the assisting team had not put the room numbers onto each letter as they sorted them into hotels. They set about reordering the letters by room number. Finally they were bundled up and sent out for delivery just as the Prime Minister's words could be heard on Radio 4. The whole party was caught unawares and embarrassed in front of the nation. The party lost the next election. The moral of this story is that vital data must be available to be ordered and used to the user's requirements.

Problems not at all dissimilar to these riddle the CRS system that I have seen for our Cluster.

Useful IT systems can only be developed by systems analysts who are interested in people and the work that they do, are curious about current processes and can develop solutions that make the user say " Wow, that is good, when can I have it!" . The PACS for X ray viewing is a winner like that, the CRS is a disaster like the three scenarios above – but worse!

A really useful really simple IT system to improve patient care

What would be really good and useful and simple? One NHS Intranet page for every NHS number holder containing each person's demographic data (name, address, GP, next of kin), his diagnoses and health related problems, his medications ordered alphabetically and some free text, in an open architecture system, i.e. the data could be merged into clinic letters, discharge summaries, referral letters, letters to take on overseas travel. A clever IT programmer could devise this within a week, and could transform patient care and safety, because medical language is one of the most economical and effective languages in the world – huge meaning can be transmitted in a very few well chosen words. Computers can deal with tiny amounts of data very effectively. These tiny amounts of data about each person are of major meaning to a doctor or nurse, and can support clinical judgement and decision making.

2.2. What CfH Could and Should Learn from Defence Procurement (11 Oct 2006)

By Malcolm Mills:

In November 2005 e-Health Insider published a letter of mine saying 'what a pity people in CfH had not sought experience from the Defence field'. The text below is based on the reply I gave to a doctor who asked me to be more specific regarding the lessons that I had in mind.

The magic bullet is the employment of high calibre and properly experienced people in pivotal posts in the programme management organisation. In the UK, US and Europe, much basic and operations research has been carried out in Defence, and many many volumes published, on the development and procurement of IT-based systems and services in the years since computers were first used towards the end of the 2nd WW. Some fortunate people (yours truly included) have been lucky to have been involved with these developments for some of this time. Unfortunately, many of the cognoscenti have not practiced outside of Defence and take their knowledge into retirement, and the grave. Little encouragement is given or interest shown for them to pass on to other communities the basics of what they have learned. A few fortunate ones do look over their shoulders from time to time and when they do, they see much in common.

Why should this be? Well, although the health environment may (appear to) be different, much is similar. And of key significance, critical programme 'building blocks' are the same: 'people are people' (whether they wear a military uniform or a white coat) -they have the same two arms, two legs, one brain, can be trained, have the same basic cognitive, perceptive, neurological and social, behavioural characteristics etc etc. And the basics of 'computers in defence' are the same as the basics of 'computers in health'. They are constructed with the same physics, same von Neumann architecture, same EM theory, logic, Shannon's Laws, etc., etc.

Years ago when software was recognised to be a pivotal and evolutionary issue in Defence, we agreed the need to pursue a 'software-first approach' in procurement in an attempt to get software 'off the critical path' of the programme timescale. In addition it became obvious you can design, and redesign, the (software) machine (not that easily to be sure - software is brittle rather than flexible) but you cannot redesign the human being (at least not in project timescales!). To be sure people can and should be trained to perform new tasks and procedures but their basic characteristics must be allowed for and cannot be redesigned to any great extent. (People are God given, machines are man given).

With these thoughts in mind, we now realise the delivery of these systems and services requires not just a software-first approach but a more evolutionary and radical emphasis called: the socio-technical approach. Orthodox technological determinism, with its classical engineering, intellectual, legal, financial and contracting baggage is not man enough for the job. The process must be changed (modernised!) to suit the needs of the new era.

Requirements are the critical item. Who are the End users, who are users, who are operators. How are (output) requirements elicited from them. Do they do it themselves or will surrogates be used. Who has the authority to verify the requirements. How and in what language will they be specified. How will they be documented and accounted for. Will software prototypes be used to aid the requirements process. How are they communicated to suppliers. Are they testable quantitatively and/or qualitatively. What role for subjective assessment. Can they be validated in a trials programme. What about safety requirements. How does one specify output requirements. Will requirements be put under configuration control and linked to issued software versions and contract. Who will do this. What procedures will be used to manage change in requirements. How will risk in over grandiose requirements be assessed. How will requirements be downsized to be realisable within project costs and time-scales. How are requirements for 'business' interoperation between cooperating institutions, organisations and specialist communicated elicited, verified, validated, changed etc etc. How are requirements then tuned to legacy functionality and the characteristics of new 'off the shelf' software from UK or elsewhere.

Tackling User issues in Defence has been a major challenge over the years and continues to be so to this day. It is an intractable problem and needs deft management by people who know what they are doing. And at last those at the top of the MoD seem to be aware of this issue. Military users are now taking responsibility for the ownership of their requirements.

Notwithstanding the requirements problems in Defence, it probably has fewer specialist user stakeholders than in the Health user community, recognising the latter includes requirements for a very

diverse patient community as well as clinicians, managers etc. This must or should be recognised as the Big Issue, more so in Health than today in Defence.

Yet from the way CfH is being progressed, this does not seem to be the case. Classic Public Sector Procurement is geared to the purchase of physical goods e.g. widgets, machinery, bridges and roads. To put it crudely, it is geared to the assumption you can specify, a priori, in objective testable quantitative and unchanging terms what you require. IF this is true, then it follows specifications can be put out to competitive tender and terms and conditions of contract awarded on a fixed price basis to a contractor who accepts all the risk for delivery. Finance underpinning the contract is geared to the provision of the good alone and follows the premise that beneficial capability comes from the operation of the physical good. Any roles people might provide in delivering the overall capability will be funded from existing operating budgets. Savings in costs in more efficient operation are also expected.

BUT we know from defence experience the key risk and cost of providing capability in these kinds of application concerns the risk and cost of the people who use and operate the system - their salaries, benefits, development of new user procedures, training in new procedures, recruitment, organisational restructuring, locums etc. The overall costs of getting the people 'right' in the procurement and operation of IT- based business services can be 5 times the life cycle costs of the equipment. In Defence, much effort is underway to trade-off and optimise the costs of different lines of development (LoD's) (people, training, safety, equipment etc) early in corporate planning, and well before contracts/suppliers are even considered. In this context, there is an opinion HM Treasury should re-examine the overtly technical (and not socio-technical) emphasis given in its Green Book (Appraisal and Evaluation in Central Government) - the appraisal guideline used in the Gateway reviews of the OGC/Gershon process for large investments in the Public Sector.

Interoperability. The emergence of on-line networks has heralded a shift from services operating in isolation to services being interconnected both within and between organisations and communities. The first major examples in Defence occurred in the late 50's onwards with real time computer-based (wireless) networking of fixed radar installations across continental land masses, and between ships, submarines and aircraft at sea in mobile integrated command and control systems. These examples networked military staff and weapons systems across different Services (e.g. Navy and Air Force) and between differing Nations (egg UK and US). Many lessons have been learned from this experience and are being applied today in the 'joining up' and integration of many of the previously stove piped services in the administrative, logistic as well as the operational defence arena.

The enabling technology initiating this pan-organisation change is the new £4B Defence Information Infrastructure (DII) backbone - the defence equivalent of the NHS CfH IT initiative. Amongst the many interoperability lessons learned to achieve seamless interoperability across disparate organisations are the following: need for agreed joint purpose, the importance of the human factor, agreed functional requirements, cultural/ organisational compatibility, team working, development of common, and new, business procedures and rules of operation, semantic/ lexicon understanding and awareness, extensive training and cross organisation trials AS WELL AS technical issues such as data dictionaries, communications protocols, message standards, electrical, physical compatibility etc.

The true costs of achieving seamless interoperability involve not only the costs of the technology (included in the capital expenditure) BUT ALSO the more significant user costs hopefully adequately provisioned from the many different operating budgets of the participating organisations. Included in user costs should be the need to establish, for example, a minimum but authoritative coordinating layer of management to fund and develop the necessary business operating procedures and rules of engagement deemed necessary for organisations to achieve the needed degrees of joint working.

This country has spent many many £B of Tax Payers money on failed and successful IT-based projects in Defence. Much has been learned but most is kept 'in the box'. We shall have to wait and see whether the National Audit Office, in its new inquiry into 'IT successes in the Public Sector', has the wit and experience to include the lessons learned from Defence in its report.

I hope this provides some indication of the kind of lesson now well learned. Inevitably because of the nature of the Defence beast, mistakes as well as successes will continue to occur. But from what I have read, it does appear to me the planners of the NHS/CfH programme are unaware of the relevance of the Defence experience. That's quite a loss for us patients, clinicians and tax payers.

Malcolm Mills is a graduate of the Royal Military College of Science, Shrivenham and London University. Following a general list career in the Engineering Branch of the Royal Air Force in mostly software-related appointments, Malcolm became a Principal in the Civil Service Science Group as a project manager for Royal Navy surface ship combat systems and NATO real-time data exchange networks before leaving to join Software Sciences Ltd (now integrated into IBM Global Services) some 20 years ago. He then joined Gregory Harland Ltd in January 2000 to focus on the changing role of the user in the evolution of interoperable corporate information systems, one of his professional interests. Malcolm is a Chartered Engineer and Fellow of the Institution of Electrical Engineers. He has been an active member of the Electronics Industry Trade Associations and work of the Defence Scientific Advisory Council. He retired this year.

2.3. A note on the NHS National Programme for IT for the Committee of Public Accounts

Submission to the PAC by Robin Guenier:

It is impossible to exaggerate the importance of the NHS National Programme for IT (NPfIT). It is my view, shared by others including many clinicians, that if the NHS is to be properly effective in the 21st Century its information systems must be transformed. So it was excellent news when the Government announced in early 2002 that it was to take the advice of the review it had asked Derek Wanless to undertake and had decided to invest a huge amount of time and effort in an ambitious programme of NHS IT reform. This project must succeed – its failure would mean a substantially ineffective health service and it is inconceivable that the Treasury would release so much money again (now estimated at over £12 billion) if it fails. In any case, the failure of such a massive and important project would probably create major disenchantment about public sector IT projects with both the public and politicians. There would be no winners.

Yet, after four years, it begins to look as if NPfIT may well be heading for failure. There are many signs of this – late deliveries, disappointed users, cost growth, loss of key suppliers, etc. The extraordinary thing is that this is happening largely because the Department of Health has chosen to disregard the clear lessons of earlier project failures and, in particular, the advice of Government and Parliamentary experts.

There are many reasons why projects fail. But I believe that nearly all successful projects share three essential characteristics: first, a recognised leader with full understanding of the project's objectives, full authority for its success or failure and hands-on responsibility for the entire project; second, detailed, widespread and regular engagement with key staff and end users; and third, arising from these, an understanding of current processes and of how they must be aligned with the new processes plus a willingness to be brutally realistic about the project – is it likely to meet its objectives and, if not, what action is necessary?

Not one of these applies to the Department of Health's management of NPfIT:

1. The concept of a " Senior Responsible Owner" with overall authority, an understanding of the organisation's key strategic priorities and detailed hands-on responsibility was originally defined and is commonly referred to by the Office of Government Commerce in the Treasury. Its importance has been emphasised by the Cabinet Office and I understand it to be endorsed by the National Audit Office.

   Yet NPfIT has not had a true overall SRO since Sir John Pattison retired soon after the project was started. One consequence has been that wholly inadequate priority has been given to the project's implementation – e.g. local funding, user engagement, process change and staff training.

2. Government and parliamentary reports on project management are full of references to the critical importance of user engagement. For example, giving evidence to the House of Commons DWP Select Committee in February 2004, Sir Peter Gershon, then CEO of the Office of Government Commerce, said, " If the staff are not brought into new ways of working, new processes, new ways of delivering benefits to the population, however successful the technology is, the systems will not be successful." Even the document that launched NPfIT in 2002 stressed the need for " full involvement of interested parties" to overcome the risk of " lack of co-operation and buy-in by NHS stakeholders to investment objectives" .

Yet clinician engagement in NPfIT has been poor from the outset. Six surveys of doctors' opinions carried out by Medix UK plc and two by Ipsos MORI have established a clear pattern: most doctors are positive about what the programme could do for clinical care but are increasingly negative about whether it is worth the cost and, most worrying, continue to know little about it. An Ipsos MORI survey this year for the Department of Health, for example, found that 68% of doctors had little or no information about NPfIT, including an extraordinary 11% who said they had none. A recent survey of nurses' views, conducted for the Royal College of Nursing, had very similar results.

3. It is a commonplace of project management that current business processes should be brought into line with the proposed new systems (or vice versa) and that the identification of what is needed is usually a direct consequence of user engagement. It is a concept that has been strongly endorsed by the National Audit Office – e.g. in relation to the Libra project for the magistrates' courts: see NAO report dated February 2002. Likewise, in its report " Releasing resources to the front line" in July 2004, the Office of Government Commerce said that it was " critical that new technology investments were effectively rolled out with the full involvement of front line staff and appropriate process redesign" .

   Yet, because of poor staff engagement (see above), process alignment inevitably has been a very limited part of NPfIT. Moreover, there are no signs – at least in the public domain – that the project has been subject to a hard review of whether it is likely to meet its objectives and, if not, of what must be done to ensure that it does.

All this is most disappointing – made worse by the failure of the National Audit Office's recent report on NPfIT to do more than refer in passing to these matters. However, I am sure that it is still possible to get the programme back on track (1) by appointing a respected and senior person, preferably from within the NHS, as its Senior Responsible Owner, (2) by carrying out a massive and urgent programme of clinical engagement and (3), when the first phase of engagement is complete and clinicians' views are known, by carrying out a thorough programme to ensure that all current and new processes are understood and fully aligned and that Trusts have sufficient funds to ensure that the programme can be fully implemented. One result might well be a major rethink and recasting of some elements, including technical elements, of the programme. These actions would inevitably take time and cost money – proper clinical engagement alone would probably cost several hundred million pounds. But they must be worth it: a radical improvement in NHS IT systems is essential if we are to avoid a diminished and substantially ineffective health service.

I would urge that the Department of Health be advised to give the most serious consideration to taking these actions now.

Robin Guenier – 3 November 2006.

Guenier is an independent consultant and chairman of the medical online research company Medix UK plc. In 1996 he was Chief Executive of the Central Computing and Telecommunications Agency reporting to the Cabinet Office. He is a Liveryman of the Worshipful Company of Information Technologists and is chairman of its medicine and health panel. He has written this note in his private capacity: in no way is it intended to represent the views of Medix or of the WCIT.

2.4. A Consultant's Eye View (3 Nov 2006)

I am a Consultant Physician with considerable expertise in clinical systems. I also am an experienced clinical user. I am writing to explain why I have been so disappointed and concerned after my training sessions on an NPFIT Clinical Records Software system (CRS) featuring a Patient Administration System (PAS) and Orders and Communications. My fear is that should we " go live" with this system, our hospital might close down within hours.

As soon as the contract for NPFIT was awarded in our cluster, I contacted the supplier, inviting systems analysts to come and spend time with me in the clinical setting, so that they could learn how clinicians work. I know that to make a good system the supplier must understand the processes and end users. I also know that clinicians are poor at explaining their activities and how these vary by individual, speciality and hospital.

In response to my invitation, I was invited at short notice to numerous meetings in distant places. In the 18 months of the project, only one supplier employee came on one ward round for one morning. A few

months ago, I had my first glimpse of the system and asked how it would work in outpatients. The supplier's consultant asked " What is outpatients?" It worried me that the supplier did not seem to know about something so fundamentally common to all UK hospitals.

Two months ago, I was involved in a training pilot of the CRS. I found that the system could not produce a list of all the patients' under my care in the hospital. In a more recent training session, I was taught how to write a query to list all my patients on screen, but I am not allowed to print the list out; the list on screen does not show what the diagnoses are. The situation appears far worse for nurses.

In the new system, routine processes, such as logging into the system, discharges, room booking and follow-up appointments are complex, sometimes incomplete and laborious. By laborious, I mean that processes that currently take seconds take minutes on this new system. A specific example is routine ordering of blood and urine tests. It was unclear who would receive the results or even if the samples were ever taken. I ordered a standard set of bloods and a urine test and had to enter 23 mandatory fields to complete the order.

I was dismayed as were several other senior clinicians and expert IT users around the hospital. I see a system with no evidence that anyone in the supplier's team has observed UK clinicians at work, or probed to understand what we do. There appears no understanding that confidentiality in medicine is to do with not disclosing information under an ethical and legal code, rather than not knowing the information. I believe that I saw an unusable system, which would have slowed every process in the hospital to the point where we could not handle the daily clinical emergencies and routine care. Their plan was to switch our PAS off for six days and revert to manual mode while the new system was installed!

What would I suggest as a starting point for a nationwide CRS? I suggest a single web page for every NHS number holder, on which are their demographic details, current significant medical health problems and an alphabetical list of drugs, doses and frequencies, and significant allergies, with one free text comments field. This tiny quantity of data, updateable on one page, would transmit so much useful medical data to make patient care more safe - ask any doctor or nurse! If these data could be linked to clinic letters, discharge summaries, etc, its usefulness would be enormous. If we understand each other and work imaginatively we can crack this apparently insoluble problem!

Dr Gordon Caldwell FRCP

[A copy of this note has, at the author's request, been forwarded to the PAC]

2.5. Submission to the PAC by Larry Benjamin (6 Nov 2006)

Mr. Larry Benjamin
Consultant Ophthalmic Surgeon
Stoke Mandeville Hospital
Mandeville Road
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HP21 8AL

6/11/06

Mark Etherton Esq.
Clerk to the Committee of Public Accounts
House of Commons
London SW1A 0AA

Dear Mr. Etherton,

Re: The National Programme for IT in the NHS

I am a consultant ophthalmic surgeon working at Stoke Mandeville Hospital, Aylesbury.

I have a long-standing interest in IT and its use in Medicine and although a member of the Worshipful Company of Information Technologists, I am writing as an individual and a consultant in the NHS for the last 16 years.

I would like these comments to be included in the documents to be read by the Public Accounts Committee relating to NpfIT.

My worry regarding the implementation of NpfIT is that it has been introduced " backwards" . By this I mean that the national spine and its associated infra-structure has received much attention whilst very little effort has been put into useable local systems for day to day input of clinical data – the very life blood of any clinical system.

For a clinical system to be deemed useable by the staff using it, their involvement in its development is vital. Clinical systems have evolved over many years to allow the recording, storage, retrieval and analysis of data relevant to sometimes complex clinical situations. Although the time taken to input data into a new system does not necessarily have to be faster than the existing systems, if longer is required then there must be some added value. Data retrieval and analysis with plotting of trends would be an immediate benefit which would, I believe, stimulate staff to input meaningful information.

In my speciality, three or four software systems already exist in clinical use, which have been developed by and for ophthalmic units and their staff. All of these are already able to comply with the requirements of the national cataract dataset (which I helped to develop via the Royal College of Ophthalmologists). An interesting project recently took place between the 20 or so of the eye units who have installed one of these systems whereby details of 56,000 cataract operations performed recently were analysed. The data capture was input routinely and the retrieval near instantaneous.

It is highly unlikely that local service providers will achieve this level of detail and use-ability for at least 5 years. My suggestion is that more effort is put into interfacing between the national spine and local systems such as that mentioned above which are already fit for purpose. This will save time and money but most importantly, will gain user confidence very quickly.

Thank you for considering these comments.

Yours sincerely,

Larry Benjamin

2.6. Information Technology in the NHS - What Next (7 Nov 2006)

Submission to the PAC by John Mason

This document is triggered by the Richard Bacon and John Pugh suggestions and is a comment on the present state of IMT in the NHS, with suggested ways forward.

2.6.1. History

While the NHS Information Authority may have been thought to be a cumbersome organisation, a considerable baby was lost with bath water when it was dismantled. This baby included:

- continuing work on the NHS number to accurately identify patients and clean data on existing local systems
- confidentiality
- information standards and the need to share information between healthcare
- messaging
- the need to include the patient in the equation.

There was professional advice available from BMA/Royal Colleges both Medical and Nursing and Allied Healthcare Professionals, together with an Information Group chaired by Sir Kenneth Calman which placed an emphasis on the patient pathway, and included social services input. It was recognised that the information needs and the shape of the record would be different for several groups, and that there is a particular difference between so-called primary and secondary care.

Historically, the hospital record has a high content of lab and specialist test results together with input from speciality groups e.g. anaesthetics, cardiology, oncology, genetics etc. It is often typed (legible), contains correspondence, and in addition the activity is coded by professional coders using the International Classification of disease ICD10, and our UK Office of Population Census and Surveys (OPCS) codes for procedures. There is a National summary front sheet HMR1 which must have coded and dated diagnostic and procedure entries for each patient discharge. The diagnostic inpatient information is required by the World Health Organisation from all countries in ICD coded form. Latterly the data quality of the hospital returns has been subject to audit.

Historically, primary care or more accurately General Practice used a National format, the Lloyd-George envelope, a brown A5 sized container with an external summary of uncertain quality, often containing hospital discharge letters and lab results. General Practitioners led the way in the use of computers in practice, originally, it has to be said, to keep track of remunerable items of care e.g. cervical smears particularly the sending of recall letters etc. Systems improved, and there was a need to record clinical data. James Read recognised that the use of a computerised hierarchical system allowed speedy recording of clinical information to the level of detail felt appropriate e.g. heart disease which embraced valve disease, coronary heart disease, congenital heart disease and so on. These Read Codes exposed the first problem of leaving untrained clinicians to code, which was the tendency just to use the highest level rather than being precise e.g. to record heart disease rather than mitral valve disease. ICD and OPCS are of little use for general practice coding as there are few social and disability codes in ICD9 although this has improved somewhat in ICD10. Equally the attractive speed of entry of data led hospital doctors using local systems to look for something which covered hospital medicine and National work produced expanded the Read codes to ReadV3. Disappointingly General Practice suppliers were unwilling to alter systems which had embedded the earlier codes; hospitals, still intent on the existing coding methods (now essential for payment with the arrival of resource management) put no pressure on suppliers to incorporate the codes and nothing came of it all.

Newer GP systems recognise the need for input from nurses and other staff involved in the care of a patient, whereas hospitals tended to develop separate systems for nursing, physiotherapy, renal clinics and so on. The central hospital Patient Administration Systems (PAS) are exactly that, recording clinic appointments, waiting lists and inpatient occupancies, only latterly taking on the HMR1 role with coded admission and outpatient summary information. It should be added that many of these systems although ageing are very effective and robust administrative tools, even with the bolt-ons now needed to provide waiting-time data etc. The arrival of Choose and Book has made upgrading of these systems now essential. Finally many hospitals already recognised the need for electronic image storing of X-rays and had started to attempt to fund PACS as individual trusts before the advent of NPfIT.

2.6.2. Historical problems

During this time there have been repeated changes in the management structure of the NHS. These changes have, or will even yet, seriously damage attempts to build information systems which will meet clinical needs and which will only be supported (i.e. funded) by managers certain of obtaining the data demanded by the management and financial structure of the day.

Although input from the professions was funded and sought, it has to be admitted that the Royal Colleges failed to grasp the chance to have major input. The BMA, very much GP oriented felt that existing systems for general practice filled a need. The organisation perhaps rightly became much more concerned about confidentiality of patient information and made valuable progress in that area.

Attempts to get agreement on the structure of the record were an uphill struggle, and when agreement was reached between the healthcare professionals, the advice from the growing speciality of medical informatics was that such a structure was impossible in an integrated medical record with messaging. This could be an area where input from the 23 academics could be of great value.

In spite of agreed advice on training needs it would seem that training has fallen behind in the competition for funds. In particular there is shortage of funding needed to backfill staff absent for training in IM&T, and no provision for this has been built into any implementation plans.

When the time came to transfer electronically the patient record GP to GP all the issues of lack of structure and data quality emerged and are taking years to correct.

The decision to make choose and book a priority has been an error. It was not high on the professional agenda and was badly scoped. At one stage it had taken no note of the quite complex hospital processing of referrals using human intelligence not easily replicated electronically. The lack of thought about adding clinical information particularly drug information is a fatal flaw, as was the lack of thought about the actual processing of appointments in the primary care setting.

The National Library for Health (NLH) is a successful venture; NHS direct has good points and bad points.

2.6.3. From here

Although it may not be a politically correct question to ask, what do healthcare professionals really want?

- GP to GP record transfer which would eliminate the delay in transmission of the paper record. That is without asking for a justification of the inordinate delays which occurred in the transfer of the paper record.
- GP systems which as well as recording clinical information from many sources allow the recording and retrieval of information required as part of remuneration, and allow reception of results from laboratories and hospital discharge information to the patient record.
- Hospital staff need specialised local systems for branches of surgery, anaesthesiology dermatology etc as well as a central hospital record. The local system often has to also meet the needs of the clinical secretary responsible for the correspondence from the unit.
- All of these systems would benefit from an ability to transfer limited data without endless re-transcription. That core information will be demographic, but past evidence shows that huge amounts of time could be saved and patient safety improved by including a current drug list and allergies, and a list of problems agreed by patient and prior medical attendants. The full record is often of little value.
- To allow immediate care of known problems e.g. out of hours GP cross cover of the ill patient, then some means of recording immediate information is needed applying only to the group of carers and social services. This has already been achieved in ERDIP pilot studies. Again, structure of that cover may change in scope, and perhaps this was the thinking behind the grand plan of a National record.
- Social service input

Much of this will be most readily achieved by building systems which allow the transfer of information rather than creating a single huge repository. The transfer of information needs a vehicle and such exists and is in use. Health Language v7 (HL7) exists, having started out in laboratory use. It should now become the required messaging standard for the NHS.

Earlier versions are used to deliver Lab results in a safe and reproducible way to GP systems. Within the vehicle, in the seats as it were, needs to be appropriate and reproducible clinical information. Mention was made earlier of Read V3. Work done with the American College of Pathologist's Systematic Nomenclature of Medicine (Snomed) has allowed the introduction of all of the Read V3 clinical terms work and the classifications (ICD10 and OPCS4) into Snomed to produce SnomedCT, and the NHS has a licence to use this tool, and well tried systems for updating the content. It will generate ICD10 and OPCS codes for HMR1 returns. It should be mandated for use with HL7. There is a related drug product, previously UKCPRS now known as dm+d (dictionary of medicines and devices), which links with Snomed and would allow an accurate reproducible and transferable drug and dosage list to be created. This must become the required standard for all clinical systems.

Local systems for Hospital, private sector and other use should be encouraged. There should be a proviso that any such system must be able to produce summary information for each episode of care in a format appropriate for messaging in HL7, to the main hospital record, and onwards to primary care systems. The present large annual financial turnover requirement for companies tendering to supply local clinical systems eliminates all but the largest suppliers. A sensible compromise should be reached to allow the small companies to thrive.

An opportunity to make data quality a clinical responsibility was lost in the new NHS contract negotiations. Quality data makes quality control easier.

2.6.4. Conclusion

If clinical information is to be safe, accurate and transferable it has to be structured, and staff training is needed. Speed of access and of data entry is critical. It should be unnecessary to state that the NHS number must be used by all providers of healthcare to identify patients.

Having core information available in a reliable form for electronic transfer into local records can save large amounts of clinical time.

The means of transfer could be by smart card or on-line messaging.

Such information will then be in a form which allows meaningful analysis for audit and epidemiological purposes.

Links to NLH could be built using this structure to allow quick decision support and to allow patients to find reliable information about their specific problem.

2.6.5. References

1 Learning to manage Health Information – a theme for Clinical Education BL ISBNo. 0 953 27190 8

2.6.6. Further reading

Audit Commission For your Information. A study of Information Management and Systems in the Acute Hospital London HMSO Publications 1996

Information for Health. An Information Strategy for the modern NHS 1998-2005 NHSE publication

The Reduction of Uncertainty J R Mason British Journal of Surgery 1998 85 115-116

Kaiser Permanente's experience of implementing an electronic record: a qualitative study BMJ 2005 331 1313-1315

John Mason FRCS, FRCSE, FRCSG

About the Author

John Mason is a retired General and Vascular surgeon with an interest in audit who implemented hospital wide local clinical systems from 1985. These were based on an existing GP system. As medical director in a Trust he was involved in the commissioning of a Cerner Pathology system, and is very aware of the problems of translating an American system to UK use. He was a member of the Royal College of Surgeons Audit Group, chairman of the Academy of Medical Royal Colleges Information Group, and member of the Chief Medical Officer's working group on clinical information until 2000. He served on the American College of Pathologists Snomed editorial board until 2003. He is a member of the Worshipful Company of Information Technologists Medicine and Health Panel.

2.7. Notes on a Speech by Richard Bacon, Royal Society of Medicine, (28 Nov 2006)

(By Colin Tully.)

2.7.1. Nine propositions about NPfIT that he believes to be true

(1) The scale of expenditure is so huge as to be incomprehensible and therefore to resist effective scrutiny.

(2) Local implementation costs are likely to be three-to-five times larger than procurement/development costs.

(3) Major problems have arisen from the speed at which central contracts were let.

(4) Patient administration systems are being put into hospitals before the hospitals are ready.

(5) Trust managers are being browbeaten.

(6) Deployment has not gone according to CfH's schedule.

(7) We should learn lessons from the fact that key players in the industry did not bid, and from the withdrawal of key contractors.

(8) We should ask why CSC have stayed in.

(9) We should question the assumption that the Care Records Service is of central importance. It won't be delivered by 2010. That means that providers will fall short of their revenue targets, and trusts will fall short of the services they've been promised.

2.7.2. Four propositions about NPfIT that he believes to be questionable

(1) Patient records need to be available anywhere in the country.

(2) Local trusts can't procure IT effectively.

(3) We need a single massive system.

(4) Having a national programme saves money.

2.7.3. Final remarks

(1) Bad projects cannot tolerate/withstand scrutiny and criticism. Good projects can and do.

(2) There was a very abbreviated reference to recent work by " Doctor Foster" . It is possible that this related to the report entitled " Understanding the information needs of SHA and PCT boards" , at http://www.drfoster.co.uk/library/localDocuments/IntellCommBoardJuly2006.pdf.

(3) There have been six Senior Responsible Officers [within DH? responsible for NPfIT?] in three years.

(4) The entire thrust of the NAO report was changed during the year when its content was being " negotiated" with CfH. NAO were " ground down" .

2.8. Comments by Stephan Engberg on CfH's Security and Confidentiality FAQs (20 Dec 2006)

(The CfH's Security and Confidentiality FAQs are at:

http://www.connectingforhealth.nhs.uk/faq/security_confidentiality)

This is what I call a Single Point of Trust Failure system, where you have massive concentration of risk and no inherent security except perimeter security. Since perimeter security must be considered void for anything but totally isolated systems, this is a ticking " trust bomb" .

- There are in fact many potential attack points:
- The biggest threat is of course the central authorities, who will not be able to keep their hands off this data. They can demand anything, finding a wide range of excuses for their actions, and at the same time can easily ensure that the logs are overridden.
- There will be rapidly growing function creep that also escalates the security risks exponentially.
- Of course the direct attack route is through the (assumed perfect) security.
- They will not be able to protect legitimate users from Identity Theft.
- There will be a large number of people with backdoor-access to the database management system.
- There will be a large number of systems with access to this data. These systems will be leaky.

In fact the purpose of this " security" system is more legitimisation and centralisation, with dis-empowerment as a (possibly intended) side effect, than security of patients, as that would involve active identity management and especially empowerment.

Because they have organised the system with insufficient security, they will not be able to share data for value-creating purposes, such as outsourcing, privatisation, etc., without escalating the security risks. As such they will face an inescapable choice between value creation and security erosion. - this is a lose-lose situation.

My advice is clear:

- Assume the central servers are already hacked, cracked and taken over by a criminal gang. And then redesign accordingly.
- Move control away from the centre and ensure damage control on all levels.
- Don't create the security risks in the first place.

Stephan Engberg is founder of Priway, which focusses on solving the fast growing security and privacy problems, based on experience in Customer Relationship Management and eBusiness strategies and technologies. He is member of the Strategic Advisory Board of EUs ICT Security & Dependability Task Force, and the International Advisory Board of Privacy International - a London based international NGO. He participated as a member of the EU's Network of Excellence in Privacy and Identity Management. He is a member of the Board for the Danish Chapter of ISOC (the Internet SOCiety) and former member of the Board for Interactive Marketing at the Danish Marketing Association, and lectures and gives seminars in Security,

Privacy and scalable eLoyalty at various graduate level courses at Copenhagen Business School, and the Danish IT-University.

2.9. A Brief Note On The Apparent Divergences Between Europe's Data Protection Commissioners And The Government With Respect To The Electronic Patient Record (May 2007)

Dr. C. N. M. Pounder

(Editor of Data Protection & Privacy Practice)

[Late submission to the Select Committee on Health's Inquiry into the Electronic Patient Record]

The Working Party of European Data Protection Commissioners has published a document on the privacy of medical data within an Electronic Health Records (EHR) system[1]. The document states that unless there is a substantial public interest to the contrary, the patients' wishes concerning the processing of their own medical data via an EHR system should prevail. There are several important elements which, at this late stage, I draw to the attention of the Committee.

The Working Party has also concluded that centralized EHR system (i.e. on the UK model) "assumes there will be single controller for the whole system separate from the healthcare professionals/institutions" – in the UK's case, this data controller could be the Secretary of State for Health[2]. The Working Party notes that in such a system "liability for the confidentiality of the system is taken out of the hands of medical professionals", and that this "might influence the amount of trust invested by patients into such a system".

The Working Party notes that risks associated with a lack of trust do not arise in a decentralized EHR system "where the health care professional/institution" is responsible for the medical file, or in patient-centric EHR systems (for example, the French EHR system) where patients exercise a significant degree of control over their own medical personal data.

I should add that when the Government offers an "opt-out" with respect to the EHR system, it is assuming that it is a data controller and not only the medical professional[3], as only the data controller has the obligation to offer the right to object to the processing found in section 10 of the Data Protection Act 1998.

The Working Party states that "all data contained in medical documentation in electronic health records" should be considered to be "sensitive personal data", even the "administrative data" associated with a medical record. The Party notes that if these administrative data "were not relevant in the context of treatment of a patient, they would and should not have been included in a medical file".

This does not appear to represent the position adopted in the UK, as it treats administrative personal data differently from those data which have a medical content. For example, the Statistics and Registration Service Bill[4] before Parliament has excluded health personal data from the substantial degree of data sharing of administrative personal data (e.g. as contained in the Summary Care Record) on the grounds that these administrative data are devoid of medical content.

The Working Party states that if patient consent is used as a basis of legitimising the processing of health personal data for other purposes, then such consent has to be freely given and fully informed. The document notes that it is "misleading" if the patient does not have "a genuine free choice and is subsequently able to withdraw the consent without detriment". When giving consent, the patient must be made aware that he is "renouncing the special protection" granted to medical records (i.e. the prohibition on the processing of health data in the absence of such consent).

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[1] Working Party on the processing of personal data relating to health in electronic health records

[2] see Appendix 1 – section 251 of the NHS Act 2006.

[3] BMA may seek NHS records system boycott, http://www.out-law.com/default.aspx?page=7603

[4] Clause 40 permits the Secretary of State or other public authority to disclose patient registration information to the Board

The Working Party states that the processing of medical records within an EHR system can be legitimised by statute but only if that statute supports a "substantial public interest". In assessing this public interest, the Working Party stresses the need to respect "self determination" of patients whereby the patients' wishes with respect to the processing of their medical data plays a "significant role as a major safeguard".

This appears to contrast with the practice in the UK. For example, the Secondary Uses Service in the UK will consider wider uses of health personal data in the absence of consent. The position adopted by the Service is that if there is a substantial public interest for that secondary use, then there is no need to consider any aspect of "self determination".

The Working Party adds that the processing of health personal data can be legitimised on the grounds that the processing is undertaken by a health professional for a necessary "medical purpose". The Working Party then state that "medical research" is not included within the meaning of "medical purpose", and this implies that medical research by a health professional needs patient consent or has to be legitimised in terms of a "substantial public interest" where self determination is an important factor.

Finally, the Working Party states that only those professionals who are "presently involved" with a patient should have access to the health record (e.g. this limitation should apply to access to the Summary Care Record), and that "a patient should have the chance to prevent access to EHR data if he so chooses".

In summary, it appears that there are several requirements, which the NHS's own EHR system have yet to fully adopt. If I can be of assistance to the Committee, please do not hesitate to ask.

SECTION 251 OF THE NHS ACT 2006

251 Control of patient information

(1) The Secretary of State may by regulations make such provision for and in connection with requiring or regulating the processing of prescribed patient information for medical purposes as he considers necessary or expedient-

(a) in the interests of improving patient care, or

(b) in the public interest.

(2) Regulations under subsection (1) may, in particular, make provision-

(a) for requiring prescribed communications of any nature which contain patient information to be disclosed by health service bodies in prescribed circumstances-

(i) to the person to whom the information relates,

(ii) (where it relates to more than one person) to the person to whom it principally relates, or

(iii) to a prescribed person on behalf of any such person as is mentioned in sub-paragraph (i) or (ii),

in such manner as may be prescribed,

(b) for requiring or authorising the disclosure or other processing of prescribed patient information to or by persons of any prescribed description subject to compliance with any prescribed conditions (including conditions requiring prescribed undertakings to be obtained from such persons as to the processing of such information),

(c) for securing that, where prescribed patient information is processed by a person in accordance with the regulations, anything done by him in so processing the information must be taken to be lawfully done despite any obligation of confidence owed by him in respect of it,

(d) for creating offences punishable on summary conviction by a fine not exceeding level 5 on the standard scale or such other level as is prescribed or for creating other procedures for enforcing any provisions of the regulations.

(3) Subsections (1) and (2) are subject to subsections (4) to (7).

(4) Regulations under subsection (1) may not make provision requiring the processing of confidential patient information for any purpose if it would be reasonably practicable to achieve that purpose otherwise than pursuant to such regulations, having regard to the cost of and the technology available for achieving that purpose.

(5) Where regulations under subsection (1) make provision requiring the processing of prescribed confidential patient information, the Secretary of State-

(a) must, at any time within the period of one month beginning on each anniversary of the making of such regulations, consider whether any such provision could be included in regulations made at that time without contravening subsection (4), and

(b) if he determines that any such provision could not be so included, must make further regulations varying or revoking the regulations made under subsection (1) to such extent as he considers necessary in order for the regulations to comply with that subsection.

(6) Regulations under subsection (1) may not make provision for requiring the processing of confidential patient information solely or principally for the purpose of determining the care and treatment to be given to particular individuals.

(7) Regulations under this section may not make provision for or in connection with the processing of prescribed patient information in a manner inconsistent with any provision made by or under the Data Protection Act 1998 (c 29).

(8) Subsection (7) does not affect the operation of provisions made under subsection (2)(c).

(9) Before making any regulations under this section the Secretary of State must, to such extent as he considers appropriate in the light of the requirements of section 252, consult such bodies appearing to him to represent the interests of those likely to be affected by the regulations as he considers appropriate.

(10) In this section “patient information” means-

(a) information (however recorded) which relates to the physical or mental health or condition of an individual, to the diagnosis of his condition or to his care or treatment, and

(b) information (however recorded) which is to any extent derived, directly or indirectly, from such information,

whether or not the identity of the individual in question is ascertainable from the information.

(11) For the purposes of this section, patient information is "confidential patient information" where-

(a) the identity of the individual in question is ascertainable-

(i) from that information, or

(ii) from that information and other information which is in the possession of, or is likely to come into the possession of, the person processing that information, and

(b) that information was obtained or generated by a person who, in the circumstances, owed an obligation of confidence to that individual.

(12) In this section "medical purposes" means the purposes of any of-

(a) preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of health and social care services, and

(b) informing individuals about their physical or mental health or condition, the diagnosis of their condition or their care and treatment.

(13) In this section-

"health service body" means any body (including a government department) or person engaged in the provision of the health service that is prescribed, or of a description prescribed, for the purposes of this definition,

"processing", in relation to information, means the use, disclosure or obtaining of the information or the doing of such other things in relation to it as may be prescribed for the purposes of this definition.

3. Bibliography of Published Concerns Regarding NPfIT

This ever-growing set of quotations from the public media (now greatly expanded from the original version provided to the Health Select Committee in May 2006) gives just one side of the case, so to speak - no doubt a number of alternative published quotations relating to NPfIT could be selected that would paint a somewhat rosier picture - this however is a task for Connecting for Health.

3.1. Supplier Problems - iSOFT

3.1.1. Isoft issues FY profit warning after delays in NHS contract (28 Apr 2006)

Forbes

http://www.forbes.com/markets/feeds/afx/2006/04/28/afx2706539.html

" Healthcare software supplier iSOFT Group plc said full year results would fall short of expectations after problems with a key contract with the UK's National Health Service. ISoft said it had 'experienced difficulty in delivering a trading result in line with the current market estimates' following a severe profit warning in January linked to delays on the 6.2 bln stg refit of the NHS's computer systems."

3.1.2. iSoft restates accounts and axes 150 jobs (8 Jun 2006)

E-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=1932

" Healthcare software company iSoft has seen its shares tumble to a new low, on the back of an announcement this morning that it expects full-year revenue and profit to be significantly lower than expected due to a change in accounting policy. . . The Manchester-based firm also announced that it will make 150 of its UK staff redundant by the end of the year as part of a cost cutting-drive to slash operating costs by £25m. A 90 day staff consultation began on May 15. The company says it will also look at disposing other assets. iSoft has contracts to deliver clinical software in three of the five clusters of the NHS National Programme for IT (NPfIT). Currently providing versions of legacy products the company is developing a next-generation Lorenzo product. E-Health Insider understands that Lorenzo, originally due to be available for NHS implementation in 2004-2005, is now not expected to be available for significant numbers of NHS deployments until 2008-2009."

3.1.3. Accenture may drop iSoft from NHS work (1 Jul 2006)

The Independent

http://news.independent.co.uk/business/news/article1152068.ece

" The management of the troubled UK software developer iSoft came under further pressure yesterday after Accenture, a key contractor of its software for the £12bn upgrade to the National Health Service's IT infrastructure, suggested it might be prepared to use another supplier on the project. John Weston, the chairman and interim chief executive of iSoft, is already grappling with a renegotiation of the company's banking arrangements as well as a rejig of the NHS contracts. Over the past six months, iSoft has lost about 80 per cent of its market value after several profits warnings and restating its previous accounts to reflect a change in its accounting policy. As if Mr Weston did not have enough on his plate, Accenture has cast doubt over iSoft's future involvement in the NHS upgrade. Bill Green, Accenture's chief executive, told analysts on a conference call after its third-quarter results: " We are watching the iSoft situation closely ... we have a series of alternatives that we can take forward." The loss of the two Accenture contracts could result in a loss of about £200m in revenue for iSoft. ISoft reported revenue of £262m in 2005."

3.1.4. Uncertainty hits Isoft shares (1 Jul 2006)

Financial Times

http://www.ft.com/cms/s/7a3c648e-089e-11db-b9b2-0000779e2340.html

" Added uncertainty over Isoft's involvement in a large project to overhaul the National Health Service IT network sent shares in the troubled software group down by more 5 per cent yesterday. The fall

followed comments by Bill Green, chief executive of Accenture, Isoft's partner in two NHS contracts. He said Accenture " was watching the Isoft situation closely" and had a " series of alternatives" that it was " prepared to go with . . . if that became necessary" . This intensified speculation that Isoft could be replaced by Cerner, its US rival."

3.1.5. iSoft in crisis over £6bn NHS project (7 Jul 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1815307,00.html

" The future of iSoft, one of the key software suppliers in the government's £6.2bn upgrade of NHS IT systems, was thrown into doubt today as the company delayed publishing its annual results because it was still locked in crucial financing talks with its banks."

3.1.6. iSoft delays results as it looks to banks for help (8 Jul 2006)

Guardian

http://politics.guardian.co.uk/publicservices/story/0,,1815847,00.html

" The future of iSoft, one of the key software suppliers in the government's £6.2bn upgrade of NHS IT systems, was thrown into doubt yesterday as the company delayed publishing annual results because it was locked in crucial financing talks with its banks."

3.1.7. Isoft faces formal probe (8 Aug 2006)

Financial Times

http://www.ft.com/cms/s/2dc96048-2716-11db-80ba-0000779e2340.html

" Isoft faces the prospect of a formal investigation after a preliminary examination of its past accounts found evidence of irregularities. The struggling healthcare software group, which provides software for the government's £6.2bn National Programme for Information Technology, told the stock exchange Tuesday that the initial investigation launched two weeks ago by Deloitte, its new auditor, had concluded that there were grounds for a further probe. Richard Bacon, the Conservative MP for South Norfolk and member of the public accounts committee, said he would ask the secretary of state for trade and industry to consider whether there should be an investigation of the conduct of Isoft's directors under the Companies Acts."

3.1.8. ISoft suspends founder over accounts queries (9 Aug 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1840040,00.html

" ISoft, the troubled NHS software supplier, has suspended two employees, including one of the group's founders, Steve Graham, after an investigation by its auditors confirmed accounting irregularities over two years. The latest revelations at the software group prompted calls from MPs for a government investigation into the company's directors. In its statement to the stock exchange, iSoft also pointed the finger at " other employees" who had since left the company. It refused to name them, but said they " appear to be involved" and that a further investigation would be required."

3.1.9. NHS gave iSoft money upfront during year of irregularities (10 Aug 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1840840,00.html

" The NHS has admitted it made an upfront payment to healthcare software provider iSoft in the last days of its 2005 financial year. The firm's auditors found this week that revenues that year were recognised earlier than they should have been. An iSoft spokesman said the payment in April 2005 had related to future revenues from maintenance contract extensions on legacy computer systems. These are still in use as doctors and hospital staff await the next generation of software - the £6.2bn national programme for IT. Tory MP Richard Bacon, a Commons public accounts committee member, last night said: " This is clear evidence that Connecting for Health [the NHS body implementing IT systems] has been making upfront payments to a company during a critical financial period where there

are clearly now questions of accounting irregularities. It is plain the Department of Trade must investigate this." . . . Connecting for Health agreed to upfront payments to cover predicted maintenance revenues from legacy systems in 1,500 NHS trusts and practices. It said it received a discount for paying ahead. Such deals are not unusual for the NHS. ISoft directors' bonuses, set by a remuneration committee chaired until last year by former CBI boss Sir Digby Jones, were closely tied to revenues and profits."

3.1.10. Sheffield abandons iSoft iPM implementation (16 Aug 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2073

" Sheffield Teaching Hospitals NHS Foundation Trust has abandoned plans to implement a new patient administration system from iSoft, the stage of the local Care Records Service (CRS) software being offered to it under the NHS Connecting for Health programme. After delays stretching back to 2004, the independent foundation trust covering one of the eight largest cities in England outside London will now instead seek an " alternative solution" for use across the trust. This may be a non-CfH system. The Sheffield's board finally decided to call a halt to the implementation of iSoft iPM on 9 August. In a statement the trust told E-Health Insider the decision was reached because: " A number of requirements were not met before the go live date of June 2006. These requirements were agreed by senior representatives of the trust, the LSP and CfH." The trust had originally been due to receive the basic Phase 1 Release 1 (P1R1) of CRS back in November 2004, but the date has repeatedly been put back, and the project stopped and started, due to delays in completing the software. EHI has learned that the decision to abandon implementing iPM was taken after Sheffield made site visits to both Scarborough Hospital and University Hospital Birmingham to see their CfH implementations of iPM. The trust, however, denied these visits had specifically triggered the decision: " The site visits did not have any material impact on the decision made by the trust but they informed our formation of the pre 'go-live' requirements." To date Accenture, the local service provider (LSP) for the North-east region, has implemented the CfH version of iPM at just one hospital trust – Scarborough and North East Yorkshire NHS Trust, which has proved problematic."

3.1.11. Company at heart of NHS reform in serious trouble (23 Aug 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1856154,00.html (Front page lead)

http://business.guardian.co.uk/story/0,,1856163,00.html (Main story - business section)

http://business.guardian.co.uk/story/0,,1856162,00.html (Timeline)

" The full extent of the financial difficulties facing the company at the heart of the NHS's £6.2bn computer upgrade will be revealed later this week. The troubled software company iSoft must release twice-delayed financial results to the stock market by Friday or trading in its shares will be suspended. The company's results are expected to show a dramatic downward reassessment of its profitability. A series of highly unusual accounting practices appears to be behind much of the company's initial financial success. . . . One of the final payments received for the year to April 30 2005 was an up-front sum from the NHS's IT procurement arm Connecting for Health. This month the Guardian reported that the payment related to future revenues from maintenance contract extensions on legacy computer systems which are still in use as doctors and hospital staff wait for iSoft's next generation software package, called Lorenzo. The legacy software contract extensions came with software upgrade licences that allowed iSoft to recognise at least part of the NHS money in its 2005 accounts. ISoft said this was in line with accounting policies at the time. It is believed that, at one stage, a similar last minute, up-front payment from the NHS had been anticipated for the year to April 2006. That payment was not made. Meanwhile concern is mounting about iSoft's Lorenzo software, a centrepiece of the NHS's £6.2bn nationwide software upgrade, being developed at the firm's base in Chennai in India. Consultancy firms Accenture and CSC, iSoft's partners on three big NHS contracts, produced a review of the software in February which found, aside from a basic version of Lorenzo tailored for GPs, there were 'no believable plans for releases'. The review said iSoft's release date targets 'must be viewed as 'indicative' at best and are likely to be highly optimistic'. The software is at the heart of iSoft's plans for the future and was described in its annual report last year as being already 'on the market' and 'available' from early 2004. ISoft expects to give an update on Lorenzo progress when it reports its

figures later this week. Last month it signalled that it expected to take a 'material' goodwill impairment charge."

3.1.12. Government's experts urge " caution" over beleaguered Mater Dei bidder (24 Aug 2006)

Malta Today

http://www.maltatoday.com.mt/2006/08/06/top_story.html

" The British firm short-listed to provide Mater Dei's IT system, iSoft, has had its ratings revised downwards by industry experts Gartner, the same consultants government chose to assist the committees evaluating the offers from tenderers. . . .Mater Dei's crucial IT system has to be in place by December 2006 if Prime Minister Lawrence Gonzi wants to cut the inauguration ribbon on 1 July, 2007, his fifty-fourth birthday. The decision on the crucial contract is now expected to be taken shortly after iSoft and AME consortium presented their final offers earlier this week. The consortium – Austrian firm AME, Intercomp and Italian firm Inso SpA, the suppliers of Mater Dei's medical equipment – presented a EUR29,133,600 bid. iSoft presented a higher price at EUR29,630,153. . . In June 2006, iSoft announced a change in accounting policy which reversed GBP165 million of revenue it had booked upfront in the past three years. As a result, CEO Tim Whiston resigned in June 2006, with chairman John Weston taking over. According to Gartner, new chief operations officer Bill Henry has " no experience with complex clinical information systems" . iSoft's share value dropped by 90 per cent this year after issuing a warning that revenues and profits from the UK's National Health Service IT project (NPfIT) would be lower than expected, due to delayed delivery of iSoft applications. Irrespectively, iSoft spokesperson John White claimed last week that the company was a " strong" company, in a letter to Malta Today. London's Financial Times reported iSoft's diatribe earlier this week, but iSoft denied it had complained about the coverage through the British High Commission. iSoft is providing three of the five regional contracts for the NPfIT. According to Gartner, iSoft's Lorenzo software will require substantial investment and that iSoft " must ensure it will have the resources to make this investment. iSoft appears to have seriously underestimated the time and effort necessary to develop the Lorenzo application suite." Although Gartner notes that such delays are unsurprising given the large scale of the project, it noted that iSoft's reduced profitability and capitalisation " could impair its ability to accelerate this work, because delays in delivery Lorenzo applications will require iSoft to maintain its existing applications longer than anticipated." iSoft provides software for the transmission of information from patients to doctors. Software licences are usually spread out over several years. While some companies pay a lump sum upfront, others pay in staggered amounts over the life of the agreement. Under CEO Tim Whiston however, iSoft often booked the full value of contracts and services as revenue upfront, regardless of how customers paid. This meant that in many cases it booked revenue which the firm would not see for several years."

3.1.13. Inquiry into profits of NHS computer firm (24 Aug 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1857404,00.html (Front page lead)

http://business.guardian.co.uk/story/0,,1857221,00.html (Main story - business section)

The software company at the heart of the NHS's plans for a £6.2bn overhaul of GP and hospital computer systems is being investigated by the Financial Services Authority after revelations about irregularities in its accounts. The City of London regulator is believed to be examining whether iSoft misled investors over how much it had earned. This month, the company confirmed that a provisional inquiry by its auditors, Deloitte, had unearthed evidence that revenues for 2004 and 2005 had been booked in the accounts " earlier than they should have been" . The Serious Fraud Office is understood to have been alerted to the situation at iSoft, but a file has not been referred to it or opened by it. . . Separately, the Guardian has given notice to iSoft that it will apply to the high court to remove a gagging order secured by the company to halt a Guardian investigation into its accounting practices in 2004. Breach of confidence and defamation laws meant the dispute ended in the Guardian being unable to publish information from two iSoft-related documents."

3.1.14. Waiting for Lorenzo (24 Aug 2006)

e-Health Insider

http://www.e-health-insider.com/comment_and_analysis/index.cfm?ID=161

" A detailed review of iSoft's development of Lorenzo, carried out by Accenture and Computer Sciences Corporation this year concluded that there is a " significant risk" the software will not meet NHS requirements as defined by NHS Connecting for Health. EHI has obtained a copy of the confidential report, which indicates the development of the Lorenzo system bought for the NHS IT programme remains fraught and is still at an alarmingly early stage. By February no module had yet been completed or tested and development plans for more complex later releases were sketchy at best. Overall the report paints a bleak picture of iSoft's approach to project management and rigorous software development. It also reveals the company's limited readiness to share development plans with its prime contractors Accenture and CSC. The iSoft review warns that urgent steps must be taken " if we are to avoid the delivery of Lorenzo in a timeframe that will inevitably be far too late for CfH" . It further suggests the NHS may wind up with a solution " whose scope does not match that required by CfH, as it has not been defined from the top down with LSP in respect to the CfH requirements" . Lorenzo is the core clinical software at the heart of the NHS IT modernisation programme, and is meant to be delivered to 60% of the English NHS. The first versions of Lorenzo are now running two years late, having due to be delivered from 2004. . . The Lorenzo review, which involved a team visiting iSoft's Chennai development facility in India, assessed 39 matters relating to Lorenzo. Nineteen were flagged up as " red" - meaning they required immediate work. Of particular concern were questions over iSoft's ability to plan, produce credible roadmaps for products, and estimate how long the development process would take. Damningly, the Lorenzo review found " no evidence for the development, nor testing of, technical procedures that would be required for operation and maintenance of the live system . . . this is the main risk to the successful delivery of a fit-for-purpose solution." One of the red flags was the absence of robust change control mechanisms. . ."

3.1.15. Isoft eyes bidders as it reports £343m loss (26 Aug 2006)

Financial Times

http://www.ft.com/cms/s/e3f9276e-349e-11db-bf9a-0000779e2340.html

" Isoft, the beleaguered software supplier to the £6.2bn National Health Service IT project, is considering several informal bid approaches as it looks to improve its precarious financial footing. It comes as Accenture - the consultancy that has taken a $450m (£238m) charge for possible losses on the same project - is attempting to renegotiate its involvement with the NHS scheme. If a deal goes ahead on either front, it would add to the sense of turmoil surrounding the world's largest non-military IT project, an ambitious plan that would allow doctors fast access to electronic patient records, but which is running about two years behind schedule. . . Several potential private equity and trade buyers are understood to have approached Isoft to buy all or part of its business. Isoft yesterday declined to comment. There was no news of any renegotiated deal with Accenture. Relations between Accenture and Isoft are understood to be fraught - each side blaming the other for delays to the project. Accenture insiders say the company's involvement in the NHS project has proved hugely damaging financially and reputationally. Accenture, CSC, Isoft and Connecting for Health, the NHS's IT procurement arm, all declined to comment on negotiations involving Accenture's future role."

3.1.16. Ex-CBI boss caught up in NHS fiasco: Digby Jones drawn into row over iSoft as company reveals £344m loss (26 Aug 2006)

The Guardian

http://politics.guardian.co.uk/publicservices/story/0,,1858833,00.html (Front page lead)

http://business.guardian.co.uk/story/0,,1858786,00.html (Business section)

http://politics.guardian.co.uk/publicservices/comment/0,,1858814,00.html (Leader)

" Sir Digby Jones, one of Britain's best-known businessmen, was last night enmeshed in the worsening controversy over the government's £6.2bn effort to overhaul the NHS computer system. . . Sir Digby, who until recently was director general of the Confederation of British Industry, the " voice of British business" , was an iSoft non-executive director in 2004-2005. This is the period when the accounting issues now under the microscope took place. He also served on its audit and remuneration committees. When Sir Digby was questioned during a Guardian inquiry into iSoft's accounting in August 2004, he said he had thoroughly investigated allegations put by the newspaper. Sir Digby, who made his name campaigning for high standards in corporate governance, accused the paper of " serious and unfounded

insinuations of impropriety" . He was " satisfied that the company has followed best practice" . In a statement yesterday he said he " welcomed the investigation by [City watchdog] the Financial Services Authority into the affairs of iSoft. I will be making no further comment."

From the Leader: " Even more worrying than the corporate scandal is the fact that iSoft's failure to deliver on time could threaten the future of the massive health service reforms on which Labour has pinned many of its electoral hopes. The disaster scenario is that iSoft's problems will eventually trigger a domino collapse among other firms, halting the transformation of the NHS or postponing completion for yet more years. It could also be a swansong for Britain's indigenous health technology industry, a sector that had been flourishing until recently. Many of the smaller companies involved have been acquired by iSoft, which may find it hard to survive as an independent company."

3.1.17. Accenture refuses to rule out dropping iSoft from NHS job (26 Aug 2006)

The Times

http://www.isoftplc.com/corporate/media_files/Preliminary_Results_April_2006.pdf

http://business.timesonline.co.uk/article/0,,9075-2328828,00.html

" Doubt surrounds IT company's contracts as it wins banks' backing and issues its twice-delayed results. ACCENTURE, the American information technology group that is rolling out new computer systems to GPs and NHS hospitals, refused to rule out dumping iSoft as a contractor yesterday as the British healthcare IT company said that it had secured backing from its banks for another 15 months. The US group refused to expand on its relationship with iSoft, beyond noting comments that it made in March, when it blamed iSoft for its expected losses on the NHS work and said that it was " actively exploring all options with respect to the contracts" . John Weston, iSoft's recently appointed chairman, conceded that Accenture was " still looking at other alternatives" , but said that he was " reasonably optimistic" of a suitable outcome for iSoft. " We're waiting to see what happens," he said. ISoft is working on two contracts with Accenture, in the North East of England and the East Midlands. It is working with CSC, a rival to Accenture, on the North West and West Midlands regional deployment. CSC said yesterday that it was " fully committed" to iSoft as it extended an existing agreement with the company to supply its software to seven NHS trusts in London and the South East of England."

3.1.18. Preliminary results for the year ended 30 April 2006 (26 Aug 2006)

iSOFT Group plc

" The second half of the financial year ended 30 April 2006 was a turbulent period for iSOFT and long-term shareholders will be feeling deeply disappointed by the events of recent months. . . LORENZO is iSOFT's flagship strategic offering and it is central to the Group's future. . . Within the NHS, hospitals and general practice surgeries vary enormously in the sophistication and maturity of their use of IT and their methods of working. The functional requirements which the software has to satisfy are also open to a number of different interpretations, which has led to disagreements with the LSPs about whether software meets the functional requirements. . . A number of difficulties experienced on the programme are outside the Company's control, but some have resulted in formal correspondence being exchanged between the Company and both Accenture and CSC, alleging material contractual breach by the Company. . ."

3.1.19. Bidders prowling round troubled health service supplier Isoft (27 Aug 2006)

Sunday Times

http://www.timesonline.co.uk/article/0,,2095-2330116.html

BIDDERS are circling Isoft, the embattled software firm at the centre of the National Health Service's multi-billion- pound IT upgrade programme. Health-industry sources said last night that BT and CSC, the American computer giant, were both looking over the company, although it was not clear whether either would bid. Both have big contracts under the NHS programme, to which Isoft is a key supplier. It is the software subcontractor in three of the five regional " clusters" under which the IT revamp is organised. Last week Isoft cemented an important additional supply deal with CSC. But Connecting for Health, the agency running the NHS programme, might take a dim view if either group decided to make a play for Isoft. " They are not particularly keen on the idea of a reduction in the number of

suppliers to the programme, or in vertical integration between prime contractors and their suppliers, particularly when it involves such a key player as Isoft," said one health-industry source."

3.1.20. Millions advanced for crisis-hit NHS system (27 Aug 2006)

The Observer

http://observer.guardian.co.uk/uk_news/story/0,,1859513,00.html

The crisis surrounding the rollout of the NHS's multi-billion-pound computer system took a new twist last night when it emerged the government had paid a key contractor working on the project millions of pounds for services in advance of delivery. Paying for services up front is a highly unusual move when it comes to IT projects. The revelation has been seized upon by critics who claim the project is in danger of becoming a white elephant costing the taxpayer billions of pounds and appears to contradict statements made by the health minister, Caroline Flint, who told the BBC's Newsnight programme that 'we don't pay until we get delivery'. . . In a letter in today's Observer, Flint also maintains contractors are paid only 'once IT systems have been delivered, protecting the taxpayer'. . . However, a letter seen by The Observer, sent in May 2005 from Gordon Hextall, the project's chief financial officer, to all NHS trust executives, confirms that the Department of Health 'agreed to make annual payments to iSoft (the company supplying the software that powers much of the NHS's system) in respect of predicted charges payable by trusts/GPs'. The Observer understands these advanced payments totalled more than £30m. . . The Tory MP Richard Bacon, a member of the Public Accounts Committee, has a list of questions about where the money has gone. 'I want to know about every payment, how much it was, who paid it and who it went to,' Bacon said. 'There have been forward payments: we just don't know how many. This is a City scandal funded by the taxpayer.'"

3.1.21. What IT crisis? ministers ask (28 Aug 2006)

Daily Telegraph

http://www.telegraph.co.uk/money/main.jhtml?xml=/money/2006/08/28/cnhs28.xml

The Government last night insisted there was no risk to its multi-billion pound overhaul of the NHS computer system despite its main software supplier iSoft diving into the red, being investigated by the City's financial watchdog and openly squabbling with its partners. In a statement, the Department of Health said: " The NHS IT programme is not at risk of stalling, in jeopardy or close to collapsing because of iSoft's recent troubles. It [iSoft] confirmed that it will make its new software through 2008 - so in no way is the programme at risk." The news was greeted with incredulity by MPs from both main parties. Paul Farrelly, Labour MP for Newcastle-under-Lyme, said: " The Department of Health was alerted to iSoft in parliamentary questions over two years ago. It responded with a very complacent statement then. This is not the time to repeat that mistake. From iSoft's results announcement... it was quite clear that question marks remain over the future viability of the company." Richard Bacon, Conservative MP for South Norfolk who is also a member of the House of Commons' Public Accounts Committee, added: " The idea there is no risk at all around this project is nonsense." Last week iSoft revealed a pre-tax loss of £343.8m and admitted that it is being investigated by the Financial Services Authority over possible accounting irregularities. Auditors Deloitte & Touche gave a qualified opinion on its accounts which were published on Friday after delays."

3.1.22. Press reports question future roles of iSoft and Accenture (29 Aug 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2093

" Weekend press reports raised further questions over the future shape of the NHS National Programme for IT and the long term involvement of key software contractor iSoft, together with raising questions over the future involvement of consulting giant Accenture. . ."

3.1.23. Hewitt admits £82m payments to stricken iSoft (13 Sep 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1871050,00.html#article_continue

" The government has admitted making two upfront payments, totalling £82m, to iSoft, the financially stretched software group playing a central role in the NHS's £6.2bn overhaul of computer systems in

hospitals and GP practices across England. The health secretary, Patricia Hewitt, said payments of £58m and £23.8m were made to iSoft in 2005 and this year respectively. On each occasion, transfers were made just days before the company's financial year came to a close on April 30. . . The health secretary disclosed the upfront payments in a written answer to the Tory MP Richard Bacon, a member of the public accounts committee. Mr Bacon said: " It is hard to avoid the conclusion that Connecting for Health [the NHS's IT procurement arm] has repeatedly bent over backwards to try to rescue this company from its financial crisis, presumably to avoid the disaster that would hit it if a vital software supplier were to collapse. . . "

http://www.guardian.co.uk/letters/story/0,,1876289,00.html (Rebuttal letter from James Herbert, CfH Director of External Affairs)

3.1.24. ISoft problems surfaced after NHS pulled plug in April (15 Sep 2006)

The Guardian

http://politics.guardian.co.uk/economics/story/0,,1873013,00.html

The government refused a last-ditch request by iSoft, the troubled NHS software supplier, for a multimillion-pound up-front payment - on top of £82m already advanced by the Department of Health - in a move that precipitated the near financial collapse of the company. In April, the then chief executive Tim Whiston banked on delays to the NHS's £6.2bn National Programme for IT providing a short-term windfall for the firm. Because of the delays, he believed, a contract relating to its ageing software - used across almost 400 NHS trusts and GP practices - would have to be extended by the Department of Health. . . By April, not only did Mr Whiston expect the Department of Health to extend contracts relating to antiquated iSoft systems, but he anticipated payment would largely take the form of a multimillion-pound up-front sum. Connecting for Health, the NHS's IT procurement arm, told Mr Whiston there would be no contract extension and no up-front cash. The government had already made a £58m up-front payment to iSoft a year earlier - a vital cash injection helping the company to meet its financial targets for 2005. The payment was made after Mr Whiston and iSoft's three founders had begun building personal fortunes through the sale of shares. Mr Whiston made £5.2m after cashing in shares last year. ISoft founders Patrick Cryne, Steve Graham and the late Roger Dickens netted £41m, £30m and £10m respectively between 2001 and 2005. . . The disclosure that iSoft had received payments for work yet to be carried out is highly embarrassing for Ms Hewitt. The government has repeatedly insisted no cash would be paid for work on the National Programme until services are proven to be delivered and operational. Old iSoft systems, Ms Hewitt has stressed, are not part of the National Programme."

3.1.25. Sheffield concluded iPM was 'not fit for purpose' (26 Sep 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2155

" A confidential review of the two Local Service Provider versions of iSoft's iPM patient administration system carried out by Sheffield Teaching Hospitals NHS Foundation Trust concluded the system was not, in its team's opinion, " fit for purpose" and created " clinical risks" , due to a series of performance issues. The team looked at versions of the initial Care Records Service (CRS) software implemented by CSC in Birmingham and by Accenture in Scarborough. The Sheffield trust is in the North-eastern cluster being managed by Accenture. . ."

3.1.26. NHS computer system target will be missed in two weeks (17 Oct 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1923939,00.html

" A key delivery target on the NHS's £6.2bn IT upgrade will be missed in two weeks time as the troubled project fails to meet a promise to have iSoft patient-administration systems installed at 20 acute trusts by the end of October. The latest NHS figures show 11 of the iSoft systems were operational at the end of September - just one more than when the promise was made to MPs in June. Richard Granger, NHS director general for IT, wrote to the public accounts committee four months ago detailing which acute hospitals would receive the iSoft systems by October 31. Promising 21 new patient-administration systems - 10 of them from iSoft - he told MPs the information was " as accurate and up to date as possible" . Since then the only new acute trust to be added to the list of iSoft users

under the NPfIT has been Robert Jones & Agnes Hunt, a specialist orthopaedic trust in Shropshire. . . The NHS had planned to have more than 100 acute hospitals operating patient-administration systems and clinical systems by April this year. Patient-administration software is one of the first building blocks of the NPfIT. It handles appointments and patient movements around hospitals. Clinical tailored systems hold information on blood tests and other investigations as well as best practice for treatments. There are no NPfIT clinical systems installed anywhere as yet. . .”

3.1.27. iSoft ‘in talks with potential buyers’ (17 Oct 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2202

“ iSoft, the UK health software vendor, has announced that it will open discussions with potential bidders and partners to clarify the strategic options open to the company. The company said this morning confirmed that it has received expressions of interest in buying the group and is in talks with potential buyers. It has appointed advisors and said that discussions “ may or may not lead to an offer for the company” . . .”

3.1.28. ISoft puts itself up for sale as it sees off shareholder rebellion over pay (18 Oct 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1924592,00.html

“ ISoft, the troubled software supplier to the National Health Service, put itself up for sale yesterday in an effort to secure its future after warning yet again about falling sales. The firm also suffered a blow as a shareholder revolt over pay deals for directors saw 40% of votes at its annual meeting in Manchester cast against iSoft’s remuneration report. . .”

3.1.29. iSoft and its former auditors targeted by accounting inquiry (25 Oct 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1930678,00.html

“ Accountancy regulators are to investigate troubled NHS software supplier iSoft over “ recent events” at the firm and the conduct of management, auditors and non-executive directors. The Accountancy Investigation and Disciplinary Board has decided to focus on financial statements from 2003 to 2005. Two months ago iSoft said an investigation by Deloitte, its new auditor, had unearthed “ accounting irregularities” relating to 2004 and 2005. It suspended co-founder Steve Graham from his post as operations director and also pointed the finger at “ other employees” who had since left the business. The AIDB’s decision to delve further into iSoft’s past is understood to have been made without consulting the company, which is under new management. Meanwhile, the Deloitte report has been handed to City watchdog the Financial Services Authority, which is carrying out its own investigation into whether iSoft statements misled investors . . .”

3.1.30. Backers sought for beleaguered iSoft (26 Oct 2006)

VHUnet

http://www.vnunet.com/accountancyage/analysis/2167308/backers-sought-beleaguered

“ iSoft under pressure to deliver National Programme for IT: Under-fire healthcare IT company iSoft has put itself in the shop window in a bid to resurrect its ailing fortunes. The decision concludes a catastrophic financial year for the once-booming AIM company as management decided to seek backers before iSoft fortunes took a further nosedive. The news was released hours before iSoft’s AGM, which did nothing to appease its long-suffering shareholders, but hopes of attracting a potential buyer were dealt a massive blow on the eve of the highly-charged meeting. It emerged that serious problems with one of iSoft’s most complex hospital computer system installations were threatening to wipe more than £16m off the expected income of an NHS Trust hospital. The University Hospital of North Staffordshire, which is struggling to claw back debts from last year of £15m and is shedding 1,000 staff, is having problems getting the new IT system to generate basic information on patient treatments in order to send bills to the primary care trusts. It said the problem could leave the trust short

by between £4.5m and £16.2m for the full year. 'The sums look pretty scary,' said its finance director, Mark Mansfield last week. . ."

3.1.31. Revealed: iSoft's U-turn on accounts problems (2 Nov 2006)

The Guardian

http://politics.guardian.co.uk/egovernment/story/0,,1937306,00.html

" The software company at the heart of the NHS £6.2bn IT overhaul added £30m to its revenues in 2004 in a move that had the effect of misleading the stock market, the Guardian can reveal, following the lifting of a gagging order which has prevented the publication of an investigation into accounting irregularities at the firm. The investigation discovered that questionable accounting at iSoft can be traced back to 2002. It suggests the company's non-executive directors past and present, including Sir Digby Jones, a former non executive director and former director general of the Confederation of British Industry, were called to deflect questions about the company's accounting. ISoft is now being investigated by the Financial Services Authority and the accountancy profession's disciplinary body. The authorities indicated yesterday that the information gathered by the Guardian in 2004, but suppressed for two years, would be reviewed as part of their continuing investigations. . . For two years, iSoft claimed information the Guardian had found relating to £30m in revenues came from confidential company papers containing errors that were later corrected. Yesterday iSoft's new management conceded the information in the original documents seen by the Guardian was accurate. The £30m figure was much higher than investors had expected. The glowing full-year results reported in June 2004 pushed iSoft shares to a new high of 446p. A week later five directors and a company founder sold shares worth £44m. . ."

3.1.32. iSoft's future uncertain after more losses (11 Dec 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/12/11/220532/isofts-future-uncertain-after-more-losses.htm

" Troubled healthcare IT firm iSoft, a key supplier to the NHS's £12.4bn National Programme for IT (NPfIT), has admitted it may not survive after six-month results showed further losses. The firm revealed pre-tax losses of £14.3m in the six months to 31 October, with revenues down by 11.6%. The losses figure includes £11.6m of exceptional costs relating to restructuring, including redundancies and the closure of the firm's former Manchester head office. The results announcement said the supplier, which is contracted to provide its Lorenzo care records system as a core part of the NHS scheme, was " now delivering NPfIT milestones on schedule" . . . In a statement released with the results, iSoft warned, " In preparing these projections the directors recognise that there are material uncertainties that may cast significant doubt on the Group's ability to continue as a going concern."

3.1.33. iSoft in talks with Irish health service after admitting it won't deliver on time (12 Dec 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1969936,00.html

" iSoft, the debt-laden NHS software provider, is in discussions with the Irish health service after conceding it would be unable to deliver elements of the group's next-generation software, Lorenzo, on time. John Weston, the chairman, insisted the discussions were " amicable" and that " everybody is happy" with older, stop-gap computer systems installed in 19 hospitals in the Republic of Ireland. " I wouldn't get overexcited," he said. " It's a couple of technicalities really." iSoft is further in breach of its contract with the Irish government after failing to provide a letter of credit when the group's net assets fell below an agreed €75m (£51m) threshold. Mr Weston said such a move was " kind of difficult to do" given iSoft's already fully stretched finances. . . Under the NHS's £6.2bn National Programme for IT, iSoft's software is earmarked to be provided in 60% of GP practices, hospitals and other health trusts in England. Accenture and CSC, the consultancy firms responsible for deploying the software, did not install any of iSoft's patient administration systems in acute NHS trusts in the half year."

3.1.34. Auction of iSoft nearing conclusion (23 Jan 2007)

The Times

http://www.timesonline.co.uk/article/0,,29390-2561009.html

"At least three final-stage bidders are being vetted by iSoft's key £6.2 billion NHS contractor as the sale of the beleaguered IT firm for about £200 million nears, The Times has learnt. It is understood that two American healthcare firms — Cerna and McKesson — and General Atlantic Partners, the American private equity firm, are meeting Computer Sciences Corporation (CSC), a top NHS contractor that subcontracts the government work to iSoft. "It's got to a critical stage where to get any further they need to meet with CSC," a source close to the process said. John Weston, iSoft chairman and acting chief executive, told shareholders in October at the company's annual meeting that it had been approached by financial and trade buyers that were keen to buy the company, take a large stake or form an alliance and that the board had entered talks. Sources close to the process said that iSoft had been in discussions ever since and has narrowed the bidders to a shortlist of three or four. The bidders have had access to its books to conduct due diligence and are ready to proceed with final bids. . . ISoft was given a lifeline by its banks, but the interest-rate payments on the loans are such that it needs to find new equity fast, or face another cash crunch, the sources said. Of the three bidders, General Atlantic Partners already owns a small stake of about 6 per cent in iSoft and is thought to be keen to snap up more. It recently bought a healthcare software firm Eclipsys in the United States and could derive synergies from the two. McKesson is one of the largest drugs distributors in the US but has been slow to expand overseas. Cerna runs the other key NHS contracts that iSoft does not already own, in London and the South, so buying up iSoft would effectively put the American company in control of all the UK's patient records systems. If CSC can not get comfortable with any of the bidders, then it could bid for iSoft itself, the sources said, although it is in the IT firm's interest to push through a sale, they added. . ."

3.1.35. ISoft sale falters as suitor's demands rejected (14 Feb 2007)

The Times

http://business.timesonline.co.uk/tol/business/industry_sectors/technology/article1381585.ece

"The £200 million sale of iSoft could be in jeopardy after talks with the preferred buyer were put on hold, potentially forcing the beleaguered IT company to consider a rights issue, The Times has learnt. It is understood that American drugs distribution company McKesson was front-runner to buy iSoft but in recent weeks talks with Computer Sciences Corp (CSC), iSoft's key NHS contractor, have broken down over certain contract conditions that McKesson wants included as part of any deal. "McKesson would be the best buyer because they're a cash bidder, but they would have to be persuaded to drop all their current demands," a source close to the sale said. "Until they do that, they've been told that they're not going forward." Two other bidders, General Atlantic Partners, a US private equity firm, and IBA Health, a listed Australian healthcare firm, also made it on to the shortlist. But talks with General Atlantic are also on hold because the US firm is proposing a debt for equity swap on terms not acceptable to CSC, while IBA would need a large rights issue, which makes it unlikely to succeed, sources said. Shares in the IT group lost more than 90 per cent in 2006 after a string of profit warnings and the discovery of accounting irregularities, which led iSoft to restate its accounts and wipe out most of its profits. The scandal is the subject of a continuing investigation by the Financial Services Authority. . ."

3.1.36. Australian firm in talks to buy NHS software group (17 Feb 2007)

The Guardian

http://business.guardian.co.uk/story/0,,2015199,00.html

"IBA Health, a small Australian IT group with a turnover of only £24m, confirmed yesterday it is considering an audacious takeover of iSoft, the debt-laden software company at the heart of the government's troubled £6.2bn NHS IT upgrade project. The proposed deal is believed to be all in shares, though IBA will have to raise huge amounts of debt to plug iSoft's working capital shortfall and refinance its increasingly crippling borrowing commitments. It is understood to be in discussions with investment bank ABN Amro. . . Under pressure to strike a deal, iSoft last summer said it needed two years of "significant additional working capital facilities", having previously won up-front payments

for work it is now carrying out. There will be no net cash coming in until May 2008. Onerous debt-related commitments were raised last month and will increase again at the end of March."

3.1.37. NHS seeks rival IT firms as trusts lose faith in iSoft (5 Mar 2007)

The Guardian

http://business.guardian.co.uk/story/0,,2026498,00.html

"The NHS will start recruiting alternative software suppliers to its troubled £6.2bn IT upgrade project this month, in a move which could see the government's vision for a single IT system for the health service in England unravelling. The move is a tacit admission that a fully integrated IT system may never be completed. NHS bosses had until recently discouraged hospital trusts from deserting the scheme. But disaffection is now so widespread and delays so long that officials are working on a list of accredited alternative suppliers, which is widely seen as a move to appease hospital trusts. Under the government's National Programme for IT (NPfIT), trusts were promised centrally bought software to be installed from mid-2004 - all free of charge to them or heavily subsidised. As a result, hospital trusts held back from buying new systems, content to get by with their old software in the belief that NPfIT would soon deliver replacements. But these have now been delayed for so long that trusts are seeking alternatives. New plans to introduce alternative suppliers with proven products that are ready to install is likely to prove a particular blow for the financially stretched iSoft, which relies on its NHS systems for income. . . Last October the NHS IT boss, Richard Granger, played down the significance of an alternative supplier list, suggesting it was "in the event of things going wrong". Some industry insiders see the introduction of alternative suppliers as a step towards a more radical "interoperability" model, similar to that proposed by senior members of the Commons public accounts committee - the Conservative MP Richard Bacon and the Liberal Democrat John Pugh - last year. Mr Bacon cautiously welcomed NHS plans for an alternative supplier yesterday: "This may be an important step towards building an IT programme for the NHS that could actually work but it will only be effective if local trusts are given real freedom of choice quickly. The [alternative supplier] catalogue needs to include all key systems - including PASs as well as clinical and departmental systems - and it needs to make them available within months rather than years." Other suppliers such as EuroKing, Clinisys, Ascribe and System C are likely to make significant inroads into iSoft's user base as these companies have already been winning several contracts with trusts that have lost patience with NPfIT promises. ISoft is still in talks with a much smaller Australian firm, IBA Health, which is considering an all-share takeover offer. ISoft said last summer it needed two years of "significant additional working capital", having previously won upfront cash for work it is now carrying out."

3.1.38. Suspended iSoft co-founder removed from board (28 Mar 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2576

"Co-founder of iSoft, Steve Graham, who was suspended from his post as commercial director in August last year after an initial investigation into accounting irregularities, has been removed from his place on the board. An announcement from the troubled healthcare IT software firm yesterday, said: "The company is today announcing that Steve Graham has been removed as a director and has ceased to be an employee of iSoft." An iSoft spokesman said that company would not be replacing Graham in short term. Asked about compensation for loss of office, he said: "We are not paying any compensation." Graham remains an iSoft shareholder. iSoft holds contracts for supplying major healthcare IT systems in three of the five English regions covered by the National Programme for IT. Delays in delivering systems lie at the heart of the company's problems which have seen its share price plunge from over £4 to yesterday's closing price of 35.75p. In recent months, rumours of an imminent acquisition of the company by various potential buyers have circulated but not yet come to fruition."

3.1.39. iSoft director says NPfIT systems 'interchangeable' (3 May 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2662

"Nick Harte, product management commercial director at iSoft, says the systems being delivered into the five clusters of the English NHS National Programme are all "interchangeable", thanks to Connecting for Health's decision to adopt a Service Orientated Architecture based around the spine

services. Harte, who led the development of iSoft's Lorenzo product, said that this approach, combined with mandating of tough standards, means that iSoft could in theory now deliver elements of its software the South and London, with Cerner potentially doing the same into the three clusters iSoft software has been chosen for. . . Speaking at a recent European E-Health Conference in Berlin Harte said the decision had been taken by CfH to begin by first replacing NHS organisation's core patient administration systems – a task he described as extremely challenging. "We had to replace the engines while in flight". He told the audience that "the National Programme had wanted a very, very aggressive timetable". Despite the initial pain he said the NHS National Programme for IT (NPfIT) had taken the right route in mandating tough standards and adopting a Service Orientated Architecture (SOA), the benefits of which were now being seen. . . Through its national procurement, NPfIT had "defined standards and demanded ruthless adherence to them." Harte stressed this ruthless standardisation included prohibiting local NHS trusts from selecting their own systems "It doesn't allow individual trusts to do their own procurements." Referring to the way IT systems had previously been bought by NHS organisations he said: "Because the way we purchased and procured systems was never going to support the patient journey." In the old world of local NHS IT procurements, he said "requirements for an integrated architecture were always an afterthought." But with an SOA and the national core systems now in place he said that the national programme was being made more locally responsive, with a local ownership programme now being introduced. "It will be possible for local SHAs to determine what systems they want, or at least what order they come in." Harte said that, with standards and core national infrastructure now in place, the additional supplier procurement was a "logical next step", which he described as a "vindication" of Connecting for Health's approach. . . Identifying the key lessons that others could learn from the programme he cited the need for a SOA model to deliver at scale, providing the core infrastructure and business services "you can then plug in around the periphery." He also urged others not to try and develop and deliver software simultaneously. "Don't mix development with delivery – there are already a lot of good things out there today." "

3.1.40. NHS upgrade at risk after IT firm's rescue bid is blocked (30 May 2007)

The Guardian

http://business.guardian.co.uk/story/0,,2090881,00.html

"The future of NHS software supplier iSoft was thrown into doubt yesterday after a rescue takeover offer for the business was blocked. iSoft now has until November to secure an urgent cash injection or go bust - a move that could be calamitous for the government's £6.2bn NHS IT upgrade. iSoft last month told investors it was recommending an all-share rescue offer from IBA Health, a much smaller Australian rival. The proposed deal was to come with new equity and debt to fund iSoft's urgent need for working capital. The deal was effectively blocked yesterday by consultancy firm Computer Sciences Corporation, which deploys iSoft's software under the government's troubled National Programme for IT (NPfIT). CSC's contract with iSoft contains a "change of control" clause which gives the US firm the right to ditch iSoft if the business is sold. . . Should iSoft collapse into administration and alternative software suppliers be appointed, it could set back NPfIT by more than a year. The programme is already two years behind schedule. Many analysts believe no alternative rescue bidder is likely to emerge, leaving a refinancing deal as iSoft's only other hope of survival. If iSoft directors believe there is no possibility of securing the required cash they will be forced to review whether the business is a going concern. . ."

3.1.41. CSC says iSoft deal not in 'best interests' of NPfIT (30 May 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2730

"Computer Sciences Corporation, local service provider to three NHS regions, today said that it has refused to back the IBA takeover of iSoft in the 'best interests' of the National Programme for IT (NPfIT). The LSP, which holds contracts for the North, Midlands and East regions, confirmed today that it has vetoed the takeover of iSoft by Australian firm IBA Health. In a statement CSC said: "CSC is committed to the successful delivery of the NHS National Programme for IT (NPfIT). CSC's decision not to consent to the proposed change in control of iSoft has been governed solely by what it considers is in the best interests of achieving this goal." CSC said that it had been working with iSoft to find a suitable buyer, but discussions with IBA have left them concerned about the impact the sale would have on the work on NPfIT. "Discussions and correspondence regarding IBA commenced in

January, and we have continued in active dialogue with the company up to the present date. During this time, CSC has undertaken due diligence to assess the impact of the IBA transaction on NPfIT. "Our ongoing discussions and correspondence with iSoft clearly reflected CSC's concerns and position, resulting in CSC confirming on 28 May, that it does not intend to consent to the IBA transaction." They add: "CSC has engaged with iSoft and its banks to explore ways to underpin the long term financial stability of iSoft." CSC is currently deploying iSoft's iPM and iCM systems into trusts in the North, Midlands and East and are working on the Lorenzo solution with iSoft. . ."

3.1.42. CSC considers rival bid for Isoft (6 Jun 2007)

Financial Times

http://www.ft.com/cms/s/771cb248-1407-11dc-88cb-000b5df10621.html

"Computer Sciences Corporation confirmed on Wednesday that it was considering a bid for troubled healthcare software company Isoft, its partner in the £12.4bn National Health Service IT programme (NPfIT). Any bid by California-based CSC for the UK group would rival an all-share offer from IBA Health, of Australia, which valued Isoft at about £140m. CSC, which is responsible for delivering Isoft's software as part of the much delayed NPfIT, the world's largest civilian technology project, said it was considering an all-cash offer. "Computer Sciences Corporation continues to review its options in light of this objective, including its contractual rights and obligations, and does not exclude the possibility of making an offer for Isoft," CSC said in a statement. . ."

3.1.43. NHS issues ultimatum to resolve iSoft dispute (7 Jun 2007)

Guardian

http://business.guardian.co.uk/story/0,,2097124,00.html

"NHS bosses have forced iSoft and other squabbling companies linked to the troubled £6.2bn health service IT upgrade to suspend an increasingly acrimonious dispute over the software firm's future and attempt to reach a compromise before the business goes bust. Richard Granger, the director general of NHS IT, has made it clear that he will invoke draconian intervention rights - tearing up billion-pound contracts and replacing suppliers - if the dispute over iSoft's future is not resolved swiftly. His warning yesterday led to emergency talks between iSoft, its largest customer CSC, and IBA Health, the Australian firm proposing an all-share takeover for iSoft. The three had become embroiled in a bitter row after CSC used a "change of control" clause in its contract with iSoft to block IBA's agreed takeover. ISoft, which will go bust if it does not receive a substantial cash injection by November, responded by filing a legal claim against CSC suggesting the American IT firm was unreasonably blocking the IBA deal to further its "wider interests". That action has now been frozen and NHS IT bosses expect the talks to end in CSC allowing the IBA offer to proceed in exchange for the US firm gaining greater control of Lorenzo, iSoft's software package being developed for the NHS's national programme for IT (NPfIT). . ."

3.1.44. CfH on standby to take over Lorenzo development (7 Jun 2007)

e-Health insider

http://www.e-health-insider.com/news/item.cfm?ID=2762

"Connecting for Health, the Department of Health body responsible for the NHS IT programme, is reported to have warned Computer Sciences Corporation and iSoft that it is prepared to step in and take over development of iSoft's Lorenzo patient record software if the companies cannot resolve differences. Today's Financial Times newspaper cites DH sources as saying, a team has already been put on standby to take over if required, following a meeting reported to have taken place between the two companies and CfH boss Richard Granger on Monday. According to the FT CfH is now so alarmed at the potential for a dispute between CSC and iSoft to derail the whole programme that it is now threatening to exercise its full step-in rights on the development of Lorenzo. The official line from CfH last week was that the future of iSoft was a matter for its prime contractor CSC to sort out. Lorenzo is the next generation clinical software that iSoft is contracted to deliver for CSC to install in 60% of the English NHS as part of the NHS IT programme. The troubled software programme is already over two years late with development still underway. . ."

3.1.45. iSoft's last ditch hope (19 Jun 2007)

The Guardian

http://politics.guardian.co.uk/publicservices/story/0,,2106234,00.html

"Cash-strapped NHS software supplier iSoft has agreed to surrender management of its lead development product in a last ditch deal to secure the firm's financial survival. The deal provides an awkward truce between iSoft and its largest customer, US consultancy firm CSC. The two have had an uneasy relationship after development of iSoft's Lorenzo software in India fell behind schedule. CSC is contracted to deploy Lorenzo across 60% of the NHS in England. The American group will now take full management control of Lorenzo, which has been described by iSoft as its "flagship strategic offering . . . central to the group's future". Isoft will pick up the development wage bill and retain licensing rights outside of CSC's contracted work in England. In exchange, CSC will give its blessing to an all-share takeover of iSoft by the Australian firm IBA which secures the British company's future. CSC had previously invoked a clause in its contract with iSoft to block the deal and iSoft had responded with a legal action claiming the US firm was acting unreasonably. Isoft yesterday said it would see the value of its Lorenzo contract with CSC cut by 5%, though revenues will still be "in excess of £300m". Because iSoft is no longer in charge of the project, CSC has agreed to stagger two-thirds of payments over time rather than pegging them to Lorenzo's revised delivery schedule. The deal between iSoft, CSC and IBA came after the intervention of outgoing NHS IT boss Richard Granger. He said he would use draconian intervention rights, tearing up contracts and replacing suppliers, unless a compromise was reached. Isoft chairman John Weston said: "Our relationship with CSC has clearly been tested in recent weeks, however, this agreement underpins our good working relationship which we look forward to continuing."

3.1.46. CSC to buy iSoft division working on key NHS system (23 Jul 2007)

ComputerworldUK

http://www.computerworlduk.com/management/it-business/supplier-relations/news/index.cfm?newsid=4128

"Lorenzo system will pass to key health service contractor in iSoft carve-up. NHS contractor CSC is set to buy the division of troubled software supplier iSoft that is developing the Lorenzo care records system at the heart of the NHS's £12.4bn National Programme for IT (NPfIT). The news follows the shock decision of the iSoft board to recommend a £160m bid for the company by German firm Compugroup in place of an expected £140m takeover by Australian firm IBA. Continuing uncertainty over the future of iSoft has raised questions over the delivery of the Lorenzo care records system – which is already running more than two years late. Lorenzo is set to be supplied as a crucial NPfIT component in three out of five regions where CSC is the lead contractor. CSC had initially blocked iSoft's move to sell to IBA, because it felt this would not support delivery of Lorenzo. But after iSoft threatened legal action – and NHS Connecting for Health, which runs NPfIT, intervened to bring the two sides together – the two companies agreed to integrate their teams working on Lorenzo, under CSC's leadership and the IT services firm gave the green light to IBA's acquisition. CSC, which already had around 100 of its own staff working on Lorenzo within iSoft, was expected to step up that number and assume greater control. But now that iSoft has abandoned the IBA takeover in favour of a higher cash offer from Compugroup, CSC will take ownership and control of the business delivering Lorenzo to NPfIT. The lead NHS contractor has confirmed that it has "held discussions with Compugroup and that it will acquire those parts of iSoft relating to development of Lorenzo for the NHS". . ."

3.1.47. NHS care records system 'in safer hands' with CSC than iSoft (26 Jul 2007)

ComputerWorldUK

http://www.computerworlduk.com/management/it-business/services-sourcing/news/index.cfm?newsid=4203

"The NHS can have "more confidence" in the development of its centrepiece care record system after CSC agreed to buy parts of troubled software supplier iSoft, analysts believe. The crisis-stricken software firm is contracted to supply its Lorenzo care record system as the core element of the NHS's £12.4bn National Programme for IT (NPfIT) in three out of five regions where CSC is the lead NHS contractor. But uncertainty over the future of iSoft has increased concern over the delivery of Lorenzo,

which is already running more than two years late. In a shock move earlier this week, the iSoft board abandoned its planned sell-out to Australian firm IBA in favour of a £160m cash offer from German firm Compugroup. The announcement was followed by news that CSC would itself buy the parts of iSoft that are developing Lorenzo for the NHS. CSC will acquire all iSoft's NPfIT contracts, along with an NHS version of Lorenzo and the existing iSoft NPfIT products, i.Patient Manager and i.Integration Engine. The complex deal will mean Compugroup will also be free to develop its own version of Lorenzo – and may try to sell future versions to the NHS – as well as retaining responsibility for iSoft's NHS legacy products. Ovum analyst Tola Sargeant said NHS Connecting for Health (CfH), the agency that runs NPfIT, could "have more confidence that the development of Lorenzo is in the hands of a company it trusts" when it is taken over by key contractor CSC. The NHS would also "know who to blame if things go wrong with the NPfIT rollout", she said. But Sargeant added: "With CSC becoming a software provider as well as the prime contractor, it will be harder for NHS CfH to switch software if Lorenzo doesn't come up to scratch." CSC will take on "more risk but gains more control over its own destiny" as a result of the planned acquisition, Sargeant said. . ."

3.1.48. iSoft will deliver NHS system to CSC 'in new year' (6 Aug 2007)

ComputerWorldUK

http://www.computerworlduk.com/management/it-business/services-sourcing/news/index.cfm?newsid=4422

"Troubled NHS software supplier iSoft will deliver its Lorenzo care records system to CSC by early 2008, it has said. This will leave the way clear for CSC to start rolling it out to the NHS National Programme for IT from mid-2008 onwards. It set out the timetable in posting a 13% drop in revenues to £175.2m and a 50% fall in "normalised operating profits" as it limps towards its acquisition by German firm CompuGroup. The software supplier is contracted to provide the Lorenzo care records system as the core part of the NHS's £12.4bn National Programme for IT (NPfIT) in three out of five regions where CSC is the lead contractor. But the turmoil surrounding the company has increased concern about the delivery of Lorenzo, which is already running more than two years late. Last month, iSoft announced its shock sale to CompuGroup, abandoning previous moves to sell to Australian firm IBA. . . CompuGroup is set to buy iSoft for £160m and will also buy out its debts. But CompuGroup has agreed that CSC will then acquire all iSoft's NPfIT contracts, along with an NHS version of Lorenzo and the existing iSoft NPfIT products i.Patient Manager and i.Integration Engine. . . Weston said this would mean CSC gaining 700 staff in the UK and India from iSoft – about a quarter of the software firm's total staff. Roll-out of the latest version of Lorenzo was now taking place at sites in Germany and the Netherlands, Weston said. . . NHS trusts' existing iSoft applications would be "upgraded to Lorenzo functionality from mid-2008 onwards" to provide a phased, low-risk migration of systems, he added. The CompuGroup takeover is expected to be agreed by iSoft shareholders at a meeting set for 31 August."

3.1.49. Bradshaw promises Lorenzo and Millennium by summer (1 Apr 2008)

e-Health Insider

http://www.e-health-insider.com/news/3604/bradshaw_promises_lorenzo_and_millennium_by_summer#c8701

"Health minister Ben Bradshaw has said despite ongoing delays new Lorenzo and Millennium software will be delivered to NHS sites this summer. Replying to a parliamentary question the minister also confirmed last week that development work on Cerner Millennium for the South of England had ceased while the NHS remains in a deadlocked contract dispute with Fujitsu and Cerner. The minister also addressed concerns about the financial stability of iSoft's parent company, IBA Health, saying this had been verified by iSoft's prime contractor on the NHS IT programme Computer Sciences Corporation (CSC). O'Brien asked for the minister's assessment of the progress of the development and implementation of the delayed Lorenzo and Millennium clinical systems. The health minister said regular reviews were being conducted and promised new systems by the summer. . . Commenting on when Lorenzo will finally be deployed to NHS sites, Bradshaw said: "It is understood that the development plans will enable the deployment of Release 1of Lorenzo into early adopter sites in the North, Midlands and East Programme for information technology, formerly North West and West Midlands, North East and the East Midlands, in the summer." . . . On the development of Millennium software by Cerner, to be delivered in the South by Fujitsu, Bradshaw said eight hospitals were currently using the software, but confirmed further development and deployments remain on hold until

deadlocked contract negotiations are resolved. "The development of the Cerner Millennium by Fujitsu in the South of England, where eight hospitals are using the Release 0 version of the software is the subject of a current contract reset." The minister said BT has delivered Millennium software to two London hospitals since last summer "and a further deployment is now due". He said the next Release LC1 "is due to be implemented in the summer". All the LSPs confirmed to EHI that the minister's answers were factually correct. Though trusts are now responsible for deployment plans under the National Programme for IT Local Ownership Programme (NLOP), NHS Connecting for Health (CfH) are responsible for reviewing and assessing the delivery of systems by LSPs. . ."

3.1.50. NHS says Lorenzo won't be complete until 2016 (20 May 2008)

e-Health Insider

http://www.e-health-insider.com/news/3764/nhs_says_lorenzo_won%E2%80%99t_be_complete_until_2016

"North West Strategic Health Authority says it does not expect full installation of the strategic Lorenzo electronic patient record software until 2016, a year later the date set out in last week's National Audit Office report. A board paper from the SHA says a new contract between CfH/NHS and local service provider (LSP) CSC is due to be signed that will stretch out deployment dates into 2016. First meant to be delivered at the end of 2004 Lorenzo is already running four years late. Last week's NAO report on the NPfIT programme said delivery of the late-running software to NHS trusts is not exepcted to be completed until 2015. The NAO report said delivery by the end of 2015 would represent a four-to-five year delay. However, the NAO report said repeated past delays raised questions over the latest roll-out timetable. "There is considerable uncertainty about when the care records system will be fully deployed and working across the country." The extent of this uncertainty is highlighted in the North West SHA paper. "Included within the Project Agreement (contract) is a revised plan for deployment of the LSP up to 2016," states the SHA Board paper from May 2008. . ."

3.1.51. Minister confirms low Lorenzo usage (17 Dec 2008)

Kablenet

http://www.kablenet.com/kd.nsf/FrontpageRSS/C508502F29AA98728025752200376E45!OpenDocument

"Health minister Ben Bradshaw has acknowledged that so far just 24 people are using one of the core systems in the NHS National Programme IT (NPfIT). Bradshaw said that University Hospitals of Morecambe Bay Trust is making "limited clinical usage in a single ward, with 10 system users", of the Lorenzo patient administration system. At South Birmingham Primary Care Trust the system is restricted to the 14 user podiatry team. In a written parliamentary answer on 16 December 2008, he added that Bradford Teaching Hospitals foundation trust will go live in the new year with Lorenzo. Lorenzo software is being developed iSoft for use by all trusts in the north, Midlands and east of England, where CSC is the NPfIT local service provider. In reply to questions from Conservative MP Richard Bacon, Bradshaw confirmed delays in the release schedule for the software. As part of a contract reset in January 2007, the intention was for Lorenzo release 3.5 to appear by 30 June 2008 and release 4.0 by 30 June 2009, but the minister said that Lorenzo release 2.0, containing care management functionality, should now be available for testing in the UK by the end of December.

3.1.52. NPfIT officials threatened Foundation trust with penalty (15 Jan 2009)

Computer Weekly - Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2009/01/npfit-officials-threatened-fou.html

"Health officials sought to discourage a foundation trust from buying systems outside the NHS IT scheme by threatening to charge for national software even if the trust bought an alternative system, Computer Weekly has learned. The threat, if carried out, could have left Rotherham paying for two hospital systems when it needed only one. The board of Rotherham NHS Foundation Trust has gone to open competitive tender for a hospital administration system. It is due to make a decision shortly on which system to buy. But officials regionally and centrally want trusts in the Midlands and north of England, including Rotherham, to commit to the "Lorenzo" system which is due to be delivered under the £12.7bn National Programme for IT. Brian James, Chief Executive of the Rotherham trust, revealed in an interview with Computer Weekly that health officials had threatened to charge his trust for

Lorenzo- even if the trust buys an alternative technology. Computer Weekly understands that health officials have made similar threats to foundation trusts in other areas. If carried out it would leave trusts paying millions of pounds for systems they do not install - money that could end up the NPfIT suppliers as compensation for deployments that Whitehall contractually promised but which didn't happen. . . James said his trust needs to replace its "Totalcare" patient administration system from US-based healthcare specialist McKesson because support for the product is being withdrawn in 2010. Rotherham could not wait for Lorenzo. "We have been unable to get any firm dates for the delivery of Lorenzo," said James. Asked by Computer Weekly if health officials had put financial pressure on Rotherham to buy Lorenzo, James said: "They told us we would probably have to pay more. We would have to pay for the system they would have given us [in addition to any other system the trust bought]. It would still from a financial perspective pay us to do that." If all trusts buy from BT and CSC, it will help the Department of Health's NHS Connecting for Health to meet its contractual commitments to the suppliers. CSC and BT have £4bn worth of NPfIT contracts which commit the Department of Health to giving them a minimum amount of business. If trusts refuse to buy from the two suppliers, the companies can levy a "non-deployment" charge. A lawyer, John Yates, a partner at legal firm Beechcroft, said in an article last year that non-deployment charges were becoming a bone of contention between trusts and the Department of Health. . ."

3.2. Supplier Problems - Accenture

3.2.1. Accenture Reports Second-Quarter Fiscal 2006 Financial Results (28 Mar 2006)

Accenture

http://www.accenture.com/xd/xd.asp?it=enweb&xd=_dyn/dynamicpressrelease_974.xml

" Accenture (NYSE: ACN) today reported net revenues for the second quarter, ended Feb. 28, 2006, of $4.10 billion, a 13 percent increase in local currency. GAAP diluted earnings per share were $0.11, including a pre-tax provision for future losses of $450 million related to the company's future deployment of systems for the National Health Service (NHS) in England."

3.2.2. CfH demands heads roll at Accenture (May 2006)

The British Journal of Healthcare Computing & Information Management

http://www.bjhc.co.uk/news/1/2005/n508002.htm

" NHS Connecting for Health — the DoH agency in charge of the policy for, and implementation of, England's National Programme for IT in the NHS — has issued an icy rebuttal to claims by local-service provider Accenture that delays by its subcontractor iSOFT in developing the core-software solution Lorenzo were responsible for recent losses suffered by the firm. Instead, CfH shifted the blame onto Accenture for failing to manage its suppliers properly, and contrasted the LSP's performance to date unfavourably with that of another, CSC, which also manages iSOFT as a core-software supplier. Connecting for Health stated that it has demanded sackings of key project managers within Accenture to rectify the firm's failures."

3.2.3. Accenture ready to axe NHS IT contract (27 Aug 2006)

The Observer

http://observer.guardian.co.uk/business/story/0,,1859025,00.html

Accenture, the international consultancy and technology group, is ready to resign from the government's controversial £12bn IT programme designed to keep electronic records of 30 million NHS patients throughout the UK. If it does, it would be a major blow to the project, which has drawn fire from politicians, contractors and the City. The programme is £6bn over budget and more than two years behind schedule. Accenture, the largest prime contractor, is in negotiations with the authorities in a bid to ditch its £2bn contract. But there is something of a Mexican stand-off here, because the government agency overseeing the project is sticking to its position that Accenture is liable to a £1bn penalty if it walks away. Accenture says the sum should be reduced to take account of the fact that the contract has changed in nature since it clinched the deal three years ago. One analyst said: 'In essence, what Accenture is saying is " we want compensation because this thing isn't going to plan, and it's costing us a bomb" .' Earlier this year, Accenture, which is based in Bermuda and was once part of

accountancy firm Arthur Andersen, took a $450m hit because of cost-overruns and delays. A compromise solution would see the whole NHS IT contract renegotiated on more favourable terms for the contractors in recognition of the new trend towards local autonomy in the NHS, which means GPs and NHS trusts can take systems other than those being developed by Accenture and the other prime contractors, BT, CSC and Fujitsu. If Accenture does 'walk', it is understood that CSC is ready to step in to take on its responsibilities."

3.2.4. Accenture winds down acute hospital trust work (31 Aug 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2098

" Accenture, the local service provider for the NHS IT programme in the North-east and East of England, is winding down its implementation team working on putting new patient administration system into NHS hospitals. E-Health Insider has been told that the acute implementation team was almost completely disbanded at the beginning of July, with a number of redundancies and contractors let go. Some Accenture staff were redeployed to work on primary and community care projects. . . Industry speculation, however, is increasingly pointing to CSC being allowed to take over Accenture's acute hospital work in the two clusters – taking over responsibility for implementing iSoft products in trusts across two additional regions. Accenture would potentially continue to be responsible for community and primary care work. " The rumour is that they [Accenture] will get out of secondary care and do primary care across all three clusters," the source said. . . Whatever the final outcome it is clear that new installations of administration and clinical software at hospitals the North-east and Eastern regions of the NHS IT programme have largely ground to a halt, with the troubled £6.2bn NHS IT project beset by yet more uncertainty and delay. In June Accenture and NHS Connecting for Health stated in a written response to the House of Commons Public Accounts Committee member Richard Bacon MP that it would install iSoft's iPM patient administration system at five trusts by the end of October. Only one, Ipswich NHS Trust, now says it is working towards meeting this date. The remaining four NHS trusts named by Accenture two months ago have now told E-Health Insider over the past week that they no longer plan to take the system or don't have an implementation date. . ."

3.2.5. Consultant may sue to quit IT upgrade (15 Sep 2006)

The Guardian

http://politics.guardian.co.uk/economics/story/0,,1872995,00.html

" Accenture, a lead contractor on the £6.2bn upgrade of National Health Service IT systems, is preparing legal action against the government as part of an attempt to extricate itself from the project. Accenture, the US-listed consulting group responsible for implementing the National Programme for Information Technology (NPfIT) in eastern and north-eastern regions, has already made provisions of $450m (£238m) against potential losses from its contract with the government and has been rumoured for some time to be keen to withdraw. Industry sources suggest that Accenture has threatened legal action by the end of the month if it cannot reach a satisfactory agreement with Connecting for Health, the NHS's IT procurement arm, on ending or substantially renegotiating the contract. Any withdrawal would be a further blow to the NPfIT, already beset by worries about cost overruns and delays. The move comes as BT said it would consider taking the place of Accenture if given the opportunity by Connecting for Health."

3.2.6. Accenture to quit NHS technology overhaul (28 Sep 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1882423,00.html

" Accenture, the biggest and most successful regional contractor working on the NHS's troubled £6.2bn IT overhaul, is poised to pull out of the project. This will be a body blow for the NHS as Accenture has been responsible for deploying more than 80% of the systems installed so far by the four lead contractors under the National Programme for IT. An exit deal has been agreed with health executives. A joint statement from Accenture and the NHS could be issued as early as tonight, when the consultancy firm is due to report full-year earnings figures in the US. . . The loss of Accenture from NPfIT - the world's largest non-military IT project, designed to revolutionise the health service's largely paper-based systems - raises questions about the performance of the other lead contractors, BT,

Computer Sciences Corporation and Fujitsu. None of them has disclosed provisions or write-downs despite NHS figures showing that their work on comparable NHS contracts remains some way behind Accenture's. According to figures released by the NHS, of the 1,028 systems deployed by the regional lead contractors so far under the programme 827 were carried out by Accenture. The US consultancy has deployed 89% of general practitioner surgery IT systems so far installed, 94% of community primary care systems and 82% of primary care child health systems. While NPfIT still has a long way to run, it is losing its largest and most advanced contractor. . ."

3.2.7. Accenture pulls out of national programme (28 Sep 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2163

" Accenture has departed from the NHS National Programme for IT, walking away from two contracts worth a total of more than £2bn. The company, which is the second biggest supplier to the national programme, made the announcement before its fourth quarter earnings call today. It is understood that the firm has been unable to reach an agreement with NHS Connecting for Health on renegotiation of its contracts. As widely predicted by industry and city sources, Computer Sciences Corporation (CSC), the local service provider (LSP) in the North-west and West Midlands cluster, will take over both of Accenture's two national programme regions: the North-east and Eastern clusters. The departure of Accenture is a body blow for the NHS IT modernisation programme, raising tough questions over why one of its most experienced international contractors has decided it is best served by walking away from over £2bn worth of contracts. It also raises a question mark over the viability of the programme for the other prime contractors: BT, CSC and Fujitsu. According to CfH figures, of the 1,028 systems deployed by the regional lead contractors so far under the programme 827 were carried out by Accenture. . ."

3.2.8. iSoft was central to Accenture's NHS pull-out (28 Sep 2006)

ZDNet UK

http://news.zdnet.co.uk/business/management/0,39020654,39283714,00.htm

" On the day major contractor Accenture announced it was pulling out of the NHS' NPfIT programme, troubled subcontractor iSoft emerged as key to its departure. Healthcare software provider iSoft has emerged as the central cause for Accenture's withdrawal from the NHS' massive IT rehaul. Accenture confirmed on Thursday afternoon that it was pulling out of most of its £2bn contracts with NHS Connecting for Health, the department responsible for implementing the National Programme for IT (NPfIT). With the exception of its role in moving medical imaging services to a digital platform in the North West, Accenture's work will now all be handled by Computer Science Services (CSC), another of the major NPfIT contractors. In a teleconference on Thursday afternoon, Guy Hains, the European president of CSC said the rollout of new NHS software and infrastructure could be sped up following Accenture's withdrawal, mainly because of new arrangements surrounding iSoft — which had been subcontracted into NPfIT by both Accenture and CSC. . . The transferral of work from Accenture to CSC will take place over the next three months. A sizeable proportion of Accenture's NPfIT staff will move to CSC to ensure " an orderly transfer of services and to minimise disruption" , according to NPfIT boss Richard Granger. Accenture's withdrawal means the technology services and consultancy firm will have to repay £63m of the £173m it has already been paid by the NHS. It will, however, be unable to recoup any of its losses by bringing legal action against iSoft, as any potential litigation relating to the period between 2 April, 2004 and 28 September, 2006 was annulled in the termination agreement between the two companies. . ."

3.2.9. MPs say Accenture's departure evidence of NPfIT failure (29 Sep 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2166

" Opposition MPs were quick to voice doubts about Accenture's departure from most of its work under the National Programme for IT, seeing the move as evidence of failure. Liberal Democrat health spokesman, Steve Webb, said: " This is yet more evidence of a project in deep trouble that will doubtless mean more instability distracting health professionals from concentrating on patient care. " This firm's departure will generate yet more fears that the NHS IT project's costs and problems will

escalate further. Inevitably, when you change supplier there will be handover costs and the danger that people with valuable knowledge will leave." Conservative MP and member of the Commons Public Accounts Committee (PAC), Richard Bacon, said: " This just replaces one regional contractor with another which has less experience. However, the main problem is not with the regional contractors but with the product they are being asked to implement, iSoft's Lorenzo system, which still does not work properly. . ."

3.2.10. Inquiry call into NHS IT project (29 Sep 2006)

BBC News

http://news.bbc.co.uk/1/hi/england/staffordshire/5391222.stm

" A Staffordshire MP has called for an inquiry into an NHS computer programme set to cost £6.2bn. It comes after one of the main contractors, Accenture, pulled out of the Connecting for Health programme which will link GPs with hospitals. NHS chiefs said the move would not cause significant further delays to the IT project. Labour MP for Newcastle, Paul Farrelly, said the Department of Trade and Industry should carry out an inquiry. Accenture has handed over £1.9bn of its contracts to another US company, Computer Sciences Corporation. " The big question about this contract is whether in actually designing the system for the NHS it is too ambitious by half," said Mr Farrelly."

3.2.11. Life support for the NHS IT programme (23 Oct 2006)

Information Age

http://www.information-age.com/article/2006/october_2006/nhs_it_programme

" Is Accenture's decision to abandon the NHS IT programme an indication that the project is heading for disaster, or just good management? The computerisation of the National Health Service (NHS) is the most ambitious public sector IT programme ever undertaken. The new system – due for completion in 2014 – will connect hundreds of thousands of doctors, nurses and other health professionals, creating an integrated electronic patient management network. . . But while there is little debate about what the overall objectives of the NHS IT project are – ultimately saving lives through increased efficiencies – the enormous size and scale of the project has attracted plenty of detractors. Doctors have complained about a lack of consultation, and concerns about patient confidentiality in an electronic system accessible by any health professional in the UK have not yet been resolved. . . Richard Granger, CEO of Connecting for Health, the UK government agency responsible for the implementation, has taken a hard line in dealing with contractors not able to meet deadlines. After Accenture's exit, he announced that CfH will tender for extra suppliers to increase capacity and ease its reliance on sub-contractors. Ultimately, whether Granger's hard-line stance is viewed as good vendor management, or overly-aggressive bullying, will depend on the success of the project."

3.2.12. Accenture pulls out of core NHS IT services (11 Jan 2007)

ZDNet UK

http://news.zdnet.co.uk/itmanagement/0,1000000308,39285428,00.htm

"Consulting firm Accenture has completed its withdrawal from delivering core IT services to the National Health Service. The company withdrew from the National Programme for IT (NPfIT) — the largest civilian IT project in history — in September 2006, abandoning most of its £2bn contracts with the NHS in the process. . . Accenture's transfer of core services in the East and Northeast to CSC was completed on Monday as planned, according to the NHS department responsible for NPfIT, Connecting for Health. However, Accenture will still be responsible for delivering medical imaging systems. . ."

3.3. Supplier Problems - Others

3.3.1. BT Takes Second Penalty In NHS Programme (4 Oct 2004)

MCN Direct Newswire

http://www.conferencepage.com/mcndirect/issues2004/mcndirect041004.asp#4

" BT's services business, which is the biggest supplier to the programme, admitted the NHS withheld £300,000 in July - around 30% of the monthly payment on the national application service provider contract - because BT failed to meet a target of 99.8% availability for the national data spine."

3.3.2. Secrecy of NHS contracts begins to unravel (10 May 2005)

Computer Business Review

http://www.cbronline.com/article_news.asp?guid=3CC199E8-47F7-4A54-A5F8-B889DCC6EDA5

" The UK National Health Service's enormous IT overhaul is beginning to show signs of strain, only 18 months after the NHS signed deals worth a total of GBP6bn ($11bn) with a number of vendors. So far though, it is the suppliers rather than the UK government that are looking decidedly unwell. The companies involved are being gagged by some totalitarian-style privacy rules, but news of problems is beginning to surface. Accenture was forced to reveal earnings shortfalls from its NPfIT (National Future Information Technology) contracts, Tata Consultancy Services blamed delays in its NHS work for its recent revenue shortfall, and a new UK law threatens to expose the details of the deals. . . Controversially, the government has deemed it necessary to demand that suppliers keep secret the details such as delivery deadlines of the contracts, hoping to avoid the bad publicity it has suffered previously. So far, very little is known about the structure of the deals, but this could change. The Freedom of Information Act came into full effect at the beginning of the year, which gives the public greater access to government-held information, and may well be invoked to force the NHS to reveal some of the details of the contracts. In March, a leaked memo revealed that the government has put pressure on NHS executives to refuse requests for information under the act, while it considers publishing some details of the contracts."

3.3.3. BT risks losing NHS contract (13 Jul 2005)

Computing

http://www.computing.co.uk/computing/news/2139734/bt-risks-losing-nhs-contract

" BT must start meeting its London NHS commitments or risk losing its £996m Connecting for Health (CfH) contract, says NHS IT director general Richard Granger. In an exclusive interview with Computing, Granger acknowledges that there are considerable implementation problems in the capital, and blames the supplier's handling of subcontractor IDX."

3.3.4. Tata blames NHS National Programme for IT for revenue slowdown (22 Aug 2005)

The British Journal of Healthcare Computing & Information Management

http://www.bjhc.co.uk/news/1/2005/n508002.htm

" Tata Consultancy Services, a key supplier of data-migration services to the National Programme for IT in the NHS in England (NPfIT), has blamed delays in implementing the National Programme across the whole country for a slowdown in its revenues from its European operations."

3.3.5. ComMedica closes diagnostic imaging business (23 Feb 2006)

North Mersey Connect Portal - I & M T News

http://www.northmerseylis.nhs.uk/news/shownews.asp?id=3608

" ComMedica Limited, the UK-based developer of Picture Archiving and Communications Software has announced that it is closing its diagnostic imaging software business. The company has announced a " significant restructuring" , including the closure of its diagnostic imaging software business, resulting in over 100 redundancies at its Woking office and elsewhere. ComMedica said the move followed the Department of Health's decision to suspend deployment of CSC's ComMedica/Kodak PACS/RIS reference solution for the North-West and West Midlands region."

3.3.6. NHS trusts pay millions in fines to suppliers of delayed IT system (6 Jun 2006)

The Guardian

http://www.guardian.co.uk/uk_news/story/0,,1790952,00.html

" NHS trusts are being made to pay multimillion-pound penalties to computer suppliers because of a clause in contracts for the health service's £20bn IT scheme. Arrangements disclosed today by the magazine Computer Weekly show the government committed trusts to provide 200 staff to work with the computer companies to devise the best possible systems. In southern England the NHS was unable to meet an obligation to second 50 full-time employees to the Japanese-owned Fujitsu Corporation. The trusts will now have to pay Fujitsu £19m."

3.3.7. NHS IT costs hospitals dear: Fujitsu scores £19m compo (6 Jun 2006)

The Register

http://www.theregister.co.uk/2006/06/06/nhs_contract_chaos/

" More bad news for the UK government's NHS IT programme - cash-strapped health authorities are having to pay millions in compensation to Fujitsu and CSC . When contracts were first set up by central government, NHS trusts promised to provide staff to help work on the new systems. But according to reports, health authorities in the south of England have failed to find enough people so they have to pay Fujitsu $19m compensation. The south of England was supposed to find 50 staff to work at Fujitsu. The Department of Health told the Guardian: " An agreement has been reached to buy out the liability at a cost of £19m in 2006-07 as NHS trusts have decided not to supply the staff resources." In the north west and west Midlands, the NHS is contracted to provide 50 staff but is struggling to find enough people. Part of the problem is that NHS staff will be paid their standard salary even after moving. The staff were supposed to go to CSC, which is entitled to £6.9m every year for the 10 year term - or just under £70m. Health trusts are looking at ways to buy their way out of the agreements, according to documents seen by Computer Weekly which has more details here. . . Government IT projects either fail because of overambitious, and under-achieving, suppliers or because of incompetent and feckless civil servants. Rarely do they manage to do such damage to both suppliers and customers before anything is actually delivered."

http://www.theregister.co.uk/2006/06/12/npfit_talks_back/ (Response from CfH)

http://www.theregister.co.uk/2006/06/13/letters_1306/ (Readers' responses)

3.3.8. Cerner predicted to replace GE in London (13 Jun 2006)

e-Heath Insider

http://www.e-health-insider.com/news/item.cfm?ID=1937

" An analyst report from the US has said that there is a high probability that clinical software firm Cerner will replace GE Healthcare as main the supplier of clinical systems to the NHS in London. If a change does occur it is likely to initially result in further delivery delays to modernising NHS IT systems in the capital, as part of the late running £6.2bn NHS National Programme for IT (NPfIT). BT is understood to have been examining options for a replacement for IDX since the beginning of the year due to the difficulties in delivering the system to NHS trusts in the capital. In the past 30 months BT has implemented the software at just one hospital trust. . ."

3.3.9. Less than 1.5 per cent of electronic prescriptions seamless (23 Jun 2006)

e-Heath Insider

http://www.ehiprimarycare.com/news/item.cfm?ID=1962

" E-Health Insider has learned that of the 1.6m electronic prescriptions issued by the Electronic Prescription Service, just under 30,000 have been seamlessly sent and received all the way through to dispensing. Out of the 1.6m scripts created electronically by GPs, just 29,386 have then been sent over the NHS spine, received and called down by a local pharmacist for dispensing. Of those called down, 26,676 have been dispensed to patients. This means that less than 1.5% of electronic prescriptions issued are actually being managed electronically end-to-end by the initial version of the EPS -- which still involves the printing of a paper prescription. . . The major efficiency benefits of the national EPS system are only likely to be possible when the majority of scripts generated are entirely electronic. This is a goal that remains a long way off. In a typical week the NHS dispenses 13.7m prescriptions."

3.3.10. Inside the NHS Connecting for Health project (7 Jul 2006)

Computer Business Review

http://www.cbronline.com/article_cbr.asp?guid=0FD865FC-2602-4606-80D8-6A00FF41A833

" Richard Granger, director general of IT at the National Health Service, not only hit back at critics of the $10bn Connecting for Health (CfH) project last month, he also claimed that there is an " essential dishonesty" between IT services vendors and their customers. Granger singled out major NHS contractor Accenture for particular criticism, and said that the project's detractors have failed to appreciate the enormous complexity of the program. . . He added that there remained an, " essential dishonesty between the IT industry and the consumer, with the IT industry still trying to claim that there's a scientific basis behind its estimations of the costs involved in outsourcing projects, when practical experience shows that there isn't."

3.3.11. NE trust faces clinical systems conundrum (20 Jul 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2015

" A mental health trust board formed from three merged organisations has been advised to stop using a clinical information system supplied under the National Programme for IT on part of its new territory and use another single system across the whole trust. Northumberland Tyne and Wear NHS Trust board members received a paper on options for clinical information systems (CIS) which has been leaked to E-Health Insider. Board members were recommended to continue negotiation with CSE-Servelec for its RiO mental health system and to support the development of detailed plans to implement RiO, which is already used in part of the trust. NTW is not alone in its deliberations over strategy to fill the gap between the arrival of national programme solutions and the expiry of existing IT contracts. In December 2005 Norfolk and Norwich NHS Trust, located in the Eastern cluster of the national programme, decided to shelve implementation of an interim PAS system. In the same month Tees and North East Yorkshire NHS Trust, a mental health trust, also postponed an Accenture implementation of iSoft iPM. South West Yorkshire Mental Health Trust has also gone outside the NPfIT programme to procure a new integrated clinical system, as an 'interim solution'."

3.3.12. IMS signs contract with BT for London trust (17 Aug 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2075

IMS MAXIMS Plc today announced that it had signed a three year contract with London local service provider, BT, to supply its web-based clinical software to Barking, Havering and Redbridge NHS Trust (BHRT). . . A BT spokesperson told E-Health Insider that the deal for IMS at the east London trust was not long term: " This is a time limited, interim arrangement The plan is for BHRT to migrate to the strategic solution in due course." . . . The announcement of the deal further confuses the picture of how the £6.2bn Connecting for Health NHS IT programme is now to be delivered in London. In December 2003 the DH awarded BT a £996m 10-year contract to modernise NHS IT in the capital. To date it has installed core patient administration software at one acute trust - Queen Mary's, Sidcup. BT's clinical software provider is currently GE Healthcare, but the company has made clear its intention to switch to Cerner. A contract has yet to be completed."

3.3.13. When Bill met Tony, seeds of a grandiose scheme were sown (26 Aug 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1858787,00.html

" When Bill Gates met Tony Blair at Downing Street in 2001 the seeds were sown for the hugely ambitious plan to transform the NHS with the power of computers. Mr Gates, the billionaire software pioneer, had just written a book about how IT could transform economies. The prime minister, determined to reform Britain's public services, was hooked. Just one year later, representatives of Mr Gates's Microsoft empire attended a seminar at No 10 at which the NHS's £12bn IT programme was conceived. A core principle of this grandiose plan was that it should never rely on a single computer contractor and that the work should be carried out by global players. It is a measure of the crisis that these principles have been sacrificed and the NHS finds itself heavily dependent on one contractor, iSoft, a British-based specialist formed only in 2000. . . To create this system, the Department of Health in 2002 appointed Richard Granger, a former management consultant whose last project was the

London congestion charge, as IT director at a salary of some £250,000. . . In placing contracts, Mr Granger says that he consciously structured the procurements to attract global players back to the NHS. He divided the NHS in England into five regions: the north-east, the east, north-west with west Midlands, the south and London. Each placed a 10-year contract worth about £1bn with a prime contractor to install standard systems. . . NHS Connecting for Health, the agency set up to run the programme, says that the choice of subcontractor lay entirely with the prime contractors, which carry the risks. . . In this arrangement, the NHS's safety net was always to have a backup supplier if one failed. The first to fail was IDX. In the south of England, Fujitsu has replaced IDX with Cerner. Last month, London followed suit. Hence the importance of iSoft, which although it has so far delivered only the first basic models of its hospital system and has financial troubles, is still seen by the NHS as the star performer, especially in its partnership with CSC. Mr Granger likens his relationship with suppliers to that of a polar explorer with his huskies: he once warned companies that weak performers would be fed to the strong. His problem is that he is rather short of huskies to shoot."

3.3.14. BT gets only £1.3m for two years' NHS work (28 Aug 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1859650,00.html

" BT has been paid just £1.3m for the first two years of its work introducing new computer systems across GP practices and hospitals in London, despite spending an estimated £200m-plus of its own cash. The company insisted last night it would not be forced to follow competitors and write down the value of the London NHS contract in its accounts. Three years ago, BT announced it had won a £996m 10-year deal as lead contractor to design, deliver and operate next-generation computer systems in the London area as part of the NHS's £6.2bn nationwide IT overhaul. At the time, it was heralded as a landmark deal for BT by chief executive, Ben Verwaayen. He said: " These wins are BT's biggest ever, and evidence of the new face of BT truly emerging. This is BT taking on world-class competition on its own territory, and winning." Last month, again, BT chairman Sir Christopher Bland, who received his knighthood for services to the NHS, told investors: " BT has achieved some notable successes on its NHS National Programme for IT contracts." But it has emerged that for the first two years of its London contract, BT has been paid by far the least of any of the NHS's lead contractors - just £1.3m. This is believed to reflect the extent to which the NHS thinks BT has met its delivery targets. A spokesman for BT said it was perfectly normal for revenues to be slim at the start of a lengthy contract. " There is a lot of investment up front, but the profitability comes towards the end." But the NHS's other lead contractors, operating similar-size projects around the country, have all been paid at least 20 times more than BT over the same period. . . . BT's reputation in London took a heavy blow earlier this year when it emerged that a child health computer system it designed and installed in several primary care trusts had many shortcomings. The system failed to hold correct data on whether babies had routine health checks, vaccinations, visits from health visitors and assessments for special needs. A spokesman for BT insisted many of the problems related to inaccurate paper records and said the trouble had largely been rectified."

3.3.15. BT faces watchdog inquiry into work on NHS computer revamp (29 Aug 2006)

The Times

http://business.timesonline.co.uk/article/0,,9076-2332472,00.html

" BT is facing a fresh inquiry into its work on the NHS's ambitious IT upgrade, amid growing concerns about the £12.4 billion project. The National Audit Office (NAO), the parliamentary watchdog, said yesterday that it may undertake a fresh examination of the mammoth NHS IT upgrade project, on which BT is one of four main suppliers. Another supplier is the troubled software group iSoft. The threat of further scrutiny followed the revelation in a parliamentary answer that BT has been paid just £1.3 million for about two years' work on one £996 million contract. Though the group insisted yesterday that this was in line with its expectation of laying down investment initially with revenues coming through later, some analysts speculated that the tiny size of the payments could reflect delivery failings by BT. The developments will increase pressure on BT to provide further details about the project's progress when it updates investors about its global services division — the arm that supplies telecoms and IT services to business — next month. The NHS work, worth in total more than £2 billion over ten years, is one of the biggest contracts in the division."

3.3.16. British Telecom ... And the £1billion con-tract (15-28 Sep 2006)

Private Eye

" Now that the Financial Services Authority (FSA) has decided to investigate one of the companies involved in the multi-billion pound NHS IT project, iSoft, over presenting dodgy figures to the stock market, will it dare take a look at another of the big players, BT? The Eye has already questioned BT's performance on the troubled programme . . . On the largest and most crucial part, its £996m contract for the London region, up to March this year it had received just £1.3m for installing only a fraction of the IT systems it should have, while its expenditure on the deal is likely to have exceeded £200m. Yet its accounts up to 31 March 2006 showed no losses from the project. Then last month BT ditched the software contractor it had been using as it shed all this cash, IDX, casting doubt as to whether its huge costs were, as its accounts would have it, " work in progress" and not money down the drain. . ."

3.3.17. Healthy Competition (11 Sep 2006)

New Statesman

http://www.newstatesman.com/200609110041

"A more innovative approach to IT could have prevented the NHS records fiasco. The recent announcement that the Financial Services Authority is investigating iSoft, the troubled computer software company charged with delivering a large part of the new, centralised patient records system for the National Health Service, is just another sorry episode in the government's Connecting for Health initiative. In June 2005, Fujitsu, winner of the contract for southern England, changed horses midstream and dumped its software supplier. BT, the national telecoms provider, which owns the London contract, followed suit last month. And in July the Computer Sciences Corporation suffered an outage at its Maidstone data centre that left clinicians in the north-west and West Midlands stranded without computerised patient records for three days. . . Partly why we feel so powerless when our computers crash is that most of us are locked in to services provided by a monopoly supplier. Remarkably, it's the same at state level: familiar company names appear regularly in the news, because governments are flogging the same dead horses. Government IT contracts are often so tight that only huge companies will touch them. In the case of the NHS, the decision to pay on delivery for a highly complex system meant smaller, potentially more innovative producers could not take on the risk of tendering. Rather than nurturing a competitive ecosystem, such practices entrench the position of monopoly suppliers, regardless of actual past performance. The demand for centrally controlled systems is another hurdle. The most successful information pool is the internet - essentially a decentralised network run on open standards - yet governments persist in demanding control from the centre, and allow contractors to keep their standards hidden. If the government used its leverage as the largest spender on IT in the UK to demand that suppliers forfeit their intellectual property rights, they could open their code to smaller innovators. Managed correctly, such a move could change public IT for ever: rivals could salvage botched projects, and smaller producers could develop additional, specialised tools that plug in to the system."

3.3.18. Delays to NHS computer system could cost taxpayers £40bn (1 Oct 2006)

The Observer

http://politics.guardian.co.uk/egovernment/story/0,,1885133,00.html

" The company charged with rescuing the NHS's troubled IT system has consistently failed to meet its deadlines for introducing the project across the health service, The Observer can reveal. Last week Computer Sciences Corporation (CSC) was awarded a £2bn contract to take on a bigger role in overseeing the implementation of the Connecting for Health system, the biggest civilian computer project in history which is supposed to electronically link all doctors' surgeries and hospitals. But government hopes that CSC will prove the £12.4bn project's salvation have been hit by news that the company has itself experienced huge problems in implementing even the most basic parts of the project. According to its original business plan, obtained by The Observer, CSC was contracted to install new computer systems to 32 acute hospitals by April 2006. However, according to the NHS, only eight of the hospitals had received the basic 'administrative' systems by that date and the company had failed to deliver any working clinical systems - the key part of the project which is supposed to record a person's medical data electronically. . . Critics suggest the eventual cost to the taxpayer of fixing the system's myriad problems will push the total bill for Connecting for Health to in excess of £15 bn. Some have suggested it will rise to as much as £20bn - enough to fund 40,000 nurses

for the 10-year lifetime of the contract. . . 'This just replaces one regional contractor with another which has less experience,' said Richard Bacon, a Conservative MP who sits on the Public Accounts Committee. 'By passing the baton to CSC with indecent haste, the government has missed a golden opportunity to think again and to give more control to hospitals locally. I feel very sorry for hospitals who will have to put up with more delays and with systems that just don't work properly.' IT experts predicted the system's delivery could be completed on time and on budget only if it was scaled back. They warned patients' health could suffer unless problems were resolved soon. 'This is about more than taxpayers' money, this is about people's lives,' said Stephen Critchlow, chief executive of Ascribe, an IT company that supplies computer systems to hospitals."

3.3.19. CSC says it will implement iPM at Bradford in six months (18 Oct 2006)

e-Health insider

http://www.e-health-insider.com/news/item.cfm?ID=2205

" Bradford Teaching Hospitals NHS Foundation Trust, which had gone outside the NHS National Programme for IT to procure for a new patient administration system, has come back into the fold. The trust has signed a deal with Computer Sciences Corporation (CSC) to implement iSoft's iPM in just six months, in a deal underwritten by NHS Connecting for Health. Having abandoned its procurement the trust is now dependant on CSC successfully installing iPM more rapidly than it has previously managed. Should this not be achieved NHS Connecting for Health has pledged to meet the extra cost to the trust of paying for continued support of its existing Siemens IRC system. . ."

3.3.20. Fujitsu under spotlight for NHS failures (24 Oct 2006)

The Guardian

http://business.guardian.co.uk/story/0,,1929770,00.html

" Fujitsu, one of the lead contractors on the NHS's troubled £6.2bn IT upgrade, has installed only three patient-administration systems in two-and-a-half years on the project. It has recently all but frozen further installations while it struggles to fix problems at these sites. Fujitsu's problems are the latest blow for the health service's ambitious IT upgrade, the biggest non-military project of its kind in the world, which has been dogged by delays and contract disputes. Concern about the Japanese consultancy's work has until now been eclipsed by fears over Accenture and iSoft. . . In addition to these other challenges, health service IT bosses have become increasingly concerned about Fujitsu's progress on installing patient-administration systems. In March 2004, having signed a £900m 10-year contract, Fujitsu said it would have the systems up and running in 17 acute trusts, 36 community trusts and eight mental health trusts by this April. But by April Fujitsu had managed only one installation, at Nuffield Orthopaedic, a small acute trust in Oxford. Two months later, Fujitsu promised it would install 12 further systems in acute trusts by the end of this month, but it has added only two more so far and NHS IT bosses now privately admit the target will not be met. Fujitsu's installation programme has been paralysed by problems at the first three trusts to receive the systems. Nuffield Orthopaedic, Fujitsu's first acute trust project, recently said it blamed problems with its computer systems after it lost its top-level three-star performance rating and was assessed as " weak" . In a " serious untoward incident" report to the Strategic Health Authority weeks after the Fujitsu system was installed last December, the trust said disruption caused by the installation could have put the safety of patients at risk. Concerns over Fujitsu installations have led to planned " go-live" dates at hospitals across the south of England - the region for which Fujitsu is lead contractor - being repeatedly put back, sometimes with just a few days' notice for staff. A spokesman for Milton Keynes, which has twice had its go-live date delayed, said Fujitsu was " sorting out the odd glitch" , but the installation has now been postponed with no new date set. . ."

3.3.21. QMS to ditch IDX for Cerner in 2007 (16 Nov 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2270

" Queen Mary Sidcup (QMS), the only London trust to have received a new hospital IT system under the NHS computerisation scheme, will now have to replace it less than a year after the system became fully operational. QMS first switched on IDX's Carecast system after a fraught implementation in November 2005, but it has taken until October 2006 for the system to become fully operational and

integrated with Choose and Book. But following the November 2005 implementation, BT, the local service provider for London, stopped work on further hospital PAS installs. For most of 2006 BT has been locked in negotiations with Cerner and GE Healthcare, which in January purchased IDX. Last week BT finally announced that it had replaced GE Healthcare with Cerner and would now offer Cerner's Millennium as its clinical software for the acute sector. Kate Grimes, QMS chief executive, has exclusively confirmed to E-Health Insider that her trust will now replace IDX Carecast with Cerner Millennium in 2007. . . The planned switch will mean that the trust will have had to go through two full PAS implementations in less than two years. Last month Grimes told a health IT conference how disruptive the implementation of IDX has been for the trust, to the point of creating a severe financial risk to her trust. One of the biggest problems for QMS was that following go live last November it took almost another year for Carecast to be become Choose and Book compliant. The system was only finally integrated last month... QMS says that it only learned that Carecast was not Choose and Book compliant last July. . ."

3.3.22. System C issues profit warning as NPfIT slows (18 Jan 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2428

"System C Healthcare has issued a profit warning citing a dramatic slowdown in deployments under the NHS IT programme as a result of a three month "hiatus" during the handover from Accenture to CSC. A spokesperson for System C told EHI: "The hand-over from Accenture to CSC caused a significant hiatus in activity for us during that period. With the hand-over now complete, the amount of work is increasing steadily, but we know now that the ramp-up will not be as fast as we expected." They added: "This means that in the time left to us in our current financial year, we won't be able to make up the shortfall in our numbers – hence the need for profits warning to the City." System C is one of the main companies implementing computer systems as a sub-contractor to the local service providers (LSPs) delivering the £12bn NHS National programme for IT (NPfIT). In its trading statement the company said "System C continues to operate in challenging conditions in our core English market". The firm indicated that the slow down stemmed from the protracted contract wrangles last year between NHS Connecting for Health and one of its prime contractors, Accenture, eventually resulting in Accenture's replacement by Computer Sciences Corporation. . ."

3.3.23. Fitter, healthier, more productive (15 Mar 2007)

The Guardian

http://technology.guardian.co.uk/weekly/story/0,,2033496,00.html

"Britain's medical practitioners are making lifesaving technological advances at local level - by effectively ignoring the costly NHS IT programme . . . As you walk into the waiting room of Thornley House Medical Centre in Hyde, Cheshire, the first thing you see is a giant plasma screen inviting you to apply to view your medical records on the web. Meanwhile, at Queen Alexandra hospital in Portsmouth, nurses routinely enter patients' vital signs into handheld personal digital assistants. . . In Hyde, the revolution in healthcare information may have even more profound consequences. It is the first practice in the world to invite every patient to inspect their electronic health record and, if they want, to have it available online. . . Two triumphs of the £14.6bn NHS programme for IT? Hardly. Electronic medical records at Hyde and Portsmouth may be achieving what the national programme, conceived five years ago this spring, is setting out to do. But they are independent efforts, happening not because of the national effort but almost despite it. While Hannan and Smith and other pioneers dotted around the country have patients' full clinical details available at the touch of a button, the much-vaunted NHS programme is only now about to start loading basic clinical details on to the care records "spine". These will contain only the allergies and current prescriptions of patients at a few primary care trusts. Next week the annual Healthcare Computing conference in Harrogate will buzz with accusations that the national programme has held back progress. There are two reasons behind this charge. First, under the £1bn contracts signed early in the programme, hospitals have to replace their administrative systems which record patients' details with systems from centrally chosen suppliers. As this involves considerable local effort for little benefit, progress is painfully slow. The second problem is the potential threat to confidentiality arising from making records available on a national scale. . ."

3.3.24. Update: Fujitsu shock £1.2bn loss driven by problems in UK (20 Mar 2007)

ComputerWorld UK

http://www.computerworlduk.com/management/it-business/supplier-relations/news/index.cfm?newsid=2302

"Problems at Fujitsu Services, the UK subsidiary of Japanese computer giant Fujitsu, have played a key part in shock forecast losses of £1.2bn for the 2006 financial year. Today's profits warning, made at the end of the business day and ahead of a public holiday in Japan, came after years of problems with Fujitsu Services, which holds a number of high-profile public sector contracts. Fujitsu Services is a lead contractor for the southern region of the NHS's £12.4bn IT programme. It is also an important IT provider to HM Revenue and Customs where its £930m outsourcing contract has been absorbed into the Aspire contract held by Capgemini. The Japanese computer giant, which had earlier forecast profits of £238m, said it now expected to record a loss on devaluation of its stock in Fujitsu Services. . . Fujitsu's relations with the NHS National Programme for IT (NPfIT) were strained last month when Andrew Rollerson, its healthcare consultancy practice lead, spoke out at a conference to discuss implementation of the programme, warning of a "gradual coming apart of what we are doing on the ground". The slow progress of NPfIT in the southern region where Fujitsu Services is the lead contractor was recently revealed in a parliamentary written answer that showed the firm had completed just £27m worth of work – less than 10% of the £287.5 paid out to contractors in the other four regions. . ."

3.3.25. NHS pours £100m into finding additional software suppliers (29 Mar 2007)

The Guardian

http://politics.guardian.co.uk/publicservices/story/0,,2045089,00.htm

"NHS bosses charged with delivering the much-delayed £6.2bn IT upgrade to health trusts throughout England have launched a £100m-plus drive for "additional" IT suppliers to meet "immediate business needs". Separately, the Guardian has learned that the Australian group IBA Health is close to abandoning talks over a potential all-share takeover of cash-strapped software supplier iSoft, which is contracted to provide systems for 60% of the NHS's troubled National Programme for IT (NPfIT). The decision by NHS bosses to seek new suppliers is a significant move away from the troubled NPfIT, which has been running for four years, mired in delays and software setbacks. Concern has been mounting among clinicians and trust executives that the NPfIT has become over-reliant on software sub-contractors iSoft and Cerner and the suitability of their systems. The two firms have been blamed in some quarters for delays. Official tender documents were filed with the European Union yesterday, stating: "The [NHS] anticipates that, as a result of immediate business needs and projects planned, services ... will be procured at an early stage following the establishment of a framework." The framework, the papers said, would "assist with the success and delivery of the NPfIT". However, "it is not intended" that this would conflict with existing NPfIT contracts. Industry insiders and some NHS sources were at a loss to explain how some of the items sought would not come into conflict with contracted NPfIT agreements. They include maternity, A&E and patient administration systems. Richard Bacon MP, a member of the public accounts committee, said: "It is a tacit admission that the current approach is not working. More clarity is needed about ... how fast people in the NHS will actually be able to acquire new systems from these suppliers". A number of trusts have become so disillusioned with the NPfIT delays that they have begun buying their own IT systems outside the programme, forgoing central NHS funding. Meanwhile, it is believed iSoft will remain in talks with at least one other party should IBA end takeover discussions. IBA is thought to have been unable to win the backing of US firm CSC, through which iSoft is a NPfIT supplier."

3.3.26. Atos Origin suspended from NHS contract (13 Apr 2007)

ZDNet UK

http://news.zdnet.co.uk/itmanagement/0,1000000308,39286700,00.htm

"Atos Origin has insisted it will continue to work with the Department of Health and the NHS despite the suspension of a key health service contract. Ultrasound and medical imaging services, which were being provided by the IT consultancy, were suspended on 20 March after NHS North West claimed that "operational issues had led to incomplete patient information being included and delays in reporting diagnoses". The crisis deepened last week when it was revealed that there were technical as

well as administrative problems with Atos Origin's service. Up to 900 patients from areas including Manchester and Liverpool may now have to be called back to hospital to have their scans repeated. The problems arose during a contract that expired at the end of March. A follow-on contract due to start in April has now been shelved for the time being. A spokesperson for Atos Origin said on Friday that the consultancy had "taken the decision to stop accepting referrals for all diagnostic examinations while a full process review takes place. [Atos Origin, the Department for Health and the NHS] continue to work together in preparation for service delivery scheduled to commence in the coming months". Atos Origin is also developing Choose and Book, the appointments system that is one of the major elements of the National Programme for IT (NPfIT). NPfIT is the largest civilian IT project in the world and will bring together the UK's hospitals and GPs all on one network which shared access to patient information."

3.3.27. NHS chief exec pledges to help resolve CRS issues (5 Jun 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2753

"NHS chief executive David Nicholson has told Milton Keynes Hospital NHS Trust that they can count on his full support in resolving the problems they encountered in April after going live with the Millennium Care Records System provided by Fujitsu. In April 79 members of staff from the trust signed a letter outlining their frustrations at the Millennium CRS system, describing the system "awkward and clunky" and stating: "In our opinion the system should not be installed in any further hospitals. Problems cited included incidences of lost records. To help rebuild confidence and get a first hand picture on 14 May NHS chief executive David Nicholson and IT director Richard Granger visited the trust. "Mr Granger and Mr Nicholson gave the Trust their full support resolving issues related to CRS. The Trust is committed to working with CfH to improve CRS," a spokesperson told EHI. NHS Connecting for Health said in April that there had been some "unacceptable problems" with the new system installed at Milton Keynes which "require immediate attention". Prime contractor Fujitsu said there had clearly been "some high impact problems". The trust's finance director Rob Baird was quoted as saying: "The service to our patients in some areas has diminished in this period. At the moment we have quite a confused situation and it's like everyone had started a new job". Since early April Fujitsu and Cerner have had a team working on site at Milton Keynes to resolve the problems. . ."

3.3.28. NHS trusts seek software outside NPfIT (3 Aug 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/08/03/226007/nhs-trusts-seek-software-outside-npfit.htm

"NHS trusts are going outside the £12.4bn National Programme for IT (NPfIT) to find software to manage patient tests, it has emerged. Computer Weekly has seen board documents from three trusts showing that they are looking outside the programme for software to manage doctors' requests for radiology and pathology tests, a function known as "order communications". Trusts were expecting this functionality to be part of the NPfITs patient administration systems. United Bristol Healthcare now plans to install a third-party system to cover this functionality. The trust will go live with the second version of the Millennium patient administration system next year, but does not plan to use the system for order communications. . . North Bristol NHS Trust said it had bought an alternative product to handle order communications, following delays of more than two years for Millennium. The trust said it expected to go live with R1 next year, but it does not plan to use the system for order communications. Concerns have also been raised by clinicians at Worthing and Southlands NHS Trust about whether the first release of Millennium, known as R0, will support order communications. Despite going live with the first release of Millennium, the trust said it would continue to use manual processes for order communications. . . The Department of Health set the requirement for patient administration systems, and contracted service providers to build these systems with suppliers of their choosing. Fujitsu said it did not believe trusts were seeking an alternative to Cerner for order communications. Steve Isherwood, head of marketing for health at Fujitsu, said that since last year, there had been a lot of discussions over order communications and resolution over how it had been deployed. "R1 and R0 have order communications as part of their functionality. If there are any issues on any areas, we will work with the trusts on these issues. We will identify the issues and provide solutions and resolutions for them," he said. Cerner said the order communications functionality was part of its product, but it declined to comment further. . ."

3.3.29. Contract 'reset' underway in the South (9 Aug 2007)

e-Health Insider

http://www.e-health-insider.com/news/2940/contract_'reset'_underway_in_the_south

"The new NHS programme director for the NHS IT programme in the South of England says she is not happy with the core patient administration system delivered so far, and confirmed that a far-reaching 'reset' of contracts has been launched. Sarah Elmendorf took up the new post of programme director at the Southern Programme for IT earlier this summer. Already she has acquired a reputation for straight talking and demanding results in a hurry. In an exclusive interview with EHI she spoke candidly of the problems with Cerner's Millennium patient administration system, as provided by local service provider Fujitsu: "I am not happy with what has been delivered thus far, but with the focus of Cerner, Fujitsu, the NHS and ourselves, we can get an acceptable baseline PAS." She added: "The NHS needs a good PAS and an excellent clinical system quickly. For this to happen the interests of the NHS Fujitsu and Cerner need to be fully in alignment." Her appointment, the three southern SHA's creation of a Southern NHS IT programme and decision to hit the 'reset' button on contracts are proof power shifting from the centre. But it was the centre, in the shape of Connecting for Health, which originally negotiated local service provider contracts, and remains "the owner of the contract and the commercials". To get change through the Southern NHS IT programme will need CfH's co-operation. Only at the end of the current reset period will it be clear whether NPfIT Local Ownership Programme (NLOP) is made of straw or whether the reins have either been surrendered or wrested from the centre. Before taking up the new role in June Elmendorf was the CIO for South Central SHA. Previously she held senior IT positions in telecoms and banking, roles in which she says the focus was always on 'delivery' and staying close to customers and suppliers. She confirmed to EHI that one of the first steps taken by the Southern Programme for IT has been to 'reset' the contract with Fujitsu the culmination of mounting pressures and NHS frustrations over many months. This is a far reaching review of the detail of Connecting for Health's contract with Fujitsu, including revisiting the requirements of what is to be delivered and how and when this is done. Elmendorf suggested the current 'reset' may just be the last opportunity to get NPfIT to work for the NHS. A previous contract 'reset' was completed in November 2006, but failed to draw a line under implementation problems and delays. The difference this time is that it the process is being led by SHAs and trusts. . . Priority areas requiring immediate attention in Millennium include: outpatients, waiting lists, A+E and reporting. . ."

3.3.30. Some NPfIT PAS systems barely used (21 Aug 2007)

e-Health Insider

http://www.e-health-insider.com/news/2972/some_npfit_pas_systems_barely_being_used

A number of Connecting for Health funded patient administration systems (PAS), installed in primary care and community trusts, are only being used by a handful of staff months after installation, according to official figures seen by EHI Primary Care. Internal figures, prepared by local service provider (LSP) CSC Alliance, show an average number of monthly users of just one for North Staffordshire, less than 20 for Cambridgeshire PCT, South Essex and Bedfordshire and Hertfordshire health community, and less than 50 for Dudley, Fylde Coast and North Cheshire. Usage figures for PAS systems in the North, Midlands and East Programme for IT show that, in several cases, less than 20 staff are using the CfH supplied PAS system each month. CSC is responsible for delivering new IT systems to three-fifths of the English NHS. Latest CfH figures report that it has installed 99 NPfIT versions of iSoft's iPM PAS system, mostly in its original North West and West Midlands cluster. The majority of the systems have been installed in PCTs, community and mental health trusts. . ."

3.3.31. Future of centralised NHS IT in doubt as BT 'resets' contract (22 Nov 2007)

ComputerWorld

http://www.computerworlduk.com/management/government-law/public-sector/news/index.cfm?newsid=6336

BT has completed the renegotiation of its £1bn contract to deliver new computer systems to the NHS in London, in another sign that the centrally managed model for the health service's £12.4bn National Programme for IT (NPfIT) has had its day. NHS IT agency Connecting for Health had originally kept a tight central grip on contracts for the huge IT overhaul, under its combative director general Richard Granger. But in July, Granger announced he would quit his post by the end of the year – and the

Department of Health has not advertised for a replacement.Instead, the management arrangements of Connecting for Health and NPfIT are being reviewed by NHS chief executive David Nicholson, while the lead contractors for the programme are involved in renegotiating their deals to enable a more locally tailored approach that meets the needs of strategic health authorities and trusts. A BT spokesperson confirmed that the new contract for the London region would establish a "best of breed" approach to the software it supplies rather than a rigid one-size-fits-all model. Negotiations had begun in summer 2006, when BT sought to switch the patient record system it supplied from one supplied by IDX to Cerner's Millennium product, he said. But the new deal had been completed this summer, after the advent of the NPfIT local ownership programme (NLOP) – which transferred responsibility for the delivery of NPfIT from Connecting for Health to SHAs. A Connecting for Health spokesperson insisted that the renegotiation of the BT contract should be described as a "reset", adding: "The contract reset is a normal repeatable commercial process to ensure the detail of the contract reflects the progress to date, current priorities and deployment plans for the future." Another "reset", relating to "changes in development methodology and deployment" was under way with Fujitsu and CSC - lead contractors for the South, and North and Eastern regions – the spokesperson said. But in September Lester Young, NHS account director for Fujitsu, confirmed that his company was expecting to sign a new contract with the NHS and would even be open to changing the original output based specifications for NPfIT set by Connecting for Health in 2003. Changes to the contract – which is ultimately held by the health secretary on behalf of the government – would "deal with the differences" between what strategic health authorities in the southern region want and the requirements set out nationally by Connecting for Health, Young said. It is unclear what the new contracts will mean for the overall cost of the NPfIT programme. The Connecting fro Health spokesperson said: "The original value of the contracts for the same services remain unchanged. However, when additional requirements are identified in conjunction with the NHS then any additional charges will either be funded separately or funded from within the original contract value, depending upon the particular need and the work required."

3.3.32. N Yorks GPs protest over system choice (27 Nov 2007)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/News/3258/n_yorks_gps_protest_over_system_choice

"GPs claim their PCT is acting outside the GP Systems of Choice initiative by outlining a plan to encourage all practices to move onto the local service provider solution TPP's SystmOne. North Yorkshire and York PCT 's IM&T strategy states that the introduction of SystmOne will be "actively promoted and supported by the PCT" giving consideration to the objectives of the strategic health authority, the principles of GPSoC and the best interests of patients. . . The strategy says around 80% of the 102 practices covered by the PCT currently use the GP system EMIS with only four currently using SystmOne but outlines the SHA plan to see 100% of practices in the region on TPP by 2011. Dr Brian McGregor, a GP in York and a director of district's LMC, said the committee first heard about the strategy at a liaison meeting with the PCT at the beginning of this month. It went before the PCT board for approval five days later. He told EHI Primary Care: "First of all we believe it is factually incorrect as it presents SystmOne as the NPfIT solution when our understanding is that this is only an interim solution and the ultimate aim is for practices to move onto Lorenzo primary care. That could mean practices that move to SystmOne having to go through a second change. "We also think it's not for the PCT to promote one system over another which is something for practices to decide for themselves." Dr McGrgeor said the LMC feared that practices would be forced into changing systems against their will and said it was "even more galling" that a local primary and secondary care intranet in the York area, linking EMIS practices with York District Hospital, was already delivering the vision of primary and secondary care linked services that the strategy involved. Dr McGregor said the intranet, set up two or three years ago, now delivers 1000 plus letters sent electronically direct to patient records every day and access to a shared care record was planned soon as well as possible links to the intranet for practices using other GP systems. . . Dr McGregor said GPSoC documents issued to all practices include a statement that those signing up to GPSoC are committing themselves to migrate to the fully integrated LSP solution when that is available. He said the LMC's advice to practices was not to sign the document until that statement had been removed. . ."

3.3.33. NHS records system delays cost CSC £5m (7 Jan 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/01/07/228759/nhs-records-system-delays-cost-csc-5m.htm

"Services supplier CSC has paid penalties of about £5m following delays in the deployment of patient administration software across several NHS trusts under the National Programme for IT (NPfIT). The disclosure undermines claims by NHS Connecting for Health and the Department of Health in a briefing paper to the prime minister in February 2007 that "much of the programme is complete, with software delivered to time and budget". NPfIT regional minutes seen by Computer Weekly show that CSC has made penalty payments following delays in rolling out software in the North, Midlands and East of England, where it is the NHS local service provider. . . CSC is due to supply NHS trusts with iSoft's Lorenzo patient administration and electronic record system under the NPfIT. CSC has worked with trusts to deploy limited interim versions of iSoft's patient administration systems following delays in the "strategic" Lorenzo releases, which could provide joined-up health systems across England. . ."

3.3.34. Fujitsu may quit NHS National Programme for IT (22 Jan 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/01/22/229021/fujitsu-may-quit-nhs-national-programme-for-it.htm

"The board of an NHS trust has learned of a "significant" risk of Fujitsu ending its £900m contract to supply and implement hospital systems across southern England as part of the National Programme for IT (NPfIT). A withdrawal would add to delays in installations of NPfIT systems, deepen scepticism among doctors over whether the programme is feasible, and could indicate that the NPfIT is in deeper trouble than widely thought. In 2006 Accenture withdrew as a local service provider, making provision for write-offs of about £230m. Fujitsu and NHS Connecting for Health, which runs part of the NPfIT, and the Department of Health are discussing a contract "reset", which involves a renegotiation of large parts of the £896m deal signed in 2004. The contract is not due to finish until 2013. Computer Weekly understands that there are differences of views over the cost of the requested work which amount to tens of millions of pounds. If an agreement over price cannot be reached, Fujitsu has the choice of seeking to reduce the amount of work and risk it is being asked to take on, absorbing any extra costs or withdrawing. The Royal United Hospital at Bath has warned of a series of risks to its planned go-live of NPfIT systems this spring. It has categorised as "significant" a risk of "further delays if Fujitsu ceases to be the local service provider for the South [of England]". The trust's staff are involved in the contract reset. To mitigate risk, the trust would have to establish an effective working relationship with Fujitsu sub-contractor Cerner to "ensure satisfactory continuity in the event of Fujitsu's contract ending", said Richard Smale in a paper to his board, which he wrote as head of information services at Royal United Hospital. Fujitsu is known to be a tough negotiator and, according to a National Audit Office report, it threatened to withdraw from the Libra contract to supply a national case management system for magistrates courts. In the end, the value of Fujitsu's Libra contract was increased from £146m to £232m and it was reduced in scope, with the government's agreement. A spokeswoman for Fujitsu declined to comment on whether it may cease to be the South's local service provider, or that in the contract reset negotiations there are differences of views over the cost of the requested work of tens of millions of pounds. The spokeswoman said, "We cannot comment on ongoing commercial negotiations." NHS Connecting for Health made a similar comment."

3.3.35. Some NPfIT "major issues" - did the PM get a full briefing in 2007?(17 Jan 2008)

Computer Weekly - Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/01/some-npfit-major-issues-did-th.html

"Some of the major NPfIT issues identified by Helen Bellairs, Chief Executive, Western Cheshire Primary Care Trust, seem at odds with a briefing paper to the prime minister in February 2007. Helen Bellairs is a local senior responsible owner of the National Programme for IT [NPfIT] in the NHS. Under NLOP, the NPfIT Local Ownership Programme, all chief executives of primary care trusts in England have been appointed senior responsible owners. It means they may be held accountable for failures and realising any benefits of NLOP and the NPfIT. In a briefing paper to the North West Strategic Health Authority NPfIT board, Helen Bellairs outlined what has been achieved locally; and she identified six "major issues" with the NPfIT. Some of the issues have a general significance to the national programme. The paper referred to the “Lorenzo” product supplied by iSoft – now owned by

Australian company IBA health – and CSC, the NPfIT local service provider for the North, Midlands and East of England. . .

- The continuing delays in the availability of the Lorenzo system, which undermine the credibility of the whole of National Programme for Information Technology. In the meantime, existing suppliers continue to develop their products, which make it even harder to persuade Trusts to move onto Lorenzo.

- A lack of confidence in how strategic instances are going to work in practice. It is very hard to see how a large database across the whole of Cheshire and Merseyside will work when all hospitals and community settings are on it. This needs to be addressed through strong governance and general interaction between the Local Health Communities.

- The lack of confidence created by repeated undelivered promises. An example of this would be the recent failed upgrade in Morecambe Bay.

- The lack of a clear strategy in relation to the sharing of clinical data in relation to i) meeting organisational requirements ii) information governance issues and iii) the technical infrastructure to support it.

- There is widespread dissatisfaction at the local level with the performance of the National Service Desk (Fujitsu). Despite escalation of these issues, no discernible improvements have been identified. This issue has been addressed to some extent by the formation of the shared Cheshire and Merseyside Service Desk, but this would not have been required if the National Service Desk delivered what they promised.

- The lack of clinical functionality in the current patient administration system from CSC means that clinicians are disengaging from the programme and looking elsewhere for clinical solutions. . ."

3.3.36. Minister defensive over Cerner NPfIT NHS sites (4 Feb 2008)

Computer Weekly - Tony Collins Projects blog

http://www.computerweekly.com/blogs/tony_collins/2008/02/minister-defensive-over-cerner.html

When advisers to ministers write replies to Parliamentary questions they have no legal duty to be candid. Within reason they can say what they like. So for them answering written Parliamentary questions may be no more challenging than playing tennis with the net down. Indeed, when asked about the NHS's National Programme for IT [NPfIT], ministerial advisers can use Parliamentary replies to make light of the concerns of clinicians and others. And this is what happened when Worthing MP Peter Bottomley put a question about Cerner sites to Ben Bradshaw, who's the latest in a series of ministers to be put in charge of the NPfIT. Cerner's "Millennium" software will be used to help NHS staff administer hospitals and keep records on the care and treatment of patients. It's due to be installed at hospitals across London and the South of England as part of the NPfIT. Bottomley asked Bradshaw what representations he'd received from clinicians in hospitals about Cerner Millennium go-lives. Bradshaw's reply in January 2008 suggested that clinicians are concerned only about things such as the number of keystrokes to carry out certain functions. . . There have been some successes with Cerner go-lives. Barnet and Chase Farm Hospitals NHS Trust, for example, now has near a real-time overview of when beds are vacant and where. The reality, also, is that at some hospitals where Millennium has been installed there have been protracted difficulties, not necessarily through any fault of NHS trusts or Cerner, or the local service providers, Fujitsu and BT. The Audit Commision, in the latest annual audit report on Weston Area Health NHS Trust, referred to the implementation of what it called the Cerner National Care Records System. The Commission said that remedial work continued for months. It said: "Significant problems with the implementation of the Cerner system have resulted in poor data quality and a lack of robust information...Weston Area Health NHS Trust was included within the first deployment of the Cerner National Care Records Service (NCRS) and implemented the NCRS system in October 2006. However, it was soon recognised that the system was not providing the services required by the Trust and that significant remedial work would be required.Over the last nine months the Trust has been working with the suppliers and the SHA to resolve these issues..." Bradshaw's reply gave no hint that an independent organisation such as the Audit Commission had deemed as "significant" problems arising from a Cerner implementation. . . Buckinghamshire Hospitals NHS Trust went live with the Cerner Care Records System on 25 September 2006. More than a year later, in November 2007, the trust's board was told of some of the day to day difficulties. On the matter of keeping track of patients with MRSA and C Difficile, the Care Records System was "not working

consistently" although Fujitsu, the supplier of Cerner's Millennium system in the South of England, was working on a fix. . . Avon, Somerset and Wiltshire NHS Cancer Services has said that "Current opinion regarding Cerner is that it will not support cancer data collection and reporting requirements for at least 5 years, possibly nearer 10 years." And NHS South Central reported in November 2007 that "Deployment problems at those sites that have implemented the [Cerner] system has created concern amongst those organisations in the deployment pipeline. Regular communication is now taking place to rebuild confidence and keep organisations up-to-date with progress on the contract reset." . . It has been said before but if ministers and officials continue to play down the problems of NPfIT implementations they'll carry on alienating clinicians and other NHS staff whose support they need to make a success of the programme. Ministers and NHS Connecting for Health, which runs part of the NPfIT, do not need to put the programme in a zoo enclosure marked "Say kind things only - this enclosure is for the worried and nervous". . .

3.3.37. NHS multimillion pound IT: the risks (20 Feb 2008)

Channel 4 News

http://www.channel4.com/news/articles/society/health/nhs+multimillion+pound+it+the+risks/1613452

"It's costing millions but the new NHS computer system in London and southern England poses a risk to patients say some consultants. The new NHS IT system is causing serious concern among clinicians. Last summer, the then boss of the National Health Service IT system, Richard Granger, candidly admitted he was "ashamed" - saying some of the hospital software was "appalling". Seven months on, Channel 4 News has spoken to clinicians who are seriously concerned about the system. NHS bosses insist the software being installed in hospitals to manage all the information on every patient who walks through the door will bring huge benefits. It's a key part of the £12bn NHS computer project, Connecting for Health. With electronic medical records and on-line scheduling of treatment and tests, it's meant to save time and improve efficiency. But the reality for some has been rather different. Consultants we have talked to in a number of trusts paint a disturbing picture. They talk of repeated delays in getting the system up and running. And far from making things more efficient, they say that hundred of thousands of pounds have had to be spent to employ extra staff to make it work. In one hospital they have had to abandon many of the system's functions because they believe it could be putting patients at risk. In southern England and London, the NHS is buying and modifying off-the-shelf software from the US company, Cerner. The new patient information system has already been introduced into 13 hospitals across London and the south. It has not impressed some consultants who've used it. Chris Taylor decided to speak out because of her experience in one hospital. She concluded patients might be at risk after she found the system couldn't do simple things like print labels for blood samples quickly. She said: "It happened on more than one occasion; I was walking around the department with a handful of blood samples in my hand afraid of putting them down because I didn't want to get them mixed up with the samples that others had in their hands which were equally unlabelled because the system couldn't cope. "So if you are asking me whether it puts patients at risk? Yes, it does, because sometimes you must not delay treatment." We put her concerns to Connecting for Health's national clinical director for the new hospital system, who is himself an accident and emergency consultant at a London hospital. Dr Eccles said: "Well that needs to be investigated and interestingly has not been escalated. I am unaware of that. "We do have a very clear escalation policy for any issue that offers risk to patients. It is unacceptable to leave patients at risk and we don't do so." Cerner, who makes the software, told us: "The Cerner Millennium solution has passed all... testing and assurance requirements." As for speed, Cerner said it had conducted performance tests with satisfactory results. Another trust where the Cerner system has run into trouble is at the Royal Free Hospital in north London. The system was due to be up and running at Easter - that's next month - but at the end of January the chief executive wrote to all staff in an email that start-up had been delayed until May. He said: "The trust was not prepared to accept a system that is not yet demonstrated to be fit for purpose." The Royal Free says the delay is frustrating, but not uncommon for programmes of this scale and complexity. They told us it was caused by the need for more testing of computer programs that provide extra clinical functions beyond the basic patient administration system. For some hospitals, too, the new system has led to extra costs. In just three of the 13 trusts with it - Taunton, Worthing, and Winchester - extra staff and other costs add up to around a £1m. The pressure is now on Connecting for Health to show that IT in the NHS brings real benefits. But the opinions of some doctors who've experienced the systems are making that difficult. Chris Taylor added: "Given that the system has been in some form implemented in hospitals for over a year and that there have been entire consultant groups who have raised their concerns, almost protests, it is beyond comprehension that this system, in its current form, is now being implemented. It just really is beyond comprehension. I have no other

word for that." The stakes, then, couldn't be higher for the future of the NHS IT programme. Because unless the problems with the new hospital system are resolved soon, the chance of realising genuine longer term benefits of IT in the NHS could be in jeopardy."

3.3.38. Millennium remains a 'challenge' at Worthing (4 Mar 2008)

e-Health Insider

http://www.e-health-insider.com/news/3525/millennium_remains_a_'challenge'_at_worthing

"The chief executive of Worthing and Southlands NHS Trust has said in a letter to staff that the Cerner Millennium system installed six months ago by Fujitsu continues "to be a challenge across the trust". In a letter posted on the trust's intranet, Stephen Cass, told staff: "All staff - whether you use the system or not - will be aware that the new care records system - or Cerner - is continuing to be a challenge across the trust." Cass added he was aware of the difficulties staff faced in using the system: "I know the ongoing issues are causing difficulties and adding to your workload." The trust's Millennium R0 was installed by Fujitsu in September 2007. At the time in the months since the go-live has consistently been described as the best implementation yet of Cerner Millennium under the NHS IT programme. In his letter, Cass says that the trust has invested in extra functionality and training resources, to help staff get used to the system. "As an organisation, we have put in additional resources to improve the system's functionality. The trust is also making additional resources available for training and support," he wrote. He stressed that as Millennium is the chosen software for the whole of the Southern NHS the trust had no alternative but make it work: "There is no going back for us - and we are committed to making it [Millennium] work." In February the trust came under scrutiny from Channel 4 News when Dr Patrick Carr said it had been abandoned in the hospital's A&E department: "Every process we used to do by hand seemed to take longer using the Cerner solution." Problems with Millennium are also acknowledged in a letter written by Candy Morris, chief executive of the South East Coast SHA, sent to local MP, Peter Bottomley who had raised questions about problems with Millennium. Morris told the MP that the functionality 'deficiencies' have resulted in Connecting for Health (CfH) asking Fujitsu to explain why implementation dates continue to slip for trusts in the South. "Following the deployment project, whatever the ultimate gains, further deficiencies in functionality have emerged. We are very mindful of these. You may be aware that NHS Connecting for Health with the support of the three SHA chief executives in the South of England has escalated the issue with Fujitsu in relation to their failure to deliver key implementation milestones in their work for the Southern Programme for IT. Negotiations continue, and there are no rose-tinted glasses. We await Fujitsu's remediation plan," she told the MP. EHI contacted staff working at trusts live in the South live with the Millennium R0 solution and found a number were still experiencing difficulties with the software. One anonymous member of the Somerset Health Informatics Service, responsible for Taunton NHS Trust, told EHI: "It's not been as easy an implementation as we hoped it would be. Staff have found the Cerner system difficult and tedious, and there have been a series of complaints arising from the deployment. We have had to bring in outsourced floor walkers to deal with the disruption, and help clinicians get used to the Cerner solution. They added: "We have had a team of people working on this for over two years, testing and retesting the system to make sure that it does what we need it to, and to some extent it is making a difference, but it doesn't surprise me that Worthing are still experiencing functionality deficiencies." A senior nursing staff member at Surrey and Sussex meanwhile told EHI: "Worthing followed our lead in deploying Millennium after the solution was signed off three months after deployment and given a great review in E-Health Insider when they did so. In reality, we have had difficulties and the system isn't the great clinical management asset we needed. It still has some real problems in generating information which nurses need - especially when it comes to printing. The SHA are well aware of our problems and hopefully Mr Bottomley will look to take action on this." In her letter, dated 26 February, Morris told Bottomley the Southern Programme for IT's contract reset with local service provider Fujitsu was still under negotiation. According to health minister, Ben Bradshaw, the next Southern Programme of IT site to get the system will be Bath Royal United Hospital NHS Trust in May, though the trust were unable to confirm this to EHI. . . Cerner and CfH had not responded to questions by the time of publication."

3.3.39. Plans to replace legacy NHS systems put on hold (7 Apr 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/04/07/230170/plans-to-replace-legacy-nhs-systems-put-on-hold.htm

"Hospital executives have put plans to replace legacy systems on hold after protracted negotiations between the NHS and Fujitsu, its main IT supplier in southern England. Computer Weekly has learnt that several trusts have delayed plans for new systems under the NHS's National Programme for IT (NPfIT). Although training of staff in the systems has continued in some areas, some trusts have been unable to set go-live dates. Fujitsu and the NHS have been negotiating for more than nine months on a "contract reset" to allow for changes in the NPfIT since the 10-year, £896m deal was signed in January 2004. A memorandum of understanding, which allowed the NHS and Fujitsu to operate as if a revised contract were in place, expired on 31 January, and the two sides have reverted to the original deal. The renegotiation of parts of the contract has involved secretary of state for health Alan Johnson and Fujitsu's parent organisation in Japan. Talks on the reset were due to finish last November. They were then expected to be complete by the end of March, but there is still no word on whether a deal has been agreed. Officials working on the NPfIT had announced in 2006 that St Richard's Hospital in West Sussex would go live with an NPfIT care records service in October of that year. But the Royal West Sussex NHS trust confirmed last week that it had been unable to set a date for implementation. The contract reset was one of the uncertainties. The trust's board also wants to learn from a go-live of the Cerner Millennium care records service at Worthing Hospital, where it said there had been "issues concerning functionality". The board of the Southern Programme for IT - part of the NPfIT - has reported that, "The operating plan for the delivery of the care record service deployments for 2008 is being reviewed to take account of local deployment verification and detailed planning, and the current position on contract reset." NHS Connecting for Health, which runs part of the NPfIT, and Fujitsu declined to comment on the contract reset."

3.3.40. All eyes on the NPfIT go-live at Barts? (18 Apr 2008)

Computer Weekly - Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/04/all-eyes-on-the-npfit-golive-a.html

"Some staff at the Barts and The London were without their new systems, delivered under the NHS's National Programme for IT, for half an hour on Tuesday during the busy morning period when many patients come into hospital. . . Barts is a particularly complex installation. It's the oldest hospital in the UK, founded in 1123, and is spread over several sites. But that's not the reason its go-live has a potential importance which goes beyond London. It's because of a re-negotiation of parts of a £896m contract signed in 2004 under the National Programme for IT [NPfIT] between the Department of Health and Fujitsu. The so-called "contract reset" leaves ministers with a decision on whether to pay Fujitsu a significant extra sum. It's possible a deal will be done. Or it's conceivable that Fujitsu will quit, gradually handing to a different main supplier for the NHS in the south of England. A Memorandum of Understanding between Fujitsu and the NHS is understood to have been signed, which gives ministers another 90 days to decide what to do. The Department of Health is understood to be seeking to enlist the support of Downing Street and HM Treasury in securing the extra money. But the question is: what will happen after the 90 days? This is why the go-live at Barts has some potential significance. With the help of BT, the local service provider for London, Barts has installed LC0, a version of Cerner's Millennium system, which been tailored for use by the London Programme for IT. There's interest in the NHS in Barts because, if Fujitsu announce a gradual withdrawal from the NPfIT, who would replace it? Just as CSC took over Accenture's contract as an NPfIT local service provider in the north of England, BT could take over Fujitsu's contract as the local service provider to the south. In which case eyes are turned towards BT's challenging installation at Barts. If everything settles down quickly at Barts and Fujitsu quits the NPfIT, BT could slide into position as one of the two remaining NPfIT local service providers for the whole of England, CSC being the other. But serious problems at Barts or at two other London trusts that are planning to go live this side of summer, could affect BT's chances of taking over from Fujitsu. . ."

3.3.41. Worthing says Cerner's functionality 'inferior' (28 May 2008)

e-Health Insider

http://www.e-health-insider.com/news/3795/worthing_says_cerner's_functionality_'inferior'

"The chief executive of Worthing and Southlands Hospitals NHS Trust has said the Cerner Millennium care records system is still suffering from 'inferior functionality', leading to 'significant level of discontent among clinicians'. Attempts to install manual and electronic workarounds - where possible - have already cost over £2m of extra spending, with a further £1m now required by the trust. The Cerner CRS system was provided by Fujitsu as part of the £12.7 billion NHS IT programme. Workarounds

have had to be installed for nurse handover reports, establishing a separate patient database for A&E and a data warehouse to allow statutory reporting. As a result, Worthing - which had been hailed by Fujitsu as a flagship site - has already had to borrow £2m from West Sussex PCT to cover 'extra expenditure incurred as a result of the Cerner implementation', on extra staff and software, straining the relationship with its main customer. Despite these extra investments Worthing's chief executive has said the trust is "still unable to satisfactorily capture, record and bill all activity", which was "contributing to contractual difficulties" with the PCT. . . Problems with the system include: staff being unable to effectively locate and track patients or case notes, no facility to record A&E procedures or provide fit for purpose discharge summaries, no capability to track and monitor 18-week waits, serious problems with correspondence, no provision for printing and annotating patient lists, and no ability to print off specimen labels. . ."usable.

3.3.42. NHS hit as Fujitsu fired from IT project (28 May 2008)

Financial Times

http://www.ft.com/cms/s/0/41dbc5f0-2cf3-11dd-88c6-000077b07658.html

"The NHS's £12.7bn programme to provide every patient in England with an electronic care record suffered a severe blow on Wednesday as the project fired one of its key suppliers after failing to resolve a wrangle over the contract. Ten months of renegotiations with Fujitsu, which holds the £896m 10-year contract for installing the record across the whole of the south and west of England, have broken down, according to both the company and the NHS. . . The breakdown is a blow to the programme, although its defenders will argue that the contract structure of having an original four big suppliers is likely to work as BT or CSC is likely to step in. But the breakdown can only further delay a programme whose core product - the electronic record - is already running more than four years late. . ."

3.3.43. Fujitsu's £896m NHS IT contract to be terminated (28 May 2008)

e-Health Insider

http://www.e-health-insider.com/news/3798/fujitsu%E2%80%99s_%C2A3896m_nhs_it_contract_to_be_terminated

"NHS Connecting for Health is to terminate the £896m contract with Fujitsu to upgrade NHS IT systems across the South of England after the IT services giant withdrew from contract re-set negotiations. Negotiations to 'reset' the Fujitsu local service provider contract have been underway since July 2007. Senior NHS staff in the South of England were told of the news today, after last ditch attempts to broker a deal failed last Friday with a final unsuccessful effort made on Tuesday. By withdrawing from the contract re-negotiations Fujitsu placed itself in breach of the original contract signed. In a statement NHS CfH told E-health insider: "Regrettably and despite best efforts by all parties, it has not been possible to reach an agreement on the core Fujitsu contract that is acceptable to all parties. The NHS will therefore end the contract early by issuing a termination notice." In a statement to EHI Fujitsu said: 'Fujitsu Services can confirm that we have now taken the decision to withdraw from the National Programme for IT (NPfIT) contract re-set negotiations with NHS Connecting for Health as we did not feel there was a prospect of an acceptable conclusion. The NHS has advised us that they intend to end the contract early by issuing a notice of termination. The Fujitsu statement added: "For the moment our work on the contract reverts to the terms of the original programme. We will work closely with the NHS to provide a smooth transition to the new arrangements.' CfH has begun a crash programme of working up contingency arrangements. The agency said it acknowledged the work Fujitsu had done and "commitment to smooth transition arrangements", but stressed it had to "protect the interests of the taxpayer and preserve the basis of contracts which ensure payment on delivery. Gordon Hextall, the chief operating officer and interim director of programme and systems delivery for CfH, said in a letter today to trust chief executives in the South: "There are no immediate implications for live sites and Fujitsu Services Ltd will continue to support these Trusts to current service levels in line with the contract. We are working co-operatively and constructively with Fujitsu Services and the NHS to review the overall arrangements for providing systems to the sites that have not yet gone live with Cerner Millennium."

3.3.44. Fujitsu's departure from NPfIT leaves project floundering, experts say (29 May 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/05/29/230866/fujitsus-departure-from-npfit-leaves-project-floundering-experts.htm

"The National Programme for Information Technology, the NHS's flagship project to produce a national networked information infrastructure for patient care, could become the government's biggest IT disaster yet, experts have said. Their comments came after Fujitsu walked away from negotiations on a "more flexible" contract to supply an electronic patient record system to hospitals in the south and west of England. Martyn Thomas, who represents the UK Computing Research Committee (UK CRC), a policy committee for computing research in the UK that consists of computer science professors at 23 leading universities and an expert witness in IT-disaster court cases, described the national programme as "a train wreck in slow motion". Speaking in response to the news, Thomas said UK CRC had warned the parliamentary select committee on health several years ago that the NPfIT "was exhibiting signs of failure" and called for an independent review to identify ongoing risks and ways to manage them. Thomas said Richard Granger, then head of the NPfIT, and his successor, David Nicholson, had accepted the comments, but had been overruled by ministers. MP Richard Bacon, who sits on parliament's Public Accounts Committee, said Fujitsu's refusal to sign a renegotiated contract was an opportunity to give back to local trusts the right to buy what they liked. "The original approach of handing over monopolies to a handful of local service providers was never going to work and has been shown not to work," he said. Bacon warned against handing Fujitsu's contract over to the other two main suppliers on the project, CSC and BT. It was a way to screw things up completely, he said. "This whole thing was built on the detailed patient record system. We have not seen much yet, but we are already four years late and £4bn in." Bacon and Thomas both noted that the successes claimed for the programme, such as the ability to send digital X-rays over IT networks, were not part of the original NPfIT, and in fact preceded it. Thomas said the X-ray system was part of the argument for the programme made to the then prime minister, Tony Blair. . ."

3.3.45. Where now for NHS National Programme after Fujitsu exits? (29 May 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/05/29/230859/where-now-for-nhs-national-programme-after-fujitsu-exits.htm

Only 10 days ago a deal aimed at rescuing the NHS's National Programme for IT in the south of England seemed imminent. Officials and Fujitsu had spent nearly a year negotiating changes to a 10-year contract worth £896m, signed in January 2004. The two sides had agreed a deal in principle. Papers were ready for signing by David Nicholson, the chief executive of the NHS, who is also the predominant senior responsible owner of the £12.7bn National Programme for IT (NPfIT). But at what one NHS official said was the "59th minute of the eleventh hour" Fujitsu informed Nicholson that it was withdrawing from the negotiations. The NHS responded decisively, by terminating Fujitsu's contract. The NHS had threatened to terminate the contract even during the "contract re-set" negotiations. Nevertheless, the way Fujitsu withdrew has taken many in the NHS by surprise. . . Why did a proposed deal collapse? NHS officials believe that Fujitsu's board in Japan decided to intervene. The board was concerned that Fujitsu's potential losses on its NPfIT work, as one of three local service providers to the NHS, could be much greater than its directors had thought at first. Fujitsu is the monopoly supplier of Cerner's Millennium care records service, which is mandated to be the main hospital system for the south of England. Now that Fujitsu is withdrawing as the local service provider for the South, and trust boards do not have the freedom to buy elsewhere, uncertainty has been piled onto uncertainty for the boards of NHS trusts. Some in the NHS say this is a characteristic of the NPfIT as a whole. "We are into a period of turmoil. There are the exit arrangements with Fujitsu to manage, especially for the early-adopter sites, and there will probably be some months of discussion about what we should do. There is no uniformity of view within the NHS on that," one official said. There are several options. One is for the government to give trusts the freedom to buy care record systems from other suppliers, under Connecting for Health's Additional Supply Capability and Capacity (ASCC) framework, which came into force recently. This would give trust boards in the south of England the option of buying the Millennium system directly from Cerner - rather than from Fujitsu as the middle-man. Or they could choose to buy from another accredited Care Records Service supplier. Most IT executives in the NHS are expected to favour this option, particularly if the software is funded centrally

irrespective of what ASCC choice the trust makes. Other options include passing Fujitsu's work to one or both of the two other local service providers, CSC and BT. But both of these suppliers have had serious difficulty delivering a national strategic system to the NHS. Some NHS staff believe that Cerner can be made to work across the UK. It is a successful product in the US and elsewhere. But others are concerned that Millennium is a client-sever system rooted in the 1990s. NHS staff need extensive training to use it. It is not as intuitive as, say, an online banking system. There are also wider concerns among some officials that the NPfIT itself is dated in concept as well as practice. Since the programme was announced, trusts have become subject to competition for patients from private companies and even within the health service, particularly foundation trusts. They want IT to give them a competitive edge, which makes them less inclined to favour systems chosen for them centrally. . ."

3.3.46. NHS bosses may not replace contractor after Fujitsu's walkout (30 May 2008)

The Guardian

http://www.guardian.co.uk/society/2008/may/30/nhs

"NHS bosses may not appoint a replacement for Fujitsu as one of three regional contractors leading the health service's troubled £12.7bn IT systems overhaul following the Japanese firm's decision this week to walk away. This is being called for by disaffected trusts across the south of England who want to pick their own suppliers. It would be a big blow for BT which had been seen as favourite to replace Fujitsu because it is already lead contractor for the neighbouring London region and is deploying the same software package, Cerner Millennium. BT has said it wants the Fujitsu contract, but many medics and IT workers within the NHS remain deeply sceptical about the suitability of Millennium, a US product, for Britain's hospitals. NHS Connecting for Health, the body which oversees the National Programme for IT, was last night weighing up whether to go with BT or to allow trusts to select their own suppliers. . . A report this month by the National Audit Office revealed that just 13 Millennium systems had been deployed in acute trusts, nine of them in the southern region. In several cases trusts have withheld payment, something they are only supposed to if systems are not working properly. The Lorenzo software package, earmarked by CSC for the Midlands and the north of England, remains in development phase. It was originally supposed to start being rolled out in trusts from April 2004, but the development schedule has slipped repeatedly. Early versions of Lorenzo are now promised to go live in some hospitals this summer, but many experts believe that deadline will also be missed. Despite its considerable success building an IT "spine" and nework designed to link National Programme systems across the country, BT has had a mixed track record running the care records services contract for London. By the end of March it had deployed just four patient administration systems in acute hospital trusts out of 32 in total. Last month it added Barts to the list, but this deployment is already believed to be suffering serious data collection and reporting problems. A spokesperson for Barts last night denied there were serious concerns. "The system is largely working as intended and gradually becoming embedded into normal operations." Proceeding without a lead contractor for the southern region would mark an end to the original vision of a centrally orchestrated programme - the largest non-military IT project in the world - which the NAO this month confirmed was already running at least four years late. . ."

3.3.47. Leading article: Another tragedy of errors (30 May 2008)

The Independent

http://www.independent.co.uk/opinion/leading-articles/leading-article-another-tragedy-of-errors-836714.html

"In almost any enterprise, the news that management has plans to install a new computer system tends to be greeted as a threat rather than a promise. Nowhere, though, are there more grounds for IT apprehension than in the public sector, where one project after another has been dogged by severe overruns in time and budget, and the end product invariably falls some way short of being, in that celebrated phrase, fit for purpose. The latest example, or rather the latest episode, in the long-running tragedy of errors that is the NHS electronic database concerns the computerising of patient records for the whole of southern England. Government negotiations with the supplier, Fujitsu, have broken down and the contract has now been terminated. The overall project, currently running more than four years late, is likely to be further delayed. What with penalties for terminating the contract and the extra expense of finding a new supplier, the final cost to the taxpayer, at present estimated at almost £13bn, looks set to rise another notch. Why should it be that ministers stumble so predictably over big

computer projects? Other countries have experienced problems, to be sure, but our government seems to have a particularly lethal touch. From the ill-fated Child Support Agency onwards, it is hard to think of any major public-sector IT project that has been delivered on time and on budget and done everything it was required to do. One explanation may be that too many people and interests are involved in drawing up the specifications; another is that because the Government came to computerisation relatively late, it was unrealistic about what a single system could accomplish and its aspirations were over-centralised. It has also been suggested that the qualities of senior civil servants are not necessarily those required to commission, or oversee the commissioning of, IT systems. Yet, surely, in the time since the CSA debacle, something should have been learnt - if not from mistakes here, then from successful projects overseas. . . If the Government is having so much trouble computerising patient records, the chances for a trouble-free introduction of ID cards must range from slender to nil."

3.3.48. Bad software bursts £1bn NHS bubble (2 Jun 2008)

The Inquirer

http://www.theinquirer.net/gb/inquirer/news/2008/06/02/bad-software-bursts-1bn-nhs

"Fujitsu escapes to reality: A KEY ELEMENT of the UK's gargantuan health IT scheme was exposed as a fallacy yesterday when Fujitsu, one of four original suppliers of patient systems, dumped its £1bn contract, becoming the second supplier to have jumped ship. The IT industry has taken Fujitsu's resignation as evidence that both its £1bn contract with Connecting for Health (CfH), the UK health IT quango, and the original aims of the National Programme, had become untenable. Fujitsu's contract had another six years to run and, according to sources close to the firm, had only been paid half of the £300m to £400m it had spent doing the work. When Fujitsu signed the 10-year deal in 2004 (then for £896m) it was under the assumption that the £12.7bn National Programme for IT, the grand NHS IT scheme, would force all 86 local health trusts in its patch to use the software it provided, guaranteeing income and justifying the infamously stringent contractual terms it signed up to. Crucial changes in the Programme have since left Fujitsu in a position were it can can no longer guarantee its income under the original deal. It is said to have bailed out after failing to secure, after 10-months of negotiations to reset the contract with CfH, a position that would recover its costs, with an asking price of £1.2bn. CfH was expecting Fujitsu to accommodate moving goal posts without charging any more money, but the moving goal posts made it a more costly exercise for the supplier. What has changed is the perception that the Programme could force legally autonomous trusts to take its software; and the idea that a centrally-designed system could be suitable for all trusts alike. The façade of the centrally-dictated national scheme crumbled over the last year, revealing an NHS which looked little different to before the Programme started, said NHS IT advisor Murray Bywater of Silicon Bridge. NHS IT has reverted to a market-led structure in which CfH is only one competing supplier with software that the National Audit Office said this month was still four years from being completed. "The original contracts were awarded on the mistaken premise that the National Programme would be able to force everyone down the route they envisaged. That was part of their pricing algorithm," said Phil Sissons, former supplier liaison manager for the Programme. . . The writing appeared on the wall for the national scheme last April when CfH devolved responsibility for the programme on Strategic Health Authorities, by which it recognised that it had no right to foist its systems on their health trusts. That left Fujitsu and other contractors in the position of having to go out and convince the trusts to use the software they were selling under the auspices of the Programme. This would have added a 10 per cent cost of sale to their balance sheet, said Bywater, and that in addition to ballooning development costs. This situation was clarified further last week when CfH finalised the contracts under its Additional Systems Capacity and Capability (ASCC) contract framework, which lets the LSPs off the hook by helping trusts do what they had always done, which is choose their own software. . . Roger Wallhouse, who chairs a number of health IT firms including one that was already offering a fully-fledged PAS to the UK market before the Programme kicked them all out, said Cerner was trying to charge an "outrageous" amount of money for its unfinished software. "The NHS could buy those systems from UK suppliers for 30 per cent of the £900m that Cerner wants," he said. "You could get them faster than Cerner could deliver and that's always been the case," he said. . ."

3.3.49. Royal Berkshire 'may walk' from NHS IT programme (3 Jun 2008)

e-Health Insider

http://www.e-health-insider.com/news/3810/royal_berkshire_'may_walk'_from_nhs_it_programme

"The chairman of the Royal Berkshire NHS Foundation Trust has said the trust "may walk" from the NHS IT Programme, to ensure it gets the IT systems required. Speaking last Thursday, the day after Fujitsu had its £1.1 billion NHS IT contract for the South terminated, Colin MacLean the chairman of Royal Berks said it was "very worrying" the NHS IT programme had ground to a halt in the region. Royal Berks has experienced repeated delays in receiving an electronic patient record system - or Care Records Service - from Fujitsu under the £12.7bn NHS IT programme. With Fujitsu no longer leading the programme in the South the trust now has no immediate prospect of getting a new patient IT system. As a result the chairman said the Foundation Trust (FT) was now working up a Plan C based on going it alone. Foundation Trusts are strongly encouraged to take NPfIT systems but their independent status means they are not required to. "Plan A was to try to work with the national programme, Plan B was to start propping up our own IT systems and to continue working with the national programme, and just over six months ago we were made aware that we needed to start thinking about a Plan C to go out on our own," MacLean was quoted as saying. . . Trust board papers from Royal Berks show that contingency planning for delays to the NPfIT CRS were begun in January 2007, when the trust was also suffering significant delays. It had hoped to begin implementation by November 2007 at the latest."

3.3.50. Fresh trouble for NHS IT system (5 Jun 2008)

The Guardian

http://www.guardian.co.uk/technology/2008/jun/05/egovernment.nhs

"The loss of Fujitsu puts growing pressure on the NHS computerisation scheme, which is still waiting on essential software. Losing a major contractor is a serious problem for the largest ever non-military IT project. But the Guardian has established that the £12.7bn NHS computerisation scheme has growing troubles besides the decision last week by Fujitsu to abandon the project. Besides being four years behind schedule after five years' work (according to the government spending watchdog, the National Audit Office), and having seen consultant Accenture jump ship two years ago, the National Programme for IT now has another difficulty. The Lorenzo patient administration system, which is earmarked for hospital trusts across the midlands, east and north of England, is no longer expected to meet its already much-delayed release date of October. Instead, senior NHS directors are talking about Lorenzo "release 1" being ready by autumn. This would be a toe-in-the-water clinical system, software far short of a patient administration system - the core building block on which all clinical systems will eventually sit. . . Last week, the project was dealt another body blow. Fujitsu quit, becoming the second of the original "big four" contractors to depart, after Accenture two years ago. The move is expected to cost the Japanese firm hundreds of millions of pounds and its reputation will be damaged around the world. No matter, said Fujitsu. The £1.1bn contract was no longer worth the candle. All of a sudden, the NAO's estimate for completion of the electronic care records project by 2014-15 begins to look very optimistic. On June 16, NHS chief executive David Nicholson and Gordon Hextall, the health service's most senior IT boss, will appear in front of the MPs' public accounts committee to give a progress update. Given the slew of bad news in recent weeks, they can expect a tough reception. Questions will undoubtedly centre on the loss of Fujitsu and the uncertainty this has created. It remains to be seen which firm, if any, will be chosen as a replacement within the south of England contract being abandoned by the Japanese firm. The NHS is believed to be weighing up whether to take the quick and easy option of transferring the contract to BT or CSC, or to permit trusts to chose from an accredited list of alternative suppliers. The latter option would be popular with many disaffected trusts. Grassroots demand for fresh suppliers follows repeated broken promises on delivery dates for Lorenzo in the midlands, east and north, and by a scepticism about the suitability of rival patient administration system Millennium, which is being rolled out in London and the south. . ."

3.3.51. Fujitsu may lose southern NHS PACS deal (16 Jun 2008)

e-Health Insider

http://www.e-health-insider.com/news/3853/fujitsu_may_lose_southern_nhs_pacs_deal

"Fujitsu may not have its contract renewed to provide Picture Archiving and Communications Systems (PACS) services to NHS trusts in the south of England. The development comes two weeks after Fujitsu had its £1.1bn contract as local service provider (LSP) for the region terminated on 28 May, following its withdrawal from contract re-negotiations. Fujitsu had previously been expected to get the lucrative PACS deal renewed. When the LSP contract was terminated, the linked PACS contract was also ended, leaving NHS trusts across the south with systems that were not covered by formal support

contracts. E-Health Insider has been told that as a result, key clinical systems in the region - including PACS, Radiology Information Systems (RIS), child health, Map of Medicine and Cerner Millennium - are only covered by a "promise" of support from the ex-LSP. EHI has learned that NHS Connecting for Health (NHS CfH) originally indicated that it would renew its contract with Fujitsu to provide PACS services after terminating Fujitsu's LSP contract. . . In a 28 May letter to NHS chief executives in the south about the ending of Fujitsu's LSP contract, Gordon Hextall, head of NHS CfH said: "However, the PACS and RIS contracts are not expected to be affected by this outcome." The agency now appears to have reversed its position and to be proceeding on the assumption the terminated PACS contract will not be renewed. . ."

3.3.52. UK: NHS still looking for Fujitsu replacement (2 Jul 2008)

Ovum

http://www.ovum.com/news/euronews.asp?id=7129

"More than a month after the National Health Service (NHS) announced the termination of Fujitsu Services' £996 million contract to deliver electronic patient records to the South of England, the future of these services in the Southern Programme for IT (SPfIT) is still unclear. For NHS Connecting for Health (NHS CFH), the agency in charge of England's £12 billion+ National Programme for IT in the NHS (NPfIT), the most pressing issue is finding a replacement for Fujitsu Services. News late last month that 700 or more Fujitsu employees could be made redundant as a result of the contract termination brings home the importance of resolving the situation quickly and putting an end to the uncertainty surrounding SPfIT. The longer the programme is in limbo, the more likely it is that skilled staff will be lost to other sectors; that clinicians will lose any remaining confidence in the programme in the South; and that the deployment of acute patient record systems in the South will be further delayed. BT has confirmed it is in talks with NHS CFH to take over responsibility for the eight trusts in the South that have already received Cerner's Millennium software from Fujitsu. However, it is likely to be the end of July before any take-over arrangements can be finalised. This is a sensible course of action that should add further NHS coins to BT's coffers. However, the future for trusts in the South that have yet to receive Millennium is far from clear. In testimony to the Public Accounts Committee (PAC) last month Gordon Hextall, COO and Interim Director of Programme and Systems Delivery for NHS CFH, stressed that the decision on an alternative supplier was up to the NHS in the South and that the process could take 'a few months'. He implied, however, that systems were more likely to be provided by existing LSPs (BT or CSC) - who have extant contracts offering known products at a known price - than by a new LSP contracted through the ASCC procurement framework, a process which 'would take time'. While the former route certainly has advantages - notably the known price and potentially a quicker deployment (since it avoids a fresh procurement process), it would seriously damage suppliers' confidence in ASCC, a framework for which many bid assuming it would be used in a situation like this. Should BT and/or CSC be called upon to provide services in the South, they will need to scale up quickly (good news for those about to be made redundant by Fujitsu) and make full use of their partners. This would undoubtedly benefit the likes of System C Healthcare (an implementation partner for CSC) and Perot Systems (a key partner to BT in London), as well as specialist application providers that are already subcontracted to either BT or CSC, such as mental health system suppliers CSE-Servelec and SystmOne. Whichever supplier - or combination of suppliers - does eventually take over from Fujitsu, it will face many of the same challenges that led the Japanese firm to part company with SPfIT. The biggest challenge will be striking the right balance between local demands for the tailoring of software and the ideal of standard systems across the NHS in the South. As Fujitsu found, without a certain level of standardisation, upgrading and integrating systems becomes more difficult and costs escalate. Any supplier bidding to replace Fujitsu should be doing so with their eyes wide open and will expect to be suitably compensated."

3.3.53. Health trust abandons NHS care record upgrade (22 Jul 2008)

Silicon.com

http://www.silicon.com/publicsector/0,3800010403,39262815,00.htm

"Uncertainty sees Bath jump ship: A health trust serving more than 500,000 people said it has pulled out of the national NHS IT electronic care record programme because it has lost confidence in the project following the departure of key supplier Fujitsu. The Royal United Hospital Bath NHS Trust (RUH) has stopped the deployment of the Cerner Millennium electronic care records system - part of the £12.7bn national NHS IT modernisation programme. The Trust said it terminated the

implementation because it had lost confidence in the delivery of the system following Fujitsu's exit as the provider delivering the National Programme for IT (NPfIT) in the south of England. Fujitsu will continue to deliver the system in the south until it departs in November and health authorities are now in negotiations with Bath about whether it will use its own provider to implement the Millennium care records system or turn to other NPfIT providers, BT or CSC. The RUH provides acute treatment and care for a catchment population of around 500,000 people in Bath, and the surrounding towns and villages in north east Somerset and western Wiltshire. . ."

3.3.54. Milton Keynes' CRS caused 'near melt down' (29 Jul 2008)

e-Health Insider

http://www.e-health-insider.com/news/4003/milton_keynes'_crs_caused_'near_melt_down'

"The deployment of a national programme care records system at Milton Keynes Hospital NHS Foundation Trust "developed into an untenable situation which resulted in near melt down of the organisation." According to papers from the CRS project board, obtained by E-Health Insider under the Freedom of Information Act, the trust experienced a far from smooth go-live of the Cerner Millennium system. The CRS project team described it as "eight weeks of extreme pressure and operational issues to the acute trust." Board papers from the CRS project board, dating from July 2005 to June 2007, show a turbulent journey before the system finally went live on 24 February 2007. Milton Keynes was an early implementer site for the local service provider, Fujitsu, and the acute trust urgently required a new patient administration system to replace its existing legacy system, which was considered obsolete. An initial go-live was scheduled for 16 June 2006. The system was meant to include basic PAS, clinical noting and order communications, maternity, A&E, theatres and information for analysis functionality. . . When EHI reported on Milton Keynes's implementation, which also covered the community hospitals run by Milton Keynes Primary Care Trust, Fujitsu said it had benefited from the experience gained from earlier implementations. However, the minutes from the CRS project board show problems being continuously identified and go-live dates continuing to slip. In two years of planning, the go-live date changed seven times. The cost of the slippages was almost £800,000. . . The green-light to go ahead with the deployment was only given three weeks ahead of the actual go-live. However, post-go-live, doctors began to identify a series of problems, resulting in the "near melt down" described by the project board. The board papers suggest that problems at this stage included bed availability not displaying correctly, notes for clinics going missing, patient appointments not displaying on lists, reports not printing correctly, GP labels being unavailable, clinic rebuilds being necessary, back office help being unavailable, printers not working and passwords being forgotten. . ."

3.3.55. NHS faces £700m legal action over IT project (30 Aug 2008)

The Independent

http://www.independent.co.uk/news/science/nhs-faces-163700m-legal-action-over-it-project-913298.html

"The NHS is facing an unprecedented £700 million legal action from a Japanese computer firm over a failed project to store electronically the health records of millions of Britons. Fujitsu's contract with the NHS was terminated in May after negotiations between the company and health officials broke down. The Independent has now learnt that the Japanese firm is seeking to recoup the bulk of the £896m it would have been paid for the entire computer system. Neither the company nor the NHS was prepared yesterday to comment on the precise details of the compensation figure, but sources close to the negotiations said Fujitsu was ready if necessary to go to court to press its £700m claim. The development is the latest setback in the troubled history of NHS computing, which has been beset by cost overruns, defective systems and late deliveries. The cancelled contract was part of the £12.7bn Connecting for Health programme to modernise NHS computers and provide every patient in England with an electronic health record. It it ran into difficulties when the NHS tried to renegotiate the terms. Health officials wanted Fujitsu to provide a more localised records system for southern and western England, but the company said this would increase its costs substantially and asked for more money up-front. When the NHS refused to stump up, Fujitsu walked away from the negotiations – which caused the Government to terminate the contract. Now Fujitsu is gearing up for a major confrontation with the Government with what could be the biggest compensation claim against the NHS in its 50-year history. Asked whether it could end up in court, a company spokesman said: "At the moment we're in dialogue with the NHS and we hope to come to a satisfactory outcome." It is understood that only a small amount of the £896m has been paid to Fujitsu in upfront costs for the computers and

software development. Some industry analysts estimate the company has spent about £300m since it secured the contract in 2004. Fujitsu's deal was one of the biggest of the four regional contracts awarded by the NHS as part of the 10-year Connecting for Health programme, which is already four years late in terms of its overall implementation according to a report by the National Audit Office (NAO). By last March, Fujitsu had supplied just nine out of 41 acute hospitals in southern England, and the systems were working so badly that the company had not been paid for most of them, according to the NAO. . ."

3.3.56. Hospitals: London health trusts plot legal action over new IT system (1 Sep 2008)

The Guardian

http://www.guardian.co.uk/society/2008/sep/01/nhs.egovernment

"Some of London's largest hospital trusts are drawing up claims for compensation relating to the disastrous performance of computer systems installed by BT under the government's controversial £12.7bn overhaul of NHS IT systems in England. Board minutes from the Royal Free Hampstead NHS Trust show members discussing who is to blame for shortcomings in a patient administration system, additional spending required to cope with the crisis, and the possibility of legal action. Minutes dated August 28, seen by the Guardian and Computer Weekly, describe trust chief executive Andrew Way outlining his view of who is to blame. "With regard to compensation, Mr Way reminded members that the contract was with the Secretary of State and that currently it was considered the NHS as a whole was failing to deliver more substantially than BT." The papers show the board also noted one other trust - not named - was known to be seeking compensation. The Royal Free board has instructed staff to log "all problems ... encountered to be used in the event that a claim proves possible". In 2003 BT Global Services won a £993m 10-year contract to build a care records service throughout the NHS in London. BT has given no indication its London NHS contract is under pressure. But two out of its three fellow NHS IT contractors in other regions in England - Fujitsu and Accenture - have withdrawn from similar contracts. Work on the BT London contract has been mired in difficulties, particularly around administration systems produced by US software sub-contractor Cerner. Cerner's system has been installed by BT in four London acute trusts. In each case, trust board minutes detail a litany of glitches, bugs and system failures. The latest minutes from Barts record: "Clinics were reduced in some areas and issues with bookings meant that some clinics and operating theatres were not operating at their usual capacity." Hospitals earn income from primary care trusts for the patients they treat, so reduced activity is expected to hit Barts' income. As a result of "data quality issues" from BT's implementation of Cerner systems, Barts is forecasting "an under-performance of £3m for the year". At Barnet 14,000 patients contacted the trust with concerns about their treatment compared with 5,500 in 2006. . ."

3.3.57. NPfIT Cerner: a user writes (30 Sep 2008)

Computer Weekly - Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/09/npfit-cerner-a-user-writes.html

Gordon Caldwell, a UK consultant in endocrinology and diabetes, writes to the IT Projects blog about a few of the practicalities of trying to make Cerner work. He says that its use in hospitals may require extra staff (which is the experience of trusts so far). Cerner's software is due to be rolled out across London and the south of England as part of the NHS's £12.7bn National Programme for IT [NPfIT]

3.3.58. Is the NHS IT programme weighing down BT? (9 Nov 2008)

Computing

http://editor.computing.co.uk/2008/11/is-the-nhs-it-p.html

BT Global Services has until very recently been a shining star of the telecoms giant, and even after its shock profit warning last week, the division still accounts for £9bn of the group's £20bn revenue. In all the recrimination, resignation and share price falls since the financial announcement, one potential aspect of Global Services' problems has been little discussed. I've heard a few people wondering how much of the division's troubles are down to its involvement in the NHS National Programme for IT (NPfIT). BT is one of only two major contractors still involved, along with CSC. Accenture and Fujitsu have already pulled out due to concerns over potential losses, and BT had been expected to pick up the region ceded by Fujitsu's departure. Former NHS IT director general Richard Granger negotiated some

tough terms and conditions for the key suppliers to the programme - in particular, that payments would be made on delivery of finished product. This is great news for the NHS - now that key parts of the project have been delayed, it doesn't have to worry about the costs of software and services that are not yet fully operational. This was a big factor in Accenture's withdrawal as the supplier saw its costs increasing and its revenue being pushed further into the future. In the early days of NPfIT, former BT chief executive Ben Verwaayen was asked by reporters about the impact on the firm's bottom line, and he proudly explained that BT had not budgeted for a profit from the programme for some time ahead, seeing it as a long-term investment. A wise move - but one now wonders exactly when those profits were expected. The core part of NPfIT -electronic patient records - is an area BT is most exposed to, and is the area most delayed. Recent reports suggested that many NHS trusts are refusing to implement software until they can see it working elsewhere. Considering that one of the BT pilot sites, the Royal Free Hospital in London, has just revealed it lost £7.2m due to the project, it isn't looking promising. BT meanwhile, is funding development and providing services to implement software and try to make it work - essentially without getting paid for it. There has been no official word from BT one way or the other, but observers cannot help but speculate that the troubled National Programme may be a factor in Global Services' current struggles. And if it is, and BT feels it has to reconsider or renegotiate its involvement, then the risks to the NHS IT scheme would be significant.

3.3.59. Government plans for London NHS IT in tatters (19 Nov 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/11/19/233469/government-plans-for-london-nhs-it-in-tatters.htm

"Health officials in London are working with BT, Cerner and IT specialists to rescue plans for integrated e-health records in the capital amid signs that the government's one-size-fits-all approach is disintegrating, Computer Weekly has learned. The original plan which was announced in 2002, in a document "Delivering 21st Century IT Support for the NHS", was for the National Programme for IT [NPfIT] in the NHS to deliver "ruthless standardisation". In London a single database to support electronic health records for eight million people was to be rolled out to all trusts and other NHS sites. That plan turned out to be too ambitious - and was watered down when officials and the NPfIT local service provider in the capital, BT, decided to install different releases of the US-based Cerner "Millennium" system to support e-records in NHS trusts. Now that plan, too, has run into trouble, Computer Weekly has learned. BT, NHS IT specialists and Cerner have ended up customising the standardised smartcard-based Cerner system for one London trust, the Royal Free, after it ran into serious problems. In June 2008 the Royal Free Hampstead NHS Trust became the first trust to install the London Configuration Release 1 [LC1] of Cerner Millennium Care Records Service. It was the first installed Cerner system in England where users had smartcard access to electronic records. Three other London trusts are using the earlier LC0 of the Cerner system. But because of continued problems with the LC1 installation, the Royal Free Hampstead NHS Trust, BT, Cerner and the London Programme for IT have put in place a 90-day rescue plan of the trust's systems, which began on 6 October. The plan involves setting up on site what the Royal Free calls a "full systems and support team". The trust says the team is working on a software build directly for the Royal Free and is "thus changing the London programme model of one build appropriate for all trusts". Health officials and BT had hoped to start rolling out LC1 to other trusts and NHS sites in London - but work has been halted. It is unclear when - and if - it will restart given the Royal Free's problems and the customisation of its software. The Royal Free's staff have had to cope with system crashes, delays in booking patient appointments and data missing in records. Some health IT experts say the problems at the Royal Free and other London trusts could end up with BT delivering a non-standard system to NHS sites in the capital. This would wipe out some of the cost savings of having standard software which could be upgraded easily across NHS sites in the capital. It would also mean an end to the NPfIT vision of fully integrated IT systems across England. . ."

3.3.60. Evidence mounts for NPfIT review (28 Nov 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/11/28/233640/evidence-mounts-for-npfit-review.htm

"It is often said that good results on IT-related projects and programmes rely on good communications. This helps to explain why the NHS's £12.7bn National Programme for IT (NPfIT) is such a good case study - an exemplar of how poor communications corresponds with poor results. The point is

underlined by the details which have emerged this week on the confusing and, as it turns out, overly optimistic public and internal communications over the go-live of the Cerner R0 e-records system at Weston Area Health Trust. . . The Department of Health's public communications over Weston began in 2006, when it tried to use the trust for political advantage. This backfired. In a memo in 2006 to MPs of the Public Accounts Committee, who were sceptical about the claimed successes of the NPfIT, the Department of Health quoted Weston as being particularly satisfied with its installation of the Cerner system. In fact Weston came to regard its Care Records Service as disruptive and "never going to deliver what the NHS needed", according to a paper this year to the trust's board of directors. All trust boards need to report externally on how many patients they are treating, for what, and how quickly. Patient administration systems such as Cerner Millennium should provide this information, at least to ensure that trust boards are paid for treating people. But in the 18 months since its go-live, Weston was never sufficiently certain of its management information from the system to know it would get paid. A deleted section of a draft report of Weston's Audit and Assurance Committee said in February 2008, "The fact remains that the trust is still not at a stage, despite 18 months of work, of having the certainty that we are able to communicate on activity [treating patients] and charge for all the work undertaken". The Department of Health also miscommunicated when giving an assurance to the Public Accounts Committee that mistakes from an earlier go-live of the Cerner system at Nuffield Orthopaedic Centre would not be repeated. Weston repeated some of the mistakes at Nuffield. Both Nuffield and Weston - and other trusts since - have had difficulties producing external statutory reports on their care and treatment of patients. What has happened at Weston could answer the question so many in the NHS are asking: how is it that mistakes are unknowingly replicated every time a trust goes live with the Care Records Service? The answer, from the facts at Weston, is that the board of a trust which is due to go live with Cerner is assured that problems at other trusts have been solved. But the team going live find out only too late that the problems are still there. It is arguably time for the Department of Health to come clean about the NPfIT. Trust after trust has gone live with Cerner only to find that problems have not been fixed. It is uncomfortable for Computer Weekly to criticise the NPfIT in this way. Many thousands of people are working on the programme, or have a stake in its wished-for success. They want it to work. So do doctors. Paper-based records that go missing can cause lives to be lost unnecessarily. E-records make unequivocal sense. But the NPfIT is demonstrably not the best vehicle to deliver e-records. We say again, but now with more evidence in our possession, that there needs to be a thorough, independent published review of whether the NPfIT will meet the needs of NHS trusts. Meanwhile, money continues to be poured into the programme - before anyone really knows whether the money is being well spent or wasted on archeologically excavating ground which has little or nothing worthwhile beneath the surface."

3.3.61. NPfIT future in question as BT reviews contract (23 Jan 2009)

ZDnet

http://news.zdnet.co.uk/itmanagement/0,1000000308,39600666,00.htm

"One of the two remaining main suppliers for the £12.7bn National Programme for IT, BT Global Services, said on Thursday it expects to take a £340m writedown on earnings from 15 of its 17 largest contracts due to poor "cost controls". BT chief executive Ian Livingstone warned another writedown of "some hundreds of millions" of pounds more on the remaining two contracts, which are still being reviewed, could be on the cards. A £1bn contract to link up and standardise all of the NPfIT computer systems in the London area, due to run until 2013, is thought to be among these final two, according to director of analyst house TechMarketView, Richard Holway. Under the deal, BT is replacing an ageing patchwork of 5,000 different NHS computer systems with a nationwide infrastructure connecting more than 100,000 doctors, 380,000 nurses and 50,000 other health professionals. Holway said the NHS must renegotiate less ambitious and more rewarding terms with BT for its NHS contract or risk the vendor walking away as previous suppliers Fujitsu and Accenture have. "Clearly a huge question-mark hangs over the future of the NHS IT programme. I believe there is a great deal of contract renegotiation going on behind the scenes," he said. . . A spokesman for BT told ZDNet UK's sister site, silicon.com, that a "handful" of the 17 contracts have become "loss-making" but that it is too early to say whether BT will walk away from them. "We cannot rule anything out at this stage," he said. . ."

3.3.62. Worthing decides to switch off Cerner (16 Feb 2009)

e-Health Insider

http://www.e-health-insider.com/news/4575/worthing_decides_to_switch_off_cerner

"Worthing and Southlands Hospitals NHS Trust has agreed plans to switch off its Cener Millennium electronic records software and move back to its old Sema-Helix software. As first reported by E-Health Insider on 26 January, the trust has been examining whether to move from its current Cerner Millennium system back to its old Sema-Helix patient administration system as part of a merger with neighbour Royal West Sussex (RWS). The new NHS trust, to be created in April from the proposed merger of RWS and Worthing and Southlands Hospitals (WaSH), will adopt the Helix Patient Administration System to ensure the continued safe management of medical records across the three sites. The future IT plans will still have to be ratified by the board of the newly merged trust, but had previously been described as one of several options. The Helix system is currently in use at RWS and was also used at WaSH prior to the introduction of the Cerner Millennium Care Records Service (CRS) software in September 2007. The trust says it remains committed in the long-term to adopting a National Programme solution to implement a Sussex-wide CRS. E-Health Insider understands that the Worthing and Southlands trust board decided to switch back to Sema-Helix following an options appraisal exercise. EHI has learned that the WASH board decided it was more sensible to transfer to a familiar system still being used at RWS, than to move RWS to an entirely new platform - one unsupported by an LSP - on a temporary basis."

3.3.63. The road not taken (6 Mar 2009)

Health Investor

http://www.healthinvestor.co.uk/(A(ur1fkg7VyQEkAAAANGIwNzI2YjItOWFkYi00OTg2LTliM2MtOTlmNDhjMDc0MjNlSnlX28cGalW7EluCtbLL307oW7Q1)S(o3sp2kzmauj5umutqce5onrc))/ShowArticle.aspx?ID=499

"Some parts of the National Programme for IT (NPfIT), the NHS's $pound;12.7 billion computer system overhaul, are so late and working so badly that hospital trusts are beginning to look elsewhere. . . Rotherham, Worthing & Southlands and Newcastle-upon-Tyne trusts are all going off-piste in their attempts to get working systems. Each is a special case, however, and Connecting for Health, the government body which oversees the NPfIT, is keen to stress the trusts are looking for interim solutions - which implies eventually they'll be brought back into the fold. But it's by no means sure that will ever happen. MPs are so disillusioned with the care records element of the programme, in particular, that they called on the Department of Health (DH) to give the scheme just six more months to get better. Unless the position "improves appreciably," says the Commons public accounts committee in its new report, "the department should assess the financial case for allowing trusts to put forward applications for central funding for alternative systems compatible with the objectives of the programme". All three of the trusts currently looking for alternatives to the NPfIT have foundation status, giving them control over their own financial affairs. They aren't obliged to take what the national programme offers. But David Nicholson, chief executive of the NHS, told the public accounts committee in July 2008 that they would have to show pretty good reasons why they were treading their own path. "They have to have a business case which sets out the benefits or otherwise of taking something alternatively, and I think it is a very difficult thing for them to be able to prove," he said. "In fact, I have not seen one that has done it yet." Rotherham invited tenders for its patient administration system because the current TotalCare system won't be supported by supplier McKesson after 2010. TotalCare is already over 24 years old and a spokeswoman for the trust describes it as "an antique in computing terms". The trust had expected that its local service provider, CSC, would install iSoft's Lorenzo software system in its place in 2006-07 - but there's still no word on when it might be ready. In the words of the public accounts committee, "given the continuing delays and history of missed deadlines, there must be grounds for serious concern as to whether Lorenzo can be deployed in a reasonable timescale and in a form that brings demonstrable benefits to users and patients". It adds that "pushing ahead with the implementation of Lorenzo before trusts or the system are ready would only serve to damage the [national] programme". The shortlisted providers for Rotherham are understood to be Meditech, SystemC and the University of Pittsburgh Medical Center (UPMC) working with Cerner. This would not be the same 'Millennium' product which Cerner provides to trusts under the national programme. That's plagued by implementation problems, including at Worthing & Southlands trust which is getting ready for its merger with the Royal West Sussex trust, Chichester, in April. Millennium was installed at Worthing & Southlands Hospitals (WaSH) in September but was dumped last month in favour of a return to the previous system, the 20-year-old Sema-Helix software which Chichester still uses. A spokeswoman for WaSH said: "Continuing with separate systems until the proposed deployment of the new national programme system was not considered a viable option as the

timetable for this has not yet been finalised. Running parallel systems would also be more time-consuming and less efficient than switching to a common one." Eventually, says a spokesman for Connecting for Health, the organisation may well take a NPfIT system, but in the interim, "it is more sensible for Worthing to transfer to a familiar system used by Chichester, than for Chichester to move to an entirely new system on a temporary basis. NPfIT is happy to help with these arrangements to support a smooth transition to a new larger organisation." Newcastle also opted to bypass its local service provider, CSC, and has entered a joint venture with UPMC. Not only is the joint venture going outside the programme, it also hopes to sell systems itself to other NHS organisations. . .

3.3.64. BT faces multimillion pound writedown on NHS computer upgrade (12 April 2009)

The Guardian

http://www.guardian.co.uk/business/2009/apr/12/bt-writedowns-nhs-computer-upgrade

"BT Group will next month become the third major contractor in as many years to take a multimillion pound writedown on its work with the government's crisis-stricken £12.7bn overhaul of the NHS computer system. The writedown at BT's struggling Global Services division is expected to be accompanied by news that thousands more jobs will be lost as BT is forced to slash costs. Some reports have suggested that more than 10,000 jobs could go, though BT described the figure as "speculation". . . The National Programme for IT - the largest non-military computer project on record - has already lost two of its four regional contractors, Accenture and Fujitsu. Both quit contracts similar to BT's work in the London region, writing off hundreds of millions of pounds. A poor-performing BT contract to install NHS computer systems in the capital will be the main element in a £1bn-plus package of writedowns when the company reports full-year results next month. Global Services last year announced a £336m provision against 15 of its 17 contracts, but the two remaining deals - widely believed to be the NHS and Reuters - are thought to be the most troublesome. The NHS-related writedown comes despite BT two weeks ago winning highly lucrative bolt-on deals, including a contract to manage IT systems at eight hospital trusts across the south of England installed by Fujitsu before the Japanese firm quit. Without this additional work, as well as a low-profile deal to reset the existing London contract, BT's writedowns may well have been substantially larger. NHS IT bosses had been aware for years that BT's work in London - started in 2003 as a 10-year £996m contract - had not been going well, but are eager to ensure another regional contractor does not leave. Until it struck the new or revised deals with the NHS at the end of March, it is understood that BT was considering whether to quit the project. Since its London contract began BT has installed just four patient administration systems (PASs) in acute hospital trusts - at the Royal Free; Barnet & Chase Farm; Queen Mary's Sidcup; and Barts & The London. In many cases the systems deployed were blamed by the trusts for a series of IT problems which cost them millions of pounds in financial penalties. . ."

3.3.65. CfH on the brink of new deals with CSC and BT (14 Apr 2009)

e-Health Insider

http://www.e-health-insider.com/news/4743/cfh_on_the_brink_of_new_deals_with_csc_and_bt

"NHS Connecting for Health is on the cusp of signing renegotiated deals with both of its two main regional contractors, Computer Sciences Corporation and BT. CfH says "agreement has been reached" with both suppliers. But while the final 'Penfield agreement' with CSC" has been signed, the agreement with BT is understood to be a non-binding Memorandum of Understanding. The two deals are intended to ensure that the struggling local service providers can successfully deliver iSoft's Lorenzo and Cerner's Millennium electronic record software to a significant number of hospitals by the end of the year. Extra money appears to have been found, functionality scaled back in some areas, previous release schedules ditched, and the central concept of single shared system sacrificed in a final attempt to achieve delivery through the LSP model ahead of a 2010 general election. The deals cover the three LSP contracts CSC holds for the North, Midlands and East of England and BT's LSP deal in London. Termed 'Contract Change Control Three', they are the third major renegotiation of the LSP contracts since they were signed in 2003. . . E-Health Insider understands the renegotiation of the three CSC deals focuses on reworking the Penfield delivery strategy for the Lorenzo software and concentrating resources on implementations of the initial versions of the software now in use on a small scale in South Birmingham, Morecambe Bay and Bradford. EHI has learned that development work with NHS trusts has been suspended for later versions of Lorenzo, which was set to include clinical modules such as maternity and theatres from release three onwards. CSC will also continue to provide trusts with

versions of older iSoft software, where required. In London, the new LSP contract is understood to focus on moving to a new delivery model for NPfIT, which focuses resources on a series of stand-alone acute implementations of Cerner Millennium, with more local configuration at a much higher cost than originally planned. In London, BT is also understood to have negotiated a deal that will see it hand back responsibility for providing new GP systems out of a hosted data centre. The LSP will, however, continue to offer CSE-Servelec's RiO community system. BT Group is reported to have examined all options in London, including quitting the LSP contract, unless it could agree a new delivery model. The exit of BT would have left the NHS with just one surviving LSP out of the original four appointed; Accenture and Fujitsu having already departed. But a clear indication that deadlock had been broken came at the end of March, when BT was awarded a lucrative deal to support eight existing Cerner sites in the South. The eight sites have been in limbo since Fujitsu exited as LSP for the south last May. BT's beleagured Global Services Division last year announced a £336m write-down against 15 of its 17 contracts; one of the remaining two is thought to be NHS London. Originally signed in 2003, the deal is worth £996m. The company is expected to announce further write-downs against the London NHS deal next month. BT Global Services has already slashed thousands of contractor jobs, with further cuts expected. . ."

3.3.66. Barts' waiting list worst in country as it struggled with IT (7 Jul 2009)

Computer Weekly

http://www.computerweekly.com/Articles/2009/07/07/236791/barts-waiting-list-worst-in-country-as-it-struggled-with.htm

"Hundreds of Londoners have waited longer than they should have for their first hospital appointment, as staff at Barts and The London NHS trust struggle to keep track of patients on their IT systems. The waiting list delays during March at Barts and The London were the worst in the country. The Government has set a target that all patients should see a consultant or doctor within 13 weeks of a referral by a GP. Most trusts in England reported to the Department of Health "zero" patients in March who had waited longer than 13 weeks for their first outpatient appointment. But the latest papers presented to the Board of Barts and The London said that it had 834 patients who were still waiting in March - and 675 of these had been waiting more than 17 weeks. The number of patients waiting was higher than all the trusts in England put together. Computer Weekly understands that some of the patients have shown up incorrectly on the waiting list - they had duplicate e-records and were actually seen but not recorded as being seen on their duplicate file. Other patients gave up waiting and were referred by their GP to another trust. Still, hundreds of Barts' patients were still waiting for their first appointment after a GP referral, for weeks and sometimes months beyond the Government's 13-time limit. Staff at Barts and The London have struggled to keep track of patient appointments since implementing the Cerner Millennium "Care Records Service" last April. Their difficulties have been compounded by inefficient management information systems. Last year Barts reported that patients with suspected cancer were not receiving urgent appointments to see specialists within the government's two-week target. The trust said this was "directly attributable to the erroneous migration of outpatient clinics [data] at the change-over to [the] Care Records Service". For Barts, one challenge has been to attune management processes and train staff to work differently since the introduction of the Care Records Service. The trust's board says it is of "extreme concern" that Barts has been unable to report on the number of patients who have or have not been treated within 18 weeks of being referred by a GP. The trust is having trouble keeping track on its systems of patients who are due to be treated and by when. The problems at Barts have hit the performance ratings of London primary care trusts - particularly Tower Hamlets - which pass their patients to Barts for care and treatment. . ."

3.3.67. FSA starts criminal proceedings against former iSOFT directors (6 Jan 2010)

Computer Weekly

http://www.computerweekly.com/Articles/2010/01/06/239832/fsa-starts-criminal-proceedings-against-former-isoft.htm

The Financial Services Authority (FSA) has begun criminal proceedings against four former directors of the healthcare software supplier iSOFT Group plc. The directors face charges over the offence of conspiracy to make misleading statements, contrary to the Financial Services and Markets Act 2000 and the Criminal Law Act 1977. Patrick Cryne, Stephen Graham, Timothy Whiston and John Whelan have been summonsed to appear at City of Westminster Magistrates Court on 29 January 2010. At the

time the four were directors of iSOFT, it was a major supplier to the £12.7bn National Programme for IT (NPfIT), as a subcontractor to services supplier CSC, which is not involved in the criminal proceedings and faces no accusations. iSOFT has faced Parliamentary scrutiny and allegations of financial irregularities in its accounts. It has since been taken over by an Australian company, which continues to supply iSOFT products as part of the NPfIT. In a separate announcement, iSOFT said today that it welcomes the FSA's decision to discontinue its investigation into the company. Australian company IBA Group, which renamed itself iSOFT Limited, acquired the UK-based iSOFT Group plc in October 2007, after the events that were the subject matter of the FSA investigation. iSOFT said it has "cooperated fully with the FSA throughout the investigation, which involved former management of iSOFT Group plc and had no bearing on any of the current management or employees of iSOFT Group Limited". . .

3.3.68. NPfIT cuts put future of Lorenzo in doubt (5 Mar 2010)

Computer Weekly

http://www.computerweekly.com/Articles/2010/03/05/240511/npfit-cuts-put-future-of-lorenzo-in-doubt.htm

Ministerial plans to cut £600m from the NPfIT have put the usefulness of the Lorenzo software, which is due to be installed at NHS sites across large parts of England, in doubt. Supplier CSC is delivering the iSoft Lorenzo Care Records Service under an NPfIT contract worth more than £3bn. Though delayed by four years, the Lorenzo system is due to be installed at NHS sites in England, outside of London and the south. But the usefulness of Lorenzo is under threat now that officials are negotiating fresh deals with the two NPfIT local service providers, CSC and BT, to reduce the overall cost of their contracts by hundreds of millions of pounds. A cut in the planned functionality of Lorenzo will bring the product's whole efficacy into question, said Duncan Robinson, associate director of IT at South Warwickshire General Hospitals NHS Trust. In South Warwickshire trust's latest board papers, Robinson said, "Statements made during the last quarter by the health minister around the need to save £600m from NPfIT have resulted in a number of the functional modules planned for the later releases of the Lorenzo Regional Care product being removed. "The original Lorenzo model contained five major release phases. However, certain functionality from releases 3 and 4 has now either been brought forward or has been axed altogether, bringing the efficacy of the product as a whole into question." Robinson's comments are likely to increase Tory concerns that health minister Andy Burnham wants to sew up new NPfIT deals with CSC and BT before a general election. The deals would commit CSC to delivering a cut-down version of Lorenzo even though there are deepening doubts that parts of the NHS would want it. A CSC spokeswoman said, "No decisions have yet been made about changes to future releases of Lorenzo as a number of options are currently being discussed with the local NHS."

3.3.69. Bacon says 'prove value of NPfIT deals' (24 Mar 2010)

eHealth Insider Primary Care

http://www.ehiprimarycare.com/news/5767/bacon_says_%27prove_value_of_npfit_deals%27

A leading member of the Commons Public Accounts Committee has written to NHS chief information officer Christine Connelly, questioning how negotiations to ‘descope’ the two remaining local service provider contracts will deliver value for money. In an interview with E-Health Insider, Richard Bacon said it was essential that civil servants leading the contract renegotiations were clear that the deals would deliver clear value for money and provide the NHS with working systems. . . Two new, cut down local service provider deals - that dramatically cut the amount of functionality and slash the number of hospitals to get new systems - are thought to be on the brink of being signed. Both involve up-front payments to remaining LSPs, BT and CSC. The new CSC deal hinges on a successful go-live of Lorenzo at University Hospitals of Morecambe Bay NHS Trust. Bacon is concerned that the new LSP deals will fail to deliver systems urgently needed by NHS hospitals. "I remain very concerned about the acute hospital care record systems that are at the heart of the national programme," he said. . . E-Health Insider has learned that up to 18 London hospitals trusts are thought to have withdrawn from the LSP upgrade programme, out of an original total of 32. Seven of these are existing iSoft sites. . . . The latest date for a go-live at Morecambe Bay of Lorenzo Regional Care Release 1.9 appears to be 2 April. However, Bacon points out that: "Over the last seven years, the Lorenzo PAS [patient administration system] has missed deadline after deadline. We were expecting it in 2004-05; and then in 2008 Mr Nicholson told us that it was ready to deploy; and I understand that it is about to miss the March 2010 drop dead date which you set last year." Bacon told EHI that he his current information

was that over 100 bugs still exist with Lorenzo at Morecambe Bay, indicating the software is not ready. . .

3.3.70. Is CSC 'on brink of dismissal' from NHS IT delivery? (1 April 2010)

Computer Weekly

http://www.computerweekly.com/Articles/2010/04/01/240796/Is-CSC-39on-brink-of-dismissal39-from-NHS-IT-delivery.htm

CSC, which has £3bn worth of contracts under the NHS IT programme, is "on the brink of being fired from a key part of its contract after failing to meet a deadline to install systems at hospitals in the north-west", according to the Financial Times. The Department of Health had given CSC a deadline of 31 March 2010 to go live successfully with the iSoft Lorenzo 1.9 Care Records Service at Morecambe Bay University Hospitals NHS Trust, which is an ardent advocate of the National Programme for IT (NPfIT) Lorenzo system. Had a go-live happened successfully, the Department of Health and its agent, NHS Connecting for Health, would have paid CSC tens of millions of pounds, in recognition that Lorenzo 1.9 had proved itself capable of being rolled out across other NHS trusts. But the deadline passed yesterday without a go-live, and although officials had been willing to put back the deadline to this month, a go-live in April now seems highly unlikely as well. The failure to go live means that Connecting for Health has been unable to sign a memorandum of understanding with CSC, which would have set out a schedule for the delivery of new systems to NHS trusts under a new government. CSC will now put forward a new deadline for going live at Morecambe Bay, which will have to be agreed with the Department of Health's CIO, Christine Connelly. She told the FT that if progress is not made, the Department of Health has the option of cancelling CSC's contract to install the systems in acute hospitals, which is worth about £1bn. Connelly could end up allowing hospitals to choose from other suppliers. Connelly said that CSC has to be given time, under its contract, to propose a fresh deadline for deployment at Morecambe Bay. The Department of Health will then assess the credibility of the new deadline and decide whether to agree it. "We have to walk through this step by step," Connelly told the FT. "In a contract as large and complex as this we cannot just set a deadline and say that is it. We have to act responsibly and not expose the department and the taxpayer to risk." The Department has signed a new memorandum of understanding (MOU) with BT, the NPfIT local service provider in London and parts of the South of England. The deal means £112m will be cut from BT's £1bn local service provider contract and BT will need to deliver the Cerner Millennium system to about half of the trusts in London. Originally it was contracted to supply all of them. A Department of Health statement said: "We made clear last year that it is important to improve the certainty of delivery of NHS IT in the acute sector while ensuring that any innovation matches the changing needs of the local NHS. We want trusts to be able to choose how National Programme for IT products can work with local systems that remain fit for purpose. "This new flexible framework is the basis of our MOU with BT and will be the basis for an MOU we expect to sign with CSC once University Hospitals of Morecambe Bay NHS Trust goes live with Lorenzo. "While we are disappointed that we have not been able to agree both MOUs, we are expecting our current review with CSC of delivery plans to achieve significant savings, while building on the gains already made for patients, clinicians and managers."

3.3.71. Officials nervous over Morecambe Bay's planned go-live (27 May 2010)

Computer Weekly Tony Collins IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2010/05/officials-nervous-over-morecam.html

NHS staff and executives at University Hospitals of Morecambe Bay NHS Trust are planning for an important go-live of iSoft's Lorenzo system this Bank Holiday weekend. A spokeswoman for the Trust said this morning (27 May 2010) that she was unaware that any definite decision for a go-live had yet been taken, but all the signs are that the Trust wants it to happen this weekend. Not all officials at Richmond House, the headquarters of the Department of Health, share Morecambe Bay's conviction that a go-live this weekend is a good idea. A smooth go-live - if signed off by the Trust as successful - would in theory give the supplier CSC and its subcontractor iSoft tens of millions of pounds. But would a coalition government that is sceptical of the NPfIT want to pay CSC such a large sum at a time when it wants to prove it is serious about cutting the national debt? This is one of the problems facing the DH CIO for health Christine Connelly who has recently travelled to Morecambe Bay in Cumbria. Does she want a go-live at Morecambe Bay that would help CSC and iSoft climb several rungs of the NPfIT ladder, when the government wants to remove most of the top rungs of the same ladder? Even if Morecambe Bay goes live this weekend many other trusts in CSC's local service provider area may not

want to take Lorenzo 1.9. So CSC could end up being paid tens of millions pounds for having proved the feasibility of a system many other trusts won't install. . .

Update: Morecambe Bay's press office told me this afternoon [27 May 2010] that the Trust's directors want any journalists inquiring about the planned go-live this weekend to be referred to NHS Connecting for Health in London. This is unusual advice, because trusts are independent organisations, and CfH does not answer for what Morecambe Bay does or doesn't do. NHS trusts have their own press offices, separate from the press offices that are run by CfH and the Department of Health. I have now asked CfH for a comment on Morecambe Bay's planned go-live this weekend. I have also asked CfH who would be responsible if a new system at Morecambe Bay contributed to an avoidable injury or fatality. Would the responsibility lie with Morecambe Bay or CfH? I haven't yet had an answer.

3.3.72. Govt IT scheme 'set NHS back 10 years' (16 Jun 2010)

ThinQ

http://www.thinq.co.uk/2010/6/16/govt-it-scheme-set-nhs-back-10-years/

The chief executive of an NHS trust that opted out of the Government's National Programme for IT has slammed the scheme, labelling it "Not Fit For Purpose IT". Brian James, chief exec of the Rotherham NHS Foundation Trust, told delegates at yesterday's Smart Healthcare Live conference in London that the National Programme for IT had "put back the contribution of IT in the NHS by more than ten years". Rotherham became one of the first NHS trusts to ditch the Government's NPfIT scheme. Executives at the trust expressed their concern that plans for an electronic patient record system were slipping behind schedule. The trust rejected the NPfIT's Lorenzo system, provided by much-criticised supplier CSC, and instead opted for the Meditech v6.0 system from FileTek in a project that cost the trust £40 million. CSC came under fire earlier this year after missing a March deadline to roll out a pilot Lorenzo to the Morecambe Bay Primary Healthcare Trust. The project eventually went live on 1 June. "We are one of the bad boys who left NPfIT," James said of the trust's decision. "But we think we have a unique and completely fit-for-purpose solution that will deliver between eight to ten per cent return on our investment." James told delegates: "We were promised NPfIT products in 2005 that didn't appear, and our supplier said it would withdraw from the healthcare market in 2010 anyway." The Rotherham healthcare chief told the conference that the decision hasn't been easy. "This has also been a complex programme to manage by ourselves, with complex negotiations to make our supplier adapt and Anglicise the system... as well as stiff project management issues all round. But we feel we have delivered something that will really benefit us nonetheless." The ailing NPfIT scheme's prognosis is still uncertain. A spokesperson for the Department of Health told THINQ that, following the recent change of government, they were still waiting for policy direction.

3.3.73. MP seeks NAO inquiry into BT £546m NHS deal

ComputerWorld - Tony Collins Blog

http://blogs.computerworlduk.com/the-tony-collins-blog/2010/08/mp-seeks-nao-inquiry-into-bt-546m-nhs-deal/

Was BT paid to stay in the £12.7bn NHS IT programme? An MP on the Public Accounts Committee is seeking an investigation by the National Audit Office into a deal in which officials promised BT £546m of extra payments under the NHS IT scheme. Richard Bacon, a Conservative MP who has followed the NHS's National Programme for IT [NPfIT] for much of its eight-year existence, questions whether the Department of Health has paid a premium of hundreds of millions of pounds to BT, partly to dissuade it from leaving the NPfIT after the departures of Fujitsu and Accenture. Had BT withdrawn from the £12.7bn NPfIT - Whitehall's single largest IT investment - the scheme would have been left with only one of the original four local service providers, CSC, a limitation which would have jeopardised the programme's existence. Bacon's request for an investigation will be welcomed by many within and outside the NHS who were surprised by the size of the Department's deal with BT in 2009. The MP has written to Amyas Morse, the head of the National Audit Office. The NAO reports regularly on the results of its value-for-money investigations to the Public Accounts Committee. Bacon says in his letter that £400m of the £546m agreed with BT has not been properly accounted for and so raises questions about the proper use of public money. The £546m was for BT to take over work from Fujitsu which withdrew from the NPfIT in 2008. Bacon says he recognises that Fujitsu's withdrawal from the NHS IT scheme left the Department of Health and its NPfIT agent, NHS Connecting for Health, in a difficult position. They needed to find a supplier to take over the support of eight NHS

trusts where Fujitsu had already installed Cerner "Millennium" systems under the NPfIT. Bacon's letter questions whether the payments to BT were £400m more than necessary. "It seems to me that it would have been reasonable, indeed generous, to have paid BT £100m for taking on the local service provider work from Fujitsu. I cannot see how £546m was justified unless the Department of Health was willing to pay BT any sum to keep it within the National Programme for IT," says Bacon. . .

3.4. User Surveys and Consultations

3.4.1. Health policy debate (Feb 2004)

British Medical Association

http://www.bma.org.uk/ap.nsf/Content/media13feb

" The biggest nightmare of the National Programme for IT (NPfIT) is that significant numbers of clinical staff just refuse to change…So winning doctors' hearts, as well as minds, is crucial. Hence the top-level interest in the results of 1000 doctors' opinions published this week. It was carried out electronically by Medix, a respected sampler of medical opinion. The good news is that three-quarters of doctors…say the IT programme is an important NHS priority. The bad news was a raspberry for the project with the highest political profile, e-booking. That scored bottom on the question " is the focus on the right projects? Another worry is that doctors still believe they are not being told enough about the whole scheme."

3.4.2. EMIS users urged to protest about systems choice (2 Sep 2004)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=849

" The head of the EMIS National User Group (NUG) has written to all EMIS users calling on them to lobby their MPs, local Primary Care Trusts or Local Medical Committees to express their concerns about National Programme for IT (NPfIT) strategy on choice of GP systems. . . " The LSPs don't appear to be paying the slightest bit of attention to the GP contract commitment to choice [paragraph 4.34]," Dr Mary Hawking, EMIS NUG committee member told E-Health Insider."

3.4.3. Medix UK plc survey (Q558) of doctors' views about the National Programme for IT - NPfIT (Oct 2004)

Medix

http://www.medix.to/Q558.pdf

" As a practicing clinician, I am concerned that this IT programme has all the hallmarks of previous governmental IT failures, for example failure to consult with end-users about how it will integrate with their daily work and make their work easier. If it is perceived as management or government driven additional tasks (which it is currently, by the few who have heard of it), then it will fail. Dr James Woolley, Psychiatrist, London."

3.4.4. A Baseline Study on the National Programme for IT (Jul 2005)

MORI for NHS Connecting for Health

http://www.connectingforhealth.nhs.uk/delivery/serviceimplementation/engagement/morifull.pdf

" Overall, the findings are positive, showing that staff are supportive of what the programme is trying to achieve and consider it an important priority for the NHS. However, they also indicate that some staff groups, especially front-line staff, are not yet fully engaged in rolling out the programme. . . Managers are most favourable towards the programme as it currently stands and Doctors are most critical of the programme."

3.4.5. QinetiQ survey reflects health professionals concerns about NHS IT security (19 Jul 2005)

QinetiqQ

http://www.qinetiq.com/home/newsroom/news_releases_homepage/2005/3rd_quarter/qinetiq_survey_reflects.html

" As the National Health Service's (NHS) national programme for IT (NPfIT) is rolled out, a QinetiQ sponsored survey about NHS requirements reveals that 71% of healthcare professionals place IT security at the top of a list of current issues likely to remain a concern over the next three to five years. These are the headline results from QinetiQ's health sector survey reported today in Health Director magazine. The concerns about IT security are set against the background of implementation of the NPfIT scheduled between 2004 and 2010 and wide-spread criticism of patient confidentiality, cost and impossible deadlines. The NHS Care Records element - intended to hold electronic patients records securely on line and make them easily accessible to healthcare professionals and patients, and the Choose and Book element, an electronic hospital appointments booking systems for GPs and patients, are two areas under fire. Both are scheduled to be implemented in 2005."

3.4.6. Doctors " demoralised" by £6.2bn NHS IT scheme (5 Aug 2005)

Silicon.com

http://management.silicon.com/government/0,39024677,39151068,00.htm

" Frontline health service staff are " heavily demoralised" over the lack of information and communication around the £6.2bn NHS IT modernisation programme. Researchers at the London School of Hygiene and Tropical Medicine (LSHTM) claim the situation is so serious that the whole Connecting for Health programme (formerly known as the National Programme for IT) is at risk because it is falling behind schedule in key areas. The research team looked at four hospital trusts in England and, in the first part of what will be an ongoing study, talked to 23 managers and doctors involved in the implementation of the new NHS IT systems. Although the new IT systems are centrally funded under the Connecting for Health programme, the research found NHS managers are still concerned about where the money will come from for staff training and to accommodate changes in the way the NHS will have to work once the new system is up and running. Doctors are also concerned that previously scheduled upgrades to creaking radiology or pathology systems have been put on hold while funds are diverted to installing the new patient record system in every NHS trust. LSHTM health policy researcher Dr Naomi Fulop warned there is a risk of current systems failing before the new one is ready."

3.4.7. Challenges to implementing the national programme for information technology (NPfIT): a qualitative study (6 Aug 2005)

BMJ Information in Practice

http://bmj.bmjjournals.com/cgi/content/abstract/331/7512/331

" Results: The trusts varied in their circumstances, which may affect their ability to implement the NPfIT. The process of implementation has been suboptimal, leading to reports of low morale by the NHS staff responsible for implementation. The overall timetable is unrealistic, and trusts are uncertain about their implementation schedules. Short term benefits alone are unlikely to persuade NHS staff to adopt the national programme enthusiastically, and some may experience a loss of electronic functionality in the short term.
Conclusions: The sociocultural challenges to implementing the NPfIT are as daunting as the technical and logistical ones. Senior NHS staff feel these have been neglected. We recommend that national programme managers prioritise strategies to improve communication with, and to gain the cooperation of, front line staff."

3.4.8. Knowledge of the Choose and Book Programme Amongst GPs in England (Sep 2005)

D.n for the National Audit Office

http://www.nao.org.uk/publications/gp_survey_2005.pdf

" An overwhelming majority of respondents felt that the consultation on implementation of Choose and Book was inadequate – 93% of respondents felt this."

3.4.9. BMA response to 'Clinical development of the NHS care records service' (5 Oct 2005)

BMA

http://www.bma.org.uk/ap.nsf/Content/ncrsresponse

" Whilst the BMA supports the sharing of information to improve patient care, we are disappointed that the architecture of a system, which will have huge implications to the delivery of healthcare, was commissioned and built prior to stakeholder consultation."

3.4.10. Medix UK plc survey (Q850) of doctors' views about the National Programme for IT - NPfIT (Jan 2006)

Medix

http://www.medix.to/reports/Q850.pdf

" . . . many doctors believe that NPfIT could provide valuable benefits to clinical care in the NHS. However, they also confirm Medix's finding a year ago that doctors are increasingly critical of its costs and of the way it is being implemented. For example, whereas three years ago 47% of doctors thought NPfIT a good use of NHS resources and 27% thought not, today 17% say it is and 57% disagree. And, when asked to rate progress so far, only 1% considers it good or excellent. One aspect of earlier survey findings is unchanged however: most doctors have little information about NPfIT and continue to say that there has been inadequate consultation with them about it."

3.4.11. GPs dissatisfied with IT system (30 May 2006)

BBC News

http://news.bbc.co.uk/1/hi/health/5028762.stm

" Doctors have called for a review into the £6.2bn NHS computer project, according to a survey by BBC News. The IT upgrade aims to link up 30,000 GPs to nearly 300 hospitals in a radical overhaul of the NHS IT network. Half of the GPs said the " choose and book" online booking system was poor or fairly poor. The poll was completed by 447 hospital doctors and 340 GPs. . . Four out of five GPs had access to the computer system, but half said they rarely or never use it. Only about one in five said it was good or fairly good. The overwhelming majority - 85% - say there should be an independent review of the entire scheme by technical experts to check its basic viability."

3.4.12. Speech by Mr James Johnson, BMA Chairman at the Annual Representative Meeting 2006 (26 Jun 2006)

BMA

https://www.bma.org/ap.nsf/Content/ARM2006JJohnson

" I hear concerns from NHS managers, civil servants and politicians too. You tell me that the breakneck pace and the incoherent planning behind systems reform are seriously destabilising the NHS. The message I am getting from the medical profession is that the NHS is in danger and that doctors have been marginalized. The message I pick up from every meeting I attend, every bit of research that crosses my desk, every seminar is the same. Everyone is telling Government – you must get the professions on board; you must involve clinical staff; you can't make this work without doctors. Connecting for Health is the obvious example. Last year at the ARM, I criticised the failure to engage with clinicians. There are some very good doctors involved with the project now, but overall I would have to say that another year has been wasted because doctors are still not at the heart of determining how the systems should work."

3.4.13. CfH still sidelining doctors, BMA chair claims (27 Jun 2006)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=1967

" The chairman of the British Medical Association has told his members that " another year has been wasted" in efforts to implement the National Programme for IT. In his keynote address to the BMA's

annual representative meeting (ARM) Mr James Johnson claimed that doctors were being marginalised in all aspects of system reform and that Connecting for Health was the obvious example of that."

3.4.14. Mixed feelings on NPfIT in primary care, poll shows (21 Jul 2006)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=2018

" Only one in four GPs feel favourably about the National Programme for IT although the overwhelming majority rate NPfIT as an important priority, according to Connecting for Health's latest poll of opinion among doctors, nurses, NHS managers and IM&T staff. GPs felt substantially less favourable than hospital doctors, with 25% of GPs liking what they had seen so far compared with 46% of hospital doctors. MORI, which conducted the telephone survey of 1197 NHS staff between January and February this year, believe Choose and Book may be to blame for the lack of enthusiasm from GPs."

3.4.15. CfH " to learn" from nurse disquiet over IT programme (22 Aug 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/08/22/217878/CfH+%E2%80%9Cto+learn%E2%80%9D+from+nurse+disquiet+over+IT+programme.htm

" Connecting for Health, the organisation in charge of the NHS's £12.4bn National Programme for IT, has pledged to learn from a survey that showed nurses losing faith in IT developments. The Royal College of Nursing's survey of nearly 4,500 nurses found that only four out of 10 believed current IT developments were a good use of NHS money – fewer than the 43% who disagreed. The level of dissatisfaction was nearly four times higher than the 2004 figure of 11%. Nurses also echoed concerns raised by doctors that they had not been sufficiently consulted over IT plans."

3.4.16. Nurses and NHS IT developments: Results of an online survey by Nursix.com on behalf of the Royal College of Nursing (22 Aug 2006)

Royal College of Nursing

http://www.e-health-insider.com/tc_domainsBin/Document_Library0282/nursix-rcn-survey-2006.pdf

" This survey was commissioned by the Royal College of Nursing to investigate the views of UK nurses about NHS IT developments. 4,451 nurses responded. The objectives were (a) to investigate nurses' views about NHS IT developments, especially the proposed integrated electronic patient record system, known in England (and in this report) as the Care Records Service or CRS, and (b) to consider how those views had changed over the past two and a half years. . . although many nurses are enthusiastic about CRS, that enthusiasm has declined over the past two and a half years. Further they continue to know little about it – inadequate consultation having barely improved over the years. . . there has been a sharp reduction in those believing that spending several billion pounds on IT is a good use of NHS resources: two and a half years ago, 67% said " yes" and 11% " no" whereas today the figures are 40% and 43% respectively . . . If current NHS IT developments are to succeed and to realise the hopes many have of them, a fresh approach by the Department of Health seems essential: if understanding of the benefits of these changes amongst individual front-line nurses were to be massively increased by rigorous, interactive, detailed and widespread personal communication, their support and enthusiasm for changes is likely to strengthen. That should vastly improve the chances of a successful outcome."

3.4.17. NHS staff in London lack confidence in the new IT system (10 Nov 2006)

Amicus

http://www.amicustheunion.org/Default.aspx?page=4981

" According to an independent survey commissioned by Amicus union, NHS staff in London lack confidence in the implementation of the NHS' controversial new IT system to link GP surgeries to hospitals. Only nine per cent of respondents believed that their views had been taken into account and only eight per cent believed the new system will represent value for money. Eighteen per cent disagreed with the statement 'the new IT system will help them do their jobs better' and 49 per cent did not know. The respondents were asked a number of questions on their attitudes towards the

implementation and eventual outcome of the IT new system. A surprising number of respondents were unable to answer many of the questions, choosing the " don't know" option. 42% of the respondents did not know whether the new IT system for transferring patients records between GP surgeries and hospitals would be quicker and more efficient. 48% did not know whether the new IT system would decrease bureaucracy. The survey was conducted to gauge the level of consultation over the introduction of new IT systems in the NHS. NHS Connecting for Health is delivering the National Programme for IT to bring modern computer systems into the NHS aimed at improving patient care and services. The NHS over the next ten years intends to connect over 30,000 GPs in England to almost 300 hospitals and give patients access to their personal health and care information. BT, is responsible for deploying NPfIT (National Programme for IT) software in London. Whilst the union acknowledges the importance of the new IT system for improving patient care, the lack of staff involvement is symptomatic of the NHS' and its providers failure to listen to its staff who are responsible for delivering patient care. Amicus is calling on the NHS and its providers to give end users a greater say and more information on the delivery of the new IT system. Whilst the NHS has undoubtedly got better, morale amongst health service employees is at rock bottom, made worse by a series of rapidly introduced changes without the involvement of staff. . ."

3.4.18. Medix UK plc survey (Q1066) of doctors' views about the National Programme for IT (NPfIT) – 21 Nov 2006)

Medix

http://ixdata.com/reports/106620061121.pdf

" Most doctors recognise the benefits of NPfIT. For example the majority, 58% of GPs and 69% of non-GPs (mainly hospital doctors), believes it will improve clinical care in the longer term. And most of the main NPfIT services are supported by respondents: for example 64% regard the Care Records Service as important with 51% of GPs and 65% of non-GPs agreeing it will help clinicians make better decisions. However, overall support for NPfIT continues to fall: nearly four years ago, 67% of GPs said that it was an important priority for the NHS – now 35% do so. For non-GPs, the equivalent figures are 80% and 51%. And, although 25% of GPs and 41% of non-GPs are still enthusiastic about the project, that is down from 56% and 75% nearly three years ago. Further, most doctors, 76% of GPs and 61% of non-GPs, do not consider NPfIT a good use of NHS resources. Only 1% of doctors rate its progress so far as good or excellent. . ."

3.4.19. Survey reveals doctors' pessimism about NPfIT (19 Feb 2007)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=2491

"A survey of over 3000 doctors has revealed that the overwhelming majority are not optimistic that the National Programme for IT (NPfIT) will change the NHS - but only a small minority thought it should be abandoned at this stage. Only 9% of doctors expressed optimism about the programme's potential to change the service and a resounding 91% disagreed with them. The survey, commissioned by The Times, and carried out by doctors.net, also revealed that 76% thought NPfIT had been a "frustrating project". . . Overall, responses to the five survey questions relating to NPfIT, showed that the 3,092 NHS doctors surveyed were not convinced of the programme's merits but did not believe it should be abandoned or receive any additional funding. Respondents to the survey came from NHS doctors of all grades working in both general practice and hospital medicine. The results come after the chairman of the British Medical Association council, James Johnson revealed that a BMA survey had found that systems like Choose and Book are overwhelmingly unpopular with both GPs and hospital consultants. . ."

3.4.20. PCTs struggle to support patients exercising choice (15 Mar 2007)

Health Service Journal

http://www.hsj.co.uk/healthservicejournal/pages/N1/p13/070315

"Most primary care trusts are struggling to support patients who need help choosing a hospital, a survey by the King's Fund has found. . . GPs' hostility was compounded by the enduring problems with IT and with delays experienced by PCTs in getting leaflets and other information to disseminate. In many areas PCTs had focused on IT problems rather than equity. One PCT said: 'The focus to date

has been on rolling out booking (to DoH targets that we consistently fail to hit because of technical problems with the hospital software). We have therefore focused very little energy on choice.'"

3.4.21. Majority of GPs blame NPfIT for worsening morale (19 Apr 2007)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=2624

"Almost three out of four GPs blame the National Programme for IT for worsening their morale in the last year, according to a survey of almost 500 family doctors. The poll of 477 GPs conducted by Medix and Doctor magazine found that more than half of GPs said their morale had worsened in the past year with most blaming workload (76%), followed by NPfIT (74%) and central targets (67%). The survey follows on from a poll conducted by Medix and co-sponsored by EHI Primary Care in November last year which found that only 35% of GPs rated NPfIT as an important priority for the NHS compared to 67% four years ago. The Medix/Doctor survey which also questioned almost 1000 doctors in secondary care found that GPs are the group of the clinicians who feel the most badly affected by NPfIT. A total of 36% of GPs said NPfIT had worsened their morale with a further 38% blaming it for "significantly worsening " morale compared to figures of 31% (worsened) and 26% (significantly worsened) for the entire survey group of 1437 doctors. One GP commented: "Patient Choice and "Choose and Book" have had a major negative impact. They have led to a two-tier system." Another said: "The massive waste of resources to achieve almost no potential benefit in Choose and Book is breathtaking.""

3.4.22. 50% of GPs won't upload records without explicit consent (19 Apr 2007)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=2623

"One in two GPs have signalled their intention not to upload patients' clinical details to the NHS Care Records Service (NCRS) without explicit patient consent, in direct opposition to Department of Health (DH) policy. The position being adopted by doctors in primary care, is revealed in a survey of 1026 doctors' views about the National Programme for IT (NPfIT) carried out this month and commissioned by EHI Primary Care. The survey is the latest of seven polls on the subject conducted by the healthcare online research organisation Medix and also found doctors are increasingly critical of the cost of NPfIT and how it is being implemented. The extent of doctors concerns about confidentiality are highlighted by the survey results with 51% of GPs, and 47% of non-GPs, saying they will not or are unlikely to upload a patient's clinical details to the NCRS without specific consent, just months ahead of DH plans to begin uploading patients' details as part of a pilot for the Summary Care Record. Almost four out of five GPs (79%) also think the NCRS will lessen patient record confidentiality. . . Overall support for NPfIT appears to be continuing to fall with only 35% of GPs now rating it an important priority for the NHS compared to 67% four years ago. In the longer term just under one in five GPs (19%) believe NPfIT is likely to lead to a significant improvement in patient care with 39% expecting a slight improvement and 21% believing it will make no difference. . . On a slightly more positive note the survey shows support for Choose and Book is growing, up from 17% at the beginning of this year to 26% today. Four out of five GPs now have experience of Choose and Book and about half of those now say they use it for more than 40% of referrals. However, of those using it regularly, more than 90% say that it increases the time in dealing with a referral and more than 70% think it either make no difference to or is detrimental to patient outcomes. . ."

3.4.23. Two-thirds of GPs against sharing their medical records (24 Apr 2007)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=2635

"A survey of GPs by Pulse magazine has found that only a third plan to advise patients to allow their details to be shared using the NHS Summary Care Record. The survey revealed that GPs are also cautious about sharing their own records with just a third saying they will allow full sharing, while four in ten say they will opt out completely and allow none of their details to be shared. Some 66% of the GPs who responded said they won't allow their own records to be shared. Pulse reported that despite a concerted Government PR and marketing campaign to sell the merits of the NHS IT programme in general and Summary Care Record in particular, some 80% of the GPs who responded still believe that

shared electronic care records threatened patient confidentiality. The survey results also indicated that the majority of GPs who responded – some 67% - oppose the implied consent 'opt out' model, which currently forms the basis for the roll-out of SCR under NPfIT. The GP magazine also reported that in an interview Lord Warner, the minister formerly responsible for the NHS IT programme, had warned that GPs had become over-protective of their existing record systems. "GPs too often moved themselves from a position where they had been the leaders on IT in the NHS and were turning themselves into Luddites." In an earlier April poll of almost 500 GPs by Doctor magazine almost three in four blame the National Programme for IT for worsening their morale in the last year."

3.4.24. Researchers warn NPfIT delays risking patient safety (17 May 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2695

"Lack of effective communication and delivery delays are leaving trusts disenfranchised and weakening local commitment to rolling out the National Programme for IT creating risks to patient safety, leading academics have warned. Competing priorities, lack of financial resources and repeated delays in the delivery of new systems are all said to be hindering efforts by senior NHS trust managers interviewed to sell the programme locally. The study, published in the BMJ, warns of the risk to patients' safety if Connecting for Health, the agency responsible for the NHS IT programme, continues to leave trusts in the dark. It says trusts are attempting to mitigate clinical risks by opting for interim systems, but warns that interim systems outside of the programme will be inefficient when the new national programme systems are eventually introduced. The researchers say: "The lack of integration offered by interim applications has left senior trust staff questioning whether NHS-wide connectivity will ever be achieved and why trusts have had to wait several years for the new systems." The findings come from a quantitative study of progress on the NPfIT programme in acute trusts. The research was carried out by researchers from Imperial College, King's College, the London School of Hygiene and Tropical Medicine and Bristol University, found that senior NHS managers interviewed supported the goals of the programme, but had several concerns. The researchers interviewed 25 senior managers and clinicians responsible for implementing the programme in four NHS hospitals in England. Interviews were conducted in two stages, 18 months apart, to compare progress and perceived challenges over time. . . In a response the paper, CfH said patient safety was not an issue: "It is untrue to suggest patient safety is being compromised. NHS CfH is giving full priority to trusts with the oldest existing systems. In the past twelve months alone, we have installed 162 systems in the hospital sector including 15 hospital patient administration systems and 62 Picture Archiving Communications Systems, which capture and store images electronically. "Progress introducing systems in acute hospitals, like the four in this study, has been slower than expected and some of this has been dependent on legacy IT suppliers and ensuring trusts are fully prepared for the new systems. We and the local service providers work alongside trusts to fully support existing systems ahead of installation of national programme systems." The CfH statement added that the paper identified challenges which they take seriously and work hard to address. . ."

3.4.25. A fifth of patients reject e-records (8 Jun 2007)

Healthcare Republic

http://healthcarerepublic.com/news/GP/662815/fifth-patients-reject-e-records/

"A two-man practice in rural Dumfries and Galloway has dealt a serious blow to NHS Scotland's consent-seeking process for the electronic patient record. NHS Scotland mailed households explaining its emergency care summary (ECS) and telling patients how to opt out of having their data available for download outside their GP practice. As a result, 646 patients out of a population of five million (0.01 per cent) have refused consent for data extraction. But when Wigtown GPs Dr Gordon Baird and Dr Mary Donnelly sent a personal letter to their 1,710 patients explaining the data extraction process and asking the same question, 326 - 19 per cent - withheld consent. The Wigtown refusal rate is more than 1,500 times higher than in the whole of Scotland. . . In August 2006, households in Scotland were sent an eight-page booklet on the ECS and told to let their GP surgery know if they did not want data uploaded. . . Joint GP clinical lead in England for Connecting for Health Dr Gillian Braunold said she understood the leaflet was sent as 'junk mail'. GPC chairman Dr Hamish Meldrum said: 'In England we are still in discussions but the intimation is that patients will be given the chance to review what they want to be uploaded.' He said public confidence in Scotland might have been dented by problems with the Medical Training Application Service."

3.4.26. MPs call for pharmacists to have access to CRS 3 Jul 2007)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=2836

"Pharmacists in primary and secondary care must be given read-write access to the NHS Care Records Service (NCRS), according to a report from MPs. The All-Party Pharmacy Group's (APPG) report on the Future of Pharmacy argues that pharmacy needs access to the NCRS to realise its potential as a health service provider and criticises Connecting for Health (CfH) over lack of consultation with pharmacists. The report states: "We do not believe that CfH has engaged adequately with the profession or its representative bodies and we are concerned that pharmacy is not being regarded by CfH as an essential participant in the NHS's IT connectivity programme." . . . Dr Howard Stoate MP, chairman of the APPG and a former GP, said almost all those who gave evidence to the APPG were in favour of pharmacy access to the NCRS. He told EHI Primary Care: "It's absolutely essential – GPs and pharmacists can't share care of patients if neither knows what the other has done." The report says the British Medical Association told the APPG inquiry that it questioned how much of the record pharmacists should be able to access and had concerns about pharmacy's ability to protect patient confidentiality, particularly within a commercial environment. The MPs says they were unconvinced by those concerns. . . The APPG report claims that consultation and engagement with pharmacists by CfH has been disappointing and focused largely on the Electronic Prescription Service (EPS) while largely ignoring wider connectivity issues and the Care Record. The report adds: "We were surprised and concerned to hear that stakeholders not involved in the consultation process included multiple pharmacy chains, independent local pharmacies, local pharmaceutical committees and pharmacy system suppliers." The report claims progress on EPS has been "slow and erratic" and says CfH's original target that EPS would be fully operational by the end of 2007 is unlikely to be met. . ."

3.4.27. Nurses raise doubts over NPfIT (26 Jul 2007)

BCS

http://www.bcs.org/server.php?show=conWebDoc.13306

"Nearly a third of nurses believe the security of the NHS National Programme for IT (NPfIT) will not be an improvement over that of current paper-based records, according to a new survey. The poll, conducted by the Royal College of Nursing (RCN), also found that while two-thirds of nurses welcome the idea of electronic patient records, just half believe the initiative will boost patient safety. In addition, two-thirds of respondents said they had still not been consulted about the new system and the data that it will hold. 'The health service has a challenging time ahead if it wants nurses to be ready for the new software, which will have a positive impact on professional practice and the contact nurses have with patients,' commented RCN general secretary Dr Peter Carter. Earlier this week, the NHS began the national rollout of the GP2GP software application, which allows electronic patient records to be transferred between GPs."

3.4.28. 'Widespread concerns' about NPfIT penalties (1 Aug 2007)

e-Health Insider

http://www.e-health-insider.com/news/'widespread_concerns'_about_npfit_penalties

"In a new survey NHS foundation trusts have reported 'widespread concerns' about the limited functionality of key systems from the NHS National Programme for IT. Some foundation trusts (FTs) that have sought to delay taking systems until problems are fixed say they have been told to expect fines running into many millions of pounds. The FTs report that in many cases the nationally purchased software is incomplete or less capable than their current systems. NHS Connecting for Health the agency running the £12bn NHS IT programme, and which drew up the contracts, including penalties termed 'non-deployment charges', confirmed to E-Health Insider that a number of trust chief executives had recently written expressing their concerns at the potential fines. The DH agency said no fines have yet been levied. Carried out by the Foundation Trust Network, part of the NHS Confederation, the survey examined foundation trusts' experiences of the National Programme for IT (NPfIT) and found "widespread concerns about the functionality of NPfIT systems as a whole". E-Health Insider has obtained a copy of the confidential June survey, which includes responses from 48 of the 54 FTs, representing the cream of the health service. One acute FT reported being told that its local health community would have to pay a £20m fine if it decided not to take the early software

offered for NHS Care Record System (CRS). Another reported facing a potential fine of £11m if it delayed installing software. While national systems including e-booking and digital x-ray communication and storage are widely used, the report says 'most' FTs have opted out of certain parts of the national NHS IT system including the crucial CRS software required to develop electronic patient records. Where some FTs have sought to opt out of using systems that only partly met their needs or were less capable than existing systems, they have been told they risk incurring penalty payments. FTs reported being told they face penalty payments to Connecting for Health (CfH) and its prime contractors if they refuse to install software they don't judge to be fit for purpose. The 'non-deployment charges' form part of the local service provider (LSP) contracts for the NHS IT programme to which the Department of Health committed all English NHS trusts in 2001. The biggest concerns about the software on offer centre on problems with the CRS, mental health systems and maternity, but also extend to picture archiving and communications systems (PACS) – often cited as the great successes of the programme. The survey results make damning reading, detailing FTs' concerns about the limitations of key systems being provided by the NPfIT programme. "Almost every respondent had concerns about the functionality of some part of the system and most had opted out of certain parts of the NPfIT system," says the survey report. NPfIT systems identified as particularly problematic include patient administration systems (PAS), mental health and maternity. The greatest cause of concern was the CRS based on Cerner's Millennium and iSoft's Lorenzo software delivered by LSPs. . . Despite the extent of the problems cited, FTs report that when they have sought to delay implementations until systems meet their needs or opt-out of taking NPfIT systems entirely they have been told they face fines running into millions or even tens of millions of pounds. . ."

3.4.29. Nurses unsure whether NHS can deliver an electronic patient record (1 Aug 2007)

British Journal of Healthcare Computing & Information Management

http://www.bjhcim.co.uk/news/2007/n708006.htm

"Over half of nurses do not believe or do not know whether the NHS can deliver an electronic patient record in the foreseeable future, according to a new survey by the Royal College of Nursing (RCN). The RCN survey (see http://www.rcn.org.uk/publications/pdf/003166.pdf) of 2,600 nurses found two-thirds of nurses (66%) welcome the introduction of an electronic patient record, although there continues to be a high degree of uncertainty about the impact the record will have on patient care, safety and confidentiality. Only half the nurses surveyed believe electronic records will improve patient safety, while 30% feel the security of the system will not be any better than the paper records currently used in healthcare. The survey also found that almost two-thirds of nursing staff had not received any IT training within the last six months and nearly half (45%) have to share a computer at work with more than five people. Worryingly, 16% of nurses say they are forced to share a computer with more than 20 people. The 2007 survey, the fourth year running the RCN has polled nurses on IT, shows two thirds of nurses have not been consulted about the introduction of the new record or the information that will be entered on it. This figure is unchanged from a similar survey carried out in 2004, which found 63% had not been involved in the new system's design or development. . ."

3.4.30. Hospitals abusing Choose and Book to bend rules (21 Jun 07)

Pulse

http://www.pulsetoday.co.uk/story.asp?storycode=4113156

"PCTs and hospital trusts are manipulating Choose and Book to manage referrals and hit waiting list targets, a Pulse survey has found. One in five GPs is being forced by trusts to make all referrals through Choose and Book, and 61% believe it is being used by PCTs as a referral management system. More than half of respondents say they are unable to refer to a named consultant through Choose and Book, and 45% say they are being blocked from referring to a hospital at risk of missing its 13-week waiting time target. More than two-thirds say they do not feel Choose and Book has been a useful addition to GPs' referral resources. The poll of 398 GPs, carried out on behalf of Pulse by doctors' mobile communications firm Pearl Medical, paints a detailed picture of the problems GPs attempting to use Choose and Book are facing, and follows fierce criticism of the system at last week's LMCs conference. The Pulse Common Sense on IT Campaign is calling for Choose and Book to be scrapped in its current form along with closer controls on patient records. . ."

3.4.31. Patients nervous over care records (5 Sep 2007)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4114350&c=2

"Far more patients want to opt out of the Summary Care Record than Connecting for Health has claimed, a new Pulse survey suggests. The poll of 2,600 patients found most were broadly supportive of care records in principle f but as many as a quarter wanted to opt out of the scheme. The research, carried out for Pulse by online market research company Opinion Health, found more than half of patients had concerns over confidentiality, and three-quarters wanted to be asked to give their explicit consent to take part. The survey gives one of the first indications that unease over the project exists in patients as well as doctors, and raises questions over Connecting for Health's implied consent strategy. . . The survey also shows widespread lack of patient knowledge over Connecting for Health's plans, with more than half of patients having no idea that plans for Summary Care Records existed."

3.4.32. Trailblazing GPs want Care Record scrapped (22 Oct 2007)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4115393&c=2

"Two-thirds of GPs in the first area to adopt the Government's controversial Summary Care Record want to scrap the project, Pulse has learnt. Plans to roll out the scheme in Bolton, Lancashire, are already three months behind schedule. But now an LMC survey shows most of the town's GPs are opposed to forging ahead with uploading patients' details and sharing them with local hospitals. The LMC said GP opposition remained despite months of Connecting for Health road shows and events aimed at winning them over. Ninety-eight of the town's 169 GPs responded to the survey. Just 20 respondents were in favour of forging ahead with the Care Record while 67 were against. So far, 8 practices in the town have uploaded their patient details but the Summary Care Record has yet to be deployed in unscheduled care. Dr Chris Woods, a member of Bolton LMC, said: 'It's a statistically useful survey and it seems to point to the fact that the majority of doctors don't want it.' Dr Bernard Newgrosh, a GP at Great Lever health centre in the town, said he was 'totally against' the project.. Some 166 of his patients have already opted out of having a Summary Care Record - even though his practice is not taking part. 'A girl came to see me practically on the first day of this thing and asked if her termination of pregnancy was in her record. She said she was 'dead meat' if details of the termination got out.' Bolton PCT admitted the project had caused 'a degree of controversy' among GPs. Dr Gillian Braunold, clinical director for the summary care record and a GP in Kilburn, north London, claimed a 'critical mass' of GPs were already on board with 34 of the town's 57 practices signed up. 'I met 40 of them on Wednesday who were very happy,' she said. The PCT had hoped to start using the records for unsched-uled care in July and in the out-of-hours service by late September but the project has been delayed. Chris Russ, assistant director of IM&T at Bolton PCT, blamed the slow progress on key staff being away over the summer holidays but insisted: 'The PCT now plans to introduce access to the out of hours service shortly, which will be followed by the walk-in centre and A&E at the Royal Bolton Hospital..'"

3.4.33. Doctors' support for NHS IT programme plummets (19 Nov 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/11/19/228173/doctors-support-for-nhs-it-programme-plummets.htm

"Doctors' support for the NHS National Programme for IT (NPfIT) has declined sharply in the past three years, the latest survey from medical research company Medix has revealed. The survey of 1,000 NHS doctors, sponsored by Computer Weekly, raises questions about the project's success and adds weight to calls for a published independent review of the £12.4bn scheme. It found that 23% of GPs and 35% of other doctors supported the aims of the NPfIT, compared with 56% and 75% in 2004. Seventy six per cent said it was important to have an independent review of the NPfIT. The falling support from doctors is a worry, said professor of software engineering Martyn Thomas, a spokesman for 23 academics campaigning for a review of the NPfIT. "This is not good news for the project because without this support it cannot possibly succeed. It is serious and depressing that support is falling as the project progresses. You would expect this to rise as the project goes forward," he said. The Medix report said, "Five years after it began, doctors still support the principles of the project, but

most are critical of its costs and believe it is being poorly implemented." The survey found that less than 50% of doctors believe the NPfIT is an important NHS priority, compared with 80% in February 2003. Comments from those surveyed suggest that management mistakes and spiralling costs have led to disenchantment among doctors. "Computerisation of the NHS is inevitable, and if it works well I am in favour of it. But many good ideas have floundered on computerisation, and huge sums have been wasted by government on some projects," said one doctor. Angela Eagle, exchequer secretary to the Treasury, told parliament last month that the NPfIT was a success. "Without the programme, the NHS could no longer function, and it is already providing essential services and significant benefits to tens of thousands of clinicians and millions of patients. It is therefore a success story that ought to be acknowledged," she said. A spokesman for NHS Connecting for Health, which runs the NPfIT, said it consults with a wide range of clinicians in the development of systems and in their use. "In the light of wider experience and evidence, the results of the Medix survey do not appear to reflect the general picture on the ground or chime with other recent comprehensive surveys," he said.

3.4.34. Family doctors to shun national database of patients' records (20 Nov 2007)

The Guardian

http://www.guardian.co.uk/society/2007/nov/20/nhs.health

"Nearly two-thirds of family doctors are poised to boycott the government's scheme to put the medical records of 50 million NHS patients on a national electronic database, a Guardian poll reveals today. With suspicion rife across the profession that sensitive personal data could be stolen by hackers and blackmailers, the poll found 59% of GPs in England are unwilling to upload any record without the patient's specific consent. Three-quarters of family doctors said medical records would become less secure when they are put on a database that will eventually be used by NHS and social services staff throughout England. Half thought the records would be vulnerable to hackers and unauthorised access by officials outside the NHS. A quarter feared bribery or blackmail of people with access to the records and 21% suspected that social services staff would not adhere to the confidentiality rules. The poll of more than 1,000 doctors was conducted by Medix, a healthcare online research organisation previously used by the Department of Health to test medical opinion. It found GPs are increasingly concerned about the department's plan to automatically upload the records of everyone who does not register an objection. . . The summary care record is part of a £12.4bn programme to modernise the NHS's IT systems. The poll found 70% of GPs and hospital doctors do not think the programme is a good use of NHS resources and only 1% rate its progress as good or excellent. Three-quarters said they wanted an independent review before further sums were committed. . ."

3.4.35. Four out of five doctors believe patient database will be at risk (31 Dec 2007)

The Times

http://www.timesonline.co.uk/tol/life_and_style/health/article3111428.ece

"Only a fifth of doctors believe that a national electronic system for storing patients' records will be secure, a poll for The Times has shown. More than three quarters are either "not confident" that data will be safe or "very worried" that data will leak once the £20 billion National Programme for IT (NPfIT) is running. Asked how well they thought that local NHS organisations would be able to maintain the privacy of data, only 4 per cent said very well. The majority, 57 per cent, said quite or very poorly. The poll was carried out online over Christmas. In general, the GPs, who have the greater experience of IT systems, are more sceptical than the consultants. Asked the question "Do the benefits of electronic patient records outweigh the risks?" a narrow majority of all doctors polled said no. Among GPs, the gap was much wider, with almost two thirds doubting that the benefits would outweigh the risks. . . When it was announced, little effort was made to consult the medical profession or the public. The Government is now paying the price, with scepticism in the profession and evidence that some patients will fight to keep their medical records off the system. Admissions by the Government that data on millions of families had been lost by Revenue & Customs, and that nine NHS trusts had lost patient data, have sharpened the security. The poll, carried out for The Times by Doctors.net.uk, shows that while doctors see virtues in centralised electronic records they are also well aware of the risks. More than two thirds (70 per cent) agree that such records will improve patient care. Consultants are more strongly in favour than GPs, with 78 per cent agreeing or strongly agreeing that care will be improved, against 53 per cent of GPs. . ."

3.4.36. Doctors have no confidence in NHS database, says BMA News poll (1 Feb 2008)

BMA

http://www.bma.org.uk/pressrel.nsf/wlu/SGOY-7BELTV?OpenDocument&vw=wfmms

"Nine out of ten doctors have no confidence in the government's ability to safeguard patient data online, a poll conducted by BMA News has revealed. More than 90 per cent of respondents (93 per cent) to the survey said they were not confident patient data on the proposed NHS centralised database would be secure. A series of recent high-profile data losses, such as the HM Revenue and Customs computer discs containing the details of 25 million child benefit claimants and security breaches during last year's online training recruitment fiasco for junior doctors, have left doctors sceptical about safety. Nine out of ten of the 219 doctors who responded to the Doctors Decide poll said they did not feel they were in a position to assure patients that their data would be safe. More than eight out of ten (81 per cent) said they would not want their surgery data stored on the national NHS 'spine'. Wiltshire trainee cardiologist Dr Sally Simmons was one of those caught up in the medical training application service security breaches last year. Her personal details became publicly available and could potentially have been used by identity thieves. She said: 'I have received no apology from the Department of Health despite writing to the former health secretary [Patricia Hewitt]. I was also affected by the loss of the two child benefit CDs with my bank details on them. Not surprisingly, I have no faith in any form of IT security that this government proposes.' However, Berkshire GP and consultant in family planning Dr Meg Thomas said: 'This will help with continuity of care and communication between primary and secondary care … There may be a risk but paper records are also going astray. We need to join the 21st century and quick.'"

3.4.37. Connecting for Health faces criticism over national IT programme (3 May 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/05/03/230551/connecting-for-health-faces-criticism-over-national-it.htm

"Connecting for Health, which runs much of the NHS's £12.4bn National Programme for IT (NPfIT), is expected to come under strong criticism in a report commissioned by the government into the progress of online health records. The study by researchers at University College, London, is also expected to highlight criticisms of the government by executives at Connecting for Health. Connecting for Health (CfH) pushed primary care trusts to implement the summary care record, despite the immaturity of the technical solutions, the report is expected to reveal. The study analyses the first go-lives of the national summary care record system, a key part of the NPfIT was designed to give 50 million people in England an online summary health record including allergies and medications. Staff implementing the project said they had been asked to meet unrealistic deadlines. Local NHS project leaders struggled to reconcile political timescales with making the technology work properly. And although some GPs embraced the scheme others believed they had been coerced into it. One primary care trust informant described the command and control structure at CfH as bullying while other staff told researchers they were highly stressed, working far beyond their contracted hours. The report, scheduled for release on Tuesday, is expected to show the lengths to which health officials were prepared to go to convey the right message to the public on the summary care record programme. . ."

3.4.38. Political pressure on NHS trusts to use immature database (3 May 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/05/03/230534/political-pressure-on-nhs-trusts-to-use-immature-database.htm

"The first NHS trusts to upload medical details to a national database as part of the £12.4bn National Programme for IT (NPfIT) were pressured for political reasons to push ahead quickly despite the immaturity of the technology, an independent report is set to reveal. A year-long study of the summary care record early adopter programme - a key part of the NPfIT - will show how politics and large, complex IT projects can be a toxic mix. The study is expected to find that most users in the first trusts to go live with the system were broadly enthusiastic about giving doctors online access to medical records in an emergency and out of hours. But the researchers at University College London found that

the summary care record remains an immature technology which staff describe as clunky, which interfaces poorly with other systems, and which many staff have given up using until it works better. UCL's report is also likely to reveal that IT executives in early adopters were pressured to implement the system to redress what had been described as a worrying lack of progress on the NPfIT. . . The report evaluated live trials of the summary care record at trusts in Bolton, Bury, South Birmingham and Dorset. The system will take extracts of local medical records held by GPs. Any medication or allergy information will be uploaded onto a national database, called the "spine", which is run by BT. The UCL research is expected to report resentment among participating primary care trusts that Connecting for Health pushed forward on a tightly managed, largely non-negotiable timetable for implementing the summary care record despite the immaturity of technical solutions. There was further resentment from GP practices pushed excessively by primary care trusts in turn. The report also found that the public doubted whether the summary care record system was worth the money being spent on it."

3.4.39. Survey slams NHS computerised booking system (5 Aug 2008)

IT Pro

http://www.itpro.co.uk/605163/updated-survey-slams-nhs-computerised-booking-system

"The new NHS computerised booking system is failing to deliver sufficient choice to patients, according to research carried out by University College London. UCL surveyed 104 patients referred to Hillingdon Hospital who had used the Choose and Book system. Cerner, in partnership with Atos Origin, developed and implemented Choose and Book as part of the National Programme for IT (NPfIT), the tech upgrade run by NHS Connecting for Health. The Choose and Book system seeks to provide patients with choices regarding the time, date and place of their first outpatient appointment via a computerised booking system. The survey found that 66 per cent of respondents said that they were not given a choice of date for their outpatient appointment. A further 66 per cent of patients said that they were not given a choice of appointment time and 86 per cent said that they had been given a choice of fewer than four hospitals. Meanwhile, 32 per cent reported not being given any choice of hospital at all. The study also revealed that 63 per cent of patients had not been aware before their GP appointment that they were entitled to choose which hospital they were referred to. Those who had booked through their GP surgeries appeared to experience less choice than those who had booked online. Patients who had used online booking did report some technical difficulties. Patients using the old booking system found that they were not given the same level of choice of hospital as those who did use Choose and Book. However, Choose and Book patients did not report being offered a choice of time and date any more frequently than those who had used the old system. Shockingly, the survey found that only one patient reported that they had been offered a choice of four hospitals, appointment date and time, which is the desired level of choice that Choose and Book was designed to offer everyone. . ."

3.4.40. Public Service Review: Health Issue 16 (12 Aug 2008)

PSCA International

http://www.publicservice.co.uk/feature_story.asp?id=10105&topic=Health%20and%20social%20care

Professor Naomi Fulop, Director of NIHR King's Patient Safety and Service Quality Research Centre, evaluates concerns over the National Programme for IT:

". . . Continuing impact of financial deficits. . . Managers distracted from implementing the programme by other priorities. . . Poor communication between Connecting for Health and local managers. . . Continuing delay in replacing patient administration systems (PAS). . . Growing risk to patient safety associated with delays. . . Loss of integration of components of the programme. . . An important lesson from our study is the difficulty in achieving an appropriate balance of responsibility between government and local healthcare systems. Devolving control of IT to local managers results in a lack of standards, and disparate functionality. However, with central control the sheer size of the task makes communication and realistic goal-setting difficult. A third strategy is now in place, setting central standards but with local implementation. The role of Connecting for Health is shifting from implementation towards providing a national infrastructure and standards-setting body. Implementation will be devolved more locally. Even with these changes, the issues raised in our study still need to be addressed. Connecting for Health still needs to involve local end-users in discussions about the form, the national infrastructure and national standards; these should not be imposed. Further, devolving responsibility for implementation locally raises questions about the degree of local customisation

permitted. We found that local customisation is an important factor in successful adoption. However, too much customisation might weaken national standards and the ability to pass data between providers. Finally, a national infrastructure needs to help trusts to prioritise IT modernisation against competing financial pressures, for example, by its inclusion in performance management frameworks. New plans need to be communicated throughout the NHS with clear timetables to end the uncertainty. A recent Audit Commission study (May 2008) reported that the National Programme is running four years late and that a single NHS electronic patient records system will not be in place anywhere until 2014, increasing concerns that delays in replacing old systems may compromise patient safety."

3.4.41. Half of GPs will refuse to take part in Summary Care Record rollout (17 Nov 2008)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4121179&c=2

"The national rollout of the Summary Care Record faces foundering on a wall of opposition from GPs after it emerged that half are refusing to take part. A Pulse survey of 314 GPs showed a slight thawing in the profession's attitude to the plans, with 56% now supportive and one in three saying Connecting for Health's switch to a 'consent to view' model had helped win them round. Yet 49% said they still had no intention of taking part in the programme when a rollout beyond six early adopter PCTs begins next April, and 51% said they would not share their own records. One in five said they planned a blanket opt-out and would automatically remove all their patients from the scheme - a claim which drew an exasperated response from Connecting for Health. A spokesperson said: 'It is the patient's choice if they would prefer to opt out of having a Summary Care Record created.' Dr Catti Moss, a GP in Guilsborough in Northamptonshire, said she planned to opt out all her patients' records because she considered 'a major data leak almost certain'. 'The whole idea of having a unified record system for the whole NHS is potentially disastrous,' she said. 'It would have been faster, safer and more reliable to have simply concentrated on developing systems for existing systems to communicate safely and securely.' Dr George Paige, a GP in Coventry, added: 'The changes to consent are a move in the right direction but unenforcable with any corrupt user of the spine. 'I do not believe with the hundreds of thousands of people working for the NHS that none is corrupt or unbribeable.' A Connecting for Health spokesperson remained tight-lipped on how plans for a wider rollout were progressing, but said: 'There are no plans to incentivise rollout.' GPs also expressed fears over widening access to the Summary Care Record, with four in five opposing access to records for pharmacists - a proposal the Department of Health is considering."

3.4.42. Readers back reformed NPfIT (5 Oct 2009)

http://www.ehiprimarycare.com/news/5264/readers_back_reformed_npfit

e-Health Insider Primary Care

The National Programme should not be scrapped although it should be reformed, a major survey by E-Health Insider and Doctors.net.uk has concluded. The poll on the future of electronic health records in England was run last month in response to the publication of the Independent Review of Health and Social Care IT and the Conservative Party's response. Although the Conservatives did not call for the programme to be scrapped, they called for much of its central architecture to be "dismantled" and for its multi-billion pound local service provider contracts to be renegotiated in favour of more local control over IT decision making. Respondents to the survey, which has been released today to coincide with the start of the Conservative Party conference in Manchester, broadly backed this approach. EHI readers, in particular, backed interoperability rather than centrally purchased systems as the way forward. Jon Hoeksma, editor of E-Health Insider, said: "The support given to the national programme was surprising, but it probably reflects a growing recognition that the NHS needs to get good IT systems in place. Doctors, NHS IT professionals and suppliers all want a national programme. Just not the one that they have got." Doctors were keener than IT managers and suppliers for the national programme to be scrapped. Indeed, more than half (54%) of the GPs who took part through Doctors.net.uk agreed that the programme should be ended, in comparison with 43% of consultants and just 25% of junior doctors. Just 22% of EHI readers working in the NHS and 28% of suppliers felt the programme should be ended. But an overwhelming majority - in excess of 80% in all groups - wanted it reformed. In line with this, two thirds (66%) of EHI readers felt that centrally purchased, common systems were not the best way to develop detailed electronic patient records; and 86% felt a wider range of interoperable systems using standards to share data would be. Doctors were less clear on this

point. But then, doctors had different views from other groups on why progress on implementing IT in the NHS has been so slow. EHI readers were much more likely than Doctors.net.uk readers to blame "centralised policies" (with 24% and 16% picking this as the biggest obstacle) but fewer blamed "political interference" (13% and 25%). Doctors were more likely to blame lack of consultation with clinicians in designing systems (46% and 29%). Asked about the importance of the different things that the national programme is trying to do, there were some clear differences of opinion. There was overwhelming support among all groups for detailed care records and Summary Care Records except among GPs (only 9% of whom rated SCRs as "very important"), but much less for Choose and Book, particularly among GPs (only 3% of whom rated it "very important"). Asked about the Clinical 5 for hospital systems, there was strong support for a patient administration system and order communications. But EHI readers were much keener on e-prescribing than Doctors.net.uk readers (with 12% and 5% picking this as "most critical to clinical care"). Doctors were more anxious to see discharge letters with clinical coding in place (27% to 8%). "The survey shows that reforming the programme may not be as straightforward as some of its opponents suggest," Hoeksma added. "The principles of Dr Glyn Hayes' independent review are well supported, but a further round of highly-politicised change is not."

3.4.43. NPfIT study urges 'middle-out' approach (3 Sep 2010)

eHealth-Insider

http://www.e-health-insider.com/news/6211/npfit_study_urges_'middle-out'_approach

The largest study of the national roll-out of the NHS Care Records Service to date has concluded that its top down, standardised approach has led to much slower progress than originally envisaged. The study, led by Professor Aziz Sheik from the University of Edinburgh, says the original approach of the National Programme for IT in the NHS has had to evolve to "admit more variation and greater local choice." It says that further implementation will be a "long, complex and iterative process requiring flexibility and local adaptability, both with respect to the system and the implementation strategy." It adds that whilst there is no clear evidence that a "middle out approach" will achieve the programme's goals, experience suggests that neither a purely top-down nor a purely bottom-up approach is likely to do so. The study, which is published in today's British Medical Journal, was conducted by researchers from four British universities. It looked at the experiences of five 'first-wave' implementation sites for NPfIT electronic health record systems. These comprised one Cerner Millennium site, one RiO site and three Lorenzo sites, although some took only element of a system or only took it for a specific department. The researchers examined documents and undertook observerations and interviews to determine the impact of the systems, and found "considerable delays and frustrations." Despite this, they say that "support for electronic health records remains strong, including from NHS clinicians." However, they also note that clinical enthusiasm tends to be generated by benefits in their immediate area of work "not necessarily to the benefits that would come from geographically widespread sharing of patient data." The study finds that the central contracts negotiated by the national programme in 2002 have led to a number of adverse consequences. "These include convoluted communication channels between different stakeholders, unrealistic deployment timelines, delays, and applications that could not quickly respond to changing national and local NHS priorities." After reviewing alternative approaches from Europe, North America, Australia and elsewhere, it concludes that a "middle-out" approach should be tried, which "combines government direction with increased local autonomy and for restricting detailed electronic health record sharing to local health communities." The study makes four specific, policy related recommendations. These start with a need for fundamental questions to be asked and answered about what the country needs and what the country wants to pay for. It also identifies a need for the Department of Health to provide clear information on the future of NPfIT and provide consistency in its leadership. In addition, its says that trusts should be allowed to "communicate changing local and national NHS priorities directly to those working with them" and that linking contract payments to more "thoughtfully agreed outcomes" could potentially control costs and benefit both NHS trusts local service providers. The researchers are now undertaking a longer term, multi-site case study evaluating data collection that is due to end in 2011.

3.5. Privacy and Safety

3.5.1. NPfIT wins a Big Brother Award (Sep 2004)

The British Journal of Healthcare Computing & Information Management

http://www.bjhc.co.uk/news/1/2004/n40923.htm

" Human-rights watchdog Privacy International (PI) announced the winners of its Big Brother Awards 2004 in July. It is the sixth year that the privacy group has run a competition to name those who have " done the most to devastate privacy and civil liberties in the UK" . The Most Appalling Project accolade went to England's National Programme for IT in the NHS, for its national database of medical records and its continuance of plans to computerise medical records in a way that is both insecure and dangerous to patients' privacy. Issues involving patients' informed consent and overall control of the information in the records are currently of most concern."

3.5.2. Computer loophole hits hi-tech NHS trial (14 Nov 2004)

Sunday Times

http://www.timesonline.co.uk/newspaper/0,,176-1358226,00.html

" Part of the trial for the government's multi-million-pound scheme to computerise the National Health Service has been halted over fears that patient confidentiality may be compromised. Medical staff in a pilot project for the " choose and book" appointments system — designed to speed up referrals to consultants — claim it gives any doctor access to any GP's patient's records and allows them to make changes. Confidentiality is just one problem detailed in a leaked memo by a project leader in the national programme for information technology (NPfIT) which outlines seven reasons why doctors have refused to use the system, even in trials. . . The leaked document informed trusts involved in the scheme that doctors in Barnsley had refused to use the system. Although clinicians had been given access from July, " no actual live bookings have taken place" . The scheme was then temporarily halted. The memo details a wide range of problems. In addition to allowing any user to access a patient's records, the system does not keep sensitive details such as HIV and pregnancy terminations from being made available on the NHS's central computer."

3.5.3. Sources of Complexity in the Design of Healthcare Systems: Autonomy vs. Governance (10 Mar 2005)

Workshop on Complexity in Design and Engineering, University of Glasgow

http://www.dcs.gla.ac.uk/~johnson/complexity/Proceedings/Dave_England.PDF

" . . . In both the UK and US there are national initiatives to introduce greater use of IT in clinical settings. The broad aims of the NPFit (UK) and PACIT (USA) programmes are similar. They aim to streamline data processing to cut costs and reduce clinical errors. For example, it is proposed that electronic prescribing of medicines will cut costs in paperwork and reduce prescribing errors which account for a large number of patient deaths (44,000 to 98,000 deaths caused by medical errors in the USA). Both schemes aim to introduce electronic patient records, again to cut costs of paper records and reduce errors from paperbased systems. Both systems also look to more clinical governance and audit of medical processes so that medical staff are more accountable for their actions. The UK initiative is already displaying the signs of a large project out of control with the projected costs of £6Bn rising to between £18Bn and £31Bn. The lack of user centred design is evident by a recent (BBC) poll showing 75% of family doctors are not certain that NPFit will ever meets its goals. The first stage of the electronic appointment systems has largely failed to meets its use targets. However, a smaller scale introduction of region-wide IT in the Wirral was more widely accepted with 90% of family surgeries and the vast number of patients accepting the system. Thus IT systems can succeed. This is important for our work, for in order to succeed, it requires a working IT health infrastructure. Furthermore the twin goals of cost and error reduction may be mutually incompatible. As Reason points out (Reason 1997) organisations have processes for productivity and safety but circumstances will arise, either through unsafe acts or latent system weaknesses, which lead to organisational failure. Safety protocols may be violated in the name of efficiency or sets of latent weaknesses will line up to cause an accident. Many individual errors are the result of cognitive under-specification (Reason 1990) of the user's tasks. In our project we aim to over-specify and support clinical tasks by describing them in the situation

calculus. This will provide a robust means of supporting decision making and ensuring that chances to decisions protocols remain valid. . .” [A. Taleb-Bendiab et al]

3.5.4. Doctor’s notes (29 Mar 2005)

The Guardian

http://www.guardian.co.uk/g2/story/0,,1447062,00.html

“ Electronic medical records for all UK patients are in the final stages of planning. . . . But electronic medical records will not just be open to your necessary healthcare staff. Pilot studies have shown instances where the Department of Work and Pensions has accessed medical records in respect of benefit payments.”

3.5.5. NHS Confidentiality Consultation - FIPR Response (25 Jun 2005)

FIPR

http://www.cl.cam.ac.uk/~rja14/fiprmedconf.html

“ The fundamental question is whether the Department of Health should have a database containing a fairly complete record of every hospital treatment in the UK, including not just the treatment code and the cost, but also the name and address of the patient. A secondary question is whether the Department of Health should have an accessible central record of all a patient’s care relationships. . . FIPR believes that no one in central government - whether ministers, DoH officials or NHS central managers - should have access to identifiable health information on the whole UK population. This is backed up by studies showing that although patients trust their carers with medical information, the majority do not trust NHS administrators.”

3.5.6. Confidentiality - the final betrayal (25 Jun 2005)

BMJ Careers

http://careerfocus.bmj.com/cgi/reprint/330/7506/gp259.pdf

“ . . . The NHS National Programme for Information Technology (NpfIT) in England and Wales, now renamed as “ Connecting for Health,” has ordained that there will be an electronic patient record, and Scotland is not far behind. That record will not be in the form of a smartcard in the possession and control of the patient, but will be on a central database that will be shared among “ the NHS family,” albeit that blandishments over “ need to know” are regularly issued. Initial ministerial promises that patients will be able to control what information is placed on what is known as “ the spine” (information accessible to clinical staff outside the practice) are inexorably being undermined. Patients are authoritatively told that in an emergency it is essential that information is instantly available to wherever a patient may turn up; they seem to forget that Alexander Graham Bell’s invention was sufficient for this purpose during the whole of the 20th century. Until the potential consequences of this information incontinence are thought through, patients are initially attracted by it, perhaps forgetting that they developed their antibiotic rash after treatment for an embarrassing illness acquired during an extramarital adventure while on a business trip to Amsterdam. Once the genie of confidentiality is let out of the bottle it cannot be put back in, and the unintended consequence could well be that patients become reluctant to discuss the most intimate details of their health with their general practitioners. “ There will be high security and audit trails,” say the enthusiasts of electronic medical records, but I suggest that they are the equivalent of making your bank username and password potentially available to the entire clinical staff of what is the largest single employer in northern Europe—the NHS. In the United Kingdom we already have a flourishing business in identity theft. Am I being told that it will be impossible for a corrupt NHS employee to acquire the IT identity of another clinician? The first enquiry to be actively encouraged by unscrupulous investigative journalists will be for access to one Blair, Leo, dob 20 May 2000, address London SW1A 2AA, to see what childhood injections were administered. . .”

3.5.7. PCT safety culture needed to prevent errors (30 Sep 2005)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=1458

"A lack of understanding about IT systems and a failure to establish a safety culture are to blame for the publication of confidential information about 92 patients by a primary care trust, according to an investigation into the error. Melton, Rutland and Harborough PCT accidentally included identifiable information on 92 patients in its board papers and sent the information out to 35 people including the local media. The details, including patients' names, addresses and telephone numbers and the reasons why they had called an out-of-hours centre, were also available on the PCT's website for a short time. The 32 page report into the incident by the PCT includes recommendations that the PCT promotes a safety culture in the use of information, raises staff awareness of IT systems, policies and procedures and reviews the use of patient identifiable information. . . The report says that the out of hours software package used by the PCT, Adastra, was not able to provide the detailed information required by the board so the PCT downloaded the data for more detailed analysis using Excel software. The subsequent document produced by 'manager A' and overseen by 'director B' included graphs created in Excel and then cut and pasted into a Word document with embedded information on all the patients who had attended two out of hours centres on two bank holidays in May. The report adds: "Neither Director A or Manager B were aware of the presence of embedded data within these graphs or that patient identifiable data was present for the May Bank Holiday attendance." The report reveals that due to pressure of work Manager A had also breached PCT policy by taking the relevant information home using a USB memory stick, making changes to the document and emailing it back to Director A in the early hours of the morning. . ."

3.5.8. Thousands of children at risk after computer fault (26 Feb 2006)

The Observer

http://www.guardian.co.uk/medicine/story/0,,1718325,00.html

" As many as 3,000 babies and toddlers may have gone without crucial vaccinations because a privatised NHS computer system has failed to monitor which children are due for jabs and whether they have received them. An Observer investigation has found that the child health information system, introduced last summer as part of the government's £7 billion IT programme, has derailed the country's entire vaccination programme, leaving health staff resorting to slips of paper to work out who needs immunising. Several women whose babies were stillborn have received letters asking them to take their babies for their first vaccinations. . . The problems began last summer, when primary care trusts across north London and Essex, covering some five million adults and children, switched over to a new system - Child Health Interim Applications (CHIA), run by BT. The system was supposed to work across different health districts, replacing one that for years had collected all the data of the immunisation of pre-school children. It was supposed to trigger an automatic response when a child was due to have a jab. . . But, according to the Health Protection Agency and others, it soon emerged that CHIA was not capable of producing the lists needed to record immunisation status of children. Nor was it capable of monitoring the health of the children, to show whether any suffered side-effects from vaccines. "

3.5.9. Focus: Anatomy of a £15bn gamble (16 Apr 2006)

Sunday Times

http://www.timesonline.co.uk/article/0,,2087-2136718.html

" The Nuffield Orthopaedic Centre was at the forefront of a multi-billion-pound revolution to modernise the entire computer system of the National Health Service — and the screens had suddenly frozen. Medical staff looked on in disbelief as they tried to retrieve lost records. . . Although the system was functioning again the next day, some patient files seemed to have disappeared completely. The trust was so alarmed that it sent a report to the National Patient Safety Agency, warning that it had posed a potential risk to patients."

3.5.10. Paradoxical access (May 2006)

Dr. Paul Thornton

http://www.ardenhoe.demon.co.uk/privacy/Paradoxical%20access.pdf

" Patient records will be unavailable for care with consent but widely accessible to others contrary to the wishes of patients. . . Large numbers of patients who live close to the boundaries between clusters will find that their GP in one " cluster" is unable to share a detailed care record even with the patient's

consultant in the local District General Hospital if it is in the adjacent " cluster" . GP's may even be disconnected from cross boundary district nursing teams. . . The active, expressed dissent of the patient will be required to place limited restrictions on the access to information. The proposals do not reach the standard of dialogue required for " implied" consent that was set by the previous Information Commissioner."

3.5.11. When did we last see your data? (8 Jun 2006)

The Guardian

http://technology.guardian.co.uk/weekly/story/0,,1792102,00.html

" Last month, the Information Commissioner's Office (ICO), the state-funded watchdog for personal data, published a report, What Price Privacy?. The title's question was answered with a price list of public-sector data: £17.50 for the address of someone who is on the electoral register but has opted out of the freely available edited version; £150 to £200 for a vehicle record held by the Driver and Vehicle Licensing Agency; £500 for access to a criminal record. The private sector also leaks: £75 buys the address associated with a mobile phone number, and £750 will get the account details. . . Medical professionals are concerned about risks to data security caused by the creation of the NHS's Connecting for Health's Care Records Service. That will establish electronic patient records for everyone in England, accessible at any NHS site, and replace on-site computerised or paper patient records. Users log on using a " chip and pin" smart card and number. Access will be limited to those with a reason, and there will be an audit trail. Patients will be able to put sensitive information in an electronic " sealed envelope" . Last week Lord Warner, the health minister responsible, said the overall programme is more than two years late - due partly to software problems, but also to disagreements over access to records. Of 787 doctors contacted recently by researcher Medix for the BBC, 44% disagreed that the proposals to maintain confidentiality of records were satisfactory, while 21% agreed. Among GPs, 57% disagreed and 13% agreed. Dr Richard Vautrey, a Leeds GP and member of the British Medical Association's GP committee, says the technical security seems state of the art. However, " the proposal is that there will be an assumption of consent that records can be shared" , he says. Patients will have to opt out of sharing. And it is not clear who might see records, Vautrey says. " The patient may be happy for a consultant to have access, but not a social worker." But once data is on the national system, patients may be unable to stop access by other parts of government, he adds. That could damage the trust between patients and doctors. Patients might refuse to divulge data, or demand a second " private" record is created - just what the system was meant to prevent."

3.5.12. GPs and their families urged to boycott NHS 'spine' (20 Jun 2006)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=1956

" Last week's local medical committees' conference voted in favour of a proposal to advise GPs to consider withdrawing from the spine after hearing about access to the personal demographics service (PDS) which holds demographic data on every patient in England. . . A total of 54% of representatives voted in favour of the proposal with 46% against despite a speech in defence of the PDS from Dr Gillian Braunold, national GP clinical lead for Connecting for Health and a GP in London."

3.5.13. Don't trust our data to NHS computers (22 Jun 2006)

Times Online

http://www.timesonline.co.uk/article/0,,8122-2236581,00.html

" . . . If hackers could penetrate the Pentagon programs, the NHS database with its countless access points and numerous bona fide password holders will be easy pickings for hackers. It will also provide all the data that any government department should decide it must have so that, for example, an identity card database would be superfluous. And what happens when the system goes down, either for maintenance purposes or it crashes? No computer program is guaranteed crash-proof. I wouldn't want my data to be unavailable when the worst happens to me. I would want it on hard copy. If the powers-that-be wanted a safe method of storing personal data, surely the smart-card system, whereby everyone had their own data on their own card kept in their purse or wallet, would be free from hackers and free from computer crashes."

3.5.14. NHS database? No one asked me! (7 Jul 2006)

The Register

http://www.theregister.co.uk/2006/07/05/nhs_readers_letter/

" I was horrified to discover that here was the government creating a database of everyone's patient records, records which up until now I had thought were privy only to my doctor and a few others at local level. . . I wrote to Patricia Hewitt's office and demanded an explanation and got by return a snooty letter saying how everyone would benefit from having access to their medical notes countrywide and how I should be grateful the database is being formed. . . Let's hear the other side of this debacle, how the Public is not being ASKED if it WANTS this database - what do you think the average person would say if they knew the implications of some nasty neighbour who worked in the NHS getting to look at their records or some hacker publishing their records on the Net? How cheated do you think a rape victim will feel if everybody gets to know because someone accidentally, or deliberately makes the information public? How long will it be before we all start getting refused insurance with no explanation and then find our insurance companies have read our medical history?"

3.5.15. NHS trust uncovers password sharing risk to patient data (11 Jul 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/07/11/216882/NHS+trust+uncovers+password+sharing+risk+to+patient.htm

The UK's largest NHS trust has discovered endemic sharing of passwords and log-in identifications by staff, recording 70,000 cases of " inappropriate access" to systems, including medical records, in one month. The Leeds Teaching Hospitals NHS Trust said there was a " wholesale sharing and passing on of system log-in identifications and passwords" and it warned that uncontrolled access " presents a considerable risk to the security of patient data" and consequently puts the trust at risk. The Leeds trust is the largest in the UK and includes the biggest teaching hospital in Europe. It has a budget of £730m, employs 14,000 people across eight sites and treats about one million patients a year. A management paper to the trust's main board, dated 6 July, said that in one month alone " 70,000 examples were detected of inappropriate access of IT systems by trust staff" . The paper added, " This took the form of wholesale sharing and passing on of system log-in identifications and passwords. The system misuse was widespread across departments, sites and disciplines." Doctors said the sharing of codes which give access to NHS systems and medical records was an ingrained practice within the NHS. This culture was recognised as a threat to the confidentiality of medical records which are due to be uploaded from local systems to a national data spine under the NHS's National Programme for IT (NPfIT). Under the NPfIT, sensitive information on 50 million people in England is due to go online, although this has not happened yet. NHS managers can discipline staff after a breach has occurred - but they cannot stop it happening. . ."

3.5.16. Doctors attack NHS IT system: Patient confidentiality at risk, say concerned sawbones (26 Jul 2006)

The Register

http://www.theregister.co.uk/2006/07/19/patient_confidentiality_risk/

" Doctors have spoken out against the controversial £12.4bn NHS IT system that is over budget and behind schedule, claiming that patient confidentiality is being put at risk by the system. Writing in the British Medical Journal, a series of doctors have said that it is unwise to put the medical records of the entire population on one computer. . . Meanwhile a report has discovered that NHS IT system security is being compromised because of poor or non-existent mobile device security. Carried out by Pointsec Mobile Technologies and the British Journal of Healthcare Computing and Information Management, the survey has found that two thirds of mobile data storage devices have inadequate security."

3.5.17. Call for national standards on remote access (22 Aug 2006)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=2081

" GPs are calling for national standards on remote access to practice computer systems because of concerns that present methods could potentially put patient data at risk. Dr Paul Bromley, a GP in

Leek, Staffordshire, and colleagues from the EMIS National User Group are unhappy that the current arrangements delegate decision-making to primary care trusts (PCTs) and argue that definitive national guidance is needed. Dr Bromley, who has developed a special interest in remote access over the last few years, says that for several years he used the solution offered by Cable and Wireless, and latterly BT, which secured the connection between the remote computer and NHSnet. He told EHI Primary Care: " It was only later, after somebody pointed it out to me, that I realised the virtual private network tunnel only went as far as the NHSnet connection, not all the way to our practice server and so could be intercepted form within NHSnet." . . . The issue of remote access was the responsibility of the NHS Information Authority. Since its demise, however, this has been delegated to PCTs. GPs say they are concerned that no-one at PCT level will have sufficient expertise in remote access security."

3.5.18. Connecting for Health: IT and Patient Safety (24 Oct 2006)

Patient Safety

http://www.patient-safety.org.uk/October24.htm

" This meeting of the All-Party Parliamentary Group on Patient Safety aimed to discuss issues surrounding the Connecting for Health programme and to consider more broadly how IT solutions can best benefit NHS patients and practitioners.. . . Nigel Hawkes CBE, Health Editor of The Times stated that in principle the Connecting for Health programme is a positive step forward in providing safer patient care in the NHS. However, Mr Hawkes stressed that the Connecting for Health programme is currently largely incomplete and thus at present largely untested. He expressed concerns about system failures on the programme that have already happened in isolated areas and added that such failures could be disastrous if they occurred on a national scale. Mr Hawkes called for a greater provision of public information from the Government around the programme, so that patients fully understand how Connecting for Health will operate across the NHS. . . Dr Hamish Meldrum, Chairman of the General Practitioners Committee at British Medical Association, stressed that the introduction of IT systems to the NHS must be an evolutionary process and not thrust upon staff. From a GP's perspective, Dr Meldrum stated that Connecting for Health would in theory provide fast and reliable access to patients' medical records, which in turn will help inform clinical decisions. . ."

3.5.19. Warning over privacy of 50m patient files (1 Nov 2006)

The Guardian

http://society.guardian.co.uk/health/news/0,,1936403,00.html (Front page lead story)

" Call for boycott of medical database accessible by up to 250,000 NHS staff: Millions of personal medical records are to be uploaded regardless of patients' wishes to a central national database from where information can be made available to police and security services, the Guardian has learned. Details of mental illnesses, abortions, pregnancy, HIV status, drug-taking, or alcoholism may also be included, and there are no laws to prevent DNA profiles being added. The uploading is planned under Whitehall's bedevilled £12bn scheme to computerise the health service. After two years of confusion and delays, the system will start coming into effect in stages early next year. Though the government says the database will revolutionise management of the NHS, civil liberties critics are calling it " data rape" and are urging Britons to boycott it. The British Medical Association also has reservations. " We believe that the government should get the explicit permission of patients before transferring their information on to the central database," a spokeswoman said yesterday. And a Guardian inquiry has found a lack of safeguards against access to the records once they are on the Spine, the computer designed to collect details automatically from doctors and hospitals. The NHS initiative is the world's biggest civilian IT project. In the scheme, each person's cradle-to-grave medical records no longer remain in the confidential custody of their GP practice. Instead, up to 50m medical summaries will be loaded on the " Spine" . The health department's IT agency has made it clear that the public will not be able to object to information being loaded on to the database: " Patients will have data uploaded . . . Patients do not have the right to say the information cannot be held." Once the data is uploaded, the onus is on patients to speak out if they do not want their records seen by other people. If they do object, an on-screen " flag" will be added to their records. But any objection can be overridden " in the public interest" . . ."

http://society.guardian.co.uk/health/news/0,,1936149,00.html (Full story: " From cradle to grave, your files available to a cast of thousands")

3.5.20. Spine-chilling (1 Nov 2006)

The Guardian (Leader)

http://www.guardian.co.uk/commentisfree/story/0,,1936254,00.html

" The most closely guarded of secrets are often medical. A history of depression, a sexually transmitted disease or a long-ago abortion may well be deeply personal matters which many people would wish to remain private. Likewise, anyone who has recovered from a drug problem or from a suicide attempt may dread nothing more than these facts about their past getting into the wrong hands. Sometimes the desire for privacy reflects disposition, sometimes the potential impact on work or on family. Whatever the grounds, there is a right to expect that the confidentiality of one's medical history should be respected. Which is why there are good causes for alarm in our reports today about the way in which such data is being transferred to electronic records. There is a cause for real doubt about whether medical privacy can continue to be guaranteed. The creation of a centralised " spine" of all English medical records is at the heart of the government's £12bn IT programme, Connecting for Health. Modernisation, if carried out properly, offers advantages over a paper-based system. Currently, if someone falls ill away from home, a doctor can be left treating them with one hand tied behind their back, until the sluggish paper-trail catches up. A well-run computerised system should allow records to be accessed wherever they were needed. In principle, it should be possible to devise the system in a way that couples these gains with stringent privacy safeguards. But that is not what is happening. For one thing, under the plans, non-medical authorities could sometimes access the data when this is judged in the public interest. For another, it remains unclear whether patients will be able to block sensitive facts about themselves from being put on the general database. A third worry is the lack of clear rules limiting the type of information held on the database. Reassurance is especially urgent because of the poor record of government IT in general, and the unhappy history of Connecting for Health, in particular. With 250,000 people having access to the spine, the records will be as good as public unless the technology carefully controls who sees what. The Information Commissioner's recent damning report on privacy revealed a flourishing trade by private investigators in snooping out personal information from supposedly secure systems. Until it can be shown that confidentiality can be guaranteed, patients will be understandably uncomfortable about entrusting the system with their records. The case for efficiency is strong, but not at any cost. Privacy matters too."

3.5.21. A national database is not essential' What health professionals say about the new NHS database (1 Nov 2006)

The Guardian

http://society.guardian.co.uk/health/news/0,,1936174,00.html

" Paul Thornton, who has a website and runs a GP practice near Birmingham, wants the BMA to get counsel's opinion on the scheme. He says the Spine is dangerous and unnecessary. " A national database is not essential ... other mechanisms exist for the sharing of relevant information between directly involved health professionals ... without the need to leave a copy of the information on the nationally accessible database." This view is supported on practical grounds by Richard Fitton, a Derbyshire GP who has pioneered computer access by his patients to their own local records and was a member of the government's NHS IT advisory body. He told a Warwick University conference he disagreed with data being loaded on to a central system and preferred localised databases for patient care. He is an enthusiastic supporter of electronic record-sharing, with patient consent. But he says: " I've never liked uploading to the Spine - it's the wrong idea." . . . Richard Vautrey, who is a member of the BMA and the GP working parties on the subject, says " sealed envelopes" are probably unworkable, no agreement has been reached yet over the issue of explicit consent, and the data on the Spine could be attractive to the police. . ."

3.5.22. The woman falsely labelled alcoholic by the NHS (2 Nov 2006)

The Guardian

http://society.guardian.co.uk/e-public/story/0,,1937302,00.html

" Helen Wilkinson was mistakenly labelled an alcoholic after a simple computer error by the NHS. An unknown official at a hospital was updating her medical records and inputted a wrong code. The mix-up meant she was recorded as having received treatment for alcoholism, instead of surgery. Ms Wilkinson, 40, was furious and began a campaign to have all information about her permanently

removed from the hospital's databanks. But she ran into a problem: the NHS already keeps electronic records on everyone who receives treatment from the health service, whether they are seen by a GP or at a hospital. She succeeded in her campaign only because she took drastic action - she withdrew from the NHS altogether so that her records were deleted. Now she is refusing to be treated on the NHS ever again if her personal details are stored on an NHS computer. " I am putting myself at risk. I am not going back on a database if it kills me," she said. Her case highlights two problems which are likely to grow with the government's plan to create a national database for all patient medical records. Firstly, millions of patients will inevitably have mistakes in their computerised records which will in the future be read by more people than in the past. The government has not yet delivered on a promise that patients will be able to check their records on the internet for mistakes. Officials say that " there is no firm date yet" . Secondly, there is an unresolved question of whether patients who refuse to go on to national databases will still be allowed to receive treatment. . ."

3.5.23. Ministers to put patients' details on central database despite objections (2 Nov 2006)

The Guardian

http://www.guardian.co.uk/uk_news/story/0,,1937012,00.html

" Health ministers vowed yesterday to press ahead with uploading millions of medical records on to a central NHS database, even if many people objected to their personal details being included. The Department of Health scorned a campaign, described in the Guardian yesterday, to force the government to abandon the scheme on the grounds that it could breach the confidentiality of personal information. . . But some doctors and security experts have cast doubt on whether sensitive personal data might be divulged to the police or stolen by computer hackers. Ross Anderson, professor of security engineering at Cambridge University, said: " If enough people boycott having centralised NHS records, with a bit of luck the service will be abandoned." The government said there was no question of backtracking. Lord Warner, the health minister, said: " Health professionals cannot treat patients and decide to keep no record of it. Those records are not the property of GPs. Other health professionals need to access them to provide safe treatment. In that context, we have no intention of moving away from implementing the electronic care record. But we will ensure there is a public information campaign so that people know what is happening." The department will start uploading information about patients in two " early adopter" areas of England in the spring. " We will go ahead on the basis of implicit consent ... People can then choose to opt out of the system, but we will counsel them that if they do so they might jeopardise their safety. They would be saying nobody could have access to the information without their informed consent - and that might be difficult after an accident." By opting out, people could not get their medical record removed from the national database. . ."

3.5.24. NHS plan for central patient database alarms doctors (21 Nov 2006)

The Guardian

http://society.guardian.co.uk/e-public/story/0,,1953185,00.html

" A poll of doctors about the new £12bn computer system for the NHS shows growing unease about a potential threat to patients' rights. After answering questions by the medical pollsters Medix, the GPs and hospital doctors were invited to volunteer comments. Richard Johnson, a GP from Dalton-in-Furness, Cumbria, said: " I am extremely concerned that the public is unaware of the fact that their personal medical records may be uploaded to the national Spine [central database] without any real safeguard about who can access them. I believe such a move will destroy the concept of medical confidentiality and that patients will be unwilling to confide in their doctors and doctors may well be unwilling to record information given in confidence." Another GP said: " I feel we are being pressured into disclosures that would have been actionable by the GMC a few years ago." . . . The GPs were particularly critical of Choose and Book, which allows them to electronically book hospital appointments at a time convenient to their patients. The poll found half of GPs use the system for more than 40% of referrals. But among these regular users 90% say it increases the time taken to refer a patient to hospital and 70% think it is detrimental to patient care or makes no difference. One GP said: " Choose and Book is an unmitigated disaster. Patients want to be referred to a doctor I know, not a building from a brochure." . . ."

3.5.25. GPs revolt over patient files privacy (21 Nov 2006)

The Guardian

http://society.guardian.co.uk/health/story/0,,1953212,00.html

" About 50% of family doctors are threatening to defy government instructions to automatically put patient records on a new national database because of fears that they will not be safe, a Guardian poll reveals today. It shows that GPs are expressing grave doubts about access to the " Spine" - an electronic warehouse being built to store information on about 50 million patients - and how information on it could be vulnerable to hackers, bribery and blackmail. . . Ministers have committed a large slice of the NHS's £12bn IT upgrade to developing the Spine. They acted on the assumption that doctors would provide the information without asking their patients' permission first. The new system has been constructed to upload information from GPs' computer systems automatically, without giving patients a say. But the poll found 51% of GPs are unwilling to allow this uploading without getting each patient's specific consent. Only 13% say they are willing to proceed without consent and the rest are unsure or lack enough information to comment. Asked to identify the three most important concerns about confidentiality, 62% of GPs and 56% of hospital doctors said they were worried about " outsiders hacking into the system" ; 62% of GPs and 51% of hospital doctors similarly feared " access by public officials outside health or social care" . Other big fears included " bribery or blackmail of people with access to the records" and concern about " clinicians not adhering to the rules" . . ."

3.5.26. GPs threaten to snub NHS database (21 Nov 2006)

BBC News

http://news.bbc.co.uk/1/low/health/6167924.stm

" Half of all GPs will consider refusing to put patient records automatically on to a new national database in defiance of the government, a survey finds. The Guardian newspaper poll of 1,026 GPs and hospital doctors found many doubted the security of the new system. Four out of five thought the confidentiality of their patients' records would be at risk. The government hopes the new database will store medical information on about 50 million patients in England. The electronic warehouse, dubbed Spine, is part of the NHS's £12bn IT upgrade, which aims to link up 30,000 GPs to nearly 300 hospitals and give patients access to their personal health and care information. The Guardian poll found that while most GPs believed a national electronic record would bring clinical benefits to patients, 51% were unwilling to allow people's data to be uploaded without their permission. More than 60% said they feared the system would be vulnerable to hackers and unauthorised access by public officials from outside the NHS and social care. . ."

3.5.27. Children's Databases: Safety and Privacy - A Report for the Information Commissioner (21 Nov 2006)

Foundation for Information Policy Research

http://www.fipr.org/childrens_databases.pdf

" . . .Conclusion: This is a critical point at the evolution of data protection law and practice in the UK. Britain has paid less attention to privacy than our continental partners; the weak implementation of European data-protection law and the poor resourcing of the Information Commissioner's office are familiar enough complaints. At the same time, a number of centralising initiatives (from the NHS Care Records Service to the ID cards project) have combined to raise public disquiet about privacy. . . The children's database systems will shortly be followed by other social-care systems, notably for older people and for the mentally ill. Data collection under the rubric of social care will leave few families in Britain untouched. Ultimately, if illegal systems are built, they will be challenged in the courts. If the Commissioner prevents that by regulatory action now, he may irritate the system owners in the short run – but will save much more anguish and expense later."

3.5.28. Doctors have 'very legitimate concerns' over NHT IT patient records say Lib Dems (22 Nov 2006)

PublicTechnology.net

http://publictechnology.net/modules.php?op=modload&name=News&file=article&sid=6853

" Commenting on a survey suggesting half of all family doctors could refuse to put patient records on a new national database because of fears they will not be safe, Liberal Democrat Health Spokesperson, John Pugh MP said: " These doctors have very legitimate concerns. The Government's new computer system will enable private patient records to be uploaded and available to a number of agencies outside of the NHS without the patient being any the wiser. There is a danger the public interest exception may be used as convenient catch-all to justify any kind of snooping by a public body. Patients and doctors need to know how access to this highly personal information is to be controlled in practice, and how unnecessary intrusion into a very private sphere is to be identified and prevented. Without real clarity and meaningful assurances, the NHS IT system risks being yet another expensive bureaucratic mess that undermines civil liberties." In a letter to John Pugh, Richard Thomas, the Information Commissioner (16th November 2006) confirmed: 'It is my understanding that a disclosure will not be made to an organisation beyond the NHS unless the patient consents, the law allows it; there is a court order or the disclosure is considered to be in the overriding public interest.' . . ."

3.5.29. Work begins on merging Health and Social care records (24 Nov 2006)

The Register

http://www.theregister.co.uk/2006/11/24/health_social_record/

" Work has begun on a social care equivalent of the care records guarantee for medical records, paving the way for merging health and social care records. The plans were disclosed as part of a debate at the annual Care Records Development Board meeting in London, yesterday. The work is still at a very early stage, and no final decision has been taken as to whether or not a single record will be created. But the possibility of two services sharing data in this way illustrates exactly those concerns about patient privacy and confidentiality that have been raised by opponents of a centralised medical records database. The workshop - a group of forty or so patients, health professionals and other interested parties - was asked to debate the proposition that there should be a " single holistic record" of patient care, encompassing not just health records, but social care information. The idea, the session chair explained, is that information should meet the needs of the individual, rather than the other way around. It was during the ensuing debate that the news of the planned social care records guarantee emerged. The care records guarantee (pdf) sets out the rules that will govern the management of information in medical records when the NHS Care Records Service goes live next year. . . Many of those attending the workshop were concerned that sharing records would dilute the quality of care, and could compromise the quality of a patient's relationships with his or her carers. Some people might be reluctant to share information with their GPs if they thought social services would also have access to that information, one delegate suggested. . ."

3.5.30. CfH report confirms confidentiality risk (27 Nov 2006)

The Register

http://www.theregister.co.uk/2006/11/27/care_record_conf/

" Plans to upload medical records onto a central database - the so-called spine - will put patient confidentiality at risk, Connecting for Health (CfH) has been told by its own consultants. In its own risk analysis of the project, the agency responsible for centralising the country's medical records has acknowledged that GPs' concerns about patient confidentiality have merit, and that it would be safer to store records locally. According to Helen Wilkinson-Maker of The Big Opt Out, a campaign group opposed to the spine, the risk analysis was intended to consider two scenarios: a spine with and without " sealed envelopes" , sections of the medical record marked by the patient as not to be shared. However, during the consultation with health professionals, civil servants, and patient representatives, a third scenario was put forward for analysis: that of locally held, digital medical records. This was found to present much lower risk of confidentiality breaches, according to the report. . . The consultants identified a conflict between patient safety and confidentiality: records with some details kept hidden were found to put patient safety at a greater risk than those with all the medical information in the clear. This is because the potential for error in diagnosis or treatment is much higher if all the facts are not known, the report says. Meanwhile, patient confidentiality is at its most secure when some information is not just sealed in a single envelope, but in a variety of envelopes, with data being stored locally, and therefore only being accessible locally. . .

3.5.31. GPs fear flawed computer system (28 Nov 2006)

EDP.24

http://new.edp24.co.uk/content/news/story.aspx?brand=EDPOnline&category=News&tBrand=edponline&tCategory=news&itemid=NOED28%20Nov%202006%2017%3A18%3A14%3A203

" A central database of patient records is proving expensive and potentially flawed, doctors in East Anglia are warning. An electronic system, called the Spine, is being set up to store the medical details of 50m patients across the country. But there are concerns about who will have access to it and whether it will be vulnerable to computer hackers. Half of family doctors in a recent survey said they would refuse to add their patients' records to it. Simon Lockett, secretary of Norfolk's Local Medical Committee of GPs, said: " There is no particular reason why the technology shouldn't ensure good confidentiality, but obviously human error is possible and I know some patients feel very strongly about confidentiality. Most of us feel the technology is possible and can probably be operated in a safe way, but I am sure it will cost an awful lot and may not happen at all." Geoff Reason, Eastern region head of health for public sector union Unison, said: " Our concerns are around the management of the project. The NHS has not got a completely brilliant record when it comes to implementing IT. There is a feeling they have tried to do too much at once and there are real concerns around privacy given the ease with which people might be able to hack into computers." Some patients in Norfolk have already written to their doctors to ask that their details are not added to the Spine."

3.5.32. Local sealed envelopes 'probably safer' (28 Nov 2006)

e-Health Insider

http://www.ehiprimarycare.com/news/item.cfm?ID=2302

" A risk analysis conducted for NHS Connecting for Health has concluded that patient care would probably be safer using locally held sealed envelopes rather than storing them on the NHS data spine. The recommendations in the internal document, written by risk management company Det Norske Veritas and delivered to CfH in September, would seem to cut across the Department of Health's original vision that Detailed Care Records for every patient will be held on the spine, including sealed envelopes. EHI Primary Care understands that CfH's current policy on sealed envelopes, as outlined by Professor Mike Pringle, co-GP clinical lead at GP engagement events across the country, is for a two tier system of " sensitive" and " extra sensitive" information for sealed envelopes with extra sensitive information not available outside the clinical team that created it. Dr Paul Thornton, a GP in Kingsbury, Warwickshire who is campaigning against the consent and confidentiality proposals for the NHS Care Records Service (NCRS), is publicising the report which he says highlights the problems of holding all patients' records on the spine. He said: " These confidentiality risks to health have been found to outweigh the benefits from automatic sharing of health information on a national database. The more that information is accessible by all health workers, the less likely it becomes that crucial information will be divulged to any one of us." The Det Norske Veritas consultants were originally asked by CfH to weigh up the relative risks of sealing information against a situation where sealed envelopes were not available. During the course of compiling the report a third possible approach, of sealed envelopes held locally, was included in the review and the conclusion was that it provided the lowest risk to patient safety and confidentiality. . ."

3.5.33. Most patients reject NHS database in poll (30 Nov 2006)

The Guardian

http://www.guardian.co.uk/uk_news/story/0,,1960170,00.html

" A national campaign was launched last night to persuade people to refuse on privacy grounds to have their medical records uploaded to a national database. Guy Herbert, of the No2ID group, which is also campaigning against the introduction of identity cards, said: " We'd like to get up to a million people to contact their GPs." The campaigners, who are part-financed by the charitable Joseph Rowntree trust, released ICM poll findings commissioned by the trust which they said showed a majority of the population was hostile to Whitehall's plans. The figures show 53% of those questioned were either " strongly opposed" or " tended to oppose" the centrepiece of the Department of Health's £12bn NHS computerisation scheme. . . On the platform at last night's campaign launch in London was the former Conservative foreign secretary Sir Malcolm Rifkind. Although he and the Tories are not officially linked to the NHS data opt-out campaign, he spoke in support of opposition to identity cards, and to

government databases in general. Sir Malcolm said: " The case for identity cards or other large databases must be based upon hard evidence." There had to be safeguards in place against potential abuse: " These criteria are not being met on either ID cards or other measures that restrict civil liberties." . . . The government claims there will be elaborate safeguards built into the system which will prevent unauthorised access to the intimate medical details of 50 million people. But Connecting for Health, the NHS agency responsible for the database programme, suffers another blow today. The latest issue of the GPs' magazine Pulse describes an internal health department report which found that so-called " sealed envelopes" - a key part of the planned data safeguards - were likely to be insecure. The department was hoping to deal with this problem by introducing a further layer of security - the " sealed and locked envelope" , which could only be opened by the clinician who originally composed the file. But Dr Paul Thornton, a GP in Kingsbury, Warwickshire, who is one of the No campaigners, said this would not necessarily solve the problem.

3.5.34. GPs angered by call to reveal names of NHS database rebels (2 Dec 2006)

The Guardian

http://www.guardian.co.uk/uk_news/story/0,,1962282,00.html

" The Department of Health provoked uproar among doctors yesterday by asking GPs in England to send in correspondence from objectors who do not want their confidential medical records placed on the Spine, a national NHS database. Sir Liam Donaldson, the chief medical officer, said letters from patients who want to keep their private medical details out of the government's reach should be sent to Patricia Hewitt, the health secretary, for " full consideration" ." . . . GPs wrote to the General Medical Council asking for a ruling on whether Sir Liam had broken the doctors' code of good practice by using his authority to encourage GPs to breach patient confidentiality without clinical justification. Sir Liam's letter complained about " misleading statements" in a Guardian article on November 1 that the police and other agencies might be able to access medical records once they had been loaded on to the national database. The article included a form of words patients could use to ask Ms Hewitt to refrain from uploading their records without their explicit consent. Sir Liam said patients were sending a similar request to GPs instead of the health secretary. He added: " If you do receive any such letters I would ask you to send them to the Department of Health so they may receive full consideration." Hamish Meldrum, chairman of the BMA's GPs' committee, said: " The chief medical officer's intervention is not helpful and GPs should not forward these letters. It is possible that some patients might think this is a breach of confidentiality in that a letter sent to their GP is forwarded to somebody else without their consent." Paul Cundy, the BMA's spokesman on IT, said: " For a GP to forward such letters without the explicit consent of the patient would be a gross breach of privacy. In effect it is asking GPs to spy on his behalf. He should retract immediately. . ."

3.5.35. Health officials reject requests to opt out of patient database (4 Dec 2006)

The Guardian

http://www.guardian.co.uk/uk_news/story/0,,1963222,00.html

" Patients who have complained about the idea of having their confidential medical records uploaded on a new centralised NHS database were sent letters over the weekend flatly rejecting their concerns. In an uncompromising statement, the Department of Health said nobody could have genuine grounds for claiming " substantial and unwarranted distress" as a result of having their intimate medical details included on a national computer system, known as the Spine. For that reason, " it will not agree to their request to stop the process of adding their information to the new NHS database" . . . Last night doctors' leaders said the department's letter failed to take account of patients' rights under the Data Protection Act to refuse to allow information about them to be copied from one database to another. Paul Cundy, joint chairman of the IT committee set up by the British Medical Association and Royal College of GPs, said: " Patients do not have to prove severe distress. If patients decide they do not want their medical notes to go on the national system, they have an unalienable right under the Data Protection Act to refuse." He said the department asked any patient with " unique and personal reasons for claiming substantial and unwarranted distress" to write explaining them to its Whitehall customer service centre. But Dr Cundy said this put patients in a Catch-22 situation. They were being asked to reveal to officials the specific reasons why they did not want information revealed to officials."

3.5.36. The temptations in a digital society (4 Dec 2006)

Media Guardian

http://media.guardian.co.uk/mediaguardian/story/0,,1963047,00.html

" The government's plans to digitise the nation's personal records could be a goldmine for journalists willing to break the law. Details on millions of people will be compiled in databases accessed by thousands of officials. The bigger the system and the more people that use it, the less secure it becomes. Ross Anderson, professor of security engineering at Cambridge University, sees a parallel in banks' moves from branch-based computer systems to centralised ones in the mid-1980s. Previously, accessing account data meant nobbling someone within the target branch or group of branches; and at present, a patient's GP notes are normally only available at their surgery. " It makes it much easier to get information out," he says. Staff using NHS systems, which will eventually include summary health records for all patients in England, log on with a smartcard and Pin number, but Anderson says he knows of an emergency ward where a nurse logs on at the start of a shift and leaves it open, to save time. The Department for Education is planning an index including every child in England. The Association of Chief Police Officers is using number plate recognition technology to record the details of all vehicles passing CCTV cameras . The National Identity Register, which will eventually hold data on all adults including fingerprints and facial scans, may also act as a key to other databases. The Home Office says it vets staff - misuse of National Identity Register data can lead to jail sentences of up to 10 years. The Information Commissioner has called for stronger penalties for misuse of other data. But for unscrupulous journalists and investigators, the pickings could be rich."

3.5.37. Patients win right to keep records off NHS computer (16 Dec 2006)

The Guardian (Front page story)

http://www.guardian.co.uk/frontpage/story/0,,1973338,00.html

The government has bowed to privacy concerns about a new NHS computer system and conceded that patients should be allowed a veto on information about their medical history being passed from their GP to a national database. Following a Guardian campaign against the compulsory uploading of personal details to the system known as The Spine, Lord Warner, the health minister, will announce a plan that would allow individuals to review and correct their records and withhold them from the database. . . This month the Department of Health sent more than 1,300 curt letters rejecting requests from patients for their medical details to be kept off the national database. But ministers have changed their minds after advice from a taskforce on patient records headed by Harry Cayton, the department's " patient tsar" . Under his scheme, GPs would ask every patient to give their explicit consent for a summary of their record to be put on the national database. They would be given a few weeks to review the summary and call for corrections or amendments to be made before they consented to the upload. In a key departure from the previous position, the taskforce said: " Some patients may ask for their summary care record not to be shared or uploaded at all." Lord Warner said it was not yet possible to guarantee a right of veto. Some doctors were concerned that patients might be putting themselves at risk by refusing access to records that could save their lives in an emergency. . . But he conceded it was technically possible for patients to refuse to let their data be uploaded and the government was considering how to make this happen. . . Lord Warner said the government remains firmly committed to the creation of a national database and hopes to persuade the vast majority of patients to consent to their records going on it. . . Lord Warner said 1,351 people wrote to Patricia Hewitt, the health secretary, demanding that their medical records should not be uploaded, using a form of words devised by Ross Anderson, professor of security engineering at Cambridge university, a leading critic of the scheme."

3.5.38. How patients' protests forced a rethink on NHS computer records (16 Dec 2006)

The Guardian

http://www.guardian.co.uk/uk_news/story/0,,1973239,00.html

" The government's change of policy on patient records, disclosed in the Guardian today, is the first departure from a roadmap drawn by Tony Blair in 2002 when he approved a scheme to spend billions on a new IT system for the NHS. The prime minister was captivated by the vision of a national database containing the medical records of 50 million patients throughout England. Heads of the

corporations developing cutting edge technology convinced him that lives could be saved if doctors, nurses and paramedics could gain instant access to key information about patients that might cause conventional treatments to cause life-threatening reactions. nstead of consultants waiting for hours to locate the patient's GP and ask for relevant information, a paramedic on the scene would be able to access data from a palmtop computer. Who could object? Mr Blair thought nobody would when he authorised what eventually became a £12bn scheme to connect more than 30,000 GPs to nearly 300 hospitals and their outposts in the ambulance service. . . From the outset, the patient record was a key component, but nobody thought to ask whether patients minded having medical details put on a national system which could potentially be accessed by a large proportion of the NHS's 1.3 million staff. The British Medical Association was divided. Consultants in hospitals with poor IT systems were enthusiastic. GPs whose IT systems tended to be more up to date were anxious about sharing patients' medical secrets without asking consent. Lord Warner, the health minister, set up a taskforce under Harry Cayton, the patients' " tsar" , to work out a compromise between GPs who wanted patients to choose to opt into the scheme and others who feared the most vulnerable patients would not bother to make the choice. For civil liberties campaigners, the internal debate missed the point. They mistrusted promises of electronic security locks. On November 1, the Guardian carried a coupon compiled by Ross Anderson, professor of security engineering at Cambridge University. It prompted 1,351 people to write to Patricia Hewitt, the health secretary, using the coupon or words from it, to demand their medical records should not be uploaded. . . Lord Warner's response will fall well short of a guarantee of a complete opt-out from the system. But he said the government is now concentrating on how to give the opt-out, not whether to give it."

3.5.39. Electronic care records go ahead (16 Dec 2006)

BBC News

http://news.bbc.co.uk/1/hi/health/6184043.stm

Ministers are to press on with plans for a controversial electronic medical records system. The government's patients' tsar Harry Cayton will say the system, which will hold records for 50m people in England, is needed to modernise the NHS. Only people who can prove the system will cause them substantial mental distress will be exempt. But doctors warned creating the record without a patient's consent could harm the doctor-patient relationship. Health correspondent Adam Brimelow said the computerised patient record scheme is central to a huge and expensive upgrade of the NHS IT system. Under the system, everyone will have a computer-based care file with basic information such as medication and allergies, drawn from GPs' records. A poll of over 1,000 GPs by the Guardian newspaper last month found half would consider refusing to put patient records automatically on to a new national database. Many said they doubted the security of the new system. Pilots will begin in the spring with national roll-out expected by the end of the year. The government says it aims to make unscheduled treatment - including care in emergencies - quicker and safer, as well as protect patient confidentiality. Patients will only be able to have their records removed if they can show holding them will cause them substantial mental distress. However, they will be allowed to check the details are correct and make amendments online. How more detailed and sensitive data will be stored is still being looked at. . ."

3.5.40. Minister admits U-turn on NHS database amid privacy fears (19 Dec 2006)

The Guardian

http://www.guardian.co.uk/guardianpolitics/story/0,,1975035,00.html

" The government gave a categorical assurance yesterday that NHS patients would have an absolute right of veto on any part of their medical records being uploaded to a national database. The health minister Lord Warner confirmed a report in the Guardian on Saturday that the government was abandoning an attempt to oblige GPs to provide a medical summary on every patient for a centralised electronic record. He acknowledged changing the policy over the past few weeks in response to the concerns of patients who feared unauthorised disclosure of their medical histories. He said the fears were groundless but offered assurances that were firmer than in the briefing to the Guardian last week. He said: " For all of them, if they don't want to have their information uploaded, they can stop it before it is uploaded." However, he said that the campaigners did not have the right to stop the scheme completely: " People who want to say a curse on the devil and all his works can stop their information being uploaded, but they can't stop other people having the information about them uploaded." . . Helen Wilkinson, national coordinator of The Big Opt Out, a campaign against the database, said: "

People should opt out now, if only to wait and see if the government delivers the 'protections' that it is promising and whether they are credible." . . ."

3.5.41. A question of consent (19 Dec 2006)

The Guardian (Leader)

http://www.guardian.co.uk/leaders/story/0,,1974883,00.html

" Seventy five pounds for an ex-directory number, £150 for the address a car is registered at and £500 for a criminal record. These are just some of the tariffs that the information commissioner last week revealed had been paid by journalists for personal data, exposing how established the market in snooping has become, in spite of strong theoretical safeguards. When, against this background, a new national patient register is being introduced - which a quarter of a million people will have some measure of access to - it is right that claimed guarantees of confidentiality be treated sceptically, however worthwhile the new database may be. And electronic records certainly could be useful, bolstering care where patients run into emergencies away from home, as well as speeding the transfer of information needed for day-to-day care when a patient moves from one physician to another. But with medical data being so personal, and with confidentiality at the heart of the patient-doctor relationship, both the Guardian and the British Medical Association expressed fears about whether the new centralised " spine" was really secure enough. Then, last month, our survey revealed that most family doctors shared these concerns and that half might defy the official requirement to upload their patients' details, potentially rendering the whole project unworkable. Yesterday, as it unveiled the next steps towards implementation, the government showed at least some signs of having listened. When the first information is uploaded, in trials next year, aside from demographics it will cover only allergies, medication and adverse reactions, all details that there is a clear clinical advantage in sharing. Yet, even with such tightly defined information, extremely serious implications for privacy remain. People on very many medications - from anti-depressants to Viagra to contraceptives - may have deep anxieties about this being known by anyone but their own GP. That is why it is so crucial that the government seemed to signal yesterday that patients should be able to amend their details before they are uploaded, or indeed, to opt out of having their record shared at all. . . With such personal data, truly personal consent for sharing is surely needed."

3.5.42. Sending a shiver down my Spine (20 Dec 2006)

The Times

http://www.timesonline.co.uk/article/0,,6-2512104,00.html

" An electronic record, which we may see and correct, available instantly to any doctor or nurse who needs it? Sounds wonderful. Yet the Government is facing a wave of protests from patients and GPs. Most of this is down to arrogance: the " we know best" attitude that characterises not just much of the medical profession but Whitehall as well. Take the broken promise about compulsion. At first, two years ago, ministers said that people would be allowed to opt out of the electronic system. Then, this year, in an abrupt change of policy and a Big Brotherish assumption that the national pooling of information was more important than your right to privacy, it said that patients would be allowed to opt out only if they could prove that it would cause them " substantial and unwarranted distress" to be included. Thankfully, that decision was overturned this week and the Department of Health said anyone can ask to keep his or her medical records off the register after all. You have to ask, mind; consent will be implied if you do not. A further safeguard is promised, if you are on the register: you will be able to nominate specific information to be placed in a " sealed envelope" that will be opened only with your consent or in urgent circumstances. So far, so reassuring. So why won't I be on the so-called Spine, this record of 50 million patients? Because I do not trust the security. Some 250,000 health staff will have access to your details, at varied levels, with individual access codes. Social workers, health managers, private medical firms and researchers will be given access too. How careful will they be with the information? What to a doctor or statistician is one lady's banal decision to have an abortion in 2006 might to that woman be her most personal and delicate secret, and perhaps it might even be a secret to her husband too. Now imagine that woman was called Madonna (I am making this up, obviously) and weeks after the abortion she adopted an African baby — that information would be worth tens of thousands of pounds to some journalists. Now imagine that you are a nurse coming to the end of a six-month contract and about to be sent packing back home to the Philippines or Malawi. You are on triage at A&E, logging patients on arrival. You are using one of the hundreds of spare log-ons for the thousands of temporary staff whom the NHS employs daily. And you will have access to the

entire database; A&E is the sort of place that has to have access, because people arrive unconscious or confused. Now imagine the temptation to sell that information about Madonna. You will be back home with enough money to buy the village by the time it appears in the papers. . . I have no doubt that at some point we shall all have electronic medical records. I would prefer them to be in my hands, with a smart card I carry if I choose, giving access to people I select, and to NHS emergency staff if I am unconscious or incapacitated. I'll take the risk of mislaying it. Now that would really be putting power in the hands of the patients. But until the Government can at least answer detailed questions about exactly how its proposed system will work, I cannot think why anyone would want every spit and cough of their personal medical details made available to hundreds of thousands of people, and more. I, for one, would prefer to remain spineless."

3.5.43. NHS records pilots set to run (21 Dec 2006)

IT Week

http://www.itweek.co.uk/computing/news/2171358/nhs-records-pilots-set-run

" The first pilots of the national electronic health records system will go ahead in the spring, against a backdrop of compromises over patients' security concerns. The control of access to centrally-held information has been an ongoing issue for the £6bn National Programme for NHS IT (NPfIT). Login to the database is controlled by a high-security smartcard and only clinicians with a 'legitimate relationship' will be able to see health data. But concerns remain over patient control of their information. Following a report from an independent taskforce, patients will now be able to check, and potentially veto, the data being uploaded to the central data spine. Those not actively opting out will be considered to have consented. NHS IT director general Richard Granger, who is responsible for the technology programme, says security concerns must not be allowed to undermine the improvement of patient care. 'Concerns about data security may be marshalled by an active lobby of healthy sceptics to the detriment of the ill, and avoidable fatalities will result,' he said. The debate highlights continuing communications issues between clinical groups and the central programme. The British Medical Association says a lack of early consultation with doctors is at the root of the confidentiality concerns. . ."

3.5.44. Headed for the rocks (21 Dec 2006)

The Guardian

http://www.guardian.co.uk/comment/story/0,,1976589,00.html

" The NHS's ill-starred computer project is in the news again. After polls showed that most doctors and patients oppose a compulsory national database of medical records, health minister Lord Warner produced a report on Monday and promised an opt-out. But don't break out the champagne yet. The report was cleverly spun; hidden in an appendix is confirmation that you can opt out of the Summary Care Record, but not the Detailed Care Record. The first is merely a synopsis for emergency care. It will have your current prescriptions, and will say, for example, whether you are diabetic. But ministers are not offering an easy opt-out from the second - the database replacing your current GP and hospital records. They plan to " upload" your GP data over the next year or two to a regional hosting centre run by a government contractor. The data will initially remain under your GP's nominal control but, after hospital records have been uploaded too, the chief medical officer will be the custodian of the whole lot. Your " electronic health record" will be used for many purposes, from cost control through audit to research. So the Home Office plans to use health data to help predict which children are likely to offend (despite a recent report to the information commissioner that collecting large amounts of data on children without their parents' consent will probably break human rights law). Yet confidentiality is often vital for care. . . The NHS computer project also has grave safety and performance problems. Moving patient records from the hospital or surgery to remote computer centres means that network failures cause havoc. What's more, the NHS computer system is showing all the classic symptoms of turning into a software project disaster, with changing specifications, slipping deadlines and soaring costs. The NHS must not be dependent on it. The convoy is heading for the rocks, and perhaps only one man can alter its course. Gordon Brown will have to decide soon whether to scrap the central database and build safe systems that will work. If he calls it wrong then - as with Blair and Iraq - it may well be the decision for which he is remembered."

3.5.45. BMA may seek NHS records system boycott (22 Dec 2006)

The Register

http://www.theregister.co.uk/2006/12/22/bma_nhs_record_systems_boycott_call/

" Doctors will be advised to refuse to use the NHS's computer system unless the Department of Health (DoH) changes its mind on behaviour which the British Medical Association says is unlawful. The DoH has refused to allow a large number of patients to opt out of its controversial computerised patient records system, which is still in development. The BMA says that that refusal is unlawful and could result in a boycott of the system by GPs. " We believe this particular suggestion by the DoH is unlawful and certainly it's outwith our understanding of the Data Protection Act," said Dr Richard Vautry, the BMA's negotiator on IT issues and a member of its GP committee. " If they insist on that position, which we think is untenable, then it would mean that we would be obliged to advise practices not to get involved in putting any information into the summary care record," Vautry told OUT-LAW. The system depends on GPs inputting the information and would be likely to collapse if GPs refused to carry out that task. " I'm sure practices would be very unwilling to do so because they would feel that it would put them in a very legally indefensible position," said Vautry. The DoH did not respond to a request for comment before publication. The controversy stems from a letter sent by the DoH to a large number of people who asked to opt out of the system. The Department told them that they could not opt out unless they could show 'substantial and unwarranted distress' would be caused by being in the system. The BMA says that the Department had no right to make that judgment. . ."

3.5.46. Time to go public (27 Dec 2006)

The Guardian (Leader)

http://www.guardian.co.uk/commentisfree/story/0,,1978859,00.html

"Privacy is one of those concepts which are easier to understand than define. A human life of any quality relies on a reasonable expectation of privacy. Yet modern technology - whether deployed by corporations, individuals, media or the state - offers unlimited scope for intrusion into private lives. . . With official databases so easily penetrated it is reasonable to ask searching questions about the drive in government to centralise digital information about our lives. Ministers talk sweet reason in making the case for ID cards and national NHS records. But they must know that such systems are always open to abuse. CCTV cameras on the streets may offer reassurance and help fight crime. But how relaxed would people be if, as happened in recent experiments, cameras were augmented by microphones to monitor street conversations? The debate over these and associated issues has been slow to get off the ground, but is now gathering pace. Many people feel increasingly anxious about the potential loss of civil liberties and it would be ill-advised for governments to dismiss such concerns. . ."

3.5.47. Patient Concern: Database a threat to patient confidentiality (15 Jan 2007)

Politics.co.uk

http://www.politics.co.uk/issueoftheday/domestic-policy/civil-liberties/identity-cards/patient-concern-database-threat-patient-confidentiality-$463285$463273.htm

"A patients' campaign group has called on medical authorities to unite against plans to create a single government database. Ministers believe allowing government departments to share information will make public services more efficient. But Joyce Robins, co-director of Patient Concern, said: "The announcement of plans for a national database accessible by any government department couldn't come at a worse time. "It will fuel the public's fear that confidentiality is meaningless in respect of their medical condition and sabotage patients' trust in their doctors' ability to protect their privacy." The group is concerned the commitment to privacy in the NHS's integrated IT system will be overridden by the new database. "Not only the information commissioner but the health service regulatory bodies and medical royal colleges should be seriously worried and unite to oppose the threat to patient confidentiality," said Ms Robins.

3.5.48. A Vision of HAL (16 Jan 2007)

The Times

http://www.timesonline.co.uk/article/0,,542-2548779,00.html

"Joined-up government needs joined-up computers. "I know I've made some very poor decisions recently," HAL admits at a critical point in 2001: A Space Odyssey. "But I can give you my complete assurance that my work will be back to normal. I've still got the greatest enthusiasm and confidence in the mission. And I want to help you." The original spacefaring supercomputer could have been articulating the Government's position on its own supercomputer projects. Disastrous errors have been made with the specification, procurement and installation of costly public sector IT systems. But Tony Blair insisted yesterday that he would press ahead with them nonetheless — and require them to pool personal information on citizens much more efficiently — because he believed it would enhance the delivery of public services. . . The scheme launched yesterday is aimed at lowering some of the barriers to information-sharing set up by the Data Protection Act 1998. Mr Blair has said it will only involve the creation of the new combined database so feared by civil liberties activists if a series of "citizens' panels" consent to the idea. It would be naive to suppose that the plan will not entail some erosion of personal privacy: easier citizen access to government necessarily means easier government access to citizens. But in all advanced democracies certain individual liberties are sacrificed for the sake of collective security. If executed efficiently and transparently, this project could deepen that social compact rather than threaten it. It is a big "if". The NHS's £20 billion Connecting for Health project is, notoriously, at least two years behind schedule with no guarantee of delivering the improvements in healthcare that its architects promise. Myriad smaller government IT schemes are plagued by delays, cost overruns and unrealistic expectations. More than half of all government websites are to be scrapped within the next three years. Even if the new goal of more intelligent sharing of information is achieved securely, it runs the risk of spreading errors throughout the system. Against this, citizens are promised a realisation of the dream of "one-stop" government: one phone call to notify the authorities of a death in the family, not 44, as in one case cited by the Work and Pensions Secretary; a single point of reference handling all pension and benefit enquiries for the elderly; and an undoubted boon to police if related plans to create a national DNA database receive the go-ahead. The potential benefits are real and the momentum to aggregate information may, in any case, prove unstoppable. Like HAL, the Government must therefore learn from its mistakes and raise its game."

3.5.49. Anger over EC medical data-sharing scheme (26 Jan 2007)

ZDNET

http://news.zdnet.co.uk/itmanagement/0,1000000308,39285644,00.htm?r=1

"Experts are outraged by a plan that would make UK citizens' medical details accessible across Europe. The European Commission is about to call for proposals on how patients' medical details would be shared between its member states, with the UK almost certain to be included in the scheme. . . . The data that will be shared will include some kind of emergency care records and patients' medication histories. The aim of the scheme is that if, for example, a UK citizen falls ill while in Spain, doctors there will know what medication the patient cannot take or what existing conditions they already have. But according to Ross Anderson, a Cambridge University security engineering professor and longstanding critic of the NHS' multi-billion pound centralising systems upgrade, the National Programme for IT (NPfIT), the scheme is unnecessary and could even be counterproductive. . . It is unclear at this stage what level of security will be built into the Commission's initiative. Comyn confirmed that "it will be up to the member states to take appropriate actions on security and make sure the level of security they choose is in line with the national levels". As there is already disquiet within the UK about the security implications of having a centralised national health database, the idea of those details being available in other countries, under those countries' home-grown security restrictions, seems sure to cause further concerns. It is also not clear whether this interoperability was part of the original specification for the UK's NPfIT, or whether it will create new requirements and costs for the scheme. Richard Granger, the head of NPfIT, had not responded to a request for comment at the time of writing. . ."

3.5.50. Patients can boycott NHS system, says Commissioner (26 Jan 2007)

OUT-LAW News

http://www.out-law.com/page-7704

"The Information Commissioner has been told that patients will have the opportunity to refuse to have their details uploaded onto the new NHS medical records system. The news comes just weeks after the Department of Health refused patients that right. The Information Commissioner's Office (ICO) has issued a report on the NHS Connecting For Health system, the patient record system which has

suffered cost over-runs, delays and controversy over the right to opt-out. OUT-LAW recently revealed that the Department of Health had refused a large number of requests from patients that their details not be uploaded, and that the British Medical Association has threatened to ask doctors to boycott the system. Such a boycott would likely cripple the £12 billion project. . .”

3.5.51. NHS security dilemma as smartcards shared (30 Jan 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/01/30/221461/nhs-security-dilemma-as-smartcards-shared.htm

“An NHS trust board has approved the sharing of smartcards, in breach of security policy under the £12.4bn NHS National Programme for IT (NPfIT), because slow log-in times would restrict the time of doctors treating emergency patients. South Warwickshire General Hospitals NHS Trust has allowed some staff to share smartcards used to access patient records, after concluding that log-in times for systems were too long for high-activity areas such as Accident and Emergency. The move raises the question of whether the Care Records Service system installed under the NPfIT has been supplied with busy hospital departments in mind, and just how stringent security can be in highly pressured environments. Connecting for Health, which runs the NPfIT, has stated in policy papers that smartcard sharing by NHS staff is “misconduct” that may result in disciplinary action. Paul Cundy, spokesman for the British Medical Association’s GP IT subcommittee, said the actions of the trust “drive a coach and horses through the so-called privacy in the new systems”. He said, “This is precisely what we have long predicted and shows that security systems, although highly specified on paper, need to be tested against live environments before they can be said to be secure.” But Duncan Robinson, director of IT at the trust, said it had decided specifically in Accident and Emergency to slightly depart from what he called security “guidelines” to allow the sharing of smartcards on certain PCs. He said the trust was concerned that logging on could take up to 90 seconds. Without smartcard sharing, if doctors using a secure PC are called away when accessing a file, they may have to log off and on again when they return to it. Sharing the shift leader’s smartcard, more than a dozen clinicians can access files on PCs without logging on and off each time. . . A spokesman for Connecting for Health said smartcard sharing policy and guidance was unambiguous - it is misconduct and should be dealt with via disciplinary procedures or professional bodies. . .”

3.5.52. Faulty software puts child health at risk (14 Feb 2007)

The Times

http://www.timesonline.co.uk/tol/news/uk/health/article1375405.ece

“The health of children is at risk because an NHS computer system wrecked 20 years of accurate immunisation records. Faulty software introduced in 2005 has left some primary care trusts (PCTs) unable to track whether children have been vaccinated and screened for genetic conditions, raising fears that many are unprotected against diseases. Parents are not being reminded when their children are due for jabs and check-ups. The Health Protection Agency cannot publish full statistics on the uptake of vaccines because the five worst-affected London trusts cannot provide accurate data. When the shortcomings of the Child Health Interim Application (CHIA) software were disclosed by The Times a year ago, the Department of Health stated that the problems were being addressed. Staff were said yesterday to be “in despair” at continuing difficulties with the system supplied by BT. Christine Sloczynska, consultant community paediatrician at Waltham Forest PCT, in East London, said: “I’m sure there will be kids who slip through the net and will be unimmunised. Our immunisation take-up has fallen from 94 per cent to 58 per cent, but we don’t know how much it is due to children missing their vaccinations, or to lack of data.” The Health Protection Agency said that five trusts had been excluded from national figures for uptake of MMR and other vaccinations as their data were considered unreliable. Pat Troop, head of the agency, said: “There is still a gap in the data, and it’s something the local NHS are concerned about, not just us. Not monitoring coverage of measles is how infections might happen.” Mike Catchpole, of the agency, said that it was not possible to predict when the affected PCTs could provide the data. The CHIA software was introduced in ten London trusts when an older system was withdrawn. Dr Slocynzska said that the system could not be used to generate lists of those who match particular criteria, such as missing vaccinations. This makes it difficult for GPs to issue reminders. Parents are still issued with a “red book” listing a vaccination schedule, but the problems with the computer make it hard to tell them when new jabs are available. Birth records formerly sent online from maternity units must be entered by hand, and there is a backlog. “We are

sometimes told of a child's death before we know it has been born," Dr Sloczynska said. BT has promised to replace the software."

3.5.53. BMA chair says smart card policy 'preposterous' (15 Feb 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2485

"Connecting for Health's policy of requiring doctors to repeatedly log-in with a smart card every time they use a computer system has been described as 'preposterous', by the chairman of the British Medical Association. Speaking exclusively to E-Health Insider Mr Johnson said: "The idea that we have to log in and out of each terminal we use is complete nonsense. There is no reason why patients should be left waiting whilst staff log onto a system." Mr Johnson, who is also chair of the BMA's Working Party on NHS IT, was commenting on whether he thought South Warwickshire NHS Trust were right to allow clinicians to share smartcards in the Accident and Emergency department due to the 60 – 90 seconds it took to log into there new patient administration system. [http://www.e-health-insider.com/news/item.cfm?ID=2449] Johnson felt that the sharing of smartcards was "totally unacceptable" and they should be replaced with individual authentication methods such as lapels or devices that are pressed onto a reader when accessing confidential data. . . He said he also strongly favoured the creation of Role Based Access Controls (RBAC) to limit who sees what data and says work with Connecting for Health to create a firm set of job roles within a healthcare environment that will determine staff access rights. . ."

3.5.54. The NHS Database: Lord Warner's opt out decoy: A review of persisting privacy and confidentiality issues (Mar 2007)

Dr Paul Thornton MPH, FRCGP

http://www.ardenhoe.demon.co.uk/privacy/decoy.pdf>http://www.ardenhoe.demon.co.uk/privacy/decoy.pdf

"As a parting shot just before Christmas, resigned Health Minister Lord Warner generated extensive press coverage by announcing unequivocally that patients would be allowed to keep their information off the national database that is being created by Connecting for Health, the Department of Health's IT wing. This was trumpeted as a substantial concession in response to letters sent to the Department of Health by patients. It appeared that Lord Warner belatedly recognized the political and ethical obligations on the Department of Health (DH) - obligations that were increased by the editorials and comment from newspapers across the political spectrum once they came to understand what the NHS had otherwise been trying to do. Lord Warner's announcement was trailed by Mr Harry Cayton in an interview with The Guardian. The newspaper had previously printed a proforma letter that was sent to the Department of Health by readers. Mr Cayton is "National Director for Patients and the Public" at the Department of Health, a political appointment dubbed "Patient's Tsar". . . It is nearly two years since Mr Cayton previously reassured on BBC TV news that patients would be able to opt out of the national database entirely if they so choose. Despite the gestation period of an elephant, the board he chairs has failed to amend the National Care Records Guarantee to inform patients of that choice and how it can be exercised. Nor has the board given any indication of how the care of such patients might be taken forward if they are ever able to exercise that choice. . . All that is being offered by the ministerial working party is an "opt out" from the "summary care record". This limited opt out is important because all information in the summary care record will otherwise be accessible to all NHS staff nationally. Initially the summary care record will include only current medications, allergies to medication and adverse reactions. This is sufficient information to imply highly sensitive diagnoses. If you know the treatment you know the disease. It is intended that the summary care record will include even more data as summary information will initially be generated from data currently held by General Practitioners on their discreet and discrete systems. But this limited opt out is not sufficient. . . CfH intend that all clinical, psychological and social information will be recorded by professionals in a "Detailed Care Record", a subset database of the entire scheme. The information will be stored on centralised computers that are remote from the unit treating the patient. A single individual should therefore have a different "Detailed Care Record" created by each NHS unit by whom they are being treated. Previous CFH documents confirm that detailed care records will certainly be accessible by all staff who work in the same NHS unit as the professional to whom private information has been divulged. This may be as small as a single GP practice or as large as an NHS Trust covering 2 or 3 District General Hospitals. In addition, enormous numbers of staff in all the units which share the

same I.T. infrastructure, described curiously as an "instance", will have the ability to access the detailed care records created in those other units in that "instance". Connecting for Health (CfH) have divided health services in England into five geographical areas, called "clusters". Each cluster database may be divided into as few as two or three "instances". The number of staff and patients served by a single "instance" will be huge. Users of an "instance" will be widely spread geographically. Some restrictions might be placed on who is "allowed" to access the records but this is substantially exceeded by a recognition of the numbers who are "able" to access the records. The biggest security risk to any large database arises from illegitimate use by staff with at least some degree of legitimate access. . ."

3.5.55. First test launched of NHS's controversial 'Spine' database (15 Mar 2007)

The Guardian

http://www.guardian.co.uk/uk_news/story/0,,2034101,00.html

"The government's plan to put the medical records of every NHS patient in England on a central electronic database will begin first trials tomorrow at two carefully selected GP practices in the north-west. About 14,500 patients in Bolton will be told their confidential medical details will be uploaded to a national data warehouse known as the Spine, unless they object. Their reaction will be the first test of whether patients accept the government's argument that a national electronic record can save lives - or agree with campaigners for personal privacy who see the scheme as a lurch towards a Big Brother state. . .The agency said it was taking a cautious approach and would learn lessons from Bolton before testing the scheme in six or seven other primary care trusts before the end of the year. If all goes well, a summary of the medical records of 50 million patients throughout England will be uploaded in spring next year."

3.5.56. Gadget will help to save patient lives (16 Mar 2007)

Portsmouth Today News

http://www.portsmouthtoday.co.uk/ViewArticle.aspx?ArticleID=2128480&SectionID=455

"THOUSANDS of patients are to benefit from a potentially lifesaving new information system. Health bosses have launched handheld computer technology so patients in need of urgent medical attention can be identified and treated more quickly. Clinicians in the medical and surgical assessment unit sat Queen Alexandra Hospital, Cosham, Portsmouth, can now monitor a patient's condition throughout their hospital stay - saving a massive £1m a year. . . Nurses now record and store vital signs such as pulse, blood pressure, heart rate and temperature electronically at a patients' bedside. VitalPAC analyses data alongside other important information, such as blood test results stored in other hospital databases. The system uses an early warning score to identify seriously ill patients. Specialists are then automatically alerted when a patient's condition deteriorates. These records were previously kept on charts at the end of a patient's bed. . . 'There's a level of disillusionment among doctors and staff with the national programme,' said trust critical care consultant and project clinical lead Gary Smith. We believe this system will compliment it. We're doing things that Connecting For Health cannot deliver to make our patients safer.' Learning Clinic managing director Roger Killen said: 'Not only will it help ensure the safety of the patient, but it also promotes their progress through the tests that help the clinical teams make accurate diagnosis and treatment.'"

3.5.57. Dilemmas of Privacy and Surveillance: Challenges of Technological Change (26 Mar 2007)

Royal Academy of Engineering

http://www.raeng.org.uk/policy/reports/pdf/dilemmas_of_privacy_and_surveillance_report.pdf

". . . In relation to privacy and surveillance, levels of trust are vulnerable if government appears unresponsive or is deemed too slow to react to the dangers posed by the use of those technologies. Trust has a rational basis, and is accorded only when institutions perform their roles satisfactorily. Institutions generate trust when they perform well and when they do not they are deemed untrustworthy and generate scepticism. . . It is with respect to trust as role performance that governments are most vulnerable. This form of trust is based on people's experiences, as the performance of institutions is monitored by the public and opinions and perceptions subsequently develop. While it might take years of effective governance to establish institutional trust, it can be wiped out very quickly, however fairly or unfairly, by high profile mistakes or accidents. Moreover,

trust problems over a particular issue can translate into a mistrust of a whole government (which can be electorally punished), but leave trust in the state (in the police or National Health Service for example) unaffected (though state bodies such as the police or the NHS can lose public trust in some circumstances). . . There are a number of incidents in which a government or series of governments have suffered loss of trust due to poor role performance, or perceived poor performance. Crucially to the interests of this report, a number of these relate to the introduction of new technologies. For example, the implementation of a new computer system in the Child Support Agency (CSA) was considered a disaster, with many vulnerable people failing to receive child support payments due to its inadequate functioning. The failures associated with the CSA have been brought up in criticisms of plans for the NHS project 'Connecting for Health' which involves bringing modern computing systems to the NHS. They have also been raised in connection with the ID cards scheme and the associated National Identity Register (NIR). Both past problems and recent difficulties mean that government is vulnerable when it comes to trust in their ability to implement a large IT project, or any other complex business change project. Of course, government is not alone in experiencing difficulties in implementing complex projects with a large IT component, but it is particularly vulnerable since its projects use public money and involve critical services such as the NHS. . ."

3.5.58. Safety first: the benefits of e-prescribing (26 Mar 2007)

Health Service Journal

http://www.hsj.co.uk/healthservicejournal/pages/GM2/P24/070329

"The deadline for the introduction of electronic prescribing in secondary care is 2010. But so far very few hospitals have explored it. E-prescribing reduces prescribing errors, removing the potential for problems with doctors' handwriting, for example, and can eradicate erroneous changes when transcribing a prescription to a new form. But NHS Connecting for Health, the agency responsible for the national IT programme, says only a 'small number' of trusts have experience of e-prescribing. Barriers include the time taken by the IT programme to provide the technology and difficulties faced by support companies in setting up systems in the required time. But two trusts are ahead of the game. Doncaster and Bassetlaw Hospitals foundation trust has been gradually bringing in the technology since 2002. It aims to extend it to all wards in Doncaster Royal Infirmary inside a year. The trust's objectives were to reduce clinical risk and improve discharge communication. A study showed that, where the technology was used, compliance with the policy rose from 37 to 96 per cent. All the records of the medicine given to patients were accurate, compared to 65 per cent before e-prescribing. Adverse drug events were reduced by 60 per cent. Winchester and Eastleigh Healthcare trust uses the JAC system, which manages prescription, supply and administration cycle. Senior pharmacist Joyce Bould says the way the system interacts with other systems has caused problems, but 'it's now accepted that this is the way to go. The NHS is recognising it is a safety issue.'"

3.5.59. Information Commissioner must investigate junior doctor website blunder (26 Apr 2007)

Liberal Democrats

http://www.libdems.org.uk/news/information-commisioner-must-investigate-junior-doctor-website-blunder-lamb.12487.html

"The Liberal Democrats have today written to the Information Commissioner asking him to urgently investigate the release of sensitive personal data of junior doctors on a Government website. . . 'The lack of consideration for the security of personal data in this case seems to constitute a serious breach of the Data Protection Act. I am sure you will agree this is an extremely concerning situation. I therefore ask that you thoroughly and urgently investigate this matter. I would also like you to consider whether this development casts further doubt on the advisability of persisting with the MTAS system without further thorough piloting and without cast iron reassurance as to the integrity of the system and safeguards to protect sensitive personal data. Are there any lessons to be learnt from this debacle in respect of the plans to establish a national database of patient records under the 'Connecting for Health' IT programme? . ."

3.5.60. Information Governance will be ongoing challenge (1 May 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2654

"Connecting for Health have told the House of Commons Health Select Committee that addressing the information governance challenge for shared records and use of patient data in an electronic NHS would be an ongoing challenge for the coming decade, in the same way that getting clinical governance right had been the challenge of the previous decade. Quizzed about privacy and consent issues, Dr Gillian Braunold, joint national GP clinical lead for the DH agency, told the committee that information governance was beginning to be looked into and there would be further answers in a year's time when an independent evaluation by University College London (UCL) of the early adopter sites was completed. . . In the later session, the ten year gap was greeted with horror from Andrew Hawker, a former systems developer, giving evidence as a NHS patient. . . Harry Cayton, DH national director for patients and the public, told the committee that the decision to go forward with the NHS CRS as an implied consent model was decided as a 'professional agreement' and one that was necessary to save GPs' time. . . Eyebrows were also raised when the issue of use of data from the CRS for research purposes came up. CfH said that pseudonymising data meant that researchers would have access to personal health records that have no identifiable information except a postcode and a date of birth. Dr Paul Cundy, chair of the General Practitioner's Joint IT Committee, responded to this suggestion by telling the committee: "Anonymisation is an absolute condition for research. Data is either anonymised or its not. Saying something is pseudonymised is a clever way of avoiding saying its not anonymised. On the basis of the evidence we heard from CfH it would seem that the Secondary Uses Service is illegal". . . However, Richard Granger, the director general of IT for the NHS, had earlier shrugged off concerns calling both information and computers 'vulnerable'. "All computers are vulnerable and no-one can guarantee a flawless system," he said, adding later: "Our suppliers all have experience with security and we are introducing functionality incrementally, mitigating risks and examining any necessary changes before the next stages." . . . Dr Martyn Thomas representing the UK Computing Research Committee told the committee that CfH had no security limits. "I have asked Richard Granger directly if he has targets for unacceptable levels of security and he says no – no targets means you will end up spending more money or you take it as it comes – which is unacceptable in practice, as it means taking systems offline."

3.5.61. Securing information in primary care (9 May 2007)

e-Health Insider

http://www.e-health-insider.com/Features/articles.cfm?docId=102

"The world of primary care IM&T is evolving rapidly with a move away from local systems, only accessible to local practice-based staff, to remotely hosted systems in which patient information becomes available to NHS staff across an entire health community. According to Ewan Davis, chairman of the British Computer Society's Primary Health Care Special Interest Group, the big change in security considerations in primary care is scale: "Instead of 12 people in a practice looking after 6,000 patients you are now looking at PCT or even cluster-wide data sharing." With this change in scale new security measures and mechanisms are required that don't just depend on trusting staff. "We are now moving beyond the domain of trust, you can't know everyone in a local health economy," says Davis. The underlying trends driving these changes are the moves to shared clinical information systems and the actual ownership of patient data. Davis commented: "The ownership of data is changing. Previously you could only get at GP data with the consent of the GP, with the development of national and shared record systems this is no longer the case." For many in primary care the move to remotely-hosted systems, which connect to national applications such the NHS Care Records Service, Choose and Book and the Electronic Prescription Service creates new risks and concerns around confidentiality, consent and information governance. Davis said that a particular current concern was around the personal demographic service (PDS) of the NHS Spine. "A lot of people have expressed worries around PDS data being searchable by anyone in the NHS." The second current issue worrying many in primary care is around Choose and Book and the claims that people can get access to clinical information not relevant to them. Ironically, Davis said that NPfIT appears to have developed good mechanisms to maintain the confidentiality of patient data on the CRS system, but some of them such as the sealed envelope and facilities for 'stop noting' have yet to be implemented. Ian Nottage, information manager at Western Sussex PCT, says that the biggest issue for his PCT currently are around information governance. "We have concerns around the creation of large central databases in which we have no control over what happens to data once it goes to the centre," says Nottage. "We already get concerns over what will happen with Choose and Book data once it is sent to the centre." . . ."

3.5.62. 'Sealed envelopes' on hold as policy debate continues (10 May 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2680

"Local service providers (LSPs) are unable to deploy sealed envelope functionality because a clear specification looking at how the policy should work is not yet available, the Commons Health Select Committee heard today. Computer Science Corporation's president of the Europe Group, Guy Hains told the committee that the LSP to the North-west and West Midlands, North-east and Eastern clusters was ready to add in sealed envelopes functionality to its deployments, but was unable to do this because Connecting for Health has not decided on how the system will work. "There is an issue of a specification for sealed envelopes. Technology-wise we understand how to add in the functionality, but we need a clear specification, and we don't have that. We need to know how it will be used, when it should be deployed and an idea of the data-sets involved with this addition." Hains said that CSC had a timetable to implement the sealed envelopes functionality, but they have to wait to hear exactly what was wanted before the LSP can complete and deploy such a system. . . CSC is confident that the technology they are deploying will bring great benefits to the NHS and iSoft's Lorenzo will bring the NHS into the next generation, Hains said. He said that the delays in Lorenzo pointed to a number of factors: "Firstly, the ambition of CfH in terms of care pathways is demanding in software terms. We demand the best quality software with rigorous testing, different to the way software is made now and enables us to use it more widely than just the UK, like for the spine in Holland perhaps. "Secondly, there is no doubt that the uncertainty regarding iSoft and its future ownership is an unwelcome distraction, but we are duly supportive to iSoft and Lorenzo, which is why we have sent 100 of our people to work on it and 23 NHS clinical professionals are also working on it. We expect delivery in the middle of next year." Hains attempted to allay security concerns, but was interrupted by Professor Brian Randell, professor of computer science at Newcastle University, who said that Richard Granger [NHS IT director-general] has told him that there are no written security measures for NPfIT. Hains replied: "It is true to say we don't have any specific statements on security but we do have targets and we have targets and an environment with a 100% no data loss requirement. All trusts deploy systems on a voluntary basis and we have to support them with the change management. Our experience has been positive though, and we are deploying faster than ever before." He said that CSC had been working hard to ensure the system was as robust as possible. . . Hains said lessons have been learnt since the Maidstone data crash last year which left 80 NHS trusts across the North West and West Midlands, including eight acute trusts, without access to patient data on their clinical and administration computer systems, adding that he was confident that new measures would prevent similar problems at other trusts. "We have learnt several things from Maidstone. We now know it is better to have four back-up centres, instead of just two and we have tightened our targets and expectations for how quickly systems get brought back up from 72 hours to 24 hours and much shorter times for critical environments." Today's hearing was the second evidence session by the parliamentary select committee into the electronic patient record. Two further sessions will be held in June."

3.5.63. Safety now number one priority for CfH (17 May 2007)

e-Health Insider

http://www.e-health-insider.com/comment_and_analysis/index.cfm?ID=216

Professor Michael Thick, the chief clinical officer for Connecting for Health, says that the Department of Health's IT agency has transformed itself from being largely technical to one that places patient safety as its number one concern - safety trumping contract considerations or delivery timetables. . . He said that the current focus on clinical safety dated back to a 2004 review by the chief medical officer of whether the NPfIT programme was taking patient safety seriously – placing it as its first priority. "This found that there was not a patient safety culture in what was largely a technical organisation that saw how you use information as someone else's concern." However, since the 2004 review far-reaching changes had been made said, Professor Thick. In addition to his appointment he said: "NPfIT has established a clinical safety programme, led by a secondee from the NPSA [National Patient Safety Agency], adopted the IEC 61508 patient safety standard and set up clinical training on safety for all clinicians within the programme." . . . He said that clinical risk management was now of paramount concern with detailed documentation developed for clinical risk assessment. . . Professor Thick said this commitment to patient safety was best seen in the fact that every product delivered by NPfIT had

to secure 'Clinical Authority to Release' before it could be deployed into the NHS. He said this over-rode all other concerns and delivery schedules. . .

3.5.64. Confidentiality of millions 'at risk' as IT chief exposes security flaws (24 May 2007)

Pulse News

http://www.pulse-i.co.uk

"Robert Navarro, whose firm is handling key security aspects of the rollout of the controversial care record, told Pulse of his fears as our Common Sense on IT campaign builds momentum. He warned records could be leaked unless extra safeguards are put in place. Mr Navarro, managing director of Sapior Ltd, is a leading expert on pseudonymisation, a security technique which reduces the risk of records in a database being identified by replacing data in key fields, such as a patient's NHS number. 'BT say if it's pseudonymised, it's safe – that is just not true,' he said. Sapior is subcontracted by BT on behalf of Connecting for Health, and developed the pseudonymisation software currently used by the Secondary Uses Service. The service currently only provides data to NHS organisations, but information is likely to be shared with researchers more widely when the care record programme has been rolled out. Mr Navarro told Pulse that if pseudonymised records were shared beyond the NHS, they would be vulnerable to so-called 'inference attacks', whereby the identity of patients could be revealed through details in their records which remain in their electronic files after pseudonymisation. In August last year, newspaper journalists and computer hackers used inference attacks to successfully identify thousands of internet users after online giant AOL made pseudonymised search data about more than 600,000 of its users available to researchers. 'When you're sharing beyond the current group you have to go to an extra level of protection in order to prevent the AOL kind of attack,' said Mr Navarro, who fears the same threat could be posed to NHS patients via the care record. 'Every researcher who says pseudonymising is fine is just ignoring inference attacks,' he said. Pulse's campaign calls for a watertight anonymisation system before records are made available for research purposes. Dr Paul Cundy, chair of the GPC IT subcommittee, said of Mr Navarro's revelations: 'This news confirms our fears about the Secondary Uses Service. 'It is now clear that the SUS must not be connected to anything new, nor external access granted to the data it holds, until we know it is anonymised.' Dr Paul Thornton, a GP in Kingsbury in Warwickshire and IT campaigner, said sharing data with the Secondary Uses Service without explicit patient consent would be 'unlawful'."

3.5.65. BMA votes for non co-operation on central records (29 Jun 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2827

"Doctors have called for a public inquiry into NHS Connecting for Health (CfH) and have called on the BMA to advise doctors not to co-operate with the centralised storage of medical records. The National Programme for IT was the subject of strong criticism at the association's annual representative meeting (ARM) this week where doctors claimed the NHS IT project was doomed to failure unless a grip was taken on the project and that patient information held on the NHS Care Records Service (NCRS) was not secure and confidential. Dr Charlie Daniels, a GP in Torquay and chairman of Devon Local Medical Committee (LMC), told colleagues that patients and doctors would be the biggest losers if there was no public inquiry to into NPfIT. He claimed key elements of the programme were not working and that costs were escalating, suppliers were in trouble and stakeholders were being ignored. He said that in 2002 everyone had hoped that NPfIT would drag local hospitals out of the IT Stone Age and connect them with GP surgeries. He added: "Do I see Torbay Hospital with an all singing and dancing IT system that can give me a basic e-mail discharge summary? No – we still get a badly handwritten flimsy note which arrives days later." Dr Grant Ingrams, secretary of West Midlands Regional LMC, failed to convince colleagues that CfH had started to listen more carefully to what clinicians and patients needed and that calls for an inquiry were unnecessary. . . On the NCRS Dr Daniels described the smartcards already in circulation in the NHS as "300,000 keys to open one lock" and said many patients had reasons for not wanting to have their details on the spine. "Patients are being bullied when they are told that their care will suffer or that they are putting their lives at risk if they do not have their details on the spine. Patients are also being bullied when they are being told that they will not be able to access services if they do not have their details on the spine. This is disgraceful and should be deplored." Doctors backed a motion, against the advice of Dr Richard Vautrey from the BMA's working party on NHS IT, which called on the association to advise doctors not to co-operate

with the proposed centralised storage of all medical records which they claimed seriously endangered patient confidentiality. . .”

3.5.66. London NHS paper reveals plans to share patient data (3 Jul 2007)

The Register

http://www.theregister.co.uk/2007/07/03/london_nhs_patient_data/

“A document produced for London NHS reveals plans for extensive sharing of personal data between the NHS, social services, education and the police. Obtained by William Heath’s Ideal Government blog, it says that the “Health and Social Care Integration Project” should fit with “known and future national developments... e.g. ContactPoint for Children, the Common Assessment Framework for Children, the Care Programme Approach, the Single Assessment Process for Older People, the Proposed Common Assessment Framework for Adults and its link with the NHS Connecting for Health National e-SAP Project. In addition, the system “should provide access to... details of entry on the Vulnerable Adult Register; details of entry on the Child Protection Register” and “should display details of a person’s family members or carers who may also be receiving services.” Responding to publication of the document, London NHS Chief Information Officer Kevin Jarrold protests that the paper is intended simply to agree “what is the minimum information needed to help those staff providing care to vulnerable people within London, while protecting patients’ care and privacy. This initiative is to improve the methods used to access that information which is already shared between Health and Social Services. There is no intention of implementing any solution without the say-so of the NHS, Social Care and the public.” It was, he says, produced to clarify what should and should not be accessible “by authorised colleagues within the NHS and our partners in Social Care, while ensuring patient safety and confidentiality.” . . . The NHS Programme for IT anticipates very large numbers of authorised users, as does ContactPoint, and both of these are already widely seen as privacy disasters waiting to happen. By producing a system that “will enable the sharing of a person’s information between” between these and other systems, the project is arguably substantially increasing the risks of abuse. And as an increasing amount of individual data is being shared by statute, at the government’s behest (so the individual can’t opt out and the professionals have no choice), it’s all too likely that London’s “vulnerable people” are about to get even more vulnerable.”

3.5.67. Who controls the UK’s electronic health record? (Jul 2007)

Data Processing Quarterly, Issue 19

“The Working Party of European Data Protection Commissioners has published a consultation document devoted to the Electronic Health Record (EHR) in response to the fact that most European countries are now developing EHR systems. These systems create a single patient record to contain the patient’s entire medical history, whether the details are created by a GP, hospital, pharmacy or by any other relevant health professional. The document is of interest because there are several important conclusions reached by the Working Party which appear to provide challenges for the EHR system proposed for the NHS. At the heart of the NHS plans for an EHR system is the Summary Care Record. This is a centrally held, index record that is to be created for every patient in the UK and will contain contact details for the patient and doctor (e.g. name, address), administrative details (e.g. NHS Number, date of birth) and limited health information (e.g. allergies, current prescriptions). The Summary Care Record will also eventually point to the location of the Detailed (Health) Care Record which is the next stage of the project; current plans are for these Records to be stored on a number of inter-linked, regionally-based systems. . . The Working Party has concluded that a centralized EHR system (i.e. close to the UK’s approach to EHR) ‘assumes there will be a single controller for the whole system separate from the healthcare professionals/ institutions’. The Working Party warns that in such a centralised system ‘liability for the confidentiality of the system is taken out of the hands of medical professionals’, and that this ‘might influence the amount of trust invested by patients into such a system’. The Working Party also notes that risks associated with a lack of trust do not arise in a decentralized EHR system ‘where the health care professional/institution’ is responsible for the medical file, or in patient-centric EHR systems (for example, the French EHR system) where ‘patients exercise a significant degree of control over their own medical personal data’. . . The Working Party also states that ‘all data contained in medical documentation in electronic health records’ should be considered to be ‘sensitive personal data’, even the ‘administrative data’ associated with a medical record. The Party notes that if these administrative data ‘were not relevant in the context of treatment of a patient, they would and should not have been included in a medical file’. . . Finally, the Working

Party states that only those professionals who are 'presently involved' with a patient should have access to the health record (e.g. this limitation should apply to access to the Summary Care Record), and that 'a patient should have the chance to prevent access to EHR data if he so chooses'. In summary, the Working Party is proposing an unconditional right to object to the processing. This contrasts with the tests described in section 10 of the Data Protection Act where the data subject has to establish unwarranted substantial distress or unwarranted substantial damage and where section 10 also gives the Secretary of State the power to negate the right to object."

[Working Party Report - http://ec.europa.eu/justice_home/fsj/privacy/docs/wpdocs/2007/wp131_en.pdf]

3.5.68. Locking horns over the care record: arch sceptic versus true believer (23 Aug 07)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=20&storycode=4114196&c=2

"As Pulse's Common Sense on IT campaign gathers pace, veteran IT campaigner Dr Paul Thornton goes head to head with Connecting for Health's Dr Gillian Braunold in a special email debate, here published in full, unexpurgated form."

3.5.69. Security warning as NHS staff view celebrity record (17 Sep 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/09/17/226792/security-warning-as-nhs-staff-view-celebrity-record.htm

"An NHS primary care trust has warned of a new risk to the confidentiality of medical records under the National Programme for IT (NPfIT), after more than 50 staff viewed the electronic records of a celebrity admitted into hospital. . . A spokesman for North Tees Primary Care Trust said the accessing of a celebrity's records took place elsewhere, not within the trust. The spokesman was unable to give any details of the incident or where it took place."

3.5.70. EU law could scupper Care Record (21 Sep 2007)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4114746&c=2

"Health minister Ben Bradshaw has admitted the rollout of the NHS Care Record could be banned under European law. The revelation, which comes following fierce criticism from the health select committee over the safeguards being put in place to protect the confidentiality of patient data, comes three months after Pulse first reported that the Government's IT plan could fall foul of European legislation. In a letter to an opposition MP, who raised concerns on behalf of a GP IT campaigner, Mr Bradshaw confirmed that the draft European Data Protection Directive, currently going through the European courts, would throw major question marks over the programme, if it becomes law. . . However, writing to Conservative MP for Rugby and Kenilworth, Jeremy Wright, Mr Bradshaw said the Department of Health still disputed Professor Korff's claim, although he refused to reveal details of the Government's legal advice. Mr Bradshaw said he expected the EU legislation to be amended, after consultation with European governments, adding that as a consultation it carried 'no legal weight'. However, he admitted that the working group running the consultation in Europe 'has suggested that it may be difficult to provide electronic health records with a robust legal basis.' Mr Wright took up the case on behalf of veteran IT campaigner, Dr Paul Thornton, a GP in his constituency. Dr Thornton said: 'Mr Bradshaw seems to be demanding greater privacy between him and his lawyers than he is willing to allow for patients in their dealings with their doctors. If he is so confident of the legal advice he has been given, and that he expects health care workers to follow, he should have no difficulty in publishing the advice in full.'"

3.5.71. Staff breaching smartcard security (17 Oct 2007)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4115280&c=2

"NHS staff routinely breach security policies on the confidentiality of patient records, a health service IT chief has admitted. The warning came as new figures revealed Connecting for Health has issued nearly 400,000 NHS smartcards – but keeps no record of how many have been lost or stolen. Philip Scott, head of IT projects and development at Portsmouth Hospitals NHS Trust, said it was common practice for staff to log on using colleagues' electronic smartcards and left activated all day, because the log on process was so cumbersome and slow. Mr Scott warned: 'Despite NHS security policies, logging on and off each application takes so long that often one hospital worker will log on to a workstation in the morning and remain logged on all day, with other people accessing information through that login. . . New figures released to Pulse under the Freedom of Information Act set out for the first time the true extent of smartcard access to patient records. Thousands of non-GPs have been given GP-profile access rights, and 22,729 individuals have been made sponsors, enabling them to approve registrations for new smartcard uses. But Connecting for Health said although it counted the number of smartcards issued, it was unaware of how many cards had been lost or stolen and subsequently reissued. . ."

3.5.72. You're better safe than free - the mantra of the Whitehall Taliban (21 Oct 2007)

Sunday Times

http://www.timesonline.co.uk/tol/comment/columnists/simon_jenkins/article2702727.ece

". . . Jacqui Smith, the home secretary, wants to give the police and others access to all mobile phone records - and one day possibly the satellite tracking of car movements. Smith wants to supplement this material with electronic identity cards, including personal and criminal details, and computerised medical records. If the lord chief justice and others get their way the DNA of every native of, and visitor to, Britain will be added to this mighty store. Given the number of access points - police, National Health Service, Whitehall, local councils and insurance companies - and given the ease of modern computer hacking, every Briton's life story will be open to all and vulnerable to all. One result is that millions may find it impossible to get credit or insurance cover. . . I accept that there is a case for ID cards: a few careless fraudsters and immigrants might be stopped from cheating on social security but this is not remotely worth £12 billion of public money. The case for a nationwide medical computer is equally trivial. It is that paramedics might give the wrong drug to an accident victim who has forgotten his allergies but can remember his NHS Pin number. Nobody balances a cost above £15 billion against the benefit, let alone against the general infringement of privacy and the certainty of computer hacking by insurers and others. In all these cases, ministers merely deploy the dictator's gambit that the "innocent have nothing to fear". . . The only real defence of Blair's "liberty, democracy and freedom" is to demand, constantly and tediously, that each extension of state power be justified as proportionate, cost-effective and consonant with these values. The onus should be on the executive to justify intrusion and repression, not on individuals to resist it. . ."

3.5.73. Security probe over Care Record crime (6 Nov 2007)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4115750&c=2

"NHS IT bosses have launched a review of security surrounding the Summary Care Record amid fears it will be targeted by blackmailers and identity thieves. Connecting for Health told Pulse the review had been ordered to assess the risk posed by so-called blaggers. The BMA warned 'highly skilled' con artists were set to seize on the care record rollout and try to trick staff into giving away private information. Dr Paul Cundy, chair of the joint RCGP and GPC IT committee, said: 'These people realise that because of the wide distribution of electronic records, it's easy to blag this information.' Dr Cundy said blaggers could come from a variety of sources, including health insurers, private investigators, blackmailers, fraudsters and identity thieves. 'They use NHS terms to sound plausible - they might call and say "my PDS is down, can you have a check on yours". 'Practice staff need to be reminded of the importance of not being duped into revealing confidential information.' A Connecting for Health spokesperson said: 'We are reviewing this threat along with a group of NHS organisations. The evolution of information systems will require the NHS to regularly review this threat."

3.5.74. Government claims on Care Record security 'simply false' (19 Nov 2007)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4115928&c=2

"Critics of the National Programme for IT have attacked a Government report as 'simply untruthful', after it backed security measures used in the controversial Secondary Uses Service. In its response last week to the Health Select Committee's inquiry into the electronic patient record, the Department of Health rejected calls for patients to give consent before particularly sensitive data, held inside so-called sealed envelopes, is used for research purposes. The report said: 'Patient consent to the use of anonymised or effectively pseudonymised data is not required by law.' But campaigners attacked the government's response, arguing NHS staff already access to patient-identifiable data through SUS. Last week Pulse revealed that three SUS users in every organisation within the NHS have been given access to patient-identifiable information contained with Commissioning Data Sets and Payment by Results data. Professor Ross Anderson, a world expert in security engineering at the University of Cambridge, said: 'The Department's justification is not just an evasion but is simply untruthful. They claim that the design of SUS 'ensures that patient confidentiality is protected' when it fact it doesn't. Even if you ask for your data to be kept private, three people at each of hundreds of different organisations get to paw through it.' Dr Neil Bhatia, a GP in Yateley in Hampshire, described the response as a 'farce', and Dr Paul Thornton, a GP in Kingsbury in Warwickshire, said it was 'a complete falsehood.' The Department accepted other criticisms from MPs over the Secondary Uses Service – but claimed it had 'already taken steps that will address these recommendations.' A new National Information Governance Board, which will replace the existing Patient Information Advisory Group, has been established to oversee the use of patient data in the SUS. A majority of the board's members will be members of the public recruited via 'a national public advertising campaign'. The department has also launched research into the effectiveness of pseudonymisation. Meanwhile in an exclusive interview with Pulse, GPC chair Dr Laurence Buckman this week denied the BMA had endorsed the department's plans for the Secondary Uses Service. 'Are there secondary uses for data that is collected through Connecting for Health?' he said. 'No. Patients gave that data for specific purposes, it shouldn't be used for anything else.'"

3.5.75. Second-class and lost in the post (21 Nov 2007)

The Times

http://www.timesonline.co.uk/tol/comment/columnists/alice_miles/article2910272.ece

". . . It is beyond farce, past comprehension, criminally irresponsible and beneath contempt. All those lectures from government and authorities about keeping our personal data safe; every statement ever made about the security of the proposed NHS database of everybody's personal medical records; each claim that the Children's Database containing all their personal details will somehow make our kids safer; and of course each and every promise about the safety of the national identity register — exposed as quite, quite worthless. . . "

3.5.76. Another day, another disaster (21 Nov 2007)

The Guardian

http://politics.guardian.co.uk/comment/story/0,,2214510,00.html

"Standing up in parliament yesterday afternoon, making his second emergency statement in as many days, Alistair Darling cut a battle-weary figure. No wonder. Neither the near-collapse of Northern Rock nor the loss of two CDs containing details of 25 million people are the chancellor's personal fault. . . The Treasury argues that the loss of such a colossal amount of confidential data is a purely "operational" mistake, made by another department answerable to the chancellor, but not run by him. True enough. And, hearing the details yesterday (a junior staffer couriering data over to the National Audit Office, but not registering or recording the package), it was hard to detect a strong case for a ministerial resignation, although the Revenue and Customs head, Sir Paul Gray, has stood down. But the chancellor's failure to disclose the package's loss for 10 days and his assurance that any "innocent victims" of fraud would be compensated did not smack of sure governance. . . What began as a careless slip has major implications for all government attempts to store huge amounts of personal data on its citizens - including the troubled NHS Spine, under which all our medical records would be centrally held. . ."

3.5.77. NHS database 'could be targeted' (21 Nov 2007)

BBC

http://news.bbc.co.uk/1/hi/uk_politics/7103667.stm

"The man in charge of setting up the NHS medical records database has admitted that "you cannot stop the wicked doing wicked things" with information. Richard Jeavons, director of IT implementation at the Department of Health, said there were instances where staff "abuse their privileges". These had to be "pursued", he told the Commons home affairs committee. The plan to put 50 million patients' records on the database is part of a £12bn NHS IT overhaul. The scheme has raised concerns over cost and the security of information. A poll for the Guardian suggests that 59% of GPs in England are unwilling to upload any record onto the database without the patient's specific consent. Three quarters of more than 1,000 doctors questioned believed medical details would become less secure when they are put on a database that will eventually be used by the NHS and social services. . . By 2014, 30,000 GPs in England will be linked up to nearly 300 hospitals giving the NHS a "21st century" computer network. It involves an online booking system, Choose and Book, a centralised medical records system, e-prescriptions and fast computer network links between NHS organisations. . . Opponents say it is too expensive and will compromise the confidentiality of records. The home affairs committee is looking at whether the UK has become a "surveillance society". . . Government chief information officer John Suffolk told the MPs that setting up a nationwide database going across Whitehall departments and other government agencies would create more problems. He said: "When you work at a national scale, to continue to put more eggs in a single basket is a foolhardy approach." Mr Suffolk added: "The more and more you put it into a large database, with more and more people having access, it becomes more complex... "If we can avoid setting up large-scale citizens' databases, that would be a wise thing to do." The Information commissioner last year warned the UK risked "sleep-walking into a surveillance society". The committee's inquiry will include the impact of identity cards, the expansion of the DNA database and the rise in the use of CCTV cameras."

3.5.78. Crisis over lost data (21 Nov 2007)

The Herald

http://www.theherald.co.uk/features/editorial/display.var.1847285.0.0.php

". . . The breathtaking incompetence of a system by which a relatively junior civil servant could download sensitive material to discs and send them as unregistered post immediately and properly prompted questions about the security of the proposed national identity cards and a central database of NHS patient records. The government suggests the biometric material that will be a component of identity cards will make them much less susceptible to fraud and that much newer technology will provide a safeguard for the patient-record database. Nevertheless, this experience will deepen the anxiety ordinary people feel about the storage of personal data required by these measures. Both should be re-examined carefully in the light of the lessons to be drawn from this calamitous failure of procedure. . ."

3.5.79. A mass movement is needed to tackle the state's snoopers (25 Nov 2007)

The Observer

http://politics.guardian.co.uk/comment/story/0,,2216768,00.html

"Ministers will quickly lose their shame over the missing 25 million files and continue to stockpile our most personal secrets. There's no time to crow over the government's loss of 25 million people's details; no time to rejoice at the obvious mortification of Gordon Brown, Alistair Darling, his sidekick, Andy Burnham, Jacqui Smith and Harriet Harman. These people will not be deterred by the calamity of last week. They are shameless. In a month or two they will bounce back. The ID card scheme will be relaunched and Jacqui Smith will continue with her plans to demand 53 pieces of information from people before they travel abroad. The Children's Index, the Children's Assessment Framework, the National Health database, the ever-expanding police DNA database will all continue to scoop up information. Why? Because the control of the masses is coded in the deepest part of Labour's being. So let me just say it now: the politicians we saw ranged before us on the front bench last Tuesday, like defendants in a mass trial, are dangerous, misguided and incompetent; and they are still in a position to cause havoc. Under a plan known by the reassuringly dull title of Transformational Government, a huge process of centralisation has taken place, creating countless opportunities for security breaches, as well as abuse by the state. At the time, the government defined it as 'transforming public services as citizens receive them and demonstrating how technology can improve the corporate services of government so more resources can be released to deliver "front line" services'. Anyone emerging from this phrase with a clear meaning in their mind deserves an award, but it has resulted in the demonstration of an almost mathematical truth. The larger the database and the more people who have

access to it, the greater the lack of security. Professor Ross Anderson, the leading British expert on this kind of engineering, believes it is impossible to go for scale, security and functionality without one suffering. . . Some 300,000 people will have access to the NHS database. There are already stories about the records of a well-known patient being viewed for entertainment by 50 hospital staff in the North East. 'Imagine a doctor or professor leaving a laptop on a plane that includes the entire nation's health records,' said Anderson. 'It's not impossible.' Indeed, at the last count there had been 14 lapses in major government IT projects in the last two years. It's not just about patient privacy or the outrageous decision by Whitehall to override the need to gain people's consent before their records were uploaded; a failure of the internet or large-scale power cuts could leave hospitals without access to x-rays or medical records. . . Each of us should understand that personal information is exactly that - personal - and that the government has only limited rights to demand and retain it. The scale of its operations and the innate weakness of the systems is a very grave concern to us all. What is needed - and here I hope someone is listening - is a mass movement on the lines of the Countryside Alliance, which goes across all parties and absorbs the skills and expertise of countless activists. Now is the moment to create a movement in defence of our privacy, security and freedom."

3.5.80. Patient 'data may go abroad' (26 Nov 2007)

The Guardian

http://www.guardian.co.uk/uklatest/story/0,,-7102999,00.html

"The Government is reviewing whether sensitive information about NHS patients could be sent overseas for processing, it has been claimed. GPs expressed concerns this would create a "risk to confidentiality" - particularly if records are sent to countries with a different culture of data protection. A leaked internal NHS Connecting for Health document reveals a review is under way into whether patient data could be processed by "approved organisations" abroad, according to IT magazine Computer Weekly. It is understood there are currently no plans to do this. . ."

3.5.81. Fears over NHS patients' records (29 Nov 2007)

BBC

http://news.bbc.co.uk/1/hi/england/bristol/7119075.stm

"Patients' confidential medical records are regularly being accessed by people who have no right to them, research by the BBC has revealed. Figures obtained under the Freedom of Information Act reveal that in the last year there have been several data security breaches in the West. Confidential medical records should only ever be seen by doctors and nurses who are working with the patient concerned, with the government spending some £13bn to digitise the medical records of every patient in Britain. By 2010, the NHS Care Records scheme aims to have an electronic NHS Care Record for all patients. The record will detail the key treatments and care given to each of the NHS's 50 million patients. But in the last year there have been incidents in Gloucester and Cheltenham where staff have shared passwords, giving unauthorised people access to confidential records. At Bath's Royal United Hospital the same type of breach took place while breaches of security also took place in Swindon and Bristol. The North Bristol NHS Trust has reported catching a member of staff looking at friends' records, although they were just issued with a warning. . ."

3.5.82. A spine waiting to snap (4 Dec 2007)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=20&storycode=4116277&c=4

". . . Today I've had a letter from Her Majesty's Revenue and Customs, somewhat apologetic in nature, although not apologetic enough for my liking. . . In the meantime, as these craven letters are being distributed to 12.5 million families, another section of our well-oiled efficient government machine is continuing with its plans to upload the medical records of the entire population to another national database. We have learned to refer to it as the national spine. No one asked for it and there was no demand for it. There is no precedent for it, and no evidence that it can be done or that there will be any benefit from it. . . My personal medical records will not be joining this ludicrous Keystone Cops experiment. Neither will those of any of my patients. It is simply not possible that our government can give us any sort of guarantee that some berk in Birmingham will not download the lot and send it to his DVD rental club by accident. About 2,000 people in Sunderland are relatively well protected,

confidentiality wise, because none of their personal medical details can be divulged without their written consent and my personal supervision - and while I'm not guaranteed to be error free in every department, I'm unlikely to bugger things up on this one. I will be advising my patients to allow me to continue to protect their confidential information, because I trust me and so should they. I trust the national spine as much as I trust Her Majesty's Revenue and Customs. It will go wrong - seriously, drastically, terminally, expensively. But you knew this already." [Dr Phil Peverley]

3.5.83. Blind Data (8 Dec 2007)

Financial Times

http://www.ft.com/cms/s/0/10b0ca14-a532-11dc-a93b-0000779fd2ac.html?nclick_check=1

A civil servant sends a couple of discs containing personal information on half the UK's population through the internal mail and they get lost. Is it reasonable to assume that if those details had not been held on two CDs but on 25m pieces of paper, they might not have been mislaid quite so easily? This widely reported "data disaster" happened just after the government published its response to the parliamentary Health Committee's recommendations about the proposed electronic medical record, a cradle-to-grave medical database available to all NHS staff, currently being piloted in Bolton. In its wake, my unease with the transfer of paper-based medical records on to electronic systems has hardened to distaste because of the threat this poses to confidentiality. Most hospital records are a mixture of paper and electronic records. Some general practices run either paper-light or paper-based medical notes, with some or almost all clinical details stored on electronic records. Currently these are mainly stored locally and are not available to be sent electronically to every other doctor in the UK. But the electronic medical record would mean that our records would be available anywhere, anytime. Supporters of the system say that if you are allergic to penicillin and are found unconscious, then it might be useful to have electronic records instantly available. But this plus point is also a danger. Electronic records are too easy to access and distribute. One of the "problems" with paper records - that they are less transportable - is, in terms of confidentiality, a strength. At least they can be locked away in a cupboard. In the case of unconscious patients and life-threatening allergies, is an electronic record really the answer? If someone is found unconscious, the doctor has to work out their identity before knowing which records to open. Far better for the person to be wearing a device that immediately alerts doctors, such as a bracelet inscribed with the medical information. The General Medical Council states: "Patients have a right to expect that information about them will be held in confidence by their doctors." But the electronic medical record does not allow for this, and it will also operate on an opt-out basis, rather than an opt-in. . . The government argues that there will be "sealed envelopes" on the electronic record, which can store sensitive information - for example, mental health problems or HIV testing - that will only be accessible with consent from the patient. But these envelopes have yet to be tried and tested and, quite astonishingly, contrary to the health committee's recommendations, the government plans itself to access this information to furnish a long-standing database. . . The government's disregard for the need for confidentiality is the reason I will ask for the opt-out code to be added to my medical notes. In my view, the depth and breadth of data capable of being accessed via the electronic record makes the loss of two CDs of bank details look trifling. [Dr Margaret McCartney]

3.5.84. Thousands of staff details leaked (11 Dec 2007)

BBC

http://news.bbc.co.uk/1/hi/england/merseyside/7138426.stm

Thousands of staff have had their personal details leaked after a Merseyside health care trust "accidentally" sent them out. Trade union Unite is calling for an urgent investigation into why Sefton Primary Care Trust sent staff details out to four medical organisations. The blunder includes dates of birth, National Insurance numbers, salary and pension details for all staff. The companies were bidding for services within the trust. The chief executive of Sefton PCT Dr Leigh Griffin, has sent a letter to all staff apologising for the "accidental release of their personal data". The exact number of people affected is not yet known. However the PCT said it would not reveal who the four organisations were due to "commercial confidentiality". Union officials said medical staff were concerned they would be vulnerable to fraud. They have asked all members to take precautions by examining their bank accounts, and changing their passwords. Kevin Coyne, Unite national officer for health, said: "It is disgraceful that an organisation trusted to protect the highly personal and sensitive medical details of thousands of patients can expose their staff in such a dangerous way and then deny them the information of where the information has been illegally sent. This is a clear breach of the data

protection law and if it was an accident, an inquiry must be launched into how and why such sensitive information was passed on to so many external organisations."

3.5.85. Hospital patient records dumped in bin (19 Dec 2007)

Norwich Evening News

http://www.eveningnews24.co.uk/content/News/story.aspx?brand=ENOnline&category=News&tBrand=enonline&tCategory=news&itemid=NOED19%20Dec%202007%2008%3A59%3A30%3A250

"Hospital records containing highly-confidential medical information about scores of sick people have been found dumped in a wheelie bin by a member of the public. The discovery of detailed information on around 30 patients at the Norfolk and Norwich University Hospital has today raised serious questions surrounding patient confidentiality. The shocking findings were made by a woman living in Bowthorpe who found several sheets of information about patients who recently attended the N&N when she went to empty her bin. The documents state the name and hospital number of each patient, along with past medical history, their nursing care while at the N&N and details of discharge plans, next of kin and referrals. Many of those affected by the security breach were very sick with medical history including ovarian, lung, breast and colon cancer, leg amputations, diabetes, liver disease and severe stomach disorders. The Evening News has today handed the documents back to the N&N, who have apologised and promised to launch an immediate inquiry. . ."

3.5.86. Nine NHS trusts lose patient data (23 Dec 2007)

BBC News

http://news.bbc.co.uk/1/hi/uk/7158019.stm

"Nine NHS trusts in England have admitted losing patient records in a fresh case of wholesale data loss by government services, it has emerged. Hundreds of thousands of adults and children are thought to be affected by the breaches, which emerged as part of a government-wide data security review. The Department of Health says patients have been told and there is no evidence data has fallen into the wrong hands. It follows losses of millions of child benefit claimant and driver details. The DoH said the security breaches were being dealt with locally and it did not have details of how many patients were affected. It said investigations were under way and action would be taken against anyone who had failed to fulfil their responsibilities under data protection laws. However, the Sunday Mirror reports that one of the breaches was thought to involve the loss of names and addresses of 160,000 children by City and Hackney Primary Care Trust after a disc failed to arrive at an east London hospital. . . The other trusts involved are Bolton Royal Hospital, Sutton and Merton PCT, Sefton Merseyside PCT, Mid-Essex Care Trust, Norfolk and Norwich and Gloucester Partnership Foundation Trust. Maidstone and Tunbridge Wells NHS Trust has reported two breaches meaning that 10 cases have occurred in total. The East and North Hertfordshire Trust reported a loss but has since found its missing data. One set of data, that reported lost by Gloucester Partnership Foundation Trust, consisted of archive records relating to patients treated 40 years ago - none of whom is still alive. . ."

3.5.87. Government in new data loss fiasco (23 Dec 2007)

Guardian

http://www.guardian.co.uk/uklatest/story/0,,-7174538,00.html

"Ministers have been plunged into another data loss storm after nine NHS trusts admitted losing patients' information. Hundreds of thousands of people are thought to have been affected by the breaches of strict data protection rules by the health service. Critics said the disclosure raised fresh questions about the Government's handling of confidential personal data and the future of a new centralised IT system for the NHS. It follows anger at the loss of child benefit claimants' details by HM Revenue and Customs (HMRC) and those of three million learner drivers by a DVLA contractor. Richard Vautrey, deputy chairman of the British Medical Association's GPs' committee, suggested the Government was not serious enough about data security. "Patients need to be absolutely confident that the information that is held securely cannot be lost in some haphazard way as appears to be the case today," he told the BBC. He said the development was especially worrying given the Government's plans for a centralised NHS computer network, Connecting for Health, featuring every patient's records. . ."

3.5.88. NHS 'can be trusted' over records (24 Dec 2007)

BBC News

http://news.bbc.co.uk/1/hi/uk/7158688.stm

"The NHS can be trusted to handle patient information despite the loss of 168,000 patient records by nine trusts, its chief executive has said. The Tories want a planned database of 50m patient records to be reconsidered. . . Mr Nicholson said the level of security for the proposed new database system would be way beyond, for example, the level currently in internet banking. "This is a very high level of security. There isn't going to be a huge national database," he said. "What we're talking about is a series of regional databases that are connected together." Shadow health secretary Andrew Lansley said the data loss was further evidence of the government's failure to protect personal information. . . BBC News political correspondent Reeta Chakrabarti said Mr Nicholson was saying the government's plans for a national database were not what the Conservatives were saying it was. A series of regional databases linked together did not sound all that different from what the Tories were themselves suggesting, she added. . ."

3.5.89. Privacy tsar warns over data losses (24 Dec 2007)

Guardian

http://politics.guardian.co.uk/publicservices/story/0,,2232094,00.html

"The series of data security breaches that has seen the personal details of tens of millions of people lost is pushing Britain to a "tipping point" over how such records are handled, the information commissioner has warned. Richard Thomas demanded "clearer accountability" and responsibility from organisations holding personal records following the loss of files by government departments and public bodies. He was speaking as the NHS chief executive, David Nicholson, insisted that patients' medical records were not at risk after it emerged that nine health trusts had lost the records of 168,000 people. . . Thomas, in a veiled criticism of the government, said failure to keep personal information secure put organisational credibility at risk and undermined public confidence and trust. "Right across the piece people here have got to take personal information a great deal more seriously. In the last few months people have got to a tipping point where they are suddenly taking data protection far more seriously," Thomas told the BBC. "What this has brought home to everybody is the importance of clear accountability and responsibility to make sure to get it right." He warned data protection was about "credibility" and not just complying with the law. The loss of medical records was "particularly sensitive" given the confidentiality enshrined in the doctor-patient relationship, he said. Thomas has raised concerns with NHS managers about the government's Connecting for Health project, which is intended to make patients' records accessible by computer to NHS professionals across the country. "They have got to be absolutely certain they have identified all the risks and are managing these very carefully indeed. Any mass loss of data from centralised databases would be very catastrophic, but medical information is of particular sensitivity," he said. Nicholson insisted that Connecting for Health would rely not on a single centralised database, but on linked regional databases, which he said would enhance security. Clinicians and other NHS employees would be able to access details only with a secret user name, password and smartcard, and access would be "role-controlled" so that each user saw only a relatively small number of patient records relevant to their specific area of work. . . Professor Ross Anderson, a computer security expert at Cambridge University, criticised systems allowing an entire database to be accessed by one individual. "The question is not whether the data was encrypted or password-protected but the deeper question of why is it that somebody has access to 160,000 children's records. Surely that's not right." The NHS revelations prompted the Tory shadow health secretary, Andrew Lansley, to call for the planned single database of 50 million patient files to be scrapped in favour of a network of local ones."

3.5.90. GPs' electronic records to go live despite data loss (7 Jan 2008)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4116654&c=2

"Electronic patient records held by GPs are to be made available to hospital staff for the first the first time this month, just weeks after the NHS had to admit losing hundreds of thousands of patient records. Moves to press ahead with the rollout of the Summary Care Record came as a pressure group claimed 200,000 people were already preparing to opt out of the programme because of fears over

confidentiality breaches. More than 110,000 patient records in Bolton and Bury have now been uploaded to the spine. Staff working for local out-of-hours providers already have access to records, and A&E staff at the Royal Bolton Hospitals will follow 'within weeks.' But patient concerns over confidentiality have been heightened after nine NHS trusts admitted losing data on hundreds of thousands of patients. . ."

3.5.91. Patient confidentiality and central databases (Feb 2008)

British Journal of General Practice (Ross Anderson)

http://www.cl.cam.ac.uk/~rja14/Papers/bjgp.pdf

"2008 may be the year when GPs find themselves in the firing line over confidentiality, as ever more patients try to opt out of 'the NHS database' and the Government tries ever more desperately to keep the project on track. But I believe this should not be seen as a problem, but an opportunity - a once-in-a-lifetime chance to make a decisive change. GPs, by acting as the patient's advocate, can not merely retain patients' trust and defend their professional autonomy, but also rescue health policy from a serious wrong turn. Public concerns about the centralisation of health data have grown in recent years, especially since the press took up the issue in 2006. In November that year, a poll revealed that 53% of patients opposed a central medical records database with no right to opt out [1]. At the same time, a report for the Information Commissioner (of which I was an author) described government plans to share health information on children widely with other services, including social services, schoolteachers and the police. It concluded that the proposed measures were both unsafe and illegal [2]. In September 2007, the House of Commons Health Committee called for more information to be published on the proposed design, and for data placed in 'sealed envelopes' to be withheld from the Secondary Uses Service (SUS) - a suggestion that the Department rejected . . . Several national databases of identifiable health information already exist, ranging from the Prescription Pricing Authority's records of all prescriptions to SUS which contains identifiable data on finished consultant episodes in secondary care and from which the Health Committee believed patients should be entitled to opt out. Other national services have recently been built, such as the Picture Archiving and Communications System that centralises the storage of digital X-rays, and there are many plans for further data sharing in the public sector: the children's databases described above are to be followed by similar systems for the elderly and the mentally ill. Without robust consent procedures and effective opt-outs, these systems will make it increasingly difficult for a patient to get any kind of NHS care without appearing on central databases. . . Britain needs to turn over a new leaf in healthcare IT. As in the Netherlands or Sweden, central government should restrict itself to setting standards for interoperability and maintaining an approved product list. GP Systems of Choice are a useful step in the right direction, but we need a real transfer of power away from the centre and to the people in the best position to tell suppliers what new systems should do. That means local rather than central purchasing - and by the practice or hospital, not the PCT. This is how things are moving overseas: no country is as centralised as the UK, and almost everywhere there is more progress. . ."

3.5.92. Security fears on missing NHS smartcards (6 Feb 08)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4117088

"Thousands of NHS smartcards have already gone missing, raising fresh fears over the security of patient data held online, a Pulse investigation reveals. After requests to hundreds of NHS bodies under the Freedom of Information Act, Connecting for Health revealed 4,147 smartcards had been reported missing – 1,240 last year alone. At least 142 have been stolen, including 17 in one area – Hammersmith and Fulham PCT. Smartcards have now been issued to 438,314 NHS staff, although the number of users is eventually expected to top 1.2 million. Information obtained by Pulse suggests the number of missing cards could be higher than NHS chiefs admit. Among 221 NHS bodies replying to FOI requests, 2,887 cards were reported missing, including 1,400 last year alone. Extrapolating from this, the number of missing cards would be closer to 6,000. Connecting for Health insisted its data is accurate, with multiple reporting explaining the discrepancy in the figures. Either way, Pulse's investigation shows an alarming lack of attention to security. In almost every case, lost or stolen smartcards were reissued automatically without investigation, and no disciplinary action has been taken against any staff member. One trust in 10 admitted it had no idea how many cards had been lost or stolen. Professor Ross Anderson, a security engineering expert at the University of Cambridge, said: 'You can't expect stuff to remain confidential if a few hundred thousand people have access. There will

be several hundred at any time who've lost their smartcards and thousands who leave terminals logged on or share cards in other ways. 'There just isn't either the culture or incentives for trusts to investigate data compromises properly.' A Connecting for Health spokesman said: 'As soon as a smartcard is reported lost it is disabled. It cannot be used by anyone finding it without a six-digit pin number, which is issued directly to users.' This week a BMA poll found that nine out of 10 doctors have no confidence in the Government's ability to safeguard patient data online."

3.5.93. Who Do They Think We Are? (Feb 2008)

Centre for Policy Studies

http://www.cps.org.uk/cpsfile.asp?id=995

". . . NHS computerisation: a study of the failure of personalisation: The Government's scheme for 'personalisation' of the NHS through a central database demonstrates the enormous practical and ethical difficulties inherent in such projects. Described by the National Audit Office as "wider and more extensive than any ongoing or planned healthcare IT programme in the world...the largest single IT investment in the UK to date", the scheme was launched in 2002 and has already cost more than £2 billion (of an estimated £12 billion). Yet according to the Public Accounts Committee it is already two years behind schedule with no firm implementation date. The medical profession has expressed unease about the risks to patient privacy. A poll for The Guardian in November 2007 found that 59% of GPs in England would be unwilling to upload any record onto the database without the patient's specific consent. Three quarters of doctors surveyed said that medical records would become less secure on the proposed database. More recently a survey for The Times found that more than three quarters of doctors are either 'not confident' or 'very worried' about the possibility of data loss from the proposed database. When asked how well they thought that local NHS organisations would be able to maintain the privacy of data, only 4% of doctors said 'very well.' The majority, 57%, said quite or very poorly. Members of the British Medical Association are currently supporting a campaign to encourage patients to opt out from the database. A pro forma letter has been produced for patients to send to their GPs to stop their records being included on the new system. This follows much confusion and uncertainty over likely consent arrangements. Following opposition to an 'opt-out' system, the current proposal from the Department of Health is for a hybrid system where patients will have to 'opt-out' from the Summary Care Record (containing basic information) and 'opt-in' for more detailed records to be uploaded. Concerns over access to these potentially sensitive health records were fuelled when the director of IT implementation at the Department of Health told a Select Committee that "you cannot stop wicked people doing wicked things" with information and admitted there are occasions when staff "misuse their privileges" with data. It was recently reported that more than 50 members of an NHS hospital's staff had illicitly viewed the medical records of a celebrity, adding to concerns about the potential misuse of a national database. Meanwhile the Government Chief Information Officer John Suffolk has echoed the concerns of the Information Commissioner: The more and more we put it into large databases where more and more people have access to it, it becomes more complex. I think there is a balance to be struck, but clearly what we want to avoid doing is creating yet another large-scale citizen database when we have a number of those already because that would not be a wise thing to do. . ."

3.5.94. NHS database must go ahead, say MPs (25 Feb 2008)

Computing

http://www.computing.co.uk/computing/news/2210437/nhs-database-ahead-say-mps

"The chairman of the House of Commons Health Committee has brushed aside the confidentiality fears that have delayed the £12.5bn NHS summary care record database plan. Labour MP Kevin Baron attacked medical professionals for propagating "palpable nonsense" in suggesting the government will profit by selling the intended 60 million health records to pharmaceutical and insurance companies. He also accused the British Medical Association (BMA) of "scaremongering" with claims earlier this month that people were wrongly accessing records through the network. "My issue with some BMA members is that that is not a reason not to go ahead with using IT to bring health into the 21st century," he said in a Westminster Hall debate last week. "I am not a clinician, but one could well argue that not having a central database could be a matter of life or death." Baron said it was not going to be possible to stop all unauthorised access to patient records. But "sadly" the problem affects manual records now, he said. Patients have to accept that "people other than the doctor are likely to access some of their records for purposes of looking after their interests", said Baron. The question is what action should be taken against fraudsters. Barron argues in favour of the plan for electronic "sealed envelopes", within

the record, containing information the patient wanted to keep confidential. Health Minister Ben Bradshaw said the government "strongly supports the committee's recommendations about having stiffer penalties for breaches of the Data Protection Act." He blamed delays "pretty much entirely because we took extra time to consult on and try to address record safety and patient confidentiality." Patients will have the right to see their summary care record, and challenge and correct any errors, he said."

3.5.95. We don't need a high-tech Domesday Book (25 Feb 2008)

Daily Telegraph

http://www.telegraph.co.uk/opinion/main.jhtml?xml=/opinion/2008/02/25/do2504.xml

". . . Until very recently, it was a central tenet of government that data held by one department should not routinely be available to another. Indeed, many Acts of Parliament specifically outlaw data sharing because of concern that the state would be able to obtain a comprehensive picture of an individual's life when it had no need to. Yet these considerations have simply been brushed aside in the past few years, and anyone questioning why this is happening is regarded as a conspiracy theorist or a Luddite. There is now an assumption that the state should know everything about us and be able easily to access that information. This is justified as being good for us because it facilitates the provision of services that may be to our advantage, and on the grounds that anyone who is unhappy with the prospect must have something to hide. It is in the nature of states to want to obtain and store information about their citizens. They have been doing so since the year dot in order to tax them; but retaining vast amounts of detailed personal and private information has been nigh on impossible in any democratic state. Totalitarian ones have been more successful, relying on spies and bureaucrats to keep their records up to date. But information technology now allows democracies to collect and keep the sort of data about us all that more malign regimes of recent history would have killed to possess, and possessed to kill. Simply because the technology is available does not mean that the central issues of personal freedoms and privacy have gone away. If anything, they are more important than ever. The blithe acceptance that our identity is something that the state should possess, in the form of our DNA or fingerprints or iris biometric or health records, is misguided, though there will clearly be times when it is to our benefit that it should. . . Then there is the NHS computer system that will enable our electronic health records to be accessed centrally, which sounds like it must be a good thing until you consider the implications for people's faith in the confidentiality of the consulting room if the wrong people see the information. In a recent poll of GPs, more than 90 per cent said they were not confident patient data would be secure. Furthermore, none of them was asked before the Government decided that it was going to make our most intimate information readily available and many are opting out of the system. Why did ministers not look at the opportunities provided by IT from the other direction, from the point of view of the individual? Instead of spending £12 billion to upload all our health records to an insecure national database, or to a centrally accessible "spine", we could each be issued with a card, which we would keep for ourselves, and every time we visited the GP or a hospital, the details of our consultation would be downloaded from the doctor's computer. We would then be free to carry it with us - or not to, as we chose - wherever we went and the information would be kept between us and our GP. This would be less intrusive, far less expensive, would mean we "owned" our private information and would meet one of the often-overlooked requirements of liberty, which is the right to be private. What we are now witnessing with this explosion in the number of centrally controlled databases is the development of something awesomely intrusive, the creation of a gigantic high-tech Domesday Book to take down all our particulars and track us from cradle to grave. If by rejecting any notion of a universal DNA database, the Home Office now recognises there is a line to be drawn, then that is to be welcomed. The debate we need to have is not about how to expand the database state but what we can now do to limit and reduce it."

3.5.96. Police to be allowed searches of national database of NHS patient records (28 Feb 2008)

Computer Weekly - Tony Collins IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/02/police-will-be-allowed-searche.html#more

"News analysis: It went largely unnoticed but the minister for the NHS's National Programme for IT, Ben Bradshaw, has confirmed that data on a central database of millions of confidential health records will be made available to police where there is an "overriding public interest". The phrase "overriding

public interest" is not defined. Some people will say "So what? If police can better protect us by accessing health records we should be grateful the technology is now being provided". Others may say that allowing police access to the national electronic database of patient records information is a step towards allowing access to other public authorities, such as social services; and later on private organisations, including employers and insurance companies. Officials at the Department of Health would argue that every access to the records leaves a flag in the audit trail. But we will be reporting on evidence shortly that NHS staff may not have the time to check increasingly long audit trails of electronic healthcare records. . ."

3.5.97. Patient database open to access by non-qualified NHS staff (29 Feb 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/02/29/229636/patient-database-open-to-access-by-non-qualified-nhs.htm

"A new national database of confidential patient records is being opened to access by NHS staff who need no professional qualifications - despite official assurances that records will only be accessed by specialists who are providing care or treatment. A document obtained by Computer Weekly under the Freedom of Information Act also provides evidence that NHS Connecting for Health - which runs part of the £12.4bn National Programme for IT [NPfIT] - has quietly decided to weaken assurances given to patients about the confidentiality of records. Doctors are angry because they say that patients were given an assurance that non-clinical staff would be unable to access the national summary care record database which is being trialled at NHS trusts in various parts of England. The document from Bolton Primary Care Trust, the first of the trial sites, says that patients were mailed leaflets informing them about the summary care record, a national database which will include the names of patients, medication history, serious illnesses and allergies. The leaflets being used in the "early adopter" trials at Bolton and at other sites tell patients the benefits of having a national database but also give them the option of "opting out" of having their records uploaded. One gave specific assurance to patients that receptionists will "not need to see your full clinical records". But after the leaflets were mailed to thousands of patients it was discovered that receptionists at Royal Bolton Hospital's Accident and Emergency department had been looking at the patient records, then printing them to add to the casualty record card. GPs involved in a trial of the NPfIT summary care record said they did not want receptionists to see clinical files unless patients were contacted again and told of a change of plan. Bolton Primary Care Trust has decided to change the procedure at hospitals to allow healthcare assistants - sometimes called nursing auxiliaries - to view the care records database instead of receptionists. But GPs say healthcare assistants usually have no professional qualifications and are not clinical staff treating patients. Paul Cundy, spokesman for the British Medical Association's GP IT committee said the papers obtained by Computer Weekly showed there has been an "erosion of the confidentiality of patient records that we feared would happen". He said that healthcare assistants were in essence "trained receptionists"."

3.5.98. Healthcare assistants' access to SCR defended (4 Mar 2008)

e-Health insider Primary Care

http://www.ehiprimarycare.com/news/3522/healthcare_assistants'_access_to_scr_defended

"Connecting for Health has defended the decision to allow healthcare assistants to access Summary Care Records (SCRs) in accident and emergency departments. Royal Bolton Hospital's A&E department has been criticised by BMA IT representative Dr Paul Cundy after a document, released under the Freedom of Information Act, revealed that healthcare assistants are asked to print out SCRs for clinicians. Dr Cundy, chairman of the BMA's GP IT committee, told the BBC's Today programme that such a practice "breaches all common concepts of privacy and confidentiality." However, Dr Gillian Braunold, CfH's clinical director for the SCR, claimed the policy had been approved by the SCR Advisory Group, which includes BMA membership. . . Dr Braunold said CfH did not dictate to NHS organisations which groups of staff should access records, leaving it to local organisations to decide for themselves following their own information governance procedures. . . When GPs in Bolton discovered that receptionists were printing out records for clinicians in the A&E department, they demanded that the PCT write to patients again to tell them of the change in plan. The PCT decided to change the procedures to allow health care assistants to print out the records. , , Dr Cundy told EHI Primary Care that it was unacceptable for patients to be told that only clinicians would access their record sand then for that position to change within a few weeks of the early adopter site going live. . ."

3.5.99. FOI papers reveal more lessons from Bolton NPfIT trials (19 Mar 2008)

Computer Weekly - Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/03/foi-papers-reveal-more-lessons.html

Papers released by Bolton Primary Care Trust under the Freedom of Information highlight some of the lessons learned from its trial of the NPfIT summary care records system. . . "Officials were surprised by the number of leaflets on the summary care records which were returned because the recipients had changed address - which increases the risk of patients having their medical information uploaded to the data "spine" without their knowledge or consent. The papers say that the returned mail was "a lot larger than anticipated" - up to 3%. . . "If a search is performed for any patient on CSA [the clinical spine application which allows NHS staff controlled access to the national Care Records Service], the software will give consent status as "Implied Consent". For any patient who [is] not yet part of SCR early adopters, this is incorrect, as implied consent implies they have been informed about SCR. . . GP systems continue to be affected by performance issues, and the source of these performance problems is still to be totally identified and resolved. . . Local public reaction is really unpredictable at present [to the summary care record] but is likely to be mixed. . . There are many duplicate records within the Adastra [out-of-hours] system run by Bolton Out of Hours. If OOH continue to generate duplicate records there is a risk that Summary Care Records usage may be impacted as there will not be easy access to NHS number, if original record is not found." Separately Bolton has reported "excellent progress" on its trial of the summary care records.

3.5.100. CfH says SCR audit trails 'clunky' (25 Mar 2008)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/3585/cfh_says_scr_audit_trails_%E2%80%98clunky%E2%80%99

"Connecting for Health has acknowledged the audit trail facility in the first Summary Care Record pilots 'has been clunky', after minutes from the board of Bolton PCT expressed concerns over the functionality. Problems are reported with the time required to review audit trail alerts - created by the SCR system. In official minutes, a member of Bolton PCT's SCR board branded the amount of time required to use the audit trail functionality as 'ridiculous'. The ability to track and review who has viewed a patient's summary record is one of the key security features of the SCR. According to papers released by Bolton PCT under the Freedom of Information Act to Computer Weekly magazine, the PCT, one of the SCR early adopter sites, had difficulties keeping up with alerts on its audit trails. The magazine reports the board papers saying: "[Name unknown] is having to put a lot of time into this task and, at the moment, we do not have all that many alerts coming in as the system is not being used to its full potential yet. [Name unknown] felt that the audit trail is ridiculous and asked how they hope to be able to manage it nationally. "[Name unknown] informed the group that NHS Connecting for Health had envisaged that this task would take one day per week for each primary care trust which [name unknown] pointed out is still a great deal of time. At the moment it is taking [name unknown] around an hour to look at 10 alerts." CfH's clinical director of the SCR, Dr Gillian Braunold, told EHI Primary Care that the audit trail facility was not yet working in the way that she hoped it would. . ."

3.5.101. 290 patient safety incidents reported under NPfIT scheme (25 Apr 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/04/25/230450/290-patient-safety-incidents-reported-under-npfit-scheme.htm

"NHS trusts have reported nearly 300 incidents that put patients' safety at risk since 2005, when the National Programme for IT began systematic records. The disclosure provides evidence that new IT systems in the health service can put the safety and health of patients at risk if they fail or are used wrongly. Maureen Baker, national lead for clinical safety at NHS Connecting for Health, revealed the incidents at a conference in Harrogate. "We have had just under 300 incidents in two and half years," she said. "They cover just about every area that CfH has activity in." It has also emerged that ministers launched the NPfIT in 2002 with no formal structure for identifying incidents that could affect patient safety. Many of the incidents reported under the safety scheme centre on radiology information systems and picture archiving and communication systems (Pacs), which allow digital X-ray images to be stored, retrieved and distributed to computer screens. One incident involved two NHS trusts that had

connected Pacs systems. Both used similar ID numbers to store and retrieve images, but some numbers were duplicated, so sometimes a correct number would retrieve the wrong X-ray image. There have also been incidents of drugs "mis-mapping", which could lead to the wrong drugs being given, or a clash of medication occurring. NHS Connecting for Health, which runs part of the national programme, put a new structure for reporting incidents into place only after DNV consulting compiled a highly critical - and unpublished - risk assessment of the safety of the NPfIT in 2004. Speaking at the HC2008 conference, Baker said there had been a big improvement in mechanisms for reporting incidents and dealing with them since 2005, three years after the launch of NPfIT. . . Last year the partner of a patient who died in hospital complained to the General Medical Council that X-rays on a Pacs system may have been mixed up. She told Computer Weekly she is waiting for a date for a judicial review over whether there should be a fresh inquest. It is not known whether this was one of the 290 incidents that put patients' safety at risk. . ."

3.5.102. Urgent review of SCR consent model recommended (6 May 2008)

e-Health Insider

http://www.e-health-insider.com/news/3720/urgent_review_of_scr_consent_model_recommended#c8841

"The independent evaluation of the Summary Care Record has recommended an urgent review of its implied consent model and questioned whether a national system should be rejected in favour of a series of linked smaller systems. The 138 page report on the SCR early adopter programme raises a series of issues to which it recommends that Connecting for Health pays urgent attention, including a review of the existing consent model. In response Connecting for Health has promised that the SCR Advisory Group will urgently consider the report's findings. A statement from CfH adds: "The report provides a number of important learning points, particularly on the question of patient consent to use the Summary Care Record, and the need to retain a clear focus on the purpose and scope of the Summary Care Record as it is implemented." The evaluation team from University College London, led by Professor Trisha Greenhalgh questioned the continued use of the existing consent model which allows initial SCRs to be created on an implied consent basis after patients have been sent information about the SCR programme and their right to opt-out. The report says its own investigation confirmed the findings of an early adopter practice which withdrew from the programme after conducting its own survey which concluded that patients remained ignorant of the basic issues despite receiving information. It said that in more than 100 interviews conducted with patients a high proportion did not recall having received information about the SCR or HealthSpace despite an extensive public information programme. The report adds: "The fact that much of the individual resistance within GP practices has come not from IT-ignorant 'laggards' but from Caldicott Guardians who are generally the most information-literate members of staff and certainly the formal custodians of the practice's data adds weight to the argument that the current consent model should be urgently reviewed." The evaluation team recommends that the SCR Programme Board and Advisory Group should look particularly at the 'consent to view' model which is used by both Scotland and Wales and means patients must give their explicit consent to view the record at each encounter. . . The evaluation report raises a series of questions about several other key aspects of the SCR programme. It said there was some resentment among PCTs that CfH allegedly pushed forward on a tightly-managed and largely non-negotiable timetable for implementing the SCR despite the fact that not all software contractors had delivered key technologies to agreed schedule. The report also states that although the technical security measures of the SCR appeared to meet high standards "there remain unresolved questions raised by experts about whether a series of linked smaller systems would be safer than a large single system and whether the plans for operational security will be fully enforceable in the busy environment of the NHS." The UCL team also criticised the SCR team within CfH for taking what it described as a narrow focus on implementing technology rather than a broader focus on socio-technical change. . ."

3.5.103. NHS puts brakes on electronic record system - In the face of criticism (14 May 2008)

Silicon.com

http://www.silicon.com/publicsector/0,3800010403,39221435,00.htm

The NHS has pledged to halt the further roll out of its electronic patient record system while it takes stock of criticisms in a report. A report evaluating the trial rollout of the Summary Care Record (SCR) system highlighted concerns that the system was clunky, interfaces poorly with other systems and was

being foisted upon patients without their full knowledge. Connecting for Health (CfH), the NHS body responsible for delivering the £12.7bn overhaul of NHS IT including SCR, says the system will not be rolled out until an advisory group reviews any changes that are needed in light of the report. The University College London report found that about 610,000 patients had been approached about being placed on the system in the four trial areas it looked at and that while most staff were broadly enthusiastic, SCR was widely seen as too complex and that some had given up on using it "until it works better". There was resentment among some staff that CfH had forced a tightly managed timetable on the primary care trusts for implementing SCR "despite the immaturity of the technical solutions". A spokeswoman for CfH admitted that one GP's surgery had given up on using the system. She said: "SCR will continue to be implemented in the early adopter areas, although they will not be rolled out beyond these areas until the Summary Care Record Advisory Group has considered the findings of the report and decided what, if any, changes need to be made to the SCR programme." The British Medical Association says the SCR breaches confidentiality as currently patients' details are put on the system unless they opt out and backs the report's recommendations to change the ability to opt out. . .

3.5.104. Politics pushing NHS scheme (15 May 2008)

Computing

http://www.computing.co.uk/computing/analysis/2216611/politics-pushing-nhs-scheme-3999326

Early adopters felt under pressure as Connecting for Health pushed the project forward to meet targets. An influential report into the Summary Care Records (SCR) component of the £12.4bn NHS National Programme for IT (NPfIT) suggests that political agendas are still affecting rollout of the scheme. . . Although the report was focused on SCR, the wider political context has been hard to ignore, according to report author Trisha Greenhalgh. The study found that early adopters felt under pressure as Connecting for Health (CfH), the NHS agency responsible for rolling out NPfIT, pushed the project forward to meet targets. "If you make unrealistic expectations, people just aren't physically capable of finding the time to do the things you're asking of them, and that means they will resent the project," said Greenhalgh. Scepticism in the clinical community means that CfH must consider the report findings carefully. But political pressure to keep the already delayed project on time and on budget means CfH must exert a certain amount of pressure on all parties to keep the scheme moving, said Greenhalgh. The same dilemma applies to another controversial part of the scheme - the consent model of the summary care records. The current model means that those who do not opt out of the scheme implicitly agree to have their records shared with any clinician but people in early adopter sites did not understand the implications, according to Greenhalgh. . . The case-by-case model is used in Wales and switching plans would require a degree of technical refitting by CfH. But this is a workable and necessary solution, according to Chaand Nagpaul, of the British Medical Association's GP prescribing committee. "The model of implied consent is not fit for purpose. It is possible to modify the model and this is the line that should be taken," he said.

3.5.105. GPs vote to halt Care Record Service development (16 Jun 2008)

e-Health insider

http://www.e-health-insider.com/news/3851/gps_vote_to_halt_care_record_service_development

GP representatives overwhelmingly backed a motion to call a halt to development of the NHS Care Records Service at the BMA's annual Local Medical Committees conference on Friday. LMC representatives backed a motion expressing no confidence in the government's ability to store electronic patient records safely. They also backed calls to support patients who wish to opt-out of the Summary Care Record (SCR), and a motion calling for a halt on any further development of plans to develop Care Records Service plans. Proposing the motion was Dr Mike Ingrams of Hertfordshire LMC, who told the representatives: "In view of the government's unparalleled reputation for not being able to store records safely, the GPC must put a halt on any further development of a centrally-held patient record and promote locally held interconnected storage instead." Sections of the audience agreed with Dr Ingram's calls with many shouting 'Hear, Hear'. Other LMC members also backed the proposals, calling for the BMA to stop working with the government on development of patient systems until security promises were fulfilled. A call for the BMA's General Practitioner Committee (GPC) to boycott working with the government until all concerns about consent and confidentiality are addressed was rejected. . . The audience also voted to continue to follow BMA policy that no patient

medical data should be added to the national database without patient consent and pledged to continue to encourage GPs to support patients should they wish to have their details withheld from the Spine. . .

3.5.106. 30,000 NHS records lost as seven laptops stolen (18 Jun 2008)

Daily Telegraph

http://www.telegraph.co.uk/news/uknews/2151996/30%2C000-NHS-records-lost-as-seven-laptops-stolen.html

Laptops containing the personal details of more than 30,000 NHS patients have been stolen in two separate thefts. Sensitive data was been stored on laptops in defiance of rules; 30,000 NHS records lost as seven laptops stolen. More than 20,000 records were held on computers stolen from a south London hospital. In Wolverhampton, a laptop holding details on around 11,000 patients has been stolen. The missing data includes names, addresses, NHS numbers and, in the Wolverhampton theft, personal medical histories. In both cases, sensitive data had been stored on laptops in defiance of rules that are meant to protect such records from theft or loss. The disclosures follow the revelation earlier this week that Hazel Blears, the communities secretary, had stored confidential Government files relating to counter-terrorism on a laptop that has since been stolen from her constituency office. Of the two NHS thefts, the incident in Wolverhampton appeared to be the more serious, since the computer concerned contained detailed medical records and was not protected by any form of encryption. The laptop concerned was stolen from the car of an unnamed GP, according to Wolverhampton City Primary Care Trust. Some 11,000 patients have now been sent letters apologizing for the incident. . . In London, thieves stole six laptops from St Georges Hospital in Tooting. Three contained the first and last names, date of birth, postcode and hospital number of around 21,000 patients. The theft took place between 6 and 9 June, but St George's Healthcare NHS Trust only made the incident public yesterday. In an internal email to its staff, the St Georges trust said he "acknowledges that patient data should not have been stored in laptops." The laptops had been used as temporary storage, it said. Hospital managers said the patient data was protected by passwords and held in "hidden" files. . ."

3.5.107. Private companies could get access to millions of NHS medical records (20 Sep 2008)

Daily Telegraph

http://www.telegraph.co.uk/news/newstopics/politics/health/3022434/Private-companies-could-get-access-to-millions-of-NHS-medical-records.html

"The Government is considering giving firms access to a massive computer database which will contain the records of almost every man, woman and child in England. The information is a goldmine for private companies, who could use it for medical research or for helping them to sell products to the NHS. But privacy campaigners say they are "horrified" by the proposals which could see patients' postcodes, medical conditions and treatments - and in some circumstances, their names - passed on to third parties without their consent. The database, part of a long-delayed scheme to give NHS staff access to computerised medical records, will hold details of almost all visits by patients to hospitals and GPs. The plans have been dogged by controversy. Last week. ministers gave in to pressure from privacy campaigners and agreed that medics will have to gain the consent of patients before opening their computer records. Yet patients will have almost no control over the same information being passed on to companies and other bodies outside the NHS. The Department of Health says most records passed onto third parties would be made anonymous, but admits that identifiable data - which could include patient names - could also be handed on if it was deemed to be more useful. Security experts said the scheme would "hoover up" vast quantities of confidential data which could easily be traced back to individuals, whether or not names and addresses or other personal details were removed. Ross Anderson, Professor of Security Engineering at Cambridge University, said: "We have had a lot of debate about patients being able to opt out of the national scheme for patient records, but meanwhile the Government have pulled a fast one. There are no limits set on the way this data can be used; this database will hoover up all the personal medical data on every person, and it can be used for whatever the Secretary of State says it can be used for." . . . The Government public consultation on secondary uses of NHS data, which began without publicity on Wednesday, has been outsourced to a private company called Tribal, which holds contracts to organise the planning of NHS services. Its managing director Matthew Swindells was until recently chief information officer of the DoH, and before that adviser to then health secretary Patricia Hewitt. A spokesman for Connecting for Health, the government agency which oversees the patients records scheme, said that while "in theory"

anonymised data could be used to trace an individual, researchers would be more likely to examine records in batches of hundreds of thousands at a time. He described the matter of whether information should stay within the health service, or ever go outside for research - to academic researchers or pharmaceutical companies - as a "valid question" on which the consultation sought public opinion. The agency's chief operating officer, Professor Michael Thick, said patients would be able to be removed from the so callled "secondary use" database if they made an application under the Data Protection Act. Under the proposed system, third parties would need to request information from the central database, and fulfil requirements set by data custodians and ethics committees."

3.5.108. Consent to view explored for detailed records (23 Sep 2008)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/4170/consent_to_view_explored_for_detailed_records

The new consent to view model for the NHS Summary Care Record in England may also be applied to the detailed care records held by NHS organisations. NHS Connecting for Health is to explore how the principle of 'consent to view' - announced as the new model for the SCR last week - could work when patients' detailed care records are accessed. Dr Gillian Braunold, clinical director for the SCR, said the consent to view principle was being explored for cases in which information generated and held by one organisation was made available to another. It would not apply to records generated and held within one organisation. "The principle of whether or not you could bring in consent to view before you look at records, when you wouldn't normally expect the information to be available, is what is being explored." The current consent model for detailed care records means patients must give their explicit consent for information to be uploaded, but not for it to be subsequently viewed. South West Essex Primary Care Trust, the sixth early adopter site for the SCR, which has yet to go live, has already said that the consent model for detailed care records held by SystmOne must align with the consent to view model for the SCR. Dr Braunold also told E-Health Insider and E-Health Insider Primary Care that she hoped the first hospitals would be able to upload discharge letters to the SCR at the end of the year. The software would include sealed envelope functionality to allow hospitals to withhold information that patients did not want uploaded. CfH is also working with out-of-hours IT provider Adastra to enable information from out-of-hours encounters to be uploaded, she said. The information uploaded to the Spine for the SCR from GP records will remain medicines and allergies. However, GPs will have discretion to add significant past medical history. In the future, Dr Braunold said England hoped to follow Wales in introducing an 'exclusion dataset' that would mean particularly sensitive information, such as details on HIV, sexually transmitted diseases and terminations, could not be inadvertently sent to the SCR. The technical amendments needed for the SCR are due to be delivered through BT's Clinical Spine Application in release 2008b, which will be in place before Easter 2009, according to Dr Braunold. The SCR is due to be rolled out nationally in 2009-10.

3.5.109. NPfIT minister was wrong in reply on records leaving NHS (10 Nov 2008)

Computer Weekly - Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/11/npfit-minister-is-wrong-in-his.html

"The minister in charge of the National Programme for IT [NPfIT] has given an incorrect reply to a Labour MP who asked in the House of Commons about a disclosure on this blog that 300 million confidential patient records have left the NHS for an academic organisation. Ben Bradshaw, the minister in charge of the NPfIT, was unwittingly incorrect when replying to a question by a Labour MP, David Taylor, who is a former IT manager. Computer Weekly had revealed that nearly 300 million confidential medical records have transferred officially from the government to an academic organisation outside the NHS. But in the House of Commons on 4 November 2008, Bradshaw gave the impression to David Taylor that all the records were anonymized before leaving the NHS. This is incorrect. The Patient Information Advisory Group, a statutory body, has authorised an academic organisation outside of the NHS, the Dr Foster Unit, to receive patient-identifiable information. The Dr Foster Unit has received patient-identifiable information on nearly every stay by patients in hospitals in England, and visits to an accident and emergency department. Also within the patient records transferred to the Dr Foster Unit were 215 million confidential files on visits to outpatient departments. The Dr Foster Unit, which is part of Imperial College, anonymizes the information before passing it to a separate organisation, Dr Foster Intelligence, which is funded by the NHS and Dr Foster. . ."

3.5.110. NHS medical research plan threatens patient privacy (17 Nov 2008)

The Guardian

http://www.guardian.co.uk/society/2008/nov/17/nhs-patient-privacy-medical-research

"The prime minister and Department of Health want to give Britain's research institutes an advantage against overseas competitors by opening up more than 50m records, to identify patients who might be willing to take part in trials of new drugs and treatments. They are consulting on a proposal that is buried in the small print of the NHS constitution that would permit researchers for the first time to write to patients who share a particular set of medical conditions to seek their participation in trials. It would result in patients receiving a letter from a stranger who knew their most intimate medical secrets, which would be regarded by many as a breach of trust by doctors who are supposed to keep information confidential. It raises the prospect of a letter being opened by a relative, which could cause embarrassment. Harry Cayton, who is about to take over as chairman of the National Information Governance Board for Health and Social Care, the new watchdog on use of NHS data, said the proposal is "ethically unacceptable". He said: "There is pressure from researchers and from the prime minister to beef up UK research. They think of it as boosting UK Research plc. They want a mechanism by which people's clinical records could be accessed for the purposes of inviting them to take part in research, which at the moment is not allowed. I think that would be a backward step. "It would be saying there is a public interest in research that is so great that it overrides consent and confidentiality. That is not a proposition that holds up." . . . His board has written to Alan Johnson, the health secretary, asking for the proposal to be quashed. A health department spokeswoman said last night: "We are consulting on the NHS constitution to ensure that the final version is fit for purpose. We welcome the board's valuable comments and will consider them alongside other responses. We expect to publish our response shortly." . . . Cayton, the government's former patient tsar, brokered a compromise in 2006 after the Guardian criticised plans to place the medical records of every patient in England on a national electronic database, known as the Spine. Ministers conceded that patients should have the right to opt out if they were concerned that their personal data might fall into the wrong hands. He said: "The manner in which the Guardian raised the issue was frustrating at the time, but you can look back and see that it was in the public interest in the broadest sense. It caused people to have a discussion and there are benefits in having informed public debate." Cayton's board was set up by legislation this year. It will take over from the Patient Information Advisory Group, established after a scandal at Alder Hey children's hospital involving illegal storage of children's tissue samples. It will advise on issues involving consent, confidentiality, security and data sharing in social care as well as health."

3.5.111. NHS trying to access GPs' patient records by stealth (2 Dec 2008)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4121348&c=2

"NHS organisations are attempting to use data extraction systems to access patient records from practice systems without the permission of GPs. Pulse has learned of a series of incidents across the country where GPs have been forced to take action to prevent their records from being accessed remotely. It comes just a week before the end of Connecting for Health's consultation on the Secondary Uses Service. In Cornwall, mental health provider Outlook South West had planned to upload data on mental health service uses - including NHS numbers - to a central computer system operated by the Improving Access to Psychological Therapies programme. Patient data was to have been extracted from practice systems on an implied consent basis and shifted onto the PC-MIS information system based 350 miles away at the University of York. But Dr Matthew Stead, chair of Cornwall & Isles of Scilly LMC, said local GPs were opposed to data being sent without explicit patient consent. . . Elsewhere Manchester LMC has sought advice from the Information Commissioner over similar concerns relating to PCT plans for secure data extraction from GP systems. The LMC warned it had fears over 'risk of sabotage', 'the ability of the PCT to follow the rules of access' and 'mission creep, if the PCT begins to think it owns the data'. GPC leaders warned in a separate incident in Shropshire, a practice had discovered its system was being accessed externally by several healthcare workers without its knowledge. Dr Fay Wilson, a GPC member and GP in Birmingham, said: 'If people can just tap in when they feel like it, without letting us know, it could be happening all the time.'"

3.5.112. Data 'lost' in rush to create NHS database (5 Dec 2008)

Health Care Republic

http://www.healthcarerepublic.com/news/GP/LatestNews/866794/Data-lost-rush-create-NHS-database/

"Patient data may have been lost as the DoH rushed to create an NHS patient database, the BMA's representative on the new National Information Governance Board for Health and Social Care (NIGB) has said. Dr Tony Calland, who is also chairman of the BMA ethics committee, said NHS Connecting for Health (CfH) had been 'pushing ahead with all kinds of IT solutions without really considering how information governance was going to work'. 'It was under pressure from the DoH, which was under pressure from higher up the line,' he said. Dr Calland said he feared that, as a result, there had been 'a great deal of leaking around the edges before anybody started to look at becoming more restrictive with data'. He said other threats to privacy, such as councils selling electoral rolls to private companies, were far more serious. The NIGB became a statutory body in November. It has powers to investigate and monitor the security of NHS records.However, it will have no powers of enforcement, except to report its findings to regulators or the secretary of state. Dr Calland said that CfH had now begun to appreciate the need for better data security and patient consent. 'Since the HMRC debacle (in which HM Revenue and Customs mislaid 25 million sets of personal details), the loss of personal data is slowly becoming a hanging offence,' he said."

3.5.113. Researchers want access to patient data without consent (17 Dec 2008)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4121508&c=2

"Exclusive: Medical researchers could gain access to fully identifiable patient records without GPs and patients even knowing, under proposals by the UK's two largest research organisations. The hugely influential Wellcome Trust and Medical Research Council are lobbying the Government to allow authorised researchers to search GPs' records without explicit consent. Under the plans, patients eligible for clinical trials could be contacted directly by researchers and asked to take part. The proposals raise the prospect of patients being invited to participate in a trial without being aware that information about their diagnosis had been passed on. It is precisely the scenario Harry Cayton, chair of the National Information Governance Board for Health and Social Care, warned against last month. He said: 'There is pressure from researchers and the Prime Minister to beef up UK research. They want a mechanism by which people's records could be accessed to invite them to take part in research. That would be a backward step.' . . . But doctors' groups warned giving researchers access without consent would undermine the trust of patients. The BMA said explicit consent 'should be the norm' for use of patient-identifiable data, and the RCGP warned 'permission for use of identifiable data should never be assumed'. The GMC said: 'Disclosing personal information about patients without consent to allow others to invite them to join studies involves a breach of confidentiality.' Dr Neil Bhatia, a GP in Yateley, Hampshire, said: 'The Wellcome Trust does appear to think it has some God-given right to access everyone's data without consent. It comes across as supremely arrogant.' Dr Trefor Roscoe, a GP in Sheffield, said: 'If people were contacted out of the blue by researchers many would be astounded that third parties had access to their information.' Bodies responding to the consultation were divided over other aspects of the Government proposals, including flagging the records of patients willing to be contacted by researchers and the use of pseudonymised data. The BMA said there was a need for 'better understanding' of pseudonymisation and warned: 'Some NHS bodies and researchers interpret linked anonymised data very loosely, for example with name and address removed but still containing NHS number, date of birth and postcode.'"

3.5.114. Data watchdog urged to examine legality of NHS database (19 Jan 2009)

e-Health Insider

http://www.e-health-insider.com/news/4488/data_watchdog_urged_to_examine_legality_of_nhs_database

"A GP who is campaigning against the NHS Care Records Services is calling on the watchdog for NHS data to examine the legality of the government's proposals for the NHS database. Dr Paul Thornton, a GP in Warwickshire, has written a 15 page report (http://www.e-health-insider.com/img/document_library0282/PT_NIGBreport.pdf) for the National Information Governance Board for Health and Social Care (NIGB) on the legal status of the NHS database. Dr Thornton wants

the NIGB to force the Department of Health to publish its legal advice on plans for the Summary Care Record and to get that advice updated in the light of subsequent legal rulings. Dr Thornton told EHI Primary Care that the need to examine the legality of the NHS database had become even more important following the publication of the Coroners and Justice Bill last week. The Bill aims to amend the Data Protection Act to enable greater sharing of information across government departments. Justice Secretary Jack Straw said it was intended to help fight crime and improve public services but opponents claimed it marked a further step towards a Big Brother state. . . The government obtained legal advice on the SCR when it carried out a ministerial review of its proposals in 2006 but has since refused to release it. Dr Thornton also has an outstanding Freedom of Information Act appeal with the Information Commissioner arguing for release of the legal advice. In his report Dr Thornton welcomes the NIGB's criticism of DH proposals to allow health professionals to use care records for research purposes without patient consent, outlined in the Board's annual report in November. At the time Harry Cayton, the board's chair, told the Guardian newspaper that plans to give researchers access to patient information to recruit for medical trials was "ethically unacceptable." Dr Thornton said: "The standards now being demanded by the NIGB are already enshrined in UK law to an extent that the government cannot renege on as easily as it intends." Dr Thornton argues that European and UK law adds up to "at least a persisting reasonable doubt" with regard to the lawfulness of NHS Connecting for Health (CfH) proposals including the implied consent model for the SCR and the wider sharing of information on detailed care record systems. . ."

3.5.115. GPC member leads mass care record opt-out (1 Apr 2009)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4122304&c=2

"A senior GPC member is among a group of rebel GPs who have automatically opted out thousands of patients from the Summary Care Record over confidentiality fears, Pulse can reveal. A string of practices across the country have decided to conduct a blanket-opt of all their patients, and allow those who want a Summary Care Record to opt back in - a move which puts them on a direct collision course with Connecting for Health, currently overseeing the national rollout of the scheme. Last November a Pulse survey of 314 GPs found one in five planned to automatically opt out all of their patients when the Summary Care Record reached their area. Now the threats are becoming action. Dr Prit Buttar, chair of the GPC's Practice Finance Sub-Committee and a GP in Abingdon, Oxfordshire, said his practice had harboured concerns about the Summary Care Record project since it was first launched. All patients at the practice have had two read codes added to their records - '93C3 - refused consent for upload to national shared electronic record' and '93C1 - refused consent for upload to local electronic record'. 'To date, I'm not aware of a single patient who's said “actually I'd rather be on the record”,' said Dr Buttar, adding that he hoped other practices would follow his example. 'I would really encourage people to have a good hard look at the facts. It seems to me a vastly expensive hammer to crack a very thin shell, and it doesn't really seem to have that much clinical usefulness.' GPs elsewhere are also conducting automatic opt outs. The Ivy Grove surgery in Ripley, Derbyshire, has told patients: 'To ensure the data of our patients remains safe, we have decided that by default, patients should be opted out of the NHS Spine, until such time that their active consent has been gained.' Dr Neil Bhatia, a GP in Yateley, Hampshire who has publicly campaigned against the Summary Care Record, said more than 1,900 of his patients had explicitly opted out even though his practice had pledged not to upload records without seeking consent. 'My feedback has been universally positive,' he said. . ."

3.5.116. Summary care record is indelible (7 Apr 2009)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/4731/summary_care_record_is_indelible

"Patients who do not opt-out of the Summary Care Record prior to one being created for them will not be able have their record deleted later, it has been revealed. If a patient subsequently opts out of the SCR their record will be 'masked' and become inaccessible by NHS staff, but it will not be deleted. The reasons given by the DH are a combination of medico-legal requirement, to preserve a future audit trail; and technical explanation that the way the system has been prohibits deletion of individual records. The clarification on the indelible nature of each SCR comes in a response to a Freedom of Information request made by GP Dr Neil Bhatia last month. Dr Bhatia, who is vigorously campaigning against the system, requested details of the mechanism by which patients at Bury PCT could get their uploaded SCR completely deleted if they had initially opted-in to the system and later changed their

mind. In its response to Dr Bhatia's FOI request the PCT said: "If the patient changes their mind later, after a record has been created, we have to retain a copy of the record for audit trail since it may be required to demonstrate the reasons behind a previous clinical decision. "However, the SCR would be made unavailable from the moment that the patient no longer wished it to be used, so that no access is possible in a care situation. Therefore, there is no form available to have the record completely deleted if the patient has a record created in the first place." The response goes on to explain that the 93C3 read code, which is used to identify patients who do not wish to have an SCR, means that when the record is synchronised with the national Spine database, a blank care record will replace the existing SCR for that patient. However, this does not delete the original record, but instead 'masks' it. . ."

3.5.117. You've Been Uploaded (1 May 2009)

Private Eye

"The government's NHS database grows apace in its so-called pilot areas, despite its legality being cast in doubt by the European Court and, more recently, the Rowntree Trust. . . in six pilot areas (aka "early adaptors"), the government has already allowed primary care trusts (PCTs) to upload the so-called summary care records (SCRs) of some 248,000 patients - almost certainly without the knowledge of the vast majority. At one south Birmingham practice, for example, the records of more than 11,000 patients have been put on the database. Only 38 people were canny enough to opt out. To do so, they have to surmount various hurdles. . . When given full information about the database by wary GPs, virtually no one has allowed their records to be transferred. For example, at the Oaklands practice in east Hampshire, not one of the 11,500 patients have asked for their records to be transferred. Dr Neil Bhatia, the so-called Caldicott Guardian charged with data protection in the area, has decided that only those who give their express consent will have a summary care record on the system. Accordingly, no one did. The difference between the patients in south Birmingham and east Hampshire seems to be obvious. Those unlucky enough to be in the pilot areas are on the system; those with conscientious GPs scandalised by various government data cock-ups are not."

3.5.118. Google or Microsoft could hold NHS patient records say Tories (6 Jul 2009)

The Times

http://www.timesonline.co.uk/tol/news/politics/article6644919.ece

Health records could be transferred to Google or Microsoft under a Tory government, The Times has learnt. Patients will be given the option of moving their medical notes to private companies after the Conservatives said that they would replace Labour's "centrally determined and unresponsive national IT system". The Tories hope that users will be able to choose from a range of private sector websites, possibly including those operated by Bupa, the healthcare provider. This has raised issues of privacy and security, with MPs and health professionals warning it could hamper doctors' ability to access medical records quickly in an emergency. It has also raised questions about the party's links to Google. Steve Hilton, one of David Cameron's closest advisers, is married to Rachel Whetstone, the company's vicepresident of global communications and public affairs. Mr Cameron flew to San Francisco to address the Google Zeitgeist conference in 2007 at the company's expense. Five months ago, it was announced that Eric Schmidt, Google's chief executive, was joining a Conservative business forum to advise on economic policy. The drive is the first concrete proposal to emerge from the Tories' "post-bureaucratic age" agenda, in which citizens would be given more government information in order to make choices about public services. . . The final decision has yet to be taken, and the Google Health and Microsoft HealthVault services that are currently available in the US would need overhauling before they could work in Britain. The Conservatives have not worked out what would happen to the data of those who do not want their medical records handed to the private sector. The source added: "We are 100 per cent certain there will not be an exclusive deal with one provider. We fully expect multiple providers that will almost certainly be free to users." Norman Lamb, the Liberal Democrat, said: "It leaves a nasty taste in the mouth that there are repeated references to Google given the closeness of Team Cameron to that organisation, and it leaves concerns about commercial advantage being taken." A spokesman for the Conservative health team declined to comment.

3.5.119. Police probe breach of NHS smartcard security as e-records launched in London (16 Nov 2009)

Computer Weekly

http://www.computerweekly.com/Articles/2009/11/16/239006/police-probe-breach-of-nhs-smartcard-security-as-e-records-launched-in.htm

An NHS trust at the forefront of work on the £12.7bn NHS IT scheme has called in police after a breach of smartcard security compromised the confidentiality of hundreds of electronic records. Patients in Hull have expressed their dismay that an unauthorised NHS employee has accessed their confidential records; and the local primary care trust, NHS Hull, says it is "shocked" at the breach of security by a member of staff who has since left. Details of the breach emerged as health officials in London were, in an unrelated event, telling journalists about the start of a roll-out of electronic records across London, as part of the National Programme for IT [NPfIT]. The roll-out is part of plans by the Department of Health to create for 50 million people in England an electronic "summary" medical record on a central database run by BT. But doctors say that the breach of security at NHS Hull shows that an insider with a smartcard can access confidential electronic records without authorisation, if the person is determined to do so. They say that this will deepen the scepticism of some doctors that centrally-held medical records will remain confidential under the NPfIT. Before the advent of NPfIT central databases individual medical records were retained by GPs or by NHS trusts in specific areas. GP Paul Cundy, a former spokesman on GP IT for the British Medical Association, said of the Hull incident: "This confidentiality breach, in one of Connecting for Health's showcase systems, highlights the inherent dangers of the Summary Care Record and all shared record systems. This is alarming news, but precisely what was predicted." Kath Tanfield a director at NHS Hull who is in charge of IT, says: "It is shocking to us that an individual who takes on a public service role and who agrees to abide by strict confidentiality agreements should go on to abuse their position and violate patients' rights to privacy". Hull has been working with NHS Connecting for Health and the NPfIT since 2004, in part on implementing a shared electronic health record. NHS Hull has also also working with Connecting for Health on the pseudonymisation of the controversial Secondary Uses Service - in which identifiable health records are partially anonymised so they can used for research purposes by non medical staff. Hundreds of millions of patient records have been uploaded to the Secondary Uses Service database. Every patient visit to a GP or hospital is recorded on the system. NHS Hull, in a joint presentation with NHS CfH, has conceded in the past that the security of pseudonymised data represents a potential data problem. In the security breach, an employee was authorised to use collated and anonymised patient data during the course of the person's day to day work, but was not authorised to access individual patient records. After the person left, however, NHS Hull discovered that the person "inappropriately accessed identifiable medical records. The trust says: "A total of 358 patients [registered at] GP practices have been affected by this." The trust has written to the patients whose records were looked at. It says it is cooperating fully with a police investigation which is now underway.

3.5.120. London GPs make it easy for patients to "opt-out" of central NPfIT database (25 Feb 2010)

Computer Weekly

http://www.computerweekly.com/Articles/2010/02/25/240411/london-gps-make-it-easy-for-patients-to-opt-out-of-central-npfit.htm

London GPs are taking collective action which will make it easier for their patients to "opt-out" of having their medical details uploaded to a central database run by BT as part of the National Programme for IT [NPfIT]. The action is likely to be seen by the Whitehall officials as an attempt to hinder the roll-out of the Summary Care Record to six million patients in London. If many patients opt out of the scheme, the summary care records database may end up being used little or not at all by thousands of doctors and nurses. A letter is being sent to GPs by the London-wide group of Local Medical Committees, Londonwide LMCs, a trade association for general practitioners. It expresses concern about the "very short period" which primary care trusts and NHS Connecting for Health are giving patients to choose whether to opt out of having an central NPfIT "summary care record". As part of a national roll-out of the summary care record, patients who do not respond to a leaflet from their primary care trusts on the benefits of a central e-record are having some medical details uploaded to a central "spine" database which is run by BT, with Oracle as its subcontractor. Patients who "opt-out" will have their records kept solely under the control of GPs. The letter from the Londonwide LMCs says: "Many patients will have worries which they will wish to have addressed, and many may not bother or may ignore the letters [from primary care trusts on the summary care record scheme] and miss their chance to opt out from the start." Londonwide LMCs are making available online a poster for GP surgeries which gives patients simple advice on opting in or out of the summary care records scheme. The organisation is also encouraging GPs to "be more proactive and contact patients directly,

or via patient participation groups, or via the practice website and text system if you have them". The letter of the Londonwide LMCs adds that doctors have a duty to ensure that patients make an informed choice. A Londonwide LMCs factsheet for patients quotes the British Medical Association as saying that "patient medical records should not be uploaded without explicit patient/carer consent". The Department of Health's NHS Connecting for Health, which runs the £12.7bn NHS IT scheme, discourages patients from opting out. Its leaflet warns that patients could endanger their lives by opting out, because key medical information may not be available to doctors when it's needed. NHS Connecting for Health insists that patients who wish to opt out must sign a disclaimer. But London GPs are making it easier to opt out. The poster asks: "Do you want your medical records to stay confidential to this practice, or to be uploaded to the NHS central record system, the NHS "spine"? If patients are unsure what to do, or want "to be in control" of their health information, they should opt out, in which case, says the poster, "Sign opt-out form at reception". If patients want, in an emergency, "other healthcare staff" to see what medication they are on and "future health information" they need do nothing, as their data will be uploaded. One GP said that the poster and other action by the Londonwide LMCs represents a "complete lack of confidence in the Summary Care Record and fundamental confusion and reservation about the ethics of transferring records onto the SCR without the confirmed explicit consent of each patient".

3.5.121. One in six GPs snub care record (2 Jun 10)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4126184&c=2

Exclusive: GPs are boycotting the rollout of the Summary Care Record in their droves, in a move that casts serious doubt over the rollout of the project, a Pulse investigation reveals. Among practices specifically invited to join the rollout, one in six has refused to do so, according to figures obtained under the Freedom of Information Act from 91 PCTs. In 36 areas which have begun the rollout and provided complete figures, 1,732 practices have been invited to participate - with 286 so far declining to take part. In some areas, half or more of practices have refused offers to sign up, amid fears over confidentiality, lack of patient awareness and the huge workload in uploading records. In NHS North Lancashire, where all 38 practices have been invited, only one has formally signed up to a pilot, while in NHS Cambridgeshire, which began contacting practices in December, just 37 of 77 have shown interest. In other areas, PCTs appear to have ridden roughshod over GPs' concerns - writing to all patients to offer them a care record without the backing of some local GPs. NHS Peterborough wrote to all its patients in March - even though five practices have yet to agree to participate. A spokesperson for NHS Hammersmith and Fulham said: 'We haven't invited any practices to take part - it is not GPs' choice, it is patients' choice. All [practices] have been informed of our plans.'

But in other areas, PCT support appears to be wavering, with some, such as the Torbay Care Trust, having no plans to begin a local rollout until the end of 2011 at the earliest. NHS Buckinghamshire appears to have rejected the rollout entirely, arguing the care record is not fit for purpose. It said: 'Although NHS Buckinghamshire believes a summary and shared record of some form is required to support new pathway-based working, at present, Connecting for Health's Summary Care Record does not meet those requirements.' The investigation also reveals huge variation in spending on the care record rollout, over and above the £7.5 million of central funding Pulse revealed earlier this month. While some PCTs claimed to have spent nothing, or to have incorporated costs within existing budgets, others have spent thousands on training, project management and advertising. NHS Dorset, one of the early adopters, said it had spent £190,000 on the rollout, and expected to spend a further £70,000. It has so far uploaded 159,580 records - although none have yet been used. Dr Neil Bhatia, a GP in Yateley, Hampshire, and a long-time critic of the Summary Care Record, said: 'If the care record was as ground-breaking as Connecting for Health makes out, patients would be demanding it from their GPs, practices would be screaming for it from their PCTs and trusts would be banging on their SHAs' doors insisting on it.'

3.6. System Reliability and Performance

3.6.1. NHS User Survey: Appendices 1-6 (17 Jun 2005)

TFPL Ltd. for NHS Connecting for Health

http://www.library.nhs.uk/nlhdocs/Appendices_1-6.pdf

" Not surprisingly the professional population canvassed are comfortable using e-resources though not everyone was confident that they used them well. House officers experience frustration with changing Athens passwords as they moved locations. Manager's views of Athens were mixed – some had no issues, others experienced technical unreliability. Firewalls present another issue – managers get over this by using some resources from home. . . Access to Athens needs to be more reliable and easier to use. Athens takes too long to use and access is not technically reliable enough."

3.6.2. Patient data errors created by iSoft's iPM system (9 Jan 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=1632

" A flaw has been identified in the iSoft iPM patient administration system being provided as the standard solution to NHS trusts in the North West and West Midlands that can corrupt patient data creating suspected clinical risks to patients"

3.6.3. A spineless performance (12 Jan 2006)

The Guardian

http://society.guardian.co.uk/e-public/story/0,,1684068,00.html

" The system at fault was not the booking software as such, but in the underlying digital " spine" supposed to connect all parts of the NHS in England. Officials had previously boasted that the spine would be available 99.8% of the time, with recovery within 30 minutes of any crash. . . The trouble began on December 18 with the installation of a major upgrade of the spine software. . . The new software reacted badly with one of the many different systems used by GPs to manage their practices, and generated spurious messages that overwhelmed networks and servers. This rogue behaviour masked other incompatibilities between the new demographics service and the " choose and book" software. " We were into Christmas before we were able to start diagnosing," said one of the team who worked over the holiday to resolve it."

3.6.4. Paper working after disaster 'not acceptable' (1 Feb 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=1678

" . . . some acute trusts in Accenture's regions found their patient administration systems (PAS) were not working for a week and had to go back to working on paper."

3.6.5. COVER (Cover of Vaccination Evaluated Rapidly) Programme: January to March 2006 (22 Jun 2006)

Communicable Diseases Report Weekly

http://www.hpa.org.uk/cdr/archives/2006/cdr2506.pdf

" . . . This is the third quarterly report in which national trends could not be reported due to problems with new child health systems being implemented in London. Comparing the year 2005/6 to 2004/5, the number of children in London who are missing from the COVER programme is nearly 18,000 for children turning 12 months, over 14,500 for children turning 24 months and nearly 19,000 for children turning 5 years of age. These children are not necessarily unvaccinated, but the fact that no information has been collected on their vaccination status means that those who have missed out vaccines for whatever reason are unlikely to have been identified and followed-up. Child Health Systems were created to help manage the national vaccination programme at the local level in the 1980s. The systems were very successful in achieving greatly improved vaccination coverage in the UK through sending invitations for vaccination, identifying unvaccinated children, sending reminders and tracking their status for catch-up campaigns. If new child systems fail to deliver these functionalities then children risk missing out on vaccination. Thus, they remain unprotected and eventually will catch measles, mumps, and rubella infections. Ten of the 31 London PCTs are using CHIA, a system provided by BT which is the London provider for Connecting for Health, the agency delivering the NHS National Programme for IT. . ."

3.6.6. Fears over faults in NHS patient records system (25 Jun 2006)

The Observer

http://observer.guardian.co.uk/uk_news/story/0,,1805437,00.html

" The multi-billion pound computer system built to run NHS patient records is experiencing so many problems that there are concerns people could be put at 'clinical risk', with missed appointments and lost records meaning that some hospitals have pulled out of the scheme in despair. Confidential documents and emails obtained by The Observer reveal the scheme's progress is plagued by technical problems that threaten lengthy delays for patients needing to see specialists. . . Industry sources familiar with the project told The Observer that the problems have seen many hospitals or trusts postpone the system's implementation. Just 12 of England's 176 major hospitals have implemented even the most basic part of the new system which electronically books patient appointments with specialist consultants - despite the fact 104 had agreed to have it operating by April. Furthermore, not one NHS trust or hospital in England has implemented the second phase of the system, which will allow doctors to order clinical services such as blood tests or X-rays electronically - contrary to the Department of Health's planned timetable.

3.6.7. Experts try to fix NHS IT failure (1 Aug 2006)

BBC News

http://news.bbc.co.uk/1/hi/health/5233604.stm

" Technicians are trying to solve a computer failure that has prevented 80 NHS trusts gaining access to patients' records and admissions since Sunday. Eight major hospitals and more than 70 primary care trusts in north-west England and the West Midlands were hit. . . The problem affects trusts in Birmingham and the Black Country, Cheshire and Merseyside, Cumbria and Lancashire, Greater Manchester, Shropshire and Staffordshire and the southern part of the West Midlands. Computer company CSC, which runs the system, said experts were working around the clock to resolve the situation. A spokesman for NHS Connecting for Health, which oversees the multi-billion pound NHS IT service, said that no data had been lost, and that the incident was caused by " storage area network equipment failure" ."

3.6.8. NHS computer system 'won't work' (6 Aug, 2006)

The Observer

http://observer.guardian.co.uk/politics/story/0,,1838470,00.html

Leaked analysis says hospitals would be better off without national upgrade. The project to overhaul the NHS's computer systems, costing millions, is so beset by problems that hospitals would be better off if they had never tried to implement it, according to a confidential document apparently sent by one of the scheme's most senior executives. A 12-page analysis detailing why the project will never work was sent anonymously to an MP on the Public Accounts Committee from the computer of David Kwo who, until last year, was in charge of implementing the Connecting for Health system across London. . . . Kwo did not return emails or telephone calls from The Observer, but the Microsoft Word document reveals that it was written on his computer. What is irrefutable is that the devastating analysis of the flawed computer system - which is two years behind schedule - could have been written by only a handful of senior NHS IT experts who have worked on the project. 'The conclusion here is that the NHS would most likely have been better off without the national programme, in terms of what is likely to be delivered and when,' states the document, sent to Conservative MP Richard Bacon and obtained by The Observer. 'The national programme has not advanced the NHS IT implementation trajectory at all; in fact, it has put it back from where it was going.' As the problems have increased, GPs' surgeries have opted to implement their own systems, something which the document observes is 'fragmenting the national programme further'. Many hospitals are 'being forced to deliver outdated legacy systems, which the programme was established to replace.

3.6.9. E-mail reveals outage disrupted patient care (7 Aug 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2054

" One week on from the computer failure that left 80 trusts in the North-west and West Midlands without access to their IT systems the extent of the disruption to patient care of the biggest ever NHS IT failure is coming to light. Despite claims to the contrary by NHS Connecting for Health, E-Health Insider has received documentation showing the failure disrupted patient care at Birmingham Children's Hospital (BCH) NHS Trust - one of eight acute trusts that lost access to patient data last week. As a result BCH has begun a review of its contingency arrangements. . . An internal e-mail from Richard Beekan, the trust's director of operations, is explicit about the impact the loss of the Lorenzo patient administration system had. Once the trust lost access to the patient administration system (PAS) it had to revert to paper based " business continuity systems. This system was introduced expecting the system only ever to be unavailable for a maximum of 12 hours and therefore during the last three days we have experienced issues we had not planned for. In particular the absence of our case note tracking system and an ability to know where notes were had an impact in both out patients and inpatient areas." Last week NHS Connecting for Health (CfH), the agency responsible for the NHS IT modernisation project, publicly stated in bulletins that the failure at the CSC data centres had no impact on patient care. On 2 August, CfH said: " To date no impact on the delivery of patient care has been reported."

3.6.10. NHS suppliers face review of disaster plans (15 Aug 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/08/15/217689/NHS+suppliers+face+review+of+disaster+plans.htm

" Connecting for Health (CfH), which runs the National Programme for IT in the NHS, has ordered a review of disaster recovery arrangements for all five of its local service providers following failures at a data centre run by CSC earlier this month. The outages left hospital trusts in the North West and West Midlands without access to patient administration systems for up to five days. CfH contracts with local service providers specify that storage area networks at the heart of disaster recovery provisions must have no single point of failure, 99.9% availability and zero data loss. " The disaster recovery restored time within contracts depends upon the services affected. This is currently between two and 72 hours. However, by January 2007, all services must be restored within two to 12 hours," said a CfH spokesman."

3.6.11. Choose & Book - A Report from the Streets (Summer 2006)

UK Health Informatics Today

http://www.bmis.org/ebmit/2006_50_summer.pdf

" . . . At the time of writing my PCT has 30% of practices who have absorbed CAB usage into most of their daily activities – but of course that means 70% have not. Even to have got this far was largely due to the incentive payments put in by the government. There is no proper documentation of the system and little information on exactly when users should go to their local help desk or when to escalate problems to the national team. System reliability has been patchy. This doesn't sound that bad but what does it foretell about the launch of the other parts of the programme? There is no way to let users know when the system goes off line - not even a simple information cascade. This is a system that should be resilient, fault tolerant, and hot swappable with real 24x7x365 availability. Well it doesn't provide anything like this level of reliability. . ."

3.6.12. Major incidents hit NHS national systems (19 Sep 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/09/19/218552/Major+incidents+hit+NHS+national+systems.htm

" More than 110 " major incidents" have hit hospitals across England in the past four months, after parts of the health service went live with systems supplied under the £12.4bn National Programme for IT (NPfIT) in the NHS. Many of the incidents, which have been reported by Connecting for Health, the body that oversees the NPfIT, involve the failure of x-ray retrieval hardware and software, known as Pacs (picture archiving and communications systems) which allow clinicians to view digitised x-rays on screen. . . The major incidents also involve hospital patient administration systems, which hold patient details such as appointments and planned treatments. The specifications for services to be supplied under the NPfIT built up an expectation among NHS staff and clinicians that they would

receive sub-second response times, and that equipment would be available to them 99.99% of the time. But the list of major incidents seen by Computer Weekly shows that in some cases NHS staff and clinicians have lost access to their main hospital systems. More than 20 major incidents have affected multiple NHS sites. This raises questions about whether the risks of failure after go-live have been adequately assessed, and whether any independent regulator has an overview of the riskiest implementations across England. . . Some of the listed incidents were fixed quickly, though others lasted much longer. . .”

3.6.13. NPfIT systems failing repeatedly (20 Sep 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2144

“ More than 110 major incident failures have been reported by hospitals and GPs over the past four months relating to systems provided by the NHS National Programme for IT. The problems, which have affected dozens of hospitals across England, were serious enough to be logged by NHS managers as ‘major incidents’. The issues were revealed by an anonymous NHS IT director speaking to Computer Weekly. The IT director told the magazine: “ Some NHS trusts that have implemented Connecting for Health [centrally-bought] solutions are struggling to cope with poor system performance and service availability issues. “ The local service provider is working flat out to resolve the issues. However, a great deal of damage has been done in terms of deteriorating end-user confidence and satisfaction with respect to the systems.” E-Health Insider understands that the 110 serious incidents reported by Computer Weekly may actually understate the true number of problems. Industry sources say that some problems are routinely not reported or recorded or classified as less serious. For instance, the July data centre failure that affected 80 trusts is understood to have been counted as a single major incident. EHI has also learned that a 9 September failure that resulted in the iSoft system delivered by Computer Sciences Corporation to Morecambe Bay Hospital NHS Trust becoming unavailable to all staff was only treated as an ‘amber’ incident, rather than a ‘red’ major incident. The contractual specifications for services to be supplied under the NPfIT say that staff and clinicians will receive sub-second response times, with 99.99% availability. But in many cases staff have found systems can either be extremely slow, impossible to access or unavailable to them for hours or even days. . . While the early problems will hopefully just prove teething problems, they raise the spectre that staff will not be able to fully rely on CfH systems and will still need to maintain old systems and paper records. The programme has yet to begin widespread delivery of clinical rather than administrative systems. . .”

3.6.14. Some N3 links ‘too slow for Choose and Book’ (25 Sep 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2151

“ A fanfare for the near completion of the new NHS network, N3, has been met with complaints that some GP practices with new broadband connections are not receiving enough bandwidth even to use the e-referral system, Choose and Book, effectively. Announcements last week from the network’s purchaser, Connecting for Health, and supplier, BT, brought numerous comments from E-Health Insider readers who were critical of the performance experienced by some users. Clinicians in affected areas who attempt to use Choose and Book through their clinical applications are experiencing login times of up to four minutes and finding their keyboards unresponsive. Meanwhile, users are unable to distribute critical application patches and updates over their connections and GPs are reportedly “ tearing their hair out” . . . The difficulties are causing problems on a regional as well as a local level. Last month, EHI understands, a primary care trust in Leeds was unable to agree a go-live date due to the poor performance speeds of N3 over their intra-practice virtual private network. . .”

3.6.15. Hospital blames IT for fall in status (17 Oct 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/10/17/219201/hospital-blames-it-for-fall-in-status.htm

“ Executives at a hospital that pioneered systems under the £12.4bn National Programme for IT in the NHS have blamed their new technology for contributing to the trust’s loss of status as top performing health service site. The Nuffield Orthopaedic Centre in Oxford was last year awarded the maximum

three-star rating for its performance. Under a new method of rating hospitals, Nuffield was categorised by the Healthcare Commission as " weak" for quality of service. This is the bottom category of performance. The ratings matter because hospitals can lose business - and income - if their ratings remain poor and patients are referred elsewhere. On a target for seeing patients with suspected cancer, Nuffield incurred a " fail" because it was unable to submit the necessary data during the implementation of its new systems. It also failed to meet national targets on the number of patients waiting more than six months and on the number of cancelled operations. Jan Fowler, acting chief executive at Nuffield, said she was disappointed at the " weak" rating. " We believe we are providing a good quality service to our patients at this hospital but the results have been distorted by the computer problems we had earlier this year following the installation of our new patient administration computer system, which unfortunately caused some patients to experience delays to their treatment," she said. . ."

3.6.16. Trust feels pain of NHS IT roll-out (7 Nov 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/11/07/219625/trust-feels-pain-of-nhs-it-roll-out.htm

"Queen Mary's Sidcup NHS Trust was an NHS IT trailblazer late last year when it became the first trust in London to use the new patient administration system from the £12.4bn National Programme for IT (NPfIT). But alongside the technical challenge posed, trust chief executive Kate Grimes said last month that its commitment to tapping the NPfIT had also left it under financial pressure and facing an income loss of about £3m. This was due to problems encountered when rolling out the new systems from BT, which is the local service provider for national programmes in London. . . Problems with the new system began as soon as it went live in November last year. Grimes said the system was sometimes unavailable and problems with logging in were adding 36 minutes to the time patients spent in the hospital, simply because of the time wasted gaining access. This contributed to the trust just missing its accident and emergency targets for the year. The main threat to the trust's finances came from the drop in referrals because other hospitals in the area had started using the NPfIT's Choose and Book system to allow GPs to book appointments online. However, the Sidcup trust found out just before it was due to go live with the Carecast patient administration system from IDX that the system was incompatible with Choose and Book. Although the problem is now fixed, there has been a significant drop in referrals in the meantime, Grimes said. " If it had gone on for many more weeks the survival of the organisation would have been threatened by that." Another fall in revenue came from the clinical coding systems introduced as part of the new software. Hospitals need to code their procedures so that they can be paid by the government. " The new coding took a lot longer to do and a number of patients were not on the system - so you do not get paid for them," Grimes said. This was due to system downtime, lack of training and a struggle with the new role-based access approach to the application, she said. . . As Computer Weekly revealed last week, trusts are having to live with the consequence of decisions made by NPfIT contractors, which they have no part in making, with limited means to seek recompense. A lack of contractual control was a drawback to the design of the programme, Grimes said. " There is a lack of visibility of the contract or any power or control over it. If a delay increases my costs, I do not have any power to recover those costs." She said that BT had " helped out" , but it was not something that was automatic in the contract. Another drawback to the structure of the programme, which is managed by Connecting for Health, is that problems take a long time to resolve because of the lengthy chain of command. . ."

3.6.17. NHS broadband leaves GPs in slow lane (21 Nov 2006)

e-Health Insider

http://www.ehiprimarycare.com/news/item.cfm?ID=2282

" Many GP practices are struggling with inadequate broadband speeds over N3 (the new NHS National Network) which are slowing down their day-to-day work and limiting their ability to use key national computer systems from the £12.4bn Connecting for Health programme. Fair Deal on NHS Broadband Choose and Book has been particularly affected and GPs have told EHI Primary Care about the frustrations of trying to deliver the e-booking system with the connection speeds available to them. The problem particularly affects branch surgeries, linked to main practices. The problems are being exacerbated because primary care trusts say they cannot afford to buy additional bandwidth for practices from N3 service provider (N3SP) BT with quotes of up to £30,000 to upgrade a practice from a 1MB to 2MB line. The costs are partly thought to be so high because the price list is based on a seven year contract NHS Connecting for Health (CfH) signed with N3 provider BT at the beginning of 2004

when bandwidth was more expensive. BT and CfH are coming under pressure to review the contract so that it better reflects market conditions and delivers adequate broadband speeds for practices at an affordable price. . .”

3.6.18. CfH GP group to discuss N3 speed problems (28 Nov 2006)

e-Health Insider

http://www.ehiprimarycare.com/news/item.cfm?ID=2301

“ GP practices’ concerns about N3 are to be discussed at the next meeting of NHS Connecting for Health’s GP Pan User Group (GP PUG). Dr Gillian Braunold, joint GP national clinical lead for CfH, told EHI Primary Care that N3 will be on the agenda at the pan user group’s January meeting. Last week EHI Primary Care launched its Fair Deal for NHS Broadband campaign to highlight the problems facing primary care and secure a fair deal for GP practices on NHS broadband. Dr Braunold said she and Professor Mike Pringle, her co-GP clinical lead, had already passed on to the N3 team concerns about the BT-run NHS network raised during CfH’s current series of GP engagement events around the country. Issues practices have highlighted to EHI Primary Care include concerns that practices do not have adequate broadband speeds to use systems such as Choose and Book, that the cost of upgrading must be met locally and can be as high as £30,000 for a three year contract, and that inadequate broadband speeds are particularly affecting branch surgeries where the impact is felt not only on national applications but also on GPs’ clinical systems. . .”

3.6.19. N3 Internet gateway fails across NHS (7 Dec 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2326

“ Users of the NHS broadband network across England were left unable to access the internet for about two hours on Tuesday due to a problem with the internet gateway. The failure left NHS users unable to access the web-based version of Choose and Book or web-based clinical knowledge sources. The fault is believed to have affected N3 and N2 – the predecessor to the N3 network - users across England although service provider BT told EHI Primary Care that it was not possible to accurately identify how many people were affected as the problem was intermittent. A spokesperson added: “ It was down for about two hours.” GP practices and hospitals across the country reported lack of access to the internet and those using web-based Choose and Book were also unable to access the e-booking application. . . The embarrassing failure came in the same week that BT announced its N3 national service team had achieved the international ISO 20000 standard for effective IT service management.”

3.6.20. GPSoC delivery goes local in IT devolution (11 Dec 2006)

e-Health insider Primary care

http://www.ehiprimarycare.com/news/item.cfm?ID=2333

Local NHS organisations will be required to draw up plans showing how they will deliver GP Systems of Choice implementation under new arrangements announced today. Primary care trusts, as commissioners, will be required to have their own comprehensive IM&T plan and work with all providers in their local health communities to align IM&T plans to enable patient-centred service transformation. The new requirements are part of a broad strategy of devolving responsibility for IM&T to local level announced in ‘The NHS in England: the operating framework for 2007-8’. The framework was launched by NHS chief executive, David Nicholson, who says in his foreword: “ We are devolving power from the centre to the service in many ways, not least in how we allocate money, such as the unbundling of central budgets. “ Some of the key enablers of service transformation, such as the delivery of information technology, will also increasingly need to be driven and owned by the service rather than from the centre so that patients can get the full benefits as quickly as possible.” Nicholson is currently reviewing the National Programme for IT (NPfIT) and reports suggested he was keen to improve local ownership of the programme. . . Plans will be required from NHS organisations showing not only how local but national priorities will be achieved. These include: the completion of picture archiving and communications rollout; implementation and benefits realisation for the Electronic Prescriptions Service and further exploitation of e-booking. . . In addition to the responsibilities set out for PCTs, as commissioners, all NHS providers will have to have a forward

looking IM&T plan which is " core to their business, exploits fully the NPfIT opportunity and thereby demonstrates migration to the NHS Care Record Service."

3.6.21. No warning for hospital on patient system problems (12 Dec 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/12/12/220509/no-warning-for-hospital-on-patient-system-problems.htm

" A hospital trust in Oxford which lost track of crucial data on some patients after going live with a pioneering project under the £12.4bn NHS IT programme was unaware that a similar go-live at another hospital had led to a " serious untoward incident" . This is one of the findings of a joint investigation by Computer Weekly and Channel 4 News. The results of the investigation were broadcast on Channel 4 yesterday evening (11 December). In December 2005, the Oxford-based Nuffield Orthopaedic Centre installed a Cerner patient administration system as part of the National Programme for IT in the NHS. The go-live led to the trust reporting a serious untoward incident to the National Patient Safety Agency because of what the trust's executives called " potential patient risks" . Martyn Thomas, a visiting professor of software engineering at Oxford University, told Channel 4 News, " It is alarming. If there are known problems then they really ought to be communicated very rapidly to other users of the system." The Computer Weekly and Channel 4 News investigation also raises questions about the National Programme in general. A hospital consultant, Gordon Caldwell, said that if systems were too slow and badly designed, they could be a major threat to the way hospitals in England work. . ."

3.6.22. BT investigates slow connections for GPs (19 Dec 2006)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=2362

" N3 provider BT has been investigating ways in which it might improve its service for GP practices using the EMIS computer system which have been struggling with slow connection speeds to their branch surgeries. EHI Primary Care understands that BT has been running experiments on alternative configurations and that solutions identified by that work will be rolled out early in the new year. EHI Primary Care's Fair Deal on NHS Broadband campaign, launched in November, has been highlighting problems faced by GP practices with N3 connections with the aim of securing a better service for primary care. Staff working in branch surgeries have faced particular difficulties where the N3 connection via a virtual private network (VPN) connection to the main surgery means even opening attachments such as consultants' letters or clinical photographs can be painfully slow. In some cases GPs have reported occasions where there has been a delay of several seconds between making a keystroke and the character appearing on the screen. . ."

3.6.23. £600,000 payout over NHS 'crash' (10 Jan 2007)

Manchester Evening News

http://www.manchestereveningnews.co.uk/news/health/s/232/232837_600000_payout_over_nhs_crash.html

"THE North West NHS is to get £600,000 compensation after their new hi-tech computer system crashed for two days. Health staff were forced to revert to pen and paper after Connecting for Health - and its back-up - went down last July, affecting about 2,000 patients in Greater Manchester because of theatre management and appointment-booking systems. IT firm Computer Science Corporation Alliance has now agreed to pay £600,000 towards extra administration costs after staff had to make provisional appointments using paper lists, then confirm them by computer once the problem was solved. The programme to centralise and computerise all NHS systems and records has been dogged by delays. Some Greater Manchester hospital bosses are still refusing to switch to the new software because they say it is not up to the standard of their current systems. . . Pennine Care Mental Health Trust, North Cheshire Hospitals and South Manchester Primary Care Trust, which runs clinics at Withington Community Hospital, were said to be the worst affected trusts in this region. At Bolton, computerised theatre management systems were hit. The software tracks details of all surgical procedures - even down to which scalpels are used for each operation and where and when they are cleaned. . ."

3.6.24. GP Systems of Choice procurement on track but late (23 Jan 2007)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=2435

"The GP Systems of Choice (GPSoC) scheme looks likely to go ahead - although procurement will not be complete by 1 April as originally planned. A spokesperson for CfH told EHI Primary Care that the GPSoC business case was approved by the Department of Health in December 2006. Approval from the Treasury is still outstanding but EHI Primary Care understands the scheme is likely to be given the go-ahead in the next few weeks. Once Treasury approval is received CfH will go out to tender for suppliers to take part in GPSoC through an advertisement placed in the Official Journal of the European Union (OJEU). This process is likely to take a minimum of 90 days so procurement will not be complete by 1 April as CfH had planned. . . Work on providing a scheme to provide GP practices with the IT choice outlined in the GP contract in 2003 has been dogged with delays and difficulties. A previous scheme first mooted in 2005 which would allow GPs access to any system so long as it had a contract with a local service provider was scrapped because it could not be made to work and it was decided it would not offer the NHS value for money."

3.6.25. South Warwickshire authorises shared smartcard use (30 Jan 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2449

"South Warwickshire General Hospitals NHS Trust has confirmed that its board has agreed that clinicians working in part of its A&E Department can share smartcards to access patient records. The trust passed the policy after deciding that the lengthy log-in times, averaging 60-90 seconds, it takes staff to log-on to the hospital's new patient administration system (PAS) every time they use it was not acceptable in a busy A&E environment. South Warwickshire's new iSoft iPM PAS, which is connected to a national data spine, has been supplied by Computer Sciences Corporation as part of the NHS National Programme for IT (NPFIT) modernisation programme. Reports of lengthy log-ins have also reported from other trusts that have received NPfIT systems connected to the spine. Following implementation of their new iPM Patient Administration System by CSC in December, the trust's board allowed clinicians in A&E to share smartcards due to the lengthy login times for the new PAS. A spokesperson for the trust told EHI: "Count the time in your head and think of all the patients in A&E, 60 – 90 seconds is a long time." . . . A spokesperson for the British Medical Association commented: "We would not support the sharing of smartcards by NHS staff accessing computerised patient records. Sharing access not only puts at risk the security of the system but also disrupts the audit trail which tracks who has accessed parts of the record." . . . Connecting for Health says that it has commissioned software upgrades that will eventually significantly reduce log-in times."

3.6.26. Paul Charlson: We need a new start for NHS on the critical list (6 Mar 2007)

Yorkshire Post

". . . Apart from failing to control costs, the Government has made some new very expensive commitments. One of these is Connecting for Health. This is the central computer system encompassing, among other things, a central medical record and the ability to book outpatient appointments from the doctors' surgery. We started to use Choose and Book nine months ago. The system is supposed to come up with appointments virtually instantaneously. The first time I used it, I looked like a real lemon, staring at a blank screen for five minutes. The patient went away without an appointment and my secretary spent ages creating an appointment for her. This was repeated many times by our practice before we gave up. Even the National "hit squad" is struggling to sort out our problem. We are not an isolated case. Three things seem to have gone wrong with Connecting for Health. First, the time scale for its introduction was hopelessly short. Second, many good systems that were already operating around the UK have been dumped. Third, an IT system must assist its users to do their job better. This is not happening. Choose and Book should be suspended until it can made to work properly. Current systems should be supported until they can be integrated and there should be more consultation with clinicians in future developments. . ." [Dr Paul Charlson is a GP in East Yorkshire and member of Doctors for Reform. He was previously a member of East Yorkshire PCT executive committee.]

3.6.27. Hospital patient records system is a 'nightmare' (30 Mar 2007)

Milton Keyes News

http://www.mk-news.co.uk/mknews/DisplayArticle.asp?ID=77775

"A doctor has slammed the Government's new multi-billion pound patient records system after service levels at Milton Keynes Hospital plummeted due to a series of early problems. CRS, supplied by Fujitsu as part of the £12.4bn NHS National Programme for IT, replaced a 20- year-old system which was viewed as slow and out-of-date. The new service has been promoted as a faster, modernised way of storing patient records on computers rather than using handwritten notes. But consultants and front line staff are already cursing the system as records became lost in the changeover. Speaking at a recent trust board meeting, Dr Richard Butterworth said: "Outpatients is currently a nightmare with no notes. "The new system meant that 40 patients had no sets of case notes. If these problems are insurmountable this is not good news. We spent months setting up new clinics but they are no longer visible on CRS. If these are teething problems that's great but otherwise I have concerns. It's much harder to see followup patients if you haven't got the old notes." The go live date was originally scheduled for August 14 2006 but was put back so that glitches in the system could be fixed. Staff have been forced to work extra hours on their shifts to help deal with the problems. The trust has argued that the system is still developing and that problems have to be expected but the long term benefits are significant. But board members said there are still glitches and called for more staff to be brought in to help ease the crisis. Finance director Rob Baird said: "CRS is one of the biggest things that has happened in the organisation. "It's been an exhausting process for many of our staff and people have worked way beyond the expectations we could have of them. The service to our patients in some areas has diminished in this period. At the moment we have quite a confused situation and it's like everyone had started a new job. We are doing everything we can and I understand there's huge frustration. It's not possible to go back to the old system so we have to be positive. One of the problems was the system that we trained on was not the system that we went active with, it was a training version that was different. We have found that in some areas it's not been as good as we would like it to be." CRS has also gone live across the community hospitals of Milton Keynes Primary Care Trust, the first step to making a shared care records system available across the local health community, which serves a population of 230,000.""

3.6.28. Hospital's computers 'a failure' (3 Apr 2007)

The Times

http://www.timesonline.co.uk/tol/news/uk/health/article1605125.ece

"Medical and secretarial staff at a hospital have declared a new computer system as "not fit for purpose". The Patient Administration System introduced to Milton Keynes General Hospital five weeks ago as part of the Government's £12.4 billion IT scheme for the NHS, is not working, say 79 members of staff in a letter to the hospital's management. The setback is the latest to hit the National Programme for IT, run by Connecting for Health, a government agency. The rebellion at Milton Keynes emerged as Computer Weekly reported that Connecting for Health had sought to suppress a critical report into the system by the British Computer Society. In their letter, the staff at Milton Keynes say the software is "awkward and clunky". "In our opinion, the system should not be installed in any further hospitals.""

3.6.29. Stop roll-out of this records system, urge NHS doctors (10 Apr 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/04/10/222939/stop-roll-out-of-this-records-system-urge-nhs-doctors.htm

"Dozens of users of a system delivered under the NHS's £12.4bn National Programme for IT (NPfIT) want the technology withdrawn - though they have praised IT staff and the supplier for the "heroic" work involved in the go-live. Seventy-nine doctors, nurses and other end-users at Milton Keynes General Hospital have written a letter saying a new Care Records Service system is "not fit for purpose". The Care Records Service is the pivotal part of the NPfIT, the aim being to provide an electronic health record for 50 million people in England, accessible by any authorised clinician. Major NHS organisations across England are contractually bound to take the Cerner Millennium-based Care Records Service. Milton Keynes General Hospital was one of the first five to go live with the service in

Southern England. Several other early adopters have also had difficulties keeping hospitals running smoothly after going live with the system. The Milton Keynes letter said the technology was so awkward and unaccommodating that, "We cannot foresee the system working adequately in a clinical context." It added, "It should not be installed in any further hospitals. If it is not already too late, there is a strong argument for withdrawing the Care Records Service system from this hospital." The Milton Keynes News reported that Richard Butterworth, a doctor at the hospital, told a trust board meeting last month, "Out-patients is a nightmare, with no notes. The new system meant that 40 patients had no sets of case notes." Hospital finance director Rob Baird told the board, "At the moment, we have quite a confused situation." Fujitsu said in a statement that there had been some "high-impact problems" and it regretted any inconvenience caused to patients and clinicians. Of the 16 issues outstanding at go-live, six were of greater priority and five of these had been resolved, said Fujitsu. The others were being investigated. A spokesman for NHS Connecting for Health, the agency running the NPfIT, said the Milton Keynes trust identified some "unacceptable problems" and no payments would be made to Fujitsu until the system was working satisfactorily. . ."

3.6.30. 'Heroic' staff can't hide flaws (10 Apr 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/04/10/222891/heroic-staff-cant-hide-flaws.htm

"The sad thing about the IT-related crises at Milton Keynes General Hospital is that everyone involved wanted its "early adopter" systems installed under the NHS National Programme for IT (NPfIT) to succeed. . . Staff at Connecting for Health, which runs the NPfIT, worked hard to ensure success. But the problems seem to be getting more serious. We do not blame software supplier Cerner. It has a good US-based product that is proving a challenge to anglicise. Yet NHS trusts across Southern England are contractually obliged to install it. There comes a time when a minister has to say, 'Do we really want to continue with this sort of disruption? Or is there a better way, even if we have to admit we got some important things wrong when we first announced the programme?'"

3.6.31. Milton Keynes MP asks when Millennium will be fixed (20 Apr 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2628

"Reports of missing patient records resulting from the new Cerner Millennium system at Milton Keynes NHS Trust have led local Member of Parliament, Mark Lancaster, to write to the Health Secretary to ask when the Care Records System at the trust will be "fit for purpose". The system has been provided by local service provider Fujitsu as part of the £12.4bn NHS National Programme for IT but has been dogged by problems including clinic lists not being available, patient notes being lost or unavailable and problems with reporting around key areas such as 18-week waits. One senior clinician from the trust described the situation in outpatients as "a nightmare". . . The MP's letter to Health Secretary Patricia Hewitt came in the same week that local paper, Milton Keynes News, reported on the experiences of patients who had suffered the consequences of lost records. One patient, Michael Rooney, who suffers from glaucoma and relies on regular treatment at the hospital, told the paper: "For about five weeks now they've been unable to find my notes. The first time, they said you must come back in five weeks but when I did they said they hadn't found my notes. I'll be blind by the time they find them." He added: "My wife was in intensive care and the doctor said he was glad he knew her because he couldn't find her notes either." Lancaster said of the ongoing problems at the trust: "Despite patient service suffering it appears that no substantive action has yet taken place, this is absolutely unacceptable and why I have to resort to raising the issue in parliament today." In a written parliamentary question the MP asks the Health Secretary to detail "what steps are being taken to ensure that the Care Records Service computer system at Milton Keynes hospital is fit for purpose; and when this work will be complete". Responding on behalf of Hewitt, health minister Caroline Flint replied in a Parliamentary answer: "Urgent and priority action is being taken to manage resolution of the operational difficulties which have been experienced with the new acute patient administration system (PAS) at Milton Keynes general hospital national health service trust since it went live on 24 February." She said that a team from Fujitsu and Cerner were now working daily at the trust to resolve the problems being experienced. "Progress in tackling and overcoming the problems which have arisen, the majority of which have already been resolved, is being monitored daily." The minister added that the senior deployment manager for the south of England from the Department of Health agency Connecting for Health is currently being "stationed permanently on site to ensure the work of

the Fujitsu/Cerner team is completed to the satisfaction of the trust", and managed through to resolution. . . Problems with the Millennium system have also been reported at earlier NHS sites in the south, particularly at the Nuffield Orthopaedic Centre. The next site due to go live in the South is understood to be East Sussex. No sites have yet gone live with Cerner delivered by BT in London."

3.6.32. Trust hits records trouble despite assurances to MPs (24 Apr 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/04/24/223397/trust-hits-records-trouble-despite-assurances-to-mps.htm

"The Department of Health has given MPs on the Public Accounts Committee an assurance that problems following a troubled go-live of nationally-bought systems at an Oxfordshire hospital will not be repeated elsewhere in the NHS. However, evidence has emerged that some of the same problems experienced at Nuffield Orthopaedic Centre have already occurred at Buckinghamshire Hospitals NHS Trust, which went live with the same version of the Cerner Millennium Care Records Service as Nuffield. . . Anne Eden, chief executive of Buckinghamshire Hospitals NHS Trust, said in a letter to Computer Weekly that reporting was an issue. She said, "All trusts need to provide reports on areas such as in□patient, outpatient, day-case activity, etc to our funding primary care trust. In addition, we can use this information to monitor and learn from our own performance." She added that there were "some difficulties in completing some aspects of reporting". This evidence raises questions about the assurances given by the Department of Health. The Care Records Service is the main part of the NPfIT. The aim is to give 50 million people in England a medical record that can be made available to any authorised clinician."

3.6.33. NHS computer hit by fresh glitch (8 May 2007)

BBC News

http://news.bbc.co.uk/1/hi/england/manchester/6633973.stm

"Hundreds of inaccurate patient records have been created every day because of a fault on the new NHS computer system. The problem - affecting patients in Greater Manchester with appointments booked via the online system - arose after a software upgrade. NHS Connecting for Health, which is overseeing the IT upgrade, said the fault would not affect patient care. The nationwide programme has been hit by problems and has been criticised by MPs, who warned it could cost £12.4bn. A spokesman for NHS Connecting for Health said the problem was expected to be fixed in the next few weeks. He said: "Although comprehensive testing is undertaken prior to the upgrades taking place, it is not unusual for these kinds of upgrades to identify teething problems in the early stages following implementation. We estimate that around 400 duplicate patient records might have been created each day. However, the system is being continually monitored throughout each day and where a duplicate is identified data is being merged to form one single record for each patient." Before the fault is fixed permanently, an interim solution has been put in place to identify the duplicate records and correct them, the spokesman added. "This has now been put in place with the full agreement of those organisations affected and will have minimal impact on the users of the system and no impact on the delivery of patient care," he said. Among the places affected by the problem are the University Hospital of South Manchester Foundation Trust and PCT Clinical Assessment Centres in Greater Manchester. . ."

3.6.34. CSC 'learnt' from Maidstone datacentre crash (7 Jun 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/06/07/224580/csc-learnt-from-maidstone-datacentre-crash.htm

"Guy Hains, the president of Computer Sciences Corporation's Europe Group, has spoken of the causes and lessons learned from a crash at the company's Maidstone datacentre last year. The crash caused a loss of systems for NHS trusts on an unprecedented scale. About 80 NHS trusts lost the use of some of their main IT systems for several days. "I believe that the biggest risk in the computer industry generally at the moment is unreliable power supply. Generally across the world power has become more spiky which is ruinous to any sort of IT system," Hains told a Health Committee inquiry into aspects of the NHS's National Programme for IT [NPfIT]: CSC ran into difficulties after power

problems caused a short circuit which damaged a storage device. The firm had to bring experts over from Japan to fix the problem. “We transferred the operation between our Maidstone centre and the reserve centre which was effected without data loss, as was the pass back to the primary data site some weeks later. We learnt several things from that. “First, we learnt that as we scale up the system it is better to have four centres than two, which is what we have invested in, so that data is now not only mirrored but effectively held simultaneously in two places. Second, out of that experience with the authority we have tightened our targets and expectations of how quickly systems need to be brought up,” he said. Under the new plans, the expectation is that key systems are back on line within 24 hours, rather than 72 hours previously. Other more critical systems are back online sooner.”

3.6.35. A very, very long NHS appointment waiting list (30 Jul 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/07/30/225875/downtime-nhs-it-richard-dawkins-youtube-electioneering.htm

“Downtime has long suspected that the NHS IT programme may be rather unfairly picked on - it is, after all, a fairly sizeable project and a few things are always bound to go wrong. However, a letter from a reader may have forced us to change our mind. Said reader was trying to book a hospital appointment using Choose and Book, but came up against a bit of trouble in that he could neither choose, nor book. After being offered no appointment slots, one month, three months, or even a year ahead, our intrepid reader searched for appointment slots up to 2056. “When that came back empty I had a slight suspicion that something might be wrong,” writes our reader. “Realising that they had not quite mastered web services, I gave the phone number a try. I was then informed that because I had recently used the online system, the adviser at the NHS was locked out of their system for half an hour! I tried back an hour later, only to be told that they had the same problem as me - ie. no free appointments from now until eternity. So now my details will be sent to the hospital, which will contact me directly (by phone) to arrange an appointment. Technology - don’t you just love it!” Indeed.”

3.6.36. Massive inaccuracies mar GP patient choice website (9 Aug 2007)

Health Service Journal

http://www.hsj.co.uk/healthservicejournal/pages/070809/N1/choices/p8

“Primary care trusts and GP practices will be asked to correct widespread mistakes on the Department of Health’s flagship NHS Choices website. Half of the website’s information on GP opening hours and a third of practitioners’ names are thought to be incorrect, HSJ can reveal. The Information Centre for health and social care made the estimate after a survey of 4,500 practices showed wide variations in data quality on the site, run by Dr Foster Intelligence. . .”

3.6.37. NHS IT led to ‘disturbing’ incidents, says patient head (1 Oct 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/10/01/227096/nhs-it-led-to-disturbing-incidents-says-patient-head.htm

"The head of a patient group at the first NHS trust in London to go live with the BT-supplied Cerner patient administration systems as part of the national IT scheme, has warned that trusts will receive complaints from patients when they go live with similar technology. Alex Nunes, chair of the Patient and Public Involvement Forum for Barnet and Chase Farm Hospitals NHS Trust, said there had been "disturbing" incidents after the trust went live with new systems under the NHS National Programme for IT (NPfIT). . . Nunes said that the hospital had sent letters to some people asking them to come in for operations when they did not know anything was wrong, and others who were expecting to be invited for appointments did not receive letters. Nunes said he did not blame the trust for the difficulties, and he fully supported the NPfIT, which he said was a courageous plan that could lead to a "tremendous improvement" in the care and treatment of patients. But he warned that with troubled implementations "there is a danger of taking one step forwards and two steps backwards". Barnet and Chase Farm Hospitals went live in July with the R0 release of software from US healthcare specialist Cerner. It was the first implementation by BT in London of Cerner's Millennium system under the NPfIT. Diabetes patient, Fred Ciccone, told his local newspaper he felt like a ghost after staff were

unable to access his medical records on a visit to Edgware Community Hospital. Remon Gazal, then director of IT at the trust, did not underplay the difficulties for some patients. He said that there have been some significant improvements as a result of the go-live, and workarounds have been developed for defects that have an operational impact. The trust's suppliers had made no comment as Computer Weekly went to press."

3.6.38. Spine to be shut for two day 'refresh' (1 Nov 2007)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/3176/spine_to_be_shut_for_two_day_'refresh'

"Connecting for Health (CfH) and BT have confirmed that the NHS Spine will be unavailable when it is taken down for a major upgrade from next Friday evening until Sunday morning (9-11 November). The Department of Health agency describes the refresh of software and hardware as 'unusual' and 'unlikely' to occur again in the future. A practice 'refresh' of the Spine has already been carried out as a dry run in a recent technical rehearsal. CfH is warning that the planned maintenance work will affect all NPfIT systems linked to the Spine, including: the Personal Demographic Service, Choose and Book and GP2GP. The agency said the upgrades did not represent a complete replacement of the Spine. "The exercise is solely an uplift of the database management hardware and software. The application code and functionality of the Spine remain unchanged. The change will be transparent to users," said a spokesperson. . . Choose and Book will face major disruption during the planned maintenance for all users. Over the weekend of 10-11 November, clinicians and patients will not be able to view, make, change or cancel an appointment using the Choose and Book service. There will be no access to the Directory of Services and callers to the Choose and Book appointments line will only be able to have discussions about choice. CfH has advised clinics operating during this time to print patient referral information for the 36-hours downtime in advance. GP practices using the GP2GP service to transfer records will not be able to send or receive information from 2200 on Thursday 8 November to 1000 Sunday 11 November 2007, allowing for the 24 hours transfer completion time. It will not be possible to issue prescriptions with barcodes on them, so pharmacy dispensers will have to manually input prescription items into their systems. In addition, updates to patient demographic data will not be saved on the Personal Demographic Service during the downtime. . ."

3.6.39. Transplant patient has NEW kidney removed after NHS computer blunder (20 Jan 2008)

Daily Mail

http://www.dailymail.co.uk/pages/live/articles/news/news.html?in_article_id=509289&in_page_id=1770&in_page_id=1770&expand=true#StartComments

"A kidney transplant patient was forced to have the new organ removed, when it was discovered that the incorrect blood type had been recorded. A kidney transplant patient was forced to have the new organ removed after just a few hours – when it was discovered that the patient's blood type had been incorrectly recorded on a computer database. The mistake, believed to be the first of its kind in Britain, would have led to the organ being rejected – with possibly fatal consequences. The incident, which was only revealed in response to a Freedom of Information request, comes just days after Gordon Brown called for a system in which individuals are presumed to consent to the use of their organs for transplant unless they specifically stipulate otherwise. The error will intensify demands for fresh safeguards. And it will inevitably raise further fears about a planned NHS supercomputer, or centralised 'spine', on which all medical records will be held. The problems began when staff at the Royal Liverpool and Broadgreen University Hospitals Trust wrongly recorded the patient's blood type as A positive and sent it to the computerised national transplant database. This happened despite the fact that the correct blood type, O positive, was entered clearly on the hospital's paper records. The Government-run body which manages the database, UK Transplant, then sent out a kidney compatible with an A-positive patient, which was transplanted. The error, which was overlooked by a series of NHS workers including nurses, surgeons and transplant co-ordinators, was picked up only when a data-entry clerk at the hospital checked the patient's notes against the computer record after the operation. Further checks revealed that a second renal patient had also been registered with the wrong blood group. . . The blunder took place three years ago and would have remained secret had The Mail on Sunday not seen a confidential report into the "profound error". The internal investigation did not name the hospital involved. But of the three hospitals managed by the Trust, only the Royal Liverpool University Hospital has a transplant unit. The report concluded that the initial data entry mistake was

"human error" but said "there was no means of identifying" who did it, or where the incorrect information had been entered. Although the mistake was made by Hospital Trust staff, the report blamed UK Transplant for failing to set up a standard nationwide system for entering patient details. . ."

3.6.40. Healthcare at your fingertips - a Choose & Book roadtest (18 Feb 2008)

The Inquirer

http://www.theregister.co.uk/2008/02/18/choosenbook_review/

"NHS IT - money, well, spent. . ." [There follows a detailed account of fruitless attempts to use Choose and Book.]

3.6.41. UK government data protection is a shambles (10 Mar 2008)

The Register

http://www.theregister.co.uk/2008/03/10/uk_gov_data_protection_shambles/

"The UK Government has failed to put in place basic data protection and integrity policies despite recent major information breaches, according to an online ID firm. Responses to Freedom of Information requests by online identity firm Garlik reveal that all 14 of the government departments that responded lack basic systems for proving compliance with the Data Protection Act (DPA). Garlik sells services that allows consumers to identify what personal information about them is in the public domain and manage how their identities appear online. The DPA states that an organisation needs to act if someone tells it the information it holds on them is inaccurate. But only the House of Lords and the Serious Fraud Office maintained a written data correction policy or protocol. Even these government bodies failed to maintain regular independent audits. . . With the national identity register and huge NHS databases on the horizon, the public can have little confidence that data held about them by the government is correct. As a result, important decisions affecting their lives may be based on erroneous information, Garlik warns. Large scale databases typically have an error rate of between five and ten per cent, Garlik said, so a government database containing 10 million records might have between 500,000 and one million errors. Garlik is calling on the government to pull up its socks by establishing written policies and procedures for monitoring the accuracy of information and correcting erroneous database entries. It also wants government departments to publish reports based on periodic independent audits."

3.6.42. Barts NHS NPfIT go-live ends up in "The Sun" (10 Apr 2008)

Computer Weekly - Tony Collins IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/04/barts-npfit-golive-ends-up-in.html

"Barts and the London NHS trust has ended up in "The Sun" newspaper yesterday [9 April 2008] after going live with a basic version of Cerner's "Millennium" Care Records Service under the NHS's London Programme for IT. The newspaper claimed that "two top hospitals descended into chaos last night as a multimillion pound computer scheme crashed on launch day" . It said the system should hold all patient records and bookings of operations, but it "failed, forcing doctors at the Royal London and Barts hospitals in East London to write notes on slips of paper." Responding to story, Barts and The London NHS Trust issued a statement which denied the system had crashed but made no comment on The Sun's claim that doctors had resorted to writing notes on slips of paper. The trust's statement gave the impression of minor problems only, saying the "majority" of issues had been resolved within 24 hours. It apologised to patients for a "slight delay" while staff familiarised themselves with the systems. . ."

3.6.43. Choose and Book glitch gives patients wrong appointments (22 April 2008)

Onmedica

http://www.onmedica.com/NewsArticle.aspx?id=d90d1db7-4c4d-4a3b-bfe1-0c1a574ebf7a

"Hundreds of patients have been given the wrong appointment through Choose and Book, Connecting for Health has confirmed. A glitch in the software has meant that some patients were given other patients' appointments – so they received the wrong time at the wrong clinic and with the wrong

consultant. The problem has meant that Connecting for Health has been forced to delay the release of updated Choose and Book software (release 4.0). . ."

3.6.44. Spine problems force trusts to switch off CRS (2 Jun 2008)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/3807/spine_problems_force_trusts_to_switch_off_crs

"Trusts across England were forced to switch off their connection to the Personal Demographics Service, after a weekend upgrade led to the system suffering from 'intermittent problems' leading some to stop using their electronic record systems. The weekend upgrade, called Spine release 2008-A, was a major upgrade to the Spine PDS service. The PDS is the national NHS spine service, which forms the core of the NHS Care Records Service - underpinning basic patient administration and the creation of electronic care records. An NHS Connecting for Health spokesperson said the Spine was upgraded over the weekend of 30 May - 1 June, with a number of problems identified and fixed over the weekend. However on Monday morning further issues arose with the PDS. "These problems were investigated by NHS CFH and BT, the supplier of the Spine service, and have now also been resolved." Several trusts today told E-Health Insider the upgrade led to a series of glitches, which made using patient administration systems - supplied as the first stage of a CRS - difficult to use over the weekend. Some trusts have had to switch off patient record systems as a result. Three NHS trusts in the North Midlands and Eastern Programme for IT, live with the iSoft iPM patient administration system, said the system proved difficult to use during the upgrade, and they were forced to switch it off until they received assurances from NHS Connecting for Health it was 'fit for purpose.' . . ."

3.6.45. Winchester has four-day Millennium failure (12 Jun 2008)

e-Health Insider

http://www.e-health-insider.com/news/3844/winchester_has_four-day_millennium_failure

"Winchester and Eastleigh Healthcare NHS Trust, has in the past week suffered a four day problem with its Cerner Millennium Care Records System (CRS) that left it unavailable to some users for up to four days. The problems began on Thursday, 5 June, and though largely resolved by Sunday were not fully fixed until Monday, 9 June. While the system was unavailable the trust reverted to manual paper systems. Enquiries by EHI revealed that support to get the system running again was supplied by Fujitsu. In a prescient June board paper the trust identified uncertainty over support arrangements as a result of Fujitsu ceasing to be LSP as a critical 'red' strategic risk to the trust. The paper says the trust is, Working with SHA and SPfIT to ensure full maintenance contracts are in place and agree an escalation process in the event of a system failure..." Shortly afterwards Winchester become the first trust in the south to have to put the interim support arrangements for its Millennium system to the test, since Fujitsu who installed the software had its regional local service provider contract (LSP) ended. There has been a recent track record of problems with the centralised hosting of the software. In May alone there were two instances of region wide problems, resulting in the Millennium system becoming unavailable or very slow to access. . ."

3.6.46. NHS IT mess hits cancer patients (27 Jun 2008)

BBC News

http://news.bbc.co.uk/1/hi/health/7477099.stm

"Patients with suspected cancer have had urgent appointments postponed at a top London hospital because of problems with the new NHS computer system. It is one of a series of problems faced by Barts and The London NHS Trust since the IT system went live in April, according to Computer Weekly magazine. Other issues include patients being booked into closed clinics and repeatedly cancelled appointments. A spokesperson for the Trust said there had been no clinical harm to patients. A total of 11 patients with cancer have had urgent appointments postponed for between two days and a month - the government target states that every patient with suspected cancer should be seen within two weeks. . . Members of the board also heard that the hospital is not receiving any money for treating patients because the records of what work has been done are not reliable. There are also problems with meeting the four-hour wait target for seeing emergency patients because staff are struggling with the new system. The Millennium software system used at the Trust was provided by Cerner for British Telecom who are charged with upgrading IT in the London region. . ."

3.6.47. Chaos as £13bn NHS computer system falters (10 Aug 2008)

The Observer

http://www.guardian.co.uk/society/2008/aug/10/nhs.computersystem

"A £13bn overhaul of the NHS records system has suffered so many problems that hospitals have struggled to keep track of people requiring operations, patients with suspected MRSA and potential cancer sufferers needing urgent consultations. Glitches in the roll-out of the Connecting for Health computer system have also resulted in delays at accident and emergency departments, soaring complaints and failures to identify child-abuse victims. The revelations are just the latest setback for what the government has pledged will be a key factor in improving NHS services. According to the board minutes of the first London NHS trusts to install the new system, obtained by The Observer and Computer Weekly, it has had a serious effect on patient care, a problem that raises questions about its introduction to hundreds of other hospitals and trusts. A report to the Enfield Primary Care Trust in March reveals that difficulties with the system last year meant it did not have vital data identifying patients awaiting operations. As a result 63 patients of the Barnet and Chase Farm Hospitals NHS trust had their operations delayed. In April, the trust found that the system had failed to flag up possible child-abuse victims entering hospital to key staff, 'leaving the responsibility to the receptionist'. The same trust noted the following month that 272 elective operations were cancelled at the last minute for 'non-clinical reasons' and that 20 patients were not readmitted for treatment within 28 days at the end of last year because the 'surveillance system for tracking' them 'was not operational in the new ... system'. The board's minutes show 14,000 people contacted the trust last year with concerns about their treatment, compared with 5,500 in 2006. A report to the board of another NHS trust, Barts and the London, says that for six months to May this year the trust failed to meet targets for treating emergency patients within four hours, chiefly because staff were unfamiliar with the new computer system. The same report reveals that in May there were 'breaches of the two-week urgent cancer access guarantee' for the same reasons. As a result 11 patients who were suspected of having cancer did not receive consultations on time. According to minutes presented to the Buckinghamshire Hospitals NHS Trust, problems with the new system last year meant potentially infectious patients with MRSA were not isolated for up to 17 days. The problem had to be rectified manually by staff who updated the patient records themselves. 'This took approximately six weeks to do, during which time there was a possibility that some MRSA-positive patients may have slipped through undetected if medical notes had not been available,' according to the report. The revelations have prompted claims that the government is losing control of the flagship project. 'IT projects well implemented can be a huge benefit,' said Stephen O'Brien, the Conservatives' health spokesman. 'Clearly from the problems being encountered by many trusts, the benefits are not being achieved and all the risks are falling on patients.' Many trusts have delayed implementing the new system as a result of the problems and the chief executive of Connecting for Health, Richard Granger, resigned last year. Those trusts that have implemented the system complain it diverts staff from key duties. A report last month to the board of the Royal Free Hampstead NHS Trust said 12,000 patient records had to be manually amended over a three-week period. . ."

3.6.48. Patients 'at risk' from flawed £12bn IT system (5 Oct 2008)

Sunday Times

http://www.timesonline.co.uk/tol/news/uk/health/article4882792.ece

"An NHS computer system intended to revolutionise patient care has so many software flaws that seriously ill or badly injured patients are at risk of being inaccurately diagnosed, according to an internal health service document. An assessment of the system at the first hospital to launch it, the Royal Free Hampstead NHS Trust in north London, details a catalogue of software glitches and design faults. It warns that the problems pose a possible "risk to patients by underestimation of clinical condition". According to the document, the system, which is being used in the accident and emergency department, is routinely crashing, patient information is intermittently "lost" and some staff are reverting to pen and paper. Extra staff have been drafted in to help cope. Tony Collins, executive editor of Computer Weekly, said the document, disclosed by an NHS employee, warned that some of the problems could "continue indefinitely". He said: "This is the centrepiece of the Connecting for Health programme [the government's plan to computerise NHS records] and it isn't working properly." Hospital officials said this weekend that continuing problems were being "vigorously" pursued with the contractors while staff were being vigilant to ensure patient safety was not compromised. The report is the latest setback for the £12 billion Connecting for Health programme, which was meant to provide a

single nationwide IT system for the NHS containing records for every patient by 2010. While some elements of the programme have been introduced ahead of schedule, the patient record system has been beset with delays and software problems. Last June the Royal Free became the first trust to launch the most advanced version. To protect patient confidentiality, records can be accessed only with a swipe card and a code. The launch was a key test for Connecting for Health, which has faced questions about the reliability of its systems and whether patient confidentiality could be easily compromised with computerised records. Two months after the launch there were reports of missing data and delays in booking patient appointments. Now an assessment of the new system at the Royal Free has uncovered a series of problems, which appear to be unlikely to be fixed in the short term. The Royal Free Hampstead NHS Trust said the implementation of the new system was initially better than expected but there were continuing problems that would "take some time" to rectify."

3.6.49. London hospital trust loses £7.2m in upgrade debacle (6 Nov 2008)

ComputerWorldUK

http://www.computerworlduk.com/management/government-law/public-sector/news/index.cfm?newsid=11850

More NHS computer trouble as BT installs Cerner system. The Royal Free Hospital in London has lost £7.2 million over six months as a result of its implementation of new Cerner-based IT systems. Details of the loss, around six percent of the budget, were outlined in a half yearly review presented to Royal Free board last month. Hospital chiefs were given details of the additional costs and lost opportunities to treat patients – and hence get paid – incurred during deployment of the system by BT. The report stated that the new system did not properly support the trust's "patient pathway". This meant "many clinical and admissions slots were not used". It highlighted incorrect and missing data on the new system. This was "in part due to the clunky workflows and, in part to the lack of experience of our staff in using the actual Royal Free build," the board was told. Trust leaders heard that: "The system supplied was different to the system supplied for training, and there were no operating procedure manuals for the system." Additional staff were required to rectify data issues and to "maintain normal activity levels", at a cost of £1.2 million. Finally, problems with the stability of the system were reflected in declining levels of clinical efficiency, which the Royal Free estimates cost it £900,000. The LC1 system, which went live at the Royal Free in August, is London's first version of Cerner Millennium, is one of two key records systems being rolled out across the UK under the National Programme for IT in the NHS (NPfIT). It links directly into the NHS spine, which is the central database for digital records of patients. Responding to staff complaint about "chaos" after the new system went live, the Royal Free said, reports of major problems were exaggerated and that it was "certainly not correct" to call the situation chaotic. "A new system of this size and complexity inevitably meant a few teething problems and that staff had to get used to new ways of working and new processes," the trust said in a statement. "The implementation of the system involved training 4,000 staff and months of preparation."

3.6.50. Patients 'sent to wrong hospital' (2 Feb 2009)

The Times

http://business.timesonline.co.uk/tol/business/industry_sectors/technology/article5636729.ece

Patients going to see Dr Paul Thornton, a GP in Kingsbury, Warwickshire, were told that his new computer system would allow them to be referred to a consultant in a matter of seconds. There would be no more need to wait while he wrote letters to hospitals, which took weeks to process. Arrangements for their treatment could be made online in a few clicks, while they watched. But the technology, the NHS's new Choose and Book system, was slow and clunky and crashed frequently, Dr Thornton said. He complained to the agency running the NHS programme, Connecting for Health, and was given an interim system that did not work much better. In the interim system, he said: "We had to enter the patient's details and the system would give you a username and a password which we would give to the patient. They went away and rang a helpdesk which would sort out a hospital appointment. The trouble was that the patients were being diverted to hospitals which were not appropriate. Some were sent to departments 50 miles away." That system prevented GPs from matching patients to individual consultants. "It took away the personal quality of the process," he said. "It failed to take into account that we look for consultants who will be able to respond to the individual patient." Within three months he stopped using the system, as had others, he said. New technology was crucial, "but they have got to get it right". Not all NHS professionals dislike the new technology. Simon Eccles, an

A&E consultant at Homerton Hospital, East London, uses BT's Cerner Millennium to order tests and book appointments. "I work in a fast-moving environment and the system allows us to see exactly what's happening with every patient," he said. "It's fantastic."

3.6.51. NHS severe computer faults double (3 Feb 2009)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/4538/nhs_severe_computer_faults_double

NHS Connecting for Health, the health service's IT agency, has revealed that the number of severe faults in NHS computer systems has doubled over the past three years. Last year nationwide NHS computer systems suffered 820 severity-one or critical faults with national applications, provided by National Application Service Providers (NASPs) the majority relating to the N3 network. In 2006 the figure stood at 488. According to the Department of Health over 91% of NASP severity one incidents relate to the NHS national broadband network (N3). NHS CfH defines a severity one NASP fault as a problem affecting a system critical to patient care or affecting 5,000 NHS computer users or more. In addition the service suffered 1,850 severity two failures in 2008. Figures for severe reported faults with local service provider (LSP) systems have meanwhile declined from 349 in 2006 to 262 in 2008. The number of level two LSP faults has remained at around the 1100 mark for each of the past three years. The DH said that the figures related to reported problems and were not a reflection of system performance. "In practice and after investigation, many incidents are found to be local hardware, software or infrastructure problems, or they are re-categorised with the agreement of the user". The figures were revealed in a written parliamentary answer to Liberal Democrat MP Norman Lamb. In part the increased number of NASP faults is likely to relate to wider user of enterprise-wide IT systems within the NHS, as a result of the roll-out of parts of the £12.7bn National Programme for IT (NPfIT). Better reporting mechanisms, with specified service levels in contracts, may also be a factor. In October 2008 the number of critical faults in national IT systems jumped to 165, from 71 the previous month — a spike CfH attributed to "a set of issues affecting two systems". According to a ZDNet report the agency said the two unspecified problems had a "noticeable effect" on a number of NHS computer users.

3.6.52. NHS boss attacks e-records system (13 Feb 2009)

BBC News

http://news.bbc.co.uk/1/hi/health/7887438.stm

"A new NHS computerised medical records system on trial at a London hospital has been criticised by a hospital boss for causing "heartache and hard work". Andrew Way, chief executive of London's Royal Free Hospital, said technical problems had cost the trust £10m and meant fewer patients could be seen. The Department of Health said lessons had been learnt from the trial. The England scheme, part of a £12bn IT upgrade, aims to put 50 million patient records on a secure database by 2014. The Royal Free, one of a number of early adopters of e-records, has been using the system since last summer. The project, restricted to England, has been one of the most controversial aspects of the overall 10-year IT programme, which also involves an online booking system, digital imaging for X-rays and electronic prescriptions. Mr Way said the cost of the problems had meant the hospital had been unable to invest in new equipment. He also said technical glitches had caused more work for staff and meant out-patients' bookings were taking four times as long. As a result, the hospital has had to employ another 40 administrative staff to handle the extra workload, he added. The faulty system had also prevented the hospital from billing other parts of the NHS for treatment. Mr Way said: "I think it is very disappointing that the work we had to do as a trust has caused our staff so much heart-ache and hard work. Many of the medical staff are incredibly disappointed with what we have got. I have personally apologised for the decision to implement the system before we were really clear about what we were going to receive. I had been led to believe it would all work." However, he said he still believed in the idea of replacing paper records with an electronic system, but it would need more work to get it right. . ."

3.6.53. Hospital abandons Care Record plans after rollout causes chaos (3 Mar 2009)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4122017&c=2

The rollout of the Summary Care Record has caused such chaos at A&E that the first hospital to gain access has had to abandon plans for routine use of the system, Pulse can reveal. A Connecting for Health document reveals use of electronic records at the Royal Bolton Hospital A&E department led to farcical scenes and long queues of patients because it was so slow. The ability for A&E to access patient information held by GPs was one of the main reasons for introduction of the care record. But the document released by Connecting for Health's Summary Care Record Advisory Group reveals Bolton hospital had to abandon plans to access records except on the specific request of doctors and even then by printing out hard copies. A benefits realisation study found care records had been accessed for just 24% of patients - because of delays in the system and 'low numbers of patients with SCRs'. The method for checking whether patients had records uploaded was 'cumbersome' and searching for and printing out a care record took staff an average of one minute. 'Queues occur for walk-in patients when there are any delays in the booking-in processes,' the report found. There were some benefits of the care record in A&E, particularly for patients with complex and acute problems, and also in the hospital's pharmacy, community and acute medical receiving units. An NHS Bolton spokesperson said a system upgrade next year would flag up when a care record had been uploaded, 'helping reduce access time'. He added that only a minority of patients in A&E would have a care record, since only a third of patients in Bolton had had information uploaded, and patients from other areas also used the hospital. Dr Darren Mansfield, GP clinical lead for urgent care at NHS Bolton, insisted the project was on track. 'The care record is starting to show its potential to dramatically improve the quality and safety of care we deliver to Bolton's patients,' he said. But GPs critical of the care record claimed the report showed the project was of limited value. Dr Mark McCartney, a GP in Pensilva, Cornwall, said: 'The evidence is beginning to suggest there is no benefit for the vast majority of patients attending A&E. For the small minority for whom there might be a benefit, other cheaper, more secure and acceptable systems could be developed, such as patient-held records.'

3.6.54. PACS - jewel of the £12.7bn NHS IT scheme? (9 Sep 2009)

Computer Weekly - Tony Collins IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2009/09/pacs---the-saviour-of-the-127b.html

When Roger Conway, a company secretary, broke his arm at Bristol Airport, he came to understand that PACS x-ray systems cannot always talk to each other. Ministers, loyal Labour MPs and Whitehall health officials cite PACS [picture archiving and communication systems] as an example of the success of the £12.7bn National Programme for IT. But integrating PACS so that images and radiology notes can be exchanged between hospitals remains a problem. On a Sunday last month, Conway stepped into a gap between a ramp and bollards where alteration works were taking place at Bristol Airport. He was taken to Weston General Hospital, which is a pioneer of the NPfIT. It was one of the first hospitals in the south of England to install the Cerner Millennium system as part of the NHS IT scheme. It also installed a PACS system in 2006. Doctors and nurses were understandably enthusiastic, according to the hospital's publicity. To Conway, PACS has some way to go before it'll earn his admiration. He ended up having the same x-rays done twice because Weston General Hospital did not transfer the PACS images it had taken of his broken arm to his local hospital about 30 miles away in Taunton. His local Musgrove Park Hospital in Taunton is in the in the same county as Weston - Somerset - and the two hospitals are controlled by the same PCT. But PACS images are not routinely transferred between the two hospitals. Conway says that Weston was unable to put an electronic copy of his x-rays on a CD which he could take with him to Musgrove. Weston's staff had suggested to him that Musgrove would be able to access the radiology notes the next day. This proved incorrect and even an email with the x-rays attached was refused. He was told that Weston and Musgrove's PACS systems were incompatible. Today Conway could be forgiven for saying that if PACS is the main success of the NPfIT where does this leave the rest of the £13bn programme? . . . There's no doubt that PACS has been a boon to Weston. Its efficiency brought down waiting times for x-rays, images don't get lost, there's no need for storage space for films, radiology staff don't need to touch the dangerous chemicals they previously used for processing films, and patients don't have to wait for, and carry around with them, packets of x-rays. Diagnoses are made more quickly and the working space is more spacious and airy. Clinicians can manipulate areas of the image normally lost to under or over exposure. But ... One of the promises made for PACS in 2001, when it began to be installed by hospitals in earnest [before the NPfIT which was launched in 2002] was that images could be transferred to other hospitals, peripheral clinics, GPs and the homes of doctors, at least in a compressed format. Eight years after the promises, this sharing of PACS images has yet to become a widespread practice. In 2001 the sharing of PACS images was being promised even over dial-up modems. Now the NHS has a data spine and broadband. In March this year, according to E-Health Insider, a report of the Royal College of Radiologists said that PACS

systems in England are largely successful in individual hospitals but communication between systems in different hospitals is poor. . .

3.6.55. IT causes 14,000 NHS patient waiting list backlog (1 Oct 2009)

Computer Weekly

http://www.computerweekly.com/Articles/2009/10/01/237934/it-causes-14000-nhs-patient-waiting-list-backlog.htm

IT problems at one of UK's most respected hospital trusts has led to a backlog of at least 14,000 London patients on a waiting list for treatment. The backlog affects patients at St Bartholomew's (Barts) Hospital and The London NHS Trust, which serves two million people in east London, the City, and Canary Wharf. Barts, which describes itself as world renowned, has 22,000 electronic patient records on its waiting list of people who should be treated within the national target of 18 weeks. Many are duplicates, but at least 14,000 are considered by trust staff to be the records of individual patients. The trust says dealing with the backlog may mean some patients end up waiting more than 26 weeks for an operation, in breach of government targets. Doctors say there are inaccuracies in data, the system can be slow and staff do not always understand the work-arounds, and the way the system works in combination with the trust's practices. They add that, unless they fully understand the system's characteristics, they may find the data hasn't gone to the right place for the patient to be treated. Barts and The London NHS Trust told Computer Weekly: "It has been a frustration for everyone at Barts and The London NHS Trust that our desire to meet the 18-week national target has been compromised by previous weaknesses in our information management and administration systems. The Trust has no evidence, however, that any patient has come to clinical harm because of the backlog." Since installing the Cerner Millennium Care Records Service in 2008, as part of the NHS's National Programme for IT (NPfIT), staff and doctors at Barts and The London NHS Trust have lost track of thousands of patients on its waiting lists. Some in the NHS are surprised the IT problems at Barts have continued for nearly 18 months. In June 2008, Barts said: "the outstanding issues resulting from the implementation of Care Records Service are in the process of being resolved". Barts' 18-week waiting list backlog reached 26,640 in August. This had been cut to 22,000 patient cases by the end of last week. From these 22,000 staff and doctors are unable yet to tell which patients have had treatment within the government's 18-week standard. The main health authority in the capital, NHS London, said in a statement to Computer Weekly: "Barts and the London are working to address a potential backlog of around 23,000 patient records to determine those who have been treated within 18 weeks and those who have breached this standard." The strategic health authority is meeting monthly with the Trust and its commissioning PCT to ensure that this backlog is addressed." Computer Weekly has also learned that Mike O'Brien, the health minister responsible for the NPfIT and the 18-week standard, is receiving fortnightly reports on the efforts at Barts and The London to reduce the backlog. The problems at Barts - and at other London hospitals which run the Cerner Millennium Care Records Service - could undermine a decision to resume a roll-out of the NPfIT system after a halt last October. The next hospital in line for the system is Kingston Hospital NHS Trust. The Department of Health's website says nobody should wait more than 18 weeks for the start of their treatment, from the time they are referred by a GP, unless they choose to wait longer or it is clinically appropriate to wait longer.

3.6.56. NHS IT pioneers see risks of over-optimism materialise (5 Oct 2009)

Computer Weekly

http://www.computerweekly.com/Articles/2009/10/05/237989/nhs-it-pioneers-see-risks-of-over-optimism-materialise.htm

When a group of pioneering hospitals in London went live with a major e-records system under the government's £12.7bn NHS IT scheme, a headline in The Sun set the scene for the next 18 months. "Data Woe at 2 London Hospitals," it said, pointing out that doctors had been forced to write notes on slips of paper when a new Care Records Service system crashed. Barts and The London NHS Trust and BT, the main IT contractor for London under the National Programme for IT (NPfIT), denied the story. The trust said, "The new patient administration system - also known as the Care Record Service (CRS) - did not crash A period of adjustment was anticipated with contingencies in place to support staff who experienced any problems, with the majority of issues being resolved within 24 hours." The statement proved optimistic. Difficulties at the trust have escalated, almost month by month, since the Care Records Service system went live in April last year. Backlogs of patients who were not seen or treated within government waiting-time standards grew at first to hundreds. Now, 18 months after the go-live,

Computer Weekly has revealed that at least 14,000 patients are on a backlog for treatment. Barts has lost track of their appointments - though the system was installed to keep track of the healthcare "pathways" of patients. No one should wait more than 18 weeks for treatment after being referred by a GP, under government guidelines. But hospital executives have no idea how many of the 14,000 patients are outside of the 18-week limit. Doctors at the hospital made electronic requests for their patients to be treated, but found much later, or never discovered at all, that the appointments had not been made. Doctors or their staff pressed the wrong keys, or the requests did not end up at the expected destination, or both. Data already in the system was inaccurate and some doctors found the technology was not always simple to use, or did what they expected. Most worryingly, nobody seems clear on what has caused the chaos. Since August things have got a little better. The 18-week backlog has come down from 26,640 to about 22,000. Some of the 22,000 on the list comprise duplicate records, but at least 14,000 are thought to represent actual patients. The trust's board hopes things will be back to normal by December. But the trust has been hoping since April 2008 that a return to normality was around the corner. It is difficult not to feel sympathy for Barts' IT specialists, doctors and administrative staff. The decision to go live was taken at a higher level, amid a ministerial imperative for the NHS to show that the NPfIT was delivering. London officials wanted to show that the capital could deliver. But they may have fallen victim to the "irrational exuberance" which afflicts large IT projects. Today the political pressure for the NHS to install the Cerner Millennium Care Records Service throughout London is as strong as ever. Ministers and officials hope that a succession of successful launches will throw a warm light over the NPfIT. The Care Records Service programme is running four to five years behind schedule, according to the Public Accounts Committee. Ministers want to catch up. So officials in London have announced plans to resume a roll out of the Cerner system. They say that the lessons from Barts and other sites have been learnt. But going live elsewhere before anything has been published on what exactly has caused the problems at Barts may be a further demonstration of unwarranted optimism. Ross Anderson, professor in security engineering at the University of Cambridge, said, "Hospital managers have good reason to ask why they are ordered to put in systems that are not fit for purpose and are then punished for not meeting targets when there has been a balls-up." Politics has plunged some hospitals, particularly Barts, into administrative and operational turmoil in the name of the NPfIT. It will be a pity for patients if politics continues to dictate the roll out of the programme.

3.6.57. The chaos of the NHS's electronic records (14 Dec 2009)

Daily Telegraph

http://www.telegraph.co.uk/health/healthadvice/maxpemberton/6787809/The-chaos-of-the-NHSs-electronic-records.html

"What's his name?" I asked. The nurse in A&E shook her head. "His address?" Again, nothing. "OK, do we know anything about him?" The nurse shrugged - not a thing. The mystery man had been brought in by police after he was found stumbling and acting strangely in the street. He was unable to talk and had no wallet or identifying documents on him. Although he was not wearing shoes, he looked quite well dressed and was obviously not living on the streets. At first we thought he must be drunk, but he didn't smell of alcohol and after several hours in A&E there had been no change in his presentation. "He must have come from somewhere," I said, while the police checked for missing persons. All our attempts to find his identity drew a blank. One of the nurses persevered and he managed to tell them his name. With this information, we looked him up on the new, super-duper NHS electronic records. There he was! Bingo! But what was it we were hoping to find out? We looked at his address and then got back to doing blood tests and a scan and ensuring he was stable. In such an acute setting, finding out where someone lives, that he has an ingrowing toenail or that he's allergic to peanuts is not really the priority. When someone is brought in unconscious or unable to speak or give any history, the priority for the medical staff is to ensure they are physiologically stable - that they are breathing, their heart is beating and their blood pressure is adequate. While background details are important, these are rarely the pressing concern when someone is in extremis. Yet the Government has repeatedly justified the ludicrously expensive NHS IT programme on the grounds that it is needed in precisely this situation. The reality is, it's not. Not only this, despite vast sums being spent, the system is not fit for purpose. Aside from the issues around confidentiality and the Government's refusal to allow people to opt out from having their personal details entered into the system, the whole thing has proved to be an ill-thought out, wasteful and unnecessary white elephant. Different trusts have different IT systems locally, and social services have different electronic records altogether. Mental health records are on different systems to GP records, which in turn are entirely different to the records kept in hospitals. Chaotic would be an understatement. As these systems have been developed

independently and adopted piecemeal, there is no meaningful communication between them. There is no guarantee that you will find the information you are looking for. There are duplicate entries; details are wrong or out of date. Not only this, but now that hospitals have moved away from paper-based records, wards have had to be provided with laptops, and everything must now be typed. Systems crash, work is lost, hardware is lost or stolen, or breaks. Of course, rolling out IT programmes costs money in itself - staff have to be trained, support staff employed, and space found for training centres. In the pre-Budget report last week, Alistair Darling announced that the National Programme for IT will be scaled back. The cost of this programme has already spiraled to more than £12 billion. This is one NHS cutback that I wholeheartedly welcome, but I wish that it had happened before so much money had already been spent. Most doctors and nurses I know are only too well aware of the impact of wasteful, unnecessary spending in the current economic climate. We are only too aware that if some non-essential things are not sacrificed now, then cuts in the future may have to impact on patient's welfare. None of us want that. We want the NHS to be lean, focused and financially robust. As much as IT professionals would like to tell us otherwise, a computer programme does not save your life. It doesn't check your feet when you've got diabetes or plaster your leg when you fall over. It doesn't operate on your hip or turn you when you've had a stroke. As the NHS IT programme has shown, if anything, it can actually hinder clinical practice. We eventually stablised the mystery man and diagnosed a rare type of withdrawal from alcohol. Up on the ward he began to speak and told us his personal details himself. The address we had for him was wrong; he'd recently moved. I'd expect something better for £12 billion.

3.6.58. Newcastle expands use of Millennium (17 Dec 2009)

E-Health Insider

http://www.e-health-insider.com/comment_and_analysis/545/tooning_up_millennium

Last month, Newcastle Upon Tyne Hospitals NHS Foundation Trust went live with the Cerner Millennium system it contracted from University of Pittsburgh Medical Centre, outside the National Programme for IT in the NHS. . . a few hours into a tour of the Freeman Hospital, one of four city hospitals to go live with a brave 'big bang' implementation of Cerner Millennium on 7 November, it's difficult to be anything but impressed by the electronic patient record system. Since the go live, the trust has been rolling out the five electronic health applications it contracted University of Pittsburgh Medical Centre to deliver after rejecting offerings from former local service provider Accenture and current LSP CSC. . . Newly recruited e-records programme director, Steve Leggetter, starts the whistle-stop tour on Ward 32, a 30-bed nephrology inpatient ward and part of the newly built renal services centre. It is the latest to be provided with Cerner's clinical functionality and is also the first in the country to implement Cerner's medicines management solution. . . The trust now has more than 1,500 of its 12,000 staff using the Cerner system and just over 700 concurrent users; more than treble the number of users across the whole of the country for the LSP product, Lorenzo. . . Visits to see healthcare IT in action can easily turn into carefully orchestrated PR tours of hospitals. Not this one. Clinicians and nurses were free to talk about what they liked and disliked about the system, and did not need prompting to come up with examples of how they were reaping benefits for themselves. In the Intensive Care Unit, where order communications have been running for a few days, results are being sent back in less than half the time it used to take, meaning that staff can change a patient's treatment far more quickly. . . Royal Berkshire NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust are also due to take Millennium outside the national programme. . .

3.7. Delays and Specification Changes

3.7.1. NHS IT suffering UK-wide delays (27 Apr 2005)

Computing

http://www.computing.co.uk/computing/news/2071710/nhs-suffering-uk-wide-delays

“ The first major local system on the timetable is the patient administration system (Pas), but suppliers in all five areas are having trouble meeting schedules. CfH has acknowledged delays in four of the regions, but Computing can reveal that there are also problems in the fifth area, the North West and West Midlands (NWWM). NHS sources say fewer than 300 users in the NWWM area are using Pas systems, out of tens of thousands of potential users. Even at such an early stage this number is

significantly below predictions, and is too low to test the scalability and functionality of the new technology."

3.7.2. Annual Audit Letter (2004/2005)

Airedale NHS Trust

http://www.wysha.nhs.uk/Library/Committee_Meetings/Board_Meeting_26_September_200/item%204%20-%20%2011%20July%202005%20minutes.pdf

" The progress of implementation has been severely limited by national difficulties, particularly delays and shortcomings in delivery of the NPfIT core services by the cluster's LSP. This is beyond the control of the local health community."

3.7.3. Suppliers advised to develop standalone software (26 May 2005)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=1225

" Connecting for Health (CfH) has confirmed that it is advising its suppliers to develop standalone versions of their applications, not reliant on the NHS Spine, in order to prevent further implementation delays. . . the implementation of the spine, which provides national infrastructure and services such as user authentication, security and data encryption for the Care Records Service, has been experienced serious teething problems and delays. Problems reported at early sites using elements of the spine have included reliability and the basic user log-in and identification process, which takes minutes rather than seconds."

3.7.4. Liverpool trust rejects delayed PACS (17 Nov 2005)

North Mersey Connect Portal

http://www.northmerseylis.nhs.uk/news/shownews.asp?id=3331

" A leading NHS trust in the North West and West Midlands cluster has been forced to scrap its implementation of a Connecting for Health (CfH) Picture Archiving and Communication System (PACS), due to delays and technical problems with the system."

3.7.5. Leaked e-mails emphasise divide between business goals and technology in NHS plan (22 Nov 2005)

Computer Weekly

http://www.computerweekly.com/Articles/2005/11/22/213038/Leakede-mailsemphasisedividebetweenbusinessgoalsandtechnologyinNHSplan.htm

" The e-booking part of Choose and Book is considered by the government to be critical to the scheme, and so the software is a key component of the NPfIT. In January 2005, the then health secretary John Reid said e-booking would be fully implemented by 2006, but the scheme is not now due to be fully rolled out until 2007 at the earliest. . ."

3.7.6. The nine projects at the heart of NHS IT (19 Jan 2006)

Silicon.com

http://www.silicon.com/publicsector/0,3800010403,39155714-1,00.htm

" Phase one of the [The NHS Care Records Service (CRS)] project, due to be completed in summer 2005, included the booking of outpatient appointments and the ability of health and care professionals to view basic patient information. . . According to the NHS Connecting for Health business plan, the aim was to have 50 per cent of the National Prescription Service in place by the end of 2005. But Connecting for Health told silicon.com: " The target was always going to be a challenging one to meet, especially given its reliance on system supplier and PCT deployment activity." . . . Choose and Book has been subject to long delays - finally coming into service a year later than expected. . . According to the NHS Connecting for Health business plan, the aim was to have 50 per cent of the National Prescription Service is in place by the end of 2005. But Connecting for Health told silicon.com: " The

target was always going to be a challenging one to meet, especially given its reliance on system supplier and PCT deployment activity." "

3.7.7. Report to the Board (25 Jan 2006)

West Midlands South Strategic Health Authority

http://www.wmsha.nhs.uk/Corporate/Papers_and_Publications/Board_Papers/25%20January%202006/13%20Report%20from%20the%20IMT%20Programme%20Board_jan.pdf

" There will be significant delays to delivery of the strategic Care Record Service solution in the North West / West Midlands Cluster. A delay mitigation plan is being developed which will deliver clinical benefits using existing technology."

3.7.8. NPfIT delays give local NHS trusts a financial planning headache (21 Feb 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/02/21/214306/NPfIT+delays+give+local+NHS+trusts+a+financial+planning.htm

" Board papers from West Yorkshire Strategic Health Authority reveal how delays to the hospital systems supplied by the programme are making financial planning " extremely uncertain" . They specify an allocation for the authority of £6.8m from Connecting for Health (CfH), which runs the programme. Also, £11.4m of the SHA's internal funds were allocated to implement CfH products in financial years 2004/05 and 2005/06. However, delays to the NPfIT mean this funding will need to be stretched over at least one extra year. It was unlikely Leeds Teaching Hospitals Trust would receive suitable systems before the end of 2008, according to board papers. Other hospitals would be in a similar position, they said. " Delays to product delivery have also made forward planning, and therefore any associated financial planning, extremely uncertain... If further funding is not forthcoming then it is possible that the [Leeds] Trust will not be in a position to implement CfH services," said the papers.

3.7.9. NPfIT delays in the south (25 Feb 2006)

Kable Public Sector Research, Publishing & Events

http://www.kablenet.com/kd.nsf/KNBetterSearchView/71811B0DE4CB7E7980256FB2004EC778?OpenDocument

" London and the southern regions of the NHS National Programme for IT (NPfIT) are reviewing the timetable for the infrastructure to support electronic care records. The changed schedule means that the clusters could face a six to eight month delay in implementing parts of the care record."

3.7.10. Implementation schedule slips in South (14 Mar 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=1763

" The introduction of the NHS Care Records Service in the South of England is set to be delayed following a revamp of the software to introduce new functionality and to address issues identified in the " white knuckle" initial implementation at Nuffield Orthopaedic Centre, Oxford. . . This additional work is understood to address issues around incorporating new clinical codes and the Choose and Book functionality. . . A leading clinician familiar with the issues involved told EHI: 'Whilst I totally support the NPfIT vision, the unrealistic timescales, the lack of local funding, the ongoing problems with delivery, the lack of openness so that lessons can be learnt, the spin and the blame culture are in danger or killing the programme.'"

3.7.11. NHS trust seeks compensation over patient records system delay (21 Mar 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/03/21/214857/NHStrustseekscompensationoverpatientrecordssystemdelay.htm

" An NHS hospital trust in south west England is seeking compensation for the late delivery of NHS Connecting for Health patient administration systems. United Bristol Healthcare NHS Trust is due to receive the electronic care records service system from Connecting for Health, the government agency running the £6.2bn national programme for IT in the NHS, to replace ageing EDS-supplied systems. Delivery of the Connecting for Health system to hospitals in the region had already been delayed by more than a year before local service provider Fujitsu replaced software supplier IDX with Cerner. A spokeswoman for the trust said it was asking for money from Connecting for Health or its local service provider to pay for the additional support cost from EDS caused by delays.

3.7.12. Summary care record delayed and abridged (25 Apr 2006)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=1850

" The content of the summary record uploaded to the spine will be cut back to include just allergy and prescription information initially, Connecting for Health (CfH) has decided. The decision to significantly abridge the initial content of the record has been made to allay GPs' concerns over the accuracy of their records."

3.7.13. Connecting for Health fails to lead on Contact (26 Apr 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=1849

" it turns out that CfH is failing to lead by example and continues to run its own Microsoft Exchange email servers. The agency was unable to tell EHI when it plans to fully move to Contact and make savings by switching off local email systems. . . The overwhelming majority of NHS and CfH emails routinely seen by EHI do not carry the tell-tale nhs.net suffix used by Contact, but instead carry other naming conventions indicating they come from local email systems. CfH failed to identify a single NHS trust that had fully migrated to the web-based system . . . According to CfH there are now 163,000 registered users of Contact, 80,000 of who are described as " frequent users" . In a bid to bulk out these registration numbers CfH has announced that all 400,000 members of the Royal College of Nursing working within the NHS, including agency staff, are to be bulk-registered automatically registered on Contact. But while the increased numbers are certain to look good in reports back to ministers, bulk registering staff for a service is very different from getting them to use it."

3.7.14. NPfIT for survival? (May 2006)

GovernmentIT

http://www.govnet.co.uk/publications.php?magazine=3

" To see the future of the NHS today, go to Salford. There, the care of people with diabetes is being transformed by electronic records shared by doctors, other health workers and patients themselves. . . A breakthrough by the £6 billion National Programme for IT? No. The Salford project is happening in parallel with the National Programme, and is at least a couple of years ahead in making information available where needed. The gap in progress between locally led innovations like Salford's and the slow pace of national projects symbolises a crisis in the world's single civil IT programme as it celebrates its fourth birthday. . . The programme's Head, Richard Granger, Chief Executive of NHS Connecting for Health, says that while enormous progress has been made, the delivery of some crucial systems is behind schedule. . . To try and keep the programme on track, local service providers are deploying a variety of 'interim solutions'. In acute hospitals, the interim solutions are little more than basic patient-administration systems, lacking EPR functions that some hospitals had already installed. Rather than accepting the proposed interim solution, a handful of trusts needing to replace their existing systems urgently for contractual or technical reasons have chosen to procure new systems outside the programme. The latest example is Northumbria healthcare."

3.7.15. Rush to fulfil prime minister's NHS vision tripped up IT programme (23 May 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/05/23/216022/Rush+to+fulfil+prime+minister's+NHS+vision+tripped+up+IT.htm

" In April 2000, the Public Accounts Committee . . . endorsed the view of the NHS Executive that five types of electronic patient records needed to be built first, before the consolidation of health records could be undertaken. These fives types of electronic patient records addressed the needs of professionals in mental health, acute hospital, GP primary care, community services and social care. . . The prime minister spelt out his vision to the government e-Summit in November 2002. He proposed that 600 million pieces of paper a year could be eliminated from the NHS. Of course, others were left with the task of trying to work out how. The recruitment of the NPfIT team in the autumn of 2002 set the framework for action. . . Forgotten, apparently, was the need for a first stage of five types of electronic patient records – a foundation upon which to build. The NPfIT concentrated right away on putting the national central building blocks in place, signing up a supplier for a national electronic booked appointments database in October 2003, and BT for the national element of the Care Records Service in December 2003."

3.7.16. NHS electronic records are two years late (30 May 2006)

Financial Times

http://news.ft.com/cms/s/d8aca40c-ef49-11da-b435-0000779e2340.html

" Plans to give all 50m NHS patients in England a full electronic medical record are running at least two to two-and-a-half years late, Lord Warner, the health minister who oversees the project, has confirmed. He also admitted that the full cost of the programme was likely to be nearer £20bn than the widely quoted figure of £6.2bn. The latter figure covered only the national contracts for the systems' basic infrastructure and software applications, he said. . . The delays to the electronic care record, which mean it may not be in place until early 2008, come in part because of delays in providing the software, which is being developed by iSoft and other companies. But the record's introduction is also being stalled by a fierce and unresolved dispute within the medical profession over what should be included on the national medical record, and how patients' data should be added. Some see it as threatening to " derail" the programme."

3.7.17. Regular check-up with a difference (31 May 2006)

The Guardian

http://society.guardian.co.uk/e-public/story/0,,1786033,00.html

" If you live in Salford and have type 2 diabetes, a regular phone call could keep you out of hospital. Care Call is a new service from Salford primary care trust that involves specially trained advisers keeping in touch with patients in their homes to update their records, advise them on their diet, and remind them to take medication and exercise regularly. It is an example of the kind of innovative service that becomes possible when carers have seamless access to electronic case records. Unfortunately, it is a beacon of excellence in an unjoined-up world. Plans to create electronic case records for both health and social care are falling behind schedule, the Guardian has learned, while a target of joining up the two by 2010 appears to have been quietly dropped. . . The Care Call service is underpinned by an electronic medical record drawing information from a collection of dedicated systems. Joining up information is tricky in long-term care because of the many different people and places involved in any individual's care. " Diabetes is multi-disciplinary and multi-locational," says project manager John Burns. " All information is held at the locality, all in different systems. In diabetes, these might include a podiatrist and an eye clinic as well as the GP and acute trust." The solution is a system from Graphnet, a specialist healthcare IT firm, that takes data from different repositories and presents it in a web format that can in theory be viewed from anywhere, including the Care Call headquarters and, eventually, the patient's own home. . . Salford is not the only local initiative developing electronic health records that share information from across disciplines, but it is one of the most advanced. It is at least two years ahead of the " official" NHS version - the Care Records Service - being developed under the NHS National Programme for IT."

3.7.18. NHS has another stab at records - Going one step at a time after all (20 Jun 2006)

The Register

http://www.theregister.co.uk/2006/07/20/nhs_ncr/

" A high-powered taskforce has been assigned to tackle problems with the overdue care records system, the core element of the troublesome £12.4bn National Programme for IT. The reputation of the national care records system was undermined in last month's House of Commons Public Accounts Committee on the NHS programme. It found development had been rushed without proper consultation with patients and clinicians. The Department of Health said in a statement yesterday that the task force would address " outstanding issues and concerns" and aid the introduction of the first phase of the care records system in 2007. The last official word on the timetable for care records was given at last month's PAC hearing. Then scheduled for late 2006, they were already running two years late. This had been blamed on suppliers having " difficulty in meeting the timetable" and clinicians wanting to see the system piloted. . . The taskforce is being chaired by Harry Clayton, national director for patients and the public at the DoH. It will consist of two British Medical Association chairs, an executive director of quality at Ealing PCT, and bosses of the Royal College of Nursing, Royal College of General Practitioners, the Terrence Higgins Trust, the college of emergency medicine, an ethics professor from Oxford and a patient advocate."

3.7.19. Lengthy delivery for NPfIT maternity systems (26 Jun 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=1965

" The delivery of new maternity systems as part of the NHS IT programme has stalled, E-Health Insider has learned. Not a single hospital has yet received a new system, and a leading obstetrician has warned that the delays are creating potential " clinical risks" to mothers and children. The lengthy delays to maternity software are causing huge frustrations for NHS trusts that urgently need modern systems to meet the latest statutory reporting and child screening initiatives, and effectively manage their clinical litigation risks. But the Evolution maternity software from iSoft, offered as a stopgap solution in 60% of England under the NHS National Programme for IT (NPfIT), is said to be out-of-date and requiring considerable development before it can be implemented. An NPfIT-compliant version of Evolution that connects to the central NHS data spine was meant to have been provided as an 'emergency bundle' from the beginning of 2005 to hospitals across the north west and west midlands, north east and east of England. This had only been intended as an interim solution to meet urgent needs before maternity functionality was delivered by NPfIT as part of an integrated 'strategic' clinical systems suite. But no hospitals have received any new maternity systems. The cumulative delays are said to be acting as a deadweight on the modernisation of maternity services, which had previously been considered leaders in using IT to deliver improved patient care."

3.7.20. Implementation dates for hospitals continue to slip (31 Aug 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2100

" An investigation by E-Health Insider has found that two-thirds of the 22 NHS acute trusts that were meant to be receiving a replacement patient administration system by the end of October say they will not hit the target. In late June NHS Connecting for Health and its local service providers told Richard Bacon MP, a member of the Public Accounts Committee, that 22 trusts would get replacement PAS systems by the end of October. Two months later, just seven of the trusts named have told EHI they believe the target will be hit. . ."

3.7.21. New setback for NHS computer (3 Sep 2006)

The Observer

http://observer.guardian.co.uk/uk_news/story/0,,1863760,00.html

" The troubled multi-billion-pound NHS computer system suffered a fresh blow last night when it emerged that two-thirds of the hospital trusts due to have installed an electronic patient administration system for booking appointments with consultants by the end of October will not meet the deadline. The delay has raised concern that the project - already two years behind schedule - may be continuing to overrun. The government believes it will cost £12.4bn but critics fear more delays could mean costs spiralling to more than £15bn. Of the 22 NHS acute trusts supposed to be receiving the new patient administration system by the end of October only seven believe they will now hit the target, according

to a survey by E-Health Insider, a specialist online magazine for health professionals. The system is crucial to the entire project as it is the foundation on which all other aspects of the IT system are built. . ."

3.7.22. Choose and Book set to miss 90% referral target (10 Oct 2006)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=2188

" The Department of Health's target for 90% of referrals to be made through Choose and Book by next March looks almost certain to be missed, as latest figures reveal every strategic health authority is behind schedule. The statistics show that while the average percentage of bookings made through the system is now 27%, many primary care trusts are still in single figures making the achievement of a 90% target by all 150 new PCTs highly unlikely. Figures reported to the September board meetings of the new SHAs show that in the case of the worst performing authorities less than half of the planned bookings had been made through the system during the summer. In South East Coast SHA 12% of outpatient bookings went through Choose and Book in August compared to the projected 28%, and in the East of England 13% of bookings went through Choose and Book, only just over a third of the 35% the SHA said it hoped to achieve by that stage. The figures for August from South East Coast SHA include some trusts that performed well, such as Croydon, which achieved 28% of referrals through the system. However, eight of the 25 old-style PCTs had used Choose and Book for 5% or less of referrals with East Elmbridge and Mid-Surrey PCT referring no patients through the system and East Surrey PCT only 1%."

See also: http://www.ehiprimarycare.com/comment_and_analysis/index.cfm?ID=172

3.7.23. Granger compares BMA to the National Union of Miners (13 Oct 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2198

" NHS IT boss Richard Granger has compared the British Medical Association to the National Union of Mineworkers, describing the influential doctors' trade union as a block to change in the NHS. His inflammatory comments came in a New Statesman round table on IT modernisation, in which he spoke of obstacles to the late-running £12bn NHS IT project. " There are some blocks to radical structural change. I have encountered an incredibly powerful union, comparable to the National Union of Mineworkers, and that is the British Medical Association." Dr Jonathan Fielden, the Chairman of the BMA's Consultants Committee, told EHI: " I think clearly remarks like that are unhelpful, particularly when the general tenor of relations with the government are good and improving." . . . Dr Fielden, a consultant intensivist at Royal Berkshire hospital, added the comments were unfortunate given the problems being experienced by the programme. " The CfH agenda needs friends and it needs help right now," he observed. " The programme is way behind schedule and significantly over budget." He added, " Richard Granger must be under intense pressure to deliver." . . . Dr Fielden added that it was a particular " frustration" that CfH had only sought clinical involvement on key issues such as the confidentiality of patient records " late in the day" . Dr Richard Vaughtrey, deputy chairman of the GPC and its lead on IT issues, told EHI that while communication with CfH had improved " There are still times we feel our views are not being taken on board." He added: " The key area is around the summary record, what it will look like, what it will contain and how it will work in practice." In a statement CfH told EHI the NHS IT director general's remarks were not taken from a verbatim transcript and " the full context is therefore missing" . The missing context was not supplied. . ."

3.7.24. HM Treasury unplugged - Government's IT late list (14 Oct 2006)

The Register

http://www.theregister.co.uk/2006/10/14/it_tyranny/

" The Conservatives have helped expose, again, the systemic failure of Government IT projects with a seemingly trivial parliamentary question about costs and timescales at HM Treasury. A written answer extracted by Theresa Villiers, shadow chief secretary to the Treasury, discovered that IT projects were running a total of 17 years late at HM Treasury under the leadership of Gordon Brown. . . On 4 September, in answer to a similar question by the Liberal Democrat MP Vince Cable, the Department of Health provided a tally as well. The only project for which the department had no clue of when it

started, when it would end and what it might cost was the infamous National Programme for IT, the IT industry's answer to the Millennium Dome. The DoH answer waffled that NPfIT didn't really having a start or end date because it was sort of, well, " substantial" , being planned on the fly, " incremental" , and " providing increasingly richer functionality over time." . . . NPfIT faltered because it was imposed from above, without reference to the clinicians who were to use it. Connecting for Health, the organisation responsible for NPfIT, admitted that if it had consulted the intended users of the system more widely and included their views in its design, they might have a better idea of what it was doing. It was trying to be too big, too clever, and had tried to impose its world view on too many people. . ."

3.7.25. Specialists dispute keyword changes for C+B (25 Oct 2006)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=2215

" A dispute between specialists and the Department of Health over use of keywords for Choose and Book clinic types has led the British Society for Rheumatology (BSR) to recommend that consultants do not populate their directories of services. Dr Andrew Bamji, the society's president, said that he and other members spent the last year drawing up a list of 177 keywords mapped to clinic types after a request by NHS Connecting for Health. He told EHI Primary Care: " We submitted it and we thought we have done a good job there but then discovered by chance that the lists that we had submitted were not the lists that were published." Dr Bamji claims that another group within CfH, not including specialists, had reviewed the list, cut the keyword list down to 140 and changed some clinic types. He said: " We were taken aback. Our part of CfH had no knowledge that the keywords were being revised by this other group. We have put an enormous amount of time into it and then to have someone else fiddling with it and not even be told about the changes is not helpful." Dr Bamji says the discovery of the changes led the society to alert other speciality groups who had also drawn up keyword lists mapped to clinic types as part of CfH body called the Specialist Association Reference Group. He added: " They found that they also had had changes put in to their lists that they were not happy about." Professor Angus Wallace, who leads the specialties on the group, told Hospital Doctor magazine that specialties might pull out of SARG as a result of the problems. . ."

3.7.26. Newcastle develops options outside CfH (26 Oct 2006)

eHealth Insider

http://www.e-health-insider.com/news/item.cfm?ID=2217

" Newcastle Hospitals NHS Foundation Trust has gone out to tender for key elements of a new Electronic Health Record system, outside the National Programme for IT, to hedge risks created by delays to the Connecting for Health programme growing beyond the current two years. The trust faces an urgent requirement for a new Maternity system, as its existing McKesson system will not be supported beyond next June. The Foundation trust is also seeking a new PAS system, a replacement for which CfH had originally promised to provide by January 2005. Newcastle becomes the latest independent Foundation hospital trust to seek to procure for key systems independently of the late-running £12bn NHS IT upgrade programme. The trust says that it is developing alternatives as the CfH programme is now running two years late, and may be subject to further delays. . .

Earlier this year Newcastle issued an OJEU notice for three other key operational systems: order communications, electronic prescribing and theatres. Bids are currently being evaluated by the trust with contracts due to be awarded by February 2007. The trust has now also tendering for a maternity system, an A&E system and patient administration system. The September trust board paper explains why: " The business and operational circumstances as a Foundation trust do suggest there is an urgent need to consider replacement of these systems as matter of priority and outside the national programme." The paper says " the original Connecting for Health programme is running two years late" with there being " no immediate prospect of system delivery" . It adds: " The Trust had originally planned to implement a replacement PAS on 18 January 2005 as the start of an incremental EPR development." . . . Newcastle makes clear that it plans to keeps its options open for the time-being and that its OJEU advert could result in more competitive submissions from suppliers yet keeping the trust's options open if CfH be subject to further delays. . ."

3.7.27. LSPs fail 'acid test' on PAS deployments (30 Oct 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2226

" Delivery of the patient administration systems due to form the foundation for future electronic patient records in NHS hospitals has stalled with only a fifth of the systems promised in June actually installed. In June NHS Connecting for Health said that 22 acute NHS trusts would get new PAS systems by the end of October. With just one day left, only four have actually been delivered, and in three of the five clusters none have been installed. Just four months ago NHS Connecting for Health told Commons Public Accounts Committee member Richard Bacon MP that its local service providers (LSPs) would install new PAS systems in 22 hospital trusts by the end of October. London was not included in the October target. Bacon told E-Health Insider that the 31 October PAS target was " a very clear test of the ability of the programme to do what it said it would." The conservative MP added: " It's an acid test in terms of what the programme is doing on hospital PAS deployments. We're not even talking here about clinical deployments." He said that he had written to Richard Granger, head of CfH in August asking for an update on progress, and had received no response. Bacon told EHI he has now written to Health Secretary Patricia Hewitt asking what deployments have since taken place. . . No acute PAS implementations have occurred for more than six months in three of the clusters: London, the North-east and Eastern. In June BT, the LSP for London, had pledged to deliver new PAS systems to three unspecified acute trusts by the end of December. No new implementations have since occurred and with BT currently negotiating to replace its clinical software supplier it looks like a prediction highly unlikely to be met. Similarly, no new hospital PAS systems are believed to have been delivered in either the North east or Eastern clusters. LSP Accenture had been due to implement four of the iSoft iPM patient administration systems, at Northampton, Airedale, Weston Park and Ipswich. . . The LSP which said it would achieve the most deployments by the end of October was Fujitsu, prime contractor in the South. Having completed its first Cerner implementation in December 2005, it offered a bullish forecast saying it would deliver four implementations by the end of August, rising to 12 by the end of October. In the event just two, Weston and Mid and South Bucks, have occurred since. The remainder of the projects either postponed or delayed at short notice. Milton Keynes has twice had go live dates cancelled at less than a weeks notice. . . CSC committed to implementing six iPM iSoft systems at hospital trusts by the end of October. Since June one hospital, The Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust, has successfully gone live across an entire hospital trust. In addition, North Cheshire Hospitals NHS Trust has received a PAS system, but this is so far only used in physiotherapy and occupational therapy. The other four go-lives that had been predicted have since stalled or been delayed and CSC have confirmed they will not meet their prediction. . ."

3.7.28. More delays as NPfIT overhaul is ordered (27 Nov 2006)

The Register

http://www.theregister.co.uk/2006/11/27/reviw_npfit/

" The NHS' new chief executive is setting the stage for further delays at the already tardy National Programme for IT (NPfIT), by ordering an overhaul of the entire programme. According to the Financial Times, David Nicholson has told Connecting for Health (CfH) to review both the scope and operation of the programme. NPfIT chief executive Richard Granger has said he wants to focus on getting key aspects of the project done: digital imaging systems, electronic prescriptions, and a new payment system for the NHS. Other aspects of the programme, such as new patient administration systems, will fall even further behind schedule, he said. However, by stepping in now and effectively taking control of the way the project is run, David Nicholson at the very least appears to be undermining Granger's position. The idea is to resolve many of the ambiguities and conflicts about implementation and policy within the project. It could resolve the question of whether or not patients should be able to opt out of having their record stored on the spine, and whether the scheme is currently " too prescriptive" being run centrally. The embattled Granger told the paper that policy questions were being " pinned" on him, but that responsibility for sorting out things like patient consent lay elsewhere in the Department for Health. The paper reports that CfH will become smaller after the review. Staff will be transferred to other posts in the NHS. Granger accepts that this is a necessity, in the face of slipping deadlines."

3.7.29. Hospitals reluctant to embrace systems (27 Nov 2006)

Financial Times

http://www.ft.com/cms/s/bfb63156-7dbb-11db-9fa2-0000779e2340.html

" The National Health Service's financial troubles and delays in getting the right software are blamed by Richard Granger, head of the NHS's information technology programme, for hospitals' reluctance to install key parts of the new technology. Many hospitals need a new patient administration system, or PAS, to allow the full electronic care record to operate when it becomes available, Mr Granger told the Financial Times. But only 19 systems have been installed out of 43planned to be in place at the end of November. Hospitals are increasingly reluctant to take them, he says. This is in part due to problems with the software. Of the two versions of software available, Cerner's provides extra clinical benefits but does not easily provide reports on patients' appointments in a format preferred by hospitals that enables them to claim money from primary care trusts, he says. Isoft's product does that, but as yet offers few clinical gains. Neither does " everything that people want" and in addition, " it is not a great time to ask people to take new computer systems. Money is tight, targets are tight, these systems are disruptive and there is not an enormous amount of benefit to trusts at the moment" . Staff have to be taken off achieving NHS targets to be trained, and hospitals " have to go through a laborious data cleansing exercise" before the system goes in. That, he says, is throwing up duplicate records, hospitals are discovering patients who have breached the government's waiting time targets, and discrepancies are showing up over the payments made by primary care trusts. " You never find good news when you do data cleansing," he said. . ."

3.7.30. NHS IT schemes 'under-funded and over-ambitious', trust board is told (5 Dec 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/12/05/220345/nhs-it-schemes-under-funded-and-over-ambitious-trust-board-is.htm

" A confidential paper issued to the board of the UK's largest NHS trust says that new initiatives under the £12.4bn National Programme for IT (NPfIT) are " invariably under-funded and over-ambitious" . It adds that the pressure on central Whitehall budgets has increased the transfer of costs to the NHS. The paper to the board of Leeds Teaching Hospitals NHS Trust, obtained by Computer Weekly under the Freedom of Information Act, also includes praise for the NPfIT. It says that the electronic transfer of prescriptions to pharmacies and a broadband network are among key elements that are progressing well. But the most important part of the NPfIT – a national care record which puts medical information on 50 million people in England onto central systems – has been scaled back, says the paper. The central system now " essentially covers only allergies and recent GP prescribing" . . . The lack of new patient administration systems means many trusts " will be unable to meet national e-booking targets and will struggle to meet other national policy requirements" . E-booking is a top ministerial priority for the NHS. The aim is to allow patients and doctors to book hospital appointments online during a visit to the GP. The paper, by the trust's director and deputy directors of informatics, also says that, since core software has been delayed, trusts are " increasingly looking to procure new patient administration systems outside the National Programme" . With the creation of several large contractor conglomerates, " smaller often more innovative companies have struggled to survive" , it adds. . ."

3.7.31. Great Ormond Street gets single sign on (6 Dec 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2322

" Great Ormond Street Hospital (GOSH) is set to use a single sign on system that will not only cut the number of passwords clinicians need to access patient information, but also give them a converged view of data from different applications. The system will be deployed initially at the hospital to enable access to a core set of applications, including those used for electronic prescribing, medication administration, medical imaging, pathology results and e-mail. Additional applications will be added into the system, supplied by Sentillion, later. David Bowen, GOSH's electronic patient record project manager, told E-Health Insider: " However many applications you have got open you always know you don't have to worry that you are going to look at somebody else's record." The search for a suitable solution for the internationally-renowned London children's hospital dates back to 2002. Bowen explained that the hospital faced a choice between going for a heterogeneous model with applications drawn from different sources or a more homogenous HISS-type [hospital information support system] approach. . . GOSH's plan diverges significantly from the route mapped by the National Programme for IT for the NHS in England, but Bowen said that all along Connecting for Health had recognised the hospitals' particular circumstances and been supportive of the approach taken."

3.7.32. Concern over slow progress in acute sector (11 Dec 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2330

" A board paper written for the largest NHS trust in England says that its region of the National Programme for IT does not have a roadmap for delivering an electronic care record. The report, submitted to Leeds Teaching Hospitals NHS Trust, by director of informatics, Brian Derry and his deputy, Alastair Cartwright, in October says: " Other than PACS (digital radiology), there are no strategic clinical systems on offer in Yorkshire and the Humber. " CFH is increasingly announcing ad hoc developments, for example blood tracking and oncology e-prescribing systems, not least as a means of increasing clinician engagement in the national programme. However, such initiatives are invariably under-funded and over-ambitious." The paper makes plain that the LTHT technology team is aiming to stay self-sufficient in IT while working in a 'new landscape' of slow progress nationally in acute trusts. . . Summarising the CfH position at the beginning of the paper - which was obtained under the Freedom of Information Act by Computer Weekly - Derry and Cartwright say the implementation of GP systems has generally been a success and good progress has been made with community and child health systems. They add however that little has been achieved in providing strategic systems for secondary care (acute and mental health) – especially in the North East and East of England. In particular, they say patient administration system replacements for several West Yorkshire trusts are running at least two years late. . . In another damning paragraph, they say: " LSPs and their sub-contractors are not keeping up with the scale and complexity of the national programme. Existing supplier offerings are obsolescent, as major policy initiatives – notably the 18 weeks waiting times target and Choose and Book – arrive with inadequate DH allowance for the significant informatics and associated change management consequences." There is also concern about the future of iSoft, the clinical systems sub-contractor to the North East and a supplier used independently by LTHT. . ."

3.7.33. 2006 - a curate's egg for Connecting for Health (21 Dec 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2369

" 2006 may well be seen as the year Connecting for Health (CfH) and its prime contractors failed to deliver on their promise of next generation integrated clinical record systems that would provide a rich, detailed local record and summary national record. During the course of the year not a single implementation of such a next generation system occurred, and it remains unclear when and whether such systems will now be delivered. . . The consequences of this fundamental failure have been huge, both on the NHS, CfH and its suppliers. In the absence of the next generation CRS systems CfH has only been able to offer existing systems. For the trusts that had little this has been a boon, but for those with more advanced IT, especially in the acute sector, the programme still offers them little. . . Given the problems on local CRS the focus has moved, rather conveniently, to the summary care record which at times is now spoken of as 'the record' rather than as one component of it. . . Meanwhile a storm rages around whether patients should have to give explicit consent for their details to be uploaded to the new service, rather than the qualified implied consent favoured by the Department of Health. . . In the absence of strategic next generation solutions, CfH and its prime contractors became increasingly desperate to deploy something, anything, which would be of use to NHS customers and enable them to get paid. Existing system suppliers – many of them recently told they had no future in the market - have been courted and in many cases provided solutions through LSPs. . . Having first been due to be implemented by the end of 2005, then the end of 2006 Choose and Book is now meant to be 90% in place by the end of March 2007. Despite generous incentive payments to GPs this target looks extremely unlikely to be met. As 2006 ended the system, which failed entirely last Christmas during an upgrade, was still being dogged by technical problems that routinely make it unavailable to some staff or too slow to use. . . Like Choose and Book the Electronic Prescriptions Service is proving slower than originally intended: phase 1 has been widely deployed, but phase 2 appears to be running badly late. . . The pledge to deliver on giving GPs a choice of systems has become like Father Christmas: comes round once a year and some people get very excitable, but few take it seriously. . ."

3.7.34. PCTs fail to reach halfway point on choose and book (1 Feb 2007)

Health Service Journal

http://www.hsj.co.uk/healthservicejournal/pages/n1/p8/070201

"No strategic health authority is on track to hit the government target to make 90 per cent of outpatient bookings through choose and book by the end of March. Figures from the last round of SHA board papers show that primary care trusts are up to 50 per cent behind planned levels of the system in some parts of the country. Even NHS North East, which had the highest choose and book take-up in the country, achieved less than 40 per cent of outpatient appointments through the system in November - nearly 40 per cent below its target for that month. Despite being identified by several SHAs as one of six 'big tickets' to concentrate on, papers suggest a combination of IT problems, lack of engagement from GPs, and a failure by acute trusts to provide appointment slots through the system have left PCTs struggling. In the worst-performing area, NHS East of England, just 20 per cent of appointments had been arranged through choose and book in November and the SHA reported that there had been a 'widening gap' between actual and planned performance. All PCTs in the SHA have now been instructed to produce 'recovery plans' in an attempt to hit March's target. Other SHAs, including South Central, have also ordered PCTs to produce recovery plans, and some are monitoring booking statistics on a weekly basis to put pressure on PCTs and acute trusts. NHS South East Coast achieved only 24 per cent of referrals in November, well under half of its target for that month of 59 per cent. The SHA acknowledged that the number of choose and book slots made available by acute trusts 'remains a concern', and trusts are being monitored to ensure they follow guidance on making appointment slots available. North West SHA, which achieved 30 per cent of choose and book appointments in November, also accepts that March's target will almost certainly be missed."

3.7.35. Millennium delays creating financial risks, trust warns (1 Feb 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2457

"A report by Worthing and Southlands Hospital NHS Trust on delayed plans to deploy Cerner Millennium warns that current reporting difficulties with the system "could have an impact on all remaining Cluster R0 go-live dates". The trust board paper seen by EHI warns that should delays to the availability of a system that meets requirements continue, it will risk local financial turn around plans. Worthing and Southlands is attempting to turn around a £6m deficit in 2006. . . A telephone survey carried out this week by E-Health Insider of ten trusts in the South found there is now a growing backlog of trust's waiting to receive a new deployment date from local service provider (LSP) Fujitsu, and Connecting for Health, to receive their new Cerner Patient Administration System (PAS). All the sites now queuing now appear to be waiting for the next two Millennium implementations, due to be in Milton Keynes and Winchester. . . Fujitsu originally told the Commons Public Accounts Committee that Release Zero systems would be deployed at these trusts by the end of October 2006. Only three trusts currently have a Millennium Care Records System – Weston, Nuffield Orthopedic and Mid & South Bucks. . ."

3.7.36. Picture this: an NHS data project that everybody loves (8 Feb 2007)

The Guardian

http://technology.guardian.co.uk/weekly/story/0,,2007594,00.html

"If you slip on an icy pavement this winter and land up in casualty, take heart. The chance of your x-rays turning up when they're needed is probably the best in the NHS's history. Digitally displayed radiological images, using a technology known as Pacs (picture archiving and communications system) are the big success of the £12bn programme to computerise the NHS. Pacs stormed into hospitals because nearly everyone sees advantages. The images are available immediately, anywhere on site, so fewer appointments are cancelled due to films going astray. And there's a tangible business case, too - immediate savings on expensive x-ray films. Unfortunately, at the moment Pacs generally extends only as far as each hospital's no-smoking zone. Five years after the government decided to chuck money at a central initiative to modernise the NHS with information technology, the dream of multimedia records available anywhere remains remote. For some parts of the health service, that dream is more remote than it was five years ago, thanks to the scale of the programme and the furore it has provoked. "Don't panic," says Richard Granger, the NHS's IT boss. "We have spent the past few years putting in the basic pipes while grabbing quick wins such as Pacs." The exciting stuff is now coming together. After many delays, the first basic extracts of medical records are due to be loaded on to the national system this spring. This will be an important step. But the programme has a long, long way to go. In large parts of the country, the process of installing basic hospital systems has ground to a halt because cash-strapped managers see no point. Controversy still surrounds the uploading of sensitive data on to

the system. This was stirred further this week by revelations that hospital staff are routinely sharing system logins. Just how far we have to go was revealed a couple of weeks ago by the NHS's new overall boss, David Nicholson. He admitted that if the IT programme is to work, the NHS will have to "own, love and understand" it in a way that it has not done up to now. That means giving local organisations more say in where they go with the programme. And, while turning down calls for a fundamental review, Nicholson suggested that the programme may be doing too much on "far too big a waterfront". This implies that some fundamental rethinking is under way. . ."

3.7.37. NPfIT's Evolution maternity dropped by Royal Shrewsbury (13 Mar 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2535

"The NHS trust that was meant to be the pilot site for the National Programme for IT version of iSoft's Evolution Maternity Information System, has given up waiting for its delayed NPfIT system and implemented an alternative system bought off the shelf. Royal Shrewsbury Hospital NHS Trust, Shropshire has been waiting for almost two years for its local service provider Computer Sciences Corporation to implement iSoft's Evolution MIS. The trust has now deployed the Eclipse system from Huntleigh Diagnostics in a bid to save up to £0.5m annually through reduced clinical negligence liability costs. . ."

3.7.38. IT delays contribute to NHS trust deficits (20 Mar 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2555

"Delays in implementing the National Programme for IT are listed by the influential Commons public accounts committee today as a factor leading to some NHS trusts plunging into the red. The PAC's inquiry into financial management in the NHS found that in 2005/06 14 trusts asked the Department of Health for money to cover "costs incurred as a result of delays in the implementation of the National Programme for IT". None was paid. The report does not name the trusts. It says: "The department reports that information on how much has been claimed by each trust is not available as the requests include a mixture of one-off costs, ongoing costs, alternative interim solutions and unspecified amounts." The information was winkled out of the Department of Health by Richard Bacon, Conservative MP for South Norfolk and a constant thorn in the DH's side on matters relating to the national programme. . ."

3.7.39. Missed 90% C+B target to remain for PCTs (3 Apr 2007)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=2588

"The target for 90% of referrals to be made through Choose and Book is to remain for the NHS, even though the latest deadline has been missed by some way. Final figures are not yet available for use of Choose and Book to March 31, but it is clear the NHS will have fallen well short of the 90% mark which was one of six key targets set by the Department of Health for 2006/67. Statistics seen by EHI Primary Care for the week ending March 22nd suggest the figure was then closer to 40%, with the highest number of bookings, 909774, made by GPs in the North West and West Midlands cluster. According to NHS Connecting for Health officials approximately 16,000 Choose and Book appointments are being made a day. In an interview with EHI Primary Care, Dr Mark Davies, CfH's medical director for Choose and Book, said the picture was very variable around the country. He said: "Some PCTs will meet the 90% target, there are a significant number in the 50-80% bracket where the majority of referrals are going through Choose and Book and some PCTs are struggling with this. The point is that whatever the national figure is there are 150 stories out there and it's very different from one PCT to another." However Dr Davies said despite the variable performance the 90% target would remain. . ."

3.7.40. PCTs still only half way to choose and book target (5 Apr 2007)

Health Service Journal

http://www.hsj.co.uk/healthservicejournal/pages/N1/P9/070405

"Strategic health authorities are planning measures - from a radio campaign to crisis support squads - in an effort to make up lost ground in implementing choose and book. Primary care trusts were tasked with referring 90 per cent of patients through the choose and book system by the end of last week, but latest SHA figures suggest that PCTs are barely half way to the target. It is one of six key goals for SHAs. Even the best-performing SHA, NHS North East, was still referring fewer than 50 per cent of patients through choose and book, according to the most recent figures available. And the worst performer, NHS East of England, saw just 22 per cent of patients referred through CAB. SHAs cite technical problems as a key reasons for falling so far short of the target, with a number of acute trusts still unable to accept direct booking via CAB. This includes eight of London's 32 acute trusts, five of them foundation trusts. Some are waiting for the national IT programme to deliver a CAB-compliant patient administration system, said NHS London. The number of booking slots offered by acute trusts has also caused difficulties. . ."

3.7.41. New national IT setback as devolution is delayed (12 Apr 2007)

Health Service Journal

http://www.hsj.co.uk/healthservicejournal/pages/n1/7/070412

"The national programme for IT is facing another setback as it emerges that plans to enhance the role of strategic health authorities have been delayed. NHS Connecting for Health and SHAs are still working through the details of the local ownership programme (NLOP) a fortnight after the 1 April deadline for transfer of the main responsibilities passed. The process, which will devolve parts of the national IT programme to SHAs, has entered a 'transition period' and now looks unlikely to take place in full before July. A 'transition assurance review' is being carried out to assess the risks the delay might pose to the successful delivery of the IT programme. . . CfH will continue to take responsibility for areas such as commercial strategy and contracts with suppliers. The SHAs, working with trusts and PCTs, are to take over local delivery and implementation of products. . . But there have been concerns over whether NLOP will provide genuine local control or just shift accountability away from CfH. Although SHAs took on this extra accountability on 1 April as planned, their full responsibilities are yet to be confirmed. . ."

3.7.42. Delays continue on NPfIT local ownership programme (25 May 2007)

e-Health insider

http://www.e-health-insider.com/news/item.cfm?ID=2718

"A review is underway to establish new priorities and additional requirements for the NHS National Programme for IT Local Ownership Programme (NLOP) with the results due to be reported to the NHS Management Board in June, E-Health Insider has learned. The review – known as the Butler Review - is being carried out to identify and prioritise new requirements to be delivered by the programme, based on the priorities identified by local strategic health authorities. It forms part of the wider National Programme for IT (NPfIT) Repositioning Programme, which includes the late-running NLOP, first due to have been implemented by the end of April, and now projected to occur in July. SHA board papers seen by EHI indicate that NLOP is facing further delays and will only offer limited freedom to local NHS organisations to set IT priorities, instead chiefly making them responsible for implementing nationally-determined systems. . . An indication of the extent of the very limited scope for local flexibility within the constraints of the national programme comes from a May East of England SHA board paper: ""Whilst the existing contractual arrangements with suppliers allow for substantial variations, the degree of change is effectively constrained by cost and commercial considerations." The same paper makes clear that while a central objective remains to not lose "the advantages of having a national IT approach and benefits of a national procurement led by a single agency in NHS Connecting for Health" the scope for local freedom will be limited. "The maintenance of these benefits necessarily limits the freedom of action of individual SHAs of trusts to make significant changes, in the shorter term, in products, services and deployment plans". Another major question mark exists over whether they will have the capacity and expertise to undertake design, build and test of CRS, together with deployment and implementation responsibilities? . . ."

3.7.43. London delays due to 'lots of factors' says BT chief (8 Jun 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2764

"BT Health's managing director has told MPs that 'lots of factors' are the root cause of delays in implementations at London's acute hospitals, but that the National Programme for IT's (NPfIT) work in the capital should be completed by 2009 with full integration of systems a year later. Patrick O'Connell was giving evidence to the Commons Health Select Committee's third session on the electronic patient record. Quizzed by the chairman, Kevin Barron for exact reasons why acute patient administration system (PAS) deployments under the London Programme for IT (the new term for the work) were running late, O'Connell said it was a result of 'lots of factors'. Asked to expand on that, he said: "It is not just one thing [delaying implementations] but a multiple set of factors, such as re-prioritisations, change of schedules and an attempt for synergy that did not work." He added: "This is a large programme. We start with timescales, they get reshuffled, things are added and some are implemented on time and some things go out of schedule. More importantly though, we are making progress and rollout should start in the summer." O'Connell was asked to explain why BT had made promises when bidding to be a supplier, which it appeared it couldn't meet. It was suggested that this was so that BT would win the contract, but O'Connell flatly denied the accusation, saying delays were due to a lack of understanding. "It takes three communities to make this programme a success: the user community, the buyer community and the supplier community. Working together, the programme would work on schedule, but all three groups are not uniformly bonded together, so there is often not a complete understanding upfront. There needs to be a coming together of groups and this lack of understanding makes all the difference between implementing on day one (on time) and day two (late)." To help London achieve the objectives of NPfIT, O'Connell said that BT had revised its strategy and chosen just three suppliers whom it considered 'best of breed'. . . He said that BT had technical pathways ready to implement the Detailed Care Record, but no actual specification was confirmed for this. He felt that the system would evolve over years, comparing it to the internet, which he couldn't see the point of in 1990 but couldn't live without in 2007. . ."

3.7.44. Trust steps ahead of NPfIT (8 Jun 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/06/08/224652/trust-steps-ahead-of-npfit.htm

"Guy's and St Thomas' NHS Foundation Trust is embarking on a major integration programme to link 650 medical applications. The move will bring together financial, corporate and clinical data, together with voice, video and images. The initiative is one of several undertaken by a group of research hospital trusts including St James in Leeds, and Coventry and Warwickshire, which are not prepared to wait for systems to be developed under the NHS's National Programme for IT (NPfIT). Speaking at the IT Directors Forum on board the cruise ship Arcadia this week, Richard Storey, head of IT and solutions delivery at Guy's and St Thomas', said that the highly innovative programme was not working against the NPfIT. "We will not step outside the National Programme, but what we are doing is one step ahead. We are well ahead of the NPfIT and we will not do anything to compromise it, but we will not be held back," he said. The programme will use service oriented architecture with a heavy focus on interoperability. Data is shared using an enterprise service bus and is converted to the medical data sharing standard, HL7 standard version 3.0. This allows Guy's to link to developments taking place in the other hospitals using open standards. Benefits will include single sign on and a contextualised portal, with a core scheduling system and clinical images available on the desktop. Because of Guy's central location, Storey is targeting City IT professionals to work on the project. . ."

3.7.45. BT claims successful NPfIT shift in London (8 Jun 2007)

Kable's Government Computing

http://www.kablenet.com/kd.nsf/Frontpage/EFBCF49AAC2E44D8802572F300583EE3?OpenDocument

"BT has claimed its revised strategy for London is helping to get the National Programme for IT (NPfIT) back on track in acute trusts. The Commons Health Select Committee heard on 7 June 2007 that BT's revised strategy to deliver services under the NPfIT to acute hospitals is "proving a success". BT is the national programme's local service provider for London. Although it has made reasonable progress in some areas, particularly primary care trusts and mental health trusts, delivery to acute hospitals had fallen behind schedule. To remedy this, the company agreed with Connecting for Health, the agency responsible for delivering the programme, to make changes to its subcontractors. This included the replacement of IDX with the Cerner Millennium solution. BT said that half of all London's mental health trusts now had new IT systems installed. Newham and Homerton trusts

upgraded to Cerner systems late last year and there are plans to go live at Barnet and Chase Farm this summer. Two further deployments are planned later this year. A key element of BT's revised strategy has been to install products initially as "standalone" deployments and then to integrate them with the cluster-wide solution. . . The MPs got a less sanguine view of the programme from Professor Naomi Fulop of King's College London. Fulop, co-author of a study on the implementation of NPfIT published last month in the British Medical Journal, said the e-patient record had been deeply problematic and is seriously behind schedule. "The detailed record is now two and a half years late. By next year it will be three and a half years late," she said. There was a growing risk to patients' safety associated with delays to the programme, according to Fulop. Also, local NHS managers are unable to prioritise implementation of the NPfIT because of competing financial priorities and uncertainties about the programme."

3.7.46. Conservatives announce NHS IT review (8 Jun 2007)

BCS

http://www.bcs.org/server.php?show=conWebDoc.12116

"The Conservatives have said that they intend to carry out a review of the NHS IT programme. Much criticism has been levelled at the scheme for its spiralling costs and lengthy delays and the review is being launched in response to a lack of similar investigation by the government, shadow health minister Stephen O'Brien said. He stated: 'The programme is two years late, so by the government's own admission the consequences of its incompetent implementation are the thousands of lives the government told us the NHS IT system would save.' The announcement comes shortly after the House of Commons' public accounts committee published a report suggesting that government IT projects need to benefit from better skills at the highest management levels in order to succeeed. This week, the NHS IT project hit the headlines again following uncertainty over the future of iSoft, one of the companies involved in the scheme. The firm is currently suffering from financial difficulty and is the takeover target of a number of other technology companies - one of which is also working on the project."

3.7.47. Connecting for Health briefing claims much of NHS NPfIT complete (11 Jun 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/06/11/224695/connecting-for-health-briefing-claims-much-of-nhs-npfit.htm

"A confidential Connecting for Health briefing paper for the prime minister has claimed that much of the NHS's £12.4bn National Programme for IT (NPfIT) is complete - although an integrated national care record system has yet to materialise, and software delivered under the scheme has been criticised by some trusts as not yet fit for purpose. The paper, dated 19 February 2007, said, "Much of the programme is complete, with software delivered to time and budget," though, "some deployment is progressing more slowly than we would wish for and is dependent on legacy IT suppliers and NHS preparedness." The paper was included in a Connecting for Health document presented to a health care technical standards conference in Canada. It said, "Key challenges and risks to delivery are now not about the technology to support NPfIT but about attitudes and behaviours, which need to be the focus of senior management and ministerial attention as we move forward." The paper's findings come despite a Public Accounts Committee report in April which found that significant clinical benefits were unlikely to be delivered by the end of the contracts in 2013/2014. Connecting for Health, which runs the NPfIT, said, "We stand by the data contained within the presentation including the working calculations for the percentage completion data as provided as all this information has been independently verified." The paper put the progress towards a life-long health record service at about 35%, although a national electronic health record system is still only at the trial stage. It also said that "procurement processes had saved £4.5bn", but this figure has not been independently audited and represents a projection of savings based on existing installations. During a debate in the House of Commons last week, MP Richard Bacon praised Accenture for its honesty in admitting its losses of hundreds of millions of dollars. He said that, in his view, local service providers BT, CSC and Fujitsu had "not done anything to try to account for the losses that must have been made". These losses could run into hundreds of millions of pounds, Bacon believed. "The government ought to be aware of that now, as it has consequences for the behaviour of local service providers in trying to claw back money

because they did not make any on the contracts," he said.Connecting for Health briefing claims much of NHS NPfIT complete (11 Jun 2007)"

3.7.48. Millennium problems at Taunton condemned by consultant (3 Jul 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2830

"Taunton and Somerset NHS Trust have delayed deploying Cerner Millennium software due to 'severe security problems', the BMA's Annual Representative Meeting heard. The software had been due to go live the weekend beginning 29 June. Calling for a public inquiry into the National Programme for IT (NPfIT), David Wrebe, consultant obstretician and gynaecologist, told the meeting last week: "We have had greater then a dozen go-live dates. I've just been told that 30 June has again been cancelled because there remain three to six absolutely outstanding and severe security problems with the software." He explained the problems were which were causing Taunton to delay deployment of the patient administration system: "Namely, if I put my name in to get my patient data you get all the health information of my entire family. There are 50 P2 problems. The maternity programme they originally showed us collected 10% of the data that was required from the old theme driven computer system and we now have to buy an entirely new maternity system to get the Millennium module to work." In a statement, the trust confirmed that the go-live had been postponed, but refused to elaborate on the reasons for this. "Taunton and Somerset NHS Trust has postponed go live of Cerner Millennium, the foundation release of the NHS Care Records Service planned for 30 June, in order to allow time for remaining final issues to be resolved. . . Wrebe, a member of the BMA's Central Consultant and Specialist Committee (CCSC), added that pressure was being applied to the trust to take the NPfIT solution and not purchase another, by its strategic health authority. . . Wrebe told the audience: "We should have a public inquiry. The people who made the original Cerner contract should be brought to book and as Cerner Millennium R0 is not fit for purpose under any kind of consumer legislation we should throw it back in the face of the suppliers and tell them if they want the money, they can take us to court." The motion was carried by the meeting, despite claims that an inquiry was unnecessary from other members. . ."

3.7.49. Project overruns 'costing billions' (13 Jul 2007)

The Guardian

http://www.guardian.co.uk/uklatest/story/0,,-6776329,00.html

"Poorly-managed Government projects are costing taxpayers tens of billions of pounds in budget overruns, a campaign group for lower taxes has claimed. Publicly-funded programmes are running up bills one-third higher, on average, than their original projections, the TaxPayers' Alliance said. Its analysis of more than 300 projects from the past two years found that the net overrun came to £23 billion above initial estimates. This was the equivalent of £900 for every household, the group calculated. Having looked at 305 schemes, including roads, hospitals, science facilities, IT systems, art galleries and defence systems, it said the biggest overruns were the NHS National Programme for IT by £10 billion, the 2012 Olympics by £6.95 billion and the Astute Class Submarine by £1.1 billion. The TaxPayers' Alliance said its figures were probably an under-estimate because departments often disguised overruns by scaling back orders and moving funds around. As well as simply failing to work out the proper costs in advance or setting prices in stone, it said many overruns were caused by lack of know-how among officials and politicians. . ."

3.7.50. NHS Choose and Book gets new chief as uptake stalls (7 Sep 2007)

ComputerWorldUK

http://www.computerworlduk.com/management/government-law/public-sector/news/index.cfm?newsid=5061

"NHS Connecting for Health has appointed a new head for its Choose and Book programme - the second senior appointment in two months – as new figures show uptake of the hospital appointment booking system has virtually stalled. Guy Dickie, formerly e-prescribing programme manager and prison health IT programme manager at Connecting for Health, will now head work on Choose and Book - a flagship component of the NHS's £12.4bn National Programme for IT (NPfIT). . . September figures show that Choose and Book was used for "over 40%" of NHS referral activity from GP surgery

to first outpatient appointment. In July, Connecting for Health put the figure at “nearly 40%” – up from 37% in April, but still less than half the Department of Health’s 90% target. . ."

3.7.51. Choose and Book fails to achieve key targets (23 Oct 2007)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4115439&c=2

"Choose and Book has failed to win over GPs and is 'struggling to deliver' on patient choice, a damning report from the Healthcare Commission warns. The commission's annual health check found only 2% of PCTs hit targets on convenience and choice – a result described as 'by far the worst level of performance for any of the existing national targets'. 'The challenge of persuading independent practitioners to adopt the new system has been far harder than anticipated,' the report said. Meanwhile, new figures from the Government's bimonthly tracking poll on patient choice showed a fall for the first time in the number of patients who recalled being offered a choice of hospital. The latest National Patient Choice Survey found 44% of patients recalled being offered a choice for their first outpatient appointment in May, down from 48% in March. A Connecting for Health spokesperson admitted encouraging GPs to use Choose and Book had been 'a key challenge' but insisted the programme was 'here to stay'. He added that 43% of first outpatient referrals were now made through Choose and Book. BMA chair Dr Hamish Meldrum said there was a lot of evidence to show imposed referral management schemes and problems with the Choose and Book IT system had worked against patient choice. 'The BMA has urged the Government time and time again to work with doctors before rolling out expensive software systems, but unfortunately this has not happened,' he said. As details of the scheme's poor performance emerged, Peterborough PCT become the latest trust to refuse to accept paper referrals from GPs. A PCT spokesperson confirmed mandatory use of Choose and Book would be phased in next year. Pulse last week revealed that Eastern and Coastal Kent PCT is due to begin phasing out paper referrals in December. Dr Rob Sadler, chair of Kent LMC, said the decision had caused 'significant disquiet' among local GPs, many of whom have doubts over Choose and Book. 'Some doctors in East Kent have not engaged at all with Choose and Book because of the workload issue,' he said. 'We have all these issues which haven't been properly thought through before imposing these arbitrary deadlines.' The Healthcare Commission blamed poor progress on the lack of contractual obligations on GPs to use the system, teething problems with the system itself and patient unfamiliarity with the concept of being offered choice."

3.7.52. N3 dominates NHS IT savings (14 Mar 2008)

Kable

http://www.kablenet.com/kd.nsf/FrontpageRSS/010FAA58D5660FDD8025740B005C404E!OpenDocument

"The N3 broadband network produced nearly all the savings generated by the NHS National Programme for IT to March 2007, according to the government. The Department of Health said that of savings totalling £208m, N3 generated £192m, with digital imaging and scanning saving a further £14m and software licensing and hardware maintenance contributing £617,000. The figures were published a part of a benefits statement on the NHS National Programme for IT (NPfIT) released by the department on 13 March 2008, covering the period from NPfIT's start in 2004 to the end of March 2007. On the basis of ongoing annual cost reductions, the cumulative savings will total £1.14bn by 2014. . . The statement also reported that NPfIT had underspent by 47%, costing just £2.4bn by March 2007 compared with its 2004 forecast of £4.5bn by that date. This included £1.3bn on the programme's core contracts, less than half the £2.8bn planned in 2004. Jeavons said this showed that the contractors are paid only when they deliver. "Delivery has been slower than the original plan," he said, particularly on electronic care records. However, he said he was confident that Lorenzo, the much-delayed patient administration and record system, will be delivered in the next few months. . ."

3.7.53. IT overhaul benefits just one in five trusts (19 Mar 08)

Healthcare Republic

http://www.healthcarerepublic.com/news/GP/794360/overhaul-benefits-just-one-five-trusts/

"Report on National Programme for IT shows many NHS trusts have still to implement the scheme. Only a fifth of acute trusts and PCTs have reported benefits from the NHS National Programme for IT

(NPfIT), according to a DoH report. The remaining 80 per cent have failed to implement NPfIT plans sufficiently enough to give feedback. Last week, the DoH published the report, which estimates that NPfIT will deliver £1.14 billion worth of savings by 2014. The estimated final cost, however, is £12.4 billion. To date, the scheme has delivered a total of £208 million in cash savings, but it has cost £2.4 billion since its 2002 launch. The DoH report also shows that due to delayed roll-out, the programme is under budget by about £1 billion. This data was published in response to a National Audit Office request for a statement on the scheme's progress. Dr Steven Millar, medical director for the Choose and Book programme and a GP in north London, said the scheme was 'half way to where we wanted to be at this stage'. While health minister Ben Bradshaw joked that he was still receiving letters about Choose and Book, Dr Millar admitted that GPs were being put off the scheme because of pressure to use it from PCTs. Despite 98 per cent of GP practices being enabled to use Choose and Book, only half of all referrals are done through the computerised system. Nevertheless, the directed enhanced service that encourages GPs to use it is being scrapped this year. . ."

3.7.54. Care records rollout hit by chaos, delays and GP pullout (8 Apr 2008)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4118304&c=2

The rollout of the Summary Care Record has been hit by massive delays and fresh controversy over patient confidentiality, Pulse can reveal. The first pilot to introduce the electronic patient records system has begun in chaos, and is lagging far behind schedule, according to confidential papers seen by Pulse. A report from Bolton PCT's Summary Care Record project board, released under the Freedom of Information Act, reveals just in four patients have had their records uploaded. Connecting for Health had pledged not to begin rollout to unscheduled care – which has now begun – until 60% of records were uploaded. The third wave of the rollout among Bolton GPs has been delayed for at least four months, after three practices backed out at the last minute, while uploaded records themselves had been used on just 167 occasions by the end of last month. Bolton LMC said a new poll conducted among its committee members found they were still opposed by a two to one ratio to the care record plans. News of the delays comes as a serious blow to Connecting for Health, ahead of an independent evaluation of the early adopter pilots due next month before the system's rollout across England. Dr Gillian Braunold, director for the Summary Care Record and a GP in Kilburn, north London, admitted the rollout had been 'slower than we would have liked' and said additional evaluation of the early adopter sites was now being commissioned, beyond the University College London evaluation due this summer. 'We're not rolling out rapidly because we're doing very, very careful safety checking of the product,' she said. But opponents of the Summary Care Record said the delays were shocking. Dr Paul Thornton, a GP in Kingsbury, Warwickshire, said: 'This is neither a blip nor a stalling, but a complete breakdown and four punctures on the starting grid.' A second document prompted new confidentiality fears after revealing receptionists at Royal Bolton Hospital's A&E department were to be given access to the care record, contrary to explicit guarantees given to local patients and GPs. Minutes of a meeting in February show the PCT has backtracked on the pledge, and now plans to give receptionists access if they ask patients directly. A spokesperson for Bolton PCT this week said it was 'the most practical way forward' but insisted 'a final decision has not been made'. But Dr Neil Bhatia, a GP in Yateley, Hampshire, who first obtained the documents, said records should not be accessed by non-clinical staff. 'If I was a Bolton GP, I'd be furious.'

3.7.55. Huge delay for care record evaluation (16 Apr 2008)

Pulse

http://www.pulsetoday.co.uk/story.asp?storycode=4118455

The Summary Care Record will remain under review for at least two years in a move which casts a shadow over the future of the programme, Pulse can reveal. University College London had been expected to produce its final evaluation next month, but a crippling series of delays, IT problems and fears over security have forced Connecting for Health to order a major extension to the timeframe. It is a huge blow to Government IT chiefs, who had planned to roll out the record nationally by the end of this year. Pulse revealed last week that just one patient in four in Bolton, the first early adopter area, has so far had Summary Care Records uploaded. Other early adopter areas, including Dorset, Bradford and Airedale and South West Essex, have yet to upload any records at all. The additional evaluation, which will also be carried out by the UCL team, headed by Professor Trisha Greenhalgh, will continue to look at the early adopter areas, as well as neighbouring PCTs which are expected to comprise the

next wave. It will cost just over £700,000 and is due to report in May 2010. Dr Gillian Braunold, clinical director of the Summary Care Record and a GP in Kilburn, north London, said she expected the interim report from UCL next month to be 'illuminating', adding: 'It may well be that it strengthens quite a lot of what we're doing that we've had to be quite defensive about – maybe we'll be able to be a bit more robust.' But Dr Paul Cundy, chair of the GPC IT subcommittee, said: 'It's rather odd to be hearing about further evaluation before the results of the first evaluation.'

3.7.56. The Summary Care Record: What's gone wrong? (16 Apr 2008)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=25&storycode=4118449&c=2

"Delays are not uncommon for Government IT projects, but even by the tardy standards of the National Programme for IT, this is a big one. When Connecting for Health officially launched the Summary Care Record in March 2007, the plan was for a rapid early adopter rollout, with the rest of the country to follow in short order. The first early adopter area, Bolton PCT, confidently predicted that within three months 'the majority of patients in Bolton will have a Summary Record'. More than a year later, the project is stuck in the mire, as internal papers obtained by Pulse reveal. The first flagship pilot, it turns out, has been beset by technical glitches, confidentiality concerns and a series of crippling delays. Just one in four patients have had their records uploaded and records have been used just 167 times. But the bad news for Connecting for Health is not confined to Lancashire. We can reveal that in other pilot areas the project has also slowed to a crawl. Bury PCT, the second early adopter, still hopes to have all the records in early adopter practices uploaded 'by the end of the summer'. But the fifth pilot, at Bradford and Airedale PCT, has yet to upload a single record four months after its launch. The Bolton minutes have also raised fresh fears over confidentiality. Project leaders had initially said that in A&E healthcare assistants, but not receptionists, would be given access to records - itself a controversial move, but one intended to mollify GPs who had told their patients only clinicians would use the records. But minutes of a meeting in February reveal that the PCT subsequently back tracked, and now plans to give receptionists access so long as 'they ask the patient directly.' By the PCT's own admission, this explicitly contradicts a guarantee to patients that non-clinical staff 'will not have access to your records'. . . The early adopter rollout has also been struck by severe software compatibility problems with the major suppliers. So far just two, InPractice and iSoft, are online, with the most widely used, EMIS, not going into testing until the end of this month. Getting GP buy-in to an the unpopular project has proved even harder. A poll last October by Bolton LMC found two thirds of the town's GPs opposed the care record rollout and a similar poll last month of committee members showed nothing had changed. . . So stung was Connecting for Health over adverse publicity it attempted to impose a media blackout, refusing for months to reveal the location of the sixth early adopter pilot - which Pulse finally revealed in February to be South West Essex PCT. It too has yet to upload a single record. University College London's independent evaluation of the early adopter projects, which was due to make a final report next month, has now been told to continue its evaluation for a further two years. . . There is some good news for Government IT bosses. With the uploading of care records for more than 150,000 patients now completed in early adopter practices, there has still been no catastrophic security breach. . . Yet despite the time and extraordinary amounts of money lavished on it, the next three months could prove make or break the Summary Care Record project. As well as the now-interim report from UCL next month, a National Audit Office progress report into the National Programme for IT due at the end of May and Lord Darzi's Next Stage Review in June will help determine the shape and scale of the wider rollout. The BMA, meanwhile, is having to decide whether to come off the fence. Despite rank-and-file members at last year's annual representatives meeting voting to 'advise all members not to cooperate with centralised storage of medical records as this seriously endangers confidentiality', the body has adopted a cautious approach. . . Dr Paul Cundy, chair of the GPC IT subcommittee, savages the Bolton project, warning patients have been 'effectively deceived' over receptionists being given access to records. 'The BMA's absolutely fundamental view is that explicit patient consent should always be the gold standard, and that's unchanged,' he says. Back in the early adopter practices, some GPs are doggedly pushing ahead. The Kearsley Medical Centre in Bolton has begun uploading 'full' or 'enhanced' Summary Care Records, with a far greater level of information beyond medications and allergies. But uploading a full record requires a patient's explicit consent, and reception so far has been mixed. While most new patients now have one, just one in three of patients with chronic illness contacted have so far opted in. . ."

3.7.57. NPfIT software implementation may stretch to 2016 (21 May 2008)

Kable's Government Computing

http://www.kablenet.com/kd.nsf/printview/70F4CE3622C85F128025744F005963B0?OpenDocument

"Further delays have beset the implementation of a key feature of the NHS National Programme for IT. According to a paper released online by the North West Strategic Health Authority, NHS Connecting for Health and local service provider CSC are preparing a new schedule for installation of the Lorenzo software within health service trusts, which extends to 2016. Lorenzo will provide the core clinical information system for hospitals in the north and east of England and the Midlands. This is at odds with a National Audit Office report released on 16 May, which said the implementation of electronic care records, the core of the national programme, had been delayed to 2014-15, making it four years late. The paper, signed by Alan Spours, chief information and knowledge officer of the SHA and dated 29 April, said that the University Hospitals of Morecambe Bay trust is scheduled to become the first trust in the country to deploy the Lorenzo in June. It added that the revised contract would include improvements such as interoperability between the Lorenzo software and GPs' systems, and mentioned that this was expected to be signed by 6 May. However, CSC and Connecting for Health said on 20 May they are still in negotiations over the contract. North West SHA said it was not able to comment on the document, given the continuation of negotiations."

3.7.58. Lorenzo likely to be further delayed (12 Jun 2008)

e-Health Insider

http://www.e-health-insider.com/news/3845/lorenzo_likely_to_be_further_delayed

"The deployment of Lorenzo release 1 to three early adopter sites is likely to be further delayed, E-Health Insider has learned. University Hospitals of Morecambe Bay NHS Trust was scheduled to deploy the first release of iSoft's key product this weekend. But the trust, its local strategic health authority and NHS Connecting for Health all refused to say that this would happen when contacted by EHI this week. . ."

3.7.59. Leaked report for NHS reveals full extent of Lorenzo slippage (19 Jun 2008)

The Guardian

http://www.guardian.co.uk/technology/2008/jun/19/software.politics

"Lorenzo, the much-delayed software package earmarked for a central role in the NHS's £12.7bn IT overhaul, remains mired in development glitches and is still struggling to get out of the technical design phase, according to a confidential document seen by the Guardian. The document paints a very different picture to the one given earlier this week by the NHS chief executive, David Nicholson, and his interim head of IT, Gordon Hextall, when they appeared before parliament's public accounts committee. Asked why, after so many disappointments, trusts should have faith in the latest set of delivery promises, Nicholson said: "We are in a position now where Lorenzo actually has a product and it would be ridiculous now to just dump that." But a confidential report, seen by the Guardian and Computer Weekly, makes clear delivery deadlines slipped several months ago - though the delays were not made public. The report was produced by CSC, the US consultancy firm delivering Lorenzo in the north, Midlands and east of England. The document in part blames delays on serious staffing issues at IBA, the firm behind Lorenzo. It also flags as "red" concerns that resources have been diverted in order to meet the first milestone deadline for Lorenzo release 1, a less complex piece of software providing clinical functionality. This has slowed progress on release 2, the patient administration system that forms the core of the care records service. With developers struggling to get the relatively small release 1 ready at three pilot sites, CSC believes the more substantive release 2 is unlikely to get much beyond early stage tests by the end of the year. Officially it is scheduled to be live in hospitals by October. Previous delays to Lorenzo contributed to the near-collapse of the Manchester-based software firm iSoft, but the business was rescued by a smaller Australian rival, IBA, which took it over last summer. Lorenzo had initially been due to be rolled out from March 2004 and has missed a series of revised delivery dates since. Two years ago, an earlier internal CSC progress report on Lorenzo was leaked to the Guardian. It said: "There is no well-defined scope and therefore no believable plan for releases." Officially, Lorenzo release 1 was due to go live at Universities of Morecambe Bay Trust at the start of this week, but was delayed. "It will go live when the quality is right," Nicholson told the committee of MPs on Monday. "The software is actually in the trust and is being tested." Meanwhile, Nicholson and

Hextall were surprised to learn from one committee member, Richard Bacon, that CSC had been offering some trusts an alternative system not owned by IBA. Asked if they were aware the US consultancy firm had two months earlier been "hawking around" the Portuguese system Alert at a healthcare IT conference in Harrogate, the men appeared baffled. "I was not aware of that," said Hextall."

3.7.60. Lorenzo stalled at Morecombe Bay (21 Oct 2008)

e-Health Insider

http://www.e-health-insider.com/news/4252/lorenzo_stalled_at_morecombe_bay

"The latest deadline for the implementation of Lorenzo at University Hospitals of Morecambe Bay NHS Trust has passed and there is currently no go-live date. Health minister Ben Bradshaw indicated that Morecambe Bay would become the first large NHS hospital to use the first version of iSoft's Lorenzo electronic patient record by the end of the summer. However, there is no published timetable for the key National Programme for IT in the NHS software to go live in its first acute reference site. The software is eventually due to be used across three-fifths of the English NHS. The latest delays to the first version of Lorenzo will innevitably push back the planned schedule for adding key clinical functionality to the software in three further releases, under a programme known as Penfield. This, in turn, raises doubts over the achievability of the current 2012 completion date for Lorenzo. . . "

3.7.61. Doctors aren't using the new Choose and Book system as much Connecting for Health has hoped. (24 Oct 2008)

IT Pro

http://www.itpro.co.uk/607527/nhs-missing-e-booking-targets

"The National Health Service (NHS) has admitted only 50 per cent of hospital outpatient referrals are made through its new electronic appointment booking system. The government has wanted GPs to put at least 90 per cent of such appointments through the Choose and Book system by the time it was delivered by contractor Atos Origin last March. Then, only 37 per cent of outpatient referrals were booked through the system, but GP usage levels have remained static lower than targets ever since, according to Connecting for Health (CfH), the agency responsible for the NHS's National Programme for IT (NPfIT). It did say, however, that every hospital and 93 per cent of GP practices in England were now using the Choose and Book system overall, where some primary care trusts offering financial incentives to participating GPs. CfH stated that the 90 per cent target remains, although it has no deadline by which to achieve it. . ."

3.7.62. NHS records project grinds to halt (27 Oct 2008)

Financial Times

http://www.ft.com/cms/s/0/b54a2e1c-a46e-11dd-8104-000077b07658.html?nclick_check=1

Progress on the £12bn computer programme designed to give doctors instant access to patients' records across the country has virtually ground to a halt, raising questions about whether the world's biggest civil information technology project will ever be finished. Connecting for Health, the ambitious plan to give every patient a comprehensive electronic record, has faced a series of problems over its size and complexity since it was first launched in 2002. In May this year, the National Audit Office said the project was running at least four years late but still appeared "feasible". Since then, however, just one of the scores of acute care hospitals due to install the underlying administration system required in order for the patient record to work has done so. The hospital, Royal Free NHS Trust in London, continues to have difficulties getting it to operate properly. In addition, the contractor originally hired to build the patient record system for the whole of the south of England, Fujitsu, has been fired. And BT, one of the two key remaining contractors, has been unable to agree a price for taking over the work Fujitsu had begun. Health ministers originally promised the long-delayed first installation of patient record software in the north of England would finally take place in June at Morecambe Bay on the Lancashire/Cumbria border. But four months on, the system has still not gone live and neither Morecambe Bay nor Connecting for Health can give a date when it might. CfH's most recent published plans for the next three months do not include a single installation of a patient administration system into any acute hospital trust. And while NHS Trusts in the south – Fujitsu's former area – are being

given a choice of working with BT, the supplier for London, or CSC, the supplier for the north, none has yet signed up with either. Jon Hoeksma, editor of the e-health insider website which has tracked the CfH programme from its start, said other parts of the £12bn project are continuing to make progress. "But this key part seems to be simply stuck. It has ground to a halt. And that is not just affecting deployments that should be happening now. It will have a knock-on effect on those that are meant to be going live two or three years down the line." Hospital chief executives, he said, did not want to take a new system "until they have seen it put in pretty flawlessly elsewhere". Frances Blunden, the IT policy specialist at the NHS Confederation, the body that represents NHS Trusts, said: "It is a little bit too early to pronounce the programme dead." She said there were "undeniable" problems, but "to say everyone is walking away from it is a bit premature, probably". She said the health department had promised earlier this year to address hospital complaints that the system was too standardised and could not be adjusted to take account of local needs. "But we haven't seen the implementation document to put flesh on the bones of that." A spokesman for Connecting for Health acknowledged that BT, which covers London, was "taking stock" given the difficulties encountered. The spokesman said it was more important to get the quality of installations right rather than promise delivery on a particular date. Talks with suppliers were under way to ensure "a smooth transition" in the south, after Fujitsu's departure.

3.7.63. NHS defers 2008 e-record go-lives - and FOI disclosures (29 Oct 2008)

Computer Weekly - Tony Collins's IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/10/nhs-trusts-defer-2008-erecord.html

"NHS trusts have deferred plans to go-live this year with electronic record systems under the £12.7bn National Programme for IT [NPfIT]. The deferral of major roll-outs of the Care Records Service comes after calamitous introductions of the system at hospitals in London and the south of England. Some observers will see the halting of e-record plans as a further sign of the slow demise of the NPfIT. But officials at NHS Connecting for Health, which runs part of the NPfIT, see the delays as a chance to understand thoroughly what has gone wrong at trusts which have implemented the Care Records Service. NHS Connecting for Health insists that trusts in London have not postponed go-lives indefinitely. A spokesman said: "Meetings will be taking place over the next couple of weeks with the London trusts to discuss the implementation dates and NHS London and those trusts hope to have revised dates as soon as possible." The cancellations of plans have added millions of pounds in extra costs for trusts which have recruited NPfIT specialists and trained thousands of NHS staff for go-lives which have not happened. Documents obtained by Computer Weekly under the Freedom of Information Act give an insight into some of the extra costs, problems and risks which face NHS trusts whose boards have taken decisions to become an "early adopter" of the Care Records Service. St Mary's Hospital in London, which is part of Imperial College Healthcare NHS Trust, has released the documents. It was due to become an early adopter of the problematic Cerner "Millennium" system which has been installed at Barts and The London, and the Royal Free Hospital, Hampstead. St Mary's has cancelled several go-live dates this year, the latest in August 2008. It is among several NHS trusts that have delayed plans to implement the Care Records Service until next year at the earliest. No major implementations under the NPfIT are expected this year, contrary to undertakings given to Parliament by NPfIT minister Ben Bradshaw. The documents released under the Freedom of Information Act say that senior executives at St Mary's in Paddington regarded an implementation under the NPfIT as carrying "huge risks". The "private" minutes of a St Mary's executive meeting said: "There were huge risks to implementation as experienced in other trusts such as Barts and The London and The Royal Free... the situation [when to go-live] was being dealt with on a day to day basis. The delay would mean that the project costs were likely to exceed the budget by £1m with the actual amount depending on the new date." The papers highlight the difficulties of producing comprehensive statutory reports from the system. They describe this as "one of the Care Records Service showstoppers". There was also concern about the possibility of a go-live having an undue effect on the health and care of patients. For example there was a risk that a failed merger of tens of thousands of duplicate files could end up with the wrong records being given to clinicians when they came to see patients. . ."

3.7.64. The 10 projects at the heart of NHS IT (10 Nov 2008)

silicon.com

http://www.silicon.com/publicsector/0,3800010403,39328119,00.htm

"It's the world's largest health IT project, its projected cost has doubled in its lifetime to £12.7bn, and parts of it are running four years late: welcome to the National Programme for IT (NPfIT). While the NHS's NPfIT has already outlasted several heads of IT, its chequered track record is not surprising given the ambitious scale of the project: replacing an ageing patchwork of 5,000 different computer systems with a nationwide infrastructure connecting more than 100,000 doctors, 380,000 nurses and 50,000 other health professionals. The NPfIT faced considerable scrutiny since its inception. A National Audit Office report in May this year highlighted serious delays in introducing the electronic care records system at the heart of the scheme due to technical challenges, while suppliers Accenture and Fujitsu pulled out of delivering the system and one trust halted implementation of the care records service. . . Paul Cundy, former chairman of the British Medical Association's IT Committee, believes the project has overall been a mixed blessing for UK healthcare.

"It is a real mixed bag - those projects that worked very well have been clearly defined as delivering the best benefits to users, where the users have had input and where there has been political support for them. The ones where there is bad political interference, where there is no user input into design or are doing things that users do not want, those are the ones that predictably fail," Cundy told silicon.com. "The key is to ask people what they want." silicon.com first put the core NHS IT projects under the microscope in early 2006. Much has changed since then, however, and silicon.com has decided the time is ripe to revisit each of the major projects in the programme to get the latest on their highs and lows, and find out just how far away the NHS is from its interconnected dream. . . The deployment of the CRS is four years behind schedule and is not likely to be implemented across every NHS health trust in England and Wales until 2014 or 2015 according to a report by the National Audit Office. Progress has been hindered by technical problems and disagreements over how patients are asked for their consent for their medical records to be digitised. Five "early adopter" primary care trusts, Bradford and Airedale, Bolton, Bury, Dorset and South Birmingham, were chosen to create summary care records for patients and upload them to The Spine. Delays to the summary care records rollout have meant that only two of the five early adopter sites, Bolton and Bury, have uploaded their records to the Spine. Currently, patients in Bolton and Bury St Edmunds are able to view their own records using the NHS personalised site HealthSpace while patients in the other three early adopter trusts - Bradford and Airedale, Dorset and South Birmingham - will have access to their records over Healthspace once their care records have been uploaded. Meanwhile, the remaining 375 primary care, hospital and mental health trusts in England are rolling out patient administration systems (PAS). These PAS will initially handle more electronic admin records - containing details such as patients' names and addresses - and share them within parts of the local trust. A later date, the PAS will be upgraded to handle summary care records as well. Further problems in rolling out PAS means that six years into the National Programme for IT only 130 PAS have been deployed in 380 health trusts while delays to the deployment mean the majority of these systems are interim solutions, to be replaced by the Lorenzo software system at some point in the future. Trusts deploying a fully-fledged PAS have a choice of two systems, Cerner and Lorenzo. To date only 14 Cerner Millenium PAS software systems and just two Lorenzo system have been deployed. While Cerner release one users have the ability to connect to the Spine and upload summary care records, trusts using Lorenzo release one will need to upgrade their PAS system before enjoying the same functionality. Both Accenture and Fujitsu have pulled out of delivering the Care Records Service, leaving only BT and CSC left as the service suppliers. Some hospital trusts in the south are without any dates for when the PAS system will be implemented since Fujitsu's departure and Bath Royal United Hospital NHS Trust recently terminated its implementation of the Cerner system. Barts and the London NHS Trust reported that problems with the introduction of Cerner system had delayed the treatment of 11 cancer patients and The Royal Free Hampstead Hospital has had problems with data entry errors and other issues which contributed to a £7.2m deficit at the trust. These problems culiminated in the NHS London Primary Care Trust halting any futher deployments of the Cerner PAS while it resolves issues with trusts already using the system. . ."

3.7.65. National Summary Care Record rollout finally begins (12 Jan 2009)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4121601&c=2

"The national rollout of the Summary Care Record is finally to begin next week, almost two years after the launch of the first pilot site. Documents posted on Connecting for Health's website reveal details of the first wave of the rollout, which will be fully underway by the end of March. Five 'fast follower' trusts are to start writing to patients in Lincolnshire, Stoke-on-Trent, Medway, Brighton-and-Hove and

the Isle-of-Wight almost immediately, while a further nine have also indicated they may take part. LMCs have in some cases yet to be informed of the rollout, which comes even though records have been uploaded for only a small proportion of patients in the six existing early adopter areas, and with some early adopters yet to upload any at all. Some 12,000 patients at three practices in Stoke-on-Trent will begin receiving letters telling them about the Summary Care Record early next week. An NHS Stoke-on-Trent spokesperson insisted local LMC leaders were 'fully behind' the plans. But LMCs elsewhere warned local GPs had been left in the dark. Dr Nigel Watson, chief executive of Wessex LMCs, said: 'We have not been consulted about the Isle of Wight. We don't know anything about it.' Dr Neil Bhatia, a GP in Yateley, Hampshire and an IT campaigner, added: 'Connecting for Health simply want to roll this out as widely as possible, without alerting the public too much, in the hope that there will be no turning back.' Asked whether LMCs had been consulted, a Connecting for Health spokesman said: 'Any fast follower that has a confirmed status will have gone through appropriate governance approval within the PCT.' A letter sent in October and seen this week by Pulse from Dame Deidre Hine, chair of the BMA's Working Party on IT, called on Connecting for Health bosses to go slow, trailing the 'consent to view' model and reviewing its public communications strategy first. The letter warned: 'Once agreed, the new model should be carefully piloted with a limited number of practices before any wider rollout.' But a spokesman for the BMA said this week that it was not opposed to the first wave rollout going ahead, insisting it would involve only a 'small number' of practices."

3.7.66. London trust apologises to patients for IT-related delays (27 Jan 2009)

Computer Weekly

http://www.computerweekly.com/Articles/2009/01/27/234437/london-trust-apologises-to-patients-for-it-related-delays.htm

Barts and the London NHS Trust has apologised to 442 patients who were not seen within maximum government waiting limits because of inadequate management systems. The patients waited an average of six weeks longer than the 13-week waiting time national standard for an outpatient appointment. The trust said the delays were caused by inadequate management systems within the Outpatient Appointment Office. The trust has launched a "serious untoward incident" investigation to identify the root cause of the issue and why management systems did not alert the organisation to delays sooner. In a statement the trust said that no patient had come to "direct" clinical harm as a result of the delays. Last April Barts and The London NHS Trust installed the Cerner Millennium Care Records Service as part of the NHS's £12.7bn National Programme for IT. After the go-live last year it had difficulty gaining an overview of which patients had been treated for what. Some patients with suspected cancer had their appointments delayed. Of the latest incident to come to light of delays in the appointments for 442 patients, the trust said matters appear to have been "compounded by the inflexibility of the Care Record Service computer system". This inflexibility was "combined with the complexity of the trust's clinic structure, which meant that some appointments could not be made during the initial phone call, even though slots were available in specialist clinics". The trust added, "The issue was also exacerbated by increased pressure on appointment slots arising from the reduction in the maximum waiting time for outpatient appointments." The trust tackled the delays by increasing capacity in its clinics and by senior clinical staff contacting patients by telephone. Staff also wrote to patients to apologise and to arrange a suitable time and date for their outpatient appointment. . . Meanwhile, E-Health Insider has reported that Worthing Hospital may ditch the Cerner Millennium system it bought under the NPfIT.

3.7.67. Spend on NHS NPfIT of £5.1bn exceeds initial budget (7 Apr 2009)

Computer Weekly

http://www.computerweekly.com/Articles/2009/04/07/235546/spend-on-nhs-npfit-of-5.1bn-exceeds-initial-budget.htm

"Taxpayer spending so far on the NHS's National Programme for IT (NPfIT) has risen to £5.1bn, which is more than the scheme's original total lifecycle cost. The programme is in its seventh year and is not due for completion until 2014/15 at the earliest. Computer Weekly is publishing for the first time the Office of Government Commerce's Project Profile Model for the national IT programme. The Department of Health expunged the Project Profile Model from the official version of "Delivering 21st Century IT Support for the NHS", the document which, in 2002, marked the launch of the NPfIT. The "secret" document is to be published on the IT Projects blog. Richard Bacon, an MP on the Public Accounts Committee who has followed the NPfIT for several years, says he is astonished that £5.1bn

has been spent on what he says is so little. The government revealed the figures in reply to a Parliamentary question by Tory shadow health spokesman Stephen O'Brien. One of the main products of the NPfIT - an e-records database for 50 million people - has yet to materialise. Originally it was envisaged that an electronic health record, what was then called a "Life-long National Health Record Service", would be in place by the end of 2005. Richard Bacon said: "It is depressing to think that this much money has already been spent and yet so little has been delivered. For £5.1bn an enormous amount should have been achieved in the NHS." NPfIT minister Ben Bradshaw said the latest figures include the original costs of NPfIT contracts but also include "new and additional requirements that have been added, supported by separate business cases and funding, as reported by the National Audit Office". Proof that the government planned for the NPfIT on the basis it would cost £5bn in total is in a document called the "Project Profile Model" which the Department of Health concealed. Computer Weekly is publishing the document for the first time. The Project Profile Model is dated March 2002. It put the total whole-life project costs of the NHS IT programme at £5.bn. Project Profile Models were used at that time to assess the risks of projects. The one for the NPfIT gave the scheme a score of 53 out of a possible 72. Any score over 40 put the project into the "high risk" category. The Project Profile Model was removed from the published version of Delivering 21st Century IT Support for the NHS, a Department of Health document which marked the launch of the NPfIT. The £5.1bn spent on the NPfIT to date excludes capital charges and the bulk of the local costs of NPfIT implementations which have not yet been measured. NHS Connecting for Health made no comment."

3.7.68. Health trust dodges NPfIT with £2.4m iSoft deal (23 April 2009)

Silicon.com

http://www.silicon.com/publicsector/0,3800010403,39423082,00.htm

Heatherwood and Wexham Park Hospitals NHS Foundation Trust has rejected the National Programme for IT in choosing a supplier for the refresh of its patient administration system (PAS). Under the National Programme for IT, health trusts in the southern cluster - where Heatherwood and Wexham is located - are due to be upgraded to the Cerner Millennium PAS. Heatherwood and Wexham Park Hospitals NHS Foundation Trust, however, has selected a PAS from health software company iSoft instead. The system will cost the trust £2.4m over five years and will see the organisation take on iSoft's i.Patient Manager PAS as well as refreshing the installation of iSoft's i.Clinical Manager, which is already in use at the hospital. The trust opted to go with iSoft rather than wait for a PAS update through the National Programme for IT (NPfIT). The rollout of PASes to health trusts has been beset by delays and the NPfIT contract with Fujitsu to install the systems for the southern cluster fell apart last year. While BT has taken over upgrade work for some of the trusts, the remainder have yet to be allocated a new supplier.

3.7.69. National Summary Care Record rollout finally begins (12 Jan 2009)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4121601&c=2

"The national rollout of the Summary Care Record is finally to begin next week, almost two years after the launch of the first pilot site. Documents posted on Connecting for Health's website reveal details of the first wave of the rollout, which will be fully underway by the end of March. Five 'fast follower' trusts are to start writing to patients in Lincolnshire, Stoke-on-Trent, Medway, Brighton-and-Hove and the Isle-of-Wight almost immediately, while a further nine have also indicated they may take part. LMCs have in some cases yet to be informed of the rollout, which comes even though records have been uploaded for only a small proportion of patients in the six existing early adopter areas, and with some early adopters yet to upload any at all. Some 12,000 patients at three practices in Stoke-on-Trent will begin receiving letters telling them about the Summary Care Record early next week. An NHS Stoke-on-Trent spokesperson insisted local LMC leaders were 'fully behind' the plans. But LMCs elsewhere warned local GPs had been left in the dark. Dr Nigel Watson, chief executive of Wessex LMCs, said: 'We have not been consulted about the Isle of Wight. We don't know anything about it.' Dr Neil Bhatia, a GP in Yateley, Hampshire and an IT campaigner, added: 'Connecting for Health simply want to roll this out as widely as possible, without alerting the public too much, in the hope that there will be no turning back.' Asked whether LMCs had been consulted, a Connecting for Health spokesman said: 'Any fast follower that has a confirmed status will have gone through appropriate governance approval within the PCT.' A letter sent in October and seen this week by Pulse from Dame Deidre Hine, chair of the BMA's Working Party on IT, called on Connecting for Health bosses to go

slow, trailing the 'consent to view' model and reviewing its public communications strategy first. The letter warned: 'Once agreed, the new model should be carefully piloted with a limited number of practices before any wider rollout.' But a spokesman for the BMA said this week that it was not opposed to the first wave rollout going ahead, insisting it would involve only a 'small number' of practices."

3.7.70. NPfIT Lorenzo - £57,500 per user so far (30 Oct 2009)

Computer Weekly Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2009/10/npfit-lorenzo-trusts-have-174.html

The NPfIT minister Mike O'Brien revealed in a Parliamentary reply yesterday that there are 174 regular users of the Lorenzo 1 system at five NHS trusts. The Lorenzo system is supplied by services company CSC and software supplier iSoft under the National Programme for IT [NPfIT]. This number of users will increase when NHS Bury goes live with Lorenzo next month. But MPs are still likely to consider the number very low given the cost to taxpayers of the system. Taking O'Brien's figure of 174 together with £2m as a conservative figure for the cost per site of installing the Lorenzo system, the cost per user of the system is about £57,000. If you take the cost per concurrent user - 19 according to the minister - the cost per user rises to about £526,000. It may also be worth bearing in mind that two of the five trusts have been live with Lorenzo for more than a year. About £4bn in total has been spent centrally on the NPfIT and ministers have trumpeted the Care Records Service as the main aim of the programme. Lorenzo is one of two main NPfIT Care Records Service products to be delivered to trusts in England, the other being Cerner's Millennium. Lorenzo was due to have been delivered several years ago under the NPfIT. A typical NHS trust has about 1,000 to 5,000 users of its hospital administration system. . .

3.7.71. Insider View: Jon Hoeksma (5 Nov 2009)

e-Health Insider

http://www.e-health-insider.com/comment_and_analysis/532/insider_view:_jon_hoeksma

E-Health Insider editor Jon Hoeksma reflects on a busy couple of weeks for news about the National Programme for IT in the NHS and says the sudden flurry of activity can mean only one thing - those November deadlines matter and judgement day is coming for NPfIT. There is nothing like a deadline to sharpen the mind, and finally the National Programme for IT in the NHS and its main suppliers are now working to deadlines that count. They fall in November. And chief among them is to successfully deliver both versions of the 'strategic' electronic patient record software purchased by the programme. Word has it that the Department of Health's chief information officer, Christine Connelly, has a three line whip from NHS chief executive David Nicholson to meet her commitment to get a problem free Cerner Millennium installation in London (Kingston) by the end of the month and to be "on track" to deliver iSoft's Lorenzo across a big acute trust (Morecambe Bay) by the end of March. It's against this background that the DH's newly published criteria for judging whether "significant progress" has been achieved have been published. For both Millennium and Lorenzo they begin with "does the product exist?" To have to even ask the question seems remarkable six years into the NPfIT programme. Otherwise, the criteria focus on reliability and scalability. They do not exactly raise the bar; rather they are the bare minimum the NHS might expect. Yet in an interview with E-Health Insider, Connelly declined to be drawn on whether she thought they would be met. It would be nice to hear the DH CIO saying that such basic hurdles will be cleared with ease. That said, the fact that NHS Bury went live with a version of Lorenzo containing some PAS-style functionality this week is a big step forward; even if going live across Morecambe Bay will require a much bigger leap. Who gets to make the call on success, and what happens next, promises to be extremely interesting. In her interview, Connelly stressed the decision will ultimately be taken by the NHS Management Board and Secretary of State for Health. Sources indicate that Nicholson and ministers have all but lost faith with the national programme, and have been pushing the November deadlines hard with little expectation of them being met. The option said to fast be gaining favour is systems of choice within a framework of interoperability and a radically reworked version of the LSP contracts. Also on Connelly's big 'to do' list by the end of November is to sort out interoperability with NPfIT systems; provide trusts in the South with a route out of the post-Fujitsu mire; and complete a new deal in London that will allow locally-configured delivery of Cerner while meeting the new requirements of polyclinics. . . Incredible though it may seem, six years after contracts were awarded, the world's largest civilian IT programme is still poised on a razor's edge between success and failure. With a Herculean effort, it may scrape

over its November hurdles, making far-reaching changes unlikely - this side, at least, of a general election.

3.7.72. NPfIT aims in London won't be achieved, says a top health official (9 April 2010)

Computer Weekly

http://www.computerweekly.com/Articles/2010/04/09/240851/NPfIT-aims-in-London-won39t-be-achieved-says-a-top-health.htm

A senior health official has told all London NHS chief executives that savings on the £12.7bn NHS IT programme mean that "it will no longer be possible to provide a comprehensive solution that was anticipated in 2003". The letter by Ruth Carnall, who is chief executive of NHS London, the strategic health authority for the capital, is confirmation that the National Programme for IT [NPfIT] in London will not deliver to trusts in the capital a single standardised hospital system. One of original purposes of the NPfIT had been to achieve economies of scale by having one local service provider - BT - deliver a common, unified systems to all trusts in London. Carnall's letter explains the cuts in services and systems that will be made because of the government insistance that BT's £1bn contract as the NPfIT local service provider in London is reduced by at least £100m. The letter says: "The £100m reduction in the available funding, inevitably, means a reduction in the scope of the Programme. It will no longer be possible to provide the comprehensive solution that was anticipated in 2003." BT will no longer have to supply systems to about 1,400 GP practices in London. The Cerner and Rio electronic patient record systems "will now not be available to all organisations", says Carnall. BT is also excused from delivering an ambulance solution. Conservative MP Richard Bacon, a member of the House of Commons' Public Accounts Committee, said that the new deal with BT represents an extraordinarily good deal for the company and an extraordinarily bad one for taxpayers. Carnall says that a new IT strategy for the NHS in London will be drawn up which will help "address the IT challenges emerging from the reconfiguration of services".

3.7.73. NPfIT's Summary Care Records system suspended (19 Apr 2010)

Computing

http://www.computing.co.uk/computing/news/2261542/summary-care-records-system

One of the most controversial elements of the NPfIT, the Summary Care Records (SCR) system, has been suspended following industry criticism of a rushed implementation. The SCR system was criticised by the British Medical Association (BMA) last month in a letter to health minister Mike O'Brien. The letter said there were some privacy concerns around the scheme and that patients should be able to "opt out" if they wanted. Dr Grant Ingrams, chairman of the BMA's GP IT committee, said that the move to suspend the SCR system was a positive one. "We welcome the decision to suspend uploads. Summary Care Records have the potential to improve healthcare for patients if implemented appropriately. We will work with government in future to ensure that the many concerns of patients and doctors are listened to and addressed." The Department of Health (DoH0 said the rollout would be delayed until there was better awareness of the scheme. Separately, the government recently signed an NPfIT contract with BT locking the next government into a contract that will see the delivery of the NPfIT reduced in scale. Chief executive of NHS London Ruth Carnall said: "The deal means [the NPfIT] will no longer provide the comprehensive solution anticipated in 2003." BT will be paid about £900m, the original contract had been for £1bn. Public sector analyst for Ovum Mike Davis explained that the contract actually affords flexibility. "NHS trusts in London can now choose their own software and an alternative supplier if they want to," he said. Although choosing their own provider will cost individual trusts money upfront, some, such as Ipswich, have opted to choose their own software and system integrator to implement an Electronic Patient Records (EPR) system because they believe it would be more cost-efficient in the long run. The EPR means that the region's hospitals' billing systems are more efficient, thereby guaranteeing payment from their Primary Care Trust. Although the Tories have said they would look to dismantle the NPfIT, Ovum's Davis argued that in reality there will be no official dismantling of the NPfIT because so many parts are up and running – however, elements of it may begin to start unravelling over time as more trusts begin to choose their own software and system integrator. "My advice to any new government is to leave the NHS and the NPfIT alone. Coping with the changes [caused by the NPfIT] has been incredibly difficult for the health service – there are so many fiefdoms and hierarchies within the NHS that change has to be managed very carefully."

3.7.74. Summary Care Records scheme "at risk" - confidential draft report (20 Apr 2010)

Computer Weekly Tony Collins IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2010/04/summary-care-records-scheme-at.html

The Summary Care Records scheme has yet to gain Treasury approval, which puts the future funding of the project at risk. SCRs are central to the success of the £13bn National Programme for IT in the NHS [NPfIT]. SCRs were launched in March 2007 when patients in Bolton became the first in England to receive information telling them about the introduction of the new electronic Summary Care Record. Since then, GP practices and primary care trusts have uploaded more than one million patient records onto a central Oracle database run by BT under an NPfIT data "spine" contract; and the Department of Health has paid financial rewards to dozens of primary care trusts for undertaking a public information programmes on the Summary Care Records scheme before March 2010. The Department of Health has told me several times over the past month that the business case for the SCR scheme is "in the process of being approved". But a confidential draft report on the SCR reveals that the scheme has been operating for three years without the Treasury's approval of the business case. The draft report by researchers at University College London, says that the non-approval of the business case is seen as the "biggest risk" to the programme by NHS Connecting for Health. The UCL report was commissioned by Connecting for Health. Ministers have decided not to publish it until later this year although it was due originally to have been published before the general election next month. The Treasury approves business cases when the full costs have been identified and justified, when there is proven support from stakeholders, and the benefits are clear, though the Treasury allows for some assumptions to be made. Last week the Department of Health announced that uploads of summary patient information will be halted in areas where the roll-out had been accelerated. No clear reasons were given for the suspension: the Department of Health said the roll-out would be delayed until there were better awareness of the scheme. The Department's spokesperson told me that the suspension had nothing to do with the Treasury's lack of approval so far for the SCR business case. . .

3.7.75. Government plans new model for Summary Care Record (21 Jun 2010)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4126359&c=2

Exclusive: The Government is planning to switch to a scaled back, 'patient-held' electronic care record, severing central control over the controversial programme, but stopping short of scrapping it altogether. A senior Government source told Pulse of moves to substantially reform the Summary Care Record after researchers found it had spectacularly failed to deliver a raft of promised benefits to patients and doctors. The official evaluation, by researchers at University College London, concluded the programme's problems were so deep routed they could not be solved, and claimed senior IT managers had deliberately rushed the rollout in the run-up to the election to save it from the axe. The Department of Health's signal that it plans a more patient-focused approach to the care record came as it emerged that almost 90% of nearly 9 million patients who have been mailed information may have given consent without realising it. A senior source said the Government was 'profoundly, deeply troubled' by the rollout and planned major changes including axing IT bureaucracy and switching to a simpler system based on patient control at a local level, including a back-up system for vulnerable patients. Connecting for Health had claimed the Summary Care Record would make GP out-of-hours telephone calls and visits 15% shorter, cut time spent on A&E and walk-in centre consultations by a third and make mental health crisis intervention encounters 60% shorter. Yet, the 250-page report, based on three years of data and costing £1m, said: 'When the care record was accessed by doctors, consultations were significantly longer.' The report, published in shorted form by the BMJ, did find a 'rare but important' impact on medication errors, but warned some records contained 'incomplete or inaccurate data,' including failing to list medication or listing allergies the patient probably didn't have. It also claimed a revised consent model brought in by Connecting for Health after huge pressure from the BMA, requiring clinicians to ask patients for consent each time they entered one of 1.2m records created as of March this year, was routinely ignored. Connecting for Health is accused of deliberately ramping up the speed of the rollout and reducing consultation with GPs, in an attempt to reach a critical mass of record use before the general election. Study leader Professor Trisha Greenhalgh, now professor of primary health care at Queen Mary's University, London, told Pulse: 'I cannot see how they are going to solve the problems we have found. The whole idea of a shared summary record sitting on a shared database is problematic.' Professor Greenhalgh added: 'If the Government ignores

this report it will be a disgrace. If we'd found out there were real benefits to health, that it saved lives, them maybe we'd think it was worth it. But it hasn't.'

3.8. General Warnings and Advice

3.8.1. More Radical Steps (2003) Initiatives (Jul 2003)

BCS Health Informatics Committee

http://www.bcs.org/upload/pdf/rsjul03.pdf

" Estimates of four to eight times current planned investment were suggested as necessary to carry out necessary professional training, organisational systems redesign and realignment to support a successful NPfIT. Until any other figure is ratified, the potential for NPfIT to have a substantial impact on care remains at serious risk"

3.8.2. NHS Confederation Briefing (1 Aug 2003)

National Programme for Information Technology in the NHS

http://www.npfit.cambridgeshire.nhs.uk/default.asp?id=24

" The IT changes being proposed are individually technically feasible but they have not been integrated, so as to provide comprehensive solutions, anywhere else in the world."

3.8.3. The National Programme and Primary Care Informatics (1 Mar 2004)

BCS Health Informatics Committee

http://www.phcsg.org/main/documents/Position%20Paper%20Release%201%20-%20Mar%202004%20.pdf

" The National Programme needs to understand GPs' current high levels of dependence and relative satisfaction with their current systems, and must provide a path to allow GP practices to move to systems that can fully realise the vision of the National Programme in a controlled manner without excessive loss of utility in the process. Critically, the National Programme needs to recognise that there is no hurry to replace current systems before proven alternatives are generally recognised as justifying the disruption."

3.8.4. National programme for information technology (15 May 2004)

BMJ 2004;328:1145-1146, doi:10.1136/bmj.328.7449.1145

http://www.bmj.com/cgi/content/full/328/7449/1145?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=humber&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT

"With the national programme for information technology, the NHS in England has set itself an enormous task. A programme of this size has never been attempted in the United Kingdom and, in many respects, elsewhere in the world. But what is the national programme, why is it so important to the government and to the viability of the NHS, and is it on course to succeed? The national programme means an investment of £6.2bn ({euro}9.2bn, $11.1bn) over a 10 year programme of change. It promises to modernise information and communications technology across the NHS and provide the tools to help streamline the healthcare services. It will create a basic health record for all 50 million patients, enabling quick and easy access to the essential information that anyone making health decisions about a patient needs to know. It will connect more than 30 000 general practitioners and 270 acute, community, and mental health trusts in a secure system. It promises to "improve the convenience and quality of care" by having the right information in the right place at the right time. It will sustain the NHS reform programme and support patients' choice. That is the hype, but why does the NHS need such a national programme? For many years the NHS has been flirting with information and communications technology. This has resulted in a multitude of disparate systems many of which are unable to share information. The publication in 2002 of the Wanless report (a review of the long term trends affecting the health service and the resources required over the next 20 years) convinced the Department of Health to commit to a fully integrated national system. The report concluded that "without a major advance in the effective use of information and communications technology, the health service will find it increasingly difficult to deliver the efficient high quality service, which the public will demand." The Department of Health thought that information and communications

technology in the NHS needed to be managed and controlled at a national level. The increasing complexity of health care, the need for timely access to quality data and the latest information by healthcare professionals, and the need to reduce clinical errors demanded a revolution in information and communications technology. The term national programme for information technology is misleading because the programme isn't just about technology. Its successful implementation will affect the ways in which people work and services are delivered. . . Will the national programme work? In a recent article in the Financial Times, Nicholas Timmins highlighted some major concerns about the programme. He reports suggestions that Peter Hutton was "frozen out" of the programme after expressing serious concerns. The programme has been criticised as being too secretive, even excluding many NHS employees from its development. Peter Hutton also raised concerns over how uniformity and continuity of care will be achieved across different local service providers, stating that local variations would raise "major safety and training implications." EMIS, the largest supplier of primary care systems in the United Kingdom, announced that it would not sign current contracts with any of the local service providers appointed to deliver the national programme. With so many concerns, and we have looked at just a few, one wonders how the national programme will succeed. However, far too much is at stake for it to fail. The consequences of failure are too ghastly to imagine. . ."

3.8.5. How To Succeed In Health Information Technology (25 May 2004)

Health Affairs

http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.321v1.pdf

". . . The most broadly implemented health IT system in the world today is that of the Veterans Health Administration (VHA). This system, known as VISTA/CPRS, covers more than 1,200 sites of care, including acute care hospitals, ambulatory facilities, skilled nursing facilities, and pharmacies. While the admiring visitor might imagine that he or she is looking at the result of a brilliantly executed, centrally conceived plan, nothing could be further from the truth. The original plan to computerize the VHA was specified and contracted in typical government fashion. It failed spectacularly. The successful system that is apparent today in every VA hospital is the result of the teaming together of physicians, nurses, and other caregivers to develop a system that works in real practice, every day. Naturally, a system as large as that of the VHA requires central management, but management has learned its lesson. The development sites are decentralized and as close as possible to frontline caregivers. . . The most ambitious project of all is on the other side of the Atlantic, that of the English National Health System (NHS), which has contracted with multiple parties to assemble a seamless $10 billion electronic health record to cover its forty million members. In each of those projects, there has been relatively little involvement, beyond some focus groups, of front-line doctors, nurses, and other caregivers. As a professional "entrepreneur" in health IT, I have learned a consistent lesson, sometimes the hard way. That lesson is that one cannot ever spend too much time talking with the users, showing them prototypes, learning their preferences, and trying things out. . ."

3.8.6. Public Value and e-Health (1 Jul 2004)

Institute for Public Policy Research

http://www.ippr.org.uk/ecomm/files/public_value_ehealth.pdf

" . . . although new ICT systems have been procured for the NHS, in order for the anticipated benefits to be delivered there will have to be significant changes to the way the NHS works in order to take full advantage of the greater availability of information. There are two potential barriers to the successful completion of this change management process. First, control over NHS ICT might have moved from being too devolved to too centralised. This could potentially make systems insufficiently flexible to take account of useful variations in local working practices and might also lead to trailblazing NHS organisations being held back. Second there may simply be insufficient capacity within the NHS to cope with the magnitude of change that will be required. Managers, health professionals and specialist health informaticians are all extremely busy and may not have the time to make sure that the change is a success. Inadequate funding, insufficient skilled staff and the competition of other priorities may mean that although ICT systems have been procured, the benefits delivered will not be as great as they might have been."

3.8.7. Transcript of File on Four (19 Oct 2004)

BBC (Interview with Jean Roberts, BCS Health division)

http://news.bbc.co.uk/nol/shared/bsp/hi/pdfs/fileon4_20041019_nhs_it.pdf

" To get these new systems introduced, the people competent to use them and for them to be day-to-day support tools will require somewhere, according to the people in the field, between four and eight times the initial investment."

3.8.8. Doomed from the start: considering development risk (1 Feb 2006)

Reg Developer

http://www.regdeveloper.co.uk/2006/02/01/development_risk/

" [The NPfIT] project does seem to exemplify one with high scores in all the risk categories I'd review before starting a project:
- It's a very large project, and the Government's record with large projects certainly isn't better than anyone else's.
- It involves massive changes to existing systems.
- It cuts across organisational boundaries (hospitals and GP surgeries, and uses outsourced services).
- It has legal/regulatory issues - doctors are responsible for the governance of patient records, and the Data Protection Act applies to much of the information.
- It is a highly visible project, raising considerable press interest.
- Top management (in this case, probably even our Prime Minister) is taking a lively and, possibly, ill-informed interest.
- It has safety-critical aspects.
- Resources are limited and, in theory, tightly controlled.
- It involves new technologies.
- Few of those involved can have much experience with similar projects - US healthcare is very different and the NHS is an unusually large operation, even in a global context."

3.8.9. BCS Response to NAO Investigation of NPfIT (4 Jan 2005)

BCS

http://www.bcs.org/upload/pdf/auditofficejan05.pdf

" Summary:

1. NPfIT is damaging the UK healthcare IT Industry by excluding many small but innovative players. Steps must be taken to make systems more open.
2. NPfIT operates in an unnecessarily secretive manner. Its contracts and other documentation need to be made public to allay suspicion and encourage trust.
3. NPfIT is too top down in its approach. It now needs to be made bottom up: owned, understood and made affordable locally.
4. Current experience in the UK is not being exploited.
5. There needs to be confidence in the quality of staff developing NPfIT. Qualified informatics staff should be the norm.
6. More staff are required at all levels to implement NPfIT at the pace planned. Education is needed in health informatics to develop a larger pool of skilled workers.
7. Centralised solutions may not perform well enough for clinical use. Consideration should be given to distributed solutions.
8. Patient care is at risk from a loss in functionality. Much current healthcare is built around and depends upon current IT solutions.
9. There are risks to physical security and privacy of content from the NPfIT approach. Rigorous but practical user access controls are essential.
10. Confidentiality constraints must not interfere with patient care by limiting what information is documented and what is available to whom.
11. Without user ownership, NPfIT systems will not be used. Clinicians need to be consulted about integrating IT systems with operational clinical services.
12. NPfIT is primarily about business change, not information technology. There needs to be an extensive education and training initiative."

3.8.10. National Programme for IT: the £30 billion question (1 May 2005)

Br J Gen Pract.

http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1463155

" The National Programme for IT (NPfIT) for health and social services in England has an anticipated cost of around £30 billion. The world's largest ever IT project aims to provide 'Better information for health, where and when it's needed'. The core strategy is 'to take greater central control over the specification, procurement, resource management, performance management and delivery of the information and IT agenda'. . . Virtually every general practice in the UK is now computerised. A rapidly increasing proportion of all practice team members, not just GPs, use computers face to face with patients every day. Arguably, UK general practice leads the way in the use of computers to support patient care. Yet, as evidenced by the medical tabloids, this key stakeholder group has become alienated and marginalised. The explanation for this lies in part with ownership and control. The NHS struggles to throw off its image as a 'command-economy state organisation' but NPfIT, which is run under firm central controls to very tight deadlines, perpetuates that image. Until recently, GPs owned their computer systems. Over more than 20 years these systems have become feature rich in response to user driven innovation. At many sites, electronic information systems and the administrative processes of running a practice have become highly interdependent. Suddenly, ownership has been taken away and procurement of all replacement systems placed in the hands of local service providers. These new people have little or no experience of the general practice domain. They are charged with providing NHS-wide integrated systems to deliver NPfIT priorities. The future of existing general practice systems, upon which GPs are increasingly dependent for delivering care and generating their income, remains unclear. There is little confidence in the quality of replacement systems, partly because what does not yet exist cannot be assessed and partly because there is a widespread perception that knowledge built up through many years of experience is not being harnessed. There is a fear that existing systems will be uprooted at short notice to be replaced with 'new' systems, resulting in severe disruption of vital practice processes. There are further fears that painstakingly collected clinical information will be lost or corrupted during this process, putting continuity of care and patient safety at risk. . . Many of the concerns expressed in this article arise because the people, organisations and technology that deliver health care together make up an unpredictable complex adaptive system. Thus far, NPfIT seems to have adopted a rational and deterministic approach to management. It systematically gathered and analysed facts to produce an output-based specification and then set clear objectives with tight deadlines. This 'well-oiled machine' is now driving IT into the health system. That may be fine to get the technology in place, but much more than just IT is required. The impact on patients and professionals has yet to be seriously addressed. A very different approach is needed to nurture culture change. We will need to feel trusted, to be encouraged to experiment in a system that encourages innovation and learning from mistakes. With powerful 'informating' systems, we should be well equipped to adapt quickly to change and be able to transform the way we work to provide truly patient-centred care. The £30 billion question is not just whether NPfIT will get the technology right but whether it can also win the hearts and minds of the people on whom the NHS depends every day." [John Williams]

3.8.11. Doctor voices concerns over new NHS IT system, UK (6 May 2005)

Medical News Today

http://www.medicalnewstoday.com/medicalnews.php?newsid=23962

" The political drive to implement the NHS's national programme for information technology is failing to take account of professionals' anxieties, argues a GP in this week's BMJ. Dr Nigel de Kare-Silver describes his experience of workshops to introduce the new system to users. " We were shown screens of a third rate computer program lifted from the existing system of US hospital administrators," while further meetings produced " lame presentations by various strategic health authority IT leaders." He goes on to describe problems with the " choose and book" system, in which doctors will select from a list of local hospitals and book an appointment while the patient waits. This has a national implementation date of the end of December 2005. " The application screens are slow, and the computers often fail to pick up the programs. There is no integration with existing clinical systems or with Microsoft Outlook," he writes. But the " really frightening module" is the inability of the software to retain advice by either the consultant or the GP, or to integrate it with clinical results. " This is a major clinical governance issue, he adds. While the ambition of the NHS agenda for IT change should be applauded, it is unfortunate that the contractors show no ability to deliver a system that is an advance on existing services, says the author. " It is frightening that the political drive to implement the system is failing to take account of professionals' anxieties." Before allowing its delivery, clinicians

from all backgrounds must demand a service that is rigorous in terms of clinical governance, friendly in its user interface, fast, and relevant to the needs of clinicians and patients, he concludes."

3.8.12. Strategic Business Management - Final Stage Examination (14 Jun 2005)

The Chartered Institute of Public Finance and Accountancy

http://www.cipfa.org.uk/students/studylounge/download/pastpapers/jun05/SBMXQ1.pdf

". . . Stories of the incompetence of central agencies — the Child Support Agency, the schools examination board and NHS drugs procurement in the past month alone — are the stuff of comment. Yet nobody examines how these matters are conducted to greater public satisfaction abroad. Nobody notes that local democracy runs schools in Sweden, hospitals in Denmark, planning in France and everything in Spain. These countries are not Utopian or naive. They have all experienced centralist drift but, at least since the early 1980s, have fought back and devolved successfully. The only Utopia is the belief of the UK Treasury that every public service can be run more efficiently from Whitehall. The latest madness is its wholly unnecessary £6bn NHS computer system. . ." [Quotation from article in Public Finance, 26 Nov 2004]

3.8.13. Masters of the universe give us a billion-pound computer fiasco (26 Jun 2005)

The Sunday Times

http://www.timesonline.co.uk/tol/comment/columnists/simon_jenkins/article537539.ece

". . . As long ago as 1997 Computer Weekly estimated that some £5 billion had been lost by Whitehall on botched computer projects. Consultants had found selling computers to ministers was like giving sweets to children. Labour claimed it would stop all this, but it did the opposite. Ministers traded up from candy to cocaine and are now hooked. The money being wasted subsidising the computer industry far outstrips what used to be wasted on nationalised cars, steel, coal and shipbuilding. Government computers are the new lame ducks. I am told that the NHS project was sold to Tony Blair by a McKinsey team at a meeting in February 2002. The team chief was David Bennett who, intriguingly, was this month appointed Blair's policy chief at an undisclosed "six-figure salary". The NHS computer was supposed to list everyone in the country with their various ailments so any doctor or hospital could treat them "on screen". Nobody ever asked for this machine, which was supposed to start in 2004. It was a pure top-down sales pitch. The medical establishment pleaded naively that the cost not be met from other health spending. The price soared within a year to £2.3 billion and is now £6.2 billion, with no known delivery date. Every industry expert is screaming at Patricia Hewitt, the health secretary, to cancel it. She has not the guts. It was a "McKinsey project" and her boss dare not be seen wasting billions on his friends, money that might have gone on patient care. Yet this gullibility is not confined to health. A planned Ministry of Defence computer is budgeted at £4 billion, sold to Geoff Hoon as linking 70,000 desktops in "real-time decision-making with network-enabled capability". Hoon also spent £195m on consultancy fees for an unbuilt aircraft carrier, under something ironically called "smart procurement". This is a ministry that cannot equip its troops in Iraq with modern kit and claims "frontline overstretch". . . The apotheosis of public sector consultancy came last week with McKinsey appointed de facto Purveyor of Policy to Her Majesty's Government. It takes the place of the cabinet, MPs, the civil service and the Labour party. Thus Sir Michael Barber left Downing Street for McKinsey to advise on "government", while the firm's David Bennett moved the other way to head "policy". Bennett's duties reportedly included approving the new head of the civil service, as well as doubtless protecting the NHS computer. With him are McKinsey associates Lord Birt, Nick Lovegrove and Adair Turner. Downing Street claims oddly that they earn no "public" money. So who pays them? If it is McKinsey, which is paid by government, is this not just salary laundering? Were these jobs or contracts properly tendered? Nobody is saying and nobody seems to know. I can see why McKinsey once boasted in a documentary that its staff were "masters of the universe", even if none had ever run a whelk stall. It seeks to locate key alumni everywhere that has money to burn. . . Consultancy, as Peter Drucker said, is not a corporate investment but rather a corporate indulgence. It is a perk, a weekend retreat, an executive jet. A boss turns to consultants when he is bored with his colleagues or wants to avoid a simple, tough decision by making it seem complex and intellectual. For Blair, consultants offer flattery and jargon. They promise top-down initiatives that circumvent civil servants, parliament and usually common sense. They are a vain attempt to depoliticise government. This is really about greed, yet another round in the old game of lifting money

from the taxpayer by bamboozling ministers and officials. Computerised government is mostly nonsense. The sums leaching from the Home Office, NHS, MoD and Inland Revenue are grotesque. . .”

3.8.14. Exploiting the potential of the NPfIT: a local design approach (Jul 2005)

British Journal of Healthcare Information Management

http://www.bjhc.co.uk/issues/v22-7/v22-7eason.htm

“ABSTRACT: England’s National Programme for IT in the NHS can be characterised as using a ‘push’ strategy to implement standardised systems across the NHS. Evidence from similar implementations in other organisations suggests that, because of local variations in healthcare requirements, this will lead to: implementation failures and delays; partial use; and inefficient workarounds. To avoid these outcomes local user communities need to develop ‘pull’ strategies in which they examine how they can exploit the new technical systems to improve local healthcare practices in ways that are important in their context. A user-centred, local design approach is proposed for this purpose based on six principles: studying the local ‘sociotechnical’ system; understanding local ambitions; establishing local planning teams; reviewing the implications of incoming NPfIT systems; designing local systems; and implementing systems using action research to review user experiences. [Ken Eason, Br J Healthcare Comput Info Manage 2005; 22(7): 14–16]”

3.8.15. NHS IT – now time to get on with the job (Oct 2005)

Silicon Bridge Research

http://www.siliconbridge.co.uk/art_nhs_it.html

“ After three years of activity, we now have a much clearer picture of the practical implications of the National Programme for IT (NPfIT). Publication of the latest business plan by Connecting for Health (CfH) has finally removed some of the wraps from this high profile Government driven project. The road to a full National Care Records Service (NCRS) turns out to be at least as long and winding as many experienced healthcare IT professionals had predicted. In reality, the original timescales of “ two years and nine months” have stretched to a decade or more. In addition to its many undoubted strategic and technical merits, NPfIT also has a strong political dimension. The original idea was first conceived in 2002, three years before the 2005 General Election, as a means of gaining strategic advantage and mitigating political risks commonly associated with high profile NHS IT projects. Now that the election is past and NPfIT has started to become a practical reality, current political priorities are rather different. The next General Election will probably take place in 2009, with build-up starting in 2008. Even under currently projected timescales, NPfIT will still be deep in the transition phase, particularly in terms of rollout by NHS Trusts. The most likely areas for political gain will therefore be in national infrastructure and application projects, most of which are already well under way. These national projects are fully capable of completion within the next three years, at least in terms of available functionality, even if take-up may be less than 100% at local implementation level. In addition to the £6billion committed by CfH (of which less than half has been spent to date), considerably more will be required to achieve successful completion. Emphasis has already switched to NHS Trusts to provide more IT resources and funding for themselves. This comes at a time when Trusts are under unprecedented pressure to balance their budgets and may find the choice between increasing IT spend and cutting back clinical services difficult to make. This will result in a softening of the hard edges of NPfIT and will allow more room for choice and diversity in local IT implementation projects. However, some difficult questions still remain to be answered in relation to NPfIT and its implications for the UK market:

- What exactly is the scope of new products being rolled out?
- How will the transition from current systems be handled?
- How will suppliers secure engagement with clinical users?
- Where will necessary implementation resources come from?
- Who will be winners and losers in the emerging market?
- What now are the future prospects for NHS IT? . . .”

3.8.16. Re-configuring the health supplier market: Changing relationships in the primary care supplier market in England (9 Mar 2006)

Integrated Health Records - Practice and Technology, National eScience Centre

http://www.nesc.ac.uk/talks/648/Papers/sugden.pdf

" The NPfIT 'top down' approach has been criticised for appearing to ignore the complexity and diversity of local requirements and developing a 'one size fits all' solution. Whilst the NPfIT goals of information sharing and interoperability across the NHS are laudable, its centralised planning approach has resulted in a shift of the locus of control to management consultants, rather than users or suppliers."

3.8.17. NHS plan is evolving but one-size-fits-all is a fundamental flaw, says hospital chief (14 Mar 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/03/14/214731/nhs-plan-is-evolving-but-one-size-fits-all-is-a-fundamental-flaw-says-hospital.htm

"Jonathan Michael, a top NHS executive, had some good words to say about Connecting for Health, an agency that is running one of the world's largest civil IT programmes. After pointing to a fundamental flaw in the NHS's IT-driven modernisation, he told a healthcare symposium at London's City University, "If that seems somewhat critical of Connecting for Health, what we have to recognise is that CfH is evolving. It is in a process of/ refreshing its view and approach. But it is listening and it is evolving." The flaw Michael sees in the national programme for IT (NPfIT) is its centralised, standardised approach at a time when the health service is decentralising. The chief executive of Guy's and St Thomas' NHS Foundation Trust, Michael wants IT support for the specific ways people work in particular parts of his organisation, such as the accident and emergency department. "There is a fundamental flaw in terms of the business," he said. "We are running a business in an increasingly decentralised competitive healthcare market, rather than a centrally managed healthcare market." A rigidly standard approach "is not practical in a competitive healthcare market where we may want to look at the business processes within our organisation, be it in accident and emergency or other areas, and to use our IT support systems to help us improve efficiency". Michael said the reality of the one-size-fits-all approach is that it doesn't fit, or if it does, it constrains managers' ability to run the business flexibly. "The idea that the requirements for all hospitals/ are the same is, I think, simplistic. Flexibility is designed out of solutions and out of the implementation process. So standardisation of IT systems effectively dictates the standardisation of the business model," he said. Michael's speech about the NPfIT commanded the rapt attention of his audience not simply because he is running one of the largest NHS trusts in the UK but because it is rare for any senior health service executive, especially one of Michael's standing, to criticise openly the NPfIT. . ."

3.8.18. NPfIT and the NHS healthcare IT market: an assessment at year four (Apr 2006)

Silicon Bridge Research

http://www.siliconbridge.co.uk/art_nhs_it.html

" Information and communications technology is evolving so rapidly that we cannot realistically plan systems implementation more than 24 months ahead. Maybe this was the thinking behind the magic figure of two years and nine months originally announced at HC2002 as the timescale for the implementation of what is now known as the National Programme for IT in the NHS in England (NPfIT)? In practice, timescales have stretched progressively from five to eight or even 10 years, depending on how one chooses to read the Connecting for Health (CfH) media releases. So how did this happen, and what are the implications? More importantly, who will pick up the pieces? . . . From the outset, CfH made it clear that specialist UK healthcare suppliers had seriously let down NHS customers with inadequate existing or 'legacy' systems. . . Anyway, as the putative NPfIT pounds rack up relentlessly from thousands to millions to billions, who is now to say the NHS has not been getting value for money from its long-serving existing systems? . . . But it would be a great mistake to dismiss the NPfIT as a totally worthless concept. There is much to be admired, particularly in the approach to central infrastructure support. . . Realisation of local NPfIT business objectives will now depend on continuing support and development of the much-maligned existing systems. This has already been recognised for GP systems and a similar situation is now emerging for hospital systems. The idea of a clean sweep with standard NHS PAS-replacement systems was never going to work in practice, and new systems will have to coexist with old for some time to come. Pending availability of a full National Care Records Service (whatever this turns out to be), GPs and hospitals must either implement their own local electronic patient record (EPR) systems or continue to operate with manual

paper records. This situation will become increasingly difficult to support without using interim local document-management systems. . . Using large-scale service suppliers as prime contractors is an effective way to channel more skilled resources into the NHS market; this is how the USA market has operated for the past 20 years. The big mistake was to force LSPs to adopt limited-choice solutions selected by CfH with little reference to user needs at operating level. Even worse was the decision to demand major modifications to standard product specifications in the mistaken belief that CfH knows more about healthcare-IT system needs than major suppliers. Worst of all was the mistaken assumption that the choice agenda does not extend to individual NHS trusts in their selection of strategic IT systems. . . The priority for CfH must now be to manage expectations for the NPfIT in such a way as to secure effective completion of the essential basic infrastructure components as originally conceived by the NHS Information Authority — without throwing the baby out with the bath water. At the same time, local NHS organisations need all the help they can get from LSPs to manage the long and difficult transition from paper-based systems to electronic healthcare records. For all the NHS users and commercial suppliers involved, the risks of failure are too great to contemplate."

3.8.19. Should Connecting for Health be Reviewed? (24 May 2006)

Presentation at the BCS Primary Health Care Specialist Group Spring Conference, 23rd – 24th May 2006 by Dr Glyn Hayes, Chairman – BCS Health Informatics Forum.

http://www.phcsg.org/main/pastconf/heythrop06/Wed/GHayes1520.ppt

" . . . What is Wrong with NPfIT? - Everything is late; Confidentiality is still an issue; Data Migration/Quality still not worked through; Centralised versus distributed systems; The scale of the NHS still causes problems; Hosted Systems. What are the Dangers of a Review Now? - Damaging political resolve; Things are beginning to happen; Many parts of the NHS are gearing up for delivery; Any further delays are unacceptable; If there is to be a Review it must not hold things up; To be meaningful it must be done by those who understand health informatics"

3.8.20. US conference gets a reality check on NPfIT (26 May 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=1909

" Former National Programme for IT industry liaison manager, Phil Sissons, delivered a transatlantic reality check this week, exposing some of the warts in the £6.2 billion programme to an American audience, US correspondent Neil Versel reports from the 22nd annual Towards an Electronic Patient Record (TEPR) conference in Baltimore. In a keynote address this week, Sissons, now an ICT consultant said that there was a lot of truth in the negative reports about Connecting for Health (CfH), the agency running the National Programme for IT (NPfIT), despite the frequent denials by NHS officials. A prime example of CfH failure, according to Sissons, is Choose and Book. " Of the 80,000 appointments that have been made, I can count probably about six that have actually been made using the system. The rest are been made by phone. And yet, Choose and Book is seen as a major step forward," he said. Similarly, the data Spine that is to make patient records portable throughout England, has 80,000 people registered to use it, but neither hospital nor surgical information systems feed information to it yet."

3.8.21. The NHS and IT: A failure to connect (15 Jun 2006)

The Economist

http://www.economist.com/research/articlesBySubject/displayStory.cfm?subjectid=348945&story_id=7065709

" A gulf of mistrust between Mr Granger's team and the GPs threatens the success of the project. Part of the blame lies with CfH for making a poor job of selling itself. But blame attaches to the GPs too. Their status as independent contractors to the NHS too often blinds Britain's doctors to the wider picture."

3.8.22. EHRs: Electronic Health Records or Exceptional Hidden Risks? (Jun 2006)

Communications of the ACM, vol. 49, no. 6 (Jun 2006) p.120.

" . . . Over the past decade, several countries such as Australia, the U.K. and the U.S. have started IT initiatives aimed at stemming rising health care costs. Central to each of these initiatives is the creation of electronic health record (EHR) systems that enable a patient's EHR to be accessed by an attending healthcare professional from anywhere in the country. . . However, the attempts at creating national EHR systems have been encountering difficulties. In Australia, the implementation cost has risen from an estimated AU$5OOM in 2000 to AU$2B today. In the U.K., the implementation costs have risen from an estimated £2.6B in 2002 to at least £15B today. In the U.S., the " working estimate" for a national EHR system runs between $100B and $150B in implementation costs with $50B per year in operating costs. The UK Connecting for Health initiative calls for everyone in the UK to have EHRs by 2008. However, there have been ongoing problems with its implementation that spurred 23 leading UK computer scientists to write an open letter to the Parliament's Health Select Committee in April, recommending an independent assessment of the basic technical viability. In their letter, they ask whether there is a technical architecture, a project plan, a detailed design, assessments of data volumes and traffic loads, adequate resiliency in the design, as well as conformance with data and privacy laws, and so on. The US. approach to creating a national EHR system differs from the U.K. approach. . . Instead of funding the building of a single, integrated networked system with a central EHR database as in the U.K., the U.S. government is facilitating the definition of standards to allow the interoperability of commercially available EHR systems as well as interoperability certification standards. . . As the UK is discovering, focusing on the technology of electronic medical records without considering the myriad socioeconomic consequences is a big mistake. . ."

3.8.23. MP says NHS IT should be flushed (8 Aug 2006)

The Register

http://www.theregister.co.uk/2006/08/08/nhsit_flush/

"A conservative MP has called for the £12.5bn National Programme for IT (NPfIT) to be scrapped after he saw a leaked report that said the NHS was better off without the computer system. On Sunday, The Observer reported the contents of a leaked report by David Kwo, who had been in charge of implementing the scheme in London. Kwo, it said, had written that "the NHS would most likely have been better off without the national programme". Richard Bacon, MP for South Norfolk, who received the leaked report, called for the NPfIT to be scrapped. "The billions of pounds already spent could have been used to run 10 district general hospitals for a year," he told the Observer. "Now it is clear that patient safety and public health could be at risk. It is time to halt this programme before things get worse." Kwo's report described how hospitals were being "forced" to implement old software, just so it looked like NPfIT was delivering something. The Observer reported that just 12 of 176 major English hospitals had implemented the most basic version of software produced by NPfIT. GPs were implementing their own systems, according to Kwo. He said while NPfIT was meant to join all the NHS's disparate systems together, they were instead "fragmenting further". The National Care Record, the keystone of a conjoined NHS IT system, is also running about two years late, having originally been expected this year. It is being reconsidered, but some means of sharing patient information around the country would have been required whether NPfIT was implemented or not. Connecting for Health, the government body running NPfIT, said in a statement its systems would "ultimately" improve patient care by giving NHS organisations around the country access to all patient information. "Currently, with most existing systems, information stays on the computer where it was originated and can't be accessed by other doctors and nurses to treat patients," it said. It also said GPs were pleased with the systems they were getting under NPfIT and it knew of none who had chosen to implement their own."

3.8.24. Toughest tests still lie ahead for NHS IT (17 Aug 2006)

Computing

http://www.vnunet.com/computing/analysis/2162411/toughest-tests-lie-ahead-nhs

" Two core problems threaten the progress of the national programme for health service technology: Having made it through the Public Accounts Committee hearing relatively unscathed, the £6bn National Programme for NHS IT (NPfIT) faces tests with far greater implications. The data centre failure that knocked out patient admin systems in 80 hospitals this month raises serious questions, not least because backup systems also failed. But they are only ripples on the surface; two far deeper currents are stirring. The first is the doctors. Progress is already being delayed by disputes with the government over reform plans, with the Connecting for Health (CfH) agency running NPfIT over lack

of consultation, and between different clinical groups over who owns what data. While discussions are cloaked by concerns such as confidentiality and security, there is more than a hint of politics, and of a turf war over who is the first and final arbiter of the relationship with the patient. The second vital area will be the suppliers. CfH director general Richard Granger was specifically hired from the private sector to broker hard-nosed, commercial deals. He did a good job. The NPfIT contracts pay only on delivery of working systems, and include punitive fines for under-performance and the scope to swap out the weak at any time. . . An optimist might say the suppliers' financial issues are evidence that the contracts are working. But private sector pockets are not bottomless, and only a fantasist would say that implementation delays – and therefore payment delays – will catch up in the coming year."

3.8.25. The good of IT in healthcare: Let's not forget the benefits in spite of poor execution (17 Aug 2006)

silicon.com

http://www.silicon.com/publicsector/0,3800010403,39161603,00.htm

" The NHS IT modernisation programme has received its fair share of criticism. Much of which, granted, might well be warranted - with costs likely exceeding £12bn, a series of rollout delays and scepticism from some doctors who wonder if it's " the biggest government IT disaster yet" . But ironically at a Northern Ireland hospital trust outside the remit of the NHS Connecting for Health (CfH) programme, silicon.com has seen just how beneficial IT can be to doctors and patients. The Royal Hospitals Trust in Belfast has rolled out a new wireless network which will be used to share X-rays easily among doctors and to speed up drug dispensing. The trust is even handing out Star Trek-style wireless communicators to staff to facilitate finding and communicating with doctors and nurses when they're needed. . . Of course execution is the big issue and that's where the CfH scheme appears to be stumbling. This publication would never argue that the scheme's organisers not be held accountable for missteps. But let's not get too jaded and forget the good that can come from this - or perhaps this just underscores how essential it is for the NHS to get its IT overhaul right, and the magnitude of the consequences if it does not."

3.8.26. NHS computer chaos deepens: MP brands electronic link for hospitals and surgeries 'a hopeless mess' as costs rise to £15bn (20 Aug 2006)

The Observer

http://observer.guardian.co.uk/uk_news/story/0,,1854311,00.html

" A multi-billion pound plan by the government to link the computer systems of every hospital and GPs' surgery is unlikely to be delivered on time and may fall short of the NHS's requirements, according to a confidential review leaked to The Observer. . . The government has consistently claimed the project will be fully operational by the spring of 2008. But the review of the software that powers the system, conducted five months ago, suggests this is now in doubt. It notes that there has been 'slippage' in the rollout of the software, provided by Isoft, of '300 per cent'. The troubled firm is providing the software for three of the five regional 'hubs' of the national Connecting for Health IT system. The review, conducted by consultancy firms Accenture and CSC, who were awarded multi-million-pound contracts to oversee the implementation of the Connecting for Health system, notes: 'Critical elements of the plan seem significantly underestimated,' and warns that dates for the roll-out of the software are likely to be 'highly optimistic'. . . The review breaks the project down into 39 parts, each of which is given a colour grading. 'Red' requires immediate work, 'amber' suggests there is a potential risk and 'green' indicates there is no problem. Of the 39, 13 are classified red, 21 amber and only five green. The review identifies the issue of clinical safety under the current Isoft system as a 'red' problem. It notes the firm has appointed a director of clinical safety in response to the concerns, but that he could not 'articulate the time frames for establishing a clinical safety team given the current financial climate within Isoft' - a reference to the company's financial problems which have caused its share price to collapse. The report is extremely critical of Isoft's ability to build a system to meet the NHS's needs. It notes that 'programme planning... is based on unrealistic assumptions that drive unachievable plans that ultimately fail to deliver on time'."

3.8.27. What price the NHS computer upgrade from hell? (27 Aug 2006)

The Observer

http://observer.guardian.co.uk/business/story/0,,1859032,00.html

" What are the lessons to be learned from the unfolding fiasco engulfing the £12bn NHS computer upgrade? It is a large and complex programme designed to hold the records of 30 million patients, one of the biggest projects of its kind, so it needed to be thought through properly. And the users - the consultants and clinicians - should have been widely consulted. Neither seems to have happened, demonstrating the propensity of government to throw taxpayers' money down the tubes. If everything was going smoothly, why would Accenture, one of the key suppliers, have written off $450m because of delays and glitches that have left its executives seething? Within the NHS, there are stirrings of discontent as fears grow that hospitals may be signing up to something they don't want. The Sheffield Teaching Hospitals NHS Foundation Trust, for example, recently announced it was abandoning one leg of the programme. The troubles at financially stretched iSoft, which is providing some of the software, illustrate what can happen when one firm's fortunes are so closely tied to a single client. They also highlight the need for careful project management, sadly lacking in this instance. It is difficult to escape the feeling that this project is being rushed with unrealistic deadlines (no one seriously believes that it can be completed by 2008) and that targets set for suppliers are too tough to meet. Perhaps the writing was on the wall at the start when IBM pulled out of the bidding - wary, no doubt, about the ability of government to execute such an ambitious task. If IBM, or 'big blue' as it is known in the US, was alarmed about the intricacies of the programme, perhaps others should have drawn their own conclusions. If Accenture decides to quit, as is widely expected, we should be concerned: this is a company which generates tens of millions of pounds from government contracts - and would bend over backwards not to upset one of its most important customers. The NHS computer programme, championed by the Prime Minister, is a wonderful idea in theory. It allows electronic access to patient histories around Britain, making it simpler for people to choose where they have treatment and easier to treat those who fall sick miles from where they live. But with forecasters now saying that the true cost of the upgrade could top £30bn, the question has to be asked: at what price?"

3.8.28. IT deals are failing public services (29 Aug 2006)

The Guardian

http://politics.guardian.co.uk/publicservices/story/0,,1860168,00.html

" As someone who was involved in NHS computer system design for nearly 20 years, the latest news, although sad, comes as no surprise (Ex-CBI boss caught up in NHS fiasco, August 26). We were told in 2003 that the contracts for the local and national suppliers were " so tight that the suppliers couldn't wriggle out of them" . My response at the time was that if that was the case, the directors would walk off with pocketfuls of money while leaving the companies to founder and their staff searching for new jobs as soon as the going got tough. However, even I am slightly surprised at the amounts these directors have creamed off. My colleagues and I attended many meetings in which the cream of consultants from the supplier companies and their advisers dismissed the painstaking and thorough analytical work that had gone on within the NHS for many years as " science fiction" and " over-complex" , before going on to adopt simplistic solutions which were under-researched, had no meaningful clinical input, and were based on naïve assumptions which may be adequate in a commercial environment but were totally inappropriate to the multi-layered, multi-disciplinary and culturally disparate environment which is the NHS. We are now seeing the inevitable results of that inept design, which is unable to meet even the most minimal requirements of patient confidentiality and is so fragile that a simple power failure creates days of chaos for many hospitals. I take no pleasure in these failures, but my main concern is that no one is learning from them and we seem doomed to continue with the same flawed model of procurement. Meanwhile, those systems which were built in and by the NHS many years ago continue to reliably provide the basic IT infrastructure which keeps the whole thing running." [Ian Soady, Former chair, NHS Information Authority]

3.8.29. MPs urge rethink of NHS records project (31 Aug 2006)

The Independent

http://news.independent.co.uk/business/news/article1222861.ece

" The controversial programme to upgrade the National Health Service's IT systems has suffered another blow after two MPs called for an overhaul of the project yesterday. Richard Bacon, the Conservative MP for South Norfolk, and John Pugh, the Liberal Democrat MP for Southport, argued that the programme should be reformed to allow hospital trusts to purchase systems locally that can then be linked into the national network. Both MPs are members of the Commons Public Accounts Committee that reviewed the programme in June. The pair said that the project's " fundamental error"

was to centralise the procurement of single systems across the NHS. " The Government is convincing no one that the situation is under control. The national programme for IT in the NHS is currently sleepwalking towards disaster ... This programme is costing taxpayers a king's ransom, but is descending into chaos," they said. A Department of Health spokeswoman rejected their claims. . . "

3.8.30. Brampton Factor: NHS IT - can this project be saved? The prognosis looks poor... (19 Sep 2006)

silicon.com

http://www.silicon.com/publicsector/0,3800010403,39162536,00.htm

" . . . what are the main reasons for pessimism with regard to NHS IT? The most damning evidence is the failure of the project to maintain the confidence of those who will use it in their daily lives. Their view has increasingly been that the project is driven from the centre and will not deliver what is needed. Surveys of NHS staff are showing decreasing buy-in and senior doctors have been publicly critical. The National Audit Office has been driven to comment on the lack of staff commitment. . . Another crucial area that is too readily dismissed by sponsors of the project is security, and in particular the interests of individual patients. Most people probably still think of their relationship with doctors as one of strict confidentiality. That is how most doctors would like it to be. A number of changes have seriously undermined that position. Changes to greater reliance on electronic systems have shifted the ownership of data away from doctors towards administrators, who are much less constrained by ethical commitments. With ever increasing centralisation, data becomes the property of faceless bureaucrats. . . Recently doubts have been cast on whether patients will be permitted any kind of opt-out from this all-embracing approach to personal data. Of course plenty of bland assurances are given about how information will be kept secure. But with leaks from banking or criminal records systems commonplace, it is highly unlikely those promises can be met. Another problem is the accuracy of records, notably illustrated by the case of Helen Wilkinson who had to go to parliament to get a potentially damaging slur in her records removed. What, then, of the financial issues? . . . A delayed and over budget project is doubly damaging - the excess costs are painful but the delay in the benefits makes the situation far worse. . . So what do we learn from all this? Unfortunately very little that is new. Imposing sweeping change on a large and complex organisation from the centre has a poor likelihood of success - especially where large numbers of professional staff are involved. Excessively centralised systems are brittle and fail easily. Consultants do not deliver value unless they are exceptionally well managed. Senior management frequently fails to understand how organisations really work. The NHS is not a business, and it is a nonsense to treat it as one. Government cares little for the security of personal data. What kind of solutions are available? We would be much better off with more diverse provision of IT services to the NHS, which actually has many varied needs. Efficiency gains would be achieved more readily by the setting of standards for data exchange rather than the imposition of all-embracing systems. Incremental improvement is a more reliable way to achieve gains than a big bang. And open source solutions, as used effectively by the US Veterans Health Administration, have huge potential for gain - both through cost cutting and also through opening up developments to greater diversity and innovation. Will any of this happen? With the current posturing by leading politicians, and numerous signs of blame-passing around NHS IT, the prospects are poor."

3.8.31. openEHR and HL7 – some thoughts on the current discontents (21 Sep 2006)

openEHR

http://www.openehr.org/about_openehr/t_21_sep2006_DI_commentary.htm

" . . . Unfulfilled aspiration for health IT has created a poker game of ever increasing stakes of ambition, resource and emotion, drawing in an ever wider range of stakeholders, to the top policy levels. Just look at the Commonwealth Fund web site in the States or view on the web the recent Public Accounts Committee hearing on CfH, in the UK. I've been around the debate a long time and have learned that the three things that matter, as I've said before, are implementation, implementation and implementation! The problem with standardising, top down, before doing, is that one tends never to have time to do, and learn well through doing. The problem with doing, bottom up, before learning how to standardise, is that one tends to spend a lot too much time and money, creating eventual ultimate havoc of incompatible legacy. This complexity can only be reduced to tractable levels through starting again, while problems of integration remain elusive. I see the waste and despair that creates in

the healthcare workforce. It's a Catch 22; I can chart five reinventions of a national programme for IT, within the NHS, in my career. At its heart, all of this is a debate about emerging discipline, notably in medicine and computer science and at their interface. It's hard because that discipline has been sorely lacking on all sides and in their intersections. No one's fault, really, but shameful, all the same, that through diverse confusions and confabulations, the protection of the multi-billions that are now spent on not serving well the information needs of healthcare, end up with money mainly directed, largely unwittingly, and not in any sense by stupid people, in ways that have still failed to reach or be allowed near the heart of the matter. That is where considerations of quality, information and governance intersect in providing health services that people trust and value. In such circumstances, there are problems best approached through simplifying and withdrawing resource; Fred Brooks and his concept of the mythical man-month is salutary. . . There is a log jam in health IT. A memorable paper claims that sorting out health care data is an $80billion per annum problem for the US economy. In some sense, we believe that it needs to be transformed to a problem perhaps an order of magnitude less than that in monetary terms. . ."

3.8.32. Government must learn to curb its enthusiasm (27 Sep 2006)

The Guardian

http://society.guardian.co.uk/serviceofthefuture/story/0,,1881490,00.html

". . . Tony Blair has been keen on electronic government, or "e-government". He promised to make all services available electronically by 2005, a target the Cabinet Office said earlier this year was met by 96% of central government services: the likes of burial at sea were deemed unsuitable for "e-enabling". But along the way, it has developed a reputation for botching IT projects. . . Critics say the scale of contracts can put the government at the mercy of the handful of companies big enough to compete for them. The English NHS National Programme for IT tackled this by offering several contracts, both national and regional, worth more than £6bn in total, although NHS trusts are expected to spend billions more. This provides Connecting for Health, the managing organisation, with some power over suppliers - a few have been replaced - and it is also paying by results, which has contributed towards financial difficulties at suppliers including UK software firm iSoft. "The government's learning from its mistakes on this one," says John O'Brien. But the National Programme, which faces two-year delays on some projects and is about to be re-examined by the National Audit Office, has other problems, particularly in creating electronic patient records for everyone in England. The government is increasingly advancing big databases containing the personal information of millions as a solution to problems. These include the Identity Card Act's National Identity Register, holding dozens of pieces of information on every adult, and an index of children in England, which will allow practitioners to share abuse concerns. Building these may be challenging, but the real test could come over the next few years as such databases go live. Last May, the Information Commissioner detailed the lucrative trade in personal information, where employees are bribed or tricked into providing data to criminals who sell it to insurers, creditors, other criminals and journalists. Following that report, the government is consulting on imposing prison sentences for this crime, but with thousands of staff having access to each new database, security may be a headache. "You can't have security, functionality and scale from one IT system," Dr Brian Gladman, formerly of the Ministry of Defence and Nato, told a conference in August. "One of them has to go." The dangers, as well the opportunities, could be amplified by government proposals for greater sharing of personal data within the state-sector, to enable joinedup administration. Again, the government is blazing its own trail: many other European countries are wary of such sharing, given the terrible ways they have seen this abused within living memory. Tony Blair has been a cheerleader for IT without being an expert. "Like many people of my generation in positions of leadership, I rarely use a computer and when I do, I usually need help," he said in 1999, adding that he planned to take a computing course. . ."

3.8.33. Increased risk may put companies off public IT projects (3 Oct 2006)

The Times

http://business.timesonline.co.uk/article/0,,9068-2385376.html

" FAILINGS in the £14.5 billion market for public sector IT projects are to be examined in a new study that comes after the controversial exit of Accenture from the NHS super- modernisation programme. Next year, the Office of Government Commerce (OGC) is to research the issues and constraints that could have an adverse effect on the delivery of IT projects in the public sector. Its decision comes after the publication of a joint pilot study by the OGC and the Cabinet Office, which concluded that

increased risk, combined with onerous terms and conditions for suppliers, could stop companies tendering for work. Companies questioned for the study included all four key suppliers on the Government's £12.4 billion NHS IT modernisation project — BT, Fujitsu, Computer Science Corporation and Accenture. Last week Accenture quit the project, which has been hampered by delays, glitches and political wrangling. The company transferred the bulk of its contracts to a rival after making a £240 million provision against potential losses. The pilot report will give further ammunition to critics of the NHS project, who argue that its problems stem from the determination of Richard Granger, who heads the project as chief executive of Connecting for Health, to avoid the problems that beset previous government IT projects by shifting much of the risk on to service providers. Critics say that this strategy makes the work financially impossible for suppliers. . ."

3.8.34. NHS IT project is force for good and worth the pain so hush the critics (24 Oct 2006)

Computer Weekly

http://www.computerweekly.com/articles/article.aspx?liArticleID=219292

" The media has been full of comment on the " problems" at the NHS IT project as Accenture ducked out. Yet again, the comment portrayed the project as a " disaster" - indeed as " yet another public sector IT disaster" . . . I have yet to meet anybody who opposes the overall objective of the NHS IT project. When it is fully implemented it will be a major force for good. It will save lives. I have little doubt that it will be looked upon throughout the world as a model to be followed. Achieving that objective will cause pain. Anybody who has ever been involved in any project - big or small - knows that. . . I have written many articles over many years against the concept of what I dubbed " one-sourcing" - i.e. putting all your eggs in one supplier's basket. Indeed I would stake a claim on being one of the first to advocate " multi-sourcing" . NHS IT is the most advanced example of just that. Accenture failing and CSC picking up the pieces is an example of the benefits of the approach, not of its failure. How many times have you read of public sector contracts failing and us, the taxpayers, picking up the costs of that failure? How many times have " one-source" suppliers been able to extract huge extra sums from the government to correct their own failures? Granger went out of his way to avoid, or at best minimise, this possible eventuality on the NHS IT project. Why doesn't that major advantage (or indeed any of the other advantages) ever get highlighted by the media? . . . Of course, I too can write much about the mistakes made in this project. I have long criticised the lack of early involvement and commitment from the medical profession something which the project was far too slow to address. The plan to sweep out all the existing systems and suppliers was also misguided. . . The government too must accept criticism. It was naïve to believe or announce that the only costs of the project were those related to its procurement. Training and implementation has cost much more than the initial procurement costs in every IT system I have ever been associated with. The timescales imposed on this project, as ever, were initially for political expediency rather than having any relationship to common sense." [Richard Holway, Director, Ovum]

3.8.35. NHS IT project should not be at the expense of patients or of the media's independence (24 Oct 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/10/24/219290/nhs-it-project-should-not-be-at-the-expense-of-patients-or-of-the-medias.htm

" Computer Weekly agrees with several of the points made by Richard Holway - for example, that health officials should be applauded for trying to stop suppliers from ripping off the NHS and taxpayers. And there are other advantages of the National Programme for IT (NPfIT). Hospitals that had cumbersome, unreliable and old green-screen technology are having it replaced under the NPfIT. A new broadband network has been installed, x-ray systems are being rolled out - though this was happening before the advent of the NPfIT. . . But the main purpose of the £12.4bn spend on the NPfIT is not to show how well suppliers can be managed, or to put new technology into ambulances, whatever the undoubted benefits. A key objective of the programme was to deliver an electronic health record for 50 million people, accessible by any authorised user across England. At a meeting last week of health IT experts, the audience was asked whether the chief objective of the NPfIT should still be the delivery of a national electronic health record. No hands went up. Some thought it better to work towards a less ambitious scheme, to deliver a reliable and easily accessible local electronic medical record rather than a national care records system which may not materialise. This brings to the fore one

of the main concerns about the NPfIT: that nobody has any real idea whether it will meet its original objectives, or whether some of those objectives are now obsolete. An independent review could ascertain whether the NPfIT will deliver what the NHS needs. But Caroline Flint, minister for public health, has rejected the call by 23 leading academics for an independent review in part because she says there have already been many internal assessments of the NPfIT. She has refused to publish all of the reports, which raises suspicions that much is being hidden - or worse, that there is much to hide possibly the fact that the programme as originally configured by the government in early 2002 was fundamentally flawed. . . We are also concerned at suggestions that the NPfIT is Richard Granger. Without Granger's impressive drive and conviction the programme is more likely to disintegrate but the programme was conceived many months before he joined, on the flawed basis it would cost £5bn and take less than three years. The NPfIT is a programme involving ministers, officials and thousands of NHS sites and people. It does not belong to one man."

3.8.36. Chris Patten: Politicians have no grasp of technology (26 Oct 2006)

ZDNet UK

http://news.zdnet.co.uk/internet/security/0,39020375,39284350,00.htm

" The former governor of Hong Kong has waded into the debate around lack of tech knowledge amongst politicians and its effect on government IT projects. Former Tory politician Chris Patten has said that a fundamental lack of understanding in government is to blame for a rash of ill-thought-out technology projects and related legislation in recent years. Lord Patten of Barnes was especially critical of the government's ID card scheme, which is heavily reliant on technology. Speaking at the RSA Conference Europe on Wednesday, Patten said the scheme would not achieve one of its possible objectives of making borders more secure. " I don't think ID cards make citizens more secure, or frontiers more secure. People would still have been blown up on the Tube last July if they'd had ID cards," he said. He also criticised the support given to ID cards in 2003 by the then Home Secretary David Blunkett, calling the scheme a " populist Pavlovian Blunkett twitch" . Blunkett resigned from the cabinet in 2005 over his involvement in political scandals. Patten, a former EU Commissioner, was speaking at the three-day conference in Nice, France, on European business and technology. Many politicians don't understand the technology issues that could affect government IT schemes, he said. . .

Privacy campaigner Simon Davies, chairman of No2ID, agreed politicians aren't in touch with the issues underlying the technology issues they legislate on, and criticised the conditions in government that have allowed the situation to come into effect. " Prime ministers and home secretaries are notorious for grandstanding on technology issues, while at the same time having difficulty setting their video recorders at home," said Davies. " The NHS programme for IT and the ID cards scheme both stand as a testament to the government's complete failure at forward planning [in technology schemes], and its inability to understand technology in the real world," Davies added. . ."

3.8.37. Government IT: What happened to our £25bn? (30 Oct 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/10/30/219476/government-it-what-happened-to-our-25bn.htm

"In 1969 the UK civil service began experimenting with large and complex schemes to use computers to standardise the running of central departments the results are still keenly awaited. Learning few of the lessons from the 1970s and 1980s, namely keep IT simple, ministers and civil servants have continued to launch ambitious and subsequently notorious schemes to help manage payments of child support, tax credits and farming subsidies, the issuing of passports, collating intelligence for the Ministry of Defence, and the handling of police suspects. Market researcher Kable said that £15bn a year is spent on public sector IT, £2.6bn of it by central government in 2005/2006. Over the 40 years since central government has used computers in earnest, the money spent on IT is thought to be far in excess of £25bn - about £400 for every man, woman and child in the UK. This huge spend has served a few major suppliers well. . . However, suppliers have not always had their own way. The Department of Health in 2002 appointed Richard Granger as director general of NHS IT, and he has managed to stop suppliers beaming all the way to the bank whether they delivered or not. There are other positive developments in the way civil servants have managed projects in central government over the past four decades. . . But the innumerable, unsung successes are dwarfed by Whitehall's taste for the dark side of computing: the overly large and complex projects which have limited support from potential end-users,

and which trudge on for years without hope of justifying their cost. . . In 1984, MPs were concerned about a proposed project called the Operational Strategy, the objective of which was to bring new advanced levels of automation to the payment of welfare benefits. . . MPs were sceptical that Opstrat, as the Operational Strategy was called, would ever work or stay within budget. Camelot, a previous benefits project, had failed at a cost of £12m. . . But the lesson of not being too ambitious was not then fully understood. Camelot cost £12m and Opstrat would cost about 60 times as much - about £700m. . . . One would like to think that the mistakes of the past few decades would have made ministers and mandarins paranoid about launching any more overambitious IT schemes. The opposite has happened. . . The Department of Health has launched the world's biggest non-military IT-based programme, the £12.4bn National Programme for IT. It has been marred by shortages of skilled staff, an underestimation of total costs and over-optimistic statements by ministers on when systems would be delivered. Officially it is already a success. The private sector has its disasters - but over the decades one can see that corporate victims tend not to repeat major failures. If anything a large-scale failure encourages boards to think small next time. It is unlikely that ministers and mandarins will ever enjoy thinking small when it comes to IT, not while a significant part of the IT industry depends so heavily on the public sector's love of high stakes gambling."

3.8.38. The importance of our right to know (30 Oct 2006)

MediaGuardian.co.uk

http://media.guardian.co.uk/mediaguardian/story/0,,1934601,00.html

" Freedom of Information has many uses. One of the most important is that it shows where public services are broken and need fixing. A sensible government would focus on these problems and set about fixing them. A bad government would prevent people from uncovering problems in the first place, ignore problems when they come out, and persecute anyone with the gumption to talk about the problems publicly. Bad government is ruled by secrecy and that's what we've had in the UK for decades. Decisions made in secret do not lead to good value for money or good public services. A stream of disasters from the BSE crisis and the Marchioness ferry sinking to the Millennium Dome and Child Support Agency all attest to the costs of secrecy both in terms of human life and public money. All that was meant to change with the introduction of the Freedom of Information Act. Sadly, it didn't take long for New Labour politicians to renege on their promise to empower the citizen. The act was watered down and passage delayed for five years. Nonetheless, for almost two years we have had a weak right, weakly enforced to ask questions of our public officials. To a government obsessed with spin, however, any information not " managed" is considered dangerous. And so the Lord Chancellor has announced the results of a consultation into open government that took place in secrecy. Not surprisingly he wants to make it harder for people to ask questions. Of course, politicians can't come out and say that, so the killer kick to democracy is couched in terms of cost, claiming it's too expensive to answer FOI requests. Politicians instead prefer to spend taxpayers' money on propaganda to convince us that something that is obviously broken works perfectly. The Home Office is a good example. Or the NHS IT programme. Or costings for identity cards. If as much energy was spent solving problems as attempting to spin them away, then these problems probably wouldn't exist. . ."

3.8.39. You can't sue unless we say so,' trusts told (31 Oct 2006)

Computer Weekly

http://www.computerweekly.com/Home/Articles/2006/10/31/219482/'You+can't+sue+unless+we+say+so,'+trusts+told.htm

" NHS trusts hit by delayed or troubled implementations under the £12.4bn National Programme for IT (NPfIT) have begun seeking compensation. But they have been told they cannot seek legal redress from suppliers without the government's specific consent. Computer Weekly has also learned that some boards of trusts that have sought compensation have received none so far. As part of the NPfIT, participating trusts are expected to spend at least £3.4bn locally on implementing systems bought by Whitehall. Trust executives operating outside the programme can turn to their contracts with suppliers to seek legal redress for poor systems or software. But for systems bought under the NPfIT, trusts are only third parties to the main NPfIT contracts, which are between the government and the principal suppliers - BT, CSC, Fujitsu and Accenture. To sue suppliers, trust officers have learnt that they need the specific consent of the secretary of state for health, who holds the contracts with the NPfIT's main suppliers. . ."

3.8.40. Agency in charge of NHS computers may be scrapped (8 Nov 2006)

Daily Telegraph

http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/11/08/nit08.xml

" The Government has admitted that Connecting for Health, the Department of Health agency in charge of its disastrous NHS IT programme, could be scrapped. The admission comes amid growing alarm in the Government at the spiralling cost of the programme which is likely to end up at £20 billion — £7.6 billion more than its original budget. . . Connecting for Health is under increasing pressure. John Yard, a respected former head of IT at the Inland Revenue, has been parachuted in by the Office of Government Commerce, a unit of the Treasury, as an adviser. It is understood that in recent weeks senior policy advisers at 10 Downing Street have suggested that IT contractors should bypass Connecting for Health and deal directly with the hospital trusts. Sources close to the programme said ministers were desperate to get a grip on the programme. . ."

3.8.41. IT project accused of bullying (9 Nov 2006)

Health Service Journal

http://www.hsj.co.uk/healthservicejournal/Search.do?dispatch=showPage&pageId=7482&page=0

" Managers have attacked the Connecting for Health IT project for 'bullying' people into talking down problems on the ground. West Herts primary care trust IM&T service manager Roz Foad was among speakers at an IT conference who criticised the scheme to create an NHS-wide clinical computer system. She told HSJ: 'There is a bullying aspect to Connecting for Health.' Local staff felt unable to voice their concerns, she added. 'We are not allowed to put out anything that is not spin, but the only real progress that is being made is with existing systems.' Ms Foad told the audience of managers and IT contractors that CFH was disrupting the work of GPs and PCTs at a time when trusts were already under huge pressure due to mergers and redundancies. Barnsley PCT chief executive Ailsa Claire said the project was focusing on the wrong issues. 'The largest users of our services are elderly people who need integrated health and social care records but that is very far down the agenda.' NHS modernisation aimed to provide patient-centred care, she believes, but CfH did not follow that ethos. 'These systems are designed to be efficient for businesses to talk to each other, not for clients to control their own care,' she said. . ."

3.8.42. Health service IT boss 'failed computer studies' (12 Nov 2006)

The Observer

http://observer.guardian.co.uk/uk_news/story/0,,1946060,00.html

" Mother of NHS computer chief casts doubt on her son's credentials. The expert in charge of the government's ailing £12bn computer modernisation programme for the NHS might expect to face criticism from IT experts, disgruntled doctors and even political opponents. But this weekend, it was his own mother who revealed he failed his university computer studies course. Richard Granger, the tough 42-year-old management consultant who runs the government's Connecting for Health project, initially failed his computer studies course at Bristol University - and took a year off as a result. He was only allowed to resit the exam after she appealed on his behalf, and he went on to gain a 2:2 in geology. His mother, Mary Granger, spoke to The Observer about her surprise at her son's role in the ambitious initiative that was supposed to transform the NHS's computers and allow patient records to be kept electronically. She hasn't spoken to her son for 10 years after a family row, but she is now campaigning to save the local hospital in Huddersfield, West Yorkshire, which is losing some services to another local trust, and believes the computer modernisation plans are a gross waste of money. . ."

3.8.43. Prescription for an I.T. Disaster? (13 Nov 2006)

Baseline

http://www.baselinemag.com/article2/0,1540,2058194,00.asp

A very extensive account, from an American source. Contents: " A Bold Vision: Lifelong Electronic Patient Records; In the Beginning, Bill Gates Pitches Tony Blair; Selecting Suitable Vendors; What's Ailing the Project?; Waiting for Lorenzo: Software Needs Major Surgery; Health-Care Executives Under Fire; The Players Under the Microscope; Calculating Costs of a Runaway-Project Recovery; Technologies That Promise a Cure; A Time Line of the Project's Progress (and Lack of It)"

http://www.baselinemag.com/print_article2/0,1217,a=193664,00.asp Text of full article

3.8.44. Richard Barker on why the IT programme is never going to come right (13 Nov 2006)

Health Service Journal

http://www.hsj.co.uk/healthservicejournal/AdvancedSearch.do?dispatch=showPage&pageId=7521&page=

" Just who is going to accept responsibility for the fiasco that is the national programme for IT? The government's much-vaunted technology led overhaul of the NHS is in chaos, with Accenture, the biggest and most successful lead contractor, responsible for two of the five regional programmes having recently withdrawn from the project. Deadlines have been repeatedly missed and projects undelivered. Yet prime minister Tony Blair has now announced that further funding, on top of the recent revelation by the National Audit Office that the expected cost had doubled to £12.4bn, will be made available if necessary to get NPfIT back on track. In the meantime, leading academics and industry commentators continue to predict that escalating project costs will see the final figure anywhere between £20bn and £40bn. NPfIT will never get back on track; it was never on track in the first place. It breaks every rule of project management - from scoping to delivery - and is patently failing to take into account the actual requirements of clinicians across the NHS. . . The manifest failure of NPfIT to have any impact on the problems facing those at the front line of patient delivery is a disgrace. For five years the NHS has endured a technology moratorium as those tasked with NPfIT have thrown money at over-complex network infrastructures yet failed to address the pressing issues facing clinicians. . . The NPfIT concept may have been created with the best intentions, but before more valuable investment is thrown at organisations that have yet to prove their competency in this area, isn't it time for some answers?

Richard Barker is managing director of Sovereign the software provider to the NHS before the introduction of the NPfIT. Sovereign was too small to bid for NpfIT contracts, but was among those to whom the successful contractors outsourced their roles."

3.8.45. Whitehall warned on IT glitches (17 Nov 2006)

BBC News

http://news.bbc.co.uk/1/hi/business/6157682.stm

" The National Audit Office has outlined ways in which bosses can avoid a repeat of the glitches that have plagued some recent government computer projects. Its findings come after a series of high-profile delays involving public sector IT schemes. These include the £6.2bn upgrading of NHS computer networks, as well as a new IT system for the Child Support Agency. It says public sector bosses need to show more leadership in such projects, but it also points to good examples. . ."

3.8.46. NHS IT disaster (18 Nov 2006)

Daily Telegraph

http://www.telegraph.co.uk/opinion/main.jhtml?menuId=1588&menuItemId=-1&view=DISPLAYCONTENT&grid=A1&targetRule=0#head2

Letter to the Editor, from Dr John Lockley, The iSOFT GP User Group

" Sir - James Herbert (Letters, November 10), the spokesman for NHS Connecting for Health (CfH), says that it is " unfair" to describe the national programme for IT as disastrous. Our members — who currently use very advanced GP software — would disagree. Despite the fact that Britain leads the world in medical IT and that primary care IT in Britain is significantly ahead of hospital computing, CfH initially treated existing GP software as the problem, not the solution. Yet the first GP systems that CfH proposed were so lacking in functionality that they would have resulted in a seven-year step backwards for the more IT-aware practices. . . "

3.8.47. How will IT be paid for? ask doctors (28 Nov 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/11/24/220169/How+will+IT+be+paid+for+ask+doctors.htm

" Sixty-six per cent of doctors believe there are not sufficient funds in their NHS area to properly implement the National Programme for IT (NPfIT), according to the latest Medix survey. Although £6.2bn of IT contracts are being paid for centrally by NHS Connecting for Health, an agency of the Department of Health, the local NHS is still expected to find funding for training, business process re-engineering and some technology upgrades. Of the 1,000 doctors responding to this month's survey by healthcare online research organisation Medix, 28% said they disagree and 38% said they strongly disagree that their NHS organisation would have sufficient funds to enable it to properly implement the NPfIT. The findings come at a time when the government has announced that the NHS is expected to suffer a £94m deficit for 2006/2007, although strategic health authorities are expected to find a contingency of £100m to cover this deficit. . . "

3.8.48. One more year - many more software project failures (Nov 2006)

BCS Review 2007

http://www.bcs.org/server.php?show=ConWebDoc.7939

" . . . The NHS programme: Given the size and scale of this programme and the amount of press it has attracted, it feels inappropriate not to discuss it here. The reporting of this programme has largely been negative, which is understandable, but this is one of the largest civilian IT change programmes in existence; why did anyone expect it to run smoothly? The really interesting story behind the headlines is the business of contract structure and the level to which risk has been transferred to the suppliers. The NHS has procured these systems at a fixed price and does not pay until services are proven to have been delivered and working. All very laudable, but this places some very high cash flow demands on each of the suppliers that could lead to some painful future consequences. Only huge corporations can afford to bid for this kind of contract and only a tiny number of the UK-based system integrators (SIs) have the financial strength to run with this kind of deal and the inevitable problems that arise. Contracts of this nature create a 'hard edge' to the relationship between the customer and supplier, often reducing the collaboration between them. When you consider that most project failures have strong roots in poor requirements and that collaboration is key to success in this area, I can't help thinking we are going to see more failures in the future. The interesting thing about failures in this context is that they could have sufficient critical mass to seriously damage or even bring down a supplier, an outcome that will benefit no one. . ." [Andrew Griffiths]

3.8.49. Transformational government: a supplier's view (Nov/Dec 2006)

National Computing Centre

http://www.nccmembership.co.uk/pooled/articles/BF_WEBART/view.asp?Q=BF_WEBART_228589

". . . The perceived inability to get departmental systems working is demonstrated time and time again e.g. the tax credit system in the Child Support Agency. The real issue here is the temptation to impose systems on users in support of modernisation and transformation initiatives without full consideration for the needs of the citizen and the front line staff supporting them. Working practices are often dictated from the top down according to the needs of the new systems not vice versa. . . The IT landscape of public sector organisations is a complex mix of systems, people and processes representing years of evolution. To create a strategy that will successfully enable implementation of the Government's transformational agenda requires an understanding and acknowledgement of all these factors and the value each one brings - as well as the cost it incurs. Only then, from this position of understanding, can a strategy that fits the organisation be created. As competition gets tougher there will always be a willingness to take on tougher contracts. Few suppliers will take these on without undergoing significant due diligence and understanding the commercial risk. Tougher contracts [like Richard Granger's NHS NPfIT contracts] however are rarely the reason for failure of the supplier to deliver the project. The contracting body must realise or accept that large-scale modernisation programmes will, by their very nature, change over time and make allowances for change in the contractual terms. Once contracted to, these terms should be honoured by supplier and customer alike. Failure to work to robust, transparent change-control mechanisms will ultimately result in a failed programme or the withdrawal of the supplier. . . Getting true consultation with the frontline users can be difficult. For example, Richard Granger claimed to have consulted 2,000 clinicians in the run-up to the NHS's Choose and Book system. But, from the squeals that were heard from GPs and hospital

doctors when the scheme was released, one wonders whether he had consulted the right 2,000, or in sufficient depth. Will suppliers continue to have any appetite to bid for major government business, when they see so many projects fail for reasons not within the suppliers' control, and within the public sector's pervasive blame culture? The withdrawal of Accenture from the NHS NPfIT project is a case in point. Suppliers and civil servants always have to calculate the effect of a change of government. Projects may be cancelled or heavily modified. As an election gets closer, or even a change of Prime Minister, commitment to radical transformation may wane. . ."

3.8.50. The Way Forward for NHS Health Informatics (15 Dec 2006)

British Computer Society

http://www.bcs.org/upload/pdf/BCS-HIF-report.pdf

" The changes in direction required: The fundamental goal is to support diverse business processes that recognize local constraints and individual patients' health beliefs and values. . . Instead of the current monolithic systems intended to meet most of the needs of users in a local health community, we need a range and choice of more innovative and agile solutions. These should contribute to a common purpose, encouraged within national standards to deliver functionality in whatever way suits the users and suppliers. This should not be interpreted as ruling out adoption of LSP products where they fit the business requirements. . . Implement at Trust level and below, where most sharing of information is required and where most of the gains are to be had. . . To achieve local implementation, it is necessary to persuade local NHS staff (including management) at Trust level and below that informatics is part of the answer to their problems and not an expensive irritation and preserve of the specialist. . . While acknowledging that some existing systems are no longer fit for purpose and need replacing, the approach should be to build on what presently works and to encourage convergence. This is particularly apt in general practice. . . NPfIT needs to decide what the National Care Record Service is and to communicate this clearly to the NHS. Is it (a) a physical IT concept – a comprehensive patient record held in its entirety in one or more national databases; or (b) an information concept – pulled together ephemerally (on demand in real time or by regular extraction processes) from disparate patient record databases and presented for a single instant for a specific user, or (c) a mixture of both? . . . If patients do not feel comfortable with the confidentiality of their data, they will not allow significant information to be recorded or will withhold it, so informed patient consent is paramount. In either case, their care will suffer as a result. On the other hand, care that is appropriate and safe can only be provided if certain types of patient information are shared. . . The NPfIT is ultimately intended to provide vastly increased amounts of patient data for secondary purposes, including NHS management, planning and research. So although the associated confidentiality issues have been with us as long as electronic patient data has been available in significant quantities, the requirement to tackle them is now more urgent than ever. People using patient data for secondary purposes should obtain patient consent to use personally identifiable data or should only be able to use anonymised/pseudo-anonymized data. . . Cost-efficient procurement is necessary but not sufficient. Issues remain with NHS and supplier capacity, capability and affordability (which may be exacerbated by NHS CFH cost-shifting driven by DH central budget cuts). . . Many thousands of patients move between the UK home countries for, or during, treatment every year, and some at least of their patient information needs to accompany them. Any strategy adopted by NHS CFH must be capable of supporting these cross-border treatments. To do this, certain basic informatics elements should be standard across the UK. . . To flourish, NHS CFH and its suppliers must be open to, and acknowledge, the challenges and problems they face. In reality, failure is only complete when we do not learn from it."

BCS Press Release summarising the above report -
http://www.bcs.org/server.php?show=ConWebDoc.8922

3.8.51. Confidential NHS paper on the health of the National Programme for IT (21 Dec 2006)

Computer Weekly - Tony Collins' Blog
http://www.computerweekly.com/blogs/tony_collins/2006/12/summary-of-the-nhs-it-programm.html#more

" Published exclusively on this blog is a confidential NHS paper on the £12.4bn National Programme for IT [NPfIT]. The paper is important because it is an objective analysis of the strengths and weaknesses of the NPfIT by senior IT executives on the front line. Its authors work for the Leeds Teaching Hospitals NHS Trust, which is the largest NHS trust in the UK. At Computer Weekly's

request, the Leeds Teaching Hospitals NHS Trust has kindly allowed this blog to make the paper available. First I have reproduced some excerpts from the paper. Second I comment on some specific parts of it. Then the paper is reproduced in full. . . My comments on specific parts of the paper: I have not seen it stated so clearly in an NHS board paper that there has been shrinkage in the scope of the national electronic patient record. No announcement has been made on scaling back of the original plan. The electronic patient record is the chief objective of the £12.4bn NPfIT programme. Innovative systems are welcome but if such initiatives are under-funded and over-ambitious this suggests they are high risk and may fail, in which case this underlines the need for more accountability and visibility, ideally in the form of an independent, published review. Also I have not seen it stated so clearly before in any trust board paper that the pressure on the budgets of the Department of Health has increased costs to the NHS. If more costs are transferred to the NHS from the centre, this could make the local implementations unaffordable in the medium and long term. Again, it's a cause for concern, and a further reason for an independent review of the programme. . . It is more than four years since the national programme was launched and nearly three years since contracts worth £6.2bn were signed. One would have expected clear plans for an electronic health record to have been finalised long before now. Nobody reading the Leeds paper should continue to have a Panglossian view of the national programme."

3.8.52. Re:Viewing 2006: The year in the public sector (21 Dec 2006)

Silicon.Com

http://www.silicon.com/publicsector/0,3800010403,39164766,00.htm

" Two massive and highly controversial projects have dominated public sector technology news in the last year - ID cards and the NHS IT. In both cases, despite a strong start the year, with the government insisting it has learned the lessons of previous tech disasters, it appears those old habits die hard. . . For the giant £12bn NHS IT project, it's been another mixed year. While there has been progress on an number of fronts - such as digital X-rays - probably the biggest news was Accenture which decided to pull out of two massive contracts. Accenture was awarded the two contracts to be the local service provider (LSP) for the East and North East regions back in 2003 but will now hand over the work to CSC, which is already an LSP for the North West and West Midlands regions. As part of the agreement Accenture will get to keep £110m of the £173m it has been paid by the NHS to date for its work on the CfH contracts, and is due to hand over its delivery obligations to CSC by 8 January 2007. . . It's probably worth noting that the Accenture exec who was responsible for the company's £2bn contracts for the NHS IT programme is the same James Hall who is now head of the government's ID card project. There has been a steady drip-drip of criticism of the project through out the year, including warnings from the British Computer Society for the need to move away from monolithic computer systems, while nurses complained they weren't getting enough training. But few NHS IT projects have created as much controversy as the electronic patient record which will contain information such as patients' current medications, allergies and adverse reactions. Many patients - perhaps spooked by the public sector's track record on IT - have objected to this. As a result, when the trials start of the project start in the spring patients will be allowed to opt out of data sharing if they want to. So as the year draws to a close government IT projects, haunted by fears of past failures, seem to be going out with more of a whimper than a bang. . ."

3.8.53. Lessons learned Connecting for Health (22 Dec 2006)

Computer Business Review

http://www.cbronline.com/article_cbr.asp?guid=75878377-E17C-4110-BFA1-6AC2EC3D5665

" It is over four years since the UK government announced ambitious plans to fundamentally change the way IT is procured, maintained and utilised within the National Health Service (NHS). Despite receiving strong political and financial backing from the government, however, the project, dubbed the National Programme for IT (NPfIT), has been mired in controversy for most of its short life; the result of delays and rumours of ballooning budgetary requirements. Richard Granger, director-general for IT at the NHS and the public face of the NPfIT, has sarcastically described his time at the helm as " four joy-filled years" , and regularly jokes that the stress of his job has been the cause of his hair loss. . . Granger is unwilling to accept much of the criticism levelled at the NPfIT, claiming that it is driven by both vested interests in the NHS and by a hostile press. While he can do little about the latter, Granger says that he " should have spent two years benchmarking what was there [in the NHS] before, because those with a vested interest don't want to tell you how bad things are" . . . According to the NAO,

previous IT procurement and development within the NHS was " haphazard, with individual NHS organisations procuring and maintaining their own systems, leading to thousands of different IT systems and configurations" . This resulted in information being kept in silos, which were not shareable even in the event of system compatibility between practices. The NPfIT aimed to change this by introducing a national data spine, to be built by BT, which would hold patient records in a central repository, and by replacing local systems at hospitals and general practitioner practices across the UK with centrally selected software. But the plan is controversial. Information Technology in the NHS: What Next?, an article by Richard Bacon, Conservative MP for South Norfolk, and John Pugh, Liberal Democrat MP for Southport, argues that: " The fundamental error made when setting up the programme was to assume that centralised procurement of single systems across the NHS would be more efficient than local decision-making guided by national standards." . . . One of Granger's first decisions as head of NHS IT was to commission a study by management consultancy McKinsey into the healthcare IT market in the UK. While the report was never published, it is thought to have concluded that no contractor working in the UK healthcare sector at the time had the capacity to become a prime contractor on such a major national programme. As a result, the NPfIT looked to global IT services vendors to head up the project. Granger chose big suppliers such as Accenture and CSC because he believed that, under the old system, patients were forced to bear the risk of IT failure, whereas the new structure would shift that burden on to the IT suppliers themselves. In January 2003, the NPfIT set out its key procurement principles, which made it clear that contractors would be expected to " retain appropriate payment and cost risks related to delivering a service or system that is accepted according to the terms of the contract" . Many in IT now believe this approach was flawed. " Transferring risk on to large suppliers never works," says [Lisa Hammond, CEO of IT consultancy Centrix]. " Once they start losing money, it's more effective for them to back out." . . . Many of the problems that have beset the NPfIT during its turbulent life have their roots in the very early stages of the project. Decisions regarding procurement, suppliers and the length and scope of the deals were taken back in 2002 and 2003, yet are directly responsible for the deepening sense of crisis around IT in the NHS. The first few months of any IT contract will define the future of the scheme and clients and suppliers alike should not allow themselves to be swept along by waves of hype and optimism. . ."

3.8.54. Newsletter - British Medical Association's Working Party on NHS IT (Dec 2006)

BMA

http://www.bma.org.uk/ap.nsf/Content/itwpnewsletter2

". . . The BMA's policy is that explicit consent should be obtained before any healthcare information is uploaded onto the spine. Doctors feel that some patients may be unhappy about having their sensitive personal data uploaded onto a central system and a more gradual approach will allow patients to fully consider what information is contained in their records and whether they wish this information to be shared. Confidentiality is central to trust between doctors and patients. The BMA is currently seeking clarification from the GMC, MDU and MPS on how exactly this would affect clinicians in terms of liability. . . Role-Based Access Controls (RBAC) are a technical means for controlling access to computer resources and an integral part of the security process. Following comments by the National Advisory Group and the BMA, CfH is considering how to simplify the system to reduce the number of job roles (currently 350), areas of work (currently 290) and activities (currently 350). The role of sponsors will be crucial in ensuring roles are correctly allocated and updated. This could require extensive training. . . There has been much press about the suppliers for the National Programme for IT. . . Soft has recently been linked with a sale as its debts and troubles mount. The BMA Working Party are keeping a watching brief on what effect this will have on the National Programme but have also expressed concerns that changes in suppliers will add to a lack of confidence in the programme amongst clinicians. . . At the July BMA Annual Representative Meeting (ARM), doctors voted in support of a motion calling on CfH to ensure that patient safety is given much greater consideration and elevated to a core requirement of the programme. . . The BMA has conducted a small survey of doctors' experiences of Choose and Book. Initial responses suggest great discontentment with the system. . . The national email service for NHS staff, including medical students, once known as 'Contact' has been endorsed by the BMA Working Party for the transfer of patient identifiable information. However, the Working Party felt that information governance issues need to be addressed, for example, ensuring that emails are not left in inboxes and making sure that the correct person receives the mail when there are multiple users with the same name. . ."

3.8.55. Lessons from the NHS National Programme for IT (1 Jan 2007)

Australian Health Review

http://www.mja.com.au/public/issues/186_01_010107/coi11007_fm.html

". . . Procuring contracts centrally resulted in vigorous supplier competition and saved about £4.5 billion. However, the speed of procurement meant that the NHS had not prepared key policy areas (eg, information governance), standards (eg, for messaging and clinical coding), and information system architecture (neither enterprise architecture nor detailed technical architecture was ready). Further, the contracts bound suppliers to a vague specification that has cost the NHS around £30 million in legal fees to sort out. . . IT can be a powerful enabler, but if poorly implemented or used, it can result in patient harm. Yet system safety was not written into the initial procurement specifications. Somewhat late in the day, CfH developed a safety accreditation process and appointed a National Clinical Safety Officer. Failure to account for safety also brings commercial risks. . . A significant criticism in the National Audit Office report was that procurement occurred before clinical engagement, perhaps because extensive consultation was thought to slow the process. This has resulted in significant disquiet among some clinicians and the priorities of the program not fully matching those of the clinical community. . . Picking the wrong patient consent model may be a deal breaker. Patients must give consent for their information to be stored electronically and made available to others.10 CfH has chosen an "opt out" model in which patients by default are included within the system, and make an informed choice to leave it. . . "Opting out", while technically simpler, may end up being the Achilles heel of the new system should significant examples of breach of confidentiality hit the media. "Opting in" might eventually prove to be the cheaper model when all costs are considered, not just the technical ones. . . Perhaps history will record that the NHS was not sufficiently prepared to take on such a fast-paced, radical and extensive modernisation program, that it was compromised by workforce shortages in health informatics, and fell into the trap of leading with technology rather than clinical need. . . ."

3.8.56. Review of BBC-2's 'Can Gerry Robinson Fix the NHS? (11 Jan 2007)

Evening Standard

". . . Nowhere is this Stalinist mentality clearer than in the looming disaster of the world's most expensive non-military IT project, to put every NHS patient onto a national database. The costs are out of control, the medical profession hates it, and it will make everyone's medical records available to any half-competent hacker. . ."

3.8.57. NHS £6bn IT system poor value, say experts (22 Jan 2007)

The Guardian

http://politics.guardian.co.uk/publicservices/story/0,,1995850,00.html

"Leading healthcare IT experts have warned that the NHS's troubled £6.2bn system upgrade is costing taxpayers substantially more than it should. They claim the same functions could be delivered for considerably less outside of the national programme for IT, dogged by delays and software setbacks. Stephen Critchlow, executive chairman of software group Ascribe, said he "could not see where value for money is coming from". There was evidence, he added, to suggest the NPfIT was installing and running systems for several times the going rate. Phil Sissons, a former executive at the software group Torex - now part of iSoft - and an ex-consultant to the NPfIT, said: "Publicity from the national programme was that they got some good deals because of the buying power of the NHS. But I don't believe they reduced the cost at all. There are multiple margins being added to the process each time there is an extra layer of management or another company involved." Doug Pollock, managing director of software supplier Cambio, who has also worked within the national programme, said these multiple margins were sometimes "scandalous". From the outset, NHS bosses promised the centrally organised 10-year IT upgrade programme - covering hospital trusts and GP practices across England - would be £3.6bn cheaper than the cost of upgrading systems on a piecemeal basis. However, the first three years have proved troublesome, with deliveries of patient administration systems (PASs) to acute, primary care, community and mental health trusts falling far short of targets - and, most importantly, without delivering the promised clinical functionality. Cost savings, NHS bosses still insist, remain on track. Meanwhile, the NHS's head of IT, Richard Granger, has been busy compiling a catalogue of alternative suppliers. Industry insiders believe they could help the troubled project - the largest civil IT project in the world - evolve from a national into a local programme. At the same time, the Department of Health continues to make multimillion pound payments to its five lead regional contractors, known

as local service providers (LSPs). . . No detailed figures for DoH spending on NPfIT are available since last March, but a number of sources within LSPs have privately confirmed multimillion-pound payments have continued to flow. A number of rogue acute trusts have become so frustrated with the NPfIT that they have opted out, forgoing central government funding in favour of selecting their own IT suppliers."

3.8.58. Why the 'rip and replace' syndrome needs to stop (9 Feb 2007)

Principia

http://www.nccmembership.co.uk/pooled/articles/BF_WEBART/view.asp?Q=BF_WEBART_232623

". . . The public sector has been committed to offering the public a better service through use of IT systems for decades. So why do so many reports state that technology is the solution, if it is already being used effectively? The problem lies in the fact that when Central Government wants to use IT to achieve greater efficiency or improve processes, more often than not it chooses to 'rip and replace' existing technology with new systems. While this might seem like a good idea initially, the cost of the purchase, resulting downtime, expense and consultancy fees for IT projects that demand huge input and radical overhauls can be huge. There is also the all too real possibility of budget overruns and project delays, and the risk of implementing untried applications. Given this approach it is hardly surprising that in the last 40 years the money spent on IT by the Government is thought to easily be in excess of £25 billion. We have seen numerous examples of Government departments embarking on painful technology implementations. A recent, high-profile case is the £6 billion National Programme for NHS IT (NPfIT), which involves the implementation of new systems and infrastructure. As the media frequently reports, parts of the programme are running into trouble as they rely too heavily on a single supplier's new, untested system. . . While upgrading legacy systems is the key to achieving joined up Government, this should not necessarily mean ripping them out and replacing them with new systems. It would be less expensive, and much less risky, to make the most of existing systems, which are tried, tested and proven. More often than not, the desired aim can be achieved through breathing new life and value into infrastructures already in place. It is possible to use what the Government already has, at the same time as making sure the demands of a joined-up, interactive and collaborative modern society are met. Service orientated architecture (SOA) makes this type of modernisation possible, avoiding the problems of projects going over-budget or taking risks with new systems. SOA is a standards-based approach to IT architecture, which builds business-focused services using 'loosely coupled' links between legacy systems. Used strategically, SOA can modernise existing technologies. It can allow disparate systems to be linked by providing an underlying set of architectural principles and standards to, for example, support the sharing of information across departments securely. Essentially it avoids the cost of ripping out systems and replacing with new expensive upgrades when policies change or business processes have to adapt. This is not a new concept and we have seen a lot of success in the private sector. For example, financial institutions have been using this type of approach for years now. Keeping downtime and expense to a minimum is a priority, so their IT departments are in the habit of taking a step back and reviewing whether modernisation can happen within the existing infrastructure. In many cases objectives have been achieved by enabling interoperability and maximising the utilisation of existing systems, using SOA techniques. . . It is obviously difficult to say whether NPfIT might have been better advised to use legacy modernisation and an SOA approach to systems design on this occasion. But moving forward, it is clear to see the advantages that SOA can bring to the public sector IT programme. The starting point for any new public sector IT project should be to carefully examine what already exists - across government as necessary - and to properly evaluate whether an approach based on legacy modernisation, supplemented by new functionality as necessary, developed in an SOA can provide the project with a head start. . ."

3.8.59. Supplier sets out risks facing NHS IT plan (13 Feb 2007)

Computer Weekly

http://www.computerweekly.com/Home/..%5CArticles/2007/02/13/221746/supplier-sets-out-risks-facing-nhs-it-plan.htm

"A senior executive at services supplier Fujitsu, a primary supplier to the NHS's £12.4bn National Programme for IT (NPfIT), has questioned whether key aspects of the scheme are working - or are going to work. The comments of Andrew Rollerson, healthcare consultancy practice lead at Fujitsu, won general acceptance from a small, diverse group of IT executives at a conference last week entitled "Successful implementation of NPfIT 2007". . . Rollerson, who is responsible for the delivery of

Fujitsu's healthcare professional services, said there was a "gradual coming apart of what we are doing on the ground because we are desperate to get something in and make it work, versus what the programme really ought to be trying to achieve". He added, "The more pressure we come under, both as suppliers and on the NHS side, the more we are reverting to a very sort of narrowly focused IT-oriented behaviour. This is not a good sign for the programme." A main aim of the programme - now in its fifth year - is to provide electronic health records for 50 million people that can be shared. This part of the programme is running two years behind schedule, and there are concerns about whether it is possible to achieve fully joined up systems given the size and complexity of the NHS. . . He said, "What we are trying to do is run an enormous programme with the techniques that we are absolutely familiar with for running small projects. And it isn't working. And it isn't going to work." He added, "Unless we do some serious thinking about that - about the challenges of scale and how you scale up to an appropriate size - then I think we are out on a limb." Rollerson's criticisms were not directed specifically at Connecting for Health, which is running the IT part of the programme, but at what he saw as a lack of vision and focus related to the wider changes within the NHS that are needed to make best use of new technology. . . Rollerson said there was a danger that suppliers would end up delivering "a camel, and not the racehorse that we might try to produce". Fujitsu is one of three companies that are local service providers to the NPfIT. It has an £896m contract to supply systems in the South of England. Responding to Computer Weekly's reporting of Rollerson's speech, Ian Lamb, NHS account director at Fujitsu Services, said, "This is a significant misrepresentation of a presentation made in support of the National Programme. "We refute any inference that has been drawn to the effect that Fujitsu in any way questions the success of the National Programme." A Department of Health spokesman said, "David Nicholson, the chief executive of the NHS, has clearly said that he is fully committed to the National Programme for IT as it is a necessary part of a modern health service, fit for the 21st century. He sees this as one of his key strategic priorities as it is key to the successful delivery of patient-centred care." Connecting for Health declined to comment."

Other Coverage

The Times: Clear as Mud - The NHS has taken a wrong turn off the information superhighway
http://www.timesonline.co.uk/tol/comment/leading_article/article1375202.ece

Daily Mail: Expert warns £20bn NHS computer programme 'won't work'
http://www.dailymail.co.uk/pages/live/articles/news/news.html?in_article_id=435728&in_page_id=1770&in_page_id=1770

Forbes: Fujitsu expert says 12 bln stg public health IT scheme 'will not work' - report
http://www.forbes.com/afxnewslimited/feeds/afx/2007/02/13/afx3421164.html

BBC News: Concerns over NHS IT criticisms
http://news.bbc.co.uk/1/hi/health/6354219.stm

3.8.60. £20bn NHS computer system 'doomed to fail' (13 Feb 2007)

Daily Telegraph

http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2007/02/13/ncomputer13.xml

"In pictures: Concerns over NHS computer systems.
Labour's multi-billion- pound project to create the NHS's first ever national computer system "isn't working and isn't going to work", a senior insider has warned. The damning verdict on the ambitious £20 billion plans to store patients' records, and allow people to book hospital appointments, on a central computer network has been delivered by a top executive at one of the system's main suppliers. Andrew Rollerson, the health-care consultancy practice lead at the computer giant Fujitsu, warned that there was a risk that firms involved in the project would end up delivering "a camel and not the racehorse that we might try to produce". His bleak assessment was delivered in a speech on the health service's national programme for IT that he delivered to a conference of computer experts last week and which is reported in today's Computer Weekly magazine. Fujitsu is one of the main firms involved in the project after winning a £896 million contract to deliver systems in the South of England. Mr Rollerson underlined his message with a series of downbeat slides, including one showing a huge oil tanker being hit by a tidal wave, one with the word "Lost?" alongside a picture of a desert island and one with a man walking a tightrope. Another slide declared "visionary leadership is still missing" alongside the famous World War One poster of Lord Kitchener declaring "Your country needs you". His presentation even featured a picture of a huge alligator with the message "We have become obsessed by the alligators nearest the boat." The final slide showed two women mud-wrestling and

asked: “Where would you rather be?” In his speech, Mr Rollerson voiced concern at the direction of the NHS programme and the lack of vision on how the health service can make best use of new technology. . . His comments are the latest sign of problems in the ambitious project, which is expected to cost the taxpayer around £7.6 billion more than estimated. Last year it emerged that there had been 110 “major incidents” involving the system in just four months. A letter signed by 23 leading computer scientists urged the Commons health select committee to launch an inquiry to “establish the scale of the risks” facing the project. Stephen O’Brien, the shadow health minister, said: “Even those from inside the programme are now telling the Government that it is coming apart at the seams. “This is another example of the heavy-handed, top-down failing approach of this Labour Government.” . . .
[In print edition only]:
Last night Fujitsu said Mr Rollerson was not directly involved in the NHS contract and was not a senior executive at the firm. It said the content of his slides “may have been ill-considered” but insisted that his quotes had been taken out of context and that he supported the programme. Peter Hutchison, managing director, public sector, at Fujitsu Services, added: “We believe the programme will achieve a huge step forward in health care provision in england and we’re proud of our part in that.””

3.8.61. The time for NHS honesty (13 Feb 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/02/13/221727/the-time-for-nhs-honesty.htm

“Years into a major IT project it is understandable that some of those involved will want to talk about the specific things that are going well, and studiously avoid mentioning the bigger things that are going wrong. This is now one of the dangers facing the NHS’s National Programme for IT (NPfIT). Andrew Rollerson of Fujitsu, one of the main suppliers to the programme, said at an Eyeforhealthcare conference last week that work on the programme so far had been “fighting fires”, and that the approach was “just not working”. We applaud his honesty. The key now is for MPs to admit the truth. That is a big step. Neither MPs nor senior civil servants are rewarded in their careers for admitting mistakes. What we have instead are civil servants who say privately that MPs do not want a published, independent review because it could expose mistakes. And MPs do not want to admit mistakes on a £12.4bn programme for fear of the political fall-out. With so much money at stake, this stalemate is increasingly ludicrous, especially when so much needs to be done and so much needs to change. John Reid, former health secretary and now home secretary, said last month, “I believe that, whether in personal, business or political life, acknowledgement of a problem is always the first step in resolving it.” We absolutely agree. When health secretary Patricia Hewitt can bring herself to acknowledge the problems on the world’s largest civilian IT programme, she will then be in a position to commission a published independent review of the scheme. This will not happen while she and her colleagues remain willing participants in Whitehall’s culture of cover-up and denial.”

3.8.62. Storm over Fujitsu executive’s ‘honest’ NPfIT remarks (15 Feb 2007)

e-Health insider

http://www.e-health-insider.com/news/item.cfm?ID=2482

“A senior executive from local service provider to the Southern cluster, Fujitsu, has said that the intense pressure suppliers are under to deliver short-terms risks the wider aims of the NHS National Programme for IT systems, resulting in a danger of it delivering “a camel”, and not the racehorse that we might try to produce.” Andrew Rollerson, healthcare consultancy practice lead at Fujitsu, the prime contractor for the NPfIT project in the South of England was speaking at a conference in London last week where he was delivering a presentation entitled ‘Lost?’. Rollinson was quoted by Computer Weekly as warning there was a “Gradual coming apart of what we are doing on the ground because we are desperate to get something in and make it work, versus what the programme really ought to be trying to achieve.” His reported remarks were seized upon up by a series of national newspapers as ‘proof’ of the programme’s failings. The public acknowledgement of widespread problems and project drift certainly comes at a delicate stage for the NPfIT programme, with the agency responsible Connecting for Health needing to attract new players into the market. One senior supplier told EHI that such a frank public exposure of NPfIT’s difficulties may also not help iSoft’s quest for a buyer, who would necessarily have to address many of the issues raised by Rollerson. . . His public warning echoes concerns that key suppliers have repeatedly acknowledged to E-Health Insider in private, about how intense pressure to deliver is working in known problems being let through, a focus on targets and payments rather than quality. Rollerson’s comments were accepted by some in the industry as welcome

breath of fresh air, providing a necessary and honest account of the state of the NPfIT programme. Benedict Stanberry, managing director of healthcare consulting firm Avienda who also presented at the conference. He told E-Health Insider that Rollerson had simply given an honest opinion of the project. . . Defending Rollerson's comments, Stanberry added: "A good consultant is always honest with their client and that means they have to be neutral and objective about the challenges involved in achieving the changes the client wants. "Andrew Rollerson was very much reviewing the IT programme from the point of view of the massive organizational and cultural changes that still need to rake place if the NHS is to realise all the benefits and opportunities that single, shared electronic records and booking systems will create." Ian Lamb, NHS account director at Fujitsu said: "We refute any inference that has been drawn to the effect that Fujitsu in any way questions the success of the National Programme." According to a press report in the Evening Standard, Labour insiders say health secretary Patricia Hewitt has been ordered by Tony Blair to explain how the project has gone wrong."

3.8.63. Tories renew their call for a full review of the NHS's National Programme for IT (27 Feb 2007)

Computer Weekly - Tony Collins' IT projects blog

http://www.computerweekly.com/blogs/tony_collins/2007/02/tories-renew-their-call-for-a-full-review-of-the-nhss-national-programme-for-it.html#more

"Senior Tories have had a meeting to discuss their strategy over the NHS's National Programme for IT [NPfIT]. It's understood that among the topics discussed was the question of whether the Tories should take a radical stance, or simply renew their call for a review of the scheme. They decided to renew the call for a review. The Conservative Shadow Minister for Health Stephen O'Brien MP referred to the need for a "zero-based" review. The phrase zero-based means, say the Tories, "from the bottom, in that we would review the design as well". O'Brien said: "The Conservatives promised a zero-based review before the last election. That promise stands. It is time for the Government to swallow their pride and follow our lead. "It is disappointing that the NHS Chief Executive [David Nicholson] has ruled out a review. I welcome the U-turns the Government has already made, but they do not go far enough. The programme must engage front-line professionals, patients and the public, and a zero-based review is fundamental to that". The statement added: "The Government has delivered notable u-turns, for example it is now offering an opt-out from having a summary care record uploaded to the Spine. It is also moving towards the localism and open provision long championed by the Conservatives - for example through GP systems of Choice. . . The Conservatives say they have:

- Consistently called for the power to be given to local providers to choose the IT most suitable for them - an interoperability rather than uniformity paradigm.
- Challenged the mission creep of the programme
- Challenged the soviet tractor production figure style of Connecting for Health's attitude to answering questions."

3.8.64. System Failure! (2 Mar 2007)

Private Eye

A Private Eye special report by Richard Brooks:

"How this government is blowing £12.4bn on useless IT for the NHS.

'Waste and inefficiency in the NHS is intolerable,' declared Health Secretary Patricia Hewitt one year ago among mounting deficits. 'A penny wasted is a penny stolen from a patient.' This is the story of the theft of 1,240,000,000,000 pennies from patients through an IT project that wasn't wanted and doesn't work. It tells how political vanity, official incompetence and vested interests have wreaked havoc on the health service - and calls for a halt to the ultimate in a long line of New Labour cock-ups before it is too late. . .

The Eye asked a leading IT specialist (who wants to remain anonymous) for his view on what went wrong and what needs to be done.

The fatal flaws of the National Programme for IT:

- It was launched without any evidence that hundreds of largely autonomous NHS organisations with their own IT would buy into one-size-fits-all systems imposed on them from Whitehall.

- No evidence has been produced that a nationally available electronic health record will work.
- Clinicians should have been consulted on what they really wanted from a large spend on NHS IT. Feasibility studies should have been published. If the scheme looked feasible by all independent assessments, only then should the National Programme have been announced. Instead it was conceived in secret and announced as a *fait accompli* - the worst possible way to engage clinicians.
- Assessments of the programme, such as gateway reviews by the Office of Government Commerce, have not been published. Some practitioners think that this is because they show the programme to be deeply flawed.
- There has been no admission by any minister of the seriousness of the problems while the gap between optimistic ministerial statements on the programme and the reality, as perceived by NHS managers and clinicians is widening - turning even the programme's enthusiasts into sceptics.
- Those running the programme talk only about the specifics of what is going well, and what can be delivered. Nobody mentions the big things that are going wrong, such as the reasons for the delayed core software. And nobody in authority wants to ask the question: will it ever work as originally conceived?

What should happen now?

- A ministerial admission that the programme is mired in delay, and doubts over costs and technical feasibility. A problem that is not admitted cannot readily be tackled.
- Nobody yet knows that the idea of a nationally available electronic health record system will work in the way it has been configured. So an independent published review is a must.
- Trusts and GPs should have the authority to make their own choice of IT systems and suppliers as long as they meet nationally agreed standards. That way they'll want what they install rather than having it foisted on them.
- Money given to trusts for upgrading IT should be ring-fenced - earmarked only for specific IT projects. There would then be no need for a huge central bureaucracy which monitors what trusts and suppliers are doing."

3.8.65. Private Eye special report on NHS IT programme (6 Mar 2007)

Computer Weekly - Tony Collins' IT projects blog

http://www.computerweekly.com/blogs/tony_collins/2007/03/private-eye-special-report-on-1.html#more

"An executive who has IT responsibilities for several large hospitals has phoned to enthuse over the Private Eye special report on the National Programme for IT [NPfiT]. He described it as very well informed. Not everyone connected with the NPfIT who reads the report will be quite so enthusiastic. Whatever your reaction to the report there is one thing in particular that should be mentioned. In the Spring of 2002 when the NPfIT was announced by ministers either they or their officials deceived Parliament, taxpayers, and the NHS. This deception has never been explained by the Department of Health. Its lack of interest in the matter could give the impression that such deceptions are the norm. This deception was significant because it involved a document that launched the world's largest civilian IT programme, and it also triggered a public consultation over the scheme. There were two versions of the document. Both were called Delivering 21st Century IT Support for the NHS. The published document had an risk-assessment appendix missing. It wasn't simply removed. It was carefully cut out. The remaining appendices were then renumbered and the text of the main document which referenced the excised appendix was altered. . ."

3.8.66. Labour has replaced heart of NHS with a computer, says Cameron (19 Mar 2007)

ITPro

http://www.itpro.co.uk/internet/news/107998/labour-has-replaced-heart-of-nhs-with-a-computer-says-cameron.html

"Conservative leader David Cameron criticises reforms to health services, including the Modernising Medical Careers program. The Labour government has "ripped the heart out of our NHS and replaced it with a computer," said Conservative leader David Cameron in a speech yesterday. During his keynote speech at the Conservative Spring Forum, the opposition leader criticised the Labour government's reforms, calling them a "mind-blowing waste in the name of modernisation and efficiency". The National Health Service (NHS) is currently undergoing a multi-billion pound, ten-year IT overhaul, which will see patients bar-coded, records digitised and the system modernised. Cameron said a Conservative government would return the "heart and soul" to the NHS by putting people back at the centre of the system and cutting back on management consultants. The Labour party have "turned the NHS into a vast, inhuman machine, a pen-pusher's paradise at the mercy of the management consultants' latest wheeze," he said. . ."

3.8.67. Cayton says legacy systems could have offered more (11 Apr 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2605

"England's NHS National Programme for Information Technology will lead to better patient care but greater emphasis on building on existing systems could potentially have delivered results faster and cheaper, according to the Department of Health's national director for patients and the public, Harry Cayton. The patients' 'tsar' who is also chair of the Care Record Development Board said that in his personal opinion more could have been achieved, sooner and at lower cost by building on existing legacy systems. Speaking at the World Health Care Congress in Barcelona, Cayton strongly backed the programme saying that will ultimately deliver better patient care to the 52m patients in England and will be of huge benefit to 1.3m NHS staff and over 36,000 GPs. However, he also pointed out that the NHS was already making extensive use of IT before the advent of NPfIT. "The NHS was and still is digitally enabled and, in my opinion, we could have thought more about using existing legacy systems, rather than spending all this time building new systems. It would have been faster, cheaper and possibly have been received with a better reception." Questioned about advice he would give to other European nations looking to invest in eHealth, the DH's director for patients and the public said: "In my opinion, it is necessary to engage with clinicians, both sceptics and enthusiasts, from the very beginning." He also said it was important to ensure that new developments included a careful balance between things clinicians want, and the systems they may be less keen on but which are needed to better manage and administer the health service. He suggested Connecting for Health should have gone down the same route as the Veterans Administration in the US, which used the technique of deploying bundles of developments that doctors wanted with those they were not so keen to adopt. "So for example, if we brought in systems at the same time as Payments by Results – which acts as an incentive for staff - then it is possible the two would have come in together without disruption. Maybe you should think about mixing the two." . . . Public acceptance of the proposals for the use, security and confidentiality of shared electronic records was an issue that must be addressed as quickly as possible, Cayton said. "Acceptance is enormously important, hence we updated the Care Record Guarantee. It was important we cold prove that we were able to protect the confidentiality and security of patient records and were working within the guidelines of the Data Protection Act and the Human Rights Act." Cayton said that it was necessary for all patients to have an electronic record, and not stay with paper records. . ."

3.8.68. Lib Dems demand rethink on NHS IT project (16 Apr 2007)

Guardian

http://society.guardian.co.uk/e-public/story/0,,2058303,00.html

"The Liberal Democrats today called for an immediate moratorium on all further spending on the NHS's £12.4bn IT programme in England pending an independent inquiry into a mounting catalogue of errors and delays. Norman Lamb, the party's health spokesman, said the government was in a state of denial about the technical, financial and political deficiencies of Connecting for Health, the agency responsible for the scheme, which is the world's biggest ever non-military IT project. A straw poll of hospital IT chiefs conducted by Liberal Democrat researchers last week found most were sceptical about the benefits of the national programme and concerned about delays in delivering equipment. . . Mr Lamb said the government rejected a proposal from a group of 23 computer academics who in April last year called for an independent technical assessment of the project. They said: "The programme appears to be building systems that may not work adequately and - even if they worked -

may not meet the needs of many health trusts." Since the academics' intervention, Connecting for Health has experienced a series of setbacks including the disruption of NHS business at 80 trusts in the West Midlands and north-west after a fire in a data centre run by one of the agency's contractors. Mr Lamb said: "Targets for progress have been repeatedly broken. Connecting for Health at one stage announced that 155 out of 176 acute hospital trusts would have electronic patient record systems operating by the end of 2006/7. However, only 16 got there." Patient groups also had serious concerns about the civil liberties implications of plans to store the medical records of 50 million patients on a national electronic database, known as the Spine. Mr Lamb said: "There can be no doubt that the government's plans have gone badly wrong. Any discussion with people working in the NHS leaves one with the overwhelming sense of loss of confidence in the project." An independent inquiry should assess whether it is still possible to achieve the programme's original objectives or better to adapt it to deliver what GPs and hospitals say they need, he said. Simon Eccles, Connecting for Health's linkman in dealings with hospital doctors, said an independent inquiry would help nobody. "If we spent even more time answering questions on what we are doing and why, we would risk further delay in the programme. We are not encountering widespread opposition among clinicians. They want us to get on and deliver useful projects as soon as possible." By the end of 2008 there would be visible proof of the programme's success, with equipment deployed across the health service. "At this point we are in a state of invisible near-success, when the full benefits are not yet obvious to everyone," Dr Eccles added."

3.8.69. Seven in 10 government IT projects fail (17 May 2007)

ZDNet UK

http://news.zdnet.co.uk/itmanagement/0,1000000308,39287110,00.htm

"Seven in 10 government IT projects have failed, according to the chief information officer of the Department for Work and Pensions. Joe Harley called for projects to be completed at a lower cost to the taxpayer, and said the government wanted to reduce the number of project failures to just one in 10. Speaking at the Government IT Summit this week, Harley said: "Today, only 30 percent of government IT projects and programmes are successful. We want 90 percent by 2010/11. We want to achieve a 20 percent overall reduction on IT spend in government, including reducing the total cost of a government laptop by 40 percent [in the same timescale]." Harley said that the criteria for success of a project included whether it was delivered on time, to cost, and to the quality promised. While private sector IT projects had a similar failure rate, government IT projects needed to be more efficient both in terms of cost and delivery, Harley said. "The government spends £14bn per year on IT in the UK. It's not sustainable as a government to continue to spend at these levels. We need to up the quality while reducing the spend," Harley added. One government project that has been heavily criticised in terms of missed deadlines and inflated costs is the troubled NHS National Programme for IT (NPfIT), which is overseen by Connecting for Health (CfH). Andy Burn, head of information management and technology planning for CfH, said that, while the project had achieved some successes, taken as a whole, it had failed so far. "The programme still has three wheels still on. It's not in hand in some respects, but it is in others. At a local level, progress has been made over the years. At an organisational level, less [progress has been made]. The challenge is joining up services — we've been struggling with that for quite some time." Burn added that it would take a lot of work to put NPfIT back on track. "Inevitably, with the size of the programme, we're bound to be up against the wall [for the next year]. For the next decade, not for the next year."

3.8.70. Whitehall's shameful secrets (30 May 2007)

ComputerWorld/Community

http://www.computerworlduk.com/community/blogs/index.cfm?entryid=20

"I am staggered that the government is trying to overturn a ruling that the gateway reviews of public sector projects should be published. This is not some esoteric argument about freedom of information: basic principles of public and professional accountability are at stake. It is not only that billions of pounds of taxpayers' money is spent on public sector IT each year, much of it wisely and effectively, but too much of it disastrously. It is about learning lessons, about spreading best practice and about not blaming IT for failures of politicians' making. The Office of Government Commerce is fronting an appeal for the government over an order to publish information from the gateway reviews of the ID card scheme. It says disclosure would fundamentally undermine the review process because those involved would not be as frank in expressing their views and commercial organisations might not wish

to be involved. I have been approached by IT staff at organisations where a gateway review was being carried out. They talked about team members being coached in what to say and what not to say. They described how the more Bolshie members of the team were sent on leave or on courses just to keep them out of the way. I have talked to gateway reviewers who, though keen to maintain some confidentiality in the process, would shake their heads in despair at the crude efforts to manage or manipulate the information they were presented with about public projects. I have also talked to IT staff and reviewers who have found the whole gateway review process invaluable as a sanity check on projects. Meanwhile, Intellect, the IT suppliers' organisation, has made plain that its members would like to see some of the information from gateway reviews published. Intellect might be too refined to say it, but some of its members working in the public sector feel they are getting a bum rap when projects are reviewed. If anyone wants to know just how much help public sector IT projects require, they need only look at the ongoing National Programme for IT in the NHS. The latest incident, where CSC is preventing the takeover of troubled supplier iSoft, is another example of just how problematic large scale public sector projects can be So who benefits from public sector secrecy? And who is protecting who with this appeal? If the OGC appeal succeeds, bad politically motivated decisions about IT projects and bad project management will be hidden from view. If writing to your MP to complain made any difference, I would recommend it." [Mike Simons]

3.8.71. Civil servants told to destroy reports on risky IT projects (1 Jun 2007)

Computer Weekly

http://www.computerweekly.com//Articles/2007/06/01/224487/civil-servants-told-to-destroy-reports-on-risky-it-projects.htm

"Treasury officials are ordering the immediate destruction of "Gateway" internal reports into risky government IT schemes to prevent information on the projects being leaked. Their action, a response to the Freedom of Information Act, comes even though the Treasury's Office of Government Commerce (OGC) has lost two appeals to keep Gateway reports secret. Managed by the OGC, Gateway reviews are independent assessments of high and medium-risk IT-based and other projects at various stages in their lifecycle: projects such as the £5.3bn ID cards scheme and the NHS's £12.4bn National Programme for IT. Liberal Democrat Shadow Chancellor Vincent Cable described the policy as "shockingly arrogant behaviour by those who should know they are accountable for public money". He said that those involved in projects, as well as parliament and taxpayers, had a right to see the Gateway review reports. The OGC paper on the Gateway review, seen by Computer Weekly, tells its teams, "You must securely dispose of the [final Gateway] report and all supporting documents immediately after delivery of the final report - which should be no later than seven days after the review." The OGC wants to cut the risk of leaks - only two people will have copies, the OGC and a department's "senior responsible owner". Nobody else has any automatic right to see the reviews. So a department or agency's internal audit committee, MPs, the department's IT team, computer suppliers and potential end-users may be denied access to the final report. . . Civil servants who undertake Gateway reviews told Computer Weekly they thought it unnecessary to destroy the final reports. They said the documents usually contained important recommendations which may not be carried out properly if people in the department or agency do not know what they are. One Gateway reviewer said the order to destroy the final reports was "odd and a little sinister". . . More than 2,000 Gateway reviews have been carried out – but the OGC has published none of them. The order for the destruction of final reports will fuel suspicion that they identify fundamental flaws in some major government IT-based projects. . ."

3.8.72. The foundations of an NHS IT system are in place: now start building (14 Jun 2007)

The Guardian

http://technology.guardian.co.uk/weekly/story/0,,2101825,00.html

"No doubt Gordon Brown's inbox is already creaking with suggestions about what he should do with the NHS national programme for IT. No doubt, too, some of these suggestions involve inserting the programme up the anatomy of certain senior civil servants. In the five years since the government published its blueprint Delivering 21st Century IT Support for the NHS, the world's largest civil IT programme has amassed an impressive array of enemies: doctors, politicians, academics and privacy groups. Despite all this, the new prime minister should resist calls to scrap the programme or radically change its governance structure. Either course would set back by decades the hope of computerising

the NHS - a project surely worth trying. But while euthanasia is a bad idea, some urgent therapy is indicated. It needn't be painful. Here are three simple steps for reviving enthusiasm for the programme. Step one: immediately abandon the pigheaded stance that patients should be assumed to have given consent for their electronic records to be shared across the NHS unless they say otherwise. Insistence on "opt out" rather than "opt in" may upset only a minority of patients, but it is at odds with the spirit of patient empowerment that is supposed to be driving NHS policy. Step two: admit defeat in the footslogging and wasteful campaign to replace basic hospital administrative systems with standard packages procured nationally through the infamous billion-pound "local service provider" contracts. This timetable is horrendously behind schedule because many trusts, rightly, see little point in going through the pain of changing to a standard system which in many parts of the country is an interim solution amounting to a step back from technology already in place. Moves are already afoot to allow hospitals to procure from a wider catalogue of systems that are compatible with the national "spine"; this should be speeded up. This would also rescue what remains of Britain's home-grown healthcare informatics industry from the industrial slaughter arising from ideological attachment to offerings from overseas. Step three: find islands of excellence and build on them. Because, alongside (and in some cases despite) the national programme, the NHS has some brilliant local initiatives in which IT is transforming the whole practice of healthcare. Surgeons at Birmingham Heartlands hospital are ensuring that patients get the right operations by tracking them with RFID tags. Nurses at Queen Alexandra hospital, Portsmouth, are entering patients' vital signs on handheld personal digital assistants. GP members of the Records Access Collaborative are in the process of recruiting 100 practices to engage patients in their healthcare by showing them their electronic records - a home-grown technology in which the UK was a leader well before the national programme. Rather than trying to move the whole NHS convoy at the speed of the slowest ship, Connecting for Health, the NHS IT agency, should be identifying such grassroots initiatives and helping them spread. Ideally, the outcome would be a handful of exemplar all-electronic NHS communities where clinicians would clamour to work and patients clamour to be treated. If a few million more quid is needed for the purpose, that is money well spent. Contrary to some commentators' opinions, the NHS national programme has quite a lot to show for five years' work. But most of what it has done is to put in place the basic components of a computerised NHS. It has quarried the stone; in some cases created useful building blocks. From the ground upwards, it's time to start building the cathedrals."

3.8.73. NHS chief attacks computer project (15 Jun 2007)

Liverpool Daily Post

http://icliverpool.icnetwork.co.uk/0100news/0100regionalnews/tm_headline=nhs-chief-attacks-computer-project&method=full&objectid=19300297&siteid=50061-name_page.html

"THE outgoing chief executive of Wirral Hospital Trust has condemned the troubled £12bn scheme to create electronic patient records, warning many doctors are "beginning to despair". Frank Burns, who carried a previous investigation into improving NHS computer systems, said the programme was losing the support of clinicians as it fell years behind schedule. The chief executive said National Programme for IT (NPfIT) was wrongly focused on linking up records nationwide, instead of connecting hospitals and local GP surgeries. Most remarkably, he said Wirral trust had rejected introducing the first version because it was inferior to the IT system it had set up way back in 1990. Mr Burns, who leaves his post next month, said: "What is eventually produced by NPfIT won't be as sophisticated as the system we introduced 17 years ago. "That is why we took the decision we did at my trust, on the grounds of possible safety. It would have been a possible danger." NPfIT, the largest non-military IT project in history, is designed to drag patients' clinical records, many of which are still paper-based, into the 21st century. . . Giving evidence to the Commons health select committee yesterday, Mr Burns said attempting to set up a national system was "putting the cart before the horse". In contrast, the Wirral IT system, for example, automatically alerted the hospital's chest clinic if a radiologist in a different department "reported something sinister on an X-ray". Mr Burns said: "The technology is slow in coming forward. In many parts of the country, people are beginning to despair if it will ever arrive. "What's important are good local care records, because most people attend their local hospital if they have an emergency. "The occasions when any of us fall over in some distant town and need emergency care are not that frequent." Mr Burns's criticisms are significant because he carried out a 1998 study, Information For Health, which called for local implementation of better IT systems. But the proposals were not funded by the Government and were overtaken by the NPfIT, which was launched in 2002. Mr Burns was appointed as general manager of Arrowe Park Hospital in 1989 and became chief executive of Wirral Hospital NHS Trust when it was created two years later. The trust has since become one of the most successful in the country."

3.8.74. Are we nearly there yet? (Jun 2007)

BCS Health Informatics Now

http://www.bcs.org/server.php?show=ConWebDoc.12737

"'Are we nearly there yet?' is the question often asked by the smaller passengers on the back seat of the car. They probably have only a vague idea of the intended destination and had no (or very limited) input to its choice. They were probably given no option as to whether they wanted to go on the journey and may even have had other things that they would have preferred to do. However, based on past experience, they probably have confidence in the driver that he/she knows where they are going and how to get there. They may have concerns that the driver does not usually welcome advice (or even stop to re-visit the map) when lost. Do you see any similarities in respect of the current plans for IT in the NHS in England? Do we hear clinicians (and some managers) asking the question 'Are we nearly there, yet?' What about their confidence based on past experience? Many of us who were working in NHS computing 20 years ago thought then that we were nearly there. Most hospitals had some computer systems working and nearly all GP surgeries were computerised. The only thing needed - we thought - was for these systems to communicate with each other. Once that had been achieved, a number of other things would be possible, including changes to the way healthcare was delivered and where it was provided. The 'C' was to be the most important letter in ICT. Where did we get it wrong? A few of you may remember that in the late 1980s, the NHS had 14 regional health authorities (RHA) in England. Each RHA had a regional computing unit (RCU) with at least 100 staff – some had more than 200. Each RCU had a capability to write, run and install computer applications - such as PAS, pathology, child health and financial systems. Furthermore, some regions wrote and even ran applications for other regions. We worked as though there was a 'national' health service. We even worked closely with our colleagues in Wales, Scotland and Northern Ireland and with those employed by the Department of Health. Our shared wisdom at the time – based on some successes (and a few failures) – had reached several conclusions. Here, in no particular order, are 12 of them:

- The most important issue is implementation since it involves many, already over-worked individuals from a number of different professions (and possibly) different organisations).
- The rate of implementation roll-out is more dependent on the health authority's willingness and capability than to any capital budget constraints.
- Maintaining the interest and enthusiasm of users is vital for a successful implementation.
- It is essential to involve users at all stages - specification of requirements, procurement (if a purchase is necessary), implementation, live running and subsequent modification/updating.
- Both user and management expectations should be managed.
- Delivery of an application or a usable sub-set should, ideally, be within six months - otherwise the users loose interest.
- It is extremely difficult and usually very costly to anglicise an application written for the American market.
- When offered a 'working' system, insist on trying it yourself - demonstrations are easy to fake.
- The importance of the procurement process is often overrated. Many health authorities got good results from poor systems and some got poor results from good systems. The local implementation is the most important factor.
- Most staff at the Department of Health have a very limited knowledge of how the NHS is managed and how healthcare is delivered.
- The power of the medical mafia(s) should not be underestimated. There is often more than one and each has its own agenda.
- If it ain't broke, don't try to fix it. . ."

3.8.75. The MTAS failure is no ripple in a teacup (9 Jul 2007)

Health Service Journal

http://www.hsj.co.uk/healthservicejournal/pages/070712/letter1

"The cuts in funding for junior doctors' pay and study leave were very bad management and smacked of panic measures when they were announced half-way through the financial year. . . Then came the introduction of the medical training application service. I fought this through every due process from 19 September 2006, and by December 2006 had to admit defeat and prepare my junior and senior colleagues for disaster, crossing my fingers that disaster would not happen. The disaster hit on 26 February. Again I involved local MPs well before going to the media. I also fought for months on the

patient safety issues around the national IT programme care records system, taking matters right up to Whitehall before turning to the media. We are meant to have an open culture for whistle-blowing on imminent disasters. This process does not seem to operate above local trust level. Our trust management has always taken seriously what I have had to say, listened and taken action. Higher up above the trust, the attitude to my raising concerns seems mainly to have been a pretence of listening, no understanding and a denial of impending problems. . . Doctors are professional and do not rush to the media. The number of doctors breaking ranks from loyalty to the NHS and the profession to speak out in the media is a sure sign of major problems in the philosophy and implementation of central management in the NHS. [NHS chief executive David] Nicholson would do well to consider this to be an early warning of issues that could be deeply damaging to the NHS, and take steps to ensure that sober, prudent professionals are heard and understood, before they feel that they have to turn to Joe Public for support through the media." [Dr Gordon Caldwell is a consultant physician at Worthing Hospital.]

3.8.76. NHS IT project needs a comprehensive review - Lamb (11 Jul 2007)

Liberal Democrats

http://www.libdems.org.uk/news/nhs-it-project-needs-a-comprehensive-review-lamb.12889.html?

The man who was behind the NHS IT system has admitted that some of the work by contractors has been 'appalling'. Richard Granger is quoted in an interview as saying 'Sometimes we put stuff in that I'm just ashamed of.' Commenting, Liberal Democrat Shadow Health Secretary, Norman Lamb MP said: "What is 'appalling' is that Richard Granger repeatedly defended the disaster prone NHS IT system when he was responsible for its delivery. Now that he has stepped down, he is more candid with the truth. How soon will it be before another technical glitch puts patients' lives at risk? Any discussion with people working in the NHS leaves an overwhelming sense of loss of confidence in the project. The Government cannot continue to charge ahead with the system, blind to ever more stark warnings. We must have a thorough independent review with no more uncommitted spending until that review is complete."

3.8.77. Senior Responsible Owner - a good idea subverted (24 Aug 2007)

Computer Weekly - Tony Collins' Blog

http://www.computerweekly.com/blogs/tony_collins/2007/08/senior-esponsible-owner-a-good-1.html

"In 2000 the then Cabinet Office minister Ian McCartney, with the help of Intellect, the suppliers' association, published a worthy guide on how to avoid IT-related failures. The guide - successful IT - recommended that one accountable individual should supervise a project. That person should be called the Senior Responsible Owner. It was a good idea, a corrective to flawed custom. Too often senior civil servants retired or were moved off projects as they began to understand its complexities. A senior responsible owner would see a project through from the time it was conceived to the point that the benefits became tangible. The McCartney report said that reviews of successful IT projects in Singapore had found that in every case the scheme was sponsored by a senior manager, who was held accountable for its success. But the McCartney recommendations have become, in the main, a tick-box exercise. . . The NHS's National Programme for IT [NPfIT] has had a variety of senior responsible owners. Sir John Pattison was on the point of retirement when he was appointed as senior responsible owner. Since then, 2002, there have been multiple senior responsible owners of the NPfIT: Professor Aidan Halligan, John Bacon, Sir Ian Carruthers, Richard Jeavons, Richard Granger and David Nicholson to name only a few. The Department of Health has this year appointed more than 100 senior responsible owners for parts of the NPfIT. . . I suggest that reality makes nonsense of some of the best recommendations in the McCartney report, at least those on the all-important role of the senior responsible owner.

3.8.78. There was no squalor when sister ran the ward (15 Oct 2007)

Daily Telegraph

http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2007/10/14/nfanu114.xml

". . . Back in the mid 1970s when I was a junior doctor at the 1,000-bed Whipps Cross Hospital in east London - one of the biggest and busiest in Europe - the "management" consisted of just six people. . . In the late 1980s, the Conservatives turned on the middle class professions and their high-minded

values of public service, portraying them as untrustworthy and inefficient. They disparaged claims to independence, dismissing self-regulation as merely a means to protecting self interest. The Tories' radical solution was to create the "internal market", with all the different elements of the NHS in competition with each other. As Kenneth Clarke, the Health secretary of the time, put it, the intention was to provide "choice, competition and a measurement of quality to be found in private industries". But now every management function had to be replicated by "purchasers" and "providers" . . . The 510 senior managers who had run the unreformed NHS swelled over three years to 13,000. . . Wave after wave of policy directives and guidelines swept over the health service. . . Most recently, the Government has changed tack again, re-introducing features of the supposedly discredited internal market, although now to be controlled by supposedly independent regulators monitoring quality and standards. Not surprisingly, given all this, the number of senior managers has expanded faster than any other category of NHS staff, and they now number nearly 40,000 - 80 times as many as two decades ago. To that figure must be added a further 250,000 "administrative and clerical" personnel that now constitute a fifth of all NHS employees. . . When family doctors need to refer to a specialist for an opinion, they would in the past have written a letter that might take a couple of minutes. Today we have "Choose and Book". Oldham GP Dr Anita Sharma explains some of the process: "To make an appointment, I have to first open the system, making sure patient demographics are copied, search for a clinic near the physician's name or speciality, and then choose between a range of dates. This whole process can take between 10 and 20 minutes, and that means angry, groaning patients in the reception area." . . ."

3.8.79. NHS IT time-frame 'ludicrously tight' (25 Oct 2007)

BBC

http://news.bbc.co.uk/1/hi/health/7061590.stm

"The NHS National Programme for IT is the largest non-military project in the world and aims to revolutionise healthcare. But the budget for the massive project was never properly explained and it was given a "ludicrously tight" time-frame a new BBC Radio 4 investigation reveals. In 2002, Sir John Pattison at the Department of Health and colleagues were invited to a seminar on IT at Downing Street. They were given 10 minutes to explain their vision for a computerised NHS. The initial plan was for a dependable electronic network connecting all parts of the NHS containing three elements - electronic patient records, booking of appointments and prescriptions. "I suggested it would take three years," says Sir John, but admits: "We did not get across that the initial time-frame of three years and budget of £2.4bn was just the first phase, and this is possibly where the concern for delayed implementation has come from". This initial timescale was "ludicrously tight" according to Dr Paul Cundy, chairman of the BMA's IT committee. "If you'd asked anyone with any sort of feet on the ground anywhere near any sort of IT project, they'd have said no it's not possible." Now the project has a 10-year plan with an estimated budget of £12.4bn. The director of the project, Richard Granger, resigned in June this year. During his tenure, he had coped with accusations of delays, problems with contractors, including one of its software suppliers - iSoft - being investigated for alleged accounting irregularities. . . in June 2006, the National Audit Office published a report assessing the NHS IT programme, which had allegedly been completed in draft form a year earlier. The editor of trade magazine Computer Weekly, Tony Collins, saw a draft version of the report which he alleges was radically different to the final one and believes it was exploited by the Department of Health and turned into "the most gushing report". . . Despite the optimistic tone of the National Audit Office report, within three months two more suppliers - IDX and Accenture - withdrew from the project and there was also a new NHS chief executive, David Nicholson, to oversee the National Programme for IT. Earlier this year he rejected fresh calls by the 23 academics for an independent review but he later announced the National Local Ownership Programme - a move away from Granger's original vision of a centralised IT delivery - to the regions - something many critics have called for in the past. The change of direction followed consultation with health professionals and trusts about their needs and has been welcomed by Dr Paul Cundy at the BMA who was so critical of the project's initial timescale and vision. . ."

3.8.80. Who lost our data expertise? (29 Nov 2007)

http://www.guardian.co.uk/technology/2007/nov/29/comment.politics

The Guardian

"The sound of two dropped CDs is still echoing around the government's £14bn-a-year IT programme. And the effects are already being felt: last week the NHS IT agency Connecting for Health warned

hospitals not to post discs containing unencrypted personal data to the central NHS Tracing Service, run by a private contractor in the Midlands. Media not meeting security standards "will be destroyed upon receipt", it warned. And on Tuesday ministers announced a five-month delay to ContactPoint, a database with details about every child in the UK. . . Data sharing between departments about individuals can have benefits; what is needed is a culture within government where both the power and the responsibility for implementing those benefits is understood throughout. Right now, however, the first priority for IT chiefs is to comply with the prime minister's request for an analysis of "systems and procedures" by December 10. The reports will feed in to a review by Robert Hannigan, the government's intelligence chief. Yet all these efforts make one big assumption: that so long as "systems and procedures" are properly followed, everything can continue as before. There is an alternative, more worrying analysis of the situation: that the child benefit data fiasco was the result of a government overwhelmed by the scale of what it is trying to do with IT. "It's indicative of a lack of expertise," says Helen Margetts, professor of society and the internet at Oxford Internet Institute and the co-author of a study that is devastatingly critical of the government's IT programme. Published last year by Margetts with her colleague, Patrick Dunleavy of the London School of Economics, the study of IT projects in seven leading countries found that governments that place big IT contracts in the hands of a few big contractors are the ones most likely to experience failures. The UK was unique in the extent to which it outsourced projects so that large IT companies had the government over a barrel. The study found that the UK had "the most concentrated government IT market in the world, with a near-monopolistic lead supplier (Electronic Data Systems, or EDS), huge contract sizes, poorly understood use of private finance initiative (PFI) contracts for inappropriate IT projects and virtually no in-house capacity to manage (let alone develop) IT systems." . . . In theory, the government has been trying to raise its game for more than two years. One of the three central aims of the Transformational Government Strategy, published in November 2005, was to create a new "IT profession in government". Part of this process is to hire people with IT qualifications for the civil service fast stream, where they can expect to rise to the top. Six fast-streamers were hired last year; 15 will shortly be selected for entry next year. In the context of the government's IT programme, this is like opening a hospital before you have put the staff through medical school. . ."

3.8.81. Ready, steady, scrap - the big and bloated Olympics are just a start (2 Dec 2007)

Sunday Times

http://www.timesonline.co.uk/tol/comment/columnists/simon_jenkins/article2983670.ece

". . . Gordon Brown should announce forthwith that he is putting his three wildest white elephants out to grass: identity cards, the National Health Service computer and the plan to locate the 2012 Olympics in Stratford. All have budgets out of control. Such is this centralist squandermongering that Brown could take 2p off income tax for a decade or give every school, hospital and library in Britain a Christmas bonus of £1m. The first two projects could vanish with no shock to the system but the impoverishment of a few consultants. The ID computer is seriously sick. A review last year led to a supposed scaling back from some £10 billion to £5.4 billion. The £10 billion was reckoned by outsiders to be a gross underestimate and the new figure has been rising by 5% each six months. A figure of £20 billion remains plausible. As for the theory that the, as yet unworkable, ID computer will "help catch criminals", most computer commentators say: tell that to the marines. Criminals will revel in it. Every month we have evidence that such giant systems are porous both to hacking and to human error. British people will not accept being interrogated by the state so that their personal details can be available to every agency in Europe and every hacker in the world. The NHS computer is, if anything, sicker. Nobody can now recall a reason for it. Lord Warner recently admitted that its cost had risen to £20 billion. Choose-and-book, already in place, is simply not required by general practice. The government is weakening in its demand that patients must opt out of, rather than opt into, making their medical records open to the world. But if they must opt in, who will bother? In the latest survey, 85% of doctors want "an inquiry" into whether the project should proceed. . ."

3.8.82. The NHS's £12.4bn National Programme for IT – Experts give their views (9 Jan 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/01/08/228789/the-nhss-12.4bn-national-programme-for-it-experts-give-their.htm

Videoed interview

"Leslie Willcocks, Professor in Information Systems at the London School of Economics, says of the NHS's National Programme for IT [NPfIT] that it is at the "outer reaches of "at the outer reaches of known territory". But is it right for the government to use public money to take such immense risks with public money – not to mention patient safety? Leslie Willcocks makes the point that there's a natural tendency on huge projects for civil servants and ministers to downplay their full cost for fear of frightening off the funders. In this video he talks about the strengths and weaknesses of the NPfIT, the lessons to be learned, and refers to a series of expert views on the programme that are published in the Journal of Information Technology."

3.8.83. Not fit for purpose: £2bn cost of government's IT blunders (5 Jan 2008)

The Guardian

http://www.guardian.co.uk/technology/2008/jan/05/computing.egovernment

"The cost to the taxpayer of abandoned Whitehall computer projects since 2000 has reached almost £2bn - not including the bill for an online crime reporting site that was cancelled this week, a survey by the Guardian reveals. The failure of the multimillion pound police site marks the latest chapter in the government's litany of botched IT projects, with several costly schemes biting the dust. Major blunders overseen by Downing Street have included the Child Support Agency's much-derided £486m computer upgrade - which collapsed and forced a £1bn claims write-off - and an adult learning programme that was subjected to extensive fraud. Top of the ministries for wasting public money is the Department for Work and Pensions, which squandered more than £1.6bn by abandoning three major schemes - a new benefit card which was based on outdated technology; the upgrade to the CSA's computer which could not handle 1.2m existing claims; and £140m on a streamlined benefit payment system that never worked properly. The Guardian's survey of abandoned projects is not exhaustive and the total of £1.865bn is likely to be a considerable underestimate of the actual cost to taxpayers because neither Whitehall nor the National Audit Office, parliament's financial watchdog, keep definitive lists of which schemes go wrong. Neither does it include the major modifications required to fix new systems that have failed to perform as required. One example is the pilot work done on the new £12bn NHS computer system - where outdated technology was installed at Bexley Hospital in south London, and has had to be replaced after it was found to be "unfit for purpose". Another is the huge modification required to the new computerised single payments system for farmers run by Defra's Rural Payments Agency, where the government has had to set aside some £300m to meet possible EU fines for wrong payments to thousands of farmers. . ."

3.8.84. Cameron slams NHS IT programme (7 Jan 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/01/07/228774/cameron-slams-nhs-it-programme.htm

"David Cameron has blasted the government's £12.4bn NHS National Programme for IT (NPfIT), saying that ministers have fallen for the sales pitch of IT suppliers and consultants who have cut corners. "I have said before that in their drive to 'modernise' the NHS, Labour have not improved it, so much as ripped out its heart and installed a malfunctioning computer instead," said the Conservative Party leader, at a speech at Trafford General Hospital. "It is one of the most shameful and disgraceful aspects of Labour's record: the way they fall for the sales patter of the management consultants and the big IT firms, who make them think they can cut corners to success." He said that the NHS is suffering from shoddy jargon-ridden schemes served up on Microsoft Powerpoint and swallowed whole by the people who are supposed to be custodians of the health service and custodians of taxpayers' money. He also criticised the Government's proposal for a vast, centralised, NHS database saying that recent events have shown how dangerous government IT systems can be if mis-managed. "Of course we need different NHS professionals to be able to access medical records. But those records should be owned by the patient, and stored locally, under the control and protection of his GP. We need local servers with interoperability," said Cameron."

3.8.85. The best virtues of British medicine are in grave peril (11 Jan 2008)

The Herald

http://www.theherald.co.uk/features/features/display.var.1957933.0.The_best_virtues_of_British_medicine_are_in_grave_peril.php

"As I approach a milestone birthday later this year, I have been reflecting on the career changes I have experienced as a rural general practitioner. . . The English NHS is set to dismantle the very basis of personal care by doctors serving a defined list of patients on the grounds of fashionable competition and privatisation. The key vehicle for this change is dilution of the confidentiality of the personal medical record, recklessly allowing its details to be automatically sucked from practice computers on to what is known as "the spine" - an electronic database to be available to anyone within the NHS "family". Connecting for Health, the latest massively expensive governmental IT disaster, is promoted as essential for the emergency care of any patient who turns up unannounced at a hospital, but the dangers of information incontinence within the NHS, the largest single employer in Europe, is conveniently forgotten. Already there are instances of illicit access to the records of celebrity patients. The real reason for this dangerous innovation, of course, is not patient care, but so that the English Department of Health can offer general practice contracts to alternative providers - commercial companies that propose to offer primary care through the same supermarkets and high street outlets that seem to have captured the imagination of the spotty adolescents who populate the No 10 Policy Unit. General practice has changed over 30 years, and most of us recognise that as welcome and appropriate in a maturing society. What must not change, however, are those enduring principles that have served the NHS and its patients so well since 1948. A personal service, provided by well-trained doctors and their teams, based locally and on families and one where there is trust that what is said confidentially in a consulting room on a Monday will not be on a government database on Tuesday. A service where there is recognition that historically one could never phone for instant advice out of hours for the least discomfort, but one where there was always help in an emergency. . ."

3.8.86. Experiences of 'Connecting for Health' (22 Jan 2008)

Technology and Social Change

http://technologyandsocialchange.wordpress.com/2008/01/22/seminar-13-02-08/

Abstract: The national NHS 'Connecting for Health' strategy has shifted the centre of gravity around ICT to big Corporations determined to impose national contractual obligations on Primary Care Trusts often with solutions that are not specified according to local service requirements. Unsurprisingly, outsourcing by stealth has been an inevitable consequence of this process as these corporations offer economies of scale. Secondly it has developed solutions around running the NHS as a business in a market environment as opposed to solutions for front line clinicians that support operational needs. Consequently the role of NHS IT in accelerating the comodification of the NHS has been a major challenge to us all as we seek to maintain 'in house' developments aligned to service needs and not just the national Connecting for Health programme. One consequence is that national systems innovation has now been conflated with management requirements as opposed to patient benefits and this feeds into a bigger political mistrust of government intentions - not least around privacy of information and the potential (mis)uses of data. In this seminar Neil will discuss his experiences of running such programmes at 'the frontline' through a number of case studies that illustrate some of these issues. [Notice of a seminar to be given by Neil Serougi (Director of ICT at Solihull Care Trust)]

3.8.87. NPfIT 'pushed the NHS into disarray' say Lib Dems (23 Jan 2008)

e-Health insider

http://www.e-health-insider.com/news/3402/npfit_%E2%80%98pushed_the_nhs_into_disarray%E2%80%99_says_lib_dems

The Liberal Democrats have labelled the National Programme for IT (NPfIT) as a waste of money which 'has pushed the NHS into disarray'. Setting out his vision for the NHS, in policy paper, 'Empowerment, Fairness and Quality in Healthcare', Liberal Democrat leader, Nick Clegg, says that NPfIT and the Medical Training Application Service (MTAS) have been over-budget messes by the Labour government. "The NHS IT system is running behind schedule and billions of pounds over the original budget; the grossly mishandled doctors' contracts with costs running hundreds of millions of pounds over budget; the new centralised computer system for doctors' recruitment – MTAS introduced without proper piloting which caused chaos. These are all examples of where the government has rushed headlong into new projects and in the process has wasted money and pushed the NHS into

disarray," the paper says. The paper also accuses the Conservatives of "almost criminal neglect" of the NHS during the party's periods in office. The Liberal Democrats say they will introduce compulsory technology appraisals, to ensure local trusts take full responsibility of the systems they install. "The Liberal Democrats would initiate regular and thorough reviews of the implementation of technology appraisals, and would publish information on which health trusts were failing to meet their legal responsibilities in order that trusts could be held democratically accountable for their decisions. "We will look at ways of allowing technology appraisals not only to make mandatory, legally enforceable recommendations, in high priority areas, but also to make some non-mandatory recommendations. Trusts would be regularly assessed by the Healthcare Commission on their compliance," the party proposes. . . The policy paper will be discussed at the Liberal Democrat Spring Conference in March."

3.8.88. Frank Burns on IT policy in the NHS (23 Jan 2008)

Health Service Journal

http://www.hsj.co.uk/Intelligence/columnists/frank_burns_on_politicians_short_cuts_and_dead_ends.html

"Anyone interested in how high-profile national policy is developed will have enjoyed the revelation, on Radio 4's Wiring the NHS programme, that in 2002 then NHS IT director Sir John Pattison was given only 10 minutes to pitch the creation of the national IT programme to prime minister Tony Blair. . . The national IT programme is the ultimate example of political impatience for results. It arose from frustration at the centre with the slow progress in local implementation of the 1998 strategy Information for Health. The creation of the programme represented a victory for those who had always favoured a top-down approach and who assumed clinical IT systems could be purchased centrally and delivered in the back of a van to NHS organisations. John Pattison's 10-minute pitch to the prime minister must have been mesmerising. It resulted in the replacement of the Information for Health approach with a diametrically opposite philosophy and a target to deliver key systems to NHS organisations in just three years. It was a confident and brave change of direction that was backed up with undreamed-of levels of resource. It was a bid for a quick win on a monumental scale. Regrettably, after allowing for the success in delivering the picture archiving and communications system (PACS), the shortcut to integrated clinical records that was the key driver for the creation of the IT programme seems to have turned into a dead end. The reasons for this are well known and are well documented in the recent report of the health select committee. Though the government came to power in 1997 with an intention that wiring the NHS would be a flagship modernisation policy, in its 11th year of office and six years after the creation of the IT programme, only a minority of NHS clinicians have sophisticated clinical IT support. A grand total of 45,000 people (in Bolton) have the beginnings of a shared clinical record which, in reality, contains only two potentially useful items of clinical information. Even the high priority Choose and Book programme is a long way from being fully implemented and supported. Whatever the true nature of any high-level discussions about the future of the IT programme that are rumoured to be under way, we can only hope that NHS leaders and politicians have finally come to appreciate that wiring the NHS is difficult, complex, frustrating and in the end far too important for 10-minute, off the cuff decision-making. We must also hope that in the interests of expediency they do not choose to abandon the more complex, clinically related components of the project, as these are the only elements of the programme that remotely justify the billions of pounds committed to it."

3.8.89. Large-scale Health IT is a risky business (25 Mar 2008)

Computerworld NZ

http://computerworld.co.nz/news.nsf/news/12022EA9678822A0CC2574110076BC3E

. . . Almost everywhere that health executives or authorities have pursued the goal of integrated electronic healthcare the dream has fallen well short of reality — and usually cost a bucket of money along the way. Most prominently right now, there is the UK National Health Service's NPfIT (National Programme for IT) project, which has redefined the term "project failure". So many things have gone wrong with this project that it is hard to enumerate them quickly, but, like our 1990s Police INCIS project, it was based on the wrong technology, and that's never a good place to start. NPfIT was based on a technology that hadn't been fully developed, iSoft's elusive Lorenzo, while INCIS was based on one — IBM's OS2 – that was shortly to be discontinued, despite IBM's insistence to the contrary. . .

3.8.90. Cameron pledges end to "hubristic" IT (4 Apr 2008)

IT Pro

http://www.itpro.co.uk/internet/news/184404/cameron-pledges-end-to-hubristic-it.html

"The Conservative leader has said his party would create modular IT projects, rather than massive ones like the NHS IT upgrade. Conservative opposition leader David Cameron has said his party - if elected - would stop massive IT projects, splitting them into modular components. Giving a speech at the National Endowment for Science, Technology and Arts in London, Cameron came out against large-scale projects such as the £12 billion NHS national programme for IT (NPfIT). "Never again could there be projects like Labour's hubristic NHS supercomputer," he said. He praised open-source development, and said the government should look to such methods to overcome difficulties with large-scale projects. "The basic reason for these problems is Labour's addiction to the mainframe model - large, centralised systems for the management of information," he said. He added: "From the NHS computer to the new Child Support Agency, they rely on 'closed' IT systems that reduce competitive pressures and lead to higher risks and higher costs." Cameron said he would make it possible for smaller open source firms to win government contracts. "We will create a level playing field for open source software in IT procurement and open up the procurement system to small and innovative companies," he said."

3.8.91. Cameron attacks NHS computers (4 April 2008)

Kable's Government Computing

http://www.kablenet.com/kd.nsf/FrontpageRSS/71FC69340E504C748025742100398997?OpenDocument

Conservative Party leader David Cameron has questioned the role of IT in the National Health Service In a posting on his blog, published on the party website on 3 April, Cameron used the phrase "No more NHS computers". This followed a speech he gave to the National Endowment for Science, Technology and the Arts (Nesta) in which he spoke about a "hubristic NHS supercomputer" and advocated "open standards that enable IT contracts to be split up into modular components". He also accused the government of being addicted to large, centralised IT systems for the management of information, and that the "NHS computer" relies on "closed IT systems that reduce competitive pressures and lead to higher risks and higher costs". A spokesperson for the Conservative Party told GC News that, despite the comment on his blog, Cameron was not advocating that the NHS should work without computers, or that the government should abandon the NHS National Programme for IT. "He's saying we should make existing systems more efficient," she said, stating that there have been errors in the programme and that "we want the systems to be more scrutinised."

3.8.92. HC2008: learning lessons from the National Programme for IT NHS IT (23 Apr 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/04/23/230414/hc2008-learning-lessons-from-the-national-programme-for.htm

". . . IT-related progress in the NHS moves so slowly that the eye can barely perceive it. The National Programme for IT [NPfIT] in the NHS was supposed to change that. Ministers wanted action, and quickly. Cynics would say that what ministers wanted quickly was their comments in innumerable media articles and broadcasts on how New Labour was using IT to modernise the NHS. . . Now, six years on from the announcement of a national programme, some NHS staff and those working for the suppliers say significant IT-related change has become slow and tentative, and at some trusts has all but stopped. They depict the NPfIT as a behemoth that nobody knows what to do with. In some ways things are worse than they were before the NPfIT. Hospitals were able to buy what they needed. Several trusts were combining for consolidated purchases of electronic record systems, which could have been mature products today - had they been allowed to go ahead. They were cancelled because of the NPfIT. Computer Weekly has recently reported on some of the trusts that have put major IT plans on hold. Trusts receive money from Whitehall for buying patient administration and other core systems under the national programme. But if those systems do not arrive - and patient record systems are running three years late - what are trusts to do? If they bypass the NPfIT, and some of them are doing just that, they have to fund major IT systems with hospital money and risk becoming outsiders to the

national programme. . . Some in the NHS argue that there should be no national programme in the sense of centrally controlled IT that is imposed on trusts. That goes too for a national programme in a guise of a local one - the so-called National-Local Programme for IT. There should instead be a choice for trusts of IT systems that should ideally, but not over ridingly, meet technical standards that are set nationally. Some independently minded NHS executives have long thought that the NPfIT should cease to be an amorphous programme under which integrated systems throughout the country deliver all that IT should and could. Better, they say, to have reliable electronic patient records within local boundaries to replace paper records that frequently are lost than a grand, risky, controversial scheme for national records that exists only in ministerial statements of intent. Yet ministers continue to hope that two main products - Cerner's Millennium system and IBA Health's "Lorenzo" in the North will give the NHS much of what it needs. But some see this strategy as a single circular railway around England that drops people off a long way from where they want to be. How did the NHS end up like this, in such a mess? Some Whitehall officials see this as a pointless question. They want to decide where to go now. But others say it is important to learn from history to avoid making the same mistakes again."

3.8.93. A whole new way of losing the election (20 May 2008)

politics.co.uk

http://www.politics.co.uk/news/domestic-policy/civil-liberties/editorial-a-whole-new-way-losing-election-$1223538.htm

"Gordon Brown has staked his reputation on the economy, but it may be his handling of the civil liberties-counterterrorism balance which ruins his premiership. Across the government the prime minister has tasked ministers with implementing his much-needed fightback. Come up with a raft of new measures. Show the world we still have energy and momentum. Aha, Home Office officials say. We have just the thing: a new database. This one is needed because of the telecommunications revolution, they explain. The internet and growth of mobile technology is changing the way criminals and terrorists communicate. If those responsible for keeping Britain safe are to keep up, they need to be able to monitor the situation. Being able to access records of phone calls would be just what the counter-terrorism official ordered. Unfortunately, anyone who has been even vaguely politically aware over the last ten years will realise the horrendously fraught dangers the word 'database' possesses. They just aren't cool. Look at the fate of Connecting for Health's patient records database which has just been delayed by four or five years. How about the furore over data security? A swathe of embarrassing admissions over the winter hasn't helped the government's reputation for competence. This government needs another database like the Titanic needed another hole. . ."

3.8.94. Frank Burns on Lost Opportunities (18 Sep 2008)

Health Service Journal Supplement

http://www.hsj.co.uk/images/080918intell_tcm11-1844607.pdf>http://www.hsj.co.uk/images/080918intell_tcm11-1844607.pdf

"I've been writing this column now for two years or so and I fear this might be my last piece - not because I want to give up this marvellous platform to peddle my personal passion for clinical IT, but because I'm beginning to wonder if my difficulties in understanding what is going on with the IT strategy in the health service disqualifies me from having this national platform. Notwithstanding the publication of the Health Informatics Review, I am none the wiser about whether the national IT programme is still expected to deliver clinical information systems to service providers or whether the encouragement to pursue interim solutions is the beginning of the end. My confusion might simply arise from my failure to grasp the subtleties of the "biggest IT project in the world" adapting to inevitable changes. On the other hand, it could signal that with the loss of another local service provider, the Department of Health is hoping the programme will die of natural causes (terminal exhaustion) and in the meantime a policy of "mess and muddle" is the best that can be offered. More worryingly, having read the review, I'm still not convinced the authors fully appreciate that the goal of improving the flow of timely, reliable information for decision making, service development and individual patient choice is fundamentally dependent on the universal availability of functionally rich clinical management systems. . . . The most frustrating thing about the review is the fact that 10 years after the publication of Information for Health (yes, I did write it and, no, it wasn't a complete success), the stakeholder engagement process has come up with exactly the same analysis of what the service requires by way of health informatics. Surely an inevitable outcome - the NHS hasn't been complaining about the goals of the national programme but about the process to achieve these goals and the snail's

pace progress in delivery. Despite this, I detect absolutely no sense of urgency in the review. The nearest it comes to a sense of urgency is the statement that "local informatics plans should identify the roadmap that achieves these 'clinical 5' as soon as possible". Well, it hasn't been possible over the last 10 years and the requirement for local funding presages the same fate for this initiative as befell Information for Health, so we may be in for another 10-year wait. . .

3.8.95. NHS e-records project has 'ground to a halt' (28 Oct 2008)

Daily Telegraph

http://www.telegraph.co.uk/news/newstopics/politics/health/3271048/NHS-e-records-project-has-ground-to-a-halt.html

The NHS's £12 billion computer programme designed to give doctors instant access to patients' records has "ground to a halt". Connecting for Health, originally launched 2002, has faced a series of problems including reports it is running four years late. Just one of the acute care hospitals due to install the system has done so - Royal Free NHS Trust in London - and that is experiencing difficulties getting it to operate properly. Jon Hoeksma, editor of the e-health insider website which is tracking CfH's progress, said other parts of the project were continuing to make progress. He told The Financial Times: "This key part seems to be simply stuck. It has ground to a halt. And that is not just affecting deployments that should be happening now. It will have a knock-on effect on those that are meant to be going live two or three years down the line." Hospital chief executives, he said, did not want to take a new system "until they have seen it put in pretty flawlessly elsewhere". Fujitsu, the contractor originally hired to build the record system for the whole of the south of England, is now no longer involved. NHS Trusts in the south have been given a choice of working with BT, London's supplier, or CSC, the supplier for the north, but nothing has yet to be agreed. The first installation of patient record software in the north of England was due to go forward at Morecambe Bay in northwest England in June, but the system has still not gone live. Frances Blunden, the IT policy specialist at the NHS Confederation, the body that represents NHS Trusts, said: "It is a little bit too early to pronounce the programme dead." She added that "to say everyone is walking away from it is a bit premature, probably". A spokesman for Connecting for Health said it was more important to get the quality of installations right rather than set a particular date for installation, while talks were underway to ensure "a smooth transition" following Fujitsu's departure.

3.8.96. NPfIT 'misconceived': O'Brien (30 Oct 2008)

e-Health Insider

http://www.e-health-insider.com/news/4287/npfit_%27misconceived%27:_o%27brien

"Shadow health minister Stephen O'Brien has launched a stinging attack on the National Programme for IT in the NHS at Healthcare Interoperability in Birmingham. Mr O'Brien said he had been surprised to see a "flurry" of stories claiming the programme was "grinding to a halt" in this week's press, since there had been no obvious "hook" for them. But he argued they reflected the "perceptible lack of progress" that it is now making. In his keynote speech to the conference, he then went further and argued that the programme had always been misconceived. He noted that one of the triggers for it had been Sir Derek Wanless' 2002 review of the likely future spending needs of the NHS for the Treasury, which argued the health service needed to raise spending on IT to business levels. "He [Wanless] felt that ICT was an important condition for a more efficient health service. The government felt it was a sufficient condition," O'Brien said. Once major IT suppliers had become involved, he added, this had translated into a programme that aimed to "drive" rather than support change in the health service. "The government was seduced by a dream of IT, instead of seeing it as an enabler of a better health service," he said. The irony, O'Brien went on, was that the Wanless report had outlined an alternative: standards based, interoperable systems focused on delivering better quality care to patients. Although O'Brien was reluctant to pre-empt the findings of the independent review of NHS IT that the Conservatives have set up under Dr Glyn Hayes, he indicated strongly that he felt this was the way that healthcare IT should go in the future. . ."

3.8.97. Michael White on IT in the NHS (6 Nov 2008)

Health Service Journal

http://www.hsj.co.uk/opinion/columnists/magazinecolumnists/2008/11/michael_white_on_it_in_the_nhs.html

". . . The word on the health street is that, whatever they cautiously say for public consumption, ministers and senior officials are seriously worried about their ambitious NHS Connecting for Health IT plans. . . Outside Westminster a well informed source tells me he hears it's "in real trouble" - not just in the South either - not least because the technology has moved on. That translates as meaning that software to allow previously incompatible systems to talk to each other now exists to render the centralised CfH vision unnecessary. But, as so often in such chats, my source adds "I don't understand the technology." Few do. The official position from the Department of Health, the NHS Confederation and CfH seems to be that - as with Wembley stadium - it is better to be late and right than on time and wrong like Heathrow's Terminal 5. There is stock-taking, a hiatus, assorted problems, but it ain't dead yet, they all say. I'm sure that's true, but when in doubt talk to smart backbenchers who do IT. Derek Wyatt, Labour MP for Sittingbourne and Sheppey (majority 79), who has blown hot and cold on the practicalities of CfH in chats with me over the years, still insists it's a good thing, albeit over-centralised. "The big change is that we've all gone mobile [as in phones]", he notes. More cautious than Mr Clegg, whose call to scrap the scheme was dismissed by the Tories as "barking mad", Liberal Democrat health spokesman Norman Lamb is calling for "a thorough review of the work in progress and how to proceed". It is when I ring shadow health secretary Andrew Lansley's deputy, Stephen O'Brien, that I get a serious blast. After Tony Blair shot his mouth off on TV in 2000 about creating the best health IT system in the world (he couldn't use email at the time) Labour rushed to make the leader's words a reality of sorts. "A typical New Labour, one-size, top-down and fits-all solution in which only lip service was paid to consulting the professions," is Mr O'Brien's view. The focus from the start should have been on the needs of the patient and the better outcomes which IT could deliver if staff consultation had been a priority. Mr O'Brien is not against the principle of a national IT network. He can see what doctors have done in Cheshire (he is MP for Eddisbury) in terms of efficiency and patient choice. But local schemes like that were urged to hang fire by Whitehall: "We're going to give you a solution that will allow you to speak across the country." It is rare, of course, that a GP has to do that. Even patients going into distant hospitals are usually conscious for interview. But ministers - generally ignorant of IT - were wooed by the big boy suppliers with their overambitious plans. "Ministers were warned that the whole design was designed for failure," says Mr O'Brien, whose complaints are echoed by other smart IT-minded Tory MPs like Richard Bacon. Of course, "low-hanging fruit" - like radiography - works well. That was the easy bit. What to do? With ministers citing commercial confidentiality to avoid debate and accountability Mr O'Brien has raised some private funding to conduct an independent review, chaired by Glyn Hayes, ex-chair of the British Computing Society. Their goal: to rescue the project. But everyone agrees that a recession-hit Treasury in search of savings may even now be casting a beady eye on CfH's billions."

3.8.98. U.K.'s Project Runaway (7 Nov 2008)

Government Health IT

http://www.govhealthit.com/blogs/ghitnotebook/350659-1.html

"The United Kingdom's ambitious plan to introduce a nationwide health information technology system has reached a turning point. The $22 billion program has scored some notable successes, including the launch of medical imaging and appointment management services. But it has also come under criticism from those who say it is spiraling out of control. Recent reports have blamed the Labour government of Prime Minister Gordon Brown for unrealistic goals and timetables that have led to major delays in the National Programme for IT (NPFIT). Meanwhile, leaders of opposition parties have targeted the program for increasing scrutiny ahead of a general election that must be held in the next two years. The 10-year program began in 2002, but deadlines have slipped by at least four years. Every National Health Service (NHS) patient was supposed to have an electronic health record by 2010, a goal that now seems unlikely. . . In a report published in May, the National Audit Office (NAO) — the equivalent of the U.S. Government Accountability Office — said some elements of NPFIT are fully deployed and some have even been delivered ahead of schedule. N3, NHS' broadband network for incorporating voice and data services, has been deployed. Other critical systems — such as Choose and Book, an online patient appointment service, and a system for storing and sharing digital images of X-rays and other tests — also met their deadlines. However, delays in other parts of the system, including the Care Records Service and the Summary Care Record (SCR), have held back the overall timetable for NPFIT, the NAO report states. The Care Records Service offers detailed health records and systems that let patients choose what information their records contain. SCRs will include basic patient information, such as current medications and allergies. The final release of the care record software is expected in 2014. Bowen said the delay is because of the software's technical complexity and the need to develop the Care Record Guarantee "to meet the concerns that patients may otherwise

have felt about the confidentiality of their records." An independent evaluation of SCR's early-adopter program by University College London detailed the objections that general practitioners and health care organizations had to the first iteration of the SCR software. Those objections included an aggressive approach by Connecting for Health to meeting SCR implementation deadlines, concerns over patient confidentiality, SCR's clunky appearance, its poor ability to interface with other systems, and the need for more training for frontline employees. Another concern was that Connecting for Health was putting too much emphasis on SCR's technology needs. . . Bowen said the Department of Health is now considering how to move forward in light of the report's findings. It's also unclear how the loss of Fujitsu, one of the key vendors on the project, will affect NPFIT. Connecting for Health dropped the company after contract renegotiations broke down in May. Fujitsu is the second vendor to depart from NPFIT in the past two years: Accenture left in 2006 because officials said the company wasn't making any money on the program. Seceding from NPFIT Despite the progress that NPFIT has made in some areas, its continuing delays are starting to take a toll. Last month, the Newcastle Upon Tyne Hospitals NHS Foundation Trust, a local health provider, opted not to go with NPFIT and instead said it would create its own electronic medical record system. Other providers are reportedly considering similar moves. Meanwhile, the program has become a target for the Labour Party's political rivals. The Liberal Democrats have taken an especially hard line. . ."

3.8.99. ASSIST says idea NHS like a bank 'fundamentally flawed' (8 Oct 2008)

e-Health Insider

http://www.e-health-insider.com/News/4219/assist_says_idea_nhs_like_a_bank_%27fundamentally_flawed%27

"NHS informatics professional body ASSIST has published a paper saying the original NHS National Programme for IT plan based on a one size fits all "does not work". The paper says attempting to treat the NHS as if it were a bank failed to understand the structure and characteristics of the health service. ASSIST says there has been too much focus on standardisation of systems rather than standards. The paper says both national and local systems have a role to play but cannot succeed if they are imposed. The ASSIST document says a revised strategy must reflect the shift to a pluralistic, federated model of care delivery, in which information follows the patient. The paper calls for changes to NPfIT to take account of the changed policy environment, for mistakes to be acknowledged and lessons learned. ASSIST, which is affiliated to the British Computer Society, says the standardised systems approach of the original NPfIT strategy, emerged from a "misguided attempt" to see the health service as analogous to a big business. . . The paper has been produced as ASSIST's evidence submitted to the independent review of NHS IT being undertaken to inform Conservative party policy. The document says priority should now be given to getting the IT basics sorted first, with a focus on deploying clinical systems based on common standards. Counted among the notable successes are: primary care computing, electronic records transfers and prescribing, picture archiving and communications (PACS), digital patient monitoring and the secure NHS broadband network. The paper says other important parts of NPfIT have failed. "It is generally accepted that deployment of ICT in acute hospitals through the national programme has not gone well for a variety of reasons." "We observe that IT-imposed solutions have always tended to failure, while IT-enabling solutions have tended to be more successful." As a result of the NPfIT ASSIST says there has been a "radical" change in the supplier marketplace. "There has been a shift from a very wide range of small to medium sized suppliers, to one where there are a few very large suppliers with relatively constrained supply chains." . . . The document calls for pragmatic flexibility on systems: "The experience of the members of the group suggest that simple systems, which offer flexibility to be configured to meet local processes and circumstances, can achieve greater success than more sophisticated systems which bring rigidity." . . ."

3.8.100. Personal touch lost in 'pass-the-patient' (21 Jan 2009)

BCS News Channel (Health Column by John Black, President of the Royal College of Surgeons)

http://news.bbc.co.uk/1/hi/health/7839235.stm "No matter how routine the operation, learning that you need surgery is an unsettling and pivotal moment in anyone's life and requires confidence in the abilities of those caring for you. A much underestimated and unmeasured factor in healthcare in this country is the importance of the rapport that develops between doctor and patient. This trust is now being eroded by a system that has reduced healthcare to a factory production line where over-reliance on numerical targets and computerisation has broken down care into a series of procedures. I believe this is driving a wedge between patients and doctors in a way that is becoming detrimental to patient

care. Until recently, your GP would refer you to a single consultant who would then see you through the whole process of your care, from initial consultation to final discharge. GPs needed to maintain direct professional relationships with local hospital doctors to be able to select the right consultant for each patient, based not just on the type of operation and technical competence, but also on personalities. However, this cord between GPs and surgeons has been cut by the computerised "choose & book" system, which purports to offer greater patient choice but which has had the opposite effect. You may now select the hospital based on sets of centrally gathered statistical measurements, rather than the right doctor for you with professional advice and support from your GP. How many patients know enough about the health service to make a really informed choice? I believe that patients genuinely welcome advice and input from their family doctor on which specialist may be right for them as an individual - a proper complex person not a statistic. Because of the target culture, continuity of care has been severely compromised. You might be seen initially by Consultant A, come back for your results to see Consultant B, go on to a common waiting list and then have your actual operation done by Consultant C, whom you might meet for the first time on the morning of your operation. You may well be sent home the following day by Consultant D and if you are fortunate enough to have a follow up consultation, you may be seen by consultant E. It should again be the norm that patients are referred to an individual consultant who will be responsible for their care. This provides numerous opportunities for mistakes to be made, and it is deeply unsettling for the patient to be handed over time and again at every stage to a new doctor. This is also demoralising for clinicians. For me, and other surgeons, the great joy of the job is in seeing a real positive difference to someone's life. When you are only part of a production line, it becomes ever harder for the healthcare professional to deal with patients as human beings. Surgeons losing control of their waiting lists has also taken away the flexibility to make appropriate professional judgements about which patients are in greatest need and should be dealt with sooner. Another factor is that surgeons gauge their own ability on the outcomes achieved for their patients. If you never see them again, how can you know how you are doing? It should again be the norm that patients are referred to an individual consultant who will be responsible for their care throughout the clinical episode. Using the latest technology to increase the efficiency of the health service and measure how patients' lives are improved is vital. But this must be sensitive to the individual patient and must retain personal professional judgement. The current system in the NHS is forcing patients and doctors apart and I believe the delivery of care is poorer without those personal relationships."

3.8.101. NHS Confed calls for IT programme overhaul (27 Jan 2009)

Health Service Journal

http://www.hsj.co.uk/news/2009/01/nhs_confed_calls_for_it_programme_overhaul.html

"The national programme for IT should be called in by government, NHS Confederation policy director Nigel Edwards has said. Instead, local programmes should be allowed to meet national IT standards. Speaking on Radio 4's Today programme this morning Mr Edwards said managers were pessimistic that the programme could improve. He said: "Levels of pessimism are now such that we have reached the point where the government needs to call this in. We can't abandon this programme but have to ask: is this really working? We need local determinations about what is needed to reach a national standard. We need this programme and need to spend the money but this is increasingly looking like it is not the best way of spending it." Mr Edwards' remarks came after a report by MPs said the Department of Health should fund hospitals to buy electronic care records systems outside of the national programme for IT. . ."

3.8.102. U.K. NHS computer system on verge of collapse & implications for the U.S investment in CHIT (27 Jan 2009)

Virtualgryphon blog

http://virtualgryphon.com/uk-nhs-computer-system-on-verge-of-collapse-implications-for-the-us-investment-in-chit

"News from yesterday indicates that the project to build an integrated healthcare information system for the U.K. is close to collapse. Reaction to a report from the Public Accounts Committee of the House of Commons indicate that key elements of the £13 billion system are not working now, unlikely to work by the projected end of project in 2015, and may never work. The system, which was supposed to make medical care in the UK "better, safer and faster", is an end-to-end integrated healthcare information system similar to that currently sought by U.S. healthcare leaders. The U.S. system is one

of the projects being targeted for a US$60 billion investment by the Congress and the Obama administration. The U.K.'s clinical healthcare information technology (CHIT) system evolution has followed the pathway of other, large, expensive IT system failures. CHIT was proposed as a remedy for many of the problematic features of an essential, expensive, and politically sensitive healthcare delivery system. The benefits of CHIT were optimistic extrapolations from demonstrations. The massive project itself was similarly optimistically planned and budgeted. Ironically, controls intended to avoid cost overruns and project delays acted as as incentives for primary contractors to pull out of the project when problems arose. Progress on relatively easy parts of the system (e.g. incorporation of already working image storage systems, network infrastructure) obscured failure to create and field core functional elements. Fielding of some crippled, partly working components was hailed as "installation" and treated as success despite clear signals that the components made clinical work harder rather than easier. When problems were raised, CHIT proponents classified them as small faults that would be resolved by future software and hardware improvements or even as evidence of "resistance" from clinicians themselves. Over time the goal of making care better, safer, and faster was replaced by the need to simply get the system working irrespective of its impact on care — with a promise to incorporate these features in a future release. The Commons committee report and the associated interviews and press reports are couched in language suggesting that political support for the system is waning. Significantly, the sunk costs (possibly £4 billion), the lost time and momentum are probably unrecoverable. As with other large scale project failures, the U.K. system owners now face Hobson's choices. They can abandon the existing system and give up the grand plan of integrated, national CHIT. Or they can persevere with a system so poorly organized and planned that it may cost so much more and take so much more time to fix that its benefits will never equal its costs. Not surprisingly for such a large project, national prestige and macroeconomic factors may have more to do with the choice than any technical assessment. As Nigel Edwards, the Director of Policy for the NHS Confederation observed "There's a real hazard of doing [with the NPfIT] what we did with Concorde". The experience with the U.K. system gives U.S. observers nightmares. One part of the economic stimulus planned by the Obama administration is a huge investment in U.S. CHIT — by some accounts as much as US$ 60 billion. The claim is that the savings will pay for this investment. If the U.K. experience is any indication, the cost/benefit ratio is not likely to be favorable. More importantly, it is unlikely that the proposed U.S. system can be made to work even for US$ 60 billion. . ."

3.8.103. Secret computer deals that are costing the taxpayer billions (2 Feb 2008)

The Times

http://business.timesonline.co.uk/tol/business/industry_sectors/technology/article5636240.ece

"It is costing the taxpayer almost as much as the autumn bank bailout. But the huge amounts being spent by the Government on information technology — £16 billion this financial year — are barely noticed. With no central regulation by one ministry, civil servants enter into contracts worth billions with a few select companies. The details are protected by confidentiality agreements and periodic progress reviews in Whitehall are kept private, despite calls by MPs and anti-privacy campaigners for their disclosure. The cost of most large projects balloons. The Government admits that only about 30 per cent are completed on time and on budget. An investigation by The Times and Computer Weekly shows that the overrun of the largest IT projects totals £18.6 billion. Those include a controversial plan to computerise all NHS patients' records, originally estimated to cost £2.3 billion over three years but the cost of which has grown to £12.7 billion. Two companies have dropped out of the project, which is already four years behind schedule. Hospitals left with obsolete equipment have had to up-grade on their own. Yesterday Whitehall sources told The Times that the NHS programme, which aims to link more than 30,000 GPs to nearly 300 hospitals, would be reviewed. Non-foundation-trust hospitals would be allowed to opt out and buy from smaller providers. . ."

3.8.104. NPfIT software unsuited to mobile use (25 Feb 2009)

Kable

http://www.kablenet.com/kd.nsf/FrontpageRSS/CB612D3C2B25FDBE8025756800543CBE!OpenDocument

"Core National Programme for IT software 'has not been developed for a mobile environment', according to the NHS's chief technology officer. Dr Paul Jones, who works for the National Programme's controller NHS Connecting for Health, said that its applications could be connected and

integrated with mobile systems. However, some were not themselves able to run on the mobile devices increasingly used within healthcare. . . "

3.8.105. No NPfIT black box to be found (29 Apr 2009)

Computer Weekly

http://www.computerweekly.com/Articles/2009/04/29/235849/no-npfit-black-box-to-be-found.htm

"If the NHS IT scheme, the NPfIT, were a jumbo jet, its frequent crashes would have putfear-of-flying courses out of business. But because the NPfIT is not an aircraft crash, there is no wreckage. The damage is not visible. The Trust's undiagnosed, sick, or injured patients have been on a hidden waiting list,lost in the systems. As delays in their treatments are below the perception of the general public they don't seem to matter. The disorder we've highlighted this week at Barts and The London NHS Trust, a yearafter it went live with the NPfIT Cerner Millennium Care Records Service, is the most serious problem to afflict the national programme. The trust's managers are uncertain who among their patients have gone untreated within the government's 18-week target. They have been trying to reduce a waiting list of more than 2,100 patients on their 18-week waiting list. Some of the trust's patients have been discovered months after they should have been treated. When patients go untreated they are likely to get worse. Some might now be seriously ill because of the delays. We don't know. Worse, Barts does not know. Fortunately the NPfIT is not an aircraft crash. So there is nothing unsightly for the the TV cameras to broadcast across the world; there is no public clamour for information; no demand for the common causes of all the crashes to be quickly established. What there is, however, is the figure of NPfIT minister Ben Bradshaw, announcing that he and his advisers can see clearly now, and that the national programme is generally doing well. It should rollout more quickly, he says. But every time there is a crash Bradshaw is advised that the lessons have been learned from earlier failures and improvements have been made in the delivery model: trusts will be able to "localise" and "tailor" the Cerner system; and there will be closer working between clinicians and solution providers. He is told that there are always challenges with early adopters of complex IT solutions; they get over them; time heals. He is told that the Royal Free in Hampstead lost some patients on its waiting lists. But the London Acute Programme Board (no names are mentioned) now has confidence in the stability of the systems. But he is unlikely to have been told that doctors at the Royal Free continue to express their concerns to the board about the Care Records Service implementation. The result of ministerial complacency is that accident trouble-shooters now have clearance to drive to the next Care Records Service implementations in Kingston, Bath, Bristol, and to London's Imperial College and St George's. The patients at these hospitals should welcome, and benefit from, the influx of NPfIT experts. But if history counts for anything, they have every reason to fear them. . ."

3.8.106. NPfIT - the good and not so good (13 may 2009)

Computer Weekly - Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2009/05/npfit---the-good-and-not-so-go.html

Glyn Hayes, chairman of the Health Informatics Forum at the British Computer Society, gave a brief but frank assessment of NHS's National Programme for IT [NPfIT] at a Westminster forum this week. Hayes is leading a review of the NPfIT for the Conservative Party. With Guy Hains, President of CSC's European Group, Hayes spoke about the NPfIT to an audience of Parliamentarians, IT specialists, clinicians and others at the Conservative Technology Forum at Portcullis House, Westminster, on Monday evening. . . Hayes' speech in summary:

- The original vision of the NPfIT "is still ok"

- There have been many reviews of the NPfIT but no independent external review. That's one reason the - It's too early to judge the work of Christine Connelly, CIO at the Department of Health. There's a danger than when people move into the Department of Health they sometimes get lost.

- A framework contract called ASCC - Additional Supply Capability and Capacity" - has not been very successful for anybody so far. Smaller suppliers find it too bureaucratic and costly. Larger suppliers complain that the framework allows maverick companies into the national programme.

- There have been successes for the NPfIT but "I do slightly worry with some of the things they claim to be a success because I know the problems they are still having out there".

- There may be too much focus on the Summary Care Record which will make an extract of a patient record held by a GP available to the rest of the NHS. Hayes said that CfH is making a "great song and dance about that [the SCR] and yet I know there are a lot of problems with it, and I don't know how well they are being addressed".

- At the HC2009 Healthcare IT conference at Harrogate last month Martin Bellamy, head of CfH, spoke of learning the lessons from the go-live of the Cerner Millennium Care Records Service at the Royal Free hospital in Hampstead. Hayes said the "fairly disastrous implementation" was caused in part by staff being trained on a generic database. "The first time they saw the real system was when they went live".

- On the lessons from the Royal Free's implementation being learned, Hayes said: "I hope that's true. I have no knowledge to the contrary. I am worried that there were a couple of people from the Royal Free there [at Harrogate] who were saying that they still haven't learnt the lessons from the Royal Free. It's not all hunky-dory. In the end no doubt they will get there".

- The one system that will really benefit patients is e-prescribing, which some hospitals are installing. It will reduce medication errors which he said are killing hundreds of patients every year in the UK. "One of my pleas would be: let's not wait another four years for the roll-out [of e-prescribing]. We need electronic prescribing now. This IT is there to help patient care."

3.8.107. BMA leader calls for NPfIT to be scrapped (3 Jun 2009)

e-Health Insider

http://www.e-health-insider.com/news/4900/bma_leader_calls_for_npfit_to_be_scrapped

One of the leaders of the British Medical Association has described the NHS IT programme as "the worst case of planning blight across the NHS" and called for it to be ended. Speaking at the BMA's Consultants Conference, Dr Jonathan Fielden, chair of the BMA's Consultants Committee also said it was time for the health service to wean itself off failed, expensive government policies, commercial contracts and management consultants. "When MPs regain probity, regain trust, then perhaps they can join our crusade to further improve healthcare; until then don't stand in our way," said Dr Fielden. Earlier this week, the BMA launched a campaign to "save" the NHS from "commercialisation", saying it should remain "publicly funded, publicly provided, and publicly accountable." The campaign includes a website on which NHS staff can sign up to the campaign and contribute examples of market reforms that they feel have cost the NHS money or harmed patient care. At the Consultant's Conference, Dr Fielden said hugely wasteful Private Finance Initiative and Independent Sector Treatment Centre (ISTC) deals should be scrapped. He also that private management consultants should be "ditched" and that the health service would do much better to rely on the experience and expertise of its 1.2m staff. "Ditch the management consultants – when we have to tell them how primary care works, when we see them flogging our ideas there is immense frustration that we are not utilising the great talents across the NHS. We have 40,000 hospital consultants, 1.3 million employees, 250 'top leaders' - surely we can utilise the talent we have?" Dr Fielden said the value of electronic patient records had been established, but that the National Programme for IT in the NHS was taking too long to deliver them. "At what stage do we cut loose from this spiralling disaster?" he asked. "It is thwarting local chances to move forward; the worst case of planning blight across the NHS. Let's free hospitals to move forward. Keep the 'national electronic super-highway' but free trusts to go their own way. It will be faster; it will deliver for patients, meet the needs of clinicians and produce another massive saving." Dr Fielden also argued that the BMA's Look After our NHS campaign was vital given the growing public sector funding crisis that is set to trigger cuts and savings in the health service. "For the first time in working memory, we may see real cuts in health spending," he said. "This will provoke some stark choices: what is kept, what is cut, what can the NHS afford? Let's ensure that it's doctors making those difficult decisions in partnership with our patients and healthcare colleagues, not faceless bureaucrats, accountants, and those out to fleece the taxpayer."

3.8.108. Tories plan localised NHS IT (9 Jun 2009)

Kable

http://www.kable.co.uk/publishing-procurement

A Conservative government would allow trusts to choose their own IT systems, according to Stephen O'Brien, the shadow health minister. O'Brien, speaking at Smart Healthcare Live on 9 June 2009, said

centralised procurement in the NHS was at its most damaging when it came to IT. "Since its inception in 2002, the National Programme for IT has stalled time and time again as a result of its centralised procurement strategy," he told attendees. "The National Programme for IT embodies the price to be paid for careless procurement," he added, both in its financial cost and in "the opportunity cost of lost lives, improved healthcare and well-being [which] is literally countless". O'Brien added that NPfIT systems are often inappropriate for specific trusts. "It cannot be right, for example, that a teaching hospital is expected to use the same system as a district hospital," he said. "In contrast to this one-size fits all strategy, a localised approach to NHS IT can enable trusts to be given a choice of information systems," he said. "Local choice can equip trusts to meet the needs of their patients and staff." O'Brien said the independent report he had commissioned on NHS IT has been delivered, and this will be published over the summer. He said it will be used by the Conservative Party in forming its policies on NHS IT, and he hoped other parties would also draw on it. "I can assure you that it is a rigorous, extensive and authoritative document that will address many of the issues we are discussing today, and propose alternative solutions to the current set up of the National Programme for IT," he said, although declining to provide any details. In response to a question, O'Brien said that there would be a need for national standards for NHS data, but said it made most sense for datasets to be controlled locally by those responsible for providing care to patients.

3.8.109. NPfIT failed nine Gateway Reviews (19 Jun 2009)

Kable

http://www.kable.co.uk/npfit-gateway-reviews-19jun09

Nearly one third of the National Programme for IT's Gateway Reviews until 2007 produced a red status demand for immediate remedial action. Of 31 reviews produced by the Treasury's Office of Government Commerce and released under the Freedom of Information Act on 18 June 2009, nine had a red status, meaning "To achieve success the project should take action immediately." NHS Connecting for Health said the reviews, which have previously been confidential, comprise all of those prepared between 2002-07. One red review, a 'gateway 0' strategic assessment of the whole National Programme released in November 2004, recorded great progress on procurement, which it credited to a large extent to then head Richard Granger. But it warned of "suspicion and cynicism of the National Programme" urgently requiring a more open approach. It concluded: "Despite the good progress on procurement, the current lack of engagement with the hearts and minds of the staff within the NHS at all levels, the lack of a coherent benefits realisation strategy and the absence of clarity regarding the organisational structure that will address these problems means that the overall status of the National Programme is red." The reviews released include 19 with an amber status, denoting the project in question should proceed but take notice of the OGC's recommendations. Just two reviews had a green status, showing the OGC felt the project was on target to succeed, both covering the N3 network. One, a strategic review of the whole programme dating from 2002, did not allocate a traffic light status. The red rated reviews covered two areas of the programme twice: Choose & Book, in 2002 and 2005, which received amber reviews in 2003 and 2004, and the state of the programme in London, in 2004 and 2005. The OGC also issued red reviews of the Southern region in 2004, the North-West in 2005, the Care Records Service in 2002 and Electronic Transmission of Prescriptions in 2004. In a statement, NHS Connecting for Health said that the reviews had taken place to highlight problems, and "were therefore deliberately critical and focused on problems," although they also found positive aspects. "We welcomed the report from the Public Accounts Committee in January this year and its acknowledgment of what has been successfully delivered," it said, adding that the delays in some areas are regrettable, while pointing out that this has also delayed payments to suppliers. "The Department of Health's Director General for Informatics has recently made clear that if significant progress is not achieved by the end of November 2009, a new approach may need to be adopted," it added, referring to Christine Connolly's speech at HC2009 in May.

3.8.110. Scrap big government IT: think tank (30 Jun 2009)

e-Health Insider

http://www.e-health-insider.com/news/4981/scrap_big_government_it:_think_tank

"A right-wing think tank has called for more open standards and open source development in IT, arguing this could lead to savings of 50% on government IT expenditure. A paper published by the Centre for Policy Studies - It's ours. Why we, not the government own our data - dismisses the government's Transformational Government strategy as disappointing, staggeringly unsuccessful and

completely at odds with what citizens need. It argues that instead of continuing with its centralised and "failing" IT projects, government should hand control of personal information back to individuals, so they can use it on a voluntary basis to transact with public services. . . It argues that individuals could use services such as Microsoft HealthVault or Google Health to store their health records and to communicate with their GP or Hospital, eliminating the need for "the NHS database". It states: "If services such as HealthVault had already existed, there would be no need whatsoever for the UK government to spend anything like £12 billion building its own centralised medical system." Apart from being intrusive, the paper argues that the government's approach has made it reliant on a "handful of IT suppliers". It describes this as "peculiar" and "dangerous" and asserts that 60% of spending is in the hands of just nine companies. The suppliers listed include the two remaining local service providers to the National Programme for IT in the NHS, CSC and BT. "One of the many dangers of awarding these sizes of contract is that when things go wrong, they can drag on for years, at great expense," the report says. As an alternative to large suppliers, the think-tank promotes cloud computing as a simple and effective platform for users to access the computing services they need. "Cloud computing systems, provided by third parties other than government will enable us to choose where to store our personal information, such as medical records," it argues. "All government departments will no longer need to procure and own all IT infrastructures itself, or to pay an outsourced company to do so. The market is now providing the IT systems needed for government systems, which are better centred on the needs of public service users rather than in government as a fumbling middleman." The paper calculates that the government's IT provision of £16.5 billion this year is the equivalent to £700 for every house hold across the country. Yet it calculates that of all the IT projects that the government invests in, only 30% succeed."

3.8.111. Docs call for clinical review of NPfIT (3 Jul 2009)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/4995/docs_call_for_clinical_review_of_npfit

Doctors have voted for a clinically-led review of the National Programme for IT in the NHS and called on the British Medical Association to campaign for local IT solutions. The BMA's annual representative meeting in Liverpool supported calls for an independent review, for NHS Connecting for Health to release money for local clinical system purchase and for it to concentrate on developing specialty professional standard clinical datasets. Dr Gordon Matthews, a consultant orthopaedic surgeon at Buckinghamshire Hospitals NHS Trust, told the ARM that doctors at his trust were still having difficulties with Cerner's Millenium system three years after its installation. He added: "Since the NCRS went live our trust has been unable to collect electronic data on surgical complications or outcomes other than death; and I'm informed it's not possible to re-programme Cerner Millenium. We are now struggling to install a piecemeal system to run in parallel with CRS to provide some clinically useful data." He said a review led by clinicians was essential to ensure the NHS got the clinical solutions it needed.

Dr Paul Flynn from the BMA's Central Consultants and Specialists Committee said he had been brought in to help doctors at the Royal Free Hospital in London following the implementation of Cerner Millenium.nHe told the meeting: "I saw doctors who were enthusiasts for IT turning to complete despair. I have seen doctors almost in tears because of how frustrated they are at being prevented from doing their jobs by the IT system." Dr Deidre Hine, chair of the BMA's Working Party on IT, told the meeting that the BMA was already insisting on a clinically led review in its discussions with the Department of Health. In a debate on data sharing and confidentiality, representatives backed calls from GPs for an opt-in approach to the transfer of patient identifiable data. They also condemned the government for its failed attempts to make data sharing easier through clause 152 of the Coroners and Justice Bill, which was eventually dropped by justice secretary Jack Straw. Dr Gill Beck from the Buckinghamshire division congratulated the BMA for its part in stopping the move but said the BMA needed to continue to fight to protect patient confidentiality. "This potential access to 50m medical records remains extraordinarily tempting for the surveillance-obsessed UK government that we have got, and they have a proven track record for reneging on their promises," she added. Dr Grant Ingrams, co-chair of the Joint IT Committee of the Royal College of GPs and the BMA's GP committee, told the conference he was being asked for advice from GPs on almost a daily basis about request for access to patient data. "Sometimes these requests are legitimate but more often than not the proposed extraction is unlawful and totally inappropriate," he said. However, professor Michael Rees from the BMA's Medical Academics Staff Committee, warned an opt-in might have a detrimental effect on legitimate research. He said: "If we are going to go for a full opt-in system, then we have to be in a position to

discuss the issues with patients. If we haven't got the time to do that and patients automatically opt out of research then we will be doing a great disservice to our patients." However, Dr Ingrams said he did not believe an opt-in approach was inconsistent with research. He also disagreed with an A&E consultant who said an opt-in might lead patients to withhold vital information, while unconscious patients would not be able to give their consent. Dr Ingrams added: "Patients should have the right to make poor decisions and just because you're unconscious doesn't mean you shouldn't still have a right to privacy." . . .

3.8.112. End the vanity projects (5 Aug 2009)

Smart Healthcare

http://www.smarthealthcare.com/norman-lamb-liberal-democrats-national-programme-05aug09

We would replace white elephant national schemes with targeted work to improve the patient-doctor relationship. The NHS IT programme has come to symbolise all that is wrong with the way that Labour has dealt with the NHS. Billions of pounds have been spent on building a shiny, high-tech and highly centralised system with little time devoted to thinking about what the aims of the project were. The result is a system which is over-budget, behind schedule and below specification. The 2006 National Audit Office report into progress in the NHS National IT hit the nail on the head: the government seems to have failed on nearly every count when it comes to building the IT system the NHS needs. It failed to negotiate effectively with suppliers, engage with NHS organisations and win the support of staff and the public. This has helped create a system which not only doesn't work but isn't really wanted by anyone except a small group of mandarins in Whitehall. Changing this state of affairs is going to require a radical rethink. I believe that one of the first things we need to do is banish the idea of huge national schemes. Successive governments have fallen for the charms of smooth talking management consultants and IT salesmen who have waxed lyrical about the potential savings and efficiencies of bespoke software packages and complex databases. Time and time again the British public have ended up paying for overly complex vanity projects which habitually under-deliver at greatly inflated prices. The great shame of the NHS IT programme is that instead of learning from past mistakes, the government seems to have set out to raise the bar when it comes to wasteful expenditure. Instead of thinking about how national programmes can transform the NHS, we need to be much more realistic about what we are trying to achieve. IT has revolutionised how we work and when it works well in the NHS it has an excellent track record of improving patient care and workplace efficiency. All too often though the various sections of the National Programme for IT have failed to do this – either because the goals were not well thought out or because nobody really knew what they were being asked to do. A great example of this is 'Choose and Book' - or 'Confuse and Book' as one of my colleagues christened it. What started out as an attempt to develop a simple booking tool has morphed into a system which regularly denies people the choices which it was meant to give them. . . We need to engage clinicians from the commissioning stage onwards rather than trying to engage them after the system has already been commissioned - doctors I know who are trying to implement the new NHS IT system have complained that they are now trying to tailor the system to their needs rather than having a system designed to service them. Given that clinicians are the ones who will work with these programs every day, we need to listen to what they have to say. The proposals that the Conservatives have hinted at, about a localised system of IT commissioning, are a positive beginning and I welcome their belated conversion to the concept of localism. However, I believe that both Labour and the Conservatives are missing the point about what IT can do for the NHS and the role it should play. As a Liberal I believe that one of the key criteria for measuring the success of a programme can be found in measuring how it improves interaction with the system. In its current monolithic form, the National Programme for IT is having a negative impact on patients and the NHS. It has led to restricted access to appointments, exposed confidential patient data to abuse and diverted resources away from frontline care into white elephant schemes. When we look at developing IT schemes in the future, we should not be looking at ways to build the NHS around an IT system, we should be looking at how IT can help improve patient care and improve the efficiency of the system. . .

3.8.113. Conservatives to 'dismantle' NPfIT (10 Aug 2009)

e-Health Insider

http://www.ehiprimarycare.com/news/5107/conservatives_to_%E2%80%98dismantle%E2%80%99_npfit

The Conservatives have promised to "dismantle Labour's central NHS IT infrastructure" and instead move to a choice of local accredited patient record and clinical systems. Following the publication of an independent review of NHS IT the Conservative party pledged to abolish the NHS national database of electronic patient records, but then say firms - including Google and Microsoft - be allowed to host patient controlled records accessed online. As a first step they promise to "Halt and renegotiate the contracts Labour have signed for IT service providers to prevent further inefficiencies." The commitment raises the prospect of an incoming Tory government becoming embroiled in legal disputes with BT and CSC, the two main IT firms that hold local service provider (LSP) contracts. The government has been locked in legal dispute with Fujitsu since terminating its LSP contract in April 2008. The Conservatives say the NHS National Programme for IT has proved bureaucratic and been plagued with delays and cost overruns and proved hugely disruptive to the NHS. They promise reform focused on local choice of systems, and pledge they will deliver cost savings from the £12.7 billion IT project. The Conservatives say that in Government they would "stop imposing central IT systems on the NHS" and instead "allow healthcare providers to use and develop the IT they have already purchased and developed, within a rigorous framework of interoperability". As part of a new approach use of open source across the public sector will be given a new priority. Taken together the Conservatives say the measures "will deliver huge cost savings and ensure that NHS IT is geared towards the needs and wishes of patients". Dr Glyn Hayes, chair of the review, said: "The review makes clear that NHS IT will only succeed in improving patient care if information is held locally and centred on the patient." Speaking on Sunday Shadow Health Secretary Andrew Lansley outlined new proposals to allow NHS patients access to their records online would give people "greater control over their own health care". Firms such as Google or Microsoft, both of which are developing personal health records, could host such patient controlled records, enabling users could update their medical records with information like blood pressure and cholesterol levels, he added. Patient records should be stored locally rather than on a national database, with the capability of transferring the information when necessary. The Tories say that buying such PHR systems "off the shelf" instead of developing them at taxpayers' expense would mean that personalised records system could be delivered at "little or no cost to the taxpayer".

3.8.114. NHS computerisation: lessons from what the bosses never learned (12 Aug 2009)

The Guardian

http://www.guardian.co.uk/technology/2009/aug/12/nhs-computerisation-independent-report

As the song goes, a man hears what he wants to hear and disregards the rest. Of all the indictments in the Conservative-sponsored independent review of the NHS's £12bn computerisation programme, the most damning may be its account of the way that the programme's originators wilfully disregarded painfully acquired wisdom. The new study, led by the healthcare informatics veteran Dr Glyn Hayes, observes that the National Programme for IT followed closely on the heels of two important reports. The first was on a series of IT pilot projects at 19 NHS demonstrator sites between 2000 and 2003. That programme, called ERDIP, tested the technical and ethical boundaries of creating community-scale electronic health records. You would have expected the national programme to absorb and build on this work, rather as the Apollo moon programme learned from the Gemini programme about manoeuvring spacecraft in orbit. Instead, ERDIP was airbrushed from history. The independent review finds it "extraordinary that the ERDIP recommendations were largely ignored". The reason, of course, was that the ERDIP findings were inconvenient. The evaluations stressed the need for closely involving system users - and patients - in the design of electronic records, and for introducing IT as part of improvements to patient care, not as an end in itself. This implied that the national programme's massive scale and gung-ho timetable were unrealistic. To return to the space example, it's as if the Gemini programme had concluded that many more years of work was needed before spacecraft docking became a realistic proposition. Even in the go-go 1960s, Nasa would have paused for thought. The NHS could dismiss inconvenient criticisms and, in the national programme's early years, it was doing its best to control the flow of information about its IT projects. Executives deployed "commercial confidentiality", misleading press releases (including one covertly modified after publication) and even the threat of legal action to deter critics. Which leads me to the second fount of wisdom ignored by the NHS chiefs. Hayes's review calls attention to a study called The Challenges of Complex IT Projects, published in April 2004 by the Royal Academy of Engineering and the British Computer Society. This identified a series of reasons why large-scale public sector IT projects tend to go wrong, and suggested steps to mitigate the risks. Again, it stressed the need for closely involving users in development, rather than foisting systems upon them. Again, the findings were ignored: the

NHS tried to impose remotely procured standard systems. Hayes's review says that "in an ideal world", the ERDIP and Complex IT Projects reports would already have been heeded. However, "since they have been largely neglected, it is important that they play their part in this review and, where there is still scope for redirection, shape future developments". I can go one better than that. Almost unnoticed outside the specialist press, the institutions behind the Complex IT Projects report published a follow-up last month, calling for the adoption of engineering values in IT. Predictably, this means putting a professional engineer in charge. But it also means building large systems in incremental steps from firm foundations, without tolerating the level of software error that is the norm in many commercial products. Most significantly, the report notes a distinguishing characteristic of engineering: that, "when a major failure occurs, the root causes are investigated, and the lessons are learned by the whole profession". However inconvenient those lessons may be. If we take only one message from the spate of investigations into the NHS's foray into large-scale computerisation, let it be that one.

3.8.115. Hospital CIOs find local remedies for IT headaches (3 Sep 2009)

Computing

http://www.computing.co.uk/computing/analysis/2248832/hospital-cios-find-local-4800501

Health service IT leaders are finding their own solutions to shortcomings in the NHS National Programme for IT. One of the common criticisms of the £12.7bn NHS National Programme for IT (NPfIT) has been that its centralised nature stifles innovation and creativity among IT leaders in the health service. The top-down approach to the UK's biggest IT project has angered many within the NHS. Hospital and health authority chief information officers (CIOs) felt they were being told how to do their job by Whitehall bureaucrats with little coalface experience. Some experts felt the solutions being imposed were so inadequate as to jeopardise the reputation of the whole programme. CIOs were being told what software to buy, how to implement it, and how to train staff, leading to many being alienated by the programme. But in recent years, NHS IT leaders have found ways to work around these challenges. Computing met with several of them at a roundtable organised by health vendor Simpl last month. Great Ormond Street has looked to introduce non-health-specific IT systems that would centre care around patient participation, according to David Bowen, programme manager at the world-famous children's hospital. "We're looking at business process management and enterprise communication platforms. That's the sort of thing that can open up our systems to effective teamwork where your role is dictated on your competencies, not what your systems are closing you off from on an architectural level," he said. "Part of the problem with the National Programme is that it is database focused, it's not about process." The sharing of health records is a problem for NPfIT and it has been slow in developing policy, sometimes leaving NHS trusts to take the lead. Though sharing is beneficial, many clinicians only want to see relevant information, complicating any central sharing model. According to Ian Herbert, until recently a senior consultant working for the NHS on NPfIT, Liverpool Primary Care Trust could not wait for central guidance and took matters into its own hands. "The trust worked with [suppliers] EMIS and Vision 360 and together they made electronic records, with the patient's consent, available in all unscheduled care situations," he said. "They also use it in the medical admissions unit and two other places in the hospital. It's crude in the sense that you see the lot but the evidence is it has been well received by clinical staff and patients alike." The model is successful because it has been built from the bottom up with the consent of all involved, and NPfIT would do well to take note, said Herbert. . .

3.8.116. Special Report: Andy Burnham's unhealthy diagnosis for NHS IT (14 Dec 2009)

PublicTechnology.net

http://www.publictechnology.net/modules.php?op=modload&name=News&file=article&sid=22108

It's entirely typical of the NHS National Programme for IT (NPfIT) that even the prospects of scaling it back should end in confusion, disarray and a rather meaningless gesture. Once proudly spoken of by Prime Minister Tony Blair as the biggest civil IT project in the world, NPfIT has come to represent all that is wrong with public sector computing. The errors and mistakes pile up one by one: from the dark days of former CIO Richard Granger taunting suppliers to metaphorically 'come and have a go if you think you're hard enough' through the shocking fact that the Lorenzo care records have only 174 regular users to the Kafka-esque defence from Whitehall that the project is well under its £12.7 billion budget, but only because it's so far behind schedule that payments haven't had to be made to suppliers! Last weekend it seemed as though the death knell might finally be sounding as Chancellor Alistair

Darling popped up on The Andrew Marr Show to call for cuts to the project, declaring that it is not a front line priority at this time. Well, maybe not from the point of view of the Treasury which sees the NHS programme as a cost encumbrance that would be a politically useful item to cut back on. But the Department of Health clearly has other ideas. After all, this is its flagship IT project, the biggest civil IT project in etc etc etc. So it's going to take more than Alistair Darling pre-announcing cutbacks to put a stop to that. When Health Secretary Andy Durham made a statement to the House of Commons he made that perfectly clear when he ignored Darling's assertion that the Programme was not front line critical and proceeded to sing its praises while lightly scarping £600 million from the (current) budget over four years. So what's going on? Is it a turf war? Will the DoH hang on in there until a possible Conservative administration slams the brakes on? Or will Darling's Treasury team manage to wrest sufficient control away from the DoH to make some significant cut backs that will actually made a serious impact? For his part, Burnham leaves little room for hope of any compromise. He began his statement with a fulsome backing of the Programme. "I want to begin by challenging the myth put around that the NHS IT Programme has been a waste," he declared. "The programme has changed the way in which the Government pay for IT by creating a contract whereby we pay for what we get from suppliers only when it is fully delivered. Indeed, we have been praised by the National Audit Office for creating such a contract." This is entirely correct. But it conveniently overlooks other damning reports on the progress (or lack of) and the (mis) management of the scheme from other bodies, including the Parliamentary Accounts Committee. And the praise from the NAO is more about the fact that the contract terms mean that less money has been wasted so far than might otherwise have been – hardly the universal and unconditional approval that Burnham implies. But he ploughed on regardless. "To put it simply, the Programme is a key part of delivering modern, safe, joined-up health care. It is supporting the ongoing reform of the NHS by giving choice and convenience to patients. The NHS could not function without it," he claimed – although it seems to have gone about the business of looking after the sick and poorly relatively well for over 50 years without a grandiose IT scheme to help it. This is a misrepresentation of what the Programme was set up to do which was to do better all the things the NHS needs IT for, not to enable them. For example, being able to share medical records via the Spine network is laudable in ambition, but it was already possible just by using basic email! . . . The overall suspicion has to be that the DoH is now so committed to a mess of its own making that it can't back out. It was Tony Blair who was so carried away by the "modernity" of it all that he kicked off the idea of the National Programme, but nothing was commissioned back then without the Chancellor's sign-off. That was Gordon Brown so the chances of there being any admission of error there is non-existent. The only way that the NHS scheme is likely to be seriously overhauled now will be as a result of a change of government – with both the Tories and Liberal Democrats committed to either substantial changes or outright cancellation. But it won't be happening on Andy Burnham's watch where this sickest of all government IT projects is still being given a healthy prognosis despite its terminal condition. . .

3.8.117. Electronic records are less efficient than paper, finds DH research lead (14 Dec 2009)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4124614&c=2

A leading academic has dealt a major blow to the Government's embattled electronic patient record rollout, after publishing a major global study claiming systems of its kind hamper rather than improve clinical care. Professor Trisha Greenhalgh, professor of primary healthcare at University College London, led a review of hundreds of previous studies from all over the world, which found that large systems such as that being developed by Connecting for Health, are less efficient than locally-based systems and often less useful than paper records. Professor Greenhalgh's research will come as a particular body blow as she is heading up the ongoing UCL study commissioned by the DH into the effectiveness of the patient electronic care record rollout. The study, which began in 2007, is published today and is the second major blow to the project in the past few months. The Government has pledged to slash £5bn from its budget by 2012-13 by measures including cutting back the NHS IT Programme and Tories are already planning to contract a string of NHS IT systems out to private providers. Despite this, the patient electronic care record rollout is about to embark on its next big phase in January, when millions of patients across London will be given three months to opt out, or have records automatically created. But the study published today, in the US journal Milbank Quarterly, identifies what the researchers claim are 'fundamental' problems with the design of such systems, finding that:

* While secondary work like audit and billing may be made more efficient by electronic patient records, primary clinical work can be made less efficient;

* Paper, far from being technologically obsolete, can offer greater flexibility for many aspects of clinical work than the types of electronic record currently available;

* Smaller, more local EPR systems appear to be more efficient and effective than larger ones in many situations and settings;

* Seamless integration between different EPR systems is unlikely ever to happen.

Professor Greenhalgh said: 'EPRs are often depicted as the cornerstone of a modern health service. According to many policy documents and political speeches, they will make healthcare better, safer, cheaper and more integrated. Implementing them will make lost records, duplication of effort, mistaken identity and drug administration errors a thing of the past. Yet clinicians and managers the world over struggle to implement EPR systems. Depressingly, outside the world of the carefully-controlled trial, between 50 and 80 per cent of EPR projects fail - and the larger the project, the more likely it is to fail. Our results suggest it is time for researchers and policymakers to move beyond simplistic, technology-push models and consider how to capture the messiness and unpredictability of the real world.' An interim report in September from Professor Greenhalgh's ongoing study for the DH already found next to no evidence the record had produced any improvement in care in the areas in which it had been rolled. It found the record was likely to make a limited contribution to A&E care, was plagued by IT problems and often failed to work in out-of-hours care.

[The full report is currently freely available at http://www.milbank.org/quarterly/8704feat.html]

3.8.118. Tories suggest new NHS IT approach (5 Jan 2010)

PublicService.com

http://www.publicservice.co.uk/news_story.asp?id=11729

The Conservatives have proposed an "information revolution" in the NHS, giving patients more control over their own personal data and a greater access to performance data. Publishing its draft manifesto for the NHS, the Conservatives said if elected they would make much more detailed data available for patients to make more informed choices. Detailed data about the performance of trusts, hospitals, GPs, doctors and other staff will be made available to the public online, the manifesto said, so the public can surmise who is providing a good or bad service. Following this, the party said it would create an NHS where patients "are in the driving seat". In terms of the National Programme for IT (NPfIT), which the Tories have promised to change on a huge scale, the manifesto said patients would be put in charge of their own health records. This new power over their personal data would allow patients to choose which providers they share it with, the party said. Writing the foreword for the manifesto, Conservative leader David Cameron said it was time for "massive change". "In the post-bureaucratic age people expect to be in control of their lives, not have their lives controlled for them by distant politicians and bureaucrats. We need a shift in power from the political elite to the man and woman in the street, through decentralising power, introducing a strong line of democratic accountability, and bringing in a new era of transparency to government," he said.

3.8.119. Lib Dems to take the axe to the NPfIT (4 Feb 2010)

PublicService.co.uk

http://www.publicservice.co.uk/news_story.asp?id=12066

A Liberal Democrat policy blueprint on the NHS has proposed severe cuts to the National Programme for IT (NPfIT). The policy document, published by the party's shadow health spokesman Norman Lamb, has proposed scrapping the Care Records Service (CRS), reducing the scope of the troubled Choose and Book scheme and shutting down Connecting for Health (CfH) – the organisation overseeing the NPfIT's implementation. Its proposals in general all point towards removing central control over IT systems. More specifically, the document called for CRS's abandonment as it is four years late, has encountered enormous technical challenges and has raised serious concerns over the confidentiality of patient records. "Most fundamentally, the clinical and business case has still not been satisfactorily made for establishing a national database," the document said. Turning its attention to the Choose and Book service, the document said it should be scaled back after the government's late changes caused serious technical difficulties. "The Choose and Book programme has caused enormous

frustration for doctors and patients. It was originally designed as an electronic appointments booking system but was later converted into a central element of the government's commitment to offering patients a choice of hospital – in theory enabling the GP and patient to book an appointment online choosing from a list of hospitals. The introduction of this system fatally lacked clinical engagement and, like the CRS, has been blighted by technical problems," the document said. Reaffirming its commitment to removing the central control of IT, the document added that CfH must also be scrapped. Remaining responsibilities would then presumably be shared between local trusts and the Department of Health. "The strategy for the future should be based on local connectivity between primary and secondary health care and social care," the document said. Citing a recent report, the document highlighted the case for building from the bottom up and engaging with both clinicians and patients. This approach would make managers and clinicians accountable and engaged in the development of IT, it said, and would encourage small and medium-sized IT companies to contribute.

3.8.120. Minister to sign new NPfIT deals before General Election? (2 Mar 2010)

Computer Weekly

http://www.computerweekly.com/Articles/2010/03/02/240457/minister-to-sign-new-npfit-deals-before-general-election.htm

Health officials are seeking urgently to sign deals with the two main suppliers to the NHS scheme, which would commit the next government to about £3bn of spending on the troubled National Programme for IT, Computer Weekly has learned. New deals could frustrate plans by the Conservatives, if they win the coming general election, to halt and renegotiate contracts with the two NPfIT local service providers CSC and BT. Whitehall officials aim to sign a memorandum of understanding with CSC and BT by the end of this month, which would commit the next government to a new schedule of NPfIT software deliveries and electronic patient record installations at NHS sites. A legally-binding memorandum of understanding with each supplier would keep the NPfIT alive, after the Chancellor Alistair Darling told the BBC's Andrew Marr programme in December 2009 that the NHS IT scheme was not essential to the frontline. New deals would also refresh the NPfIT contracts, large parts of which are no longer relevant. Delays in the delivery of software, and changes in the NHS, mean that the original contract's timetables and schedules for software functionality are obsolescent. The NPfIT minister Mike O'Brien has confirmed to BBC R4's File on Four programme - in a broadcast this evening - that his officials aim to sign new deals by the end of March. O'Brien said: "We are certainly looking for a memorandum of understanding by the end of March if we can get that." O'Brien said he could not suspend negotiations and stop the work of government just because there is a general election approaching. The minister said his officials are in negotiation with suppliers to save £600m from the costs of the NPfIT. When asked by File on 4 whether he was trying to sew up a deal by the end of March to tie the hands of the next government by giving new contracts, O'Brien said: "No. What we are seeking to do is negotiate with the industry to achieve savings of £600m. Now these savings would be over the lifetime of the programme, up to 2016." The BBC put it to O'Brien that the Conservatives are worried that a new deal would commit them to contracts they may wish to cancel. O'Brien said: "No. What they are right to want to do is ensure that the savings that we promise are actually delivered, and we are discussing that with the various companies concerned we want to focus on the core elements of the programme that have been identified as critical by clinicians you know there's a sort of party political knock-about around this to some extent. "We need to get beyond that I'm certainly not going to get into a situation where because we're approaching a general election that the whole of government stops and we can't make any contracts with suppliers of key NHS equipment. That would be complete nonsense." O'Brien - and the Conservative Shadow health minister Stephen O'Brien - have said that NHS trusts will have a choice of systems within the framework of the local service provider contracts. This could mean that Cerner and iSoft lose their status as the main software offerings to NHS trusts in England.

3.8.121. What the next Government should do about the NPfIT (3 Mar 2010)

Computer Weekly - Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2010/03/what-should-the-next-governmen.html

Tom Brooks, who spoke about NHS IT on last night's BBC R4 File on 4 broadcast, has let me have his suggestions on what the next government should do about the NPfIT. Brooks, a much-respected figure in health IT, writes:

The next Secretary of State for Health would be well advised to apply what is often known as the Harvard TEAMS test.

T - Is the proposal Technically sound or even feasible?

There have been major technical doubts expressed since the scheme's inception. The new Minister should pick up the phone to Martyn Thomas and request him to form a professorial team to report on the technical issues. The rejection by Ministers and the Parliamentary Select Committee of his offer a few years ago to conduct such a study is felt by many to have cost the taxpayer as much as a £1bn

E - Does the scheme make Economic sense?

The Treasury spokesman, Mr Mortimer, told the Public Accounts Committee that the Treasury did not believe there should be an overall business for the NHS IT programme. The Treasury got it wrong. In November 1999, the NHS National programme was five years away and was going to cost £1bn.Now, for the same objective, it is still five years away and is going to cost £12bn. The new Minister should require a national NHS IT business case to be produced and published as a matter of urgency.

A - Is Accountability aligned with responsibility?

Currently, very few Trusts have direct contracts of consequence with the Local Service Providers (LSPs). Contracts are held centrally, and suppliers are accountable to the Secretary of State. But the cost of poor implementations is felt locally by the Trusts. The new Minister should first suspend all new work under the contracts, and then announce a termination date for all contracts that are not for genuine national purposes, such as N3 and Choose & Book. Trusts that wish to continue to use LSP services can contract for them locally and ensure that they provide value for money.

M - Are the Management arrangements sound and has the Management deployed been competent?

There are many areas of deficiency and even more questions. One perhaps is the anomaly disclosed in recent Parliamentary Questions. Why, in the three northern LSP areas, had less than £500,000 been paid to the LSP on Lorenzo deployment (set-up) activity and service charge (running cost) payments, while the total payment to the LSP in the Northern three areas had already exceeded £780m? What has the management in the centre and the northern SHAs spent the £780m on if not on Lorenzo? The new Minister should transfer to local Trust posts at least half of all central and SHA IT management, thereby slimming down the expensive centralised bureaucracy, whose achievement record is suspect.

S - Are the arrangements Statutorily compliant?

The Opposition believes that the present Government policies for NHS IT are flawed. Severe doubts exist over the arrangements for patient privacy and data protection, over responsibility for inaccurate patient data and the liability for errors arising from reliance upon it. Questions are asked about Monitor's apparent failure to vigorously defend the freedom of foundation trusts from SHA 'interference' and its role in the present sorry national NHS IT state of affairs. Views have been expressed recommending that the Darzi 'Five' requirements for implementation by April 2010, but whose delivery has not been achieved by most Trusts, should now be put on a statutory duty basis. Policy is unclear. The new Minister should abandon the national centralised patient data objective for NPfIT and would be well advised to adopt the principal Obama objective of "replacing all paper records by electronic ones for each practitioner" as a sufficient challenge for NHS IT during this decade, with its expectation of tight financial constraints and over-stretched NHS management and clinical staff.

3.8.122. Delays with £12.7bn NHS software program bring it close to collapse (21 Mar 2010)

The Guardian

http://editthis.info/nhs_it_info/?title=General_Warnings_and_Advice&action=edit&section=121

The government's ailing £12.7bn IT programme to overhaul paper-based NHS patient records in England is close to imploding, potentially triggering a deluge of legal claims against the taxpayer running into billions of pounds, which could start to emerge weeks before a general election. The Guardian has discovered that mounting chaos and delays in installing core care records systems across the country is reaching a tipping point, with intense political pressure from Whitehall now falling on Morecambe Bay NHS Trust and a software "go-live" deadline set for the end of this month. Morecambe Bay is intended to be the first acute trust to take a new patient administration software

package called Lorenzo, which has been delayed for four years. After a string of missed deadlines, the Department of Health set a deadline of March 2010 for Lorenzo last April. "If we don't see significant progress... then we will move to a new plan for delivering infomatics in healthcare," Christine Connelly, the Department of Health's director general of IT, said at the time. Preparatory testing at Morecambe Bay is believed to have failed some weeks ago, though iSoft, the firm behind Lorenzo, last week insisted testing was "on track" and dismissed as "media speculation" suggestions that the deadline was in jeopardy. If Lorenzo is not running smoothly at Morecambe Bay in the next two weeks it will send financial shockwaves throughout Labour's National Programme for IT, potentially forcing profits warnings from iSoft and others. It will also be devastating for the Department of Health, which is locked in frantic contract renegotiations with contractors to keep the project alive. . . Failure at Morecambe Bay could see the largest regional contractor on the 10-year programme, US outsourcing firm Computer Sciences Corporation (CSC), come under renewed pressure to book heavy provisions against the value of three £1bn NHS contracts - a move likely to send the group's share price tumbling. It would also be bad news for iSoft, the Australian firm formerly called IBA Health, which in 2007 acquired crisis-stricken iSoft plc, the British firm behind Lorenzo, and took its name. It has told investors: "iSoft expects the milestone at Morecambe Bay to be met according to the timetable agreed between its partner CSC and the NHS, and expects this achievement to trigger a cash payment to the company." A Morecambe Bay delay could also push mounting tensions between the Department of Health and CSC into the hands of lawyers, as a squabble breaks out over who should foot the bill for seven years of underperformance since the National Programme contracts were signed in 2003. The government is already facing a reported £700m legal dispute with CSC's fellow regional contractor Fujitsu after the Japanese consultancy firm walked away from a £1bn contract to supply and install IT systems at NHS trusts across the South of England and the West Country three years ago. If CSC, an $11bn (£7.3bn) Virginia-based group listed on the New York stock exchange, were to enter into a parallel legal battle, it would leave 80% of care records IT contracts - the heart of the National Programme - in the hands of lawyers. After the departure of Fujitsu, and Accenture a year earlier, the only remaining regional contractor aside from CSC is BT, responsible for the London area. It was forced last year to wipe between half and 70% from the value of its £1bn contract with NHS London because of delays and software failings. . . As the National Programme moves into its seventh year, the Department of Health and regional contractors are trying to thrash out a back-room compromise over how to apportion the bill for an army of IT workers who have failed to deliver - particularly on patient administration systems such as Lorenzo at acute hospitals, the most costly element of the National Programme. The government has offered to slash the functionality requirements for Lorenzo as well as reduce the number of acute trusts into which CSC must install the software. . .

3.8.123. Rotherham: NPfIT has put us back 10 yrs (28 Apr 2010)

E-Health Insider

http://www.e-health-insider.com/news/5865/rotherham:_npfit_has_put_us_back_10_yrs

The chief executive of The Rotherham NHS Foundation Trust has said the National Programme for IT in the NHS has "put back the contribution of IT in the NHS by more than ten years." In a controversial speech at the Health Informatics Congress 2010 in Birmingham, Brian James renamed the programme "NFFPIT - Not Fit for Purpose IT." He also said it had "not only impacted on systems within healthcare but also on the skills of the IT profession to scope and manage projects." Last year, The Rotherham became one of the first NHS trusts to go outside the national programme for an electronic patient record programme. It rejected iSoft's Lorenzo system from CSC and instead decided to implement a £40m Meditech v6.0 system from FileTek. Speaking about the implementation, James said the trust had encountered a serious lack of skills. He said it had taken more than a year to recruit the correct people for the implementation. He said: "The lack of skills in this area, which has been caused by the delays to NPfIT, has meant that we found it really difficult to find the right people for the project. My concern is that as we go forward there is going to be a rush for these systems. Where are the skills going to come from? And how are we going to deliver this agenda, whether that's through the national programme or whatever comes after it?" He added that he hoped that trusts were starting to think about the next steps in their IT strategy because "NPfiT may be dead." He echoed concerns first raised at E-Health Insider Live last year, when he said trusts were being forced to pay penalties for opting out of the programme. He said: "What we did was put a good business case together. We showed that by implementing this EPR, we expect to reduce our operating costs by a minimum of 5% - which is £10m pounds per annum. And that's our downside scenario - the upside is closer to 10%. We also managed to get through the hoops around penalties by saying that it is an interim solution - a 15 year interim solution." In an interview with EHI after the speech, James said that the Meditech

implementation is going well. He said trust has been working for a year to anglicise the product ready for it to go-live in November this year. "I'd say that we are around four weeks behind where we should be, but we should still go live in November. However, we will take a view on that in the summer, because the quality of the product is key." James also said the trust had decided to change its go-live strategy to a two-phase big bang rather than a single one. "In November we will go-live and switch over 14 systems, then the second phase will happen within three months with an additional 12 systems."

3.8.124. National Programme for IT faces an uncertain future (17 May 2010)

V3.co.uk

http://www.v3.co.uk/v3/analysis/2263155/uncertain-future-npfit

The coalition government has laid out a clear agenda to scrap many of Labour's ideas for public databases and central IT agendas, such as the ID Card project and the ContactPoint database, but plans for the NHS and the National Programme for IT (NPfIT) remain uncertain. Pre-election estimates were that the NHS needed to achieve efficiency savings of up to £20bn by 2014. Labour had indicated that these would come mainly through improving management and productivity. However, the reality is that such a high sum will warrant a government taking tough action on many NHS back-office functions. Any spending is likely to be concentrated on the frontline in order to maintain the popular vote. The Conservative Party said in its manifesto that new IT projects would be put on hold, and discussed dismantling the NPfIT as decision-making is moved to a local level. The Liberal Democrats have been largely supportive of the Conservative view. The NPfIT underlies what had been Labour's agenda for creating an Integrated Care Records Service, also known as the NHS Spine. The NHS Spine is used by clinicians to collect patient data and share it with other healthcare professionals. However, the centralised system has often been seen as a failure owing to continued installation setbacks, rising costs and data management problems. The original cost of the system was supposed to be £2.3bn, but has now risen to around £12.4bn. The new government has been open about its cuts to the NPfIT, but it has left many important questions unanswered, such as how deep the cuts will be, whether the NPfIT will ever go ahead or whether the project of establishing a centralised records service should be seen as a failure. UK healthcare organisations and commentators still hold out hope that the NPfIT will be finalised one day, but analysts have argued that the programme has come to its end, and that this would have been the case even if the Labour party had remained in government. Considering that the Tories set forth their own NHS agenda, outlining plans for patients to control their own data and choose the online providers with which they store their health records, the latter argument seems the more likely outcome. Ovum analyst Mike Davis suggested that the government is unlikely to move ahead with a radical NHS IT project because of cost pressures, but will move ahead with its localisation plans. Healthcare providers will become autonomous Foundation trusts under the Tory proposals. . . The local NHS way of working will potentially require more rather than fewer IT services, according to Davis, and the greater choice for trusts between suppliers will open up new opportunities for vendors to engage with the NHS, especially those that were formerly excluded from such deals. Davis added that it is important for local trusts to communicate and share data even though they will be autonomous, and that this vision should have been the essence of the NPfIT. . . However, Alan Maryon-Davis, chairman and president of the Faculty for Public Health, has an altogether different view and believes that cuts to the NHS Spine will be detrimental to public health. "We feel that the sharing of data records is a good thing providing that the right security checks are in place and there is not this awful business of notes going missing," he said. "Perhaps most importantly the central system would have allowed health professionals to look at anonymised data right across the system to generate public health data statistics without intruding on privacy. "It will be a shame if this process does not happen, although I do expect it will be slowed due to a lack of money." . . . Meanwhile, Cambridge University researcher Ian Dent said that the new government's calls to localise NHS IT is clever rhetoric but simply reflects a process that was already happening under Labour. "Although the Conservatives say they will move the NHS to a regional basis, this was the way it was going under Labour anyway, like Child Agencies and the Skills Funding Agency. It also is the way Europe is heading," he said. Dent was pessimistic about the idea of an NHS Spine, holding a similar belief to many digital rights enthusiasts that the UK government and its European Union counterparts are eroding civil liberties in their rush towards an information society. "I do believe the NHS database could create better healthcare for patients, but the danger is that the government can extract data for outside purposes," he said. "The NHS central database has a similar function to the ContactPoint database, which is used to track children to adulthood. In the 1960s, the government knew where people were because people stayed where they

were, people voted and there were electricity boards. "Now the public is more invisible to the government and that is why it has set up so many central IT databases."

3.8.125. Summary Care Records - too big to fail? (26 May 2010)

Computer Weekly Tony Collins IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2010/05/summary-care-records---too-big-1.html

Emma Byrne is one of the authors of a confidential draft report on the Summary Care Records scheme. She'd worked on the report with a team from University College London. The latest report of her team was completed in March 2010 but hasn't been published, perhaps because some of its findings were not greeted warmly by the Department of Health. The Department and NHS Connecting for Health commissioned the SCR report from University College London. Now Byrne has written an article for the Open Rights Group on NHS IT, the NPfIT and particularly the SCR scheme. She is on the ORG's board. She says in the article: " ... The problems are made far worse by the way NPfIT runs its key projects. When a project simultaneously manages to be 'not much use' and 'too big to fail' you have a recipe for perverse incentives and disastrous privacy consequences. The biggest project in the NHS, the Summary Care Record (SCR), is a clear example of this. The political pressure for the SCR to be seen as a success has always been immense: it was announced in 1997 as a personally favoured project of the then Prime Minister, Tony Blair. But this was never a vision shared by the doctors and nurses working in the NHS. When we studied the way health care professionals felt about the SCR in 2008, most of them said that they didn't really see the point of it: if you have an accident they would much rather get the information from you directly, either by examining you or by talking to you or your carer. Given that it's not particularly effective at improving health care, the project has to be seen to be a success in some other way. As a result, the reported "benefits" of the SCR consist of things like "the growth in number of patient records on the system," and "the number of times that SCRs have been accessed..."

3.8.126. Highlights of confidential UCL report on summary care records (15 Jun 2010)

Computer Weekly Tony Collins IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2010/06/highlights-of-confidential-ucl.html

A report by University College London on the summary care record scheme is expected to be published on Thursday. Today this blog publishes highlights from a draft of the UCL SCR report. It'll be interesting to compare the draft and final reports to see whether the Department of Health has softened any of the already-nuanced messages in the draft report. . . The UCL draft report concludes: "Overall the evidence that the SCR programme had so far achieved the benefits set out was limited." Specifically: (i) There was evidence of improved quality in some consultations, particularly those which involved medication decisions, (ii) There was no direct evidence of safer care but findings were consistent with the conclusion that the SCR may reduce rare but important medication errors, (iii) There was no consistent evidence that the SCR made consultations quicker , (iv) There was evidence that the SCR was particularly useful in patients unable to communicate or advocate for themselves, (v) There was no evidence of a reduction in onward referral, (vi) The impact of the SCR on the satisfaction of patients was impossible to assess. . .

4. National Audit Office

(Reports and commentary)

4.1. Suggested questions for the NAO audit of NPfIT (Nov 2004)

UK Computing Research Committee

http://www.ukcrc.org.uk/resource/reports/nhs_it.pdf

" . . .UKCRC believes that: (1) No existing system can meet the current, detailed operational requirements of the NHS, therefore it is essential that a complete and unambiguous specification of the system's requirements is drawn up, and that this specification is analysed rigorously to uncover any omissions or contradictions. We know this is technically feasible even for a system of this complexity; to fail to carry out this analysis before placing contracts would be unprofessional, and a serious waste of public funds. (2) Any system that is implemented will be novel, complex, and will require the use of the best available software engineering incorporating good computer science. This requires a significant change to current procurement practices but, without such changes, the project will fail."

4.2. BCS Contribution to NAO Investigation of NPfIT (4 Jan 2005)

British Computing Society

http://www.bcs.org/upload/pdf/auditofficejan05.pdf

Summary:

1. NPfIT is damaging the UK healthcare IT Industry by excluding many small but innovative players. Steps must be taken to make systems more open.
2. NPfIT operates in an unnecessarily secretive manner. Its contracts and other documentation need to be made public to allay suspicion and encourage trust.
3. NPfIT is too top down in its approach. It now needs to be made bottom up: owned, understood and made affordable locally.
4. Current experience in the UK is not being exploited.
5. There needs to be confidence in the quality of staff developing NPfIT. Qualified informatics staff should be the norm..
6. More staff are required at all levels to implement NPfIT at the pace planned. Education is needed in health informatics to develop a larger pool of skilled workers.
7. Centralised solutions may not perform well enough for clinical use. Consideration should be given to distributed solutions.
8. Patient care is at risk from a loss in functionality. Much current healthcare is built around and depends upon current IT solutions.
9. There are risks to physical security and privacy of content from the NPfIT approach. Rigorous but practical user access controls are essential.
10. Confidentiality constraints must not interfere with patient care by limiting what information is documented and what is available to whom.
11. Without user ownership, NPfIT systems will not be used. Clinicians need to be consulted about integrating IT systems with operational clinical services.
12. NPfIT is primarily about business change, not information technology. There needs to be an extensive education and training initiative.
13. There are risks to the integrity of data with the concept of one " fat" National Data Spine.
14. NPfIT relies on the successful use of the Snomed CT clinical terminology. It needs more development by skilled staff, piloting and user training.
15. Guidance is needed on operational convergence with Social Services and the Voluntary sector which have very diverse informatics environments.

4.3. NHS Connecting for Health Process Capability Appraisal (25 Apr 2005)

QinetiQ: (Contribution to NAO Report on NPfIT)

http://www.nao.org.uk/publications/nao_reports/05-06/05061173_qinetiq.pdf

Among the " Improvement Opportunities" listed:

" - Individual stakeholder requirements cannot be explicitly traced back to specific stakeholders or stakeholder classes
- Arrangements for stakeholder requirements definition were not defined within a documented process
- Stakeholder requirements definition had proceeded directly to the production of the OBS without the production of an analyzed statement of stakeholder requirements
- There was no evidence that an architectural design process had been defined, documented or deployed.
- The authority's integration strategy - of accepting or allocating responsibility for overall integration of the NPfIT principal sub-systems - did not demonstrably minimize the risk associated with integrating a large and complex system."

4.4. Health IT Report (5 May 2005)

Security Research, Computer Laboratory, University of Cambridge

http://www.lightbluetouchpaper.org/2006/07/28/health-it-report/

Document produced by Ross Anderson " for the National Audit Office on the health IT expenditure, strategies and goals of the UK and a number of other developed countries. This showed that our National Program for IT is in many ways an outlier, and high-risk." (The contents of this document were used in the first draft NAO report, but did not feature at all in the final published version.).

4.5. NAO Report: Knowledge of the Choose and Book Programme Amongst GPs in England (Sep 2005)

National Audit Office

http://www.nao.org.uk/publications/gp_survey_2005.pdf

" The overall perception of Choose and Book was negative – 78% of respondents said the prospect of Choose and Book would be very negative or a little negative."

4.6. NAO Report: A Safer Place for Patients (Nov 2005)

National Audit Office

http://www.nao.org.uk/publications/nao_reports/05-06/0506456.pdf

" NHS Connecting for Health, has begun to roll out its National Care Record system and expects it to have full functionality by 2010. Most trusts foresee that this will help them in ensuring that patient records are no longer lost and there are better controls over prescribing (both issues have led to significant numbers of patient safety incidents)."

4.7. Press Comments on Delayed Report on NPfIT

4.7.1. Audit Office report on CfH delayed again (26 Jan 2006)

e-Health Insider:

http://www.e-health-insider.com/news/item.cfm?ID=1666

" . . . the eagerly awaited report, originally due to be published in July 2005, is now not expected to be released until " summer 2006" at the earliest, a publication date that may yet slip further."

4.7.2. NHS IT probe useless (24 Mar 2006)

The Register

http://www.theregister.co.uk/2006/03/24/nao_npfit_too_late/

" By the time the official audit of the government's £6.1bn NHS IT modernisation is published in the summer it will be too late to be of any [use to] the cash-strapped NHS, said a leading contributor to the investigation. However, the National Audit Office report might contain a valuable lesson for other arms of the public sector undergoing programmes of modernisation similar to the ambitious NHS National Programme for IT, said Glyn Hayes, chairman of the Health Informatics Committee of the British Computer Society."

MPs to probe IT fiasco at health service (7 May 2006)

Observer

http://observer.guardian.co.uk/business/story/0,,1769248,00.html

" Parliament's spending watchdog is to investigate the National Health Service's £6.2bn IT modernisation amid fears that the massive project is over budget and behind schedule."

4.8. NAO Report: National Programme for IT in the NHS (16 Jun 2006)

National Audit Office

http://www.nao.org.uk/publications/nao_reports/05-06/05061173.pdf

From the Summary: " The Programme's scope, vision and complexity is wider and more extensive than any ongoing or planned healthcare IT programme in the world, and it represents the largest single IT investment in the UK to date. If successful, it will deliver important financial, patient safety and service benefits. The main implementation phase of the Programme and the realisation of benefits is mainly a matter for the future and it will therefore be some time before it is possible fully to assess the value for money of the Programme, as this will depend on the progress made in developing and using the systems it is intended to provide."

From the Conclusions and Recommendations: " Successful implementation of the Programme nevertheless continues to present significant challenges for the Department, NHS Connecting for Health and the NHS, especially in three key areas: ensuring that the IT suppliers continue to deliver systems that meet the needs of the NHS, and to agreed timescales without further slippage; ensuring that NHS organisations can and do fully play their part in implementing the Programme's systems; winning the support of NHS staff and the public in making the best use of the systems to improve services."

http://www.connectingforhealth.nhs.uk/news/news_nao_160606

NHS CFH response to the National Audit Office outline findings] - 16 Jun 2006

4.9. Media Reactions to the June NAO Report

4.9.1. NHS computer upgrade " too slow" says report (16 Jun 2006)

Reuters

http://today.reuters.co.uk/news/newsArticle.aspx?type=topNews&storyID=2006-06-16T112131Z_01_L16439520_RTRUKOC_0_UK-BRITAIN-HEALTH-COMPUTERS.xml

4.9.2. Cost of NHS IT programme 'to double' (16 Jun 2006)

The Guardian

http://politics.guardian.co.uk/egovernment/story/0,,1799352,00.html

4.9.3. NHS computer system haemorrhaging cash (16 Jun 2006)

ITV News

http://www.itv.com/news/britain_de01caeded53f917a3d480620bc730f8.html

4.9.4. Major NHS IT upgrade hit by delay (16 Jun 2006)

BBC News

http://news.bbc.co.uk/1/hi/5086060.stm?ls

4.9.5. NHS computer scheme under fire (16 Jun 2006)

Daily Telegraph

http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/06/16/uit.xml

4.9.6. NHS computer upgrade 'behind schedule' (16 Jun 2006)

Financial Times

http://news.ft.com/cms/s/0a1f062a-fd31-11da-9b2d-0000779e2340.html

4.9.7. Analysis: NHS IT costs 'not disproportionate' (16 Jun 2006)

The Times

http://www.timesonline.co.uk/article/0,,2-2229189,00.html

4.9.8. £12.4bn NHS computer 'years behind' (16 Jun 2006)

The Guardian

http://www.guardian.co.uk/uklatest/story/0,,-5891785,00.html

4.9.9. NHS IT project is doing OK, says Audit Office (16 Jun 2006)

ZDNet UK

http://news.zdnet.co.uk/business/0,39020645,39275487,00.htm

4.9.10. Can government run IT projects? (16 Jun 2006)

BBC News

http://news.bbc.co.uk/1/hi/business/5088260.stm

4.9.11. NAO gives positive account of NHS CfH (16 Jun 2006)

E-Health insider

http://www.e-health-insider.com/news/item.cfm?ID=1951

4.9.12. NHS risks £20bn white elephant, say auditors (16 Jun 2006)

The Guardian

http://www.guardian.co.uk/guardianpolitics/story/0,,1799064,00.html

4.9.13. NAO reports slams NHS IT delays (16 Jun 2006)

VNUNet

http://www.vnunet.com/vnunet/news/2158474/nhs-rollout-slow

4.9.14. Mealy-mouthed NAO pampers NHS IT (16 Jun 2006)

The Register

http://www.theregister.co.uk/2006/06/16/nao_npfit_whitewash/

4.9.15. NHS National Programme for IT faces 'significant challenges' (16 Jun 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/06/16/216489/NHS+National+Programme+for+IT+faces+%e2%80%98significant+challenges%e2%80%99.htm

4.9.16. BMA: Report on IT upgrade raises concerns (16 Jun 2006)

Politics.co.uk

http://www.politics.co.uk/issueoftheday/bma-report-on-it-upgrade-raises-concerns-$442706$442644.htm

4.9.17. U.K. Health Service Computer System to Cost 12.4 Billion Pounds (16 Jun 2006)

Blomberg

http://www.bloomberg.com/apps/news?pid=10000102&sid=aj5ksKUAua8c&refer=uk

4.9.18. NHS computer project needs backing of health staff to succeed (16 Jun 2006)

Computing

http://www.computing.co.uk/computing/news/2158428/nhs-needs-backing-health-staff

4.9.19. NHS IT delays: National Audit Office publishes tough report (16 Jun 2006)

PublicTechnology.net

http://www.publictechnology.net/modules.php?op=modload&name=News&file=article&sid=5217

4.9.20. Partnership not penalties will deliver successful NHS IT (16 Jun 2006)

Intellect

http://www.intellectuk.org/databases/press/press_details.asp?id=29

4.9.21. Bugs in the system - The world's biggest IT project has yet to prove it is good for the health (17 Jun 2006)

The Times

http://www.timesonline.co.uk/article/0,,542-2229686,00.html

4.9.22. £12bn IT system passes health check – for now (17 Jun 2006)

The Times

http://www.timesonline.co.uk/article/0,,2-2229434,00.html

4.9.23. £14BN OVER BUDGET ..TWO YEARS LATE Yes.. it's ANOTHER government computer fiasco (17 Jun 2006)

The Mirror

http://www.mirror.co.uk/news/tm_objectid=17245884&method=full&siteid=94762&headline=-pound-14bn-over-budget---two-years-late--name_page.html

4.9.24. Watchdog criticises delays over '£20bn' NHS computer system (17 Jun 2006)

Independent

http://news.independent.co.uk/business/news/article1089764.ece

4.9.25. True cost of delayed NHS system is £12.4bn (17 Jun 2007)

Daily Telegraph

http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/06/17/nhs17.xml&sSheet=/news/2006/06/17/ixuknews.html

4.9.26. New NHS e-system 'behind' (17 Jun 2006)

Scotsman

http://news.scotsman.com/uk.cfm?id=889552006

4.9.27. NHS £14billion mega-byte (17 Jun 2006)

The Sun

http://www.thesun.co.uk/article/0,,2-2006271020,,00.html

4.9.28. NHS Transformation Proceeds: Despite iSoft debacle, the U.K.'s National Health Service is doing a good job with IT transformation; damage control (19 Jun 2006)

Line56.com

http://www.line56.com/articles/default.asp?ArticleID=7695

4.9.29. NHS IT system slammed (19 Jun 2006)

OneStopClick

http://www.onestopclick.com/news/NHS-IT-system-slammed_17193636.html

4.9.30. NHS IT project hit by rising costs (19 Jun 2006)

Computer Business Review

http://www.cbronline.com/article_news.asp?guid=0AA8ADC1-251D-406E-9027-7B04F34C7091

4.9.31. Report fuels calls for new NHS IT review (20 Jun 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/06/20/216497/Report+fuels+calls+for+new+NHS+IT+review.htm

4.9.32. NHS IT needs balanced view: There is good and bad in every project (22 Jun 2006)

Computing

http://www.computing.co.uk/computing/comment/2158768/nhs-needs-balanced-view

4.9.33. Between fact and fiction: The NHS report (22 Jun 2006)

Consultant News.com

http://www.consultant-news.com/article_display.aspx?p=adp&id=2882

4.9.34. Involve nurses in IT input (27 Jun 2006)

The Times (Letter)

http://www.timesonline.co.uk/article/0,,59-2244112,00.html

4.9.35. This examination of NHS IT scheme has failed to probe the painful facts (11 Jul 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/07/11/216832/This+examination+of+NHS+IT+scheme+has+failed+to+probe+the+painful.htm

4.10. NHS report 'criticisms deleted' (18 Aug 2004)

BBC News

http://news.bbc.co.uk/1/hi/health/5263316.stm

" A report into the £6.8bn NHS IT upgrade had criticisms removed and toned down before publication, the BBC learns. BBC Radio 4's World At One programme has obtained documents showing passages were removed from a National Audit Office report during consultation. The June study was circulated to various consultees, including the government, from January. The watchdog said its main conclusions were unaltered, but others said the report was weaker than expected."

4.11. NHS IT 'secrets' exposed: A National Audit Office PDF cock-up (The Inquirer, 23 Aug 2006)

http://www.theinquirer.net/default.aspx?article=33883

" THE NATIONAL Audit Office has accidentally revealed details of the NHS's troubled multi-billion-pound IT programme " Connecting for Health" . The watchdog released a PDF report with passages electronically blacked out to hide sensitive information. The only problem was that by highlighting the hidden text, and then copying and pasting it into a text editor, all was revealed. Amongst the details were the 'estimated costs' for each part of the NHS Connecting for Health programme. It also said that EDS's contract to provide an NHS-wide email system would have cost £212m if it had not been cancelled. It also said that BT was 'fined' £11.6 million for under-performance. The blacked out bits also contained unreported criticisms from NAO officials about the Connecting for Health. . ."

4.12. NAO report - a journey from criticism to praise (29 Aug 2006)

http://www.computerweekly.com/articles/article.aspx?liArticleID=218034

" When a report was published in June by the National Audit Office into the NHS's National Programme for IT (NPfIT), it was seen by ministers as a vindication of the UK's decision to spend £12.4bn on the world's largest civil computer scheme. The report was strongly supportive of the scheme and replete with praise for the Department of Health and NHS Connecting for Health, its agency which runs the NPfIT. But earlier drafts seen by Computer Weekly tell a different story to the final NAO report. Comparing the earlier drafts against the final version of the NAO's report shows that there has been a cover-up, with passages critical of the programme removed or substantially altered."

Page proofs of full story:
http://www.editthis.info/images/nhs23/2/2d/ComputerWeekly29Aug2006NAO.pdf

4.13. Unhealthy tale of NAO report (29 Aug 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/08/29/217947/Unhealthy+tale+of+NAO+report.htm

" The National Audit Office is a great British institution - or was. It was set up by Gladstone, in part to authorise the issuing of public money to government from the Bank of England, and it now has the express power to report to parliament at its discretion on how departments spend our taxes. This is one reason why on its website, it says that anyone concerned about the way public money is being spent should write in - which is exactly what IT specialists, suppliers, MPs, and organisations did over the NHS's £12.4bn National Programme for IT (NPfIT). These correspondents were then surprised that when the NAO published its report on the NPfIT their concerns were not reflected in the main text. Now we know why. Three draft NAO reports on the NPfIT released to Computer Weekly under the Freedom of Information Act show that many of the most serious criticisms of the NPfIT were omitted from the final publication (see NAO report: a journey from criticism to praise). Between the drafts there had been a " clearance" process with health officials in Whitehall. We recognise that facts have to be checked with departments. But changing wording in such a way as to give a more favourable impression of the programme, and removing entire passages of criticisms that had sound, quoted sources, is not the same as fact checking. We hope the Public Accounts Committee will take the unusual step of holding another hearing on the NPfIT - and that the Public Accounts Commission, which oversees the work of the NAO, will take a hard look at the specific reasons for the changes to the draft reports."

4.14. NAO Report: National Programme for IT in the NHS (Leaked First Draft)

BBC news

http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/18_08_06_nhs_auditreport.pdf

From the Summary: " There is support amongst NHS staff for what the Programme is seeking to achieve, but also significant concerns: that the Programme is moving slower than expected, that transparency is lacking as to when systems will be delivered and what they will do, and that the confidentiality of patient information may be at risk. Relations with GPs have also been damaged by concerns that they will be forced to give up their existing IT systems."

http://www.editthis.info/images/nhs23/a/af/NAO_Report-unexpurgateddraft.pdf NAO Report: National Programme for IT in the NHS (Unexpurgated Leaked First Draft)] (This version has reinstated the text that has been blanked out in the draft that had been obtained by the BBC.)

4.15. New inquiry into NHS IT upgrade (4 Sep 2006)

BBC News

http://news.bbc.co.uk/1/hi/health/5313974.stm

" Auditors are to launch another inquiry into the £6.8bn NHS IT upgrade project. The National Audit Office only reported in June on the scheme to link 30,000 GPs with 300 hospitals in England, Computer Weekly magazine says. The programme, run by a government agency called Connecting for Health, has proved controversial. The original NAO report criticised delays in the project and said it was facing a challenging future, but was not as hard-hitting as expected. Last month, the BBC revealed that a number of alterations had been made to the original draft after it was circulated to officials involved in the 10-year project. The NAO insisted the overall findings had not been changed amid criticism from opposition MPs. The project has also been dogged by criticisms from doctors, who say they were not consulted properly and that the new systems are a risk to patient confidentiality. . . The NAO said the exact remit and timescale of the new investigation had not been decided yet. " When we published the report we said we may revisit it and that is what we are doing," said a spokesperson. . ."

4.16. Audit Office pledges new report on NHS (5 Sep 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/09/05/218205/Audit+Office+pledges+new+report+on+NHS+.htm

" The National Audit Office is to publish a new report into the UK's largest IT investment, the £12.4bn National Programme for IT in the NHS. Its decision follows criticism by MPs of the Audit Office's June 2006 report on the NHS programme. Greg Clark, a member of the House of Commons Public Accounts Committee, said the June report was " the most gushing" of all NAO reports he had read. Another member of the Public Accounts Committee, Richard Bacon, said the NAO's report on the NPfIT was not up to the organisation's usual high standards. The NAO's value for money reports on IT projects are usually one-offs. So its decision to produce two reports on the NPfIT is an unusual step. . . Clark said that in the light of recent events the published NAO report " raises more questions than it answers" . He added his committee would hold a new hearing on the NPfIT, based on a new NAO report. He expected the hearing to occur next year. In its June report the NAO said it " may return to carry out a further examination at a later date should this appear necessary" . But last week its spokesman told Computer Weekly that the NAO had decided to publish a new report, though no date has been set. . ."

4.17. Was NAO report truly independent? (19 Sep 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/09/19/218551/Was+NAO+report+truly+independent.htm

" The National Audit Office's final report on the NPfIT was very different to earlier drafts, which criticised the programme. Was it influenced along the way? In the first few words on its website, public spending watchdog the National Audit Office declares, " We are totally independent of government." But last year the NAO went on the defensive after receiving a letter from Connecting for Health, which is running the NHS's National Programme for IT (NPfIT), the UK's largest computer-related investment, costing £12.4bn. Under the Freedom of Information Act the NAO has released some correspondence between one of its senior auditors, Chris Shapcott, and Richard Granger, IT head of the NPfIT who is chief executive of NHS Connecting for Health and also director general of NHS IT. In his letter dated 17 March 2005, Granger shows an apparent disapproval of the possibility that the NAO had been actively engaging and encouraging third parties to examine the work of the NPfIT. . . Granger wrote the letter after Connecting for Health received an independent paper on the NPfIT. The paper was written by the UK Computing Research Committee, which comprises an expert panel of computing researchers from academia and industry who are members of the Institution of Engineering and Technology and the British Computer Society. The health minister Lord Warner had received the committee's paper and passed it to Connecting for Health. The paper raised some awkward questions

about the NPfIT, some of which have not been answered even today. . . Warner said he is pleased with the final NAO report. So is Connecting for Health, which has cited the final NAO report as an endorsement of its work on the NPfIT. But some may be left questioning whether the NAO's final report on the NPfIT was as robustly independent as the audit office's reputation. They may also ask why Connecting for Health seemed so concerned about a third party review of the NPfIT. The NAO is to publish a new report on the NPfIT."

4.18. NAO Report: National Duplicate Registration Initiative (Sep 2005)

National Audit Office

http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/009F4715-3D93-4586-A3A0-7BF69405A449/NationalDuplicateRegistrationInitiative02Aug06REP.pdf

Commentary from http://www.ehiprimarycare.com/comment_and_analysis/index.cfm?ID=164 e-Health Insider]: " There's some interesting stuff buried in the detail of this report. For instance, look at para 34 on page 15, about asylum seekers: " The introduction of Home Office data enabled NDRI to identify patient registrations which related to persons who had been removed from the UK by the Home Office. In the majority of cases the registration has now been cancelled. However, the NHAIS sites identified some cases where the person appeared to have subsequently returned to the UK. Details of these were passed to the Home Office for them to consider what, if any, action should be taken. Based on this information the Home Office has made a number of deportations." In other words, health records were used to identify undesirables who were deported. Whilst I'm sure the numbers involved here are small, ethically this has big implications for patient confidentiality - and if data started to be " shared" with the Home Office for people in other categories - for instance, criminals on the run - the numbers affected could be much larger. Whilst from a societal perspective this use of health record data makes perfect sense, as a GP tasked with treating the patient in front of you this raises questions as to whether it's in that patient's best interests to be registered on your system. And this is before the NCRS spine is properly up and running. I don't think this is going to encourage GPs who are concerned regarding data confidentiality to upload their practice lists..."

4.19. NAO Report: Delivering successful IT-enabled business change (17 Nov 2006)

National Audit Office

http://www.nao.org.uk/publications/nao_reports/06-07/060733es.pdf - Executive Summary

http://www.nao.org.uk/publications/nao_reports/06-07/060733-i.pdf - Vol 1: Full Report

http://www.nao.org.uk/publications/nao_reports/06-07/060733-ii.pdf - Vol 2: Case Studies

" The successful delivery of IT-enabled business change is essential for improving major public services, but experience in the public sector in Britain also shows that achieving such change is particularly complex and challenging in terms of the scale of the changes required, the cross-government co-ordination needed, and the technical issues around joining new and old systems. . . Analysis of our case studies identified three key and recurring themes in successful programmes and projects: the level of engagement by senior decision makers of the organisations concerned; organisations' understanding of what they needed to do to be an " intelligent client" ; and their understanding of the importance of determining at the outset what benefits they were aiming to achieve and, importantly, how programmes and projects could be actively managed to ensure these benefits were optimised. . ."

4.20. Blair's barmy army (26 Nov 2006)

The Sunday Times

http://www.timesonline.co.uk/article/0,,2099-2456064_1,00.html

" Next month the National Audit Office is due to produce a report on government use of management consultants. " Don't hold your breath," says Neil Glass. Glass, writing as David Craig, is a whistleblower. His book, Plundering the Public Sector, paints a uniformly bleak picture of consultant greed and government incompetence. Since 1997, he says, consultants have cost the taxpayer £70 billion with either zero or negative returns. He doesn't expect much from the NAO report because the audit manager, the key figure, of the study is Ron SirDeshpande. Accenture, one of the giant

consultancy firms, employed SirDeshpande for almost eight years before he came to the NAO. . . On September 28, Accenture pulled out of its £1.9 billion contract with the NHS. Connecting for Health (CfH), a huge computer system, was cutting into Accenture's profits and threatening its balance sheet with up to $450m in write-offs. Launched in 2002 as a project lasting two years and nine months and costing £2.3 billion, CfH has become a 10-year project with a probable cost of £12.4 billion. But insiders and IT professionals now agree that it cannot work. If the government pulls the plug now, only about £1.5 billion will have been lost. But will it? Dare it admit that its multi-billion-pound gamble on the power of the consultants has failed? Meanwhile, despite the billions poured into the NHS, hospital trusts are still ending up in deficit. . . new Labour has spent £70 billion on consultants since 1997 – the equivalent of perhaps 150 hospitals or about 140m pieces of body armour . . . But perhaps more important is the astonishing blurring of the lines between consultancy and government. Patricia Hewitt, the health secretary, was head of research at Accenture when it was known as Andersen Consulting. Ian Watmore, head of the Downing Street Delivery Unit, was UK managing director of Accenture. David Bennett, chief policy adviser to the prime minister, is a former McKinsey partner. Richard Granger, head of the NHS IT programme, was with Deloitte. . . Tony Collins of Computer Weekly has studied the NHS computer project in depth. He has found that it is often impossible for anybody to question spending plans, however absurd they might be. . . At least half of the £1.5 billion spent so far on that project has gone to lawyers, consultants and PRs. The last are crucial because they are there to persuade GPs and hospitals to use the new system. The one thing the NHS fears most is professional rejection of the system. This is a bad case of a shot in the foot. Government gave GPs and hospitals autonomy in the hope that it would improve efficiency, but this also gives them the freedom to refuse a centrally imposed IT system. In addition, many hospitals already have sophisticated computer systems of their own that may not be compatible with the new system. . . " It is misleading to say that the scale is bigger than has ever been done before," said Richard Granger, director-general of NHS IT, at a conference in March 2003. " The extra spending of £2.3 billion over three years is not such a terrifyingly large project – it is comparable to other mid-size projects in industry and government that are regularly completed in time." And yet recently, Sir Ian Carruthers, acting head of the NHS, described it as the biggest project in the world. . ."

4.21. MP " looking into" how NAO report was drafted (30 Nov 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2307

" Commons Public Accounts Committee member and outspoken scrutiniser of the National Programme for IT, Richard Bacon MP, says he is trying to find out what happened during the drafting process of the controversial National Audit Office (NAO) report on the programme. . . Speaking to a meeting of the IT trade association, Intellect, Bacon, who is Conservative MP for South Norfolk, said: " I have been spending a little while trying to find out what happened. We will be coming up with a report in due course." He said papers obtained under the Freedom of Information Act by the Sunday Times, Computer Weekly and the BBC's World at One showed that earlier drafts were more critical. During his speech to Intellect he criticised the programme for its " high speed contract letting" done without seeking the views of clinicians and before understanding what the government wanted to buy. " Patient systems are being put into acute hospitals before they are ready, in a way that damages trust locally," he said. Bacon also challenged the idea of making records available all over the country. " Of course everyone can see tremendous benefits if you are run over by a bus in Cornwall, but I do not see that any assessment has been made of the cost versus the benefit." Costs to confidentiality could be high too, he said. He concluded: " I can see no point in throwing rocks. I'd like to see an informed debate. My understanding of the role of IT can play in healthcare is that it can achieve the most extraordinary transformational change." " My question is how do we get from where we are to where we want to be?"

4.22. Public spending on consultants reaches record £3bn (15 Dec 2006)

The Guardian

http://www.guardian.co.uk/guardianpolitics/story/0,,1972671,00.html

" Spending on consultants across the public sector has reached a record £3bn - an increase of over a third in two years - according to the first authoritative investigation into their costs, released today by the National Audit Office. The huge increase is almost entirely caused by the NHS, where spending on

consultants has jumped more than 15-fold from £31m to more than £500m in two years - mirroring almost the entire deficit in the hospital and GP services. The report reveals that Whitehall alone spent some £1.8bn on consultants until the end of March last year, down from £2bn the previous financial year. Another £1bn was spent by the NHS and local government. Most of the cash went on consultancy work for IT schemes, project management and new strategies for Whitehall departments. The NAO says that many of the schemes do not represent value for money and estimates that if proper controls over consultants were introduced the government could save well over £1bn over the next three years. . ."

[The NAO Report referred to is at: http://www.nao.org.uk/publications/nao_reports/06-07/0607128.pdf]

4.23. Second full NAO review of NPfIT to be carried out (26 Apr 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2641

"The Commons Public Accounts Committee has ordered a second full review of the NHS IT programme to be carried out public spending watchdog the National Audit Office, to check that the recommendations of its report into the NHS IT project are followed. Chairman of the PAC Edward Leigh said he planned to "call the Government's bluff" after health minister Lord Hunt said that the Government was already acting on the PAC's recommendations. Last week's PAC report provided a detailed highly critical analysis of the management and progress of the £12.4bn programme which said "suppliers are struggling to deliver" shared electronic medical records and made recommendations including a call for an urgent independent review and annual review of progress. The government responded last week by saying many of the recommendations were already being acted on, adding that the report was based on out of date information, based on last summer's NAO report. This despite the PAC taking detailed new evidence and calling its own witnesses. Speaking in the Commons on 19 April, Edward Leigh, chair of the PAC, said: "I notice that the Government's response this week says, "Well, excellent report by the PAC, but we're doing all this—it's an out-of-date report. "I am going to call the Government's bluff. I have talked to the Comptroller and Auditor General about the matter and, following my encouragement, we are to have another NAO report on the NHS computer in the next year so that we can have an update to check whether all the excellent recommendations of the NAO and the PAC on this £12 billion computer system—that amount is equivalent to the entire cost of the Olympic games—are being carried out.""

4.24. National Audit Office due to publish 2nd report on NPfIT by May 2008 (19 Feb 2008)

Computer Weekly - Tony Collins IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/02/national-audit-office-due-to-p-1.html

"The National Audit Office is at a draft report stage after a second investigation into the NHS's National Programme for IT [NPfIT]. It's expected the National Audit Office will publish its second report on the NPfIT by May 2008. The first NAO into the NPfIT in June 2006 report was memorably described by a BBC correspondent as a whitewash. Greg Clark of the Public Accounts Committee called it "gushing". This time the NAO is not relying quite so heavily on information supplied by NHS Connecting for Health which runs part of the NPfIT. NAO auditors have been visiting NHS trusts where patient administration systems from CSC and Isoft - and particularly Fujitsu and Cerner - have been installed. . ."

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

National Audit Office

http://www.nao.org.uk/pn/07-08/0708484.htm

From the NAO Press Notice: "Delivering the National Programme for IT in the NHS is proving to be an enormous challenge. All elements of the Programme are advancing and some are complete, but the original timescales for the electronic Care Records Service, one of the central elements of the Programme, turned out to be unachievable, raised unrealistic expectations and put confidence in the Programme at risk. Today's progress report on the Programme by the National Audit Office concludes that the original vision remains intact and still appears feasible. However, it is likely to take until 2014-

15 before every NHS Trust in England has fully deployed the care records systems, four years later than planned. In the North, Midlands and East area, the software has taken much longer to develop than planned, so some Trusts have had to take an interim system. Completing the development of the system and introducing it in this area are significant challenges still to be addressed. The estimated cost of the Programme is £12.7 billion. The costs of the main contracts have remained broadly unchanged, aside from the purchase of increased functionality. Because of the delay in deployments, actual expenditure to date (£3.6 billion by 31 March 2008) has been much lower than expected. Planned 'go live' dates were missed for many of the first Trusts to take the new care records systems and the NHS and suppliers are now increasing their emphasis on establishing realistic timelines for deployments, reflecting the circumstances of each individual Trust. According to today's report, the success of the Programme will depend on the commitment of NHS staff. The Department's latest survey, conducted in spring 2007, showed that 67 per cent of nurses and 62 per cent of doctors expected the new systems to improve patient care. Identifying and realising the benefits of the systems are essential to raising confidence further and convincing all staff of the value of the Programme. The Department reported on the benefits of the Programme for the first time in March 2008."

4.26. The NHS: a question of trust (16 May 2008)

The Times

http://www.timesonline.co.uk/tol/comment/leading_article/article3941448.ece

"For the arthritic grandmother who divides her time between Yorkshire and her daughter's family in London, today's report by the National Audit Office on information technology in the NHS will make depressing reading. For the cancer sufferer seeking expert opinions at several different hospitals, it will be worse than that. The report estimates that the centrepiece of the National Programme for IT in the NHS (NPfIT) - a secure, shareable, constantly updated electronic medical records service for all 60 million NHS patients - will not be ready until 2014 at the earliest. Privately, experts worry that as presently designed it may never work at all. At the heart of the Care Records Service's well-documented problems are two costly software products that are custom-built, national in their intended application and, so far, unworkable. There is an alternative. It would run on software bought off the shelf, that can be chosen and customised by individual health authorities, and would not crash. Not only is it not too late to adopt this approach; it is already being used. An unmodernised NHS is unthinkable. Bold and intelligent use of information technology is inevitably at the heart of this modernisation, and not just by streamlining administration. In principle, electronic records will save lives, whether by cutting errors arising from doctors' scrawls or giving paramedics instant information on accident victims' blood types and allergies. They will also improve patient care. As digital downloads replace clipboards on hospital beds, nurses' efficiency will rise. As new drugs are approved, every patient who might benefit will know. The vision of a vast, beneficent healthcare computer network is not fanciful. It is what taxpayers have been paying for since 2002, and should expect. When first outlined, too hastily, to Tony Blair, the national programme was not only the biggest non-military IT project in history, but also uniquely complex. Hence the assumption that only bespoke software could make it work. As specifications evolved, budgets and timelines stretched. Early versions of the care records software proved inadequate, recriminations flew and far too little was accomplished. Taxpayers, at least, have not yet suffered ruinously: of the programme's projected total cost of £12.7 billion, only £3.6 billion has actually been spent. By no means all this has been wasted. The high-speed broadband network to which strategic health authorities must eventually connect their own systems is complete and working. The PACS system for sharing digital imaging is also up and running, as is the choose-and-book system designed to give meaning, at last, to patient choice. But the two main Care Records Service (CRS) programmes, known as Lorenzo and Cerner, are still years from full deployment. Pilot versions have been plagued with glitches, which few expect will all be solved by 2014. NHS trusts required to use them have been customising the bespoke software rather than adapt their own systems to a national standard. Some foundation trusts, meanwhile, are abandoning the standard altogether to buy database software on the open market, with no cost in confidentiality or performance. Other trusts would like to opt out, but under current rules cannot afford to. These rules must be changed. The national programme has been appallingly mismanaged. This does not invalidate the vision behind it, but it does oblige the NHS to trust its trusts to make it a reality.

5. Public Accounts Committee

(Hearings, submissions and commentary)

5.1. The 1992 and 1998 Information Management and Technology Strategies of the NHS Executive (30 Apr 2000)

Public Accounts Committee

http://www.publications.parliament.uk/pa/cm199900/cmselect/cmpubacc/406/40603.htm

" Our Key Conclusions on Improving the Delivery of Government IT Projects:

- Decisions about IT must be treated as business decisions rather than technical ones, and have senior management involvement and commitment.
- End users must be identified before the project commences so that their needs are taken into account fully during design and development of IT projects.
- Departments should consider carefully whether projects are too ambitious to undertake in one go, particularly if a project connects with the business operations of other parties, or depends on the development of IT undertaken by other parties.
- Successful implementation of IT systems calls for imagination and well-conceived risk management, in addition to skilled and sound project management.
- It is essential that public sector bodies place IT contracts that avoid any lack of clarity, or debatable interpretation, which can lead to expensive misunderstandings and the need for possible resolution in the courts. . ."

5.2. NHS IT report plays too safe (27 Jun 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/06/27/216596/NHS+IT+report+plays+too+safe.htm

" The National Audit Office's report on the NHS National Programme for IT (NPfIT) should be the start, not the end, of independent scrutiny of the UK's largest ever IT investment. The report was expected to be the centre of discussion yesterday (26 June) at the House of Commons Public Accounts Committee hearing and is certain to feature strongly in hearings expected to be held by the Health Select Committee into the project this autumn. But the purpose of the NAO report, or an independent technical audit like that called for by 23 academics and supported by MPs of all parties, is not to provide a club to batter an opponent. Nor is it to act as a fig leaf to hide the shame of individuals or organisations that have not delivered on time or to budget. It is to give real practical guidance on how to get the best for patients, for NHS staff and the taxpayer, while giving a fair rate of return to the suppliers involved in such a high risk project. By its own admission the NAO did not look at the programme's technical feasibility. So the plan to enable doctors to access online the health records of everyone in England remains untested."

5.3. PAC Hearing of 26 Jun 2006

5.3.1. Uncorrected Transcript of Oral Evidence - PAC Hearing, 26 Jun 2006

http://www.publications.parliament.uk/pa/cm200506/cmselect/cmpubacc/uc1360-i/uc136002.htm

5.3.2. CfH accused of 'sham' on clinical consultation (27 Jun 2006)

e-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=1968

" Perhaps the most unexpected part of the Commons Public Accounts Committee hearing on the National Programme for IT this week was the appearance of two senior figures from the programme's early days – Dr Anthony Nowlan and Professor Peter Hutton – who came back to haunt the proceedings with accusations about lack of clinical engagement. Professor Hutton, a distinguished anaesthetist who resigned as chair of the National Clinical Advisory Board in April 2004, said: "A senior person said he felt the consultation was a sham. We used to meet in Starbucks in Leeds station to talk about it." He told the committee that he wrote setting out his concerns about the lack of meaningful clinical engagement ahead of systems actually being procured and within 10 days was

asked to resign. Dr Nowlan, a former director of the NHS Information Authority, said: " I was approached to provide hundreds of names of people who supported it [the NPfIT] and I declined." He said that he spoke to 10 people on the list of those who were shown to have been consulted and " none had any memory of any meaningful input into the programme." "

5.3.3. NPfIT scrutinised by Public Accounts Committee (27 Jun 2006)

E-Health Insider Primary Care

http://www.ehiprimarycare.com/news/item.cfm?ID=1969

The Public Accounts Committee hearing into the NHS National Programme for IT yesterday heard that the £12.4bn programme is largely on track, other than its central component: the NHS Care Records Service intended to deliver rich local clinical systems and a national database of summary records. So far just 12 acute trusts have so far received the patient administration systems that are meant to provide the first building blocks of detailed local care record systems. No trusts have yet received more complex integrated clinical systems – the local component of CRS. Committee chairman Edward Leigh, said: " There are 170 acute trusts and the system has just been deployed into 12, CRS is not in yet." . . . Leigh said that he had been told that CfH had fought the NAO over its report " street by street and block by block" . " I don't see it as a battle," said Sir John Bourn, head of the NAO. He added that robust debate with CfH, the examined body, was a natural part of the process. " Of course one side argued with the other." Greg Clarke, committee member and Conservative MP, said of the NAO report. " I've read 62 NAO reports over the past year and this is easily the most gushing."

5.3.4. Officials blame suppliers for NHS's NPfIT delays (27 Jun 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/06/27/216636/Officials+blame+suppliers+for+NHS's+NPfIT+delays.htm

" Lack of capacity among suppliers has led to things " going wrong" with the £12.4bn NHS National Programme for IT and is still a risk, senior officials have admitted to MPs. NHS chief executive Sir Ian Carruthers, director of IT implementation Richard Jeavons and Richard Granger, chief executive of Connecting for Health, which runs NPfIT, received a grilling at a Commons Public Accounts Committee hearing on Monday to examine the National Audit Office's report on NPfIT on Monday. The MPs were sceptical of the " almost universally positive tone" of the NAO report, described by Greg Clark MP as " easily the most gushing" he had seen, and turned the heat on the officials. Pressed by committee chair Edward Leigh, Caruthers admitted the two year delay in introducing a national clinical record service – a core part of NPfIT – was a decision taken because " some suppliers were having difficulties meeting the timetable" and clinicians wanted to pilot the scheme. Granger was forced to agree with Leigh that suppliers were showing " signs of strain" . In a heated exchange, Austin Mitchell MP challenged Granger, " You've got Accenture with an estimated half a billion dollar losses, you've got iSoft going belly up fairly soon, IDX which is blamed by BT and Fujitsu, from which BT wants to walk away and you've got Cerner brought in which I'm told is able only to support one hospital in one region using its standard software yet its been stretched to two regions." "

5.3.5. MPs slam NHS IT delays - Lack of early clinical consultation attacked... (27 Jun 2006)

Silicon.com

http://www.silicon.com/publicsector/0,3800010403,39159935,00.htm

" Delays with the £6.2bn NHS IT programme have been blamed on a lack of proper clinical consultation during the procurement of the systems. NHS CEO Sir Ian Carruthers and NHS director general of IT Richard Granger were grilled on the Connecting for Health programme by MPs during a heated Public Accounts Committee (PAC) meeting at the House of Commons this week. The National Audit Office (NAO) also came under attack for the " gushing" and " universally positive tone" of its long-delayed report into the NHS IT programme, despite the fact the cost of the scheme has risen to £12.4bn and the rollout of key systems is running years behind schedule, and was accused of being " ground down" by officials at the Department of Health."

5.3.6. Risk fears on NHS computer scheme (27 Jun 2007)

BBC News

http://news.bbc.co.uk/1/hi/uk_politics/5118538.stm

" England's NHS IT upgrade does pose clinical risks, but the system will " dramatically" cut the dangers of wrong prescriptions, MPs have been told. . . The questions session also saw the project's former senior clinical advisor claim that doctors were not consulted enough in its early stages. Peter Hutton, who was later asked to resign from his post, said people had not been sure what was needed. . . But Richard Granger, director general of IT for the NHS, said hundreds of doctors were already using the part of the system which had already been delivered. . . NAO chief Sir John Bourn told the MPs he thought the system was likely to be value for money, unlike many government IT projects. And he thought it would be delivered on time if the NHS accepted his recommendations. Sir John denied he had been " ground down by a war of attrition" with the Department of Health into producing a " gushing" report. He said there had been arguments and " proper debate" over his report - but such discussions were not " illegitimate" . But Public Accounts Committee chairman Edward Leigh said the project managers had fought " street by street, block by block" with the NAO."

5.3.7. Leader: No to any NHS IT whitewash - Why are officials refusing to admit there are problems? (27 Jun 2006)

Silicon.com

http://www.silicon.com/publicsector/0,3800010403,39159939,00.htm

" Public spending watchdog the National Audit Office (NAO) may have been able to ignore many of the problems with the £6.2bn NHS IT programme in its surprisingly upbeat progress report last week but MPs have not been as accepting. Indeed, at a packed and at times extremely heated Public Accounts Committee meeting at the House of Commons yesterday evening, MPs accused the NAO of giving in to bullying by Department of Health officials and producing a " gushing" and " universally positive" report into the Connecting for Health programme. More interesting were the barbed exchanges between MPs, NHS IT director general Richard Granger and two of his now highly critical ex-colleagues, Professor Peter Hutton. . . Granger has rightly been praised for drawing up IT contracts that avoid the mistakes of past government IT failures, only rewarding suppliers for delivery - and penalising them, rather than taxpayers, for failure to deliver. But at what cost has this come? Has the rush to procure and fit the timetable set by the Prime Minister led to a fundamental failure to engage the very people who will have to use the new NHS IT systems? Just this month we can see evidence of that in the £19m that some healthcare trusts in the south of England have had to pay to get out of a contract that could have seen them paying more than £50m per year in penalties to lead contractor Fujitsu Services for failing to provide IT resources to support implementation of new systems. And the PAC meeting heard that NHS Trusts in the northwest of England may now also have to fork out £37m to CSC to get out of a similar contractual obligation. The NHS IT programme is indeed a highly ambitious project and, understandably, with that will come risks and setbacks along the way. Yet while it is already delivering some tangible successes there are also serious causes for concern and simply trying to ignore that is a recipe for disaster. The question has to be asked: is now the time for the government to admit there should be a fully independent review of the NHS IT programme?"

5.3.8. NHS IT charade re-played - But does not stand up to PAC scrutiny (28 Jun 2006)

The Register

http://www.channelregister.co.uk/2006/06/28/pac_npfit/

" The £12.4bn National Programme for IT might not have been good value for money, said the National Audit Office on the publication of its report on the scheme only 10 days ago. This story had changed when the report's findings were quizzed by the House of Commons Public Accounts Committee earlier this week. Sir John Bourne, auditor general, said he thought the controversial NPfIT contracts would deliver value for money because they refused payment to suppliers until they had delivered results. This appeared to contradict Chris Shapcott, director of health value for money studies at the NAO, who said it would not be possible to assess whether NPfIT had been value for money until a proper cost benefit analysis had been done and the project was finished in 2010. Bourne went further, however, saying it was well thought out, and well managed considering the challenge of such an

ambitious scheme. The PAC hearing then unveiled a string of queries and revelations that appeared to support Shapcott's reserved view of the programme and less so what Greg Clark, conservative MP for Tunbridge Wells called the " most gushing" of 62 NAO reports he had read on he PAC. The committee heard how the management of the programme was haphazard. The wisdom accumulated from other bodged government IT projects holds that there should be one Senior Responsible Owner, or grand overseer. NPfIT had six SROs since 2004. NPfIT's vision had already implicitly criticised by the NAO in the one significant criticism levelled at the programme in its report, which was the lack of consultation undertaken with the system's users (clinicians) before the specification was drawn up, the contracts let and development commenced. . . Taking all the flack for this was Granger, the man brought in to do just the job he did: crack skulls and perform the miracle of pulling off the largest and most complex project of its kind ever attempted anywhere in the world, in record time. The fact that he hasn't pulled it off, that serious questions have been raised and must be taken further, should be answered by the senior responsible owner, if there had been one, or the chief executive of the NHS, had he not just resigned."

5.3.9. NHS IT faces fresh scrutiny: Claim that programme suffers a lack of clinical involvement is denied (29 Jun 2006)

Computing

http://www.vnunet.com/computing/news/2159310/nhs-faces-fresh-scrutiny

" The National Programme for NHS IT (NPfIT) is continuing to attract criticism for a lack of clinical involvement. Professor Peter Hutton, NPfIT chief medical adviser until 2004, told the Commons Public Accounts Committee (PAC) this week that the contracts signed in 2003 did not buy what doctors wanted. 'It was like being in a juggernaut on the M1 – it didn't matter where we went as long as we arrived on time,' said Hutton. But representatives from the NHS and Connecting for Health (CfH), the organisation responsible for implementing the programme, denied Hutton's claim. . . PAC chairman Edward Leigh emphasised the two-year delay to the national electronic patient record system at the heart of the programme. Of 170 acute hospitals, none is yet able to access national electronic records, he said. . . MPs questioned the report's broadly positive tone, in the light of its release a year later than expected and rumours of struggles between the NAO and the Department of Health over its contents. Bourn said the report took time be cause of the complexity of the subject. Summing up, Leigh said the programme is ambitious, with some positive elements but with systems not yet fully working on the ground. He requested further NAO investigation, to be discussed again by the committee."

5.3.10. NHS leader 'asked to resign' after voicing fears over lack of user input (4 Jul 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/07/04/216716/NHS+leader+%E2%80%98asked+to+resign%E2%80%99+after+voicing+fears+over+lack+of+user+input.htm

" He revealed the circumstances around his resignation at a meeting of the Public Accounts Committee last week into the NPfIT. The hearing was told that core software for the Care Records Service – a system designed to provide an online medical record for 50 million patients in England – has been delayed for at least two years. Hutton told the committee, " I think the situation we are in was entirely predictable in the early part of 2004." Hutton said he had written to Nigel Crisp, then chief executive of the NHS. His letter in March 2004 was written months after Whitehall had awarded £6.2bn worth of IT contracts as part of the NPfIT. The letter said, " I remain concerned that the current arrangements within the programme are unsafe from a variety of angles and, in particular, that the constraints of the contracting process, with its absence of clinical input, may have resulted in the purchase of a product that will potentially not fulfil our goals." Hutton told the committee, " Within 10 days of writing that, I was asked to resign." . . . Many statistics were given to MPs during their one-off hearing on the National Programme for IT. But they did not learn exactly why the core software is at least two years late. When an IT programme is in trouble, truth can become a precious jewel buried so deep it can be extracted only with tireless determination. That is why we continue to campaign for an independent review of the scheme. Not until last week did it emerge that a disastrous IT-related reform programme at the Child Support Agency had been the subject of 40 audit reviews, 70% of which had sounded alarm bells. None had been published, so there was no parliamentary pressure to act on them. Ministers say there have been many independent reviews of the NHS scheme. But none has been published. We

do not want to wait for years, perhaps until it is too late, to discover the real challenges and difficulties the NHS programme has faced."

5.3.11. Officials blame suppliers for delays to IT scheme (4 Jul 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/07/04/216718/Officials+blame+suppliers+for+delays+to+IT+scheme.htm

" Lack of capacity among suppliers has led to things " going wrong" with the £12.4bn NHS National Programme for IT, and it is still a risk, senior officials told MPs last week. NHS acting chief executive Ian Carruthers, director of IT implementation Richard Jeavons and Richard Granger, chief executive of Connecting for Health, which runs the IT programme, were questioned at the Commons Public Accounts Committee hearing to examine the National Audit Office's report on the NPfIT. The MPs were sceptical of the " almost universally positive tone" of the NAO report, described by MP Greg Clark as " easily the most gushing" he had seen. Pressed by committee chairman Edward Leigh, Carruthers said the two-year delay in introducing a national clinical record service was a decision taken because " some suppliers were having difficulties meeting the timetable" and clinicians wanted to pilot the scheme."

5.4. MPs prescribe 'rescue' plan for NHS IT project (18 Aug 2004)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2104

" The government has been urged to rethink its £12.4bn NHS IT project, and replace its current highly centralised national strategy with a more flexible locally-based approach based on standards. Such an overhaul is prescribed as the only way to reduce the risks of the programme, enable useful local clinical systems to be delivered and prevent costs from mushrooming and delays mounting. The call comes from two leading members of the Commons Public Accounts Committee, which reviewed the programme in June. They urge the government to rethink its plans to avoid the programme " sleepwalking into disaster" and wasting billions of pounds. Richard Bacon, the Conservative MP for South Norfolk, and John Pugh, the Liberal Democrat MP for Southport, argue the Connecting for Health (CfH) programme should be reformed to allow hospital trusts to purchase systems locally that can then be linked into the national network. . ."

5.5. MPs condemn NHS IT (8 Sep 2006)

The Register

http://www.theregister.co.uk/2006/09/08/mps_condemn_npfit/

" Two members of the Public Accounts Committee have condemned the centrally-run management of the National Programme for IT and called for a return to local decision making and procurement. Conservative MP for South Norfolk Richard Bacon and Liberal Democrat MP for Southport John Pugh picked the programme to pieces in a paper they published yesterday."

5.6. Uncorrected transcript of Oral Evidence given by Mr Andrew Rollerson (7 Mar 2007)

http://www.publications.parliament.uk/pa/cm200607/cmselect/cmpubacc/uc390-i/uc39002.htm

". . . I believe in this programme philosophically and intellectually, and have from a very early date, and have been very committed personally to doing everything in my power to make it succeed and, in fact, the talk I gave at the conference was aimed at assisting that process. I believe that there are certain elements of the deployment that could be done better but, given one cannot re□write history, the track we are going down can be made to succeed. . . My view is that there is a natural tendency to apply the techniques that one understands in any given situation, so standard project management techniques, even relatively low level programme management techniques, are applied to programmes in general. This programme is on a scale beyond anything attempted before and I believe, therefore, requires some innovative thinking and some of the best minds to be applied in terms of structuring it so that it can succeed over the long-term. It is naive to assume, in my view, that because something may go well in the early stages when things are relatively simple, crossing the foothills, if you like, as you start to

climb what is going to be an enormous mountain that those techniques will still work. Therefore, I believe this needs to be carefully thought out. . . An implementation programme of this scale and complexity continually runs into challenges and this was one of the aspects of the talk that I gave the other day, that there is a tendency to start shooting the alligators closest to the canoe in order to ensure that something at least is achieved, and this is the right thing to do provided that one does not lose sight of what one is trying to achieve overall. To extend the analogy, I suppose, if you are shooting alligators but fail to observe that you are about to go over a 300-foot waterfall, then you have essentially wasted your time by pursuing these immediate tactical goals, addressing tactical problems. In a programme this size you need to keep your eye on both. . .”

5.7. Suspended Fujitsu exec tells MPs NPfIT needs visionary leadership (8 Mar 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2529

“The senior manager at Fujitsu who said the National Programme for IT was in danger of delivering “a camel, and not the racehorse that we might try to produce”, has told a parliamentary committee that this can only be solved with more ‘visionary and proactive leadership from the NHS.’ Andrew Rollerson, who was credited as ‘formerly practice lead of the healthcare consultancy at Fujitsu’ , told the Commons Public Accounts Committee that he had faith in NPfIT but felt some issues needed correcting first. “I believe certain elements [of the programme] that need to be deployed could be done better. The current track for NPfIT can be achieved, but it is ambitious and risky.” . . . Rollerson told the committee that he was not aware of Computer Weekly’s intention to publish a controversial presentation he made last month until the day before the magazine published its edition. He has since been suspended from his duties by the company, pending an internal inquiry which could lead to disciplinary procedures. He revealed to the committee that Fujitsu, local service provider for the Southern cluster, had found NPfIT a difficult project to manage. “There has been ongoing debate in Fujitsu about the situation with the national programme,” he said. Rollerson blamed the delays in the national programme on resistance from trusts to go live with systems that had come under scrutiny from others. “There is already resistance from trusts, and there will be more if systems are just deployed on an IT path. It is essential that trusts are engaged with procurements, it could be true that trusts would be happier if they got the systems they actually want but I believe that such a fragmented approach would not have led to what we are about to achieve.” He added that the programme would not be any more successful if IT departments were left to procure and deploy systems themselves. “If NPfIT was left to IT departments to control, it would fail because the end users would not be engaged. If we’re not careful the driver will become the technology itself.” Rollerson spent all of his time away from the hearing surrounded by senior colleagues from Fujitsu. He told the committee that he felt reporting in Computer Weekly was out of context from what he thought was a presentation intended to be supportive of the national programme. He acknowledged that he did actually say what was reported by the magazine, but said he was discomforted by later coverage suggesting that he was a heroic whistleblower. This included reader comments read out to him in the PAC session taken from E-Health Insider’s coverage of the presentation. Despite not being a developer himself, he dismissed concerns from a committee member that his presentation was a “marketing gimmick”. Instead, he told the committee that in his decade with the company, he had been in daily contact with developers chosen for the project himself and has seen and learnt the issues first-hand. Asked why the LSP had not implemented in the 12 trusts it told the PAC it would by October 31 last year, Rollerson said Fujitsu had to work on changes from its initial supplier IDX and ensure Cerner was a success. . . He welcomed proposals for a catalogue of additional suppliers, but said it would not affect the LSP’s role in the NPfIT. . . He added that the national programme “requires some innovative thinking and some structure to succeed in the long term. It would be naïve to assume that systems will go well in the early stages.” , , Rollerson said that his presentation was approved by Fujitsu and he did not believe that his comments have damaged the credibility of what should be a huge success. The hearing was the second into the National Programme for IT by the House of Commons PAC following the National Audit Office Report, The National Programme for IT in the NHS, published on 16 June 2006.”

5.8. PAC Report of 17 Apr 2007

5.8.1. Department of Health: The National Programme for IT in the NHS (17 Apr 2007)

Public Accounts Committee

http://www.publications.parliament.uk/pa/cm200607/cmselect/cmpubacc/390/390.pdf

Conclusions and Recommendations:
1. The delivery of the patient clinical record, which is central to obtaining the benefits of the programme, is already two years behind schedule and no firm implementation dates exist. . .
2. The Department has not sought to maintain a detailed record of overall expenditure on the Programme and estimates of its total cost have ranged from £6.2 billion up to £20 billion. . .
3. The Department's investment appraisal of the Programme did not seek to demonstrate that its financial benefits outweighed its cost. . .
4. The Department is maintaining pressure on suppliers but there is a shortage of appropriate and skilled capacity to deliver the systems required by the Programme, and the withdrawal of Accenture has increased the burden on other suppliers, especially CSC. . .
5. The Department needs to improve the way it communicates with NHS staff, especially clinicians. . .
6. We are concerned that leadership of the Programme has focused too narrowly on the delivery of the IT systems, at the expense of proper consideration of how best to use IT within a broader process of business change. . .
7. The Department should clarify responsibility and accountability for the local implementation of the Programme. . .
8. The use of only two major software suppliers may have the effect of inhibiting innovation, progress and competition. . .
9. At the present rate of progress it is unlikely that significant clinical benefits will be delivered by the end of the contract period. . .

5.8.2. MPs dissect NHS IT plan's failings (17 Apr 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/04/17/223034/mps-dissect-nhs-it-plans-failings.htm

"After a nine-month inquiry into the NHS's National Programme for IT, the House of Commons Public Accounts Committee has today (17 April) published a forceful and authoritative report, the ramifications of which could be felt for years. The committee's concerns contrast with the comments in January of David Nicholson, chief executive of the NHS. He told an invited audience that though there were some big issues to tackle on the NPfIT, the programme was "not widely off course". He added that he saw no evidence of a need for an independent review of the scheme - as called for by 23 leading academics last year. Now, however, there is that evidence. The committee's report - which was drafted initially by the National Audit Office - depicts the NPfIT as a failure so far. It also finds that in some respects the programme might have done more harm than good, by inhibiting innovation and progress. The strongest criticisms are left to the report's final paragraph. It simply questions whether the 10-year contracts - which could cost taxpayers £6.2bn - will bring significant clinical benefits by the time they expire. This single conclusion undermines the credibility of the programme. . . The report includes quotes from papers submitted by experts. Anthony Nowlan, formerly a director of the NHS Information Authority, says the specification for national systems was produced at "breakneck speed". Thomas Brooks, a member of the all-party Parliamentary IT Committee, is quoted in a personal capacity. He criticises the idea that central procurement can produce systems that meet local requirements. . . A paper submitted by David Kwo, former NPfIT director for London, and others, including NHS staff, says that, with the delays in the delivery of the Care Records Service, "Local service provider schedules are being down-scoped behind the NHS's back and without any accountability to the local NHS trust chief executives to whom the original vision was promised." . . . The government is expected to respond to the report and its recommendations by July."

5.8.3. PAC says NPfIT suppliers are 'struggling to deliver' (17 Apr 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2617

A damning new report by the influential House of Commons Public Accounts Committee (PAC) questions the basic business case behind and contracts awarded for England's £12.4bn NHS National Programme for IT. The report focuses on the lack of progress on implementing electronic patient records which it says "suppliers are struggling to deliver" and calls for an urgent independent review. . . . Edward Leigh, chair of the PAC, said the programme, if successfully delivered, still offered huge benefits, but today warned that if it fails "it could set back IT developments in the NHS for years". . . Leigh summarised the conclusions reached by the PAC: "There is a question mark hanging over the National Programme for IT, the most far-reaching and expensive health information technology project in history. Urgent remedial action is needed at the highest level if the long-term interests of NHS patients and taxpayers are to be protected." Leigh called for "resolute action". "The department must get a grip on what it and the NHS are spending. It must thrash out with its suppliers a robust delivery timetable in which everyone, including NHS organisations, can have more confidence." He added that if advanced electronic patient record systems cannot be delivered by current suppliers within the framework of the programme, "then the local NHS should be given greater freedom to look for alternative systems which do work." Leigh warned that "the stakes are high" saying that the programme, if successful could revolutionise the way the NHS in England uses information, significantly improving patient care. . ."

5.8.4. The sickening £12 billion NHS fiasco (17 Apr 2007)

Daily Telegraph

http://www.telegraph.co.uk/opinion/main.jhtml?xml=/opinion/2007/04/17/do1702.xml

". . . The project is costing more than £12 billion, enough to pay for 60,000 nurses for 10 years, or for Britain's participation in Iraq and Afghanistan twice over. . . By now, almost every hospital in England is supposed to have key administrative software deployed as the essential first step in introducing the shiny new electronic patient record. They are miles behind schedule, yet the limited deployment has already caused havoc, with significant delays in providing inoculations to children, waiting list breaches, missing patient records and the inability to report activity statistics. Not to mention the trifling matter of the largest computer crash in NHS history, when 80 hospitals had no access to patient administration systems for four days. This is a truly grim tale. More than £2 billion has been spent, and although there is no detailed record of overall expenditure on the programme, estimates of its total cost have ranged from £6.2 billion up to £20 billion. There have been six bosses in five years. Timetables are fictitious and the programme is now years behind. Doctors, nurses and hospital managers have been left spitting with rage. Most GPs think the appointment booking system is a joke. And three fifths of the programme is dependent on a software supplier called iSoft, which is currently under investigation by the Financial Services Authority and whose flagship software product, "Lorenzo", does not exist yet (even though the company said it was available three years ago). In the meantime, iSoft has been merrily selling old software that pre-dates the national programme. Today, Parliament's spending watchdog publishes a report on this multi-billion-pound fiasco, which concludes: "At the present rate of progress, it is unlikely that significant clinical benefits will be delivered by the end of the contract period." The whole project has been an object lesson in how not do it. There are some basic rules of thumb that apply to successful IT projects: start small, do it in stages, learn from your mistakes, resist the grand vision thing, scale up only when you know what you are doing, and - above all - talk to the people who will use it. . . If Connecting for Health had been created by one of this country's enemies with the specific task of wasting as much money as possible while causing maximum anger and resentment among doctors, nurses and hospital managers, it could hardly have done a better job. Having been given responsibility for the largest sum of money ever allocated to a health IT programme anywhere in the world, at least £12.4 billion, which incidentally dwarfs the entire NHS deficit, it has failed to deliver. This disastrous agency should be put out of its misery, but most of its budget - £10 billion is still unspent - and its purchasing functions should be handed over to local hospital bosses. Any remaining functions could be handled by the Department of Health directly. IT has a tremendous role to play in healthcare and it saves lives. . ." [Richard Bacon MP]

5.8.5. PAC report brings brickbats and bouquets for NPfIT (18 Apr 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2619

"Mixed reaction greeted the House of Commons Public Accounts Committee's report on the National Programme for IT with critics and supporters dividing on predictable lines and the NHS Confederation

saying the programme must be made to work, despite its problems. Health minister Lord Hunt, claimed the evidence taken to produce the report was outdated. "This PAC Report is based on a NAO [National Audit Office] report that is now a year out of date. Since then substantial progress has been made and the NAO recommendations have already been acted on. Costs of the programme have not escalated. In fact, the NAO acknowledged that costs were under control and the strength of the contracts means that payment is not made until systems are delivered which protects the taxpayer. The NHS IT programme is already being used by clinicians and bringing benefits for patients with digital technology transforming diagnosis and treatment every day. Electronic prescriptions are now available and digital x-rays are increasingly in use across the country." . . . Dr Gill Morgan, chief executive of the NHS Confederation which represents over 90% of NHS organisations, told EHI that it was essential that NPfIT was made to work and the government should resolve any outstanding issues. . . James Johnson, chairman of the BMA, agreed with the proposal for a review of clinical involvement in NPfIT. . . Liberal Democrat health spokesperson, Norman Lamb, said: "There can be no doubt that the ministers' plans have gone badly wrong. The government has put IT in the NHS in a centrally controlled strait jacket. "The damning evidence in this report is that delays in implementation and a lack of compatibility with local systems is proving disruptive to local hospitals. How soon will it be before another technical glitch puts patients' lives at risk? Any discussion with people working in the NHS leaves an overwhelming sense of loss of confidence in the project. The government cannot continue to charge ahead with the system, blind to ever more stark warnings." Lamb said that his party felt that there should be no further spending on NPfIT until a resolution to the problems raised is found. . ."

5.8.6. Why won't DoH heed criticism of IT policy? (18 Apr 2007)

Healthcare Republic

http://www.healthcarerepublic.com/news/Opinion/651308/Why-won%E2%80%99t-DoH-heed-criticism-policy/

"Why is the DoH behaving like a spoilt child over the National Programme for IT (NPfIT)? Its reaction to any criticism of the great IT plan or any suggestion for change is the political equivalent of sticking its fingers in its ears and going 'la la la' before declaring 'No! Shan't!' repeatedly. Widespread criticism from experts and stakeholders in other areas has seen major government projects dropped, ministers resigning and in one case the wholesale reform of a government department. But not so with Connecting for Health and the NPfIT. It seems to have ignored calls for change by IT experts and survey findings, including some of GP's own, that clinicians have not been engaged in the programme and remain unconvinced of its clinical benefit. Concerns over the value of Choose and Book, the amount of time it takes up and whether the software works, have been dismissed as the rantings of luddites. Yet it is difficult to find anyone connected with it to say any thing positive about the Connecting for Health projects. Now even MPs are voicing concerns, with the Public Accounts Committee (PAC) producing what even the most generous souls would describe as a damning report, which includes evidence from the GP survey. The PAC criticises the DoH for the lack of any analysis of the benefits of NPfIT against its costs, the lack of a coherent timetable and its failure to engage clinicians in the project. In fact it says there is no sign that the programme will deliver tangible benefits during the the current contract period. Such are the criticisms of the programme that one member of the PAC has called for it to be wound up immediately, although the report merely asks for an urgent review. This time, the DoH has no excuse for another sulk. The MPs on the PAC are neither users of the system nor 'disgruntled' IT experts — perhaps it is time to listen to the facts."

5.8.7. MPs urgently demand a new IT strategy (19 Apr 2007)

Health Service Journal

http://www.hsj.co.uk/healthservicejournal/pages/n1/p9/070419

"A Commons scrutiny committee has said 'urgent' action is needed to rescue the national IT programme. In a damning 188-page report the public accounts committee said it was 'unlikely that significant clinical benefits will be delivered by the end of the contract'. The Department of Health should instead determine what will be ready by then 'as a matter of urgency', it said. But the DoH criticised this week's report as 'a year out of date' and a spokesman said 'substantial progress has been made' in IT development. The report said the shared patient record is two years behind schedule and alternative patient administration systems were 'not a substitute'. As the DoH is 'unlikely to complete the programme anywhere near its original schedule', providers should be able to 'select from a wider range' of PAS systems, it concluded. This was important, the report said, as only two major software

providers remain on the programme after the departure of Accenture, ComMedica and IDX. Having only two suppliers 'may have the effect of inhibiting innovation, progress and competition' it said. This meant a higher burden was now on the remaining suppliers, who were suffering from 'a shortage of appropriate and skilled capacity'. It added: 'It is essential that chief executives and senior managers in the NHS understand the role they need to play in the implementation of the programme.' . . . Committee chair Edward Leigh MP called for a 'robust delivery timetable' from the DoH. He said: 'Urgent remedial action is needed at the highest level if the long-term interests of NHS patients and taxpayers are to be protected.' But health minister Lord Hunt said the findings were based on last June's National Audit Office report on the programme and therefore out of date. . ."

5.8.8. Report exposes stark reality of NHS IT (24 Apr 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/04/24/223391/report-exposes-stark-reality-of-nhs-it.htm

"The Public Accounts Committee has done us a service by directing attention to the poor progress being made on the central plank of the NHS's National Programme for IT. It has reminded us that most of the benefits of the scheme will be obtained by creating detailed electronic care records at the local level, and that it is the local Care Records Service which, together with central overheads, accounts for 82% of the NPfIT's total expenditure. To their credit, the MPs on the committee have not allowed themselves to be diverted by the high profile that has been created for national services and the digital x-ray programme. The report makes grim reading. We are told that the first phase of delivering local care records is already two years behind schedule, with no firm completion date identified. This is despite acute trusts needing to do no more than replace the existing patient administration system with one from the NPfIT. By February 2007 only 18 trusts out of 150 had done this. Or had they? Well, no, actually. Not really. For in delving a little deeper, it transpires that due to delays in software development, no NPfIT patient administration systems are yet available in the three clusters served by iSoft, and in fact only old, pre-NPfIT systems have been implemented. But it gets worse. What of phases two and three, the addition of NPfIT clinical functionality to patient administration systems, which are "the key to the delivery of clinical benefits"? We are told that their implementation may scarcely have begun by the time the original local service provider contracts expire in 2014. What do we make of Lord Hunt's statement that the Public Accounts Committee's report is out-of-date? Alas, the situation described above is only too up to the moment. The committee's report is out of date only in that the latest problems, such as those encountered by Milton Keynes General Hospital, came too late to be included. . . So what is to be done? The report makes two sensible recommendations. It endorses the current move to make local chief executives accountable for implementation of NPfIT, but with one absolutely crucial proviso: that they are not merely given responsibility, but also "authority and resources." In other words, that budgetary responsibility and control of suppliers must also be delegated. The report then recommends that additional suppliers of core Care Records Service software are brought in to create an element of local choice." [About the author: Alan Shackman is a contributor to a paper published in the Public Accounts Committee's report on the NPfIT. He is an independent consultant who has worked on electronic patient record-connected matters for more than 15 years, directly for NHS trusts. He was also an interim NPfIT programme director. He has been involved in a number of Electronic Patient Record procurements.]

5.8.9. Granger says 'consultation' led to records delays (26 Apr 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2643

"Richard Granger, the director general of IT for the NHS today (26 April) told the House of Commons Health Select Committee that he blames the two year delay in delivery the electronic patient record system at the heart of the NHS IT programme on 'consultations' taking longer than anticipated, He said: "Some aspects have been delayed by 24 months because the consultation schedule on these aspects has gone on far longer than was originally scheduled. Significant further work was necessary in the task of creating an environment where the necessary specification was stable. It would be inappropriate to roll it out as it was because it would later need serious re-working at a cost to the taxpayer." Granger was giving oral evidence as part of the committee's investigation into the electronic patient record, just a week after the Commons Public Accounts Committee issued a damning reports on the delayed programme. The NHS IT boss began by making a statement of benefits delivered, reeling

off statistics on systems delivered. . . “The main problem we are facing are two extremities – waiting patients and privacy fascists and we are trying to find a pathway for the middle of the two.” Explaining the reasons behind difficulties in implementing systems in the acute sector, he said: “It is very difficult to implement in brownfield sites but we are making progress. Last week we did three simultaneous deployments in Surrey and Sussex, Ipswich and Northampton.” . . In a later session, Dr Paul Cundy, chair of the General Practitioner’s Joint IT Committee, Dr Martyn Thomas representing the UK Computing Research Committee and Andrew Hawker, a former system developer and an NHS patient dismissed Granger’s comments and called for an independent hearing into NPfIT. Dr Thomas said: “As the specification is still evolving, the plan for delivery is built on sand. This project has all the hallmarks of a massive failure, when it is meant to transform the way of working.” Dr Cundy added: “The failure to consult with us has led to the amount of consultations that have been mentioned. We would have had a much more incremental process if we had our views dealt with from the start.” When asked if he felt an independent review was necessary, Granger said: “Are the people calling for it themselves independent? We have a programme under immense scrutiny, and the minister took a decision last year that such a review was not necessary.” The hearing follows the submission of 68 pieces of written evidence compiled in a 192 page document submitted to the committee.”

5.8.10. From Private Eye (27 Apr 2007)

Private Eye

“The government still has its head in the sand over the NHS National Programme for IT, even after last week’s disastrous report from the Public Accounts Committee -- probably its most comprehensive demolition job on a major government project. MPs called for a root and branch review, yet health minister Lord Hunt claimed that the PAC was “based on a National Audit Office report that is now a year out of date. Since then substantial progress has been made and the NAO recommendations have already been acted on.” Alas, there were few serious NAO recommendations to act on as it was bullied by the agency running the programme, Connecting for Health, into producing a whitewash. And the PAC report was actually based more on information submitted by experts since the NAO reported, plus 49 questions posed by Tory MP Richard Bacon that should have been put by the NAO in the first place. And progress has been anything but “substantial” - and where there has been action “progress” is not quite the word. Milton Keynes hospital installed a new system in February, since when thousands of patient records have gone missing. Seventy-nine members of staff have written an open letter declaring the system “not fit for purpose”. The future looks no brighter as the plan to shift responsibility from the woeful CfH to strategic health authorities is already behind schedule -- partly, perhaps, because of the admin costs they would have to take on. One of Bacon’s questions revealed there were 471 consultants at work in CfH at daily pay rates up to £2,493. As the Eye might have mentioned before, the same consultancy industry now getting even richer from the programme had a big hand in bringing it about in the first place.”

5.9. NHS IT plan "is a success story" (30)ct 2007)

Computing

http://www.computing.co.uk/computing/news/2202338/nhs-plan-success-story

"The NHS National Programme for IT (NPfIT) is now so well advanced that the health service “could no longer function” without it, the government has said. Exchequer secretary to the Treasury Angela Eagle told MPs last week that NPfIT is a success despite delays implementing key aspects of the strategy, including the Lorenzo next-generation hospital administration package. "Without the programme, the NHS could no longer function, and it is providing essential services and significant benefits to tens of thousands of clinicians and millions of patients," she said. Eagle was replying to a Commons debate on a series of reports from the Public Accounts Committee (PAC) on government computing disasters. Conservative MP Richard Bacon highlighted the PAC report on the NHS which said that Lorenzo - on which three-fifths of the programme was said to depend - was not yet available despite a claim in supplier iSoft's 2005 annual report that it was. He said a Treasury minute had stated the software was not expected until 2008 and he asked that a minister announce its arrival in Parliament when it happens. But Eagle said NPfIT "is a success story that ought to be acknowledged". "More than 5.5 million appointments have now been made using the Choose and Book system, representing 44 per cent of first referrals,” she said. "In addition, 397 million diagnostic images are now stored centrally, and 42 million electronic prescriptions have been used in a service that is now available in 41 per cent of pharmacies and 47 per cent of GP surgeries. "Nearly 400,000 users are registered to use the NHS care records spine, with 45,000 NHS staff accessing it daily." Eagle said

national leadership had been strengthened by the appointment of a chief clinical officer and national clinical leads.

5.10. MPs see Lorenzo demo amid new NPFIT delays (16 Jun 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/06/16/231079/mps-see-lorenzo-demo-amid-new-npfit-delays.htm

"MPs on the Public Accounts Committee have seen a demonstration of the delayed "Lorenzo" software - a key part of the NHS's National Programme for IT - ahead of a hearing in the House of Commons today (16 June 2008) on the £12.7bn scheme. . . Morecambe Bay Hospitals NHS Trust and two other early adopters of the software, Bradford Teaching Hospitals NHS Foundation Trust and South Birmingham PCT, have issued a statement saying that "deployment testing is identifying technical issues which are being resolved on an ongoing basis". The three hope to go live this summer with Lorenzo Release 1, but they gave no commitment on any date in their statement. . . But the demonstration did not allay the concerns of all the MPs present. The Lorenzo software is already running four years behind schedule, according to the report of the National Audit Office which was published on 16 May 2008. Richard Bacon, one of the MPs present at the demonstration, said that seeing a system apparently working on a single large screen did not necessarily prove it would work when used by doctors and health staff across many PCs at various hospital sites that form an NHS trust. Ministers have tried to counter criticism of delays with the Care Records Service by giving series of dates when the first sites will go live. But the dates for go-lives have been deferred repeatedly. . ."

5.11. The National Programme for IT in the NHS: Progress since 2006 (14 Jan 2009)

House of Commons Public Accounts Committee

http://www.publications.parliament.uk/pa/cm200809/cmselect/cmpubacc/153/153.pdf

Summary Conclusions and Recommendations:

1. Recent progress in deploying the new care records systems has been very disappointing, with just six deployments in total during the first five months of 2008-09.

2. By the end of 2008 the Lorenzo care records software had still not gone live throughout a single Acute Trust.

3. The planned approach to deploy elements of the clinical functionality of Lorenzo (release 1) ahead of the patient administration system (release 2) is untested, and therefore poses a higher risk than previous deployments under the Programme.

4. Of the four original Local Service Providers, two have left the Programme, and just two remain, both carrying large commitments.

5. The termination of Fujitsu's contract has caused uncertainty among Trusts in the South and new deployments have stopped.

6. The Programme is not providing value for money at present because there have been few successful deployments of the Millennium system and none of Lorenzo in any Acute Trust.

7. Despite our previous recommendation, the estimate of £3.6 billion for the Programme's local costs remains unreliable.

8. The Department hopes that the Programme will deliver benefits in the form of both financial savings and improvements in patient care and safety.

9. Little clinical functionality has been deployed to date, with the result that the expectations of clinical staff have not been met.

10. The Department has taken action to engage clinicians and other NHS staff but there remains some way to go in securing their support for the Programme.

11. Patients and doctors have understandable concerns about data security.

12. The Department does not have a full picture of data security across the NHS as Trusts and Strategic Health Authorities are required to report only the most serious incidents to the Department.

13. Confidentiality agreements that the Department made with CSC in respect of two reviews of the delivery arrangements for Lorenzo are unacceptable because they obstruct parliamentary scrutiny of the Department's expenditure.

6. Parliament

6.1. Early Day Motion: NHS Connecting for Health Computer System EDM (27 Apr 2006)

http://edmi.parliament.uk/EDMi/EDMDetails.aspx?EDMID=30557&SESSION=875

" That this House notes with concern the contents of a letter to the Commons Health Select Committee signed by 23 senior academics in computer-related science which criticises the NHS Connecting for Health computer system . . ."

6.2. National Programme for IT - Hansard (24 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060524/text/60524w0550.htm#06052547000231

" Caroline Flint: The National programme is already the focus of regular and routine audit, scrutiny and review. It has been subject from its inception to the Office of Government Commerce Gateway process. Gateway reviews have been, and continue to be, undertaken at each of the standard stages throughout the development of every component project within the programme, and of its cluster-based deployment activity from initiation through to live running. A similar annual and ongoing programme of audit reviews has been, and continues to be, carried out by the Department's internal auditors. A National Audit Office (NAO) value for money study into choice at the point of referral, which reported in January 2005, involved close scrutiny of the work of the national programme and specifically the choose and book programme. The report on a further NAO value for money study into wider aspects of the programme has yet to be published, and this has included an independent review of programme management capability. In addition, the programme's own quality management function undertakes a broad range of reviews and audits of specific aspects of programme, cluster and supplier activity on an ongoing basis. A number of independent reviews have been commissioned under contract, including one commissioned from McKinsey to inform the approach before the start of the programme, and from other suppliers to establish the value for the national health service and taxpayer achieved through the contracts and to examine specific aspects such as disaster recovery. Ongoing review is also encouraged by transparent discussion with key stakeholder groups including the British Medical Association and through consultation initiated by the care record development board. We remain confident that the technical architecture of the national programme is appropriate and will enable benefits to be delivered for patients, and value for money for the taxpayer, without further independent scrutiny."

6.3. Blair backs NPfIT (29 Jun 2006)

Kablenet Computing

http://www.kablenet.com/kd.nsf/Frontpage/674FA43D988A25DA8025719C00340AE9?OpenDocument

" The prime minister has declared his faith in the NHS National Programme for IT. Tony Blair stated his support in response to a parliamentary question from Conservative MP Richard Bacon on 28 June 2006. Bacon asked how much has been spent on the programme. The prime minister answered that, up to the end of March 2006, expenditure on the contracts let at is outset was £654m. He took the opportunity to repeat the National Audit Office's approval of its progress and " tight control" , and that it is planned to connect more than 30,000 GPs in England to over 300 hospitals. Bacon followed up by asking for an assurance that suppliers who fail to deliver on the contracts would not be paid, citing the case of iSoft. The company is one of the biggest suppliers to the programme and has recently reduced its profits forecast due to factors related to NPfIT. Blair said he was not aware of the example, but took the chance to express his faith in the programme. " In the end, one of the huge benefits of having a National Health Service is that we can have electronic patient records that are transferable right around the system," he said. " If that happens, it means not just an end to vast amounts of paperwork in the NHS, but that things such as patient choice, for example, can become a reality."

6.4. Early Day Motion 2911: Data Intrusion (6 Nov 2006)

http://www.publications.parliament.uk/pa/cm/cmedm/61106e01.htm

" That this House notes with concern the increasing incidence of data intrusion or `data rape' as it is increasingly becoming known, the process whereby personal and hitherto confidential data is transferred to central databases established by the Government which can then be made available to third parties, such as police and security services, without consent being required; notes that the operation of the new national medical database will require medical records, which until now have remained in the confidential custody of general practitioner practices, to be uploaded to the Spine, a computer which will collect details from doctors and hospitals; supports the British Medical Association in its demand that patients should be asked for their explicit permission before their files are transferred; further notes with concern the reports of plans to establish and expand national databases in relation to the identity card scheme, DNA and the national census; and calls on the Government to establish a legislative framework that will safeguard access to personal data which has as its foundation not only the requirement for explicit consent but the right to know which agencies have a right to, and have requested access to, personal information."

6.5. Details of Relevant All-Party Groups

" All-party groups are regarded as relatively informal compared with other cross-party bodies such as select committees of the House. The membership of all-party groups mainly comprises backbench Members of the House of Commons and Lords but may also include ministers and non-parliamentarians."

6.5.1. Associate Parliamentary Health Group

http://www.publications.parliament.uk/pa/cm/cmparty/061206/memi275.htm

" Purpose: To provide high quality information to all parliamentarians on local and national health issues in order to generate greater awareness of and participation in the national health debate."

6.5.2. All-Party Parliamentary Group on Medical Technology

http://www.publications.parliament.uk/pa/cm/cmparty/061206/memi330.htm

" Purpose: To raise awareness of the benefits of medical technologies and to highlight the problems of patient access to these technologies."

6.5.3. All-Party Parliamentary Group on Primary Care and Public Health

http://www.publications.parliament.uk/pa/cm/cmparty/061206/memi382.htm

" Purpose: To raise the profile of primary care and public health within parliament; to speak within parliament on behalf of both users and those working in the NHS; to place primary care and public health high on the government's agenda; and to inform debate by parliamentarians with outside bodies."

6.6. Engineering: turning ideas into reality (18 Mar 2009)

House of Commons Innovation, Universities, Science and Skills Committee

http://www.publications.parliament.uk/pa/cm200809/cmselect/cmdius/50/50i.pdf

". . . Large IT systems are an area of Government procurement that has and continues to experience both bad press and implementation problems. Some would assert that specifications have been driven by political imperatives rather than being derived from operational requirements; a situation which would apply to both the ID Card project and the National IT Programme (Connecting for Health). It is possible that this approach has led to decisions about the architecture of systems being taken or assumed before detailed expert advice was taken. Here, a distinction needs to be made between the advice received by Government in the procurement of systems, which is often good and realistic, and the advice received in the development of policies which are delivered through the procurement of IT, which is often lacking. . ."

6.7. Troubled £12bn NHS IT system to be scaled back (6 Dec 2009)

BBC News

http://news.bbc.co.uk/1/hi/uk_politics/8397854.stm

The government is to scale back its £12bn NHS IT system in what the Tories are calling a "massive U-turn". Chancellor Alistair Darling said he would be delaying parts of the scheme in Wednesday's pre-Budget Report as it was "not essential to the frontline". The move may save hundreds of millions but Mr Darling admitted it was only a fraction of total spending cuts needed. The Tories and Lib Dems have been calling for the IT system, which has been hit by costly delays, to be axed. Mr Darling told BBC One's Andrew Marr show he was determined to halve Britain's budget deficit over the next four years and as a result public spending would be "a lot tighter than it was in the past". He stressed that the pre-Budget report was not a spending review, but added: "I do think it is necessary for me to indicate areas where we are going to cut spending or where we're not going to spend as much as we were. "For example, the NHS had a quite expensive IT system that, frankly, isn't essential to the frontline. It's something I think we don't need to go ahead with just now." . . . Treasury officials have stressed that only part of the NHS IT programme is facing the axe, and the whole project will not be scrapped. But the Conservatives said Mr Darling's words represented a "massive U-turn". Shadow Health Secretary Andrew Lansley said it was "another government IT procurement disaster". "After seven years Labour have finally acknowledged what we've said for years, that the procurement for NHS IT was costing billions and not delivering," he said. The electronic patient record system, which is thought to have cost about £12bn so far, was commissioned in 2002 by then prime minister Tony Blair, and was meant to be completed by 2010. It was supposed to computerise medical records in a central database and link up more than 30,000 GPs to nearly 300 hospitals. Mr Lansley told BBC One's Politics Show the Tories would scrap the "enormous centralised IT system" and instead give hospitals "the opportunity to buy IT systems" that could transfer images, patient records and prescriptions electronically. It comes as the Conservatives called for a moratorium on all government computer projects, ahead of the publication of the government's five-year IT strategy later this week. . .

7. Individual Members of Parliament

Written parliamentary questions (since Jan 2004), and papers, speeches, etc., relating to concerns about NPfIT, by current MPs. (The links provided for parliamentary questions and speeches in parliament are to the relevant Hansard page - ministerial answers to questions immediately follow the text of questions.)

7.1. David Amess

(Southend West, Conservative - Member, Health Committee)

7.1.1. House of Commons Debate (11 Nov 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041111/debtext/41111-22.htm#41111-22_spnew3

" I am informed that we will be given " a demonstration of the Choose and Book software which will enable GPs to make direct referrals to Secondary Care and a demonstration of the NHS Care Records Service which will allow the sharing of consenting patients' records across the NHS" . We look forward to that. However, another GP wrote to me saying: " Primary care doctors now feel more like data input clerks than general practitioners, spending much more time than ever inputting information into computer systems in order to reach targets that achieve points that have no proven clinical basis. Doctors striving to reach these unrealistic targets solely to reap the financial rewards that this brings, are compromising good standards of clinical care and 'Points mean prizes' are now the watchwords . . . . The data input requirements that are part of the Quality Outcome Framework mean doctors spend much time staring at their computer screens during what should be 'face-to-face' consultations. There is a general feeling of frustration that the data collection is detrimental to patient care. The public, who are ultimately funding the massive increase in health spending, frequently complain to primary care providers that they are seeing little in the way of improvement and know full well that there are lies, damn lies and statistics and do not believe the figures put out by the Department of Health" ."

7.2. Richard Bacon

(South Norfolk, Conservative - Member, Public Accounts Committee)

7.2.1. House of Commons Debate (12 Feb 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040212/debtext/40212-24.htm#40212-24_spnew1

" The NPfIT concerns the provision for clinicians of electronic patient records, and it is costing a fortune. Estimates have varied. A recent announcement valued contracts in the region of £2.3 billion. That figure rose to £2.6 billion, and following the recent letting of quite a few contracts, it has reached some £4.2 billion. Indeed, it is expected to rise still higher. The problem is that however much money is spent on the programme, it will not work unless there is buy-in from the users. One of the classic problems with such projects is that the users are not consulted adequately or in time. The magazine Computer Weekly and the NPfIT itself jointly undertook a study of this issue. A health care market research firm called Medix undertook a survey of people in the health service who might need to have contact with the programme. It asked, " What consultation has there been with you personally about the NPfIT?" One per cent. described such consultation as " More than adequate" ; 3 per cent. said it was " Adequate" ; 8 per cent. said it was " Barely adequate" ; and 11 per cent. said it was " Inadequate" . However, 75 per cent. said of such consultation that there had been " None at all" , and 2 per cent. were " Unsure" . The NPfIT was so furious about these results that it issued its own press release, in which it completely ignored any of the survey's negative findings. Those who want to check the survey can do so easily, as it has helpfully been made available on the internet. That is one of the few ways in which IT manages to hoist itself by its own petard."

7.2.2. House of Commons Debate (29 Jun 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040629/debtext/40629-25.htm#40629-25_spnew1

" The project has seen Professor Peter Hutton, the chief clinical adviser, resign as chairman of the clinical advisory board, and until extremely recently the views of GPs had been largely ignored.

Indeed, in respect of many of the other projects that we have considered, the advice of the National Audit Office concerning the need to consult early was also totally ignored. The NHS has contracted to buy far more systems in phase 1 than there is demand from hospital trusts, and in phase 2 the contractors will almost certainly be unable to meet the likely demand. Finally, GP magazine described the programme as " more likely to be a fiasco than the Dome" ."

7.2.3. Parliamentary Question (20 Oct 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041020/text/41020w34.htm#41020w34.html_wqn2

" To ask the Secretary of State for Health what the financing arrangements are for the National Programme for IT in the national health service; and what steps the Government are taking to secure the buy-in of clinicians to the programme."

7.2.4. Parliamentary Question (21 Jul 2005)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm050721/text/50721w59.htm#50721w59.html_wqn4

" To ask the Secretary of State for Health which primary care trusts have issued Connecting for Health smartcards with the same PIN number for every user."

7.2.5. Parliamentary Question (27 Feb 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060227/text/60227116.htm#60227116.html_wqn1

" To ask the Secretary of State for Health whether (a) her Department, (b) Connecting for Health and (c) other NHS bodies have unfulfilled contractual minimum volume order obligations to local service providers."

7.2.6. Parliamentary Question (8 Mar 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060308/text/60308w36.htm#60308w36.html_wqn0

" To ask the Secretary of State for Health: (1) what the contracted obligations of the public sector are under the Connecting for Health Supplier Attachment Scheme; what the maximum cost to public funds is of not meeting these obligations; and if she will make a statement; (2) what representations (a) her Department and (b) Connecting for Health have received from (i) local service providers and (ii) NHS bodies about the Supplier Attachment Scheme."

7.2.7. MP says Blair's NHS computer dream " won't work" (6 Aug 2006)

http://www.richardbacon.org.uk/parl/npfit2.htm

" The last few months have seen a succession of disasters for the NHS national programme for IT: The North West and West Midlands have seen the worst computer crash in NHS history; the London region has seen its major software supplier sacked and the Health Protection Agency warning of a serious risk to the health of children because IT failures have made a mess of vital vaccination programmes; the Nuffield Orthopaedic Hospital failed all waiting list targets as a direct result of the Connecting for Health deployment; and new systems in North West and West Midlands hospitals have repeatedly lost or mislaid patient records. The list of failures and delays grows ever longer. Two and a half years in, the programme is two years late" Now it seems that some of the most senior officials in the NHS know perfectly well that the National Programme will never work properly – indeed that many hospitals would now be better off if they had never taken part in the scheme in the first place. The National Programme has already cost well over a billion pounds and the final tally if it continues could rise to over £15 billion. Much of this money will be wasted. Worse still, the health of patients could be put at risk. This scheme was the personal brainchild of the Prime Minister and he must now act at once to bring this failed experiment to a speedy end."

7.2.8. House of Commons Debate (18 Jul 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060718/debtext/60718-1003.htm#0607196000134

" One of the suggestions that has been made by Connecting for Health is that 750,000 prescriptions have been issued by using the electronic prescribing service. One of the slightly alarming facts is that only 1.5 per cent. of those were received electronically by pharmacists and hence dispensed. The rest of them—some of 740,000—simply vanished into the ether, never to be seen or heard of again. The thought of thousands of NHS staff typing pointlessly away is a combination of industry and futility that I find rather depressing to contemplate. The reason for that state of affairs is that, where systems were put in place in GP surgeries, the corresponding systems were not put in place in pharmacies, and sometimes vice versa. That is a relatively small example of some of the problems. There are many others. Perhaps the most important and difficult component of the national programme is the delivery of patient administration and clinical systems into acute hospital trusts. We should by now have 110 acute hospitals with patient administration and clinical systems in place. The actual number is just 12. Of those 12, how many are clinical systems? The answer is none. Not a single hospital-wide clinical system has been delivered under the national programme. The choose and book system should allow patients to book appointments with doctors electronically. Almost half of all GP referrals—some 8.5 million a year—are supposed to be made under that system by September 2007, but so far we have only 300,000 bookings. The number of bookings can found on the Connecting for Health website. What is not on the website, but is true, is that by the Department of Health's own estimate, only about one quarter of the bookings that have been achieved were made truly electronically; the remaining three quarters were made by telephone. . . Mr. Granger, the programme's director general, is fond of using blood-curdling metaphors when speaking about IT contractors. He intends, he says, to treat them like huskies—when one goes lame, it is shot, cut up and fed to the rest—apparently, that keeps them keen. However, managing a massive IT programme is not like running a dog sled. I believe that that brand of macho management threatens to bring yet more chaos to an already tottering system."

7.2.9. Information Technology in the NHS: What Next? (Sep 2006)

By Richard Bacon MP and John Pugh MP

http://www.richardbacon.org.uk/parl/WHAT_NEXT_FOR_NHS_IT.rtf

" The National Programme for IT in the NHS is currently sleepwalking towards disaster. It is far behind schedule. Projected costs have spiralled. Key software systems have little chance of ever working properly. Clinical staff are losing confidence in it. Many local Trusts are considering opting out of the programme altogether. These problems are a consequence of over-centralisation, over-ambition and an obsession with quick political fixes. But a reformed programme can still be rescued. Recent publicity and the shake-up already underway among Local Service Providers and key contractors provide an opportunity to do this, which must not be missed. What is required is to create a proper balance between central standards and central procurement where this offers demonstrable benefits, and local autonomy and responsibility. IT offers enormous potential benefits to the NHS, its staff and above all its patients. It is not too late to make sure that these benefits are properly delivered."

7.2.10. Parliamentary Question (12 Oct 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm061012/text/61012w0009.htm#06101336010344

" To ask the Secretary of State for Health what the definition is under the terms of the Connecting for Health contracts to local service providers of a (a) Severity 1 Service Failure and (b) Severity 2 Service Failure; and how many of each there were in each local service provider area in (i) February 2006, (ii) March 2006 and (iii) April 2006."

7.3. Annette Brooke

(Mid Dorset & North Poole, Liberal Democrat - Member, Public Accounts Committee)

7.3.1. NHS staff unconvinced by new IT system (16 Jun 2006)

http://www.annettebrooke.org.uk/news/226.html

" The National Programme for IT, the most ambitious and expensive healthcare IT project ever undertaken, must not be allowed to go the way of so many other ill-fated government IT projects. If this project is to succeed, it not only has to be delivered on time and to budget, but also win the hearts and minds of the staff who work daily in the NHS. This is not happening at the moment. Many staff, including GPs, are alarmed and dispirited by having the new systems imposed by diktat from above. They are also often confused about what the new systems are going to do and when. At the moment the jury is out. But today's report makes worrying reading. We now know for the first time that the £6.2 billion announced as the cost of the project over ten years is wrong. NAO analysis indicates that this is only half the story and that a figure of £12.4 billion is nearer the mark. And the NHS Care Records Service, making information about patients available nationally to clinicians, will be rolled out in GPs' surgeries two years late. We are only a third of the way through the life of the contracts, to 2013-14, but already the signs are ominous."

7.4. Paul Burstow

(Sutton & Cheam, Liberal Democrat)

7.4.1. Parliamentary Question (11 Feb 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040211/text/40211w26.htm#40211w26.html_wqn2

" To ask the Secretary of State for Health what the scope of the NHS National IT programme is in relation to (a) social services departments and (b) pharmacies; and if he will make a statement."

7.4.2. Parliamentary Question (4 Mar 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040304/text/40304w18.htm#40304w18.html_wqn6

" To ask the Secretary of State for Health what restrictions have been placed on bidders for the National Programme for Information Technology in the NHS making public statements about the project; whether these restrictions are usual Government practice; and what the reasons are for the restrictions."

7.4.3. Parliamentary Question (4 Mar 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040304/text/40304w18.htm#40304w18.html_wqn5

" To ask the Secretary of State for Health if he will estimate the cost of (a) training and (b) installation for the National Programme for Information Technology in the NHS; and from which budgets the funding will be taken."

7.4.4. Parliamentary Question (4 Mar 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040304/text/40304w18.htm#40304w18.html_wqn4

" To ask the Secretary of State for Health what the projected cost of the National Programme for Information Technology in the NHS was when it was originally announced; what the latest available projected cost is; and if he will make a statement."

7.4.5. Parliamentary Question (15 Mar 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040315/text/40315w28.htm#40315w28.html_wqn1

" To ask the Secretary of State for Health if he will list each information technology project being undertaken by his Department and its agencies including the (a) start date, (b) planned completion date, (c) current expected completion date, (d) planned cost and (e) current estimated cost; and if he will make a statement."

7.4.6. Parliamentary Question (24 Mar 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040324/text/40324w28.htm#40324w28.html_wqn0

" To ask the Secretary of State for Health pursuant to the Answer of 4 March 2004, Official Report, column 1112W, on the IT Programme, what the total projected cost of the National Programme for Information Technology was for each year when it was announced, including local and central procurement; what the latest available total projected cost is; and if he will make a statement."

7.4.7. Parliamentary Question (25 Mar 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040325/text/40325w26.htm#40325w26.html_wqn6

" To ask the Secretary of State for Health if he will set out the (a) time scale, (b) funding and (c) content of his Department's plans to integrate community pharmacies into the national IT programme."

7.4.8. Parliamentary Question (26 Mar 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040326/text/40326w14.htm#40326w14.html_wqn5

" To ask the Secretary of State for Health what consultation has been undertaken with healthcare professionals before the awarding of contracts under the National Programme for Information Technology; and if he will make a statement."

7.4.9. Parliamentary Question (19 Apr 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040419/text/40419w54.htm#40419w54.html_wqn3

" To ask the Secretary of State for Health pursuant to his answer of 24 March 2004, Official Report, column 922W, on the national programme for information technology (NPfIT), what the total projected cost was for the NPfIT when it was announced in June 2002 (a) up to March 2006 and (b) up to and beyond March 2006."

7.4.10. Website: NHS Computer System Must Be On Budget, On Time and Fit For Purpose (31 Aug 2004)

http://www.paulburstow.org.uk/news/422.html

" This investigation into the NHS computer project is to be welcomed. When such a substantial amount of taxpayers' money is at stake it is right that the National Audit Office fulfils its role of investigating Government spending. There are huge risks involved in this IT project. Ministers must learn the lessons from past mistakes and deliver the project on time, on budget and fit for purpose. The Government owes it to patients and staff to get this right. Patients and taxpayers have seen too many broken promises and forgotten policies to trust the Government to deliver. Like many Government computer bungles in the past, this project could end up being a massive waste of taxpayers' money."

7.4.11. Parliamentary Question (4 Nov 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041104/text/41104w14.htm#41104w14.html_wqn4

" To ask the Secretary of State for Health pursuant to the answer of 14 June 2004, Official Report, column 685W to the hon. Member for Westbury (Dr. Murrison) on IT systems, if he will break down the estimated costs by (a) procurement, (b) implementation and (c) running cost; and on what assumptions the estimates were based."

7.4.12. Parliamentary Question (9 Nov 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041109/text/41109w24.htm#41109w24.html_spnew8

" To ask the Secretary of State for Health how the National Programme for IT is meeting concerns of general practitioners about (a) the change over to the new IT system and (b) the loss of IT systems in which local GP practices have previously invested."

7.5. Vincent Cable

(Twickenham, Liberal Democrat)

7.5.1. House of Commons debate (14 Jul 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040714/debtext/40714-23.htm#40714-23_spnew0

" From the documents that I have read it appears that one of the key arguments is that we will see a big leap forward in information technology. However, the Government's record in that area is abysmal. The National Audit Office suggested in a report a couple of years ago that only a third of Government IT projects succeed. We all remember the Passport Office story, and the courts and the Post Office have suffered fiascos in that area. To their credit, the Government have introduced a much improved procedure, including the gateways, and the level of error has been reduced. However, many of the projects are still highly doubtful. People close to the industry, such as Computer Weekly, are concerned that the IT programme will unravel badly with disastrous consequences, especially for the NHS."

7.6. Geoffrey Clifton-Brown

(Cotswold, Conservative)

7.6.1. Parliamentary Question (21 Jan 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040121/text/40121w28.htm#40121w28.html_wqn6

" To ask the Secretary of State for Health what the cost was of the computer contract signed between his Department and BT; what the contract covers; what time period is covered by the contract; whether this technology will be available to help the roll-out of broadband in rural areas; and if he will make a statement."

7.7. Quentin Davies

(Grantham & Stamford, Conservative)

7.7.1. Parliamentary Question (8 Nov 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm061108/text/61108w0065.htm#06111141001709

" To ask the Secretary of State for Health whether the Prince 2 criteria have been applied in full to the evaluation and monitoring of the project for the computerisation of the NHS clinical records system."

7.8. Nadine Dorries

(Mid Bedfordshire, Conservative)

7.8.1. House of Commons Debate (22 Nov 2005)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm051122/debtext/51122-02.htm#51122-02_spnew18

" Does the Minister agree that, if we cancelled the much-failed choose and book system, which cost £6.2 billion and which general practitioners are failing to use, we could use the money to provide Herceptin to everyone who needs it?"

7.9. David Drew

(Stroud, Labour/Co-operative)

7.9.1. Parliamentary Question (16 Dec 2004)

http://www.publications.parliament.uk/pa/cm200405/cmhansrd/vo041216/text/41216w31.htm#41216w31.html_wqn3

" To ask the Secretary of State for Health if he will make a statement on negotiations to introduce agreed IT systems into general practitioner practices."

7.10. Paul Farrelly

(Newcastle-under-Lyme, Labour)

7.10.1. Parliamentary Question (14 Sep 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040914/text/40914w03.htm#40914w03.html_wqn6

" To ask the Secretary of State for Health

(1) what reviews his Department has undertaken into the financial viability of (a) contractors and (b) sub-contractors of companies working on the NHS National Programme for Information Technology;

(2) if the Department will ask Accenture to report on the (a) financial standing and (b) accounting treatment of revenues and profits at iSoft."

7.11. Tim Farron

(Westmorland & Lonsdale, Liberal Democrat)

7.11.1. Parliamentary Question (26 Apr 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060427/text/60427w22.htm#60427w22.html_wqn2

" To ask the Secretary of State for Health how much her Department has (a) spent on and (b) committed to the NHS Connecting for Health computer system."

7.11.2. Parliamentary Question (26 Apr 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060426/text/60426w32.htm#60426w32.html_wqn3

" To ask the Secretary of State for Health what her Department expects to be the completion date of the NHS Connecting for Health computer system."

7.11.3. Parliamentary Question (27 Apr 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060427/text/60427w22.htm#60427w22.html_wqn2

" To ask the Secretary of State for Health what assessment her Department has made of potential security risks associated with the NHS Connecting for Health computer system; and if she will make a statement."

7.11.4. House of Commons Debate (9 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060509/debtext/60509-0195.htm#06050969000836

" The Government initially allocated £2.3 billion for the " connecting for health" project, but by their own admission, they are likely to spend £6.2 billion on it. Indeed, experts project that the figure could be as high as £30 billion. Given NHS deficits of some £600 to £800 million and the impact on my constituents of the potential closure of the coronary care unit at Westmoreland general hospital, does my hon. Friend agree that there is a juxtaposition to be made between what are relatively small deficits and vast Government overspending on administrative projects?"

7.11.5. House of Commons Debate (16 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060516/debtext/60516-0099.htm#06051658000261

" The Secretary of State has told us that the connecting for health computer project will now cost £6.2 billion, but the chief operating officer of the project predicts costs in excess of £15 billion. Meanwhile, Westmoreland general hospital's coronary care unit in my constituency faces an uncertain future because of deficits that pale in comparison to those overspends. Will the Minister commit today to a full, independent, technical and financial audit of the project to ensure that public money is spent on the public's priorities?"

7.12. Lynne Featherstone

(Hornsey & Wood Green, Liberal Democrat)

7.12.1. Parliamentary Question (29 Nov 2006)

http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm061129/text/61129w0024.htm#06113032000427

" To ask the Secretary of State for Health which (a) organisations, (b) institutions and (c) private companies have access to data stored on the NHS care records on the Spine computer system."

7.12.2. Parliamentary Question (29 Nov 2006)

http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm061129/text/61129w0024.htm#06113032000429

" To ask the Secretary of State for Health what safeguards are in place to correct errors in patient records in the NHS care records on the Spine computer system."

7.13. Andrew George

(St Ives, Liberal Democrat)

7.13.1. Westminster Hall Debate (14 Mar 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060314/halltext/60314h01.htm#60314h01_spnew14

" I was not going to cover the frankly diversionary issue of choose and book, and the expensive computer and administrative system that will need to be put in place for what is a fatuous choice for people in remote areas. It is quite absurd. Most people in my area want to be treated, and treated well, in their local hospital, for which they have enormous loyalty and respect. Instead of the resources going into administrative procedures, they want them to be spent in their local hospital, which is often struggling because of the lack of those resources."

7.13.2. Parliamentary Question (27 Jun 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060627/text/60627w1240.htm#06062890000478

" To ask the Secretary of State for Health pursuant to the answer of 8 May 2006, Official Report, columns 634W on the choose and book system, what budget had been set for the (a) choice and (b) choose and book anticipated costs (i) for administrative and other staff, (ii) incurred by consultants and acute trusts, (iii) for other computer software and hardware not directly associated with the NHS Connecting for Health Agency and (iv) for other administration infrastructure for each year the programme was budgeted to operate."

7.13.3. Parliamentary Question (18 Sep 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060918/text/60918w2415.htm#06091937000357

" To ask the Secretary of State for Health (1) pursuant to the answer of 16 May 2006, Official Report, column 935W, on the Choose and Book system, what budget has been set to cover the administrative

costs of the (a) Choose and Book, (b) Choice and (c) whole direct enhanced service system for (i) its introduction and (ii) each projected year it is planned to operate; (2) pursuant to the answer of 8 May 2006, Official Report, column 634W, on the Choose and Book system, what central departmental budget has been set for the (a) Choice and (b) Choose and Book expected costs (i) for administrative and other staff, (ii) incurred by consultants and acute trusts, (iii) for other computer software and hardware not directly associated with the NHS Connecting for Health Agency and (iv) for other administrative infrastructure for each year the programme is budgeted to operate."

7.14. Ian Gibson

(Norwich North, Labour)

7.14.1. Parliamentary Question (8 Jun 2005)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm050608/text/50608w10.htm#50608w10.html_wqn2

" To ask the Secretary of State for Health what plans she has for the development of the IT programme in the national health service; and when she expects it to be completed."

7.15. Sandra Gidley

(Romsey, Liberal Democrat - Member, Health Committee)

7.15.1. House of Commons Debate (15 Nov 2005)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm051115/debtext/51115-14.htm#51115-14_spnew13

" It is also worth mentioning the NHS IT project, a huge investment amounting to more than £6.2 billion over 10 years. Unfortunately, the process seems to be dragging on somewhat, so far with little apparent benefit for patients. For example, the choose and book system for hospital appointments was due this December, but will be at least a year late. Predictably, Richard Granger, the man in charge of the scheme, has said that that is not his fault and claims that responsibility for the late delivery lies with the policy people at the Department of Health."

7.16. Paul Goodman

(Wycombe, Conservative)

7.16.1. House of Commons Debate (16 Jun 2005)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm050616/debtext/50616-35.htm#50616-35_spnew1

" I am extremely grateful to Mr. Speaker for granting me this Adjournment debate, in which I want to tell the story to date of my constituent, Helen Wilkinson, and her medical records. The story raises profound issues in relation to civil liberties, especially privacy and confidentiality. . . Helen works as a national health service practice manager. Indeed, she has worked in the NHS for some 20 years. So when it comes to the NHS, NHS offices, staff, patients and records, it can fairly be said that she knows what she is talking about. Some time ago, Helen discovered that the University College London Hospitals trust had sent computer records of every hospital medical treatment that she had ever received to a private company, McKesson, which holds a mass of NHS records. Those records are then passed on, as Helen's were, to computer systems used by the NHS. Helen's records thus became available to several NHS bodies, such as the Thames Valley strategic health authority, Wycombe primary care trust and so on. Helen asked to see her records under the Data Protection Act 1998, as she is fully entitled to do, and she discovered when she examined them that there was a serious mistake in them. She was effectively and, I repeat, mistakenly, registered as an alcoholic. Helen resolved, given her anger about the mistake, her concern about the many people who have access to even the correct parts of her record, and her anxiety about the even larger number who might well have access to it as the NHS computerisation programme proceeds, that she wanted her records removed from NHS systems altogether. It is important to explain that, as matters stand, NHS patients have the right to object to data about them being held in a form that identifies them, but only when that causes or is likely to cause substantial or unwarranted damage or distress. It is not clear, if those data are held by a

number of NHS bodies, as Helen's are, who decides whether damage or distress is caused or is likely to be caused. I wrote to the then Minister responsible, the right hon. Member for Barrow and Furness (Mr. Hutton), last autumn. . . I asked the right hon. Member for Barrow and Furness to grant Helen's request. I received a reply from him dated 5 November that explained: " The removal of patients from the systems that Ms Wilkinson has identified is neither simple nor straightforward" . It added that the ethics advisory group of the Care Records Development Board was considering the matter. Helen then took a drastic decision, but the only proper decision that she believed was open to her. She decided to withdraw from the NHS as a patient altogether so that her records—including, of course, the mistaken registration of her as an alcoholic—could be removed from NHS computer systems. So, in summary, my constituent argues that she has had to withdraw from the NHS to protect her privacy. . . I want to discuss some wider issues raised by Helen's story, which I tried to illustrate at the start of my speech. I said that Helen's story raises profound issues in relation to civil liberties—in particular, privacy and confidentiality. It does so partly because her evolving story is bound up with the evolving story of the NHS computerisation programme. Helen's records, like those of others, are held partly on paper and partly on computer. Obviously, not all NHS staff throughout Britain have access to the paper records and not all NHS bodies nationwide have access by means of their computer systems to the computer systems of other NHS bodies. That situation will gradually change. As I understand it, the last seven years-worth of records held on the NHS-wide clearing service, or NWCS, which is a hospital computer system, and records held on GP computer systems will eventually end up on the NHS care record service, or NCRS, into which information from NHS Direct will also flow. At this point, it is important to grasp that the Care Records Development Board, to which I referred earlier, is recommending that patients should, in future, as the fully functioning NCRS comes on-stream, not be able to opt out of having a national care record. That is indeed a potential challenge to privacy and confidentiality, with serious civil liberties implications. . ."

7.17. John Hemming

(Birmingham, Yardley, Liberal Democrat)

7.17.1. Parliamentary Question (23 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060523/text/60523w0524.htm#06052520003884

" To ask the Secretary of State for Health what the status is of the Connecting for Health IT project."

7.18. Charles Hendry

(Wealden, Conservative)

7.18.1. Parliamentary Question (16 Dec 2004)

http://www.publications.parliament.uk/pa/cm200405/cmhansrd/vo041216/text/41216w32.htm#41216w32.html_wqn1

" To ask the Secretary of State for Health what steps he is taking to ensure that medical imaging records can be transferred between health regions."

7.19. Lynne Jones

Lynne Jones (Birmingham, Selly Oak, Labour)

7.19.1. Parliamentary Question (9 Jan 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060109/text/60109w30.htm#60109w30.html_wqn8

" To ask the Secretary of State for Health what estimate she has made of the (a) total and (b) net cost of (i) integrating the proposed identity card scheme into her Department's IT systems and (ii) the on-going operation of the scheme within her Department."

7.20. Andrew Lansley

(South Cambridgeshire, Conservative)

7.20.1. Parliamentary Question (19 Apr 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040419/text/40419w52.htm#40419w52.html_wqn0

" To ask the Secretary of State for Health if he will ensure that general practitioner practices will be granted at least three choices of information technology suppliers under the new General Medical Services contract."

7.20.2. Parliamentary Question (10 Jun 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040610/text/40610w14.htm#40610w14.html_wqn5

" To ask the Secretary of State for Health what plans he has to involve (a) clinicians and (b) end users in the development of the NHS IT system; and if he will make a statement."

7.20.3. House of Commons Debate (11 Nov 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041111/debtext/41111-14.htm#41111-14_spnew1

" When we discussed this in July 2003, in the short debate to which I previously referred, I expressed concern—I shall quote myself if my hon. Friend will forgive me— " about the extent to which information technology systems in the NHS are being centralised" and " that the responsiveness of the IT system to individual customers was being removed" . I wondered, in the context of the negotiation of the contract, " whether the BMA is entirely confident that GP practices will be able to exercise the same control over their service providers that they do at present" . . .Since that warning back in July of last year, we have become aware of serious disquiet among general practitioners about the system that the Government are putting in place. As my hon. Friend the Member for Christchurch (Mr. Chope) said, they have put a lot of investment into the EMIS system and 50 per cent. of GPs have adopted it, but this system is not the one that has secured a contract with a local service provider to provide GPs with their IT systems under the new arrangements. The GP contract says: " Each practice will have guaranteed choice from a number of accredited systems that deliver the required functionality" — yet GPs are not getting the choice that they want, nor the required functionality."

7.20.4. Parliamentary Question (13 Feb 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060213/text/60213w76.htm#60213w76.html_wqn8

" To ask the Secretary of State for Health if she will make a statement on the progress of the National Programme for Information Technology; and what progress the software supplier has made in supplying systems for use in the programme."

7.20.5. House of Commons Debate (9 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060509/debtext/60509-0194.htm#06050969000746

" The Government promised that every single patient referral from a GP would be booked through the choose and book system by the end of December 2005. The latest figure, in April 2006, is about 10 per cent. On electronic prescribing, the Government's target was for 50 per cent. of prescriptions to be electronically filled by December 2005. In February 2006, the figure was 1.8 per cent. Confidence in the NHS IT programme continues to fall. The latest disclosure is that an NHS care records service, which was intended to be up and running in 2005, has been put back—no date is now offered—and will have to be piloted. People who know about such programmes have said that user involvement and piloting the systems would have been the right way to proceed in the first place."

7.20.6. Parliamentary Question (8 Jun 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060608/text/60608w0834.htm#06060913002393

" To ask the Secretary of State for Health what estimate she has made of the cost to local NHS bodies of implementing the care record service."

7.20.7. Parliamentary Question (20 Jun 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060620/text/60620w1098.htm#0606216001090

" To ask the Secretary of State for Health if she will make a statement on productive time savings, as envisaged by the Gershon Review, achieved since 2003-04; and what proportion of these savings are directly attributable to products delivered through the National Programme for Information Technology."

7.20.8. Parliamentary Question (6 Jul 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060706/text/60706w1487.htm#0607077000167

" To ask the Secretary of State for Health what her latest estimate is of the total implementation costs of Connecting for Health, including the cost of local implementation."

7.20.9. Parliamentary Question (6 Jul 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060706/text/60706w1488.htm#0607077000376

" To ask the Secretary of State for Health for what reasons she has delayed the introduction of the NHS Care Records Service (CRS); where she expects the pilot sites to test the NHS CRS will be established; and what information will be uploaded onto the national system (a) under the NHS CRS pilots and (b) when the NHS CRS is fully enabled."

7.20.10. Parliamentary Question (1 Nov 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm061101/text/61101w0015.htm#0611021001906

" To ask the Secretary of State for Health when she plans to dissolve Connecting for Health."

7.20.11. House of Commons Debate (5 Dec 2006)

http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm061205/debtext/61205-0003.htm#06120554000546

" . . . It is five years since we last had a debate on public health on the Floor of the House. That debate was also on an Opposition motion. Today, we want particularly to look at the Government's record on public health, two years after their White Paper and four and a half years after the Wanless report was produced for the Treasury. . . The NHS has not achieved the productivity gains that Derek Wanless set out. We also know from the repeated delays and confusion surrounding the connecting for health NHS information technology programme that technology is not being taken up in the NHS in the way that he anticipated. I want to focus, however, on the simple fact that we are not achieving that public health objective. . ."

7.21. Edward Leigh

(Gainsborough, Conservative - Chairman, Public Accounts Committee)

Statement from Edward Leigh MP, Chairman of the Committee of Public Accounts (19 Jan 2005)

http://www.edwardleigh.net/newsarticle.php?id=262

" Plans to reform the NHS have been dealt a blow. There has been abysmal progress towards delivering electronic booking of hospital appointments from GPs? surgeries by the target date of December 2005. By the end of last month, only 63 live electronic bookings had been made, against a forecast of 205,000, at an average cost so far of ?52,000 a booking. This is against a background of some 9 million referrals each year. There is a very real danger that patient choice will be undermined if full electronic booking is not available. GPs around the country are already very sceptical about patient choice: 60 per cent are negative towards patient choice including even those who know most about it. I want to see the Department put every effort into convincing them. Nothing short of an easy to use, fully functioning electronic system for booking hospital appointments will persuade them that choice has a future."

7.21.1. Statement from Edward Leigh MP, Chairman of the Committee of Public Accounts (16 Jun 2006)

http://www.edwardleigh.net/newsarticle.php?id=421

" The National Programme for IT, the most ambitious and expensive healthcare IT project ever undertaken, must not be allowed to go the way of so many other ill-fated government IT projects. If this project is to succeed, it not only has to be delivered on time and to budget, but also win the hearts and minds of the staff who work daily in the NHS. This is not happening at the moment. Many staff, including GPs, are alarmed and dispirited by having the new systems imposed by diktat from above. They are also often confused about what the new systems are going to do and when. At the moment the jury is out. But today's report makes worrying reading. We now know for the first time that the ?6.2 billion announced as the cost of the project over ten years is wrong. NAO analysis indicates that this is only half the story and that a figure of ?12.4 billion is nearer the mark. And the NHS Care Records Service, making information about patients available nationally to clinicians, will be rolled out in GPs? surgeries two years late. We are only a third of the way through the life of the contracts, to 2013-14, but already the signs are ominous."

7.22. Tim Loughton

(East Worthing & Shoreham, Conservative)

7.22.1. House of Commons Debate (19 Jun 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060619/debtext/60619-0551.htm#06061952000127

" I note that the Secretary of State is shouting from a sedentary position about other computer programs, all of which pale into insignificance beside the £6 billion—or is it £12 billion?—spent on the national health service computer system, which is years behind schedule and is not guaranteed to work. It is the biggest single computer project that has happened to date, but it is not up and running and it has cost all our constituents as taxpayers an awful lot of money. It has not succeeded yet. Before the Secretary of State gets too excited, he needs to put it all into perspective. Let us not forget that, however proficient a computer system, it will count for nothing unless the quality of data inputted is up to scratch and the resources and professionals in the field are in place to act effectively afterwards."

7.23. Gordon Marsden

(Blackpool South, Labour)

7.23.1. Parliamentary Question (16 Jun 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060616/text/60616w1021.htm#06061911000226

" To ask the Secretary of State for Health what assessment she has made of the implications of the announcement by the Computer Sciences Corporation of a reduction of 1,200 jobs across the UK on its contract with the NHS in the north west and the north Midlands."

7.24. Francis Maude

(Horsham, Conservative)

7.24.1. Parliamentary Question (24 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060524/text/60524w0550.htm#06052547003522

" To ask the Secretary of State for Health whether she intends to commission an independent audit of the National programme for IT in the NHS."

7.25. Austin Mitchell

(Great Grimsby, Labour)

7.25.1. Parliamentary Question (5 Jan 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040105/text/40105w48.htm#40105w48.html_wqn0

" To ask the Secretary of State for Health by what mechanism he proposes to fund the estimated cost of the planned NHS electronic care record system; and where the money for the upkeep of the system will come from."

7.26. Andrew Murrison

(Westbury, Conservative)

7.26.1. Parliamentary Question (23 Feb 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040223/text/40223w72.htm#40223w72.html_wqn5

" To ask the Secretary of State for Health if he will make a statement on progress towards meeting the NHS Plan target for the electronic transmission of prescriptions."

7.26.2. Parliamentary Question (24 May 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040524/text/40524w28.htm#40524w28.html_wqn3

" To ask the Secretary of State for Health what funds will be made available to (a) strategic health authorities and (b) primary care trusts to cover the costs of (i) training clinical staff to use new IT systems as part of the National Programme for IT rollout and (ii) covering for clinical staff while they are training."

7.26.3. Parliamentary Question (8 Nov 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041108/text/41108w28.htm#41108w28.html_wqn7

" To ask the Secretary of State for Health what steps he has taken (a) to promote public awareness that patient data will be held centrally under the National Programme for IT in the NHS and (b) to ensure that patients are aware of their ability to opt out of centrally held databases in the NHS."

7.26.4. Parliamentary Question (9 Nov 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041109/text/41109w24.htm#41109w24.html_wqn6

" To ask the Secretary of State for Health if he will place in the Library copies of the minutes of meetings of the board of the national programme for IT in the NHS."

7.26.5. House of Commons (11 Nov 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041111/debtext/41111-24.htm#41111-24_spnew2

" We all agree that better IT is needed in the NHS, but we are perhaps at risk of indulging in some " group think" . We are committed to a greater or lesser extent to that approach, so we are not prepared to think of alternatives. The predecessor programme—information for health—was bottom up, rather than top down, and we have perhaps lost some of the good points of that earlier proposal. I very much hope that Ministers will listen to GPs, who feel very badly let down, especially in relation to EMIS."

7.26.6. Parliamentary Question (21 Dec 2004)

http://www.publications.parliament.uk/pa/cm200405/cmhansrd/vo041221/text/41221w43.htm#41221w43.html_wqn4

" To ask the Secretary of State for Health when the Information Management Security Forum of the National Programme for IT last met; how often it has met since its inception; what its current membership is; and what outcomes it has produced."

7.26.7. Parliamentary Question (21 Dec 2004)

http://www.publications.parliament.uk/pa/cm200405/cmhansrd/vo041221/text/41221w41.htm#41221w41.html_wqn4

" To ask the Secretary of State for Health what research his Department has conducted on the legal implications of electronic clinical records."

7.26.8. Parliamentary Question (21 Dec 2004)

http://www.publications.parliament.uk/pa/cm200405/cmhansrd/vo041221/text/41221w43.htm#41221w43.html_wqn3

" To ask the Secretary of State for Health if he will make a statement on the incorporation of implied consent into the National Programme for IT in the NHS."

7.26.9. House of Commons (18 Jan 2005)

http://www.publications.parliament.uk/pa/cm200405/cmhansrd/vo050118/debtext/50118-04.htm#50118-04_spnew6

" The director general of the national programme for IT in the NHS is reported as saying that the Government's blueprint for NPfIT had no engineering basis and had to be reverse engineered. Given that NPfIT will cost £300,000 per doctor over 10 years, can the Minister justify the appalling progress on electronic booking? Why is there so much residual concern about the security of electronically held medical records? In retrospect, would not it have been wiser, in all candour, to engage GPs fully from the start in the process? Would not it have been better to utilise existing processes such as EMIS, in which doctors truly have confidence?"

7.26.10. Westminster Hall Debate (8 Feb 2005)

http://www.publications.parliament.uk/pa/cm200405/cmhansrd/vo050208/halltext/50208h03.htm#50208h03_spnew19

" I take the Minister back a couple of moments to choose and book. Does he share the view of the National Audit Office that, to use his words, there is not a cat in hell's chance of choose and book being up and running by the end of this year, as previously envisaged by the Secretary of State?"

7.26.11. Parliamentary Question (17 Mar 2005)

http://www.publications.parliament.uk/pa/cm200405/cmhansrd/cm050317/text/50317w22.htm#50317w22.html_wqn14

" To ask the Secretary of State for Health what estimates his Department has made of the capital and revenue costs of Patient Archiving and Communication systems for each NHS Trust in England and Wales over the next 10 years."

7.26.12. Parliamentary Question (11 Jul 2005)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm050711/text/50711w26.htm#50711w26.html_wqn0

" To ask the Secretary of State for Health what instructions have been issued by Connecting for Health to suppliers to develop stand alone versions of their application which are not reliant on the NHS data spine; and for what reasons."

7.26.13. Westminster Hall Debate (8 Feb 2006)

http://theyworkforyou.com/whall/?id=2005-02-08a.380.0&s=npfit+-answer#g391.0

" We understand that NPfIT will deliver two things: the vestigial national spine, and choose and book, yet each choice booking so far has cost £52,000. The Minister should know that GPs are thoroughly fed up at having invested in kit and training that they are now told will be redundant. Crossing their palms with silver at this late stage is a poor substitute for carrying them along from the start."

7.26.14. Parliamentary Question (8 Mar 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060308/text/60308w34.htm#60308w34.html_wqn5

" To ask the Secretary of State for Health how much has been spent on IT for NHS dental services over the last three years in support of (a) Connecting for Health and (b) the National Programme for IT in the NHS; and what future spending is planned over the next three years."

7.27. Douglas Naysmith

(Bristol North West, Labour - Member, Health Committee)

7.27.1. Web-site: 'We Have The Technology' (17 Oct 2005)

http://www.epolitix.com/EN/MPWebsites/Doug+Naysmith/8298a0eb-75b2-46d0-b4d3-52a8748c0a29.htm

" New and emerging medical technology is at the forefront of creating a modern, effective NHS that responds to the needs of patients. That was the message this week (11 October) from the first Parliamentary Medical Technology Expo: 'Patients at the Heart of the NHS', which showcased the latest innovations in medical devices. Bristol North West MP, Dr Doug Naysmith, spoke at the event and saw for himself the latest advances in cardiac, vascular and many other areas of patient care where new technology is returning patients to their normal lives more quickly. . . Dr Naysmith said: " Enhancing access to advanced devices which can improve a patient's experience of primary care and hospital should be high on the agenda for anyone who has a stake in developing our health service. The latest pacemakers are no bigger than a two pence coin and have a battery life of years. New drug pumps, which can deliver insulin directly to people with diabetes, are cutting out the need for constant injections. The key message at the event was that while technology required up front investment, the cost and health benefits over time are enormous. The event had patients at its heart and has demonstrated how important it is that current reform to the NHS is focused on delivering for patients - and therefore listening to them," he added."

7.28. Mark Oaten

(Winchester, Liberal Democrat)

7.28.1. Parliamentary Question (10 Oct 2005)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm051010/text/51010w47.htm#51010w47.html_wqn7

" To ask the Secretary of State for the Home Department what advice his Department has received from chief information officers of other Government Departments and agencies on the identity cards scheme, with particular reference (a) to (i) NHS Connecting for Health, (ii) the Department for Work and Pensions, (iii) HM Revenue and Customs, (iv) the Foreign and Commonwealth Office and (v) the UK Passports Agency and (b) to the (A) costs and (B) feasibility of the project."

7.29. Stephen O'Brien

(Eddisbury, Conservative)

7.29.1. Parliamentary Question (25 Apr 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060425/text/60425w29.htm#60425w29.html_wqn0

" To ask the Secretary of State for Health what protocols are in place for the suspension and termination of contracts between providers and Connecting for Health."

7.29.2. Parliamentary Question (27 Apr 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060427/text/60427w22.htm#60427w22.html_wqn0

" To ask the Secretary of State for Health (1) why Connecting for Health has suspended its contract with ComMedica; (2) which Minister approved the suspension of the contract with ComMedica; and if she will place in the Library the advice that Minister was acting upon; (3) how much the suspension of the contract with ComMedica has cost since 10 January; (4) what part of the National Programme for Information Technology ComMedica was delivering; how it was delivering that part of the programme; what alternative delivery system Connecting for Health requires; and what the bidding process will be to deliver that system; (5) what assessment she has made of the impact of the suspension of the contract with ComMedica on the costs and the delivery of the part of the National Programme for Information Technology for which the company was responsible; (6) what assessment she has made of the costs to date of the decision of Connecting for Health to suspend its contract with ComMedica; and what estimate she has made of the likely consequential costs in the next two financial years."

7.29.3. House of Commons Debate (9 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060509/debtext/60509-0202.htm#0605102000026

" The Secretary of State has not listened to NHS staff or to patients. She has consistently meddled and interfered, using centralised, top-down management under the cloak of the word " local" , and ducking the blame as her meddling goes wrong. . . She has made little progress on the targets for methicillin-resistant Staphylococcus aureus, and her NHS information technology programme is behind schedule, under fire from the experts and of uncertain cost—and what a cost."

7.29.4. Parliamentary Question (25 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060525/text/60525w0569.htm#06052638001025

" To ask the Secretary of State for Health what assessment she has made of the ability of the NHS IT programme to respond to developments in information technology."

7.29.5. Parliamentary Question (7 Jun 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060607/text/60607w0812.htm#06060874004270

" To ask the Secretary of State for Health pursuant to the answer to the hon. Member for North-East Milton Keynes (Mr. Lancaster) of 25 April 2006, Official Report, column 1071W, on choose and book, for what reasons the statistics on the Connecting for Health website of 296,655 choose and book bookings to 25 April 2006 differs from that given in the answer."

7.29.6. Parliamentary Question (16 Jun 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060616/text/60616w1021.htm#06061911000230

" To ask the Secretary of State for Health what the (a) budget and (b) outturn was for Connecting for Health in (i) 2004-05 and (ii) 2005-06; and what the proposed outturn is for 2006-07."

7.29.7. Parliamentary Question (16 Jun 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060616/text/60616w1022.htm#06061911000233

" To ask the Secretary of State for Health if she will publish the progress statistics alongside targets on the Connecting for Health website."

7.29.8. Parliamentary Question (6 Jul 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060706/text/60706w1489.htm#06070770000412

" To ask the Secretary of State for Health what steps she has taken to achieve adoption and acceptance of the NHS IT programme by trust executives since 2002; and what estimate she has made of future levels of adoption."

7.29.9. Parliamentary Question (14 Jul 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060714/text/60714w1705.htm#06071458002001

" To ask the Secretary of State for Health, pursuant to the answers of 26 January 2006, Official Report, column 2333W, on Arm's Length Bodies, and 16 June 2006, Official Report, column 1537W, on Connecting for Health, what the reasons are for the different figures given for the budget for Connecting for Health."

7.29.10. Parliamentary Question (14 Jul 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060714/text/60714w1705.htm#06071458001999

" To ask the Secretary of State for Health pursuant to the answer of 16 June 2006, Official Report, column 1539W, on Connecting for Health, what targets she has put in place for the roll-out of detailed care record access to (a) the originating organisations, (b) local care communities and (c) larger areas."

7.29.11. Parliamentary Question (4 Sep 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060904/text/60904w2334.htm#06090723007676

" To ask the Secretary of State for Health in what way and for what reasons (a) Northumbria Healthcare, (b) Norfolk and Norwich NHS Trust, (c) Dudley NHS Trust and (d) South West Yorkshire Mental Health Trust have dispensed with the NHS IT system; how much it has cost them to do so; and what her estimate is of the impact on the NHS IT programme of their actions."

7.29.12. House of Commons Debate (6 Jun 2007)

http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm070606/debtext/70606-0004.htm#07060669001571

"I beg to move: That this House acknowledges the aims of the NHS National Programme for Information Technology (IT) and supports them in principle, recognising the potential benefits IT can bring to patients and NHS staff if implemented correctly; deplores the hasty conception of the National Programme under the noble Lord, Lord Hunt of Kings Heath, and the failure to consult adequately with service users; regrets the parallel failure by the Department of Health to implement successfully the Medical Training Application process; expresses concern about the impact of the Care Records Service on patient confidentiality; notes in particular the concerns of the Committee of Public Accounts, in the context of its criticisms of the Government's mismanagement of IT projects at large about the cost, delays in the Care Records System, the lack of a firm timetable for delivery, the struggles faced by suppliers to the programme, and the lack of engagement with frontline NHS professionals; regrets the opportunity cost to patient care and the disillusionment caused by the Programme amongst NHS staff; seeks assurances on the supply chain, particularly regarding iSOFT and an explanation for the delays in Choose and Book; and therefore calls for a full and independent review of the NHS IT programme."

7.30. George Osborne

(Tatton, Conservative)

7.30.1. House of Commons Debate (19 Jan 2005)

http://www.publications.parliament.uk/pa/cm200405/cmhansrd/vo050119/debtext/50119-05.htm#50119-05_spnew1

" . . . The NAO has again qualified the accounts of the Department for Work and Pensions because it says that benefit and fraud mistakes are costing taxpayers £3 billion a year. The report on the NHS IT system for patient choice—a multi-billion pound system that was supposed to make 200,000 bookings last year—shows that it only made 63 bookings last year. . ."

7.31. Andrew Pelling

(Croydon Central, Conservative)

7.31.1. Parliamentary Question (12 Jul 2005)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm050712/text/50712w25.htm#50712w25.html_wqn9

" To ask the Secretary of State for Health whether all NHS patients will be able to opt out of having their data held electronically under Connecting for Health."

7.32. Michael Penning

(Hemel Hempstead, Conservative)

7.32.1. Parliamentary Question (23 Nov 2006)

http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm061123/text/61123w0013.htm#06112384001957

" To ask the Secretary of State for Health: (1) what a time-limited executive agency is; for how long Connecting for Health is planned to exist as a time limited executive agency; and what the plans are for the future of Connecting for Health beyond that; (2) what conditions would need to be met to enable her Department to bring the limited time of Connecting for Health to an end."

7.33. John Pugh

(Southport, Liberal Democrat - Member, Public Accounts Committee)

7.33.1. Parliamentary Question (15 Mar 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040315/text/40315w28.htm#40315w28.html_wqn3

" To ask the Secretary of State for Health if, prior to placing an order for a bespoke software office suite, the NHS will publish the details and results of the tendering process."

7.33.2. House of Commons Debate (2 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060509/debtext/60509-0200.htm#06050987000296

" My local GPs have told me that they want to work co-operatively, to co-provide and fund new secondary care facilities, but they dare not because there are so many uncertainties about the effects of the choose and book system. The GPs might set up something for which there turned out to be no predictable demand, so their investment would go to waste."

7.33.3. Information Technology in the NHS: What Next? (Sep 2006)

By Richard Bacon MP and John Pugh MP

http://www.richardbacon.org.uk/parl/WHAT_NEXT_FOR_NHS_IT.rtf

" The National Programme for IT in the NHS is currently sleepwalking towards disaster. It is far behind schedule. Projected costs have spiralled. Key software systems have little chance of ever working properly. Clinical staff are losing confidence in it. Many local Trusts are considering opting out of the programme altogether. These problems are a consequence of over-centralisation, over-ambition and an obsession with quick political fixes. But a reformed programme can still be rescued. Recent publicity and the shake-up already underway among Local Service Providers and key contractors provide an opportunity to do this, which must not be missed. What is required is to create a proper balance between central standards and central procurement where this offers demonstrable benefits, and local autonomy and responsibility. IT offers enormous potential benefits to the NHS, its staff and above all its patients. It is not too late to make sure that these benefits are properly delivered."

7.33.4. NHS computer system must not be a Trojan horse for big brother state (1 Nov 2006)

http://www.libdems.org.uk/news/story.html?id=11219&navPage=news.html

" Liberal Democrat Health Spokesperson, John Pugh MP, has today written to the Health Secretary, the NHS Director of IT and the Information Commissioner asking for clarification on how far patients' records can be shared with other government departments. This follows concerns expressed within the Department of Health, the National Audit Office and the media over the rights of patients to keep their medical history confidential. John Pugh said: " We need to know how access to this highly personal information is to be controlled, what rights the subject of that information has and how unnecessary intrusion into a very private sphere is to be identified and prevented. " Regardless of the limited amount of data held on the spine of the system, it will be technically possible to upload full digital records from GP surgeries and access that private information from all over the UK. " There will always be a way of tracing who has accessed information but some government agencies - most notably the police - can easily justify access, sometimes in circumstances where previously a court order had to be used. " The NHS IT system must not be a Trojan Horse ushering in a Big Brother state." This follows concerns expressed within the Department of Health, the National Audit Office and the media over the rights of patients to keep their medical history confidential. . ."

7.33.5. House of Commons Debate (2 Nov 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm061102/debtext/61102-0006.htm#06110287001431

" Given the new technical possibilities of the connecting for health programme, the prospect of other Departments and bodies such as the police gaining access to medical records and the express concerns of the Information Commissioner, will the Leader of the House press the Secretary of State for Health to make a statement further clarifying the legal ground rules for handling citizens' medical data?"

7.34. Laurence Robertson

(Tewkesbury, Conservative)

7.34.1. Parliamentary Question (13 Dec 2004)

http://www.publications.parliament.uk/pa/cm200405/cmhansrd/vo041213/text/41213w50.htm#41213w50.html_wqn

" To ask the Secretary of State for Health: (1) if he will make a statement on the introduction of the National Programme for IT computer system into the NHS; (2) what the estimated cost is of introducing the National Programme for IT into the NHS; and if he will make a statement; (3) what choice users of the National Programme for IT in the NHS will have of software suppliers; and if he will make a statement; (4) what use will be made of existing computer systems when the National Programme for IT system is introduced into the NHS; and if he will make a statement."

7.35. Adrian Sanders

(Torbay, Liberal Democrat)

7.35.1. Parliamentary Question (24 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060524/text/60524w0548.htm#06052547003452

" To ask the Secretary of State for Health what the estimated cost was of the Connecting for Health computer system in each primary care trust."

7.36. Andrew Selous

(South West Bedfordshire, Conservative)

7.36.1. House of Commons Debate (8 Jun 2005)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/vo050608/halltext/50608h02.htm#50608h02_spnew7

" In the final moments available will the Minister deal with the cost overruns of NHS Connecting for Health, which could be as high as £25 billion and may come from primary care?"

7.36.2. Westminster Hall Debate (9 Jun 2005)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/vo050608/halltext/50608h02.htm#50608h02_spnew2

" The Government's national programme for information technology—I understand that it has been renamed NHS Connecting for Health—is budgeted by them to cost £6.2 billion. It is of great concern that there have been suggestions that that is a significant underestimate and that the true cost could be between £18.6 billion and £31 billion. Where will the extra £12 billion—or, possibly, £25 billion—budget overrun come from? My understanding is that it will be clawed back from the primary care trusts and from hospital trusts generally. I speak as a former member of the Select Committee on Work and Pensions, which is relevant because the Child Support Agency has been trying for five or six years to get a new computer system up and running. There have been horrendous cost overruns and much suffering to our constituents as a result. Will the choose and book system still be operational by December 2005, as the Government have promised? Why is it necessary? Why is it so prescriptive? Why, for instance, will a GP have to prescribe two private sector options? Why not let the GP decide where the best places are locally to send local patients? Has there been a proper gateway review process on the massive amount of spending on IT? . . . Will the Minister give a reassurance that in the typical 10-minute GP consultation the national programme for information technology and choose and book will not be so onerous that more time is spent looking at a computer screen than dealing with the patient? If the cost overruns are as significant as we have been led to believe, as has so sadly happened on many Government IT projects, where will the extra money come from?"

7.37. Grant Shapps

(Welwyn Hatfield, Conservative - Member, Public Administration Committee)

7.37.1. House of Commons Debate (3 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060503/debtext/60503-34.htm#60503-34_spnew0

" We are all familiar with the £6.2 billion project designed for booking appointments, the so-called choose and book system. We are also aware that the project has been mired in controversy, with backlogs, and with money going down the drain. It was supposed to be up and running by last year, but it was not. I would be interested to hear a progress report from the Minister on that system. An efficient choose and book system would of course make a great deal of difference in cutting the number of missed appointments. However, the Government seem to confuse spending vast sums of taxpayers' money on complicated computer projects with actually fixing the problem. In the context of the pledge to try to reduce the number of no shows, and the reference to the new £6.2 billion computer system, does the Minister feel that that was money well spent? Has it lived up to expectations? Clearly it cannot have done so far. Will it live up to expectations, or will that money never be recovered? I ask that question for a very good reason: £6.2 billion is perhaps six times the deficit for this year alone in the NHS. That is an awful lot of money, and so far we have seen no benefits from the system. I have figures from August last year showing that if the system had been on target, 205,000 appointments should have been made. However, only 63 appointments were booked though the computerised system. I would be interested to hear an update on those figures from the Minister."

7.38. Howard Stoate

(Dartford, Labour - Member, Health Committee)

7.38.1. House of Commons Debate(22 Jan 2002)

http://www.publications.parliament.uk/pa/cm200102/cmhansrd/vo020122/debtext/20122-23.htm#20122-23_spnew1

" The Kaiser Permanente study bears close examination because of the much shorter bed stays and fewer bed occupancy days a year per 1,000 of the population. It invests far more money in primary care, information technology and communication technology to enable that to happen. It provides a seamless service from admission to convalescence. The Government and the NHS could learn from that."

7.38.2. House of Commons Debate (20 Mar 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060320/debtext/60320-31.htm#60320-31_spnew3

" [Choose and Book] is certainly happening in my constituency, in my practice and in my primary care trust area. Of course there are teething problems; of course it is taking longer than we thought it would take; of course there are massive difficulties with an IT system that is as enormous as the new NHS IT programme. I am not saying that the arrangements are perfect. I am not saying that the NHS has achieved nirvana, because clearly it has not."

7.39. Graham Stuart

(Beverley & Holderness, Conservative)

7.39.1. House of Commons Debate (22 Mar 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060322/debtext/60322-15.htm#60322-15_spnew5

" One of the problems associated with longer GP times is the time spent using choose-and-book technology, which takes nearly twice as long to use as was originally expected when it actually works. As the hon. Gentleman knows, the Prime Minister's policy unit reported in 2004 that it felt that there had been a 20 per cent. drop in NHS productivity."

7.40. David Taylor

(North West Leicestershire, Labour/Co-operative)

7.40.1. Parliamentary Question (24 Jan 2005)

http://www.publications.parliament.uk/pa/cm200405/cmhansrd/vo050124/text/50124w48.htm#50124w48.html_wqn2

" To ask the Secretary of State for Health what progress has been made towards achieving an online system of (a) booking GP appointments, (b) health records and (c) prescription processing for NHS patients."

7.40.2. Business of the House (4 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060504/debtext/60504-08.htm#60504-08_spnew12

" A day or two ago, our Government entered their 10th year in government. The transformation of resources available to the public sector and the quality of services delivered has been very considerable. However, one area where we have, sadly, maintained the record of the previous Government is in the acquisition, design, build, implementation and running of major computer systems such as connecting for health, which had an original cost estimate of £2.3 billion. However, different estimates that have recently been made in The Sunday Times and elsewhere—twenty-three academics wrote to the Select Committee on Health—suggest a cost of £15 billion or more. As that overshoot of £12.5 billion would fund the deficits in NHS trusts for the next two decades, is it not about time that we had a debate on better ways of acquiring major new computer systems, in the way that is suggested by early-day motion 2056, of which I am a co-sponsor?

7.40.3. Parliamentary Question (13 Sep 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060913/text/60913w2361.htm#06091810000245

" To ask the Secretary of State for Health what the cost has been of the Connecting for Health IT programme."

7.41. Richard Taylor

(Wyre Forest, Independent - Member, Health Committee)

7.41.1. Web-site - Independent Kidderminster Hospital and Health Concern (2 Mar 2006)

http://www.healthconcern.org.uk/newsletter020306.htm

" I visited the hospital in Worcester with the Chairman of Patientline. I was amazed by the complexity and potential of the equipment installed at every bedside. This gives not only television and telephone access but access to the internet and enormous capability for hospital staff to display the electronic patient record, to order meals, to order drugs and to order investigations. This is the specification that the Government ordered. The only problem is that the NHS system for information technology is so many years behind schedule that none of this extra potential at the bedside can be used."

7.42. Mark Todd

(South Derbyshire, Labour)

7.42.1. Parliamentary Question (8 Dec 2004)

http://www.publications.parliament.uk/pa/cm200405/cmhansrd/vo041208/text/41208w13.htm#41208w13.html_wqn6

" To ask the Secretary of State for Health what assessment he has made of the (a) fitness for purpose of current information technology used by mental health services trusts and (b) delivery of appropriate modern information systems to those trusts; and if he will make a statement."

7.43. Keith Vaz

(Leicester East, Labour)

7.43.1. Parliamentary Question (19 Oct 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041019/text/41019w29.htm#41019w29.html_wqn4

" To ask the Secretary of State for Health what the cost is (a) nationally and (b) to individual general practitioner practices for implementing the national programme for IT."

7.43.2. Parliamentary Question (19 Oct 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041019/text/41019w29.htm#41019w29.html_spnew3

" To ask the Secretary of State for Health what the remit of the National Programme for IT for the NHS entails."

7.43.3. Parliamentary Question (20 Oct 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041020/text/41020w34.htm#41020w34.html_wqn5

" To ask the Secretary of State for Health whether the National Programme for IT has been subject to testing and user feedback to ensure that it will work as efficiently as the current system."

7.43.4. Parliamentary Question (20 Oct 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041020/text/41020w34.htm#41020w34.html_wqn4

" To ask the Secretary of State for Health what advantages the National Programme for IT has that the current system is not providing."

7.43.5. Parliamentary Question (20 Oct 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo041020/text/41020w34.htm#41020w34.html_wqn3

" To ask the Secretary of State for Health what investigation has been made into the case of the process for transferring data from the current primary care computer system to the National Programme for IT."

7.44. Theresa Villiers

(Chipping Barnet, Conservative)

7.44.1. Parliamentary Question (18 Jul 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060718/debtext/60718-1005.htm#0607196000149

" . . . The PAC and the National Audit Office carry out vital work in safeguarding taxpayers' money and rooting out inefficiency, incompetence and waste in the administration of government and the public services. . . My hon. Friend the Member for South Norfolk (Mr. Bacon) expressed grave concern that the Home Office's accounts were published with a complete disclaimer by the Comptroller and Auditor General. In effect, they were presented to Parliament unaudited, which is unprecedented for a major spending Department. My hon. Friend also outlined ways to prevent the NHS Connecting for Health scheme from turning into the sort of IT disaster that the PAC has all too often encountered. . ."

7.45. Steve Webb

(Northavon, Liberal Democrat)

7.45.1. Parliamentary Question (16 May 2006)

http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060516/text/60516w0175.htm#06051723001081

" To ask the Secretary of State for Health if she will list the pilot programmes that have been set up for the National Programme for IT."

7.45.2. Website: NHS Computer Failure Very Alarming (31 Jul 2006)

http://www.stevewebb.org.uk/news2006/news689.html

" Commenting on news that 80 NHS hospital trusts have been hit by a 'serious interruption' to their computer services, Liberal Democrat Shadow Health Secretary, Steve Webb MP said: It is very alarming that trusts are reporting practical problems with a multi-billion pound IT system. The NHS cannot rely on a computer system that is only right most of the time. If medical information is not available or supplied in error then the effect on patients can be fatal. Serious questions must be asked about whether the proper safeguards were put in place before this system went online." ."

7.45.3. Website: NHS IT Project in Deep Trouble (28 Sep 2006)

http://www.stevewebb.org.uk/news2006/news713.html

" Commenting on news that Accenture is quitting key parts of the beleaguered £12 billion upgrade of the NHS computer system, Liberal Democrat Shadow Health Secretary, Steve Webb MP said: " This is yet more evidence of a project in deep trouble, that will doubtless mean more instability distracting health professionals from concentrating on patient care. This firm's departure will generate yet more fears that the NHS IT project's costs and problems will escalate further. Inevitably, when you change supplier there will be handover costs and the danger that people with valuable knowledge will leave."

7.46. Mark Williams

(Ceredigion, Liberal Democrat)

7.46.1. Parliamentary Question (4 Dec 2006)

http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm061204/text/61204w0033.htm#06120514001657

" To ask the Secretary of State for Health what access other (a) local and (b) central Government agencies and Departments will have to electronic patient records under the Connecting for Health programme in England."

7.46.2. Parliamentary Question (4 Dec 2006)

http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm061204/text/61204w0033.htm#06120514001659

" To ask the Secretary of State for Health what plans have been made to integrate English and Welsh patient records systems after Connecting for Health goes ahead in England."

7.46.3. Parliamentary Question (4 Dec 2006)

http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm061204/text/61204w0033.htm#06120514001661

" To ask the Secretary of State for Health who will audit the use of Connecting for Health electronic patient records in England."

7.47. Derek Wyatt

(Sittingbourne & Sheppey, Labour)

7.47.1. Parliamentary Question (22 Feb 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040223/text/40223w72.htm#40223w72.html_wqn2

" To ask the Secretary of State for Health what plans he has to centralise the holding of patients' records; and if he will make a statement."

7.48. Tim Yeo

(South Suffolk, Conservative)

7.48.1. Parliamentary Question (19 Apr 2004)

http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040419/text/40419w54.htm#40419w54.html_wqn5

" To ask the Secretary of State for Health whether the EMIS IT system is one of the accredited systems for the National Programme for IT."

8. Individual Members of the House of Lords

Written questions (since Jan 2004), and papers, speeches, etc., relating to concerns about NPfIT, by Members of the House of Lords. (The links provided for questions and speeches are to the relevant Hansard page - ministerial answers to questions immediately follow the text of questions.)

8.1. Baroness Cumberlege

(Conservative)

8.1.1. House of Lords debate (9 Mar 2006)

http://www.publications.parliament.uk/pa/ld199900/ldhansrd/pdvn/lds06/text/60309-04.htm#60309-04_spnew5

". . . Not only have the Government been responsible for the debacle with the MMR vaccine, but the health of thousands of children is now being put at risk by significant failures in the new £6 billion NHS computer system. The system was imposed on primary care trusts and has destroyed 22 years of perfect record-keeping. . ."

8.2. Lord Hanningfield

(Conservative)

8.2.1. Written Question (29 Jun 2005)

http://www.publications.parliament.uk/pa/ld200506/ldhansrd/vo050629/text/50629w02.htm#50629w02_wqn3

"Asked Her Majesty's Government: (a) Whether McKinsey and Company Incorporated is currently carrying out any work for the Office of the Deputy Prime Minister; (b) how many projects the firm has carried out for the department during each year in the past five years; (c) for each project, how long such work lasted and how many McKinsey and Company employees were involved; (d) what was the nature of the contracts with the company; and (e) what was the total value of payments made by the department to McKinsey and Company Incorporated in each of the past five years."

8.3. Lord Harris of Haringey

(Labour)

8.3.1. Written Question (29 Jun 2005)

http://www.publications.parliament.uk/pa/ld200506/ldhansrd/vo050628/text/50628w02.htm

"Asked Her Majesty's Government: What were the reasons for the breakdown of computer systems in the North Middlesex Hospital and the Whittington Hospital during June 2005; how many other National Health Service sites were affected; what were the implications for patient safety; and what lessons have been learned for information services in the National Health Service."

8.4. Earl Howe

(Conservative)

8.4.1. Written Question (19 Dec 2006)

http://www.publications.parliament.uk/pa/ld200607/ldhansrd/text/61219w0003.htm#06121940000201

"Asked Her Majesty's Government: What plans are in place, or under discussion, to make electronic patient records accessible in prisons."

8.4.2. House of Lords Debate (21 Jun 2007)

http://www.publications.parliament.uk/pa/ld200607/ldhansrd/text/70621-0011.htm#07062153000161

"[Lord Warner] will be relieved to know that I am not going to make a strident attack on Connecting for Health. Indeed, I support its aims, for the most part enthusiastically. However, in April this year, the Public Accounts Committee in another place published a report on the current state of play. The

largest single element of Connecting for Health—the Care Records Service—is running about two years behind schedule. The suppliers to the programme are struggling to deliver. Not only that, but the department has failed to win hearts and minds in the NHS, especially on the question of whether the system will be fit for purpose. Four years after the programme started, there is still huge uncertainty about its cost across the wider NHS and considerable woolliness about the value of the benefits that it will eventually provide. . . Records held by a GP and made available to the local hospital present little or no difficulty, but when records are placed on a national spine there is a real problem of accountability for the security of the data. Who exactly is accountable? But there is a wider issue here. There are many who believe—I am one—that in a major respect this massive IT programme was not soundly conceived. None of us, I am sure, would argue that holding patient records in electronic format in a GP practice or at PCT level is a bad concept; far from it. But exactly what cost-benefit analysis was done to validate the central vision of a nationally accessible patient database? The answer to that, so it appears, is practically none. The underlying thought was, in truth, a pretty loose one: that it would be handy to have someone's medical records freely available in an emergency at any hospital in the country. The evidence to support that idea was nil. The overwhelming majority of patients access NHS care within their local community. If you have a heart attack or you are in a car crash miles from home, there are established clinical protocols that should make access to your medical records almost irrelevant. It is telling that in Wales the Assembly has opted for a much less ambitious and much less costly IT solution. The original estimate for a Welsh equivalent of the Care Records Service was £1.5 billion. That option was rejected in favour of a system costing a mere £3 million. For that sum of money, the Welsh NHS will get a single patient record system available to GPs, local acute trusts and doctors performing out-of-hours duties. In other words, the vast majority of situations for the vast majority of patients will be covered. I am told that doctors in Wales are more than content with this approach. That is the key difference between Wales and England, where stakeholders feel resentful about not being more involved in the procurement process and, above all, lack a sense of ownership of a system that they are being asked to operate. How do the Government propose to remedy this, given that only one-quarter of GPs now say that they support the programme? In 2004, the figure was well over 50 per cent. . ."

8.5. Lord Lucas

(Conservative)

8.5.1. House of Lords debate (21 Mar 2005)

http://www.publications.parliament.uk/pa/ld200405/ldhansrd/vo050321/text/50321-19.htm#50321-19_spnew1

". . . I am one of the 80 per cent who would like to have a national identity card, but I want a card which is useful to me. I want something that brings me benefits, which works well for me, not just in the airy-fairy world of thinking that maybe it will stop a terrorist killing me—which is a bit remote and, as I will come on to, I have my doubts about anyway—but in terms of the ordinary benefits of not having a wallet full of plastic and being able to assert my identity when I wish to do so, as the noble Lord, Lord Giddens, said. It is a thoroughly useful concept. It needs to be one that works, however, and it needs to work practically, efficiently and cost-effectively and must not take too much of my liberty away. . . This Bill needs a lot of attention. I would like to see it reintroduced as a draft Bill with a good, long period—six months, say—of consideration by a Joint Committee. There are a lot of issues, as the LSE points out, to be addressed. They range from the deeply technical to the libertarian to security. There are a lot of things to be understood. It will also take some while to persuade the Government that in some ways they have been heading down the wrong track. We are probably all saying that this is the track we are going down, but let us go down it in the right way. It is going to be a fundamental part of our lives, and we want to get it right. We do not want the traditional NHS computer system mess-up happening to us with something which is going to be such a frequent part of our everyday lives. . ."

8.5.2. House of Lords Debate (21 Jun 2007)

http://www.publications.parliament.uk/pa/ld200607/ldhansrd/text/70621-0009.htm#07062153000092

". . . The people who can really make a difference to an IT system are the users. To make something successful, you have to engage the knowledge and commitment of a user group. The buzzword term is "federated systems". In other words, you do not design a mega-project, because it never works. Instead, you look at individual user groups and give them a mandate to design systems that suit themselves. You then put the central work into making sure that those systems have standards, specifications and

interfaces that make it possible to work with the wider IT designs. That is such a basic principle, and so well known, that it is astonishing that systems such as ID cards and the big NHS project appear to have ignored it entirely and as a result have fallen flat on their faces. It must be the absolute centre of all IT development. Trust the professionals, the people doing the job, and then work with them to produce a really effective system. Beyond anything else, systems developed in that way can continue to innovate and evolve of their own accord. Something that is designed centrally gets stuck and in five years' time it is out of date. No one knows what to do with it any more because there are no mechanisms for making it fit with changed circumstances. The third underlying problem is centralisation, which is where politics comes into it. Politicians like things big and they like things fast. They are not around for long. Some Ministers stay in post for two or three years, but that is nothing in terms of the length of a big IT contract. Mostly, they want announcements and results very fast. . . When there is a real problem, as in the NHS, the Government must—for goodness' sake—do what they did on NATS and call in an outside consultant. The National Audit Office is just too much part of government to do these things well. The Government must grasp the nettle and do what was done before with such success. It is possible to get these things right, but I do not have a lot of hope that this Government will; their underlying tendencies prevent them. . ."

8.5.3. House of Lords Debate (21 Jun 2007)

http://www.publications.parliament.uk/pa/ld200607/ldhansrd/text/70621-0013.htm#07062153000231

"My Lords, I was confident that I would learn a great deal from this debate and I was right. I was equally confident that the Government would learn nothing, and I was right. . ."

8.6. Lord Morris of Manchester

(Labour)

8.6.1. Written Question (16 Nov 2004)

http://www.publications.parliament.uk/pa/ld200304/ldhansrd/vo041116/text/41116w06.htm#41116w06_wqn7

"Asked Her Majesty's Government: Whether local health communities are satisfied that the "Choose and Book" system will be delivered in time to meet the targets for booking and choice; and whether these communities are devising alternative systems to meet interim booking targets."

8.6.2. Written Question (16 Nov 2004)

http://www.publications.parliament.uk/pa/ld200304/ldhansrd/vo041116/text/41116w07.htm#41116w07_wqn2

"Asked Her Majesty's Government: Whether they will revise the targets for booking and choice, particularly interim targets, to ensure that the new "Choose and Book" system is the only booking system developed and implemented."

8.7. The Earl of Northesk

(Conservative)

8.7.1. House of Lords debate (7 Dec 2006)

http://www.publications.parliament.uk/pa/ld199697/ldhansrd/pdvn/lds06/text/61207-0004.htm#06120758000163

". . . a top-down system driven by centralised control and targeting—the Government's current proposal—is antipathetic both philosophically and practically to the concept of giving patients more control of their health and treatment. Nowhere is this dichotomy more apparent than in the Government's approach to the issue of confidentiality of patient data. . . this database will be accessible, albeit at variable levels of authority, by not only the 300,000 or so NHS staff who have been issued PIN-coded smart cards so far but also by non-medical authorities provided that their requests for access are judged to be in the public interest. It should be borne in mind that summary care records will comprise data that would fall within the category of "sensitive" as defined in the Data Protection Act, not least because at last month's annual meeting of the Care Records Development Board the decision was taken in principle that there should be a "single holistic record" of patient care,

encompassing not only health records but social care information. In effect, it does not stretch credibility to suppose that the spine represents the health and social care records arm of the national identity register. . . According to the Sealed Envelopes Risk Assessment Project report commissioned by the CfH, the security and confidentiality of patient data would be best achieved by a "sealed envelope" design, with data held locally rather than uploaded to the spine. Moreover, as evidenced by the YouGov poll on ID cards in last week's Daily Telegraph, there is growing public discomfort with the accuracy, reliability and confidentiality of centralised databases. By any measure, the trend of public sentiment in this area is towards a more patient-centred approach. It is therefore regrettable that, notwithstanding the soothing rhetoric to be found in some of the policy development literature, the Government seem to be lapsing back into an almost Stalinist mindset, an enforced centralised diktat delivered with all the subtlety of the playground bully. . . For my part, I would heartily recommend that anyone who shares those concerns should visit www.nhsconfidentiality.org. The Government really do have to make up their minds whether the avowed determination to make the NHS more patient-centred is actually delivered or just so much hot air. A good start would be to allow patients the right to opt out of the spine."

9. Department of Health

9.1. Information for health: an information strategy for the modern NHS 1998-2005 (Sep 1998)

Department of Health

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4002944&chk=kwk%2BJz

"Executive Summary: The purpose of this information strategy is to ensure that information is used to help patients receive the best possible care. The strategy will enable NHS professionals to have the information they need both to provide that care and to play their part in improving the public's health. The strategy also aims to ensure that patients, carers and the public have the information necessary to make decisions about their own treatment and care, and to influence the shape of health services generally."

9.2. Shifting the Balance of Power within the NHS (Jul 2001)

Department of Health

http://www.dh.gov.uk/assetRoot/04/07/35/54/04073554.pdf

" . . . The balance of power must be shifted towards frontline staff who understand patients' needs and concerns. A shift in the balance towards local communities so that they reconnect with their services and have real influence over their development. Frontline staff need to be in charge of frontline services and have the power to manage to meet the local communities needs – always within the context of clear national standards and a strong accountability framework. The NHS must support frontline staff and engage local communities to deliver the necessary reform to deliver faster more responsive high quality services. . ."

9.3. Service Management (18 Sep 2006)

Department of Health

http://www.connectingforhealth.nhs.uk/delivery/servicemanagement

"Statistics: The NHS is an enormous community requiring services and support which will be greatly enhanced with the introduction of new IT infrastructure, systems and services by the National Programme for IT. The technology will effectively link the many disparate NHS organisations to create a truly national health service. However, implementing the National Programme is a huge and complex operation. As such, there will be no 'big bang'; instead, systems will be gradually phased in according to priorities and when NHS organisations are ready to implement them. Our Availability Statistics and Deployment Statistics demonstrate the progress we have made to date."

9.4. DH carrying out 'confidential' review of CfH (15 Nov 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2266

" E-Health Insider has learned that an urgent 'confidential' review of the NHS IT programme and structure of Connecting for Health, the agency responsible for its delivery, has been launched by the new chief executive of the NHS David Nicholson. The new boss of the health service has commissioned a review of the £6.2bn NHS digitisation project as one of his first actions since taking up post in September. The CfH review, which has already begun taking evidence, is understood to be focusing on reviewing how to re-structure CfH to make it and the programme it is charged with delivering more locally responsive. Described to E-Health Insider as a 'confidential rapid review', suppliers have already been called in by a CfH study group to answer questions on the state of the programme with sessions being held this week. But some industry figures contacted questioned how thorough it would be and suggested the terms of reference were too limited. " It's a rush job," said one senior industry figure. " It appears to be very short and a not very thorough job." Those involved indicate that this is a review that dare not speak its name. " CfH are insisting this is not a 'review', and is nothing to do with the past but all about the future," explained one senior industry source. One CfH source stressed that the review was not being undertaken by CfH but by DH: " It's a review that's

being done to us" . However, several of the key figures conducting the review are understood to be senior executives from CfH. . ."

9.5. NHS chief executive to scrutinise Connecting for Health (28 Nov 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/11/28/220234/nhs-chief-executive-to-scrutinise-connecting-for-health.htm

" NHS chief executive David Nicholson has ordered a review of Connecting for Health, the organisation running the NHS's £12.4bn National Programme for IT. The Department of Health confirmed that Nicholson had commissioned the review, to be undertaken by CfH management " to ensure that it is correctly structured and staffed to deliver the projected programme delivery schedule" . The review comes as CfH prepares for executive agency status. A DoH spokesperson added that a separate national programme was also under way, aimed at ensuring a shift towards " local ownership" of NPfIT as " an essential part of normal NHS business" , in line with recommendations from the National Audit Office. Recent re-structuring of the NHS and the transfer of NPfIT contracts from Accenture to CSC created " a good opportunity to undertake this work" . NPfIT is also set to come under scrutiny by the Commons Health Select Committee which has announced an inquiry into the programme."

9.6. Letter to Lord Warner (12 Nov 2006)

From the Group of 23 Academics:

" . . . Last April, we wrote to the Health Committee to say that we believed that the NPfIT was showing many of the symptoms that we had seen in major IT systems that had subsequently been cancelled, or overrun massively, or failed to deliver an acceptable service to their intended users. We asked the Health Committee to call for an independent review of the Programme and to publish the results. A group of us met Dr Granger and his team in April and explained our concerns; at that meeting Dr Granger agreed that a constructive independent review such as we were proposing could be helpful, but that it would require your approval. We understand that during your speech to the Health Service Journal Conference in London last Thursday, you said *" I do not support the call by 23 academics to the House of Commons Health Select Committee to commission a review of NPfITs technical architecture. I want the programme's management and suppliers to concentrate on implementation, and not be diverted by attending to another review."*

Since we first voiced our concerns we have been contacted by many inside the NPfIT programme, at all levels, giving us details of specific problems and strengthening our concerns about the programme. This also makes us confident that a review could quickly identify some of the underlying technical and managerial problems and help to provide solutions. Some of us have experience of technical reviews of major computing projects and we know that such reviews, when carried out professionally, more than repay the time taken up. When a programme is experiencing delays there is a natural tendency to focus more on the details, to increase the pressure on staff and suppliers to meet their deadlines, and to resist any outside assistance as diversionary. Such a reaction, though understandable, is almost always a further symptom of trouble ahead rather than good management. Please will you allow us a meeting at which we can explain our concerns to you, before you finally reject our call for a constructive review?

We are amongst the strongest supporters of the basic aims of NPfIT and as professionals in the field of informatics have long espoused the importance of ICT in furthering the aims of the NHS.

For the avoidance of any possible misunderstanding, I would like to make it clear that my colleagues and I are not seeking to review NPfIT ourselves. We are entirely independent of the programme and we are acting out of strong professional concern and, we believe, in the public interest. . . "

(Full text in Appendix 4.)

9.7. Letter to Mr David Nicholson (29 Nov 2006)

From the Group of 23 Academics

" . . . Since we first voiced our concerns, subsequent problems, including those with suppliers, have increased our anxieties. People working within NPfIT, at many levels, have contacted us giving details

of specific problems. It also seems clear that NPfIT has failed to gain the confidence and support of large numbers of the NHS community. We are confident, however, that an independent review would identify the main underlying technical and managerial problems, help provide solutions and bolster confidence. Our experience of technical reviews of major computing projects is that, when carried out professionally and dispassionately, they more than repay the time and cost involved.

We are delighted now to learn that the Select Committee has decided to hold an inquiry. It may be some time, however, before its results are published. We are also heartened, therefore, to hear via the press that you have commissioned a confidential internal review. We would be pleased to present evidence, written and/or oral, for submission to the review if you would find it useful, given that your review is likely to be completed in advance of the Committee's inquiry. . ."

(Full text in Appendix 5.)

As of 12 December no reply had been received to either of these letters.

9.8. New scrutiny for IT programme as bigger role for SHAs mooted (7 Dec 2006)

Health Service Journal

http://www.hsj.co.uk/healthservicejournal/pages/n/06107/it

" Major changes to the national programme for IT in the NHS have been signalled as the NHS chief executive launched a review and MPs announced an inquiry. The Department of Health confirmed last week that David Nicholson had ordered a review to 'ensure that [IT] is a normal part of NHS business, supporting the delivery of better quality and safer care'. At the same time, NHS Connecting for Health, which runs the programme and is preparing for executive agency status, is 'looking to ensure [the programme] is correctly structured and staffed to deliver'. HSJ understands the two moves together indicate a much bigger role for strategic health authorities and a slimmed-down central team. . . Confirmation of the changes emerged as the Commons health select committee announced a new investigation into NHS IT. The move was welcomed by the British Computer Society and academics, who have been pressing for a further review since the National Audit Office issued a surprisingly positive report on the programme's early years this summer. . ."

9.9. NHS plan signals shift to local IT ownership (11 Dec 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2332

"A sharp shift of responsibility for NHS IM&T in England from the centre to local organisations is signalled in the service's new plan for 2007-8 published today. 'The NHS in England: the operating framework for 2007-8' [http://www.dh.gov.uk/assetRoot/04/14/11/95/04141195.pdf] was launched by NHS chief executive, David Nicholson, who says in his foreword: "We are devolving power from the centre to the service in many ways, not least in how we allocate money, such as the unbundling of central budgets. "Some of the key enablers of service transformation, such as the delivery of information technology, will also increasingly need to be driven and owned by the service rather than from the centre so that patients can get the full benefits as quickly as possible." . . . Plans will be required from NHS organisations showing not only how local but national priorities will be achieved including: implementation of GP Systems of Choice; preparing for the National Summary Care Record; the completion of picture archiving and communications rollout; implementation and benefits realisation for the Electronic Prescriptions Service and further exploitation of e-booking. The framework also says plans should show how organisations will carry out the deployment and benefits realisation for patient administration systems and order communications and results functionality, in line with existing commitments and targets set by each SHA, in the context of existing commercial arrangements. . ."

9.10. GPSoC delivery goes local in IT devolution (11 Dec 2006)

e-Health insider Primary care

http://www.ehiprimarycare.com/news/item.cfm?ID=2333

" Local NHS organisations will be required to draw up plans showing how they will deliver GP Systems of Choice implementation under new arrangements announced today. Primary care trusts, as

commissioners, will be required to have their own comprehensive IM&T plan and work with all providers in their local health communities to align IM&T plans to enable patient-centred service transformation. The new requirements are part of a broad strategy of devolving responsibility for IM&T to local level announced in 'The NHS in England: the operating framework for 2007-8'. The framework was launched by NHS chief executive, David Nicholson, who says in his foreword: " We are devolving power from the centre to the service in many ways, not least in how we allocate money, such as the unbundling of central budgets. " Some of the key enablers of service transformation, such as the delivery of information technology, will also increasingly need to be driven and owned by the service rather than from the centre so that patients can get the full benefits as quickly as possible." Nicholson is currently reviewing the National Programme for IT (NPfIT) and reports suggested he was keen to improve local ownership of the programme. . . Plans will be required from NHS organisations showing not only how local but national priorities will be achieved. These include: the completion of picture archiving and communications rollout; implementation and benefits realisation for the Electronic Prescriptions Service and further exploitation of e-booking. . . In addition to the responsibilities set out for PCTs, as commissioners, all NHS providers will have to have a forward looking IM&T plan which is " core to their business, exploits fully the NPfIT opportunity and thereby demonstrates migration to the NHS Care Record Service."

9.11. Health minister steps down (13 Dec 2006)

The Guardian

http://politics.guardian.co.uk/publicservices/story/0,,1971318,00.html

Lord Warner, the junior health minister, is to retire at the end of the year, Tony Blair's spokesman said today. The spokesman said that it was a " personal decision" by the 66-year-old peer to stand down. He strongly denied any suggestion that the minister's departure was connected to the troubled National Health Service IT project which he was overseeing. " His decision to retire has absolutely nothing to do with that at all," the spokesman said. " He genuinely wants to spend more time away from his red boxes." The Labour peer, who was once director of social services at Kent County council, and chairman of the Youth Justice Board for England and Wales, was considered a competent minister and a safe-pair of hands. The spokesman said that a successor will be appointed early in the New Year.**"**

9.12. Lord Warner was spearhead of blairite NHS reforms (13 Dec 2006)

Liberal Democrats

http://www.libdems.org.uk/news/lord-warner-was-spearhead-of-blairite-nhs-reforms-pugh.11543.html

" Commenting on Health Minister Lord Warner's announcement that he is retiring, Liberal Democrat Health Spokesperson, John Pugh MP said: " Lord Warner has been the unelected spearhead in parliament of the Blairite NHS reforms and was consistently on message. " With the massive NHS IT project struggling and hospitals financially destabilised, he will be relieved to step down before the problems start to multiply. " The pilot may have been dropped but the ship is still heading for the rocks."

9.13. Minister responsible for NPfIT to retire (14 Dec 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2347

" Lord Warner the health minister responsible for the £12.4bn NHS IT project is to retire at the end of the year. No 10 has announced that the Labour peer will retire at the end of the year, in what was described as a " personal decision" . The BBC reported that Downing Street had denied that his departure was linked to the growing difficulties over the NHS IT programme, and delays to the implementation of the national electronic record system. Since the 2005 election Lord Warner - a former special advisor to Jack Straw - has served as deputy to health secretary, Patricia Hewitt, with direct responsibility for some of the most contentious aspects of the government's health reforms, including the ministerial lead on competition and choice. Lord Warner, 66, has been closely linked to the CfH programme and repeatedly dismissed any criticism of the project. In October he rejected calls by leading computer science academics for a review of the technical architecture of the project to establish the scale of the risks facing the National Programme for IT (NPfIT). In June following the publication of the National Audit Office (NAO) report on NPfIT Warner was bullish about the progress of NPfIT, despite the NAO report stating that NHS Care Records Service was two years late and the

total cost of the project had doubled to £12.4bn. At the Department of Health press conference on the NAO report Lord Warner told E-Health Insider that he was absolutely sure both the summary national part of CRS and the detailed local clinical record components of CRS would be fully delivered by 2010. " I have no doubts in my mind whatsoever." And in May Lord Warner appeared to muddy the waters over the cost of the programme when he said the price tag for NPfIT, by then officially stated as £12.4bn, would actually end up as £20 billion. A No10 spokesman told the Daily Mirror that Lord Warner's retirement was not linked to the NHS digitisation project: " His decision to retire has nothing to do with that at all. He wants to spend more time away from his red boxes." It is not clear which health minister will take over Lord Warner's responsibility for the NPfIT, which is currently being reviewed by the DH."

9.14. Text of letter sent from the Department of Health to patients expressing concern over electronic care records (Dec 2006)

Department of Heath

http://www.connectingforhealth.nhs.uk/newsroom/all_images_and_docs/guardian-letter.pdf

"I am replying to your letter addressed to the Secretary of State regarding your participation in the NHS Care Record Service (NHS CRS). Your letter raised some specific concerns about your personal health information being held electronically in a new NHS database as a summary care record, indicating that having your information held by the NHS in this way may cause you substantial unwarranted distress. You therefore asked the Secretary of State for Health to stop the process of adding your information to the new NHS database. I have responded to the reasons you have indicated for your distress in detail in an annex to this letter. However, much of what has been published on this matter is inaccurate and I am therefore providing the context for my response by setting out the reasons for the introduction of the NHS Care Records Service. . ."

9.15. Hunt returns to DoH (9 Jan 2007)

Kable's Government Computing

http://www.kablenet.com/kd.nsf/Frontpage/EE91BAFA0C04451D8025725E0041616B?OpenDocument

"After a four year gap Lord Hunt is back at the Department of Health, preparing to tackle the troubled NHS IT programme. Lord Hunt of Kings Heath returned to the Department of Health on 8 January 2007, and is expected to resume responsibility for the £12.4bn NHS National Programme for IT (NPfIT). Hunt resigned from his post as health minister nearly four years ago in protest against the Iraq War. He is replacing Lord Warner who retired at the end of 2006 in what was described as a "personal decision". A spokesperson for the Department of Health told GC News that final details of Hunt's portfolio are "still being ironed out", but he will take responsibility for quality and safety, research and development, relationships with the National Institute for Clinical Excellence and the Healthcare Commission. He is likely to lead on workforce issues and Connecting for Health, which were under Warner's brief. . . Hunt's appointment comes at a critical time for NPfIT and its governing agency, Connecting for Health: there have recently been reports of an internal DoH review of the programme's structure. At a hearing of Parliament's influential Public Accounts Committee last summer leaders of NPfIT were accused of failing to consult sufficiently with medical staff and buying the wrong technology."

9.16. NHS chief dismisses fresh call for review (6 Feb 2007)

Computer Weekly

http://www.computerweekly.com/Home/..%5CArticles/2007/02/06/221619/nhs-chief-dismisses-fresh-call-for-review.htm

"NHS chief executive David Nicholson has rejected a fresh challenge issued by 23 leading computer scientists to commit to an independent review of the £12.4bn National Programme for IT (NPfIT). Nicholson also dismissed a 212-page dossier of the NPfIT's problems, which details the concerns of some consultants and other clinicians over the programme. The dossier was compiled by the 23 academics, who include senior computer experts at leading universities. His rebuff will heighten concerns among some health experts about what they see as complacency among top-tier management at the Department of Health over the state of the NPfIT. Speaking at a one-day event dedicated to the

National Programme, Martyn Thomas, visiting professor at Oxford University and a representative of the 23 academics, issued the challenge to Nicholson to commit within two weeks to launching an independent, published review of the programme. But Nicholson, who attended the whole event, repulsed the challenge only hours later. He expressed strong support for programme, while conceding that there were "issues", including a need for the NHS to "pull the programme in its direction". Nicholson said that the NHS did not respond well to being told what to do and there was a need for "more engagement and more ownership" by the NHS of the NPfIT. He added that the programme was "not wildly off course" and there was "no evidence which would lead me to believe there is a need for an independent review of the programme". Issuing his challenge, Thomas told the conference that a primary concern of the academics was whether the NHS's requirements had been correctly identified and agreed with clinicians and patient representatives, as well as being complete, consistent and feasible. "We also have technical concerns about the system architecture, the security policies, the system usability, the clinical coding standards, and other technical aspects," he said. "We believe that the professional way to address these risks is for there to be an independent, constructive review that publishes its findings and recommendations." Nicholson said he was impressed with the way the NPfIT was developing. He said he now wanted the NHS to own, love and understand the programme. . ."

9.17. NHS dismisses calls for IT review (6 Feb 2006)

ZDNet UK

http://news.zdnet.co.uk/itmanagement/0,1000000308,39285804,00.htm

"A group of IT academics has failed in its latest request to instigate an independent review into the NHS's National Programme for IT. Last October the group of 23 computer experts claimed urgent action was needed to put the £12bn National Programme for IT (NPfIT) back on track, with their spokesperson, Oxford University visiting professor Martyn Thomas, warning that the project was set to fail. Nothing came of their demands. Now, according to Computer Weekly, their latest attempt to instigate a review has failed. Speaking at an NPfIT event last week, Thomas said the academic group had "technical concerns about the system architecture, the security policies, the system usability, the clinical coding standards, and other technical aspects". The group wants an independent review to be conducted to ensure that the programme remains on track and meets the needs of medical professionals. But the NHS's chief executive David Nicholson turned down the academics' latest challenge, after Thomas called for an independent review within two weeks. Nicholson denied that NPfIT was "wildly off course" and said there was "no evidence which would lead me to believe there is a need for an independent review of the programme". The much-criticised NPfIT programme, which was been through a raft of supplier and budgetary issues, is the largest civilian IT project in the world."

9.18. The evidence base for the National Programme (15 Feb 2007)

Department of Health

http://www.connectingforhealth.nhs.uk/about/case/

"Since its inception, the National Programme for IT has evoked a huge amount of interest and debate. We present the evidence for the Programme and how it will support the NHS to provide better, safer care. We look at why it is needed and what people say about it, offering comments and opinions from patients and patient organisations, clinicans, MPs, the media and from the findings of independent reports looking at NHS Connecting for Health and the National Programme for IT."

9.19. Connecting for Health pulls speakers from Europe's largest healthcare IT conference at Harrogate

Computer Weekly - Tony Collins' Blog

http://www.computerweekly.com/blogs/tony_collins/2007/03/connecting-for-health-pulls-sp.html

NHS Connecting for Health, which runs the NHS's National Programme for IT NPfIT], has withdrawn its speakers from Europe's biggest annual IT health conference at Harrogate. The agency, which is part of the Department of Health, is under political pressure to improve its communications and engagement with the health service, which suggests its speakers would want to be at the HC2007 Healthcare computing conference in force. But two weeks before the conference and exhibition, the three speakers from Connecting for Health have been withdrawn. They are Richard Granger, Director General for NHS IT, Richard Jeavons, senior responsible owner for service implementation and Sir

Muir Gray, director of clinical knowledge, process and safety for NHS Connecting for Health. . . It is not clear why Connecting for Health has withdrawn its top people at such short notice. There is speculation that some health officials are irritated by the strong links between the British Computer Society and 23 academics who have written an open letter calling for an independent review of the NPfIT. The academics have much information on the NPfiT on their wiki, comprising published and original material. There is also some speculation that health officials are concerned about a paper published by the British Computer Society's Health Informatics Forum Strategic Panel in December 2006. The paper "The Way Forward for NHS Health Informatics" contained much praise for the NPfIT and the work of Connecting for Health. It made it clear that the BCS wants the NPfIT to succeed. The paper also made some points that Connecting for Health may have found unendearing, an assertion for example that political pressure has caused health officials to "deny problems and to defend the indefensible".. . . But the authors ensured their report was balanced. Indeed they concluded that the NPfIT is changing for the better. . ."

9.20. On the Evolving NHS IT Strategy (15 Mar 2007)

Health Service Journal - HSJ Intelligence

http://www.shop.hsj.co.uk/pdf/hsj_intelligence150307.pdf

". . . in 2002, the national IT programme was set up to move things along with 'ruthless standardisation' and procurement from a few large firms. But there is now a sense that the programme is coming to an end, and that the agency that runs it, Connecting for Health, will evolve into a standards-setting and infrastructure body. The NHS's latest operating framework makes strategic health authorities, rather than the programme's local service providers, responsible for implementation and benefits realisation. Providers have been told to draw up IT plans that take account of business needs, while showing commitment to the NHS care records service. These changes will be welcomed as they are in line with those demanded by the NHS 23 group of academics (see news in brief), the public accounts committee and various trade bodies. They may also be inevitable, since trusts are increasingly reluctant to take programme systems. . . Few will weep if the arrogant, secretive 'NPfIT' fades. Its successes have been negotiating software deals, setting standards and creating infrastructure, so it seems to make sense for it to focus on them, Its failures lie in not managing to install the systems supposed to make up the 'functionally rich' local end of the NHS Care Records Service and to align IT and reform. The irony is that this is what it was set up to do. . . [Lynn Whitfield]"

9.21. On Developing Local Strategies (15 Mar 2007)

Health Service Journal - HSJ Intelligence

http://www.shop.hsj.co.uk/pdf/hsj_intelligence150307.pdf

". . . There are two possible versions of the Department of Health thinking behind recent guidance to the NHS on developing local information technology strategies to 'fully exploit' investments by the national IT programme. Either: 'There you are NHS, the national IT programme has delivered what it was set up to deliver and now it falls to you to put the sophisticated, value-for-money systems they have procured to good use for the benefits of patients.' Or: 'Well, we've made a right mess of that - nothing for it now but to pass the buck back to the NHS and hold local chief executives personally responsible if they don't retrieve the situation.' . . . Doubtless many primary care trust chiefs will feel, in being asked to co-ordinate local IT plans, they have been handed the mother of all poisoned chalices just at the time they have neither the financial or specialist intellectual capacity to cope with the scale of the task. However, those clinicians, managers and IT professionals across the NHS who, despite everything, hope for clinical systems that help to improve care (as distinct from booking appointments, etc.) may see a glimmer at the end of what many feel has been a dark tunnel. They will see that the DoH and the programme now accept that the national project will deliver much less, in terms of sophisticated local functionality to the NHS, than was originally hoped. While this is all disappointing, it does at least provide an opportunity at last for the more visionary local NHS health managers to sit down with clinical colleagues and decide how to build what is eventually provided by the programme into the sophisticated locally integrated health record. It may also offer a chance for the many small- and medium-sized IT suppliers to develop applications that can integrate with the infrastructure provided by the programme and turn it into the clinically rich, fully integrated local system that everyone had hoped for. . . This may well be a way out of the privacy quagmire that surrounds the creation of the national care record database. People worried that their records will be held on a national database may be much happier to see their local organisations commission secure, web-based

personal electronic records - which can be made available, where they approve, to support their health wherever it is provided. . . [Frank Burns]"

9.22. NHS IT devolution plan goes into action (27 Mar 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/03/27/222674/nhs-it-devolution-plan-goes-into-action.htm

"Whitehall officials will start dismantling parts of Connecting for Health next month in a bid to "reinvigorate" the £12.4bn National Programme for IT (NPfIT). Under the plan, which forms part of an audit by NHS chief executive David Nicholson, some staff, job roles, budgets and responsibilities will be transferred from the agency to local and regional organisations. The rethink means that responsibility for meeting key local and national objectives of the NPfIT will be dispersed to more than 150 senior responsible owners at local and regional health service sites. Among these, the regional senior responsible owners - in practice, the chief executives of strategic health authorities - will be expected to commit to ensuring that deployments meet the NHS's contractual commitments to local service providers. Under the contract, the NHS has to place a minimum amount of business with these suppliers each year. The NPfIT Local Ownership Programme is Whitehall's response to a report by the National Audit Office last year that said that a critical factor in the success of the NPfIT would be the local support of doctors and other NHS staff. But so far it is unclear how much freedom local senior responsible owners will have to operate, and whether they would be held responsible for any failure of the NPfIT, which after four years continues to be beset by uncertainty - in particular over electronic health records. . ."

9.23. Passing the reins (30 Mar 2007)

The Guardian

http://society.guardian.co.uk/e-public/story/0,,2045822,00.html

"On April 1, much of the responsibility for the £6.2bn NHS National Programme for IT, parts of which are two years late, will pass from NHS Connecting for Health (CfH) to strategic health authorities (SHAs). The National Programme for IT local ownership programme will include the transfer of staff to SHAs from five super-regional "clusters" run by CfH as local delivery arms. According to a document released earlier this month by the North-East SHA, this might include redundancies. Dr Stephen Singleton, the authority's medical director, wrote: "The geographical spread of SHAs is far greater than current CfH clusters. Connecting for Health staff generally appear to be on higher grades than NHS counterparts. The two points above suggest there might be a reasonable risk that redundancies will be necessary (but there is no financial provision)." The SHAs have formed two new groups to deal with the dominant "local service provider" suppliers, according to documents placed online by SHAs, based on the areas covered by these companies. BT supplies London SHA only, but the southern CfH cluster supplied by Fujitsu - covering the South Central, South-East Coast and South-West SHAs - has established a south NHS management board, chaired by Mark Britnell, chief executive of South Central SHA, which first met on January 9. A similar structure has been created for a new "NME" (North, Midlands and East) group for the six SHAs covering the rest of England, which are all served by CSC following Accenture's withdrawal from the national programme in January. The NME NPfIT programme board met for the first time on February 21, according to the North-East SHA document. In what might be an indicator of future problems with these groups, Dr Singleton wrote that his SHA wanted a decentralised approach to CfH staff, whereas other authorities want to centralise. A spokesperson for North-East SHA said it prefers to place staff working across the region within individual trusts, to keep them in touch with frontline work. Richard Popplewell, chief executive of Stockport PCT and chair of the Greater Manchester IM&T programme board, welcomed the localisation, although he estimates it will take one to three months to become effective. . . Murray Bywater, managing director of health IT consultancy Silicon Bridge Research, said the localisation work could run into problems if SHAs and trusts disagree, or if they want to alter the terms of the local service providers' secret contracts. "There will need to be some readjustment of those contracts for [the suppliers] to operate effectively in the new environment," he said. The change comes as CfH launches a £100m tender to find additional software suppliers. Bywater said decisions including this and the localisation work show power shifting from CfH back to the Department of Health, following the national programme's numerous difficulties. "The Department of Health is beginning to reassert itself," he said. "Politically, you can interpret this as CfH having its wings clipped.""

9.24. Minister announces new directions, to overcome resistance to England's NPfIT (19 Apr 2007)

British Journal of Healthcare Computing & Information Management

http://www.bjhc.co.uk/news/1/2007/n704007.htm

"Health minister Lord Hunt announced a drastic switch in priorities for England's National Programme for IT at the HC2007 Conference in Harrogate last month. Delivery of the National Care Records Service is being 'put on the back burner' in favour of a concentration on projects that are most likely to deliver quick wins, and a transfer of ownership of the NPfIT — from the centre to organisations in the field — becomes a high priority. Both are part of a move by the Department of Health to win the hearts, minds and active support of frontline care providers in using the national IT infrastructure to enhance the quality of patient care. In his speech last month he also conceded that the Government had failed to convince the public that the goals of NPfIT — especially the shared care record — were worthwhile."

9.25. NHS computer records project chief quits (15 Jun 2007)

Financial Times

http://www.ft.com/cms/s/5a361d74-1b8a-11dc-bc55-000b5df10621.html

Richard Granger, the UK's highest-paid civil servant, is to leave as head of the £12bn programme to develop an electronic patient record for the NHS. The 42-year-old head of the IT programme, who is on six months' notice, said on Friday he wanted to go because by October he would have fulfilled the five years he originally said he would devote to the project, and "most of the building blocks are now in place". His decision to go, he said, was also "a very personal one". He wants to spend more time with his three young children in Cumbria, with a break from a job that has been "quite simply relentless". He plans to "move to the next stage of my professional career" next year. He will be taking up "one of a number of approaches that are swirling around". He will go as the state of the programme remains a matter of controversy. Its key goal - a full, detailed, local, interchangeable electronic patient record - is running at least two years late. But Mr Granger can argue the programme is on budget, suppliers only get paid after they deliver, and large amounts of the infrastructure, and a host of other applications, including the wholesale replacement of X-ray film by digital images, are now in place, or being rolled out, and are working. The programme, however, also remains well behind on installing the new patient administration systems that are needed to work with the patient record software that is now due next year. There is, however, now "no doubt about the programme's achievability", Mr Granger said.

9.26. Granger to leave in transition by end of 2007 (16 Jun 2007)

e-Health insider

http://www.e-health-insider.com/news/item.cfm?ID=2784

"Connecting for Health chief executive, Richard Granger is to leave the agency responsible for delivering the National Programme for IT to the NHS in England 'during the latter part of this year.' In a personal statement issued today, he said he would 'transition' from his full time post at the agency he was largely responsible for setting up. The controversial and outspoken IT boss who joined the NHS from Deloitte Consulting in September 2002 will return to work primarily in the private sector during 2008. The statement says he is currently considering several significant approaches. He said: "My decision should be seen in the context of the changing role of the centre of the NHS and the fact that when I took on this challenge I said I would give this job five years. I am proud of what has been achieved by the team I established following my appointment in October 2002. I passionately believe that the programme will deliver ever greater levels of benefit to patients over the coming years. There remain a number of challenges ahead, but I firmly believe that the leadership of the programme by Lord Hunt, David Nicholson and my colleagues within CfH will ensure these hurdles are overcome. I want to acknowledge the enduring professional support I have received from my team and colleagues throughout the NHS." The statement said that in due course an announcement regarding the identification of a successor and transitional arrangements will be made by the Department of Health. Health minister Lord Hunt said: "I would like to thank Richard Granger for his hard work and tremendous achievements in delivering the National Programme for IT for the NHS and wish him luck for the future. Richard will continue to lead Connecting for Health during the transition period, which

we expect to be the late part of the year, and his decision will not affect the delivery of the NHS IT programme."

9.27. Boss of troubled £12bn NHS computer project quits (16 Jun 2007)

The Times

http://www.timesonline.co.uk/tol/news/uk/health/article1942900.ece

"Britain's highest paid civil servant has announced his resignation as head of the £12 billion computer project for the National Health Service. Richard Granger, 42, chief executive of NHS Connecting for Health, was responsible for upgrading information technology (IT) systems and introducing electronic patient records. Although computer systems have been improved in many trusts, the project has been criticised for delays and design flaws. The departure of Granger, who was paid £290,000 a year, will be seen as a further setback for the project. He has been credited with updating hospital IT systems from "the stone age" and ensuring that private contractors involved in the project were not rewarded for failure. Granger will leave in the next few months and said he was considering offers to return to the private sector. "I passionately believe the programme will deliver ever greater levels of benefit to patients over the coming years," he said. The NHS project, the biggest civilian computer project, was backed by Tony Blair to deliver detailed electronic records for every NHS patient. The electronic record system is now more than two years late and Gordon Brown is expected to review its progress when he becomes prime minister. Tony Collins, executive editor of Computer Weekly, the industry magazine, which has called for an independent inquiry into the project, said: "Without Granger the risk is that this programme will now fall apart. The programme has highlighted the need for proper electronic records in the NHS, but you have to ask what it has achieved that trusts could not have done on their own. It has also not delivered on the main objective of a centralised patient record system." Granger was appointed head of the project in 2002 after successfully managing the introduction of the IT element of the congestion charge in London. Confronted with what he saw as the intransigence of the medical profession and the determination of IT suppliers to make high profits at the taxpayers' expense whatever their performance, Granger tried to introduce a tough competitive climate for the contractors. His metaphor for the project was a sledge being pulled by huskies. Those who fell by the wayside would be "chopped up and fed to the other dogs" to ensure that those who survived worked harder. The former management consultant was respected by many in the industry but others were taken aback by his abrasive and demanding approach. One contemporary once described working with him as a "deeply corrosive experience". Connecting for Health proved to be a huge challenge as NHS staff complained they had not been properly consulted and experts argued it was foolhardy to keep patient records in one central database, warning the system might be vulnerable to unauthorised users. . ."

9.28. Anger as best paid civil servant goes (17 Jun 2007)

Sunday Telegraph

http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2007/06/17/ngranger117.xml

Britain's best-paid civil servant is to quit as the head of NHS information technology, claiming the new, accident-prone computer system is on track. Richard Granger, the chief executive of Connecting for Health, said he would leave the post, and its £290,000-a-year salary, in October. "There is no doubt about the programme's achievability," said Mr Granger, who took up the role in October 2002. "Most of the building blocks are now in place." Karen Jennings, the head of health at Unison, the NHS's biggest trade union, said Mr Granger's optimism was at odds with the views of the "majority of NHS staff". She said: "Technically... things are finally coming together. But lessons must be learned from the way these over-ambitious, big-bang IT projects have been brought in late and so over-budget." Parts of the project are two years behind schedule and it may now cost a total of £20 billion, which would put it £7 billion over budget. Mr Granger can point to some successes. An electronic patient-booking service now arranges 20,000 appointments a day and 250 million X-ray images are now stored electronically. But there have also been breaches of patients' confidential details and what has been called the "biggest computer crash in NHS history", when 80 NHS trusts had no access to patient records for four days. Richard Bacon, a Conservative MP on the Public Accounts Select Committee, said Connecting for Health had caused "anger and resentment among doctors, nurses and hospital managers".

9.29. Personal statement regarding Richard Granger (18 Jun 2007)

Connecting for health

http://www.connectingforhealth.nhs.uk/newsroom/news-stories/personal

"Richard Granger has announced that he will transition from his full-time post as the Chief Executive of NHS Connecting for Health. Granger will leave NHS Connecting for Health, the Department of Health Agency responsible for delivering the National Programme for IT to the NHS in England, later this year. He will return to work primarily in the private sector during 2008. He is currently considering several significant approaches. Granger said: "My decision should be seen in the context of the changing role of the centre of the NHS and the fact that when I took on this challenge I said I would give this job five years. "I am proud of what has been achieved by the team I established following my appointment in October 2002. I passionately believe that the programme will deliver ever greater levels of benefit to patients over the coming years. "There remains a number of challenges ahead, but I firmly believe that the leadership of the programme by Lord Hunt, David Nicholson and my colleagues within NHS CFH will ensure these hurdles are overcome. "I want to acknowledge the enduring professional support I have received from my team and colleagues throughout the NHS." An announcement regarding the identification of a successor and transitional arrangements will be made by the Department of Health in due course."

9.30. NHS director general of IT quits after repeated system delays (18 Jun 2007)

The Guardian

http://business.guardian.co.uk/story/0,,2105353,00.html

"Britain's highest paid civil servant, the man in charge of the NHS's delayed £12.4bn IT upgrade programme, has resigned amid calls from politicians and academics for a wholesale review of the project. Richard Granger, the NHS director general of IT, is to wind down his role and leave the health service by the end of the year. "I am proud of what has been achieved by the team I established in 2002," he said. But there is concern that the National Programme for IT (NPfIT) is in trouble. Designed to update the NHS's paper-based records in England over 10 years, it is the largest non-military IT project attempted in the world. Four years in, repeated delays, concern about the suitability of core software and the withdrawal of a number of suppliers have left many hospital trusts and clinicians disillusioned with the project. Last year Accenture, a lead contractor, walked away from two £1bn contracts, writing off hundreds of millions of pounds relating to work on the project. Mr Granger has argued that his insistence on not paying for work on the programme until it has been delivered has meant the taxpayer has not had to bear the extra cost as suppliers work round the clock to keep the project on track. He pointed out the NHS had spent £1.5bn on delayed contracts by April last year, instead of the £2.3bn it would have cost had the work been delivered as contracted. Mr Granger last week dismissed much of the debate around the IT programme as "complete tosh". Speaking at an IT conference, he said: "We would not have got to this point without our dedicated ring-fenced funding. I think that with a bit less whingeing and more support ... we might have even got the programme done quicker." But David Nicholson, who took over as chief executive of the NHS in England last September, has been under pressure from hospital trusts to decentralise the troubled IT programme and open out elements of the healthcare IT market to wider competition."

9.31. Richard Granger's NHS IT legacy (18 Jun 2007)

Silicon.com

http://www.silicon.com/publicsector/0,3800010403,39167548,00.htm

"Will the £12.4bn project be viewed as a success or a failure? After five years in charge of the biggest IT project in the world NHS IT director-general Richard Granger has announced he is to step down later this year. The former Andersen and Deloitte management consultant came to the NHS IT post on the back of his successful stint delivering the London Congestion Charge scheme, becoming the UK's highest-paid civil servant - a silicon.com Freedom of Information request last year revealed he earns around £280,000. It has undoubtedly been a turbulent five years and opinion is strongly divided on whether his time in charge of the £12.4bn NHS computerisation programme - also known as Connecting for Health - has been a success. While Granger's hard-headed and no-nonsense approach meant tough new contracts for suppliers, which would only get paid for systems they actually

delivered, it also led to accusations of a project being imposed on the NHS with little input from the doctors, nurses and patients who would be using it. . .”

9.32. Fulsome praise for departing CfH boss (18 Jun 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2788

“The news that Richard Granger is to leave Connecting for Health and the helm of the NHS IT Programme later this year has elicited a clutch of glowing tributes from some of the most senior industry and NHS executives he has worked with over the past five years. Over the weekend Granger received effusive praise and statements of regret about his departure from NHS and industry leaders, forwarded to EHI by Connecting for Health’s communications team. EHI readers commenting on site have also been sharing their thoughts, some pointing out that despite undoubted achievements on infrastructure, PACS and introduction of systems like Choose and Book the core NPfIT objective of delivering integrated shared electronic patient records remains unrealised. . .”

9.33. Ailing project at heart of NHS (19 Jun 2007)

The Guardian

http://politics.guardian.co.uk/publicservices/story/0,,2106234,00.html

“The government’s ambitious vision for a single, standardised IT programme that would drag NHS creaking paper records systems into the 21st century was always going to be a challenge. The largest non-military IT project ever attempted - forecast to cost £12.4bn, or enough to pay 650,000 nurses for a year - it has been under strain almost since its inception four years ago.Repeated delays and lingering concern about the suitability of core software, particularly that of iSoft and the US firm Cerner, has hampered progress, as has the withdrawal of a number of important suppliers. Worse still, the 10-year National Programme for IT (NPfIT) quickly fell out of favour with clinicians and hospital trust executives, many of whom felt such a centralised project was at odds with the federal structure of the NHS in England, where trusts were used to making decisions for themselves. To date, however, these festering problems have been kept at bay, largely thanks to the determination and drive of Richard Granger, the NHS’s director general of IT and one of NPfIT’s most zealous advocates, who quickly gained a reputation as a ruthless enforcer. “I cannot exaggerate the value of Richard to this programme and the likelihood of its success,” the government’s then medical adviser, Professor Sir John Pattison, told MPs five years ago. This week, though, Mr Granger, the UK’s highest-paid civil servant, said he was quitting. The former Deloitte consultant, who introduced London’s congestion charge IT system, is to wind down his NHS role and quit by the end of the year after a successor is found. There has been a mixed reaction to the shock move. A controversial figure from the start, Mr Granger was never afraid to upset those who challenged his vision of a ruthlessly standardised NHS care records system. . . Speaking at an IT conference in London last week, Mr Granger said: “I think with a bit less whingeing and more support we might have got the programme done quicker.” In truth, however, Mr Granger’s centralised NPfIT project has been unravelling for some months. Faced with widespread disaffection, David Nicholson, chief executive of the NHS, has taken steps to appease trusts, in part by offering them greater control of IT decision-making. He has also begun to open out parts of the IT healthcare market to increased competition. Low-profile and modest in scale, these measures have quickly won the enthusiastic support of many clinicians and hospital executives, as well as scores of smaller IT groups with a long record of working with the NHS. With Mr Granger’s departure, they hope NPfIT will continue to evolve away from a monolithic, centrally co-ordinated solution into a network of “inter-operable” systems, all plugged into an electronic “spine” and accessible to trusts across the country. In public, the health minister Lord Hunt insists Mr Granger’s departure “will not affect the delivery of the NHS IT programme” but behind the scenes even NHS officials are busy drawing up plans for further IT devolution. . . Five core multibillion-pound regional contracts, linked to iSoft and Cerner, could ultimately prove Mr Granger’s most controversial legacy. The lead contractors CSC, Fujitsu and BT have refused to write down the value of their NHS work, signalling that they firmly believe the contracts will provide them with a commercial return. But with growing enthusiasm for devolution and choice within NHS IT, the future of the five regional deals looks uncertain. What is clear, however, is that at some point someone, somewhere, is going to have to pick up a colossal tab for an over-ambitious and unpopular IT project.”

9.34. NHS and IT suppliers say Granger's departure 'won't change contracts' (20 Jun 2007)

ComputerworldUK

http://www.computerworlduk.com/management/government-law/public-sector/news/index.cfm?newsid=3612

"The NHS and trade body Intellect have both dismissed suggestions that key suppliers to the health service's £12.4bn National Programme for IT (NPfIT) might seek contract changes or compensation when NHS IT chief Richard Granger leaves. Granger is to quit his post as director general of NHS Connecting for Health, which runs NPfIT, by the end of the year. The combative NHS IT chief claimed in an interview with the Financial Times that there was a "significant" risk of lead NPfIT suppliers CSC, Fujitsu and BT seeking contract changes or compensation because his departure would amount to a variation on their contracts. But a Connecting for Health spokesperson poured cold water on the idea. "Contractors cannot make a claim on the basis that Richard Granger has resigned," he said. He added: "We are currently in a transitional period. An announcement about the identification of a successor to Richard Granger and also transitional arrangements will be made by the Department of Health Shortly." Eddy Peers, vice-chair of the healthcare group at IT suppliers' body Intellect, said: "I'm surprised at the interpretation that a contract of that magnitude would be tied to a person. I would be extremely surprised if it happened." He added: "For the vast majority of major contracts, key people will change." Peers said there had been "a lot of renegotiation" of the NPfIT contracts recently – a move linked to the devolution of the programme's ownership to the NHS's strategic health authorities as some of the focus of NPfIT shifts towards implementing its systems in local hospitals. "Contractual arrangements and the way implementation takes place, responsibility and so on have been reframed on the ground in the light of experience, as you would expect in a major project," he said. Peers noted that there was "a lot of excitement in the supplier marketplace" about Granger's departure and the possibility of change "because a lot of suppliers have been put onto the margin" by the NPfIT contracts, which are structured around the three lead suppliers. . ."

9.35. NHS IT will never be the same again (21 Jun 2007)

Computing

http://www.vnunet.com/computing/news/2192474/nhs-never

"As Richard Granger prepares to step down, NHS IT programme focuses on implementation. No other public sector technology programme, however controversial, has generated quite the same furore as the £12bn National Programme for NHS IT (NPfIT). The project is held up as a paragon of tight contracting, technical vision and world-leading innovation. But it is also used as an exemplar of the worst excesses of disastrous government IT: autocratic, unworkable and a spectacular waste of money. Richard Granger's combative stewardship of the programme for the past five years has created almost as much controversy. And his departure in a few months, announced this week, will have a significant impact. Electronic X-ray systems and the high-speed N3 broadband networks are both widely acknowledged as successful. But there are still problems with the hospital software needed to make the most of the electronic bookings, prescriptions and patient records schemes. And although pilots of summary care records are about to begin, and corporate issues with key subcontractor iSoft may be nearing resolution, both remain significant challenges for the new director general. Reaction to the news of Granger's resignation veer from eulogy to condemnation. But, personalities aside, his resignation is part of wider changes for the programme. Critics of NPfIT have two major complaints. First, they say it was designed and run as a monolithic dictatorship that took no account of the diversity of the NHS. Second, they say it did not engage sufficiently with clinicians. . ."

9.36. 'The NHS programme is like a Hummer, it will drive through anything' (21 Jun 2007)

Computing

http://www.vnunet.com/computing/news/2192472/nhs-programme-hummer-drive

"What the experts say about the departure of NHS IT chief Richard Granger.

- Granger has not been ashamed to get on with things and at no point has he tried to cover his arse, which is refreshing in the public sector. But we have to step back and do things the NHS

way rather than dictating from the centre. That was a mistake from the beginning - A senior supplier

- The NHS IT community had never had any professional leadership before. Many commentators think Richard Granger is ruthless and uncompromising. And no doubt sometimes he is. But he is also a man of huge personal integrity and he has earned loyalty and respect - Andrew Haw, IT director, University Hospital Birmingham NHS Trust
- The National Programme is like a Hummer: it is not subtle, it will drive through anything and will survive a few bomb blasts. But if you want to do anything with finesse, it is not the right vehicle. Now we need to change to something a bit more attractive, that people actually want to drive - A senior NHS source
- Granger did what he needed to do to please his political masters. He decided that his reputation and his relationship with the industry could be sacrificed to deliver what the political climate demanded - A senior industry source
- Richard Granger's focus and drive transformed the multitude of healthcare principalities, dukedoms and feudal states into a single NHS information state. 'Ruthless standardisation' has allowed freedom of communication for the benefit of patients, whose care was previously fragmented between these isolated entities - Professor Sir Muir Gray, Oxford University
- Granger was always a dealmaker, not an implementer - A senior NHS source
- When [his vision] is fulfilled, millions of patients should be reaping benefits for years to come - Barbara Greggains, formerly of the Council of the Royal College of Radiologists"

9.37. Richard Granger's departure may jeopardise NHS IT programme (26 Jun 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/06/26/224976/richard-grangers-departure-may-jeopardise-nhs-it-programme.htm

"It is a pity Richard Granger, director general of NHS IT, is to leave as head of Connecting for Health, the agency that is running the National Programme for IT (NPfIT). The decision was his - he was not asked to leave. Indeed, officials at the Department of Health may soon recognise that they are losing the NPfIT's most valuable asset. Without Granger the NPfIT is at risk of falling apart, for he has given the programme a credibility it would not otherwise have had. Long before he joined the Department of Health as director general of NHS IT, the future of the NPfIT was to a large extent sealed. By then a key lesson from the failures of three separate IT-related programmes - Wessex Regional Health Authority's Regional Information Systems Plan (1992), the Read Codes version three (1998), and the Hospital Information Support Systems initiative (1996) - should have been learned. And that was that large, centralised IT schemes imposed on semi-autonomous NHS sites rarely work. They engender a scepticism among doctors that becomes impossible to overcome. Instead of avoiding this mistake, officials at the Department of Health and Downing Street made it the central ingredient of a new scheme of unprecedented scale and boundless complexity. Ministers further deepened scepticism among clinicians by conceiving the national programme in secret and announcing it as a fait accompli. Later, when Granger joined the programme in autumn 2002, he gave it a credibility based on a conviction that it was needed. And he was right. Reliable electronic health records are needed urgently. Paper notes go missing, and are not generally available after hours. So there is no disagreement on the need for easily accessible electronic medical records. But local patient record systems were already being installed successfully before the NPfIT was born. It was just happening slowly. So it is understandable that ministers wanted progress to be accelerated. The answer was for national standards to be set, money put aside for modernisation, teams from successful sites deployed as troubleshooters within the NHS, and incentives paid to GPs, IT specialists and chief executives for successful implementations in which benefits for patients were measurable. Instead, the Department of Health wanted in early 2002 to put itself at the centre of everything that happened. Bureaucracies love complexity. And so an amorphous national programme without a simple, clear objective grew around the sound idea of electronic records for everyone in England. Later, Granger joined the programme. And he and his team have achieved much. IT is now a high priority for NHS trust boards and he has broken new ground in his firm dealings with suppliers. The NPfIT has also done much to force trusts into identifying duplicate and inaccurate patient records, and some trusts have had antiquated IT

replaced with more modern systems. Connecting for Health has also delivered a number of useful systems that most people have never heard of, including the Secondary Uses Service (a healthcare planning, clinical audit and research tool), the Personal Demographics Service (a database of names, addresses, dates of birth and NHS numbers), and the Quality Management and Analysis System (a means of assessing the work of GPs). Though successful, these systems may, for the NPfIT as a programme, represent "scope creep" in that they were not among the original four main NPfIT systems. . . [Arguably] the biggest weakness in the NPfIT: ministers have politicised it. In the private sector the project would have been reviewed independently. If there were parts that did not work, and it was thought unlikely they would ever work, they would be scrapped. Money and people would instead have been directed into installing systems that yielded measurable patient benefits at an affordable price. But in politics, changing direction can be seen as a weakness, or even, dare we say it, a mistake. So changes must be made below the radar, without anyone really noticing, while transient ministers declare that all is well. Unannounced changes are indeed being made to the NPfIT. Local NHS trusts are installing standalone systems that are being adapted to national standards. These may be integrated in years to come when, for example, there is agreement among clinicians on how records can be shared. But with Granger's departure, the programme is losing a rock. About a dozen ministers with overall responsibility for the programme have come and gone, and the health minister Lord Hunt has gone and come back again. But Granger has for years remained as senior responsible owner for the IT parts of the scheme. So we are disappointed that he is leaving. And it is surprising the Department of Health is not doing more to keep him. A figure as charismatic and demanding will prove difficult to replace. We are by no means sure the programme can be held together without him."

9.38. Review of NHS could impact IT (4 Jul 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/07/04/225348/review-of-nhs-could-impact-it.htm

The new health secretary has announced a review of the NHS that could affect the direction and funding of the £12.4bn National Programme for IT at a time of cost pressures. Alan Johnson today announced an independent review of the NHS, which will help inform the Treasury when it sets the funding for the health service as part of the 2007 Comprehensive Spending Review. The review will be led by practicing surgeon Sir Ara Darzi, and it will not be "controlled from above", said Johnson. He added that one aim of the review was to ensure the NHS is "clinically led, patient-centered and locally accountable". It will draw on the views of NHS staff, patients and the public. It will look among other things at ensuring that "clinical decision-making is at the heart of the future of the NHS and the pattern of service delivery". Johnson also emphasised that money spent on the health service needed to be invested wisely. This review could be an opportunity for the government to revisit the £12.4bn National Programme for IT [NPfIT]. Many in the NHS want NHS trusts to have more discretion over what they buy, provided it meets national standards. If this happens as a result of the review, it is unclear how the programme's main suppliers, the so-called Local Service Providers, would make enough money from their NPfIT contracts to justify the investments they have made in national systems. . ."

9.39. Gordon Brown moves Lord Hunt, a ministerial head of the NHS IT plan (4 Jul 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/07/04/225342/gordon-brown-moves-lord-hunt-a-ministerial-head-of-the-nhs-it.htm

"Gordon Brown's ministerial shuffle has seen ardent supporters of the NHS IT programme moved on – which could indicate a lower profile for the project in the lead up to a possible early general election. Lord Hunt, the health minister most closely associated with the launch of the NHS's National Programme for IT (NPfIT) in 2002, has left the Department of Health as part of Brown's shuffling of ministerial posts. Another vocal and passionate ministerial spokesperson on the NPfIT, Caroline Flint, has also been moved. . . In Gordon Brown's shuffling of ministers, Lord Hunt has joined the Ministry of Justice. Patricia Hewitt, who was Secretary of State for Health, and was another ardent supporter of the NPfIT, has been replaced by Alan Johnson."

9.40. DH denies report that NPfIT is to be shelved (9 Jul 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2851

"Suggestions in a weekend newspaper that the NHS is to shelve the National Programme for IT (NPfIT) have been strongly denied by the Department of Health (DH) today. According to the News of the World, NHS chiefs have agreed to shelve the programme after admitting it was an expensive failure. The report claims: "Hospitals have been secretly told to buy in their own systems, with money that could have gone on looking after patients." The article quotes an unnamed source as saying: "It doesn't work and it's never going to." However, the DH told E-Health Insider that it 'had no plans to shelve the national programme.' No official comment has been made regarding the authenticity of the claims that trusts are being told not to wait for an NPfIT system. The DH told EHI that they are awaiting information from Connecting for Health (CfH) to see if any guidance had been issue to trusts by the NHS body responsible for the NHS IT modernisation in England. CfH told EHI they were investigating the article and would issue a statement later in the day. The DH is working on a response to the newspaper and said that the article had come as a surprise as the newspaper had not asked about the IT programme in a previous briefing. The spokesperson acknowledged that aspects of the programme were open to scrutiny due to the ongoing delays, but said that systems such as the N3 network and PACS have demonstrated the programme's benefits in bringing the NHS into the 21st century. An official rebuttal from the DH is due later today, a press spokesperson told EHI."

9.41. Health department to put record straight on NPfIT (10 Jul 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/07/10/225455/health-department-to-put-record-straight-on-npfit.htm

"The Department of Health is seeking corrections to the official records of parliament after two ministers attributed to the National Audit Office positive statements on the NHS's £12.4bn IT plan (NPfIT) that auditors did not make. The corrections being sought by the department, which follow an investigation by Computer Weekly, are likely to add to scepticism within the IT industry about the extent to which ministerial statements on the progress of major technology projects can be relied upon. The Department of Health has conceded to Computer Weekly that it gave unclear briefing notes to ministers in advance of a Commons debate on the NPfIT. In the debate on 6 June 2007, two ministers, Caroline Flint and Ivan Lewis, attributed to public spending watchdog the National Audit Office positive statements on the NPfIT that auditors did not actually make. The separate ministerial statements gave the impression that the National Audit Office had, in its report on the NPfIT, given unequivocal backing to the programme: to the way it was being managed, the excellence of contracts with suppliers, adherence to budgets, and to major savings having been achieved. But the National Audit Office report in June 2006 contained none of the specific statements attributed to it by ministers, except one – that substantial progress had been made. . . The Department of Health said it accepts that in its briefing notes to ministers about the National Audit Office report on the NPfIT there was "lack of clarity on what was direct quote and what was reported speech". The spokesman added, "We will be contacting Hansard [which keeps the official record of parliamentary proceedings] to check their transcription and set this straight."

9.42. End of the search for a cure (18 Jul 2007)

Information Age

http://www.information-age.com/article/2007/july_2007/last_word_july

"Richard Granger's decision to quit as the head of the UK government agency Connecting for Health was not the most high profile resignation in the month of June. Two of his political bosses, Tony Blair and Patricia Hewitt, both left office, leaving their own bitter-sweet legacy among the workers in the National Health Service. Among technology suppliers, and public sector IT and medical staff, however, Granger has been just as influential as his political masters, and the debates over his legacy, certainly among CIOs and IT suppliers, have been just as lively. It wasn't just that Granger presided over the roll out of the £12.4 billion National Programme for IT (NPfIT), the largest civil IT project in the world, that made his name so widely known, even outside the UK. His personal style, tough and uncompromising on certain issues, made him infamous. Within months of taking up his £280,000 a year appointment in 2002, he had become a highly controversial figure, inciting the worst kind of

criticism and the best kind of praise. From the outset, Granger set out to change the way that public organisations buy and manage their IT. As a thousand headlines and half a dozen reports from the Public Accounts Committee (Parliament's spending watchdog) have shown over the years, public sector IT has been a disaster zone in the UK for two if not three decades. Granger recognised that in most cases, suppliers made large profits regardless of the catastrophic failure of the project. He decided to make them accountable every step of the way. That strategy created a huge amount of trouble in the supplier community. Some big suppliers, such as IBM and EDS, stayed out altogether. Others such as Accenture, pulled out half way through. One small but critical supplier, iSoft, begged for help when it ran into trouble, but while it got some help, it wasn't bailed out. As a result, Granger can say that while the project might have overrun, it is not over-budget. In this, Granger should have had the media and, indeed, the entire medical profession on his side. But his willingness to talk tough with suppliers also extended to those who criticised the programme or his decisions. One of the first skills of the modern leader is to listen – to hold a genuine dialogue with all the stakeholders affected by the introduction of a new technology. But Granger seemed to epitomise the Labour government's belief that the big decisions were best taken at the start, by those with the power and the mandate. One of the key reasons why the fate of the National Programme for IT still hangs in the balance is that consultation has been treated as a means of securing acceptance, not as a co-operative process aimed at reaching the best solution. This is not a throw-away criticism, but a central one. Among the organisations that have articulated concerns about the lack of consultation or the imposition of inappropriate solutions are the British Medical Association; the Royal College of Surgeons; the Royal College of Physicians; the British Medical Journal; the Royal College of Nursing; London School of Hygiene and Tropical Medicine; and the Renal Association. In a survey by The Guardian, GPs also severely criticised aspects of the system and the lack of consultation, while many regional health trusts have also attacked several aspects of the system. . ."

9.43. Confidential briefing to Tony Blair on the NHS's National Programme for IT (31 Jul 2007)

Computer Weekly - Tony Collins' Blog

http://www.computerweekly.com/blogs/tony_collins/2007/07/confidential-briefing-to-tony.html#more

"NHS Connecting for Health has published on its website one slide from a "confidential" briefing presentation to the former Prime Minister Tony Blair on the NHS's £12.4bn National Programme for IT [NPfIT], following inquiries by Computer Weekly. Other slides in the presentation to Blair, which Connecting for Health hasn't published, give an insight into how officials wish to counter criticism of the programme. The PowerPoint presentation to Blair was dated 19 February 2007. On NHS Connecting for Health's website is a slide from the presentation that depicts parts of the NPfIT as having been completed. Following our inquiries, NHS Connecting for Health has also published on its website the mathematical workings to explain the slide, though these calculations were not in the presentation to Blair. What struck me as particularly interesting were some of the slides that NHS Connecting for Health did not publish from the presentation. They sought to marginalise critics and criticism, although listening hard to constructive criticism may be of critical importance when managing a large and complex IT-based project. One of the slides marginalised the 23 leading academics, many of them professors in computer-related sciences, who have called for an independent review of the NPfIT. The slide said: "The largely negative media has shaped public opinion by persistent criticism. An opposition campaign is being well orchestrated. The 'evidence' by the 23 academic critics is almost wholly based on media coverage, hostile submissions to the Public Accounts Committee and Select Committee and Parliamentary questions." However some of the most pertinent criticism of aspects of the NPfIT has come from the apolitical British Computer Society and a variety of independent voices within the medical and IT communities. . . What none of the slides suggested was tacking criticism by improving, modifying or removing aspects of the programme that were being criticised, or providing good arguments on why things should carry on as they are.?

9.44. Brown government rejects calls for independent review of NPfIT (9 Aug 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/08/09/226108/brown-government-rejects-calls-for-independent-review-of.htm

"The government under Gordon Brown has rejected a call by an all-party group of MPs for an independent review of the business case for the NHS's National Programme for IT [NPfIT], in the light of progress and experience to date. It has also rejected a call by the Public Accounts Committee for an urgent independent review of the performance of local service providers to the NPfIT, against the obligations of their contracts, which are worth £6.2bn. The rejections are part of a formal response by the government of a highly critical report on the NPfIT which was published by the committee in March 2007. Ministers have accepted some parts of the committee's report - but none of the recommendations that called for independent assessments of aspects of the NPfIT. The government had been due to publish its response to the committee's report by 26 May 2007. But it did not do so until 25 July, the day before Parliament broke up for the summer recess. . ."

9.45. Government says no to NHS IT review (9 Aug 2007)

ComputerWorldUK

http://www.computerworlduk.com/management/government-law/public-sector/news/index.cfm?newsid=4512&pn=1

The government has buried its response to a damning report by MPs on the NHS's £12.4bn National Programme for IT (NPfIT) in a set of Treasury minutes. The document, slipped out just before the parliamentary recess, includes a pledge to produce a first annual statement of the costs and benefits of the huge computer project later this year. In April, the powerful Commons Public Accounts Committee warned that NPfIT was unlikely to deliver significant benefits to the treatment of patients by the end of its 10-year contract without a fundamental change in the rate of progress on the project. Responses to Parliamentary Select Committee reports are usually published on the committee's web page. But at the time of writing the document was not available through this channel and spokespeople for the Department of Health and NHS Connecting for Health - the agency that runs NPfIT - could not confirm whether it had been published. The Public Accounts Committee warned that the Department of Health was "unlikely to complete the programme anywhere near its original schedule", noting that, four years in, there was still uncertainty about the costs and benefits of the scheme. If the project fails, "it could set back IT developments in the NHS for years, and divert money and staff time from front line patient services", the committee report said. But the government has rejected the MPs' call for an independent assessment of the business case for NPfIT in the light of progress and experience made so far. The response says: "The intention is to include details of both the financial and non-financial benefits within the annual statement of benefits realised." The government "does not consider there are grounds for an independent review of the business case at this stage". The response says the government "accepts the general principle" of a recommendation to set out which elements of functionality originally contracted for under NPfIT would be available for implementation by the end of the 10-year period and to prioritise deployment of the systems that benefit the NHS most. "Work is underway with the NHS to determine its priorities. The results will be provided to the Local Service Providers and plans will be adjusted as required," it says. But ministers have rejected the MPs' calls - sparked by concerns that NPfIT suppliers such as the troubled iSoft were running late in delivering key components of the scheme - to modify the procurement process to let NHS trusts select from a wider range of patient administration and clinical systems. The response says: "Centralised procurement, through a small number of suppliers, was a key feature of the procurement process so as to avoid the disadvantages, and the expense, of the haphazard approach of the past." Although there are just two suppliers of the crucial acute patient administration systems, "many more suppliers are contracted across the programme as a whole", it adds. A procurement exercise to increase the number of potential suppliers has brought expressions of interest from 221 suppliers, with 111 of these "longlisted" so far. "The intention is to award a series of framework contracts to selected suppliers who can then compete for subsequent business if the need arises," the government response says. The framework contracts would be "complementary to the existing suite of Programme contracts and provide contingency". Ministers rejected the call for an independent review of the performance of NPfIT's lead contractors. "It is better to target reviews at individual problems," the response document says."

9.46. NHS National Programme for IT faces a hazy future (10 Aug 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/08/10/226119/nhs-national-programme-for-it-faces-a-hazy-future.htm

“The National Programme for IT in the NHS seems to be destined to be dissipated, in part, into general health IT in England. There are signs the programme is in flight from ruthless standardisation; Whitehall has dropped plans to give NHS Connecting for Health, the agency set up to run the programme, the status and independence of an executive agency; officials are struggling to find money for plans to localise the scheme; and a more diffuse leadership may be poised to subsume the departing Richard Granger’s role as director general of NHS IT. At a government IT summit in May in London, a senior health official gave an assurance - of sorts - about the future of the NHS’s £12.4bn National Programme for IT (NPfIT). “It has three wheels still on, and it is still moving. But things are in hand to a certain degree. They are not in other respects but we are going to get there,” said Andy Burn, head of IM&T planning at NHS Connecting for Health, which runs much of the NPfIT. Not all trust IT directors share Burn’s confidence about the future of the programme. A comprehensive assessment of the programme by Birmingham and Solihull NHS Trust raised a question about whether the NPfIT would achieve its objectives. It said, “The NPfIT is an ambitious programme that has experienced delays, with current system migrations running two years late, and there are concerns over its achievability.” The paper was referring in part to a plan to give 50 million people in England a reliable and useful medical record - called the NHS Care Records Service - which is running at least two years late. Some trusts are now buying essential systems outside of the NPfIT. The paper said, “In priority situations, full EU procurements are being undertaken for systems outside the local or national product portfolio. “The financial impact on national contracts has yet to be resolved, but some trusts may need to pay financial penalties for operating systems outside of the national contracts.” Birmingham and Solihull NHS Trust is not the only trust to make such an assessment of the NPfIT. Given the problems with the programme, including concerns in the NHS over the quality and reliability of some NPfIT products installed so far, what is the government of Gordon Brown to do about its future? Several developments indicate that the government, advised by Whitehall officials, has decided to blend the NPfIT more into NHS IT in general. Thus the scheme may not have such a distinctive - and controversial - character. This would make it more difficult for observers of the programme in the NHS, parliament and the media to delineate what is and what is not a success. In the run-up to a possible early general election, ministers would welcome a reduction in the number of articles that cast the NPfIT in a grim light. . . NHS Connecting for Health is expected to continue refusing calls by Computer Weekly, academics and other independent voices for a new high-level, published, independent review of the programme. So there will continue to be no independent verification of the government’s claims for the success of the scheme. . . All of which may help to explain why the NPfIT - after a series of ministerial announcements about the programme during its early years of the programme - is hardly mentioned in the latest annual report of David Nicholson, the chief executive of the NHS. But if, as seems the case, some politicians and officials want the programme to head slowly towards obscurity - at least until the next general election - they may be disappointed, especially if suppliers start levying fines on NHS trusts over a lack of NPfIT orders.”

9.47. Granger's successor remains a mystery (5 Sep 2007)

e-Health Insider

http://www.e-health-insider.com/news/3002/granger's_successor_remains_a_mystery

"Richard Granger's successor as chief executive of Connecting for Health and director general of IT at the Department of Health is still unknown, twelve weeks after he announced his resignation in transition from the post. Enquiries from E-Health Insider this week have been unable to clarify when Granger will officially leave CfH, and more intriguingly when, and if, a successor will be appointed. With power and responsibility for delivering CfH now to be handed over to strategic health authorities under the NPfIT Local Ownership Programme (NLOP) the role of CfH is likely to become constrained. Some industry sources have lamented his departure saying that without a similarly strong figure to drive the NHS IT programme it risks stalling. Others argue that the last thing that NHS and health IT industry need is another leader of conviction, calling for quiet pragmatism. . . Sources within and close to CfH suggest that the director general has in recent weeks become an infrequent visitor to the organisation's Leeds HQ. Others however say he is still actively involved but on strict instructions to maintain a low profile. Granger announced his decision to leave his job in June saying he had fulfilled the job for five years as he said he would in 2002. A variety of industry sources have told EHI that in their view Granger's sudden announcement of his intention to leave "was not a planned succession". Speculation has focused on the mixed record of CfH, as set out in this year's damning public accounts committee report; and Granger's propensity to attract and generate controversy; together with the reduced role of the organisation as the programme is recast and the National Programme for IT Local Ownership Programme (NLOP) begins to gather momentum. . . The Health Select Committee will

release its report into the electronic patient record next week and it will be interesting to see who the inevitable response from Connecting for Health will be attributed to. On possible pointer to the future is the fact that recent official responses from CfH have been coming from NHS veteran Richard Jeavons, the current director of service implementation."

9.48. Wanless warns NPfIT risking NHS modernisation (11 Sep 2007)

e-Health Insider

http://www.e-health-insider.com/news/3019/wanless_warns_npfit_risking_nhs_modernisation

"In a review of NHS modernisation efforts Sir Derek Wanless has criticised the slow progress of the National Programme for IT (NPfIT) and called for an audit of the programme to ensure it supports wider health service modernisation. The report warns that considerable challenges lie ahead in modernising NHS IT systems and says there is "continuing debate over the feasibility of some current NPfIT plans". With limited progress on its core objectives, and the lack of a clear measurable business case against which savings can be measured it says that Connecting for Health, the agency responsible for NPfIT, appears to be being allowed to follow "a high-cost, high-risk strategy that cannot be supported by a business case". Concerns are also expressed about the future impact of the monopolistic contracts awarded by the agency. The report analyses the progress of NPfIT within the wider context of NHS modernisation and investments made and finds the programme wanting in key areas, particularly enabling productivity gains within the service. It observes that NPfIT has largely occurred in the absence of any published or measurable business case. . ."

9.49. Wanless report 2007 - what it says in full on the NHS's National Programme for IT (12 Sep 2007)

Computer Weekly - Tony Collins IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2007/09/wanless-report-2007-what-it-sa-1.html#more

"For those who'd rather not read the 250 pages of the latest Wanless report the following paragraphs are excerpts that relate directly or indirectly to the NHS's National Programme for IT [NPfIT] They are in the order they appear in the report. There is some repetition in the paragraphs. . . "

[From Chapter 4: Recomendations:

"There is a need for an audit of the technical aspects of the Connecting for Health programme and the financial costs and benefits before deciding whether or not to continue with the implementation of current plans. Unless there is greater clarity about the costs and benefits of the programme, it will be difficult to make assessments of the longterm costs and investment needs of the NHS. It is recommended that Connecting for Health is subject to detailed external scrutiny and reporting so that forecasting of long-term costs and benefits can be made with more confidence."]

9.50. Tories promise own review of £12.4bn NHS computer programme (12 Sep 2007)

ComputerWorldUK

http://www.computerworlduk.com/management/government-law/public-sector/news/index.cfm?newsid=5115

The Conservative Party has promised to organise its own review of the NHS's £12.4bn National Programme for IT (NPfIT) after the government refused calls for greater scrutiny of the scheme. In a follow-up to his landmark 2002 report on healthcare funding, former Nat West bank chief Derek Wanless warned that NPfIT lacked a business case setting out how benefits would outweigh costs. He called for the scheme to be "comprehensively audited" and for "detailed external scrutiny" of NHS Connecting for Health, which runs NPfIT. Wanless's criticism is significant because his original report – produced for the Treasury under then-chancellor Gordon Brown – championed investment in IT and urged that the proportion of NHS spending devoted to IT be doubled. But the government has rejected the call for greater scrutiny of the huge computer programme. "We do not consider there are grounds for another independent review of the national programme at this time," a Department of Health spokesperson said. Last month, the government turned down calls for a review of the programme from the Commons public accounts committee in a response that was buried in Treasury minutes published

during the parliamentary recess. Shadow health minister Stephen O'Brien slammed the government's refusal, saying: "Having called endlessly on the government to come up with a review, we have now decided to call our own. I will be leading work on this in the next parliamentary session." He added: "The government's IT programme has been woeful. What Wanless has shown is that despite the huge sums of money being poured into IT schemes, the results have yet to be shown. All we have witnessed in the past few years is problem after problem." Liberal Democrat health spokesperson John Pugh MP also criticised the government's response. "Derek Wanless has drawn attention to the fact that we are saddled with a centrally imposed and very expensive IT programme that doesn't evolve from the needs and requirements of hospitals and health professionals," he said. . ."

9.51. Lord Darzi pledges IT review (5 Oct 2007)

e-Health Insider

http://www.e-health-insider.com/news/3093/lord_darzi_pledges_it_review

"A review of England's NHS IT modernisation programme to ensure it "delivers real clinical benefits" is promised in health minister Lord Darzi's interim report on the health service published yesterday. Lord Darzi, a practising surgeon who joined the Department of Health's(DH) ministerial team in Prime Minister Gordon Brown's new government, says he will be considering the best way forward in the second stage of his review. He says the National Programme for IT has created an opportunity to make a step-change. "The national infrastructure established by the National Programme for IT has connected every hospital and GP surgery to a common secure network. Clinicians should benefit from access to digital x-rays and scans – Picture Archiving and Communications Systems (PACS)," Lord Darzi says. "But I believe more work is now needed to ensure that the Connecting for Health programme delivers real clinical benefits, and I will be considering in the second stage of my review how best to achieve this." The DH has stoutly resisted external calls for a review of its IT agency, Connecting for Health (CfH) and Lord Darzi's report will be seen as a U-turn by the CfH's critics. However it falls short of pledging a root-and-branch review and appears instead to signal an adjustment of the £12billion IT programme and a re-focusing of its work. . ."

9.52. Reviews of the NHS IT scheme appear to be underway - comment (11 Oct 2007)

Computer Weekly - Tony Collins' Blog

http://www.computerweekly.com/blogs/tony_collins/2007/10/reviews-of-the-nhs-it-scheme-a.html

"Health Minister Professor the Lord Darzi opens the introduction to his interim review of the NHS by saying he is a doctor not a politician. But in his comments about the National Programme for IT [NPfIT] Lord Darzi knows he needs to be the quintessential politician. He is a consultant in the field of robot-assisted, minimally-invasive surgery; and when he mentions the NPfIT in his interim report he manoeuvres delicately over the thin skins of ministers and officials at Whitehall who do not want to read any criticism of the scheme, particularly by public figures. Lord Darzi's report mentioned the success of PACS - Picture Archiving and Communication Systems. So his praise was in line with the marketing strategy of NHS Connecting for Health, which runs part of the NPfIT. A confidential briefing paper by Connecting for Health to the Prime Minister on the progress of the NPfIT said in February 2007 that there was a plan to launch a "proactive campaign, based upon the success of the Picture Archiving and Communications System." . . . To the tactful Lord Darzi, in his interim report, the success of PACS and the national programme were analogous. He also praised the linking of hospitals and GPs to a common secure network - the N3 broadband infrastructure supplied by BT. Local upgrades of the N3 broadband capacity can be expensive and on its own the network brings few clinical benefits but the bandwidth is an important advance on what the NHS had before so it is a success of the NPfIT. Lord Darzi said in his interim report . . . But IT directors in the NHS are entitled to ask why it is only after five years - the NPfIT was launched in 2002 - and after more than Â£2bn has been spent centrally on the scheme, that a professor is undertaking a review to ensure that the national programme delivers clinical benefits. Separately, the Financial Times says a review of the National Programme for IT [NPfIT] may be underway to establish "will this work?" There is no indication that this internal review will be published. It's difficult to avoid the conclusion that these are political compromises, half-done replacements for a high-level published review of the NPfIT. . . One reason for the absence of an unrestricted, independent published review is that the NPfIT has become politicized. It has become a test of the ability of govermment to manage mega-projects. This could explain why ministers and some Whitehall officials want NPfIT's realities locked in a dark bedroom.

They fear the full facts emerging into the sunlight and being judged harshly by a cruel world. So the NHS and those funding it are denied the truth, the programme limps along without clearly understood and realistic objectives and the government pretends all is well."

9.53. NHS shakes up £12bn IT programme (6 Oct 2007)

Financial Times

http://www.ft.com/cms/s/0/89fba648-7399-11dc-abf0-0000779fd2ac.html

"A big revamp of the National Health Service's £12bn IT programme is under way that will see NHS trusts given more choice of how systems are installed and which software they get. At the same time the Department of Health is launching a review of the information it collects from the service, aiming to gather less but use what it gets far better. The department persistently refuses to say that the £12bn programme is formally under review. But senior figures in Connecting for Health were expecting the announcement of a review to go alongside Lord Darzi's interim report on Thursday on the "next stage" of the NHS. That appears to have been pulled amid the general election fever for fear it would generate headlines about the government admitting mistakes over the multi-billion-pound 10-year programme. However, one senior health department official said a study was under way to establish "will this actually work?" The big local service provider contracts held by CSC, BT and Fujitsu are being moved out of Connecting for Health, an arm of the health department, to local level in the NHS, he said. He added that "a big step change is that we will give people more choice" about what systems are installed in hospitals, to go alongside the wider choice of systems being offered to GPs. One of the main problems, he said, had been that "we have forced people to take systems that were either worse than those they had already got, or were ones that they didn't want". As a result, installation of new patient administration systems that are needed to underpin the long delayed electronic patient record are themselves also running way behind schedule. Instead contractors are expected to let hospitals locally choose from "best of breed" applications that suit their local circumstances, while remaining compliant with the communication standards that the national programme has set. The big contractors are also accepting that they will have to give individual NHS trusts more support to get the systems in. One effect of the change, according to programme insiders, is likely to be more concentration on getting local systems up and running, and less on the national summary record, which many clinicians see as having little relevance. The move follows a call from the Commons health select committee last! month for hospitals to be offered a wider choice of systems."

9.54. MPs can't read Gateway reviews into NHS national programme (23 Oct 2007)

ComputerworldUK

http://www.computerworlduk.com/management/government-law/public-sector/news/index.cfm?newsid=5803

"Ministers have refused to make "Gateway" reviews of the £12.4bn NHS National Programme for IT (NPfIT) available to MPs, extending the clampdown on publication of the project assessments. Gateway reviews of major public sector projects are carried out at key points in their lifecycle by the Office of Government Commerce to assess whether they are sure of progressing to the next stage of development. But the government has been adamant that it will not publish the reviews and has filed a high court appeal against a ruling by the Information Commissioner's Office - upheld by the information tribunal - that it must publish reviews of the £5.4bn ID card scheme in the public interest. Ministers have also repeatedly refused calls for a feasibility review of the huge NHS computer project, despite support from the influential Commons Public Accounts Committee among others. Surgeon-turned-minister Lord Darzi is set to investigate how the IT project will produce clinical benefits - but he failed to reply to an offer by a Oxford University professor Martyn Thomas to supply details of the feasibility study proposed by 23 computing academics. Health minister Ben Bradshaw has now refused a request by his Conservative shadow Stephen O'Brien to place the NPfIT gateway reviews in the House of Commons library, where they would be accessible to MPs. "We have no current plans to do so," Bradshaw said in his reply. "The gateway review reports are intended to help and inform the management of the programme and the Department [of Health]'s own decisions. They are not intended for publication." Reinforcing the government's key argument against publishing the OGC documents, he added: "More generally, the government believe that the prospect of disclosure of any gateway review would restrain the frankness and candour with which participants engage in the gateway process, and that this in turn would undermine its effectiveness and the quality of recommendations

arising." O'Brien told ComputerworldUK: "It is disgraceful that this government continues to hide the NHS IT programme away from public and parliamentary scrutiny. What have they got to hide? More then £12bn of public money is being spent, but the figures, and what progress, if any, are being kept secret from MPs." Despite the change of prime minister and ministerial team, the government remained "focused on spin and secrecy", O'Brien said."

9.55. Unclear whether Granger will be replaced (29 Oct 2007)

e-Health Insider

http://www.e-health-insider.com/news/3161/unclear_whether_granger_will_be_replaced

"The Department of Health has rejected strong rumours that one of its senior policy advisers, Matthew Swindells, has been appointed interim chief executive of NHS Connecting for Health, replacing Richard Granger. In a statement to E-Health Insider the department that suggests Granger may not be replaced and that following review of NHS IT now underway, the current Connecting for Health agency may potentially be recast or even replaced. . . In a statement to EHI the DH said: "Richard Granger remains the director general [of NHS IT] until he leaves the department, which is expected to be the end of the year." Swindells is known to have led the review of the NHS IT Programme on behalf of NHS chief executive David Nicholson and be heavily involved in the wider review signaled by health minister Lord Darzi earlier this month, designed to ensure NPfIT delivers greater clinical benefits than it has achieved to date. The DH told EHI: "Matthew Swindells is working for David Nicholson on the review of informatics that was announced in Lord Darzi's interim Next Stage report." . . . The apparent lack of a replacement leaves succession plans for leadership of the UK's largest civil IT project, the £12.4bn NHS National Programme for IT, shrouded in mystery. Even after the introduction of the NPfIT Local Ownership Programme, CfH is still responsible for the national contracts for England. Clear leadership and succession planning is generally regarded as an essential attribute for the success of complex IT projects. . ."

9.56. Main NPfIT contractors paid £1.2bn last year (27 Nov 2007)

e-Health Insider

http://www.e-health-insider.com/news/3254/main_npfit_contractors_paid_%C2%A31.2bn_last_year

"Despite continued delays in many areas of the National Programme for IT (NPfIT), Connecting for Health (CfH) paid its main contractors over £1.5bn in the past financial year, with the lion's share going to its prime contractors, professional services firms and software vendor, iSoft. Figures obtained by E-Health Insider under the Freedom of Information Act, show that in 2006/2007 the five lead contractors – Computer Sciences Corporation, Fujitsu, BT Global Services, together with BT Syntegra and Accenture - received a total of £1.17bn between them. The £42m paid to ATOS Origin for the national Choose and Book service takes the total payments to principal contractors to more than £1.2bn last year. This despite very slow progress on the main NHS Care Records Service component of the programme. . . The LSP payments appeared to have little direct correlation with clinical systems delivered by the LSPs, with the possible exception of picture archiving and communications systems (PACS). BT in London, for instance, had delivered only one acute hospital core patient administration system (PAS) by April 2007 – since replaced - while Fujitsu had only completed five installations of its Cerner PAS. Accenture, which negotiated its exit from the programme as LSP for the North East and Eastern regions for all but PACS in January 2007, still received a £130m payment. Accenture virtually ceased work on hospital systems from early summer 2006, handing over to CSC. . . Perhaps the most surprising name on the list of firms to receive more than £100k in professional services fees from CfH was the US consultants Kellogg Root and Brown (KBR), part of the US Haliburton Group. Four years ago KBR was awarded an initial three-year contract for £37m to establish the NPfIT programme management office. But after reported differences sightings of KBR have become rare. Even so they were still paid £7.2m for their troubles last year."

Government spin – Whitehall tries to disparage our NHS article (28 Nov 2007)

9.57. Computer Weekly - Tony Collins' IT Projects blog

http://www.computerweekly.com/blogs/tony_collins/2007/11/government-spin-whitehall-trie.html

"On 22 November I asked a straightforward question of NHS Connecting for Health which runs part of the NHS's £12.4bn National Programme for IT [NPfIT].The question: Could you let me know, by end of today please, if the possibility is being considered of having patient data processed abroad? If so

could I have a statement please? NHS CfH's answer was straightforward: "No," said its spokesman. He passed my question to the Department of Health because it involved policy. The Department's spokeswoman was unable to reply promptly because she said the answer to my question needed to be cleared by the minister. Eventually, after phone calls and emails, I received the Department's "cleared" reply. It said: "NHS organisations are legally responsible for complying with data protection laws". That was it: 11 words signed off by a health minister that didn't answer my question. . . When my article was followed up by national newspapers and other media including, BBC Radio 4's Today programme [broadcast at approx. 6.55am on 27 November 2007], the Department of Health issued a slightly longer statement – one it hadn't given to me. Its statement to the national news media suggested my article had been fabricated. This is the department's statement: "Patient data is not currently sent abroad. There is no review, and there are no considerations relating to the National Programme for IT for patient data to be processed abroad in future. NHS organisations are legally responsible for complying with data protection laws and patient records can never be put at risk in compliance with these laws." . . . But the department's statement appeared to contradict a document issued by NHS Connecting for Health which said a review was underway into the possibility of patient data being processed overseas. . ."

9.58. Granger to depart NHS IT at end of year: But will he be replaced? (5 Dec 2007)

silicon.com

http://www.silicon.com/publicsector/0,3800010403,39169375,00.htm

"The head of the £12.4bn NHS IT programme will step down from his role in charge of the project at the end of this year. NHS IT director-general Richard Granger announced his plan to leave his role in charge of the National Programme for IT in the NHS (NPfIT) and Connecting for Health (CfH) in June and the timetable for his departure has now been confirmed. No replacement for Granger has been appointed yet and an NHS CfH spokeswoman said there will be a review of the "management arrangements" for taking the NHS IT programme forward. This will form part of NHS CEO David Nicholson's wider review of how the health service uses informatics and technology to improve patient care. The CfH spokeswoman told silicon.com: "We expect to be able to outline this before the end of the year. In the meantime, Richard Granger and his team continue to do an excellent job in leading the programme." Former Andersen and Deloitte management consultant Granger took on the NHS IT role in 2002 after delivering the London Congestion Charge scheme."

9.59. Department of Health found in breach of data protection (19 Dec 2007)

Information Commissioner's Office

http://www.ico.gov.uk/upload/documents/pressreleases/2007/doh_undertaking_pr.pdf

The Information Commissioner's Office has found the Department of Health in breach of the Data Protection Act following an investigation into a security breach on the Medical Training Application Service (MTAS) website. The ICO was alerted in May 2007 to the security breach which allowed for the sensitive personal details relating to junior doctors, including religious beliefs and sexual orientation, being accessible to anyone accessing the site. In order to protect against unauthorised access the Department of Health has been required to encrypt any personal data on their website which could cause distress to individuals if disclosed. Regular penetration and vulnerability testing must also be carried out on developing applications and systems to minimise unauthorised access. The Information Commissioner has also ruled that staff are trained on compliance with the Data Protection Act. The ICO has required the Department of Health to sign a formal undertaking to comply with the principles of the Data Protection Act. Failure to meet the terms of the undertaking is likely to lead to further enforcement action by the ICO and could result in prosecution by the Office. Mick Gorrill, Assistant Commissioner at the ICO, said: "This is an unacceptable breach of security. Organisations must ensure that the personal information they hold on us is secure - this is an important principle of the Data Protection Act. Individuals must feel confident that their personal details cannot be accessed by another party. Research by the ICO shows that nine out of ten individuals are concerned that organisations are failing to keep their information secure so it is essential that the Department of Health takes the appropriate measures that we have outlined in order to protect individuals' personal information."

9.60. 2007 in review (20 Dec 2007)

e-Health Insider

http://www.e-health-insider.com/comment_and_analysis/280/2007_in_review

"The biggest health story involving IT had nothing to do with the NHS IT programme, but was the debacle of Medical Training Application Service which resulted in personal details - including religious beliefs and sexual orientation - of junior doctors being openly viewable. The theme of breaches in data security, and the perception that government is far too often cavalier with citizen's personal data, came back with a vengeance by year end with the HM Revenue Customs' loss of 25 million personal records, and now risks undermining public confidence in electronic patient records. . . It was the year in which politicians and the Department of Health (DH) lost patience with the heavily centralised Connecting for Health (CfH) approach to delivering the NHS IT modernisation, and belatedly decided that local ownership was the way ahead. The NHS Local Ownership Programme was born, quickly labelled by beleagured NPfIT veterans as 'No Longer Our Problem'. Following NLOP there are big questions about what, if any, the future role of CfH is. Is it now about providing core infrastructure and services - similar to the NHS Information Authority it replaced? There also remain huge questions about how the local service provider (LSP) contracts can be squared with local ownership. Contract 're-negotiations' with LSP continued at the end of the year. That these are happening in secrecy does not bode well, suggesting local ownership still has some way to go. . . Its also been a year of reviews. First in April the Commons Public Accounts Committee published its report, saying the aims of NPfIT were commendable but delivery of central clinical aims badly awry: it pointed out that the project was two years late and had doubled in cost. It also questioned the ability of suppliers to deliver. The PAC called for an independent review, a call subsequently rejected by the government. In September it was the Commons Health Select Committee's turn. It concluded electronic patient record systems are vital to the future of healthcare in England, but said there remain big questions and concerns over how and when they will be delivered by the NHS National Programme for IT. Quietly the DH launched the Gibbs review of informatics, and spent much of the year trying to cut through the Gordian knot of CfH's byzantine contracts with LSPs. The change of Prime Minister in July accelerated the review process with Patricia Hewitt replaced by Alan Johnson as health secretary. An interim report from Lord Darzi called for NPfIT to focus on delivering clinical benefits and NHS chief executive commissioned DH insider Matthew Swindells to carry out a root and branch review of information in the health services. The year ends with Swindells now titled DH director-general for information and policy, and the indications are that big announcements are due on the future structure of CfH."

9.61. Connecting for Health will be leaderless for months (21 Dec 2007)

Health Service Journal

http://www.hsj.co.uk/news/2007/12/no_replacement_for_granger.html

"The Department of Health will not appoint a new chief for NHS Connecting for Health until spring 2008 at the earliest.,With current chief executive Richard Granger due to leave at the end of the year, there will be a gap at the top of the £12.4bn IT programme for at least three months. The hiatus comes at a crucial time with contractual talks under way with all the big IT companies leading the local implementation. "CfH said that no appointment would be made until a review of NHS informatics is complete" In a statement, NHS CfH said that no appointment would be made until a review of NHS informatics ordered by NHS chief executive David Nicholson is complete. Matthew Swindell, the interim director general for information and programme integration, is leading this. But the review will not be complete until March or April next year and will only produce an interim report this month. NHS CfH said: 'Since Richard announced his resignation, David Nicholson has set up a review of how the NHS uses informatics to improve patient care. This is not a review of Connecting for Health, nor of the national programme for IT, but it was recommended by [junior health minister] Ara Darzi in his next stage report. 'In the light of these developments, David now thinks the time is right to look closely at what skills and management arrangements we need to take Connecting for Health forward. We expect to be able to outline this before the end of the year. In the meantime, Richard Granger and his team continue to do an excellent job in leading the programme.' The Department of Health has failed to respond to a separate Freedom of Information request made by HSJ about Mr Granger within the time limit set in legislation. The DoH has not given a guaranteed date by which it will reply. HSJ has been told by the Information Commissioner's Office it has grounds for a formal complaint."

9.62. Announcement on CfH future due in 'weeks' (24 Dec 2007)

e-Health Insider

http://www.e-health-insider.com/news/3342/announcement_on_cfh_future_due_in_%E2%80%98weeks%E2%80%99

The future of NHS IT agency, Connecting for Health, remains unclear as 2007 ends, with the Department of Health saying that arrangements have yet to be finalised. The DH says "Interim management arrangements are being finalised and an announcement will be made in the next few weeks." The uncertanty extends to the exact status of Richard Granger, the head of the agency who had been due to depart by year end. It now looks as though he may continue at the helm into the beginning of 2008. Accounts differ as to how hands-on Richard Granger has been in recent months, though EHI did have a confirmed sighting in Leeds last week. New IM&T planning guidance issued by the DH this week, meanwhile, makes clear the future of health service IM&T is now expected to be based on local planning, ownership and delivery, with PCTs, trusts and Strategic Health Authorities now expected to take the lead. An indication of the direction of travel comes in the language and acronyms now being used. The new guidance, issued as part of the NHS Operating Framework 2008-09, no longer talks about the NHS National Programme for IT (NPfIT) in the once familiar singular, but instead refers to the Programme for IT (PfIT), comprised of the NPfIT and Local Programmes for IT (LPfIT). The contract reset negotiations underway with each of the three CfH-appointed local service providers (LSPs) are understood to have not yet concluded. Asked by E-Health Insider whether Granger would still be departing by year end, a DH spokesperson said: "Richard Granger has done a great job in leading the National Programme for IT, which has delivered new and innovative systems that have helped NHS staff to transform the services they provide for patients. Interim management arrangements are being finalised and an announcement will be made in the next few weeks. The DH spokesperson went on to add that the review, set up by NHS CEO David Nicholson, on how the NHS uses information to improve patient care was underway: "This is not a review of Connecting for Health or the National Programme for IT, but the contribution of both will be included within this wider work, as recommended by [health minister] Ara Darzi in his NHS Next Stage Review. "In the light of these developments, David now thinks the time is right to look closely at what skills and management arrangements we need to take Connecting for Health forward. We expect to be able to outline this shortly. In the meantime, Connecting for Health continue to do an excellent job in leading the Programme."

9.63. Confusion over Granger's NHS departure - No one seems to know when he is leaving... (15 Jan 2008)

Silicon.com

http://www.silicon.com/publicsector/0,3800010403,39169687,00.htm

"Confusion surrounds the future of the job running the NHS' £12.4bn flagship IT programme and the timetable for the departure of director-general Richard Granger. On announcing his decision to step down from his position running the National Programme for IT in the NHS and as CEO of Connecting for Health (CfH) in June last year, Granger initially indicated he would leave in October last year. Granger was still there in December, however, and the NHS said the former Andersen and Deloitte management consultant would leave his £280,000-a-year post at the end of 2007, after five years in the job. But an NHS spokesman admitted this week that Granger is currently still in the role and said they did not now know what the timetable was for his departure. The spokesman confirmed Granger is still employed by the department and not working on any sort of consultancy basis. . . The prospects for the IT director-general's role will not become clear until a review of the "management arrangements" for taking the NHS IT programme forward has been completed. A spokesman for the Department of Health said at Christmas a decision about the interim management arrangements would be finalised within a "few weeks" - but no decision had been made as of this week. The review is part of NHS CEO David Nicholson's wider examination of how the health service uses informatics and technology to improve patient care. . ."

9.64. DH vows to right chaos in IT strategy management (6 Feb 2008)

Health Service Journal

http://www.hsj.co.uk/news/2008/02/shakeup_promised_at_the_top_of_dhs_information_strategy.html

"No one is taking responsibility for the NHS's information strategy, the Department of Health's informatics review has been told. Review manager Tom Denwood has promised that the chaos over the management of the strategy will be put right within weeks. He told a conference of NHS information professionals that his team had found that there "doesn't appear to be one person or one bit of the organisation who owns the big picture around information". "There is no one taking a strategic view over healthcare, social care and mental health," he said. The review is being overseen by Matthew Swindells, interim director general for information and programme integration. It was commissioned by NHS chief executive David Nicholson. Mr Denwood said NHS IT leads had said "there is a complete absence of a function that translates policy into business requirements", and there was no overarching responsibility for IT within the DH. This was illustrated in continual shifting of responsibility for the NHS IT strategy around the department. Although his team's report is not due until the end of March, Mr Denwood suggested that a shake-up at the DH to achieve a "unified governance [structure] which is the decision making body" would happen "over the next couple of weeks". Mr Denwood presented some of the review team's interim findings at a conference held by NHS information contractor CHKS. And he revealed another concern which had emerged from the review: the mismatch between NHS activities and the amount of data available. "Potentially there is a lot of information where there might be little expenditure, but very little information where there is a lot of expenditure," he said. Mr Denwood said social care was his main concern - as it is a huge area of spending, yet there is relatively little information available about it. The new DH governance structure aims to bring the strategic management of health and social care information together."

9.65. DH vows to right chaos in IT strategy management (7 Feb 2008)

Health Service Journal

http://www.hsj.co.uk/opinion/2008/02/informatics_policy_finally_gets_direction_after_the_years_of_drift.html

"The Department of Health review of its NHS informatics strategy is finally revealing the secrets of the service's IT debacle. The biggest civilian IT procurement programme in the world, led by Richard Granger, the country's highest-paid civil servant, was undermined by failures right at the top. Last week the review's manager, Tom Denwood, exposed the fundamental flaws that doomed the Connecting for Health strategy from the start: no one owning the big picture on information, an absence of a system to translate policy into business requirements, and continual shifting of responsibility for IT strategy round the department. Mr Denwood is to be congratulated for his openness; without coming clean with the health service about the problems, the DH would be unable to win support for a more coherent strategy. "There is a mismatch between the volume of data generated by different bits of healthcare and the volume of activity and cost." Sadly not all of the DH is as open. Mr Granger was at the epicentre of this debacle, but HSJ Freedom of Information Act requests about his work are still being blocked, in breach of the act's rules. But looking to the future, the review team is beginning to plot a way forward. It has been listening carefully to what NHS managers and clinicians have been telling them about the problems to date and how they should be overcome. Internally, the DH is about to shake up its governance structure to deliver a single decision-making body for IT, giving the next phase of development much-needed direction. A director general-level chief information officer is being recruited to develop and deliver the information strategy for health and social care, backed up by a director of programme and systems delivery. The team has also grasped that there is a widespread mismatch between the volume of data generated by different bits of healthcare and the volume of activity and cost related to it. While relatively obscure parts of the service are awash with data, social care is a glutton for cash but a miser when it comes to churning out information. The DH is determined to address this. The informatics review matters not just because of the central importance of IT to the NHS and the amount of public money it consumes, it is also the biggest test to date of whether the department can address the shortcomings identified last year by the Cabinet Office's so-called capability review of its performance. There is a long way to go, but the early signs are encouraging."

9.66. Secret Downing Street papers reveal Tony Blair rushed NHS IT (18 Feb 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/02/18/229447/secret-downing-street-papers-reveal-tony-blair-rushed-nhs.htm

"Tony Blair repeatedly sought to shorten the timetable for the NHS IT programme in a move that would have brought results for patients in time for a general election in 2005, Computer Weekly has learned. Papers obtained under the Freedom of Information Act show that the Department of Health drastically underestimated the time it would take to make electronic patient records available online. In papers presented to an NHS IT meeting at Downing Street, the Department of Health promised systems would provide "seamless" care across the NHS by 2004/05 - less than half of the time now allotted to the scheme. The meeting, on 18 February 2002, was attended by IT suppliers, policy advisers and health experts. But Tony Blair made it clear that he regarded even the 2004/05 timescale as too long. He asked repeatedly for it to be shortened, which would have brought visible benefits in time for a general election in May 2005. Blair told the meeting that implementing the programme faster than planned would underpin the government's reform agenda and provide evidence of NHS modernisation to the public. But the timetable in the Department of Health papers has proved hopelessly optimistic. Access by patients and doctors to national summary care records are only at a trial stage. And contracts for the delivery and implementation of new national systems run until 2013 - eight years later than the timetable presented to Downing Street. The Department of Health awarded a series of contracts in record time under the NHS's National Programme for IT (NPfIT) in 2003, but some suppliers complained they were being given too little time to consider their proposals. The main part of the programme - a national electronic health record - is running three years behind the original timetable, in part because the idea is more difficult than first thought to put into practice. The papers raise questions about whether the timetable for the NPfIT was geared towards a general election, rather than the practicalities and complexities of the scheme - and whether the Department of Health put politics before realities in promising the programme in less than three years. Paul Cundy, GP IT spokesman for the British Medical Association, said it appeared that the Department of Health had been "wildly, even delusionally, optimistic about the timetable for the NPfIT in order to secure funding". Vince Cable, deputy leader of the Liberal Democrats, said the Downing Street papers showed that the NPfIT was launched after a discussion that stood out for its "amateurism, naivety and a lack of consideration of the practicalities"."

9.67. Secret papers reveal Blair's rushed NPfIT plans (18 Feb 2008)

Computer Weekly - Tony Collins IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/02/secret-papers-reveal-blairs-ru.html

". . . Papers obtained by Computer Weekly under the Freedom of Information Act show that the Department of Health drastically underestimated the time it would take to make electronic records available to doctors and patients. In a paper presented to an NHS meeting at Downing Street, which was chaired by Tony Blair, the Department of Health gave undertakings of what the NHS would be like in 2002/3, 2003/4 and finally 2004/5, if the right investments were made. The paper promised that an IT-based modernisation would provide “seamless” care across organisational boundaries wherever patients are by 2004/5 – less than half the time now allotted to the scheme. It said that by 2004/5, as a patient:

- I can receive telecare at home, so I can leave hospital sooner
- I can access my own electronic records
- I know that if I have an emergency away from home that a summary of my health record will be available
- I can book appointments where and when it is convenient for me (and get reminders)

And as a doctor, by 2004/5, the paper said:

- EPRs [electronic patient records] will enable me to have clinical data online as well as reporting of results
- I can prescribe drugs more safely at less cost by using computer support

As a junior doctor I save 30 minutes a day in chasing results and getting ready for ward rounds.

- I will be able to use patient summaries from their electronic health record eg for emergency care
- I will know that clinical terms in use are clearly defined and support analyses in practice

As a health professional, by 2004/5, the paper promised:

- I can really work as part of a multiprofessional team, and across organisational boundaries, providing seamless care to a patient wherever I see them
- I can begin to use some video-based materials from the NHS U [university]. . . "

9.68. Was NHS IT plan agreed before Downing St meeting? (19 Feb 2008)

Computer Weekly - Tony Collins IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/02/was-nhs-it-plan-agreed-before-downing-st-meeting-.html#more

"Among the Downing Street papers released to Computer Weekly by the Cabinet Office under the Freedom of Information Act is a letter which indicates that the NHS IT programme was agreed largely before a meeting of Tony Blair on 18 February 2002. It seems that Blair's main influence on the programme was, initially at any rate, to compress the projected timescales. The letter is from Simon Stevens, then No 10 health adviser. He writes to Tony Blair to brief him before a meeting on NHS IT at Downing Street. The meeting is to be chaired by Blair and attended by representatives of two IT suppliers, Cabinet Ministers, policy advisers, and health experts. The letter leaves the casual reader in little doubt that a plan for a "step change" in NHS IT has been all but decided and that one of the biggest remaining challenges is speeding up progress. . ." [Followed by transcript of the letter]

9.69. Secrets Behind the UK Electronic Health Record System Decision (19 Feb 2008)

IEEE Spectrum - The Risk Factor

http://blogs.spectrum.ieee.org/riskfactor/2008/02/secret_rush_to_uk_electronic_h.html

"Tony Collins, over at ComputerWeekly, has written a fascinating story about the secret (until now) political decisions to create the UK National Program for IT (NPfIT), the UK's attempt at creating a national electronic health record (EHR) system, similar to what Hillary is currently advocating, and what President Bush wants in place by 2014. In papers obtained by the UK Freedom of Information Act, it appears that former Prime Minister Tony Blair in 2002 wanted a full fledged EHR system by early in the year 2005, before the next general election he would have to call. Even an EHR system operational by the 2005 date was seen by Blair as taking too long! It is apparent that the potential for improved patient health care that EHRs promise was cavalierly traded off for immediate political gain - not a big surprise, of course. The haste and lack of concern for the technological implications in which the NPfIT decision was made is still breath-taking, nevertheless. Best guess is that it will be 2013 before NPfIT is fully up and running; however, doctors aren't particularly supportive of it; nine out of ten doctors don't believe that the UK government can protect patient data; many doctors and privacy advocates are suggesting patients opt of of it; and support contractors are thinking of pulling out. As I have mentioned, politicians seem to believe that they are the most brilliant and clever IT system architects that exist."

9.70. What officials promised Blair on NHS IT reform - release of secret papers (20 Feb 2008)

Computer Weekly

http://www.computerweekly.com/blogs/tony_collins/2008/02/what-officials-promised-blair-1.html

"Among the Downing Street papers released by the Cabinet Office under the Freedom of Information Act was the Department of Health's briefing to Tony Blair. The briefing was given to Blair four days before an NHS IT seminar at Downing Street on 18 February 2002 which spawned the National Programme for IT - NPfIT. The Department of Health's paper made it clear that the new programme to modernise the NHS using IT would be led by technology; it was not a project to change working practices with IT as a support tool. Indeed the paper to Blair was headed: "Strategy for modernising NHS Information Systems". The Department of Health's briefing to Blair mentioned three private sector companies that officials had been "active in learning from" including Microsoft, BT and Cisco. Bill Gates had met Tony Blair in 2001 and had discussed an IT-based modernisation of the NHS. BT much later won more than £1.5bn worth of contracts under the NPfIT. Microsoft has been briefing in secret the chief executives of NHS trusts on the benefits of the NPfIT. The Department's paper did not

denigrate the state of NHS IT in 2002 to sell to Blair the need for a new national programme. Indeed the paper quoted statistics - much as NHS Connecting for Health does now to promote the NPfIT - to show that there had been a "step change following publication of Information for Health in 1998". The paper's main objectives appeared to be to put the case for much more investment in NHS IT - with the promise of achieving a national summary care record by 2004/5 . . . When this paper was discussed at the NHS IT seminar at Downing Street on 18 February 2002, Tony Blair asked repeatedly about speeding up the timescales - 2004/5 being too long a wait. There wasn't a dissenting voice at the meeting, not to the plan or the compressed timescale. Has there ever been a society which has died of dissent? Several have died of conformity in our lifetime, said the scientist Jacob Bronowski. Less than four months after the Department of Health paper was written the NPfIT was announced."

9.71. NHS boss says NPfIT 'was not in right place' (12 Mar 2008)

e-Health Europe

http://ehealtheurope.net/news/3551/nhs_boss_says_npfit_'was_not_in_right_place'

NHS chief executive David Nicholson says the NHS IT programme had become too centralised to support the move to a health service based on plurality and far more locally-based decision making by clinicians and patients. Speaking at the World Healthcare Congress in Berlin on Monday Nicholson explained why the introuduction of the NHS National Programme for IT (NPfIT) Local Ownership Programme had become necessary to support the future structure and achieve a far more integrated and devolved health service, in which services are "wrapped around patients". Nicholson said: "It felt we'd reached a position where the balance was not in the right place". The challenge he said was extremely difficult, "How does a very central system adapt to becoming a very local one." The NHS chief executive said that as a result of listening to the views of clinicians and patients the NHS IT programme was being reviewed and reshaped. "We are working through that now." . . . Despite difficulties and changes to the programme now underway, Nicholson said the health service's IT programme had achieved significant benefit, already saved 400 lives. It also highlighted efficiency savings saying a quarter of a million paper prescriptions had so far been eliminated. "We are already seeing real benefits and real problems as well."

9.72. Senior executive Richard Jeavons quits NHS IT programme (1 Apr 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/04/01/230068/senior-executive-richard-jeavons-quits-nhs-it-programme.htm

"Richard Jeavons, senior responsible owner for service implementation in the NHS's £12.4bn National Programme for IT (NPfIT) is leaving for a different health service job. He is one of a succession of senior responsible owners to leave the NPfIT. Others who have left include Richard Granger, formerly director general of NHS IT and senior responsible owner, John Bacon, the Department of Health's director of delivery and overall senior responsible owner for the NPfIT, Aidan Halligan and John Pattison. Only last month Jeavons was one of the key figures at a press conference in Whitehall to announce details of an annual statement on the costs of the NPfIT. Jeavons was seated next to the minister in charge of the NPfIT, Ben Bradshaw. . . He has been appointed chief executive at the Independent Reconfiguration Panel, which provides expertise on NHS service change. The panel was established in 2003 to provide advice to the secretary of state for health on contested proposals for health service change in England. It also offers support and advice to the NHS and elsewhere on making changes. The panel has announced the appointment of Jeavons on its website where it said it was "finalising commencement dates and a formal announcement will be made in due course". No announcement has yet been made on the website of NHS Connecting for Health. Its spokeswoman made no comment."

9.73. Swindells quits DH ahead of review publication (10 Apr 2008)

e-Health Insider

http://www.e-health-insider.com/news/3640/swindells_quits_dh_ahead_of_review_publication

"The Department of Health's interim chief information officer Matthew Swindells is to leave the department to take up a position with consultancy firm Tribal. The news comes ahead of publication of

the Swindells review of NHS Informatics, which was expected to contain criticism of the overall strategic management of information in the NHS. A former director of clinical services at Heatherwood and Wexham Park Hospital and head of IT for Guy's and St Thomas' Swindells has been leading the DH's Informatics Review, which a DH spokesperson said will be published "later this spring". The spokesperson declined to comment on whether or not the review had been completed. Swindells had been expected to present key findings as keynote speaker at the Healthcare Computing 2008 show at the end of April. However, a report in the current issue of the Health Service Journal, suggest that Swindells report has been completed and "is expected to contain strong criticisms of the general informatics programme to date". EHI contacts indicate publication of the review may be put back until the summer. . . One industry source said that Swindells had been "very sensible" and "would be missed". They speculated that reasons for his departure might include failing to win support from the DH for his review's more critical conclusions, or being passed over by the DH for the CIO position. . ."

9.74. Another leading figure in NHS IT and the NPfIT quits (10 Apr 2008)

Computer Weekly - Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/04/another-leading-figure-in-nhs-1.html

Matthew Swindells, who has been leading a review of NHS informatics including the £12.4bn National Programme for IT[NPfIT], has resigned and is to leave the Department of Health "shortly". He has played a key role in leading NHS IT since the departure of Richard Granger in January 2008. News of his departure comes only weeks after Computer Weekly revealed that Richard Jeavons is leaving the NPfIT as its much-respected senior responsible owner for service implementation. Their resignations are a blow to the credibility of the NPfIT which is now left without strong independent voices. Some will see the departures as indicating that the programme is now in trouble. Swindells is moving to the private sector, to a consultancy Tribal. His review of NHS IT, which has yet to be published, is likely to include some criticisms of the NPfIT as it stands. . . Swindells and Jeavons are seen as independently-minded executives who are not noted among colleagues for using statistics to promote past achievements of the NPfIT, though both support the scheme. In January, at an NHS CIO Summit at the UK headquarters of Microsoft in Reading, Swindells spoke of the need to move from "monolithic providers of services to many providers that are more patient centric". However the NPfIT was founded on the principle of NHS trusts in England being supplied by a small number of large IT service providers. With some NHS trusts buying hospital systems outside of the NPfIT because of delays in the supply national systems there is pressure on the Department of Health to allow hospital executives to buy what they want provided it meets national standards. Swindells has argued for plurality and against what he called 19th-century capitalism or 20th-century nationalisation. . .

9.75. Swindells leaves NHS CIO role for consulting (11 Apr 2008)

CIO

http://www.cio.co.uk/concern/managers/news/index.cfm?articleid=2732&pagtype=allchandate

"Richard Granger success leaves within months. The NHS National Programme for IT has lost its second CIO this year. Matthew Swindells, who replaced Richard Granger earlier this year, is leaving to join Tribal Group, which provides consulting to the public sector. Swindells took up the role after Richard Granger left the Connecting for Health programme in January following a highly publicised resignation last year. In a statement the Department of Health said: "Matthew Swindells will shortly leave the department at the end of his secondment from the NHS to take up an external appointment. This has been approved under the rules that govern the acceptance of outside appointments by civil servants, subject to certain conditions. In the meantime, the department is recruiting a Chief Information Officer (CIO), at Director General level, who will lead the development and delivery of the overall information strategy for the health and social care system." Swindells and Gordon Hextall took over the Connecting fro Health programme on January 31, 2008. Earlier this month Richard Jeavons also stood down as the Connecting for Health director of IT service implementation. At Tribal Swindells will be the MD of its health division, which provides a range of services to healthcare providers, including consulting on technology; use of building space; human resources and public relations. A spokesperson for Tribal said it is a new role for the company and that he will be responsible for increasing its presence in the healthcare sector. “Matthew has had a successful career, he took the Royal Surrey County Hospital from a zero star rating to two star,” she said. Tribal hope Swindells will be in place by the summer and push the company into new directions and introduce them to new clients. In his career Swindells has been head of IT for Guy’s and St Thomas foundation

trusts, as well as chief executive of the Royal Surrey before he switched to the Connecting for Health programme."

9.76. A big week ahead for NHS IT watchers (15 Apr 2008)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=20&storycode=4118472&c=2

It may play host to more technological whizzkids and software megacorporations than rank and file GPs, but Pulse will be keeping a weather eye on next week's Healthcare Computing Conference & Exhibition in Harrogate. . . These are troubled times for Connecting for Health, the body charged with overseeing the National Programme for IT. On the one hand, real progress is being made in some areas. Choose and Book looks finally to be getting off the ground, thanks in part to PCTs deciding to fund local incentive schemes, whilst the GP2GP rollout is continuing well. But progess on the flagship project, the Summary Care Record, has slowed to a crawl. And whilst the series of data security breaches this winter were nothing to do with Connecting for Health or shared electronic records, mud sticks, and to many patients the idea of a centralised Government records database seems less appealing than it once did. The £12.6 billion question though, for the hugely ambitious/expensive national programme, is how long the political will to support it will last. Things have been very rocky for the upper echelons of the Connecting for Heatlh hierarchy lately. Richard Granger, who led the organisation for the past five years, left in January, while Richard Jeavons, head of service implementation, and the Department of Health's interim chief information officer Matthew Swindells have this month both announced they are to follow suit. Even more worryingly, the Department of Health's Informatics Review is still pending - and according to the Health Service Journal 'is expected to contain strong criticisms of the general informatics programme to date.' And with Pulse's revelation this week that the Summary Care Records evaluation will not be completed until 2010, and a general election to come, the long-delayed Tory review of NHS IT suddenly becomes that much more signification. . .

9.77. Whitehall advertises for NHS CIO (23 Apr 2008)

Computer Weekly - Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/04/whitehall-advertises-for-nhs-c.html

"The Department of Health has advertised for an NHS chief information officer. Headhunters have been recruited and interviews will take place in a couple of months. Matthew Swindells, acting NHS CIO, told the HC2008 annual healthcare IT conference at Harrogate: "This is an absolutely crucial position, linking the policy to the strategy, to the informatics. If we can drive that from the top then other things become a lot easier for everybody." Meanwhile the Department of Health has appointed its latest interim head of IT in the NHS, Professor Sir Bruce Keogh, NHS Medical Director. He has been appointed interim Director General for Informatics. His temporary appointment follows the resignation of Swindells who is joining consultancy Tribal. Keogh has helped Swindells in his Informatics Review which looks at, among other things, the future of the National Programme for IT [NPfIT]. The Swindells report was due to be published in April but has been delayed until late June or July to coincide with a report by Lord Darzi on the future of the NHS . Keogh has worked on both reviews. . . In the past few months, senior health IT executives have seemed to stay in post little longer than machine-gunners who were assigned to the trenches in the First World War. It's not because of the person but the programme. Is it becoming so labyrinthine as to be unmanageable? The NPfIT needs a robustly independent review. It should be carried out by those who have no association with the NHS, an idea which ministers find abhorrent. One of the greatest achievements of Gwyneth Dunwoody, the late, exemplary chair of the House of Commons' Transport Committee, was that she and her committee harassed the government to hold an independent review of the much-delayed Swanwick air traffic control system. The result was a report by Arthur D Little, a consultancy which was appointed by open competitive tender. Arthur D Little's was the most robustly independent report we have seen on any government IT project. And this is what the NPfIT needs. It has needed it for years. Until the government has an independent report, the NPfIT will, we believe, continue to struggle like a pilot who's getting conflicting readings from his key instruments. Which is a pity because the programme will continue to soak up billions of pounds while the country continues to wait for paper records to be replaced by dependable electronic ones - which nobody denies is in the interests of patients."

9.78. Health IT is too big for one boss: NHS needs two at £200,000 each (24 Apr 2004)

The Times

http://www.timesonline.co.uk/tol/life_and_style/health/article3803652.ece

". . . Mr Granger, a former management consultant, resigned as Director-General, NHS IT, last year after five years. But the Government is splitting his job into two, costing the taxpayer potentially 40 per cent more in managerial wage bills for the project. The Department is creating the posts of chief information officer (CIO) for health as well as a director of IT programme and system delivery, each advertised with salaries of about £200,000. Combined, the two jobs are equivalent to Mr Granger's former position, on increased wages, which critics labelled an "abuse of taxpayers' money". Some IT experts question whether it is even possible to manage effectively an unwieldy project such as the National Programme for IT (NPfIT). . ."

9.79. Summary Care Record Early Adopter Programme (30 Apr 2008)

Trisha Greenhalgh et al, University College London

http://www.ucl.ac.uk/openlearning/documents/scrie2008.pdf

"An independent evaluation by University College London. . . This evaluation used mainly but not exclusively qualitative methods, comprising around 1500 hours of ethnographic observation within CFH and the Early Adopter sites; 250 interviews with NHS staff; some 2500 pages of correspondence and documentary evidence; interviews and focus groups with 170 NHS patients and carers; and incorporation of relevant surveys and statistics produced by others. . . . The hoped-for benefits of the SCR (notably improvements in the quality and safety of care and the opportunity for patients to be more actively involved in their care) remain unproven, but this is not surprising since there has not yet been sufficient opportunity to demonstrate them. . . The SCR raises important ethical and practical questions. It has potential benefits and potential disbenefits. Public debate up to now has tended to be conducted by the minority of individuals with extreme views (positive or negative) and been somewhat simplistic, polarised and tied to hypothetical situations. It is time to focus the debate on how the balance between benefits and disbenefits might play out for different individuals in different circumstances, and how these may change over time. . . we suggest that the NPfIT National Programme Board consider carefully the finding of this evaluation (which confirms previous observations by academics and policy analysts) that 'technology push' is being prioritised at the expense of attention to wider socio-technical change and that this is, in the opinion of the evaluation team, a major risk to the success of the NPfIT. Should the Board seek to address this, it follows that fundamental changes are needed to the structure, culture and preferred change model of the NPfIT. . ."

9.80. NHS head is content about rejecting NPfIT review (17 Jun 2008)

Computer Weekly, Tony Collins IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2008/06/nhs-head-is-content-about-reje.html

"The head of the NHS told MPs yesterday [16 June 2008] that he has no regrets about rejecting calls by 23 leading academics for an independent review of the NHS's £12.7bn National IT scheme - even though the main software programme is four years behind schedule. David Nicholson, Chief Executive of the NHS, said the priority had been to ensure the delivery of software as part of the National Programme for IT [NPfIT]. He made his comments to the Public Accounts Committee at a hearing on the NPfIT on 16 June 2008. Nicholson's arguments against a review of the programme were similar to those put by National Air Traffic Services when its board fought a call for an independent assessment of delayed software to support a new air traffic control centre at Swanwick in Hampshire. Directors of NATS lost their battle after a campaign by Computer Weekly. The government ordered a review - even though directors of NATS had argued that this could distract managers from the more important task of delivering the software. The air traffic control system eventually went live in 2002 - after NATS implemented the recommendations of an independent review by consultancy Arthur D Little. At the hearing yesterday of the Public Accounts Committee over the NPfIT, Conservative MP Richard Bacon asked Nicholson whether it would have been wise for there to have been a genuinely independent review of the NHS IT programme - by those unconnected with the programme. "Do you wish you'd done that now?" asked Bacon. Nicholson replied "no" and added that officials at the Department of Health had met the "all the people who have had criticisms of the programme". Twenty-three

academics had written an open letter to the Health Committee in 2006 calling an independent review of the NPfIT - and they wrote another open letter to the committee in 2006. Nicholson said: "There was no coherent argument for us to have it [an independent review] . The most important thing people said is: you should get on and get something done and delivered. That's exactly what we have been focusing our attention on." Arthur D Little's report in 1999 on the NATS software project listed serious weaknesses in the way the scheme was being run. Computer Weekly has campaigned for a similar review of the NPfIT. Nicholson told Bacon that he had read the Arthur D Little report. He said that there have already been reviews of various parts of the NPfIT- but Bacon said the programme needed to be reviewed as a whole. "No," said Nicholson. " I don't believe that's sensible at all." Nicholson said: "The most important thing now is to deliver. The service [the NHS] is crying out for this product." He was referring to the Cerner "Millennium" software and the "Lorenzo" system which are due to be delivered to hospitals across England to provide a Care Records Service - a pivotal part of the NPfIT. The National Audit Office last month found that the Care Records Service - which would give every patient in England an electronic health record - will take at least four years longer than originally planned."

9.81. CfH boss says NHS IT programme an 'expedition' (18 Jun 2008)

e-Health Insider

http://www.e-health-insider.com/news/3864/cfh_boss_says_nhs_it_programme_an_'expedition'

"The NHS IT programme is not a "programme of paint by numbers" but more of an "expedition", Gordon Hextall the acting boss of NHS Connecting for Health told MPs questioning why the £12.7 billion programme is now running at least four years late. Answering questions at Monday's Public Accounts Committee (PAC) hearing Hextall said he had a good map and compass, but due to its sheer scale the NHS IT programme continued to chart unknown territory, resulting in almost ineviatable delays. PAC chairman, Edward Leigh, asked why even Connecting for Health's new timetables should be believed. "Why should we be any more confident about these new timescales?" NHS chief executive David Nicholson replied: "We're now experienced and working much better with the LSPs [local service provdiers] that are left. We also have a product, or are close to having a product." Pressed by Leigh on whether there had yet been a single deployment of Care Records Service (CRS) software into an NHS hospital, the boss of the NHS said: "No, no." . . . The CfH director said that Lorenzo had been "delivered" to Morecambe Bay Hospitals NHS Trust, but acknowledged it was not yet "live", with the trust testing the software. He stressed that it was for the trust to decide when it was happy to go with the software. During the hearing Hextall repeatedly returned to the theme that it was getting quality right, rather than hitting target dates that mattered. Asked when Morecambe Bay would switch on, he said: "They will go live when the quality is right." He indicated this was now expected to be by July. However, despite this clear statement that quality would trump all else the CfH director still offered an extremely aggressive timetable for Lorenzo implementations following Morecambe Bay, stating they would begin in earnest within three months - initially at two more pilot sites. . . Nicholson made clear that the aim remained to roll out the two strategic CRS systems across entire LSP areas. "We are trying to ensure all trusts take the same system in an area." Questioned by Leigh on Newcastle's recent decision to go outside the NHS IT programme, and potential liabilities this created to the NHS, Nicholson said the department can insist non-Foundation Trusts (FTs) take CfH systems. "We can direct trusts to take the system". Hextall said Newcastle had committed to continue working with the programme, and the system they were looking at was Cerner. Nicholson added that even for FTs it was extremely hard to go outside the programme, as they remain subject to Treasury rules, and have to show that whatever system they took was as cost effective as the CfH products. "We think the product we are delivering they will want to take. They have to have a business case to show the benefits of taking another system and that's very difficult to do." He said that Bedford, which had looked to go outside the programme, had become convinced that iSoft was the best system to go for and were now great advocates. "Will you force trusts to take the system?" Leigh asked. Hextall avoided a direct reply saying it would be very hard for them to make the business case necessary. . . Hextall told PAC member Paul Burstow, MP, that there had been three major changes to the delivery dates, though he later added that delivery plans were changed on an almost weekly basis. He said the programme had always been ten years in duration. Fellow PAC member Richard Bacon, MP, rebutted this assertion, saying that at its outest "Sir John Pattison said it would take two years and nine months and be completed by December 2005." He asked the DH to provide a note explaining how the programme had changed into one that will take at least ten years."

9.82. Health chiefs tell NHS trusts not to wait for NPfIT (10 Jul 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/07/10/231439/health-chiefs-tell-nhs-trusts-not-to-wait-for-npfit.htm

"NHS trusts should implement interim IT systems instead of waiting for the National Programme for IT (NPfIT) to deliver in 2012, a government review of health IT has concluded. The Department of Health's Health Informatics Review, said that trusts needed access to interim solutions before the conclusion of the £12.4bn NPFIT. . . Under the plan, trusts will be able implement interim solutions for patient administration systems, order communications and diagnostics reporting, discharge and accident and emergency letters, scheduling for beds and tests, and e-prescribing. Local Strategic Health Authorities (SHAs) and Connecting for Health, the body that is delivering the NPfIT, will develop "roadmaps", to roll out the interim systems. Trusts will be able to buy the systems from suppliers who are already developing the strategic systems for the NPfIT. The systems will be delivered on a case-by-case basis, and each trust will have to provide a business case for each system, the Department of Health said. . . Trusts will not be encouraged to find their own suppliers, said Bruce Keogh, NHS medical director and interim director general for informatics. "If people start going it alone we'll have a free for all. That would be a great opportunity cost." . . . The Informatics Review looked at how information can be better used across the NHS. It will be followed by an Implementation Report this autumn."

9.83. Doctors repeat call for inquiry into CFH (14 Jul 2008)

e-Health Insider

http://www.e-health-insider.com/news/3943/doctors_repeat_call_for_inquiry_into_cfh

"Doctors' representatives have called for an independent inquiry into Connecting for Health and demanded that trusts be allowed to seek solutions directly from IT providers. Dr David Wrede, consultant obstetrician and gynaecologist at Taunton and Somerset NHS Trust, told the BMA's annual meeting that it was "Groundhog Day" for the representatives. He said the meeting passed a motion last year calling for an inquiry because of problems with the National Programme for IT (NPfIT) and a year later problems were still continuing and there had been no inquiry. He cited problems including the Worthing trust chief executive's claim that Cerner's functionality was inferior, delays in start dates for the system at Barts and the London NHS Trust, and cancer care delays at Barts blamed on the Cerner system. He added: "What we have experienced as clinicians is a system that's very slow and difficult to get things done." Dr Wrede claimed the specification had not been properly considered and that a one size fit all approach was not right when trying to implement systems in hospitals as diverse as Weston General, St Barts and the Royal London. He said the NHS needed to understand what had gone wrong with NPfIT. . . Dr Alan Russell, BMA council member, said he was concerned that too many local trusts were not good enough to be given responsibility for local implementation and that problems with Choose and Book were often caused by trusts. He added: "There are too many trusts that take what's put out nationally and change it and make it worse than it ever was." However Dr Wrede's call for trusts to be given local autonomy on IT systems was backed by representatives. . ."

9.84. Informatics Review and NPfIT: an opportunity (15 Jul 2008)

Computer Weekly - Tony Collins' IT Projects blog

http://www.computerweekly.com/blogs/tony_collins/2008/07/informatics-review-and-npfit-a.html

". . . Some in the NHS are saying that the Informatics Review is the eulogy being read at the funeral of the NPfIT. That's a bit unfair. The Informatics Review says what NHS IT should be. But almost the same visionary words could have been written 10 or 20 years ago - and many were, in the NHS IT strategies of 1992 and 1998. Talking about a Utopian future for NHS IT will not disinter the NPfIT. It will, however, help to justify the edifice of a central bureaucracy to oversee NHS IT of the future. That's politics; and executives working for the NHS say it's time to put politics to one side and do what's best for patients, which is, within the ASCC, to give a subsidised choice of IT suppliers to the boards of NHS trusts. They can then buy products they know work, not vapourware. It's one thing for the NHS to have invested, in decades past, in a multitude of systems that weren't joined up, cost a small fortune and worked. It's another thing to put faith in a visionary IT programme in which the investment is in a minimal number of systems that aren't joined up, cost a bigger fortune and don't work. . ."

9.85. Implied consent set to be scrapped for SCR (30 Jul 2008)

e-Health Insider

http://www.e-health-insider.com/news/4012/implied_consent_set_to_be_scrapped_for_scr

"The implied consent model for the Summary Care Record (SCR) looks set to be scrapped in favour of a simpler consent model following a recommendation from Connecting for Health's advisory group. Implied consent looks likely to be replaced by a model based on 'consent to view', providing a simpler more intuitive way for patients to decide who accesses their record. The Summary Care Record Advisory Group, made up of key stakeholders for the SCR, has recommended that the NHS adopt a "refined consent model" for the SCR. The recommendation is now to be discussed with other stakeholders before a change is agreed, possibly by mid-September. A spokesperson for NHS Connecting for Health (CfH) told EHI Primary Care: "We can confirm that our external stakeholder body, the Summary Care Record Advisory Group, has met and recommended that the NHS adopts a refined consent model, simplifying decisions for patients without removing the choices available. This would provide the protection they want over accessto medical records. We are discussing the recommendation with our key stakeholders to get their views about the proposed change." CfH is not releasing any more details on the proposed change but the advisory group was to hear recommendations from the SCR team including its views on the 'consent to view' model used for summary record projects in Wales and Scotland and highlighted by the evaluation report. . ."

9.86. Foundation trusts tender outside NPfIT (21 Aug 2008)

e-Health Insider

http://www.e-health-insider.com/news/4077/foundation_trusts_tender_outside_npfit

E-Health Insider has learned that just a month after the publication of the Health Informatics Review, a number of NHS foundation trusts have begun to move to non-National Programme for IT in the NHS solutions. Royal Berkshire NHS Foundation Trust and The Rotherham NHS Foundation Trust have seperately placed advertisements for electronic patient record systems in the the Official Journal of the European Union, rather than go through NHS Connecting for Health's Additional Supply Capability and Capacity (ASCC) framework contracts. Rotherham's OJEU tender is a ten year contract for a locally configurable, fully fledged electronic patient record. The tender sets the requirement for a high degree of local control. . . Meanwhile, two further foundation trusts, Harrogate and District and South Tyneside, have put in place new, long-term contracts to support their existing patient administration systems. Harrogate and District NHS Foundation Trust has signed a new five-year support deal for ICS, an existing iSoft patient administration system already in use at the trust that pre-dates NPfIT. The same PAS is thought to be in use at South Tyneside NHS Foundation Trust. Both trusts have Computer Sciences Corporation as their LSP, and are meant to recieve the Lorenzo Care Records Service product when it becomes available. By awarding five-year support deals to iSoft they appear to have pushed back the date at which they might eventually take an NPfIT CRS solution back to 2013. . .

9.87. Patients get veto on access as NHS database expands across England (18 Sep 2008)

The Guardian

http://www.guardian.co.uk/society/2008/sep/18/health.nhs

"NHS staff are to be required to seek patients' specific consent before reading their electronic medical records under tougher rules to protect confidentiality due to be unveiled today. The government is pressing ahead with plans to upload the records of 50 million patients in England on to a national database known as the Spine. They will contain a summary of key personal data including allergies and current medications. But, in a further move to protect confidentiality, the Department of Health has decided to give patients a veto on when the information can be accessed. The electronic record was designed to give paramedics and staff in casualty units and walk-in centres immediate access to patients' records. The system - part of the NHS's £12.4bn IT upgrade - was hailed by ministers as a potential lifesaver for anyone in an accident or taken ill far from home. But ministers have accepted patients may object to personal information being disclosed to NHS staff who do not need to know it. For example, someone treated for depression may not want to advertise the fact to anyone other than their GP. After a Guardian campaign in 2006 the government conceded that patients should have the right to stop medical information being passed from the GP to the NHS Spine, if they were concerned

about leaks of information or attacks by computer hackers. During subsequent trials of the scheme in Bolton, Bury, Bradford, south Birmingham, and Dorset, Connecting for Health, the NHS's IT procurement agency, ran information campaigns telling patients they were entitled to protect their data. . . But a review of the scheme by University College London found most patients in the trial areas did not know their records had left their GP's surgery. Doctors and nurses in hospitals also did not know they had to ask permission from a minority of patients before calling up the files. New rules agreed yesterday by the NHS care records board will require staff to seek prior approval of all patients fit to give it, on every occasion that files are accessed. . ."

9.88. NHS Informatics Planning 2009/10 (8 Dec 2008)

Department of Health

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091437

". . . The NHS Operating Framework for 2009/10 outlines the need for informatics planning with board level ownership and support to deliver information enabled service transformation. This document, which includes a link to supporting tools for Chief Executives and other key stakeholders, provides further guidance. The national expectations contained in this document should be used by all NHS organisations to refresh and re-focus their informatics plans. . . Individual NHS organisations working collaboratively within local health communities should plan for the roll-out of the Summary Care Record (SCR) across LHCs with a focus on urgent care settings. Learning lessons from the Early Adopter Programme, national roll-out will have commenced during 2008/09, once compliant software is available. SHAs will agree the timeline for implementing the SCR with PCTs as commissioners, and full roll-out of the SCR will be demonstrated in LHC plans. Roll-out will be based on a two year window for the full deployment of SCR from the date on which all GP systems in the PCT are compliant. PCTs will manage compliancy of GP systems in accordance with their primary care informatics strategy and to bring forward the benefits offered by SCR. . . It is NHS policy that patient level data should not contain identifiers, including NHS Number, when it is used for purposes other than the direct care of patients. It is important that organisations commissioning and providing NHS care develop and implement plans for the use of data, which has either been anonymised or in which identifiers have been replaced with pseudonyms. This should cover all patient level data which is not used for direct care purposes and in particular NHS wide data which is extracted or received from the Secondary Uses Service. . ."

9.89. Health records scheme at 'pivotal' point (12 Dec 2008)

Financial Times

http://www.ft.com/cms/s/0/c8cff74c-c7db-11dd-b611-000077b07658.html

"The NHS's multi-billion programme to create an electronic health record has reached a "pivotal position" where it will require a big rethink if more progress is not made soon, David Nicholson, the NHS chief executive, said on Thursday. The programme is running at least four years late. New installations in London are on hold, no roll-out of the programme has yet been agreed for the north of England and the Department of Health is still deciding how to replace Fujitsu, the contractor for the south whom the NHS fired in May. Mr Nicholson told the Commons health committee he remained "confident" that the NHS would have a workable system by 2015. But in a first public admission that a rethink might be required, he told MPs: "We do have to think about how we take it forward. We can't go on and on for this." While parts of the programme had gone well, he said, there were "some really difficult issues to tackle" around installation of the clinical record. The software that was to be used for the whole of the north, Midlands and east of England was finally being tested on a small scale, he said. "Good results are coming out of that", but "we need to be careful" before rolling it out, he said. In London, the latest installation at the Royal Free hospital has hit big problems which BT, the installer, and Cerner, the software provider, are working to resolve. "We have said to Cerner and BT that they have to solve that problem at the Royal Free before we will think about rolling it out across the rest of the NHS," he said. And he hoped that around February there would be a decision about who would take over in the south. The options included BT, which is responsible for the London systems, and CSC, which runs the north; a combination of the two; or bringing in another contractor. But as MPs queried the scale of the delays, he conceded "we really are at quite a pivotal position. If we don't make progress relatively soon, we are really going to have to think it through again." With the BT and CSC contracts running until 2015 and 2016, the department refused to comment on what "thinking it

through again" might imply. It said: "We remain confident that the situation at the Royal Free will be resolved and so are not prepared to speculate about possible scenarios if it is not". BT said it was "making good progress" at the Royal Free."

9.90. CfH stripped of key roles and reorganised (5 Mar 2009)

e-Health Insider

http://www.e-health-insider.com/news/4629/cfh_stripped_of_key_roles_and_reorganised

"In a major shake-up of health service IT, key leadership roles are to be moved directly to the Department of Health, with NHS Connecting for Health playing a strictly supporting role. Documents seen by E-Health Insider indicate that the moves will make CfH a "delivery organisation", with technology policy, technology and strategy questions decided by a team reporting directly to chief information officer for health Christine Connelly. A new DH Informatics Directorate will be established, consisting of six directors reporting directly to Connelly plus Tim Straughan, chief information officer of the NHS Information Centre. The six directors will include Martin Bellamy, director of programme and systems delivery, whose key objective will be "to deliver elements of the NHS systems portfolio." Intriguingly, the National Programme for IT in the NHS is only described as a short-term objective for the current head of CfH: "In the short term, the main area of focus is the National Programme for IT." Also eye-catching is the transfer of the role of technology officer from CfH to the DH, which will now set a common technical architecture for the NHS and ensure that systems conform to it. Paul Jones will transfer directly from CfH to the DH as chief technology officer. The documents seen by EHI say: "The CTO will own the overall technical architecture to be used by the NHS and Department for Health and will ensure that systems developed conform to that architecture." The other director positions, yet to be filled are: a director of policy and planning; a chief business architect; a commercial director, informatics; and a clinical director, informatics. All sit outside CfH. One senior NHS IT professional told EHI that the restruture indicated a major shift in power and resources: "The implication of this to me is that both the informatics architecture and the financing for that is moving back into the control of the NHS." EHI understands that CfH has also announced a restructure designed to enable it to refocus efforts and "build on the culture of delivery throughout the NHS." In a letter to the agency's staff, Bellamy said the restructure will "fully align NHS CfH's systems of internal control with those used in the Department of Health." . . . The two shake-ups are the first obvious outcome of the appointments of Christine Connelly and Martin Bellamy last September, and come against a background of rumoured lively conversations behind the scenes. The changes will come into effect on 6 April."

9.91. McBride scandal exposes smear culture (16 Apr 2009)

Computer Weekly Tony Collins IT Projects Blog

http://www.computerweekly.com/Articles/2009/04/16/235662/mcbride-scandal-exposes-smear-culture.htm

One of Gordon Brown's ministers, Ed Miliband, said this week that the departure of Damian McBride should put an end to the e-mail smear scandal. But smearing is a cultural problem, as Computer Weekly discovered during Parliamentary debates in 2007 on the NHS's £12.7bn National Programme for IT [NPfIT]. During the debates the then health minister, Caroline Flint, - and a former health minister, Lord Warner, - made allegations against individuals and organisations, based on incorrect briefings they had received. The false claims have never been corrected. The allegations named individuals and various organisations in the IT industry, implying that they had become allies of the Tories in making politically motivated criticisms of the NPfIT. A few months before the debates, in February 2007, a small delegation representing the Department of Health had briefed the then Prime Minister Tony Blair that criticisms of the NPfIT were politically motivated. Computer Weekly obtained a copy of the confidential briefing paper which was given to Blair. At a debate on the NPfIT in the House of Commons in June 2007 Caroline Flint ascribed to a report of the National Audit Office positive comments on the national programme that the NAO had not made. She then claimed that a Computer Weekly reporter, Tony Collins, had briefed only the Conservative Party on the NPfIT. She told the Commons, "I am sure that members of the Conservative opposition are familiar with the content of the [NAO] report because it was laid before Parliament on 16 June 2006. I am sure that they do not rely only on the opinions of such people as Tony Collins of Computer Weekly, who has, I understand, provided briefings solely to members of the Conservative party and produced material for publication by Conservative party think-tanks." Computer Weekly has not given briefings solely to the

Conservative Party, nor produced material for its think tanks. Separately, Lord Warner, the former Health minister who had been the government's spokesman on the NPfIT, obtained a series of e-mails which had been written by Ross Anderson, Professor of Security Engineering at the Cambridge University Computer Laboratory. Anderson was at the time an adviser to the Health Committee during its investigation into aspects of the NPfIT. Lord Warner cited the e-mails during a debate on the NPfIT in the House of Lords on 21 June 2007 when he questioned the political neutrality of Anderson. Lord Warner said, "Some of my puzzlement over hostility to the programme has been removed, since leaving office, by discovering people working together to campaign against this programme. "The campaign seems to be made up of the Foundation for Information Policy Research, the Big Opt Out organisation, the Conservative Technology Forum, Computer Weekly, Medix surveys and the Worshipful Company of Information Technologists, which I only recently discovered. "An energetic presence in this network is a Cambridge professor called Ross Anderson. Some interesting e-mails of his have found their way to me." After quoting from several e-mails, Lord Warner said, "I have insufficient time to entertain the House with more extracts. I am willing to let them be seen on a private basis by my honourable friend in the other place who chairs the Health Select Committee. In a spirit of bipartisanship, I would encourage Conservative parliamentarians to look closely and sceptically at some of the sources of advice they appear to be using." Even today, and despite a request under the Freedom of Information Act, Anderson has been unable - yet - to discover how Lord Warner obtained his personal e-mails. Miliband, some ministers and the Cabinet Secretary Gus O'Donnell, see the Damian McBride affair as the beginning and end of smear. But the desire to try and debase the reputations of individuals and organisations to further political aims runs much deeper in the government system. In the case of the NPfIT, the smears served only to divert attention temporarily from the most potent criticisms of the national programme. It is worth nothing that a year after Caroline Flint's speech the National Audit Office published its second report on the NPfIT - which was strongly critical of aspects of the programme.

9.92. NHS IT programme given seven months to improve (29 Apr 2009)

Health Service Journal

http://www.hsj.co.uk/5000918.article

"The Department of Health has given the NHS IT programme seven months to make "significant progress" in installing working IT systems in hospitals. The deadline was set yesterday by DH director general for informatics Christine Connelly. She said "a new plan" for delivering informatics in the NHS would be adopted if the deadline was missed. Ms Connelly also announced plans to invite suppliers on Connecting for Health's supply framework to provide IT systems for hospital trusts in the South of England. Fujitsu was previously the service provider for the region but pulled out of the programme last May. The programme will continue to allow more flexibility in the choice of IT systems. Ms Connelly announced a DH "tool kit" that will allow software developers to design new IT products that can be plugged into the central system. Ms Connelly said: "We now want to open up the healthcare IT market to new suppliers and new technological developments, to inject more pace into this programme. Working together, we can help trusts configure systems to best meet their local needs as well as take advantage of market developments to make more use of the information held in the core systems." Ms Connelly has been reviewing NPfIT since she took over the role in August. It was widely understood that she would be publishing a report outlining her findings, but a spokesman for NHS Connecting for Health this week said there would be no report and that expectations to the contrary were incorrect."

9.93. NHS CfH boss Bellamy to depart (23 Jun 2009)

e-Health Insider

http://www.e-health-insider.com/news/4958/nhs_cfh_boss_bellamy_to_depart

Martin Bellamy, the head of NHS Connecting for Health, is to leave his position as director of programme and systems delivery for a new position at the Cabinet Office. His departure comes as part of a wider shake-up of NHS Connecting for Health that will see the IT agency become directly managed by the Department of Health Informatics Directorate. Director general of informatics Christine Connelly presented the new plans to CfH staff in Leeds yesterday. In an exclusive interview with E-Health Insider, she explained that the move was primarily intended to create a new integrated Informatics Directorate, and was not about cost savings. "I talked about embedding the Informatics Directorate within the DH and all aspects of the delivery of healthcare," said Connelly. She stressed

that the challenge was to ensure informatics permeated and underpinned all of healthcare. The very name of the agency, synomymous with the £12.7 billion National Programme for IT in the NHS, is uncertain. Connelly said consultation is now underway on how the CfH "brand" might best be used in the future. Bellamy will depart at the beginning of July to take up a new Cabinet Office position. He will be responsible for developing the government's strategy for cloud computing, GCloud, which was given prominence in the recent Digital Britain report. He will leave just nine months after taking up the post in September 2008. His appointment was announced in August 2008, alongside that of Connelly, the DH's first chief information officer. The two jointly replaced Richard Granger, the former NHS director general of IT and head of CfH, who had left in January 2008. Gordon Hextall, who left the agency this April, acted as its head in the interim. Although no direct replacement will be appointed, EHI has learned that Tim Donohoe will take responsibility for CfH, in his role as the Informatics Directorate's head of programme and operations. In March, it became clear that the DH Informatics Directorate was aiming to recast CfH as a "delivery organisation", with technology policy, technology and strategy questions decided by a team, including Bellamy, that reported directly to Connelly. Some 1,155 staff work for CfH. In her interview, Connelly said that the challenge on the National Programme and CfH was to "move from beyond programmes to operations and delivering services that will run for a very long time." To do this requires the programme "to get to stability and not large scale development." Connelly added: "I spoke today about the need to look for the time when programmes finish." She said this included planning for the world of very different needs that would exist at the end of NPfIT. "At the moment, the informatics programme is dominated by NPfIT, but when that is done there will be a whole lot of other things we need to do." Sources suggest that the relationship between Bellamy and Connelly has at times been strained, but they had worked jointly on the informatics strategy. Referring to Bellamy's Cabinet Office position, a DH spokesperson said: "They came to a mutual agreement it was a good opportunity for him to follow." Prior to joining CfH, Bellamy worked for the Department for Work and Pensions since 2003, where his main role was chief information officer for the Pension Service.

9.94. Department of Health publishes criteria for successful introduction of Electronic Patient Records (29 Oct 2009)

Department of Health

http://www.connectingforhealth.nhs.uk/newsroom/news-stories/eprcriteria

The Department of Health has published criteria for suppliers to successfully introduce information systems into hospitals which will enable electronic patient records. An end of November deadline was set for suppliers to deliver significant progress in the acute sector. This was in the context of good progress having been made in delivering the infrastructure which can support electronic records, but greater pace needing to be injected into the programme for hospitals' electronic information systems. Successful implementation has been achieved in many areas, including digitised imaging replacing x-rays, online patient referrals, electronic transfers of records when patients change GPs and a broadband network linking acute hospitals, GP surgeries and community services. Through the implementation of Picture Archiving and Communication Systems across all NHS hospital trusts in England, patients are experiencing faster and safer diagnoses and treatment while freeing up vital resources to invest in even better patient care. The new systems and services introduced as part of the National Programme for IT also support choice and convenience for patients in booking outpatient appointments and obtaining repeat prescriptions. Some 54% of all new outpatient appointments are being now booked through Choose and Book and recent evidence suggests that using Choose and Book is reducing referral response times from 25 to 5 days, making a key contribution to achieving 18 weeks targets for treatment. In April 2009, the Director General for Informatics, Christine Connelly, made clear that if significant progress was not achieved in the acute sector by the end of November, a new plan for delivering informatics to healthcare will be considered.

The criteria for success are:

* Do all the elements of the product exist?

* Is the product robust and reliable?

* Has the product been successfully deployed?

* Can the product be deployed at scale?

The NHS at trust and strategic health authority level has agreed the detail of how these criteria will be assessed.

9.95. Government to review Summary Care Record rollout (11 Jun 2010)

Pulse

http://www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4126279&c=2

The Government is to launch a sweeping review of the Summary Care Record rollout it emerged today, in a shock announcement at the LMCs conference. GPC chair Dr Laurence Buckman told delegates that health minister Simon Burns has sent a letter revealing he is to intervene following huge GP concern over the rollout. It comes amid mounting confusion over the future of the Summary Care Record. The Government announced last week that it planned to keep the Summary Care Record, despite the Conservatives and Liberal Democrats both previously pledging to scrap the national system. The Government's review will cover the possibility of a change to an opt-in model of consent and also the entire content of the record, amid concern over security. It comes with a report due out next week from the University of London expected to reveal that major inaccuracies in Summary Care Records uploaded so far have put patients at risk. The intervention came as LMC representatives supported a motion calling for the BMA to 'formally and publicly abandon its acceptance of an 'opt out' system'. Pulse revealed earlier this week that the BMA was confident it could persuade the new Government to intervene and change the consent model, despite ministerial announcements in the commons having appeared to suggest that it was pressing ahead with the rollout under the same terms as the previous Government.

In his letter Mr Burns said the Government accepted the need for electronic records but not in their current form. He said: 'We believe that the current processes that are in place need reviewing to ensure that both the information that patients receive and the process by which they opt out are as clear as possible.' Dr Ian Rummens, of Shropshire LMC, told the conference: 'The concept of complied consent is fundamentally flawed and unsound.' Dr Gill Francis, of Wirral LMC, said: 'It's a huge gamble with public money at a time when the purse is empty. Do we need it? No. Can we afford it? No.' Dr Andrew Richardson, of Devon LMC, said: 'Scrap it! It's been a huge waste of money. We've managed without it in the past.' But GPs stopped short of calling for the Summary Care Record to be abandoned altogether, with 50% voting against in favour of 43% who backed the abandonment of the SCR.

10. British Computer Society

(On the BCS's statements about NPfIT; the actual statements are referenced in appropriate parts of Section 4 above.)

10.1. Central NHS IT may not work, warns BCS (29 Aug 2006)

Computer Weekly

http://www.computerweekly.com/Home/Articles/2006/08/29/218056/Central+NHS+IT+may+not+work%2c+warns+BCS.htm

" The British Computer Society has backed calls for a technical review of the health service's £12.4bn IT programme, questioning whether the scheme's centralised approach will work in the complex structure of the NHS. . . Some of the BCS's concerns are set out by Glyn Hayes, chair of the society's Health Informatics Forum, in a letter sent to Martyn Thomas. Thomas, a visiting professor at Oxford University, was one of 23 senior academics who wrote to the House of Commons Health Committee calling for an independent technical audit of the NPfIT. Hayes' letter says the BCS is greatly concerned that a centralised IT approach will not work in the complex organisational structure of the NHS. He tells Thomas, " I do indeed support your proposal for a review of NPfIT." . . ."

[Page proofs of full story
http://www.editthis.info/images/nhs23/5/50/ComputerWeekly29Aug2006BCS.pdf]

10.2. BCS 'has not changed mind' about CfH review (30 Aug 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2096

" The British Computer Society has denied changing its tack by backing the growing calls for a technical review of the health service's £12.4bn IT programme. Glyn Hayes, chair of the society's Health Informatics Forum, has defended his position following a report in this week's Computer Weekly, which detailed a private email from Dr Hayes to Martyn Thomas. . . However, Dr Hayes told E-Health Insider: " Our position has not changed at all. We are wholly in support of NHS Connecting for Health and the national programme." The BCS has always had concerns about centralising data and the structure of the clinical record but had expressed these directly to NHS CfH, he added. " We have acted as a critical friend," he said. On the question of a centralised versus a distributed architecture, he said: " There is an argument that says it would be better having [data stored in] individual systems as long as they could communicate with each other. We are not arguing for that but it is a question that needs discussing." He said the BCS was in favour of a technical review but that it must not hold up the project. He said: " If the politicians lose their nerve because of pressure from Computer Weekly then the health service is going to suffer." Professor Thomas admitted to being mystified by the furore. " I believe that Glyn Hayes, the BCS health informatics forum and the 23 academics are completely in agreement about what needs to be done to help the national programme," he said. Dr Thomas added: " I think the BCS is walking a very delicate line and believe that they can influence the national programme better by talking quietly with Richard Granger and his team and believe that the very public campaign that Computer Weekly is running is causing damage. I am not convinced that they are right." . . "

10.3. Call for co-operation on new way forward for NPfIT (11 Sep 2006)

e-Health Insider

http://www.ehiprimarycare.com/news/item.cfm?ID=2117

" A call for the 'old guard' of health informatics and the 'new kids on the block' to work together to take the National Programme for IT forward has come from the British Computer Society Primary Health Care Specialist Group chair. Speaking at the group's annual meeting in Oxfordshire, Ewan Davis, said relations between the two groups had been characterised by mutual disrespect " and that gets us nowhere." He said some the old guard had said " here we go again" and assumed they had nothing to learn from the new arrivals, while the new kids coming from oil wells and supermarket chains and bringing new levels of skills in software engineering and project management had failed to recognise the expertise of people already in health informatics. Davis emphasised the need to work together and explained some of the thinking group members had been doing to take the national

programme forward. . . The solutions under scrutiny were those that could integrate a number of heterogeneous solutions, crossing boundaries of functionality and geography, but which also allowed competition between vendors. . . Analysing the reasons for the need for alternatives, Davis pointed to the nature of the NHS. " One of the reasons we have had problems with the current approach is that people perceive the NHS as a corporate entity and then are surprised when it doesn't behave like a corporate entity." His alterative was to see to NHS as a supply chain – a group of organisations of varying size and power that simultaneously compete and co-operate towards a common goal."

10.4. DH carrying out 'confidential' review of CfH (15 Nov 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2266

" E-Health Insider has learned that an urgent 'confidential' review of the NHS IT programme and structure of Connecting for Health, the agency responsible for its delivery, has been launched by the new chief executive of the NHS David Nicholson. The new boss of the health service has commissioned a review of the £6.2bn NHS digitisation project as one of his first actions since taking up post in September. The CfH review, which has already begun taking evidence, is understood to be focusing on reviewing how to re-structure CfH to make it and the programme it is charged with delivering more locally responsive. . .Calls for a review of the project, including calls from both the British Computer Society and from a group of 23 eminent computer academics, have all previously been rejected. . . Dr Glyn Hayes, vice-president of the BCS and chair of its health informatics forum said: " If this review is designed to refocus CfH towards a more local implementation approach we are all in favour as we want those successes that have been achieved to be built on." Dr Hayes added that a local implementation approach potentially provided the way to address a lot of the very real anxieties around confidentiality. The BCS is itself due to publish a full review of the technical architecture of the NHS IT programme within the next two weeks."

10.5. BCS calls for complete overhaul of NHS IT project (15 Dec 2006)

e-Health insider

http://www.e-health-insider.com/news/item.cfm?ID=2352

" A new report from the British Computer Society has called for a fundamental rethink of the NHS IT programme, including putting one hold current plans for a national system of summary records and for the scope of NHS Care Records Service to fundamentally re-defined. Rather than attempt to build a monolithic national database of records the BCS report urges that that electronic Care Records it argues that to resolve outstanding data and technical difficulties a distributed model based on existing systems is a better bet: " a virtual service offering views of the distributed records available for a patient would seem appropriate" . The report urges that the £12.4bn NHS national programme for IT be completely recast as a locally based programme, based on delivering specific niche clinical systems from a range of competing suppliers, supported by standards and core national infrastructure. The strategic paper from the BCS says there is a pressing need to realign Connecting for Health (CfH) if it is to be an enabler of business and service transformation and be seen as useful by NHS staff. . ."

10.6. BCS report sparks change in the NHS IT programme (8 Jan 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/01/08/221049/bcs-report-sparks-change-in-the-nhs-it-programme.htm

"Connecting for Health, the government agency that runs the £12.4bn National Programme for IT (NPfIT) in the NHS, is considering a report from the British Computer Society that recommends putting on hold the development of the data spine of 50 million personal health records. The data spine is the cornerstone of the national programme. The report, The Way Forward for NHS Health Informatics, says the BCS wants the programme to succeed and believes it could benefit patient care. However, the report sets out key concerns about the approach being taken. Connecting for Health said it is giving the recommendations full consideration and is already acting on some of them. "The BCS is a respected body that we have worked with since the inception of the national programme. We note the report and that it contains a number of positive themes. The NPfIT Local Ownership programme, which has been considering the direction of the national programme in light of the National Audit Office report of June 2006, addresses a number of the points raised by the BCS," said a spokesman.

One of the most radical changes the BCS recommends is to put work on the national spine for the care records service on the back burner. This is a core part of the NPfIT and has been designed to hold the personal details of 50 million patients in England. . .”

10.7. BCS calls for urgent realignment of NHS National Programme for IT (20 Jan 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/01/20/221370/bcs-calls-for-urgent-realignment-of-nhs-national-programme-for.htm

“A BCS report [http://www.bcs.org/upload/pdf/BCS-HIF-report.pdf] has linked the problems facing the NHS’s National Programme for IT (NPfIT) to a pressing need to realign the programme via the English strategic health authority and trust structure. The BCS believes this is a major reason why so many NHS staff view informatics, and particularly the NPfIT, as having little relevance rather than as a key enabler of business change. According to the BCS Health Informatics Forum strategic panel, the NPfIT can make a massive contribution to safer and more appropriate patient care. The panel agrees with the Wanless Report (an independent review of long-term resource requirements for the NHS) that 4% of NHS turnover should be spent on business-led informatics. Glyn Hayes, chairman of the Health Informatics Forum strategic panel, said, “One of the fundamental goals must be to support the diverse business processes that recognise local constraints and individual patients’ values, and focus on delivery and implementation at trust level. “Instead of the current monolithic systems intended to meet most of the needs of users in a local health community, we need a range and choice of more innovative and agile solutions.” The key recommendations of the BCS report include:

- The provision of a business context for the NPfIT at national and local level
- A focus on local implementations at trust and provider unit level
- An emphasis on standards to enable systems to interoperate
- An evolutionary strategy, building on what currently works.
- Adoption of a truly patient-centred approach at local health community level
- Resolution of issues about the sharing of electronic patient data
- Transformation of the NPfIT into an open partnership with NHS management, users, the informatics community, suppliers, patients and their carers
- The clinical professions, NHS management and informaticians should collaborate to provide clear and comprehensive guidance for all sectors on data management. . .”

10.8. BCS sticks to its guns over NHS IT report (3 Apr 2007)

Computer Weekly

http://www.computerweekly.com/Home/..%5C/Articles/2007/04/03/222820/bcs-sticks-to-its-guns-over-nhs-it-report.htm

“The British Computer Society has come into conflict with Whitehall officials over the publication of a report that includes some far-reaching criticisms of the NHS’s £12.4bn National Programme for IT (NPfIT). The BCS has for several years been a committed ally of NHS Connecting for Health, the government agency in charge of the NPfIT. But the two organisations have come into conflict over a report which summarises the views of health IT specialists on the strengths and weaknesses of the NPfIT. The BCS report, published in December, is largely positive about the NPfIT, but it also says that the “value for money from services deployed is poor”, that political pressure has caused health officials to “deny problems and to defend the indefensible”, and that implementation plans have frequently ranged from the “optimistic to the unreal”. The report’s author, Ian Herbert, who is vice-chairman of the BCS Health Informatics Forum, told last month’s HC2007 Healthcare IT conference that Connecting for Health chief executive Richard Granger, after seeing a draft, did not want the report published. “It was an interesting process developing that report. Richard Granger was not keen that we publish it, he was keen that we did something else rather more opaquely behind closed doors. We were not prepared to do that. We owed more to our members. So we produced the report,” said Herbert. A spokesman for Connecting for Health said, “It is a matter for the BCS and other bodies to publish any reports they commission. NHS Connecting for Health had offered to work with the BCS on a joint action plan but they chose not to accept that offer.” The BCS revealed that it had made 17 changes to the draft report at the request of Connecting for Health, though it had not made all the requested alterations. BCS chief executive David Clarke said the BCS Health Informatics Forum had always sought a close working relationship with Connecting for Health. The BCS wanted to work with

the agency on a joint action plan, but “not as an alternative to publishing our report, which we felt was balanced, fair and fully in support of the objectives of the programme”, said Clarke. Martyn Thomas, a fellow of the BCS and one of 23 academics who have called for an independent audit of the NPfIT, said the BCS had in the past acted as a critical friend to Connecting for Health. “It may be that the BCS has taken the view that they have done all the good they can behind the scenes and cannot afford to compromise their integrity by backing away from being critical in public,” he said.”

11. NPfIT Specifications and Policies

(Reports and commentary.)

11.1. Output Based Specification (OBS) for Integrated Care Records Service (ICRS) (2002)

Connecting for Health

http://www.dh.gov.uk/assetRoot/04/05/50/49/04055049.pdf

" This document provides an introduction to the ICRS OBS. This OBS is being provided to longlisted bidders for the provision of ICRS solutions and certain other services as part of the procurements being undertaken by the NPFIT."

11.2. OBS2 For Integrated Care Records Service (ICRS) V2 PT1 (2003)

Connecting for Health

http://www.dh.gov.uk/assetRoot/04/07/16/30/04071630.pdf

(The above are the two public technical specifications that could be located for this service.)

11.3. The Clinical Development of the NHS Care Record Service (Version for Feedback) (Jul 2005)

Connecting for Health

http://www.connectingforhealth.nhs.uk/crdb/docs/scrrdocument.doc

" This report . . . sets out how the vision for a patient care record, compatible with the commissioned architecture and the NHS Care Record Guarantee, can be achieved. It describes an incremental approach that will build public and professional confidence, establish working practices and allow for the effective evolution of the whole NHS Care Record Service."

11.4. The Care Record Guarantee (May 2006)

Connecting for Health

http://www.connectingforhealth.nhs.uk/crdb/docs/crs_guarantee.pdf/download

" In the National Health Service in England, we aim to provide you with the highest quality of care. To do this, we must keep records about you, your health and the care we have provided to you or plan to provide to you. This guarantee is our commitment that we will use records about you in ways that respect your rights and promote your health and wellbeing."

11.5. Information governance in the Department of Health and the NHS Sep 2006)

Connecting for Health

http://www.connectingforhealth.nhs.uk/crdb/docs/information_governance_review.pdf/download

" I define 'information governance' as: " the structures, policies and practice of the DH, the NHS and its suppliers to ensure the confidentiality and security of all records, and especially patient records, and to enable the ethical use of them for the benefit of individual patients and the public good" . Effective information governance is necessary to be sure that the new opportunities that the National Programme for IT promises will be effectively and safely realised and so that public confidence in the electronic NHS is secured. Whilst my review focuses on the areas specified in my remit, I undertook it with recognition of the wider context of information governance which includes both the Office of the Information Commissioner and other government departments and organisations. . . Although I am clear that the present arrangements will need to be improved to support an electronic NHS, I found no committee, group or individual not doing their best in the circumstances within which they were working. None of my comments or recommendations should be taken as criticism of individuals." [Harry Clayton, National Director for Patients and the Public; Chair, Care Record Development Board (2006)]

11.6. National Programme For Information Technology (15 Nov 2006)

South East Coast Strategic Health Authority

http://www.southeastcoast.nhs.uk/board/papers/documents/31-06nationalprogrammeforinformationtechnology.pdf

" . . . Repositioning the NPfIT within the NHS - Whilst NHS Connecting for Health (CFH) has achieved a level of success as recognised by the NAO in its recent review, the increased tempo of delivery in the next 6-12 months requires a new approach if it is to ensure an effective and efficient implementation of the national programme. If implementations are to be realised at the pace and with the assurance that all parties desire, it is critical that the programme governance arrangements, structures and processes are optimised. In particular there is a need to devolve responsibilities and accountabilities around implementation from NHS Connecting for Health to Strategic Health Authorities (SHAs) as soon as possible. The fundamental aims of the planned devolvement are: To strengthen local governance and ownership, so that the SHAs and PCTs are enabled to drive the NPfIT in an appropriate direction that achieves the right balance between national imperatives and local needs; To ensure NPfIT supports the delivery of better quality and safer services for patients, and reinforce the value and benefits that can be derived from NPfIT; To build governance structures and processes that are fit for task; To improve clinical engagement in the programme. . ."

11.7. Southern SHAs to pilot greater local ownership of NPfIT (23 Nov 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2288

" The three strategic health authorities in the south of England are piloting a new model of governance for the National Programme for IT that will shift responsibilities from NHS Connecting for Health at the centre to the local NHS. . . Barbara Hakin, chief executive of East Midlands SHA, told board members in her report to their November meeting this week that NHS chief executive David Nicholson wanted four things - to see a review of the technical architecture, to deal with current criticism, a review of NHS ownership and a review of whether the NHS is being too prescriptive in the programme, a piece of work which Pearse Butler, former chief executive of Cumbria and Lancashire SHA, has been asked to handle. . ."

11.8. The NHS, Standards, Security & Identity Management (26 Nov 2006)

Connecting for Health

http://www.oasis-open.org/events/adoptionforum2006/slides/ferrar.ppt

"Summary: Open standards an integral part of the National Programme for IT in the NHS. In fact, NPfIT not possible without open, accessible, interoperable and "implementable" standards. But products that implement same standards must also be compatible and efficient. Inefficient, incomplete or incompatible implementation are less than useful – in fact its expensive & dangerous. FINAL THOUGHT: What responsibility does the standards community take to ensure effective & efficient implementation?" [Presentation by Dr. Mark Ferrar, Director of Infrastructure, NHS Connecting for Health at the OASIS Adoption Forum]

11.9. Mythbusters

NHS Connecting for Health

http://www.connectingforhealth.nhs.uk/faq/mythbusters/

" Many common misconceptions exist about NHS Connecting for Health and the programmes and services it delivers. The aim of this section is to dispel these misconceptions and enable a clearer understanding of the work of the agency."

11.10. Report of the Ministerial Task Force on the Summary Care Record

NHS Connecting for Health

http://www.connectingforhealth.nhs.uk/publications/care_record_taskforce_doc.pdf

". . . In our report we acknowledge that there are differences of opinion and approach between GPs, secondary care doctors, nurses, and patients. These are based on differences of view about the practicality, ethics and value of creating a Summary Care Record. Nevertheless the Taskforce is united in believing that a national care record service is desirable for patients, clinicians and the Health Service and that the Summary Care Record, cautiously implemented, in line with our recommendations, will bring real benefits in safety, quality, efficiency and coordination of care. Our recommendations deal with several matters: implementation, patient access and consent, data quality, training for staff, equity and health inequalities, urgent care, the oversight of early adopter sites and their evaluation and public information. . ."

11.11. General Practice IT Infrastructure Specification (2006)

NHS Connecting for Health

http://www.connectingforhealth.nhs.uk/delivery/serviceimplementation/engagement/gps/systems_of_choice/gpsocpdf.pdf

". . . It is intended that this document will be used by PCTs to: Develop an understanding of the direction of travel of GP IT systems within NHS CFH, and how they impact on the developments already in progress to the way that practices are supported within the PCT; Use this understanding to make strategic decisions about support arrangements for GP practices; Estimate the needs of individual practices for an effective supporting infrastructure, based on the overall need to deliver both clinical services and local business applications; Estimate the investment required to bring practices from their existing provision to the required standard. . ."

11.12. Guidance for fhe NHS About Accessing Patient Information in New and Different Ways and What This Means For Patient Confidentiality (22 Dec 2006)

Connecting for Health

http://www.nhscarerecords.nhs.uk/nhs/docs/guidancefornhs.pdf

"This guidance is being made available to all NHS frontline staff (i.e. those directly involved with patient care) in England. It applies equally to existing electronic record systems and the developing NHS Care Records Service (NHS CRS). It explains:

- The implications of increased access to patient information by electronic means.
- What the introduction of the NHS CRS will involve.
- The impact that increasing electronic access to patient information will have on your job and patient care."

11.13. Additional systems catalogue plans 'near completion' (1 Mar 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2515

"Plans for a catalogue of 'additional systems suppliers' covering a wide range of specialist clinical systems are in the final stages of being drawn up by Connecting for Health (CfH), the agency responsible for delivering the £12.4bn NHS National Programme for IT. E-Health Insider understands that the supplier catalogue plans being drawn up may cover all major departmental systems and clinical specialities, together with areas such as A+E, maternity and theatres. Services such as acute data migration and infrastructure are also thought to be covered. . . The plan would appear to be for local service providers (LSPs) Fujitsu, BT and Computer Sciences Corporation to continue to provide base patient administrations systems into which into which "best of breed" specialist clinical and departmental systems meeting clearly defined interoperability standards would then be plugged. This would be a significant departure from the strategy of single standardised systems that has previously been pursued by CfH. . . The introduction of a supplier catalogue, comprising best of breed solutions, to meet the areas not being met by LSPs is understood to be one of the key recommendations likely to be contained in the report being drafted up by the House of Commons Public Accounts Committee. Potentially, the ASCC supplier catalogue could offer a lifeline to specialist clinical suppliers. Most were effectively excluded from the NPfIT programme three years ago when CfH chose to award

contracts predicated on four local service providers delivering integrated care record systems meeting most of the requirements of the major clinical communities. Plans for a catalogue of additional suppliers were first announced by Richard Granger six months ago, in which the original intent appeared to be to have additional capacity or options on call should contracted suppliers be unable to deliver. . . This 'spares' approach now appears to have evolved into a full blown interoperability strategy. EHI understands that the need for the new approach has only been accepted by CfH's leadership reluctantly. "Yes, it's been heavy weather. It's come through gritted teeth," one anonymous insider said, who indicated that the move had been dictated by the Department of Health. They added: "CfH has discovered it has disgruntled customers. It has to become more relevant." However, they also pointed out that a catalogue approach did not mean a free-for-all as in most specialist clinical areas there was one dominant supplier and a challenger. The pressure for a new approach has built due the limited success LSPs have had first in delivering PAS systems on a 'cookie cutter approach' - delivering standardised systems one after another. Even more striking has been the failure of LSPs and their software partners to develop and then deliver promised specialist departmental and clinical systems or equivalent functionality through their CRS solutions. As a result many NHS trusts - including independent foundation trusts - have grown increasingly impatient waiting for promised new and replacement clinical systems such as maternity, theatres, cardiology, oncology. In areas such as maternity some have begun to vote with their feet. An anonymous senior supplier told EHI: "The reason they are doing it is simple, there are huge gaps in the current catalogue of services offered by LSPs." In addition to struggling to meet the original CRS objectives the programme is coming under increased pressure to deliver systems that support policy priorities such as 18-week wait targets or integration between health and social care, and delivering care outside hospitals. One senior industry figure told EHI. "This looks to have been triggered by the GPSoC OJEU," which he said had effectively sounded the death knell for the single CRS solution approach that had been pursued by CfH. . ."

11.14. Working Group report on the 'Secondary Uses of Patient Information' (10 Aug 2007)

CfH

http://www.connectingforhealth.nhs.uk/crdb/secusesreport.pdf

"A considerable amount of information is collected during the provision of care and treatment, some of it specific to the patient being treated some of it not. The primary purpose of this information is to support and improve individual patient care and much of it is held under professional and legal obligations of confidentiality. However, this information, often in conjunction with other administrative health records, such as existing Cancer Registries, is of value for many other purposes to support healthcare and providing appropriate steps are taken to meet confidentiality obligations, whether through consent, anonymisation or legal authorisation, this information can legitimately be used to support these other purposes (called "secondary uses"). . . the expectation is that data for secondary uses should be provided in unidentifiable (aggregated or anonymised) form except where specific justification can be made and approvals provided. To implement this, it will be necessary to ensure that the data is appropriately managed and made available to users. . . Many current secondary users of health information are not accustomed to being restricted to anonymised or even pseudonymised information, particularly in the case of secondary uses by people who are also primary users with routine access to unanonymised data. It is important to ensure that valid business functions are able to continue and that users for secondary purposes are supported in understanding and observing the appropriate safeguards. . . One of the reasons previously given by users for access to identifiable data is to enable linkage between different datasets and to overcome some of the difficulties of poor quality and incomplete data. The Secondary Uses Service should enable both issues to be addressed through the use of the NHS Number as a consistent identifier for data collection, and through stringent validation checks on the data being loaded. . . Whilst consent can be assumed for healthcare purposes where a patient has been effectively informed about what may occur, it would be wrong to assume consent for secondary purposes. Additional efforts to gain consent are required for these purposes. . . Where the data used is in identifiable format and generally felt to be personally more sensitive, recorded informed consent with positive 'opt-in' is more likely to be appropriate than a communications exercise and a negative 'opt-out' consent model. Where a patient has asked that their information not be disclosed in an identifiable form then there must be mechanisms in place to ensure these wishes are implemented."

12. Refereed Studies

(Quotations from, and links to the full text of, papers providing detailed field studies of deployed healthcare systems, in particular NHS EPR systems.)

12.1. Privacy in clinical information systems in secondary care (15 May 1999)

BMJ 1999;318:1328-1331

http://www.bmj.com/cgi/content/short/318/7194/1328

". . . In the BMA consultation document Security in Clinical Information Systems Anderson identifies nine principles governing the design of a clinical information system meeting the requirements for patient privacy.2 Doubts have been raised about the feasibility of adopting the code for governing access to patients' electronic records in secondary care. Our experience is that the principles are achievable. This article is based on our experience of a large scale clinical information system in use in three British hospitals---Conquest Hospital, Hastings; Aintree Hospital, Liverpool; and Royal Devon and Exeter Hospital, Exeter. We describe the approach taken to ensuring control over access to confidential patient information on the basis of expected relationships between staff and patients. . . This can be achieved by matching a patient's current clinical contacts with a user's rights; this has been shown to be workable in a hospital-wide clinical information system . . ."

12.2. Issues in the multi-disciplinary assessment of healthcare information systems (Sep 1999)

Information Technology & People 12, 3

http://www.emeraldinsight.com/Insight/viewContentItem.do?contentType=Article&hdAction=lnkhtml&contentId=883513

"Abstract: Considers the problems of a multi-disciplinary team working together to understand and evaluate a healthcare information system, which itself is situated in a complex organisational and political environment. Provides general discussion of problems faced by evaluators of such systems. Describes this specific evaluation project (Electronic Patient Records in the UK National Health Service), gives an account of the evaluation process as it occurred, highlights some of the problems encountered, and discusses attempts to overcome these. Suggests that social, organisational and political factors are inherent in all such research enterprises, and that in order to facilitate a rich understanding of complex systems, these factors must also be considered as part of the research data." [Heathfield et al]

12.3. Construction of a Virtual EPR and Automated Contextual Linkage to Multiple Sources of Support Information on the Oxford Clinical Intranet (1999)

Proc AMIA Symp, 1999

http://adams.mgh.harvard.edu/PDF_Repository/D005850.PDF

"Abstract: We have used internet-standard tools to provide access for clinicians to the components of the electronic patient record held on multiple remote disparate systems. Through the same interface we have provided access to multiple knowledgebases, some written locally and others published elsewhere. We have developed linkage between these two types of information which removes the need for the user to drill down into each knowledgebase to search for relevant information. This approach may help in the implementation of evidence-based practice. The major problems appear to be semantic rather than technological. The intranet was developed at low cost and is now in routine use. This approach appears to be transferable across systems and organisations." [Kay et al]

12.4. Evaluating computerised health information systems: hard lessons still to be learnt (Apr 2003)

BMJ 2003;326:860-863

http://www.bmj.com/cgi/content/full/326/7394/860

"Enormous investment has gone into computerised hospital information systems worldwide. The estimated costs for each large hospital are about $50m (£33m), yet the overall benefits and costs of hospital information systems have rarely been assessed. When systems are evaluated, about three quarters are considered to have failed, and there is no evidence that they improve the productivity of health professionals. To generate information that is useful to decision makers, evaluations of hospital information systems need to be multidimensional, covering many aspects beyond technical functionality. A major new information and communication technology initiative in South Africa gave us the opportunity to evaluate the introduction of computerisation into a new environment. We describe how the project and its evaluation were set up and examine where the project went wrong. The lessons learnt are applicable to the installation of all hospital information systems." [Littlejohns, Wyatt and Garvican]

12.5. Integrating Child Health Information (11-12 Dec 2003)

Integrated Care Records: Problems and Solutions Workshop, Edinburgh

http://www.iccs.informatics.ed.ac.uk/~mjh/chameleon/ICRworkshop/Submissions/Copping.pdf

"Abstract: The Scottish Executive highlight that better sharing of children's information is crucial to providing improved co-ordinated care, for all Scotland's children, especially for those most in need. The "Shared Information Project" a £340,000, flagship 2 year programme, funded by the Changing Children Services fund was set-up to meet this goal. The project is clinically lead, by a Consultant Paediatrician, Primary Care Management and supported by a Clinical Specialist in Health Informatics, a Senior Social Worker and a Project Manager. Information Requirements have been defined using evidence based health informatics methodologies and the outcomes analysed using thematic-analysis. Importantly this work highlights the benefits of systematic evidence based informatics in defining actual requirement, their strength and variation across care providers. This project highlights that for successful integration of children's information human systems and IT systems need to be developed in parallel." [Hammond et al]

12.6. dbMotion: Virtual Health Community (11-12 Dec 2003)

Integrated Care Records: Problems and Solutions Workshop, Edinburgh

http://www.iccs.informatics.ed.ac.uk/~mjh/chameleon/ICRworkshop/Submissions/halevy.pdf

"Clalit Health Services is the largest health organization in Israel and the second largest in the world. It is a decentralized organization that provides services to approximately 3.7 million clients through 14 hospitals, 1,300 clinics and medical centres. The organization employs approximately 20,000 care providers, each of which can create medical data and, more importantly, request up-to-date data about patients. The medical information systems in the organization differ from one another and lack unification between the systems. The dbMotion system is currently installed at all Clalit hospitals, and in some specialty hospitals. The system is also in use at in all the districts and clinics. Since the system is Intranet-based, it is accessible to any service or care provider for whom an account has been defined in the organizational network. The dbMotion solution, implemented at Clalit, was based on the requirement to collect data from the existing legacy systems without the need to replace them, change their function or the way they are utilized. dbMotion integrates data from clinical sources that are dispersed geographically all throughout the Clalit, and contain various types of information. For example, the solution integrates data from the hospital Emergency Room and wards, the local clinics, as well as the several Clalit laboratories. In addition, the solution needed to utilize existing infrastructures for communication and data transfer such as the LAN and WAN networks or the Internet, as well as a web-based viewer, where the physician can browse through his patient's history. The solution provides available, up-to-date medical information while maintaining the highest level of information security." [Gillon et al]

12.7. Trusting The Record (2003)

Methods inf. med. 42,4 (2003) pp. 345-352

http://www.dirc.org.uk/publications/articles/papers/81.pdf

". . . The setting for our study is the toxicology ward within a large Edinburgh hospital. The aim was to subject work within the ward, and in particular document work, to close empirical investigation. . . Paper-based records are criticised for being hard to access, poorly organised, incomplete, inaccurate, hard to read, lacking consistency in format and use of terminology. The electronic medical record

(EMR) is consequently seen as providing the conditions for the imposition of greater discipline and structure on record-keeping practices and it has also become a major factor in the drive for the standardisation of medical record formats. This standardisation is, in turn, expected to lead to better treatment and the realisation of 'joined-up', 'seamless' healthcare. Our fieldwork data points to a number of trust issues - related to the way that record use is a fundamental aspect of the moral order of the working division of labour . . . Existing patient admission procedures involve the concurrent physical handover of the patient, and of information relating to the patient's admission in the form of the pink and blue sheets. This naturally provides the opportunity not only for the transfer of information about the patient, but also for the checking of its accuracy by the admitting nurse. . . With the deployment of the EMR, future admission procedures might reasonably be expected to dispense with the handover of paper: Ward nurses will be able to access the information recorded at A&E directly through the nurses' station EMR terminal. While this may seem to exemplify the ways in which the EMR can streamline and improve information-handling procedures, we suggest that, in as much as this will decouple the arrival of patient and patient information, it may undermine the robustness and reliability of the process. " [K. Clarke et al]

12.8. Making a Case in Medical Work: Implications for the Electronic Medical Record (2003)

Journal of Computer-Supported Cooperative Work, 12(3), p. 241-66

http://springerlink.metapress.com/content/xw4424x3u175xx63/fulltext.pdf

"… Numerous studies … have cast doubt on how effectively IT in general, and the EMR in particular, can deliver information – or service – integration as long as this is pursued using a narrowly technical approach, and without a proper understanding of the work being supported. As a contribution to this important debate, we present findings from a study of inter-organisational work in the context of the provision of UK psychiatric healthcare services. Briefly, these findings reveal important discrepancies between the assumptions of the role of the EMR and the ways that healthcare professionals actually use and communicate information within the particular work setting studied. As a result, the findings lead us to conclude that, contrary to presumptions, the EMR may have relatively little impact on issues related to inter-organisational working, at least as they are manifest within the context of current UK psychiatric healthcare service provision. Although it might be argued that this is a domain that is characterised by vagueness and negotiation -- and so is in some sense untypical of healthcare generally – our ongoing research suggests not only that many of the issues highlighted here have a more general relevance but also, and importantly, continues to stress our central point that the representation, storage and transmission of information, by whatever means, needs to take account of the lived reality of the work in which that information is used. However, our final point is not that better healthcare service integration is an impossible goal, nor that technologies like the EMR are irrelevant to its achievement. Rather, it is that technologies like the EMR will only deliver their promised benefits if the processes followed in their design, development and implementation are oriented to providing sufficient opportunity for user-led evolution of both work practices and technologies." [Hartswood et al]

12.9. Supporting Informality: Team Working and Integrated Care Records (2004)

Proc. 2004 ACM Conf. on Computer Supported Cooperative Work (2004) pp.142 - 151

http://portal.acm.org/citation.cfm?id=1031607.1031632&coll=&dl=&type=series&idx=1031607&part=Proceedings&WantType=Proceedings&title=Computer%20Supported%20Cooperative%20Work&CFID=15151515&CFTOKEN=6184618

"This paper reports findings from an ethnographic study of the work of Adult and Care of the Elderly Community Mental Health Teams in the context of the deployment of an Electronic Medical Record. Our findings highlight the importance of informal discussions and provisional judgments as part of the process by which teams achieve consensual clinical management decisions over time. . . it would appear that lessons learned from CSCW studies have not, as yet, made a major impact on how large-scale IT systems are designed and implemented. Most work is collaborative, but large-scale IT systems are often poor at supporting the collaborative dimensions of work. . . It would seem that integrated care records systems are, in the main, modelled along the same lines as airline reservation systems - always online, and always up to date. While this model may have its advantages in that it increases organisational control and enables strict auditing (what information was recorded in the system at a particular time and who had access to it), it fails to acknowledge and support the kinds of professional

practices we have described. The consequence of this in practice may well be that the system fails to achieve one of its main aims, namely to make more information accessible on time, as people develop practices around the system, committing information to it only once it is 'publication ready'. . ." [G. Hardstone et al]

12.10. Implementing an EPR Project: Everyday Features of NHS Project Work (2004)

Proc. 9th Int., Symp. for Health Information Management Research

http://www.iccs.inf.ed.ac.uk/~mjh/chameleon/ICRworkshop/Submissions/Rouncefield.pdf

"This paper considers some of the everyday practicalities of delivering an electronic health record project within an NHS Hospital Trust. Using ethnographic, observational, data we document how and in what ways the orderly character of project work is achieved against a background of battles and negotiations to deliver the project within and despite various organisational contingencies and constraints. . . System design in a large NHS Trust (and the associated processes of analysis, configuration, testing, integration, evolution etc) is a complex, messy business. Within our EPR project and our Trust it is proceeding in tandem with the implementation of a new network infrastructure. In these circumstances, issues such as hardware provision, data point placement, database configuration and population, interface design and training is inextricably linked to other projects and organisational working associated with modernisation and investment in IT. At the same time the NHS environment can be said to be characterised by upheaval and changing circumstances, policies, even governments. . . Information exchange practices and systems are rooted in local work processes as well as wider patterns of co-ordination and communication. Attempts to change practices, and redefine roles and relationships may lead to resistance, if those involved have different commitments and understandings of organisational processes and service provision. Current health and social care policy initiatives in the UK make significant claims about the desirability of integrated services for better health and social care, i.e., more patient-centred healthcare delivery, improved resource utilisation and management of information. Plans for implementing these initiatives appear to be largely predicated on information integration being a precondition for service integration. The EPR is an element of this strategy, yet as our research too readily documents, its implementation presents formidable challenges." [Mariane et al]

12.11. 'That's How The Bastille Got Stormed': Issues of Responsibility in User-Designer Relations (17 Mar 2005)

Proc. 5th DIRC Research Conference, Edinburgh

http://www.dirc.org.uk/publications/inproceedings/papers/115.pdf

"This paper presents data and analyses from a long term ethnographic study of the development of an electronic patient records system in a UK hospital Trust – TA 'Dependable Deployment'. The project is a public private partnership (PPP) between the Trust and a US based software house (USCo) contracted to supply, configure and support their customizable-off-the-shelf (COTS) healthcare information system in cooperation with an in-hospital project team. We use data drawn from our observational studies to highlight a range of responsibility issues in designer-user relationships." [Martin & Rouncefield]

12.12. Out with the old in with the new: What gets missed when deploying new technologies in A&E? (21 Mar 2005)

Medical Informatics and the Internet in Medicine. 30(2) 34-40.

http://www.uclic.ucl.ac.uk/annb/docs/cbaaHCpreprint.pdf

"Abstract: This paper presents a longitudinal study (over 4 months) of an A&E department where the existing whiteboards were replaced with PC based computer systems. The study was conducted in two parts; an observation of the physical whiteboard usage and in-depth interviews with all users of both the traditional whiteboard usage and the replacement technology. The research was conducted with systems manager and all whiteboard users (i.e. nursing management, nurses, doctors, porters, and agency staff) across a spread of time-frames. Although the technology supported simple information requirements complex co-ordination, collaboration and awareness issues were left unsupported. The important role of a 'pen-holder' (information co-ordinator) was poorly supported by the replacement

technology as was the task of annotating information with changing situations and needs. Specific deployment issues are derived from these findings that should guide designers when implementing technology replacements for current physical information formats (e.g. whiteboards, notice boards, shared paper notes)." [Broome & Adams]

12.13. Implementing digital resources for clinicians' and patients' varying needs. (21 Mar 2005)

Medical Informatics and the Internet in Medicine. 30(2) 107-122.

http://www.uclic.ucl.ac.uk/annb/docs/aaabsaHC05preprint.pdf

". . . Traditional design and implementation approaches, isolated from communities, produce users – both clinicians and patients – who are either unaware of the technology or perceived it as complex and inappropriate for their needs. Random deployment of technology within communities, with poor design and support, is perceived by many as complex, inappropriate for their needs and a threat to current roles and practices, including the maintenance of clinician–patient relationships. . ." [A. Adams et al]

12.14. Implementing the National Programme for IT: what can we learn from the Scottish experience? (2005)

Informatics in Primary Care 2005; 13:105-11

http://www.ingentaconnect.com/content/rmp/ipc/2005/00000013/00000002/art00004

"The National Programme for IT (NPfIT) promises to revolutionise the delivery of health care by enabling seamless and secure electronic exchange of clinical information within the NHS. Challenges to NPfIT highlighted in the media and academic commentary are common to such initiatives worldwide. This paper offers key messages and recommendations derived from a comparable electronic clinical communications programme in Scotland, and elsewhere, as a means to aid the implementation process. . . Observations, recommendations and lessons learned:

- Complex IT projects usually take longer than anticipated and cost more than initially estimated
- Never underestimate the complexity of a multi-faceted programme
- Target realistic and timely outcomes
- Avoid raising stakeholder expectations unrealistically
- Involve end-users early in the process of developing new systems and act on their feedback
- Ensure communication and integration between related programmes
- Clarify the conceptual nature of the programme
- When commissioning evaluation research, recognise what can and cannot be demonstrated in the timescale and budget that you are considering
- There should be openness about the processes of the programme and a willingness to accept and respond to feedback from objective observers
- Human factors are as important as technological ones in getting systems into practice"

12.15. Reflexive Standardization: Side-Effects and Complexity in Standard-Making (Aug 2006)

Management Information Systems Quarterly, Vol 30.

http://www.uio.no/studier/emner/matnat/ifi/INF5210/h05/pensum/Miria_Grisot_MISQ.pdf

". . . Based on a case study conducted over a period of three years in a Norwegian hospital on the standardization process of an Electronic Patient Record (EPR). . . The research presented in this paper explores the borders and limitations of modern standardization in the context of developing a pan Norwegian standard for electronic patient record systems (EPR). . . EPR systems can be used by individual doctors, as a common system in a clinical department, as a shared and common system in an entire hospital or even among a set of interconnected hospitals. EPRs can be an off-the-shelf product, a proprietary system, or (as in our case) a system co-developed between a group of hospitals and a vendor. An EPR system is used to specify, routinize, and uniform the type and format of clinical information to be collected. Moreover, it is meant to support coordination and cooperation between departments, professions and hospitals. A hospital wide EPR could reduce redundancy and

inconsistency of patient information, as the information would be stored in one single location being accessible from any place at any time. Standardization activities have aimed at defining the appropriate design of EPR as an information system, e.g. with respect to fundamental architecture, access control and data storage. . . With regard to the external validity of our case, we can ask: is our case representative of a new class of standardization problems? We believe so, especially in the health care domain where plans for developing electronic health records grow continuously bigger and more ambitious. For example, in his 2004 State of the Union address, George W. Bush Jr. envisioned 'an EHR for all Americans within the next decade' (The White House, 2004). In addition, to building a national health information infrastructure, establishing data interoperability and comparability for patient safety data is seen as crucial. This is expected to be facilitated through adopting standards that allow medical information to be stored and shared electronically while assuring privacy and security. Similarly, the British 'Connecting for Health' initiative proposes to establish the NHS Care Record Service. For each individual patient the Patient Clinical Record will be used to deliver direct patient care, and in addition a centralized database ("The Spine") will contain a National Summary Record in order to support urgent and emergency care (NHS, 2005). For both initiatives, huge challenges can be recognized and critical voices emanating from our analysis can predict significant obstacles. However, from official documents and presentations of these projects, the general perception of standards is the value of increased control: developing and adopting standards is definitely seen as part of the solution, rather than part of the problem. We do not claim that standardization of medical information systems is impossible or undesirable. Because our case study site is a specialized hospital, it represents a paradigmatic example of the socio-technical complexity arising from the close intertwining of technical standards with local and highly professional work practices (in terms of professional disciplines and geography). To some extent our case represents a general class of problems associated with the interactions between the complexity of information infrastructures, information processing, and local work practices. Thus, the common shared complexity in these classes is the immense heterogeneity and multiplicity of actors involved and the need to coordinate and standardize their behaviors. . . Through our analysis we argue that traditional standardization approaches can not deal with such complexity appropriately. Not only will such approaches fail to not deliver the intended outcome- order-; they can also lead to the opposite effects of greater dis-order, and instability. The need of future research on IS standardization, is therefore critical in approaches that help mitigate the increasing complexity IS standardization. . ." [Hanseth et al]

12.16. Who and what are electronic patient records for? (13 Sep 2006)

Proc. Symp, Current Development in Ethnographic Research in the Social and Management Sciences

http://www.liv.ac.uk/managementschool/ethnography/papers/14_David_Martin_-_Liverpool_Paper_Martin.pdf

"[We] report on a field study conducted between 2003 and 2005 at an NHS Trust in the North of England. The choice of case study is interesting because the Trust in question was an 'early adopter'. Before the current version of the NHS IT programme had been announced, the Trust had already signed a contract with an Anglo-American software firm - hereafter 'OurComp' - for them to implement and support a full blown EPR system. The NHS gave them the go-ahead, and so the study provided an opportunity to investigate what some of the issues might be when the larger scale deployment of such systems across England and Wales got underway. . . When the system eventually went live we were lucky enough to observe the first week in the hospital. Unfortunately our concerns were proved valid - the system proved to have multiple problems. Most notably it did not fit well with a number of existing work patterns but to compound this, due it its strict model of governance, when work did not fit with the system the system broke down. . . The unfortunate postscript to this is that after the first week our access was denied as the drama unfolded. It was not particularly unfortunate for us as our project has gone well. However, we do feel very sorry for the members of the project team as it appears that the blame fell as some of their doors even though it was clear from our fieldwork that the system had not failed through lack of skill or effort but rather it had been bound to fail because of the massive ambition for the 'EPR' in general and the way the NHS has conceived of the requirements for such systems. . ." [David Martin]

12.17. A Local Sociotechnical Design Approach to Exploiting the Potential of The National Healthcare IT Programme NPfIT (3 Nov 2006)

The Bayswater Institute

http://www.bayswaterinst.org/downloads/Exploiting%20the%20Potential%20of%20NPfIT.pdf

". . . In practice the use of a NPfIT system will depend on its match with local requirements. If the 'push approach' is limited to training the users in the operational detail of each IT system, it will be left to each specialty and each unit to find its own way of 're-constructing' the system to suit their needs. The users will decide what to use and what not to use and how to 'workaround' the obstacles or inadequacies. This will become a piecemeal approach, largely hidden and informal, and may well involve a lot of delay and stress. It is likely to be dysfunctional from the point of view of the staff and management of each Trust and also for those who have invested in the development of the systems. Is there a better way of implementing these systems? . . . A striking feature of the NPfIT programme is that many people in the NHS seem to agree with its overall goals. What they have trouble with is the way it is being implemented. There is a lot of work to be done in every Trust to implement the new systems. If we can mobilize the reservoir of expertise in healthcare matters that is available in every location it may be possible to find ways of 'pulling' these systems in the direction of significant local goals. If not, unintended consequences will be rife as we try to cope with systems that do not serve local needs. Under these circumstances neither national nor local goals will be met." [By Ken Eason]

12.18. Understanding and Improving the Design, Deployment and Use of Electronic Health Records: Final Report (2007)

Chameleon Project - EPSRC GR/R86751/01

http://homepages.inf.ed.ac.uk/mjh/chameleon/chameleon_final_report.pdf

". . . We used ethnographic studies of EHR projects, interviews with stakeholders and workshops to examine fundamental assumptions surrounding EHRs, and explore the fit with existing and emerging practices, technologies and regulatory requirements. The case study design enabled examination of factors such as project scale, clinical setting, professional and organisational boundaries, and the different integration strategies adopted by NHS England and NHS Scotland. . . Our findings raise a number of issues that must be seriously considered as NHS programmes continue:

- The NHS has seriously underestimated the scale of the task involved in deploying EHRs. Constantly changing government and NHS policies has led to EHR procurement being very protracted: requirements have to be continually re-drawn and re-shaped and often leads to unsatisfactory compromises. Procurement is also made problematic because these systems will be used as instruments of significant organisational change. However, the Trusts (and the NHS itself) do not have a concrete idea of what the results of those changes will lead to, consequently it is very difficult to assess system suitability.
- Although 'supporting medical practice' and 'patient centred' are twin mantras of EHR design in the NHS, an over-riding design emphasis is on implementing 'proper' process, and on coding medical and administrative procedures 'correctly' so they may be standardised, counted and reported on. These 'other' requirements that stem from the need to provide fully technically and organisationally integrated systems can actually disrupt current medical practices. Standardisation implies that some features of local practice will be re-configured around new models that may run contrary to the way staff organise and understand their work; technical constraints can reduce flexibility. Since these 'other' requirements must be met, support for tried and tested local work routines may be removed with serious consequences later down the line.
- Currently, NHS hospitals have a poor understanding of exactly how they function in any kind of overall, comprehensive manner. Processes, if they are documented, are done so on a departmental or speciality basis, so particularly achieving 'integrated, computer-supported' working represents a massive organisational challenge that consideration might have been better paid to before the purchase of systems. Addressing this problem calls for better management of stakeholder – and local user – participation in EHR projects but this is very difficult to achieve. Identifying the 'right' stakeholders is problematic in such large and diverse organisations, they will likely have some competing versions of current practice and competing ideas about where they want the design to go. Managing this effectively is a big challenge. . ."

12.19. Interpretive Flexibility Along the Innovation Decision Process of the UK NHs care records service (NCRS) (Apr-Jun 2007)

Int. J. of Technology and Human interaction 3(2), 1-12, April-June 2007

http://csrc.lse.ac.uk/asp/aspecis/20050093.pdf

". . . In this paper, we look at how interpretive flexibility manifests through the diverse perceptions of stakeholders involved in the diffusion and adoption of the NHS Care Records Service (NCRS). Our analysis shows that while the policy makers acting upon the application of details related to the implementation of the system, the potential users are far behind the innovation decision process, namely at the knowledge or persuasion stages. We use data from a local heath authority from a county close to London. The research explores, compares, and evaluates contrasting views on the systems implementation at the local as well as national level. . . With medical errors becoming a cruel reality in the provision of healthcare worldwide, the role of information technology in preventing those errors becomes predominant. It is recognised that more people die every year due to medical errors than from vehicle accidents, breast cancer, or AIDS . . . One way to reduce medical errors is to make efficient, accurate, reliable medical decisions, based on reliable and up-to-date information or patient records. Integrated patient records can reduce medical errors by using information technology . . . NCRS is one of the National Program for Information Technology (NPFIT) targets and, as with many healthcare IT projects, its evaluation will be difficult, provided that government led IT projects in the NHS have a history of notable project failures. The complexity of such huge investments, currently £7.6 billion, calls for a clear understanding of the environments in which healthcare networks exist. The research focus here is the diffusion of the NCRS from the policy makers at a highest decision making level to the users of the system. We examine how diffusion receivers (users, such as doctors or nurses) perceive the NCRS implementation in comparison to policy makers. We argue that there is a gap between the demand and the supply side of the diffusion process, which reveals a broad barrier in the NCRS implementation. We use primary and secondary data to capture the perceptions of both diffusers and diffusion receivers in order to get a better understanding of the NCRS diffusion process. The primary data was collected through interviews with the managerial and technical staff as well as future users of the NCRS within a specific county in the United Kingdom. . ."

12.20. Managing integration work in an NHS electronic patient record (EPR) project (2007)

Health Informatics Journal, Vol. 13, No. 1, 47-56

http://jhi.sagepub.com/cgi/content/abstract/13/1/47

"This article uses an ethnographic study of the design and deployment of an electronic patient record (EPR) system in the UK NHS to document some of the difficulties of integrating new IT systems with existing and developing practices, technologies and regulatory requirements. It highlights that `integration' in this situation produces a variety of different but connected and potentially competing requirements that create difficulties in achieving artful and successful system deployment." [Martin et al]

12.21. Implementing the NHS information technology programme: qualitative study of progress in acute trusts (17 May 2007)

BMJ

http://www.bmj.com/cgi/content/short/bmj.39195.598461.551v1

"Objectives: To describe progress and perceived challenges in implementing the NHS information and technology (IT) programme in England. Results: Interviewees unreservedly supported the goals of the programme but had several serious concerns. As before, implementation is hampered by local financial deficits, delays in implementing patient administration systems that are compliant with the programme, and poor communication between Connecting for Health (the agency responsible for the programme) and local managers. New issues were raised. Local managers cannot prioritise implementing the programme because of competing financial priorities and uncertainties about the programme. They perceive a growing risk to patients' safety associated with delays and a loss of integration of components of the programme, and are discontented with Choose and Book (electronic booking for referrals from primary care). Conclusions: We recommend that the programme sets realistic timetables for individual trusts and advises managers about interim IT systems they have to purchase because of delays outside their control. Advice needs to be mindful of the need for trusts to ensure longer term compatibility with the programme and value for money. Trusts need assistance in prioritising modernisation of IT by, for example, including implementation of the programme in the performance management framework. Even with Connecting for Health adopting a different approach of setting

central standards with local implementation, these issues will still need to be addressed. Lessons learnt in the NHS have wider relevance as healthcare systems, such as in France and Australia, look to realise the potential of large scale IT modernisation." [J. Hendy et al]

12.22. Time to rethink health care and ICT? (Jun 2007)

Comunications of the ACM 50,6

http://delivery.acm.org/10.1145/1250000/1247008/p69-avison.html?key1=1247008&key2=8843144811&coll=&dl=GUIDE&CFID=15151515&CFTOKEN=6184618

"The health care sector has explored how information and communication technology might improve patient service for the past 50 years, but there is evidence that many, even most, health care information systems are failures. Nonetheless, in the U.K., the National Health Service (NHS) has started to build a modern, dependable ICT infrastructure through an expenditure of £12–£20 billion over the next several years. The unprecedented scale of the U.K. development, along with the scope and breadth of the NHS remit in providing universal cradle-to-grave health care for all U.K. subjects and the questions raised about the underlying models used in applying ICT to health care, suggests the U.K. experience has global applicability. We therefore explore the U.K. experience here as exemplar for our study of health care and ICT. . . There are many and varied reasons for the failure of health care IS, some relating to issues that are well understood in non-health care sectors of the economy. We recognize a common understanding of the role of IS in them in terms of an underpinning "enterprise-type" model. With the ongoing multi-billion-pound NPfIT deployment of information infrastructure in the U.K. it is important to explore this understanding in two areas: First, the "enterprise" is too small a building block for health care, and models that start with national context, scale, and complexity might serve health care better. This means that health service provision is different and should be looked at differently from any other industrial or government sector. Nevertheless, we recognize that lessons can still be learned from the business sector. Second, better person-to-person models are needed to understand how the collegiate and interpersonal elements of care delivery could be embodied better in the systems used for care delivery. We have not sought to prescribe solutions but to encourage the IS community to critically consider existing models when addressing health care. This may not stop altogether the history of IS failure in health care, but once the more obvious failure mechanisms are addressed, clinical communities may be more positive about IS generally, making them more likely to benefit from its potential to help deliver the kind of service patients need most and win the public's trust." [David Avison, Terry Young]

12.23. Changing Healthcare Institutions with Large Information Technology Projects (2007)

Journal of Information Technology Research, Vol. 1, Issue 1

http://www.igi-global.com/articles/details.asp?id=7661

Abstract: "This article reviews the development of institutional theory in direct relations to historical changes within the UK's National Health Service (NHS) with an eye to contributing to the theoretical specification of healthcare information processes. This is done partly by extending certain paradigms (see Meyer & Rowan, 1991; Powell & DiMaggio, 1991; Tolbert & Zucker, 1994) through a proposed model of causes and consequences of variations in levels of institutionalisation in the healthcare industry. It reports findings from a 5-year study on the NHS implementation of the largest civil ISs worldwide at an estimated cost of $10 billion over a 10-year period. The theoretical basis for analysis is developed, using concepts drawn from neo-institutionalism, realisation of business value, and organisational logic, as well as mixed empirical results about the lack of IT investments value in the NHS. The findings suggest that large scale, IT change imposed upon a highly institutionalised healthcare industry is fraught with difficulty mainly because culturally embedded norms, values, and behavioural patterns serve to impede centrally imposed initiatives to automate clinical working practices. It concludes with a discussion about the nature of evaluation procedures in relation to the process of institutionalising IS in healthcare." [Guah, Matthew W.]

12.24. Action on Immunisation. No data, no action (11 Nov 2008)

Archives of Disease in Childhood (ADC Online)

http://adc.bmj.com/cgi/rapidpdf/adc.2008.138776v1

Abstract: Immunisation is one of most evidence-based activities of the NHS, and much of its success owes to the sensible use of information systems which both run the programme and at the same time evaluate its implementation. The recovery of the national programme from the whooping cough vaccine scare of the 1970's (when coverage fell to ~30%) owed a lot to improvements in co-ordination of the programme including the use of information technology which was rolled out nationally in the 1980's. The much smaller fall in coverage which occurred following the MMR and autism scare in the late 1990's is at least in part a tribute to these better systems. It is therefore a retrograde step that new software chosen by the local providers as part of Connecting for Health has had less functionality than the systems it is replacing. This has consequences for general practitioners, practice nurses, Primary Care Trusts, public health departments and for parents and children. The immunisation programme is something which everyone takes for granted until things go wrong. Lessons from two decades of good practice should be taking the Immunisation programme in London forwards; ignoring these lessons has taken it backwards. [Natasha Sarah Crowcroft]

12.25. Key NHS IT Programmes - UCL report (17 Jun 2010)

University College London

http://www.ucl.ac.uk/news/news-articles/1006/10061703

Press release: The Summary Care Record (SCR) and HealthSpace technologies, introduced in the NHS as part of the National Programme for IT (NPfIT), have so far demonstrated only modest benefits according to the final report of a three-year independent evaluation carried out by UCL researchers. The report's publication coincides with the publication of a research paper based on the findings in the British Medical Journal. The report authors found that while millions of people had received a letter informing them about the programmes, creation of SCRs and HealthSpace accounts was occurring much more slowly than originally planned. Progress in the programmes was delayed by a number of 'wicked' (pervasive, seemingly insoluble) problems, including the difficulty of defining a 'minimal dataset' of key medical data, the huge task of ensuring that GP records were complete and accurate, the need to gain informed consent from 50 million people (many of whom appeared to throw away the letter unread), and the numerous technical and operational challenges associated with uploading data onto the SCR database from local GP records. They also found that whilst many stakeholders shared a broad vision of an efficient, accurate and accessible national electronic record system, making this vision a reality required collaboration across a number of very different worlds - political, clinical, technical, commercial and personal. Differences in expectations, values and ways of working between these worlds accounted for many of the misunderstandings and frictions occurring at the operational level. They conclude that the future fortunes of the programmes will depend at least partly on efforts to bridge the deep cultural and institutional divides that have so far characterised the NPfIT and suggest that it may be time to revisit the logic behind the policy-level link between 'empowerment' and a state-run online records service. . .

Full report: https://www.ucl.ac.uk/news/scriefullreport.pdf - The Devil's In The Detail: Final report of the independent evaluation of the Summary Care Record and HealthSpace programmes

12.26. Adoption and non-adoption of a shared electronic summary record in England: a mixed-method case study (16 Jun 2010)

BMJ 2010;340:c3111 (Trisha Greenhalgh et al)

http://www.bmj.com/cgi/content/full/340/jun16_4/c3111

Results: Creating individual SCRs and supporting their adoption and use was a complex, technically challenging, and labour intensive process that occurred more slowly than planned. By early 2010, 1.5 million such records had been created. In participating primary care out-of-hours and walk-in centres, an SCR was accessed in 4% of all encounters and in 21% of encounters where one was available; these figures were rising in some but not all sites. The main determinant of SCR access was the identity of the clinician: individual clinicians accessed available SCRs between 0 and 84% of the time. When accessed, an SCR seemed to support better quality care and increase clinician confidence in some encounters. There was no direct evidence of improved safety, but findings were consistent with a rare but important positive impact on preventing medication errors. SCRs sometimes contained incomplete or inaccurate data, but clinicians drew judiciously on these data along with other sources. SCR use was not associated with shorter consultations or reduction in onward referral. Successful introduction of SCRs depended on interaction between multiple stakeholders from different worlds (clinical, political,

technical, commercial) with different values, priorities, and ways of working. The programme's fortunes seemed to turn on the ability of change agents to bridge these different institutional worlds, align their conflicting logics, and mobilise implementation effort.

Conclusions: Benefits of centrally stored electronic summary records seem more subtle and contingent than many stakeholders anticipated, and clinicians may not access them. Complex interdependencies, inherent tensions, and high implementation workload should be expected when they are introduced on a national scale.

12.26.1. Do summary care records have the potential to do more harm than good? Yes (16 Jun 2010)

BMJ 2010;340:c3020 (Ross Anderson)

http://www.bmj.com/cgi/content/full/340/jun16_4/c3020

A digital medical record system that shared information when appropriate between care providers, and was dependable and safe, would be of great value. However, the summary care record isn't it. It must be abandoned—for reasons of safety, functionality, clinical autonomy, patient privacy, and human rights. The summary care record was marketed to the public as a way for accident and emergency staff to check up on unconscious patients. According to Tony Blair, if you ended up in hospital in Bradford, doctors could look up your records with your general practitioner in Guildford. But this is nonsense. Very few patients have conditions that must be made known to emergency staff; for those that do, the properly engineered solution is MedicAlert. Unconscious patients often can't be reliably identified, so a database is less robust than a tag or card; the record doesn't have everything accident and emergency staff might want to see; and it is not even available in Scotland (let alone on a beach in Turkey). The truth is that the summary care record was designed to accumulate large amounts of data about patients from multiple sources. Many patients' records will start with a hospital discharge summary rather than a general practice summary, while plans are afoot to include medical images and even ambulance messages. . .

12.26.2. Do summary care records have the potential to do more harm than good? No (16 Jun 2010)

BMJ 2010;340:c3022 (Mark Wolpert)

http://www.bmj.com/cgi/content/full/340/jun16_4/c3022

. . . The primary purpose of electronic patient records is to improve patient care. As a patient I expect the following: that my records will be accurate and that I can work with my carers to improve their accuracy; that they will be treated confidentially; that they will be shared between the members of the healthcare team that collectively look after me in primary care and in hospital; and that they will provide a basis for accountability for the quality of my health care. In addition I would hope that my records could be linked to "expert systems" that would minimise the chance of treatment errors and maximise the chance of my being prescribed the best treatment. There is another huge potential benefit of a nationwide electronic patient record system, to improve treatment through research. Research provides the evidence that medical treatments work or, equally importantly, that they don't. It is an integral part of the best health systems. . . The new coalition government, coupled with the economic crisis, means that the future is uncertain for Connecting for Health. I do not believe that Connecting for Health has been marketed well to either patients or the medical profession. There has been much too much about its use as a management tool and too little about its primary aim, which should be to improve care. It may be that it would be better implemented as a more federated programme, ensuring common standards to allow interoperability. A key aim must be integration of records and communication across primary and secondary care. But one thing is certain—the best care requires the best medical records. A world class NHS demands a world class infrastructure. The future for medical records is digital.

13. Other Documents

13.1. Research Challenges in Emergent e-Health Technologies (6 Jul 2001)

Department of Computer Science, Australian National University

http://www.anu.edu.au/people/Roger.Clarke/EC/eHlthRes.html

Notes to accompany a Panel Session on 'Research Challenges in Emergent e-Health Technologies', with Joan Cooper (Chair), Carole Alcock, Lois Burgess and Tanya Castleman, at the IFIP TC8 Conference on 'Developing a dynamic, integrative, multi-disciplinary research agenda in E-Commerce / E-Business', Salzburg, 22-23 June 2001. . . The focus of this Panel Session was on information technologies applied to health care. In addition to the long-promised health care smart-card, current initiatives include electronic health records (EHR), and unique patient identifiers (UPI). These are expected to provide greater accessibility to personal health care data. They tend to assume the consolidation of data from many sources into a single unified scheme (whether the data is stored centrally, or stored in dispersed databases but within an integrative architecture), or at least into a smaller number of schemes than exists at present.

- the potential benefits of e-Health;
- the risks inherent in e-Health;
- possible solutions to the problems;
- e-consent; and
- research challenges." [Roger Clarke]

13.2. Implementing Information for Health: Even More Challenging Than Expected (10 Jun 2002)

School of Health Information Science, University of Victoria

http://hinf.uvic.ca/archives/Protti.pdf

Prof. Dennis Protti - " Over the period 6th August to 19th October 2001, and at the invitation of the heads of the Information Policy Unit (IPU) of the Department of Health and the NHS Information Authority, I once again visited England to review the state of progress of Information for Health, taking account of the implications of the emerging changes within the UK health care system. Returning to the UK, it did not take me long to realise that the NHS was once again in the midst of a significant period of transition. It was evident, even to an outsider, that the United Kingdom has a Government which believes that the NHS has to be re-organised and made to be more equitable, accountable, and customer-focused. I sensed that it is a Government that is looking for obvious progress in reforming the public sector - spurred on in particular by negative media coverage about the NHS. In its recent policy document, Shifting the Balance of Power in the NHS (StBOP), the Government expresses its desire to devolve power and decision-making down to the frontline, to decentralise, to provide patients with choice, to give local staff the resources and the freedoms to innovate, develop and improve local services. This desire pervades the changes I observed and sets the tone for my report – these are fascinating, if somewhat daunting, times for the NHS. . ."

13.3. Article by Robin Guenier (25 Jul 2002)

" There's no more pressing priority for the Government than improving the NHS. If possible, dramatically — and comfortably before the next election. It has less than three years. The money is available; although increased pay may absorb more than had been expected. How best to spend what is left? Surely to improve the lot of the patient? Apparently not. The Government has chosen a course that is likely to make it worse: sweeping and massively expensive changes to NHS computing systems. We are told it is " the IT challenge of the decade" and " a Herculean task" . Why don't people learn? Why are big IT projects seen as a badge of virility — a sign that we really mean business? They nearly always cause trouble: the bigger the change the bigger the trouble, especially in the public sector. Difficulties with this Government's earlier IT plans for the NHS (this is the third) demonstrate that the risk is especially great for such a uniquely complex organisation — employing 1.3 million people with over 50 million potential patients. Ambitious IT changes rarely deliver what is promised and commonly cause serious inconvenience for those they are intended to benefit: in this case, the patients.

Surely anyone who wishes the NHS well would be striving to introduce the minimum necessary IT change, the smallest possible challenge? . . .”

(Full article in appendix 6.)

13.4. Why general practitioners use computers and hospital doctors do not (2002)

BMJ 2002;325:1086–9

http://www.bmj.com/cgi/reprint/325/7372/1086.pdf
http://www.bmj.com/cgi/reprint/325/7372/1090.pdf

Summary:

- Almost all British general practitioners use computers in their consulting rooms, but most hospital doctors do not
- Over 30 years, leaders of the general practitioner profession have worked with government to provide incentives for computerising practices and to remove barriers
- In hospitals computing was treated as a management overhead, and doctors had no incentives to become involved
- The success of the government’s plans for “joined up,” computer based health services depends on providing appropriate incentives to hospital doctors
- General practice computerisation has been a success, but what works in a GP surgery does not readily scale up to work in a hospital
- Computer based patient records have a more diverse range of uses in hospitals than in general practice, and simple unidimensional classification schemes such as the original Read codes cannot cope
- In hospitals many different computer systems need to be linked together, requiring common interoperability standards
- Protection of privacy is a much greater problem in hospitals
- The number of potential users in hospitals makes substantial demands on hardware and networks

13.5. Green Book, Appraisal and evaluation in central government (16 Jan 2003)

HM Treasury

http://www.hm-treasury.gov.uk/economic_data_and_tools/greenbook/data_greenbook_index.cfm

“ Information is needed for a market to operate efficiently. Buyers need to know the quality of the good or service to judge the value of the benefit it can provide. Sellers, lenders and investors need to know the reliability of a buyer, borrower or entrepreneur. This information must be available fully to both sides of the market, and where it is not, market failure may result. This is known as ‘asymmetry of information’ and can arise in situations where, for example, sellers have information that buyers don’t (or vice versa) about some aspect of product or service quality. Information asymmetry can restrict the quality of the good traded, resulting in ‘adverse selection’. Another possible situation is where a contract or relationship places incentives upon one party to take (or not take) unobservable steps that are prejudicial to another party. This is known as ‘moral hazard’, an example of which is the tendency of people with insurance to reduce the care they take to avoid or reduce insured losses.”

13.6. HIPAA Compliance and Smart Cards: Solutions to Privacy and Security Requirements (Sep 2003)

Smart Card Alliance

http://www.martsoft.com/reference/healthcare/HIPAA_Compliance_and_Smart_Cards_FINAL.pdf

“This white paper was developed by the Smart Card Alliance to describe how smart cards can be used to meet HIPAA Security Rule and Privacy Rule requirements. Designed as an educational overview for decision makers, it summarizes the HIPAA privacy and security requirements, provides an overview on how smart cards work, describes how smart cards can be used to support HIPAA compliance and implement other health care applications, and outlines key implementation success factors. The white paper also includes profiles of smart health card implementations including the University of

Pittsburgh Medical Center, Mississippi Baptist Health Systems, and the French, German and Taiwanese health cards."

13.7. NHS Mobile (2003)

Celina Fox

This week's announcement of the NHS on line patient booking system reminded me of a unique preview I received a few months ago, courtesy of Virgin Trains West Coast Line. I had requested and received an Oxenholme-Euston ticket for the first-class quiet coach, hoping to work on the way. But Virgin forgot to include the coach and instead, I was treated to an episode in the life of government.uk from the man across the table, sorry desk, from me. Small, balding and in his 40s, Richard G.* appeared to be an IT manager attached to the Department of Health probably, I thought, one of that twilight army of government special advisors. Non-stop high-volume input into his mobile and dictaphone demonstrated ad nauseam he was not one to use plain English when a managerial cliché was to hand.

(See Appendix 10 for the full text.)

13.8. Electronic Medical Records for the Department of Health Services (2003)

Dan Essin

"According to the popular notion of how medicine will be practiced in the future, omnipresent, intelligent systems will acquire and store all available information about what is going on in the healthcare environment. . . The gap between our expectations and what is available today is large and may not diminish any time soon. There are reasons for this gap that can be analyzed and debated at length but that does not alter the fact that the gap exists and the gap is our problem. For years now, our unrealistic expectations have stood in the way of taking practical steps to achieve a way of doing business in the new facility that does not produce paper that required long-term storage. There are a variety of pragmatic solutions that will address this requirement in isolation and a smaller number that can also deliver some of the computerized functions that physicians associate with a computerized patient record."

(See Appendix 9 for the full text.)

13.9. New NHS IT (Feb 2004)

Parliamentary Office of Science and Technology

http://www.parliament.uk/documents/upload/POSTpn214.pdf

" The Government has recently signed contracts for a £6 billion modernisation of NHS computer systems in England. This national IT programme has four main parts: electronic patient records, electronic appointment bookings and electronic transmission of prescriptions, along with an upgraded NHS broadband network. However, it involves both managing a large IT procurement and imposing change on the highly devolved NHS. This POSTnote outlines the main projects in the national programme and their potential benefits, then examines key concerns, such as confidentiality, funding and involving clinicians."

13.10. Achieving Electronic Connectivity in Healthcare (Jul 2004)

Connecting for Health (US)

http://www.connectingforhealth.org/resources/cfh_aech_roadmap_072004.pdf

" A Preliminary Roadmap from the Nation's Public and Private-Sector Healthcare Leaders . . . Our recommendations are designed to be practical. We are proposing manageable actions to be taken over the realistic time frame of the next one to three years. It is not possible or even desirable to dramatically transform the healthcare system through a sudden " big bang," whether brought about by public or private efforts. We believe that the existing system needs to be improved and built upon, and that the effect of carefully planned incremental steps can be equally transformational and more likely to succeed over the long run. Our realistic recommendations are not intended to discourage bolder actions now or in the future, but they allow a large proportion of stakeholders to make measurable progress now. In fact, because of their strategic nature, they set the stage for bolder actions to follow. . ."

13.11. Current EHR Developments: an Australian and International Perspective (1 Sep 2004)

Health Care and Informatics Review (New Zealand)

http://hcro.enigma.co.nz/website/index.cfm?fuseaction=articledisplay&FeatureID=010904

http://hcro.enigma.co.nz/website/index.cfm?fuseaction=articledisplay&FeatureID=020904

"Abstract: The idea of electronic health records (EHRs) began at least 40 years ago but the first implementations did not really begin until the 1980s and, with the exception of a few countries in Europe, the use of EHRs is still very low in most countries. This is beginning to change rapidly, however, and the emergence of purpose-built shared-EHR systems to underpin multi-disciplinary integrated shared care in a number of countries is adding a whole new dimension to the field. Australia is in the early stages of developing its national "HealthConnect" shared-EHR network and similar projects are also underway in several other countries such as Brazil, Canada and England. The US does not have any national EHR projects as yet but there is a groundswell of interest and initiatives in relation to the EHR in the US which could foreshadow rapid progress there in the next few years. Lack of interoperability between EHR systems has been a major barrier to EHR deployment but the emergence of the openEHR model, the HL7 Clinical Document Architecture and archetypes has provided a significant stimulus to the development of interoperability and other necessary EHR standards within major international standards organisations such as ISO, CEN and HL7. There is a long way to go but there are encouraging signs that stakeholders are beginning to recognise that the very future of health systems depends on more efficient and effective information management. The EHR is arguably the most important foundation component in this pursuit. "

13.12. The Spine, *a*n English national programme (25 Mar 2005)

Ringholm White Paper

http://www.ringholm.de/docs/00970_en.htm

" The English Spine (the national IT infrastructure for healthcare) will provide a commonly accessible patient based resource, making information from multiple sources available to all those with a legitimate care relationship to the patient. This includes all health professionals whether they work in a hospital, in primary care or in community service. The architecture of the Spine is based on a centralized partial care record, supported by directory services and HL7 version 3 messaging."

13.13. Will NPfIT Suceed? (April 2005)

(Chapter 15 of Sean Brennan's book: "The NHS IT Project: The Biggest Computer Programme in the World... Ever!")

Radcliffe Publishing Ltd

http://www.radcliffe-oxford.com/thenhsitproject/br-ch15.pdf

". . . So we come to the £30 billion question. Will it work? If NPfIT is about getting the best deal for IT infrastructure for the NHS then, yes, it will be a success. The NHS was a huge spender on IT before the national programme started. Now it gets more, it gets it delivered as a service, and it gets it all at a very keen price. It will get several hundred PAS systems, clinical systems, and all sorts of associated applications delivered down a pipe to the bedside. So let's try a tougher question. Will all the software and applications work in the way that they are meant to work? Will the spine integrate seamlessly with systems in the five clusters? Will the security and confidentiality work to everyone's satisfaction? The answer to this question is probably 'eventually'. So long as the momentum is maintained and the funding is sustained, then one day it will all come together. There is, after all, very little in the programme that is totally conceptually new. But it may all take a lot longer than the NHS expects. New software always seems to take longer to design, build and test than anyone expects. This is an ambitious programme, and there are many obstacles in the path. The main software developers have a lot of code to write. I would expect to see slippages, renegotiations of deadlines, a general downplaying of expectations, and a long hard slog by the service providers, the software developers, and the NHS alike before it all starts to come together. There will certainly be scare stories along the way. The press

will gather around every hint of failure and will predict catastrophe. But in the end, this isn't rocket science. It will work because it has to work. The day will come when the systems are in and the project will be signed off. Of course, by then there will be new challenges, new technologies, new obstacles. But that will be tomorrow's problem. Another rainbow. But perhaps even this wasn't the question that you wanted answering. If NPfIT is about changing the way healthcare is delivered, then there is a third answer to the question 'will NPfIT succeed?' It will struggle. 'That's not what NPfIT is about,' I can hear from some readers, and true, the programme's remit isn't to change the world, just to deliver as a service to the NHS, an IT infrastructure for the NHS to use as it chooses. The programme is branded and perceived as a technology initiative. It is a technology initiative. Yet this perception could be its undoing. People might assume it to be non-clinical. It could become another big PAS project. And that would be a shame. The deals that have been negotiated by the national programme are there to ensure that the NHS has access to cutting-edge technology after years of 'playing around' with IT. But will clinicians see the opportunities to change the way the NHS is delivered? Will this change be an opportunity to them or a threat? The key purpose of the NHS is to deliver effective clinical care. Technology will offer alternative ways of delivering that care so NPfIT is, whether it likes it or not, central to the modernisation of the delivery of clinical care. This is not just about having an electronic record. It is far deeper and grander than that. It is about supporting clinical care with IT, and when you support clinical care with IT, you can then use that technology to influence how that care is delivered. . ."

13.14. Transformational Government: Enabled by Technology (Nov 2005)

Cabinet Office Report

http://www.cio.gov.uk/documents/pdf/transgov/transgov-strategy.pdf

" . . . Information Assurance: despite the difficulties of a fast moving and hostile world, underpinning IT systems must be secure and convenient for those intended to use them. The Government will further develop its risk management model to provide guidance on this, approved by the Central Sponsor for Information Assurance. And it will develop a simple, tiered architecture for its own networks to support this model in practice, within updated application of the protective marking scheme for electronically held information. Government will also play its part to promote public confidence by leading a public/private campaign on internet safety and by a new scheme to deliver abider availability of assured products and services. . . Identity Management: government will create an holistic approach to identity management, based on a suite of identity management solutions that enable the publican private sectors to manage risk and provide cost-effective services trusted by customers and stakeholders. These will rationalise electronic gateways and citizen and business record numbers. They will converge towards biometric identity cards and the National Identity Register. This approach will also consider the practical and legal issues of making wider use of the national insurance number to index citizen records as a transition path towards an identity card."

13.15. OpenEHR (10 Feb 2006)

Informatics Review

http://www.informatics-review.com/wiki/index.php/OpenEHR

" The openEHR Foundation is a non-profit charity based in the United Kingdom at University College London. It is now a community of more than 600 people working on an open specification for a shared electronic health record. openEHR utilises a two level modelling approach developed in Australia. This approach means that the rules about how to represent clinical information in an openEHR record are captured in Archetypes which can be shared and evolve, while the parts from which these models are constructed are unchanging and in the reference model. The result is that software can be built on the rich and stable reference model, and the changing and evolving clinical concepts can be managed in a knowledge environment - called the archetype repository. Archetypes carry with them rules that check the quality of the data and they can be used at data entry to ensure data quality. The display information is carried separately enabling the same information to be displayed in a different manner for different purposes. This makes the approach very flexible, so that personal health records can be displayed in a manner suitable for individual patients, sort of like skins for software programs. The benefits of this approach is that the richness of clinical concepts can grow with time, without needing to change the software at a fundamental level. Also, openEHR records can be carried on a USB stick or communicated in any way necessary. Australia is the first country to take on openEHR in larger scale situations, with growing interest in other countries such as Sweden, India and Slovenia."

13.16. Review of Shared Electronic Health Record Standards (20 Feb 2006)

National E-Health Transition Authority (Australia)

http://www.nehta.gov.au/index.php?option=com_docman&task=doc_download&gid=68&Itemid=139

An official review of coding standards for supporting the sharing of electronic health records - covering openEHR, EN13606, and various version of HL7, whose recommendations are that the European EN13606 standard on EHR Communication should be used as the basis for specifying the content and logica structure of shared EHR information, and as a short term measure, the use of HL7v2 as the means of specifying the syntax and representation of such information. HL7v3 was discounted as "this would be more complex, costly and take considerably longer than the recommended approach".

13.17. System Design Or Social Change (6 Apr 2006)

Parliamentary IT Committee (PITCOM) on the subject of Public Sector 'IT' procurement

http://www.pitcom.org.uk/reports/Malcolm-Mills-talk.doc

Submission by Malcolm Mills: " . . . I suggest three things. Immediately, to increase the success rate and restore confidence, I would simplify, de-risk and specify a more evolutionary set of requirements for endeavours of this kind. I would then increase their delivery time-scales to be more in keeping with the much longer timeframes we know from experience are associated with achieving successful social change. In the medium term, I would do two things: Recognising that the major risks, and by far the greater costs, lie with the addressing people issues, and not technology ones, HM Treasury should commission new 'Green Book' appraisal guidelines for scrutinising the budgeting and planning of socio-technical endeavours during the Gateway decision-making process. And finally, faced with clear evidence of an acute shortage of interdisciplinary skills and competences in Government and Industry to design and manage the range of socio-technical systems in the public programme, a task force should be established to examine how the Nation might produce a sufficient number of competent and skilled people able to lead, develop, and then support, such critical endeavours. . ."

13.18. Guidance for NHS Foundation Trusts on Co-operating with the National Programme for Information Technology (12 Apr 2006)

Monitor, Independent Regulator of NHS Trusts

http://www.e-health-insider.com/tc_domainsBin/Document_Library0282/NPfIT_guidance_Final_120406.pdf?

" . . . Condition 20 of the terms of authorisation for all NHS foundation trusts states that: " The Trust shall participate in the national programme for information technology, in accordance with any guidance issued by Monitor." This note summarises how Monitor will interpret the requirement on NHS foundation trusts to participate in The National Programme for Information Technology (NPfIT) as administered by Connecting for Health (CfH) and constitutes Monitor's guidance under Condition 20. Monitor recently published Risk Evaluation for Investment Decisions by NHS Foundation Trusts 1 which relates to high risk investments as defined by either size or risk. Each investment necessary under NPfIT should be evaluated against these definitions to confirm their status. In any event the frameworks in the guidance are good practice which should be applied to any investment decision undertaken, including those within NPfIT. . ."

13.19. NHS IT chief meets criticism head-on (25 May 2006)

Computing

http://www.computing.co.uk/computing/analysis/2156832/nhs-chief-meets-criticism-head

" When Tony Blair addressed the annual CBI dinner last week he discussed the challenges of modernisation. He also cited the £6bn, 10-year National Programme for NHS IT (NPfIT). 'The NHS IT strategy is a large and complex programme, but it is having a real impact,' said the Prime Minister. Blair's endorsement runs contrary to the condemnation that has dogged the programme in recent months. A group of academics has described the project as 'fundamentally flawed' and there have been continued criticisms of delivery delays, changing specifications, disagreements with clinicians, and financial problems for suppliers. Worse is yet to come. A National Audit Office report is due, and NHS IT director general Richard Granger faces a tough grilling by the Public Accounts Committee next

month. But Granger, while acknowledging there have been delays and variable supplier performance, says such a revolutionary programme was never going to be easy to implement. 'We are breaking new ground: some things go well, some things are difficult – and those that are difficult get a disproportionate amount of attention,' Granger told Computing. 'People seem to forget that these systems are disruptive and introducing them is disruptive, but we have to hold our nerve,' he said. . .?

13.20. 'Computer says no' to Mr Blair's botched £20bn NHS upgrade (4 Jun 2006)

Sunday Telegraph

http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/06/04/nhs04.xml

" . . . It was born in a " Wouldn't it be great?" moment, a year after Tony Blair arrived in Downing Street. In a speech about the NHS, the Prime Minister touched on what sounded a simple, laudable vision: using computers to create a more efficient, safer, patient-friendly health service. " If I live in Bradford and fall ill in Birmingham, I want the NHS to be able to treat me," Mr Blair said in 1998. . . The plan would link more than 30,000 GPs with 300 hospitals. " Up to 600 million pieces of paper a year" would be saved, Mr Blair promised. Patients' notes would be available in any hospital at the click of a mouse, and GPs would be able to book hospital appointments over the internet (" choose and book"). The Prime Minister even joked about making GPs' handwriting " legible for the first time in history" . Four years later, the joke is on Mr Blair, and the taxpayer. The " Connecting for Health" project is two years behind schedule and more than three times over its initial £6.2 billion budget. Lord Warner, the health minister, revealed this week that the real cost of the programme would approach £20 billion by 2010, its revised delivery date. A report by the National Audit Office (NAO) is expected to be damning, suggesting that corners were cut so that political deadlines could be met. More than £11.75 million of taxpayers' money has been lavished on consultants, including Ernst & Young, Price Waterhouse Coopers, PA Consulting, Cap Gemini and IBM. Yet the glitzy, " joined-up" NHS remains a low-tech hotch-potch. Doctors are largely unimpressed. Dr Richard Vautrey, a GP in Leeds and spokesman for the British Medical Association on IT, has struggled for months, for example, to get " choose and book" working. . . With its 950-strong staff and an annual wage bill of about £50million, Connecting for Health does not lack resources. Still, it has become the latest in a series of public sector IT fiascos which include the Passport Office, Air Traffic Control, the Child Support Agency and the Inland Revenue. . ."

13.21. Granger: bricks of the digital NHS coming together (16 Jun 2006)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=1949

" The pace of delivery of new IT systems to the hospital sector has been " disappointing" , says NHS IT director general Richard Granger NHS IT director but he says the bricks that will build a digital NHS are slowly coming together. In an interview given to E-Health Insider in the run-up to the publication of the NAO report into the delayed NHS National Programme for IT, he acknowledged that some things had gone well and others less well. " We've got a lot of deployment done and we've got a lot of things that are troublesome out there." He added: " I'm not sure we've got to the bottom of some of the engineering challenges." Granger says delivery to hospitals had been particularly difficult " The difficulties that independent software vendors have had in that sector are a work in progress" . . . Asked whether the NHS CRS remained deliverable Granger told EHI that the IT strategy he was brought in to procure against and implement had already been set by the time he came into post. Granger named individuals including Dr Anthony Nowlan of the old NHS Information Authority (NHSIA), Jeremy Thorp and Professor Peter Hutton as being parents of the strategy and specification procured against. " Dr Anthony Nowlan spent the early part of this decade in the IA undertaking consultation about the EPR [electronic patient record] and feeding in details of the consent model and details of that record to 21st Century IT, and then to an output specification produced by Jeremy Thorp."

13.22. Information Governance in NHS's NPfIT: A case for Policy Specification (2006)

Moritz Y. Becker, Microsoft Research (To appear in International Journal of Medical Informatics, 2006.)

http://www2.cantabgold.net/users/m.y.becker.98/publications/becker06ijmi.pdf

" . . . The NHS's National Programme for IT (NPfIT) in the UK with its proposed nation-wide online health record service poses serious technical challenges, especially with regard to access control and patient confidentiality. The complexity of the confidentiality requirements and their constantly evolving nature (due to changes in law, guidelines and ethical consensus) make traditional technologies such as role-based access control unsuitable. Furthermore, a more formal approach is also needed for debating about and communicating on information governance, as natural-language descriptions of security policies are inherently ambiguous and incomplete. Our main goal is to convince the reader of the strong benefits of employing formal policy specification in nation-wide electronic health record (EHR) projects. . ."

13.23. Plundering The Public Sector (2006)

Extract from the book by David Craig

" . . . How is CfH progressing? Actually, it is difficult to say. Firstly, because although CfH issues an impressively shiny Business Plan full of such high-sounding fashionable management gobbledegook as its 'mission, values and strategy', the document contains many more photos of happy healthcare workers than figures explaining how much money is being or will be spent. Moreover, although the Business Plan details all the remarkable achievements of CfH, nowhere does it compare these achievements with an original schedule. So we cannot see if they are on target, behind or ahead. Not only is the Business Plan less than informative, but it is also almost impossible to get any information from the CfH organization about what is happening. A cult of secrecy seems to have descended over the project. This got so extreme that journalists from one of Britain's leading computer publications, which had been critical of the way CfH was being run, were allegedly banned from attending a CfH press conference. . ."

(See Appendix 6 for the full extract.)

13.24. NHS IT systems crisis: the story so far (30 Aug 2006)

Computer Business Review

http://www.cbronline.com/article_cbr.asp?guid=35AC0F09-6C33-4D0E-AC2C-D912E2AA6042

" The NHS's Connecting for Health plan to update and link up health service systems have hit the headlines in recent weeks thanks to reported problems with key software supplier iSoft, and criticisms of the project's management and cost. CBR has been tracking the project since its creation, and in this article has brought together the story so far, beginning with the handing out of contracts in late 2003. . ."

13.25. eHealth is Worth it (Sep 2006)

European Commission, Directorate General Information Society and Media, ICT for Health Unit

http://europa.eu.int/information_society/activities/health/docs/publications/ehealthimpactsept2006.pdf

" An assessment of the economic benefits of implemented eHealth solutions at ten European sites."

13.26. Safer IT in a safer NHS: account of a partnership (Sep 2006)

British Journal of Health Care

http://www.bjhc.co.uk/issues/v23-7/v23-7baker.htm

"Following a high-level assessment of patient-safety management in England's National Programme for IT, the National Patient Safety Agency and NHS Connecting for Health have been working together to start minimising ICT-related hazards in the NHS. Dr Maureen Baker, Ian Harrison and Professor Sir Muir Gray, who are leading the execution of this new initiative, describe its aims, achievements and plans.

Abstract: The use of ICT in healthcare has considerable potential to support clinicians in practising more safely, but also has the potential to affect patient care adversely if there are faults in the systems or if implementation is flawed. This article describes the partnership between NHS Connecting for Health, the agency delivering the National Programme for IT in the NHS in England, and the National Patient Safety Agency (NPSA) in working for safer systems for the NHS and safer care for patients."

13.27. Dying for Data (Oct 2006)

IEEE Spectrum (Robert N. Charette)

http://www.spectrum.ieee.org/oct06/4589

" A comprehensive system of electronic medical records promises to save lives and cut health care costs—but how do you build one?"

13.28. 'Gung-ho' attitude scuppers public-sector IT projects (2 Oct 2006)

Computer Weekly

http://www.computerweekly.com/Articles/2006/10/02/218832/%e2%80%98Gung-ho'+attitude+scuppers+public-sector+IT+projects.htm

" Government IT heads' 'gung-ho' and reckless attitudes to risk is wasting millions of taxpayer money on over-complex, poorly tested systems, according to a think-tank study. Contrary to the stereotype, many public-sector managers have a 'reckless streak' and are dazzled by the potential of the technology, according to the Where next for transformational government? report by The Work Foundation, (September 2006)"

13.29. IT and Modernisation (9 Oct 2006)

New Statesman

http://www.newstatesman.com/pdf/itmodernisation2006.pdf

" This New Statesman round table discussion, sponsored by Atos Origin, debated issues around IT and how it affects the modernisation of society and, in turn, how society's attitudes affect the technology that seeks to make our lives easier. Public perception of IT projects as successes or failures can have a dramatic impact on those working in the industry, and which projects they take on. Projects that take several years to realise can change considerably from the initial scope. Comparisons between public and private sectors can be misleading in such a young industry."

13.30. Problems abound for Kaiser e-health records management system (13 Nov 2006)

Computer World

http://www.computerworld.com/action/article.do?command=viewArticleBasic&articleId=9005004

"An internal report details hundreds of technical issues and outages. An electronic health records management system being rolled out by Kaiser Foundation Health Plan/Hospitals has been nothing short of an IT project gone awry, according to sources at the company and an internal report detailing problems with the HealthConnect system. Questions about the project arose last week at about the same time Cliff Dodd, the company's CIO, resigned. Dodd stepped down last Monday after another Kaiser employee, Justen Deal, sent a memo to every company worker warning of technological and financial repercussions related to the rollout of the nearly $4 billion system from Epic Systems Corp.. . .

13.31. The Common Framework: Overview and Principles (5 Dec 2006)

[US] Connecting for Health

http://www.connectingforhealth.org/commonframework/docs/Overview.pdf

" The members of Connecting for Health passionately believe that the private and secure exchange of health information nationwide is essential to the well-being of patients and those who care for them. It has been nearly two years since we published the " Roadmap" report - Achieving Electronic Connectivity in Healthcare: A Preliminary Roadmap from the Nation's Public and Private Sector Healthcare Leaders. . . But we were determined not to stop at words. Within the last year we have built a working prototype of the Roadmap model - together we have learned how three very different communities, with different hardware, software, and organizational structures, can in fact share information in a private and secure way over the Internet using a Common Framework. Our partners in Mendocino County, CA, Indianapolis, and Boston worked closely with a Connecting for Health Technical Subcommittee and Policy Subcommittee made up of more than 75 people drawn from the

Connecting for Health Steering Group plus other recognized experts. The Subcommittees helped to shape and test the prototype, documented the lessons of its implementation, and drafted a first iteration of the Common Framework, which we are releasing today. Although it is just a start, we are confident that it will evolve to meet the needs of a varied and fragmented healthcare system. We invite others to use, adapt, and help us to improve the Common Framework. As Connecting for Health has been constructing a prototype and Common Framework, several complementary developments have taken place, building on the ongoing efforts of local communities: new communities for health information exchange are forming with great speed, Federal and State governments have put an unprecedented spotlight on the importance of health information technology, the Department of Health and Human Services and the Office of the National Coordinator have provided their leadership and millions of dollars toward a connected healthcare system, and Congress has sponsored many initiatives - all designed to further health information sharing. . .

Connecting for Health's Policy Principles

- Openness and Transparency: There should be a general policy of openness about developments, practices, and policies with respect to personal data. . .
- Purpose Specification and Minimization: The purposes for which personal data are collected should be specified at the time of collection, and the subsequent use should be limited to those purposes . . .
- Collection Limitation: Personal health information should only be collected for specified purposes . . .
- Use Limitation: Personal data should not be disclosed, made available, or otherwise used for purposes other than those specified.
- Individual Participation and Control: Individuals should control access to their personal information . . .
- Data Integrity and Quality All personal data collected should be relevant to the purposes for which they are to be used and should be accurate, complete, and current.
- Security Safeguards and Controls: Personal data should be protected by reasonable security safeguards . . .
- Accountability and Oversight: Entities in control of personal health data must be held accountable for implementing these information practices.
- Remedies: Legal and financial remedies must exist to address any security breaches or privacy violations.

Connecting for Health's Technology Principles

- Make it " Thin" : . . . It is desirable to leave to the local systems those things best handled locally, while specifying at a national level those things required as universal in order to allow for exchange among subordinate networks.
- Avoid " Rip and Replace" : Any proposed model for health information exchange must take into account the current structure of the healthcare system. . .
- Separate Applications from the Network: . . . The network should be designed to support any and all useful types of applications, and applications should be designed to take data in from the network in standard formats. . .
- Decentralization: Data stay where they are. . . leaves judgments about who should and should not see patient data in the hands of the patient and the physicians and institutions that are directly involved with his or her care.
- Federation: . . . Formal federation with clear agreements builds trust that is essential to the exchange of health information.
- Flexibility: Any hardware or software can be used for health information exchange as long as it conforms to a Common Framework of essential requirements. . . The network must be able to scale and evolve over time.
- Privacy and Security: All health information exchange, including in support of the delivery of care and the conduct of research and public health reporting, must be conducted in an environment of trust, based upon conformance with appropriate requirements for patient privacy, security, confidentiality, integrity, audit, and informed consent.
- Accuracy: Accuracy in identifying both a patient and his or her records with little tolerance for error is an essential element of health information exchange. . ."

13.32. Transcript of BBC Radio 4's 'Any Questions' (22 Dec 2006)

BBC

http://www.bbc.co.uk/radio4/news/anyquestions_transcripts_20061222.shtml

One of the questions discussed by the panel (Michael Portillo, Oona King, Richard Lambert, and Johann Hari) was "Do the government's intended national databases in the NHS, the national ID scheme, the children's database and so on threaten privacy and liberty and are they solutions in search of problems?".

13.33. Digital healthcare: the impact of information and communication technologies on healthcare (Dec 2006)

The Royal Society

http://www.royalsoc.ac.uk/displaypagedoc.asp?id=23269

From the Recommendations: " We recommend that the Government health Departments and their associated national IT programmes adopt an iterative and incremental approach in the design, implementation and evaluation when introducing new healthcare ICTs.

We make several additional recommendations to support such an incremental approach:

(a) We recommend that healthcare professionals and their professional bodies seek to be involved in the design, implementation and evaluation of healthcare ICTs.

(b) We recommend that healthcare managers ensure that sufficient time is made available for healthcare professionals to contribute effectively at all stages of design, implementation and evaluation of healthcare ICTs. . .

(f) We recommend that the national IT programmes ensure that all stages of the development are undertaken within standards to ensure interoperability and that evaluation is built into development."

13.34. Patient Administration Systems (Dec 2006)

e-Health Insider

http://www.e-health-insider.com/tc_domainsBin/EHI_Reports0332/e-health_PAS_Exec_Summary.pdf

Executive Summary: " Patient administration systems, managing and recording patient identification, admissions, bookings and discharge, form the foundation of any clinical IT system and the platform upon which to build electronic patient records. PAS systems are vital to the effective operation and management of hospitals and community services, generating information such as clinic lists and activity reports, enabling the hospital to record activity, monitor throughput against contracts and report to its service commissioners and performance against key targets. Delivering new standardised PAS systems has unexpectedly become a central objective of the £12bn NHS Connecting for Health IT upgrade programme in its first three years as a precursor to the Care Record Service (CRS). Mounting delays and recent switches in prime contractors and software suppliers, however, mean that the PAS market is rapidly evolving, becoming more porous with new opportunities arising. Critically, the role of 'existing suppliers' and importance of 'interim systems' is growing, creating new opportunities for suppliers and new options for NHS trust customers. . . ."

13.35. The Dossia consortium (2 Jan 2007)

One reason for scepticism about the British Connecting for Health initiative is that the USA has not so far found it necessary to give itself a nationally standardized system of electronic patient records. However, according to a story in *The Economist* ("Bit by bit", p. 77 of the issue of 9 Dec 2006), this may be about to change. The *Economist* article reports plans announced by Wal-Mart on 6 Dec for a consortium of companies, also including Intel and the American division of BP, among others, to launch an online patient-information service, "Dossia", in the course of 2007. The system will be built and operated by a not-for-profit company, the Omnimedix Institute of Oregon, and will initially cover 2.5 million employees, dependants, and pensioners.

The Economist asks what the motivation of consortium members is for taking this initiative, pointing out that while some member firms, e.g. Intel, may increase their market by supplying resources needed to create the system, others will not: "Electronic medical records will not increase sales at BP or Wal-Mart". Motives quoted by spokeswomen for consortium members include the fact that BP's employees frequently relocate, making portable records convenient for them, and the appeal of the non-profit nature of the system – Linda Dillman of Wal-Mart is quoted as saying "The data will come out

of the commercial space and become the property of the individual". A weightier motive, *The Economist* believes, is cost containment. David Matheson of the Boston Consulting Group comments "Employers are completely frustrated by the health industry's slow adoption of information technology", and this echoed by the Dossia group itself, which is quoted as claiming "with employers paying almost half of all US healthcare costs, Dossia will be an important component in making the healthcare system more efficient and effective, eliminating waste and duplication".

Evidently there have been comparable initiatives which failed in the past, but *The Economist* argues that the status of the companies involved now suggests that the time may have come for a new effort to succeed. Independently of the Dossia consortium, the magazine notes that Google is also now discussing the possibility of undertaking related initiatives. *The Economist* refers to the risk that confidentiality issues could defeat the plans, but the consortium is well aware of the need to tread carefully.

Geoffrey Sampson
Sussex University

13.36. The Information Commissioner's view of NHS Electronic Care Records (18 Jan 2007)

The Information Commissioner's Office

http://www.ico.gov.uk/upload/documents/library/data_protection/introductory/information_commissioners_view_of_nhs_electronic_care_reco%e2%80%a6.pdf

"Conclusion: The Commissioner has been consulted by NHS Connecting for Health about their plans for electronic care records and can see the potential benefits these may bring. However the NHS must continue to comply with the Data Protection Act 1998 and this is vital to guarantee that public confidence is maintained. The Commissioner will be monitoring the implementation and operation of the new NHS Care Records Service to ensure patients are provided with adequate information and choices and that their health data is maintained in a safe and secure way. As part of this he will continue to engage with NHS Connecting for Health on a number of issues, in particular those relating to the accuracy of the information to be uploaded, the way people are informed about the changes and the systems in place to allow people to access their own information."

13.37. Transformational Government: Annual Report 2006 (Jan 2007)

Chief Information Officer Council, Cabinet Office

http://www.cio.gov.uk/documents/annual_report2006/trans_gov2006.pdf

". . . The National Programme for IT is a large, complex programme, and the NHS is one of the world's largest organisations, itself undergoing radical change to deliver better healthcare for people. A key challenge is to introduce modern IT and the business changes necessary to exploit it fully without impacting the safe delivery of care. In a 10-year programme of this size, scale and complexity, it is to be expected that there will be issues and difficulties; NHS Connecting for Health has been open about this. The National Programme for IT has set itself ambitious and challenging targets to deliver systems to provide defined benefits. It believes it is better to delay implementation of a system to get it right for patients and clinicians, rather than to deploy it rapidly and get it wrong. The software to support key national elements of the programme has been delivered on time and to budget, and parts of the national systems have gone live as planned. There have been delays to the clinical record system due to the complexity of developing software that interacts with a large number of existing systems, and also due to the need to get doctors to agree on the contents of electronic health records. The cost of these delays is being met by ICT suppliers, not the taxpayer. Operating in this environment, and on this scale, inevitably presents challenges that the programme has overcome through innovation. These challenges include the following:

- Positively engaging clinicians in the business change necessary to deliver the benefits of the new technology to patients and staff, ensuring that systems deliver their full potential.
- The capacity and capability of suppliers within an innovative but tight contracting and performance environment.
- The capacity and capability of project and programme management within the NHS.

- Delivering such a major system at a time of great structural business change for the NHS, including the creation of independent trusts.
- Positively engaging all stakeholders to ensure that all concerns and criticisms are addressed. . .”

13.38. IT in the NHS: National or Local Design (Jan 2007)

The Bayswater Institute [Powerpoint lecture (with notes) by Ken Eason.]

http://www.bayswaterinst.org/downloads/Local%20Design%20Lecture%20Jan%202007.ppt

“. . . As sociotechnical systems specialists we might argue that it is not a good principle to attempt a centralised and standardised programme of IT developments on the massive scale we have in NPfIT. The way that the diversity of local requirements across the NHS Trusts has become manifest as the implementation programme has proceeded is ample demonstration that ‘one size cannot fit all’ in such a complex system. What is a bit more hidden at the moment is what is happening when these applications are implemented and are used by local healthcare teams. What is becoming apparent is that varied local ways of responding to the systems is inevitable. Unfortunately, whilst there is quite a lot of potential for local sociotechnical systems design, the process of implementation does not encourage thoughtful, evolutionary work with the user community. . .”

13.39. Community Pharmacist Access to Patient Care Records (Jan 2007)

National Pharmacy Association

http://npa.journalistpresslounge.com/npa/uploads/news/Patient%20Care%20Records%20Community%20Pharmacist%20Access%20to_Jan07.pdf

“The Government’s vision of integrated health care by 2010 is exciting and ambitious. To help realise this vision, a major Information Technology programme is underway to revolutionise communication across the NHS. Among other innovations, careproviders in all settings will have electronic access to a patient’s medical record at the point of care. This position paper makes the NPA case for both read and write access to Care Records for community pharmacists. Pharmacists need access to Patient Care Records for a number of reasons: 1. To benefit patients; 2. To prevent harm to patients; 3. To benefit other care professionals; 4. To carry out their responsibilities under the new contract; 5. To benefit pharmacists themselves.”

13.40. NPfIT – a personal view, by Robin Guenier (6 Feb 2007)

Presentation given at the 4th Annual Successful Implementation of NPfIT Conference (London, 6-7 Feb 2007

http://homepages.cs.ncl.ac.uk/brian.randell/NPfIT_pres11.ppt

“. . . NPfIT’s success is at risk – even if technically sound.
Proposal – national level:
Appoint an SRO with full-time responsibility and four immediate priorities:
- A thorough assessment of time & cost v. objectives
- A short, independent, focused technical review: is national integration practicable?
- Appoint local SROs
- Advice on project status to all end users

And two follow-on priorities:
- Develop and publish a full business case as defined above
- Start a detailed, interactive engagement programme with all end users . . .”

13.41. Lost? by Andrew Rollerson (6 Feb 2007)

Presentation given at the 4th Annual Successful Implementation of NPfIT Conference (London, 6-7 Feb 2007).

http://www.telegraph.co.uk/core/Slideshow/slideshowContentFrameFragXL.jhtml?xml=/news/2007/02/12/nhs/nhspix.xml&site=

“We have become obsessed by the alligators nearest the boat. Short term challenges have distracted us from the goal. The business goalposts have moved, but not the contractual ones. The Programme has not been structured for a dynamic environment. The challenges of scale and scaling have still not been faced. To solve the challenges faced by the Programme, our perspective has to be right, and we need to view the Programme itself from the proper perspective. The Programme needs committed partners who have staying power. There are never any road signs to your destination when you are heading directly away from it. . .”

13.42. Kaiser has aches, pains going digital (15 Feb 2007)

Los Angeles Times

http://www.latimes.com/technology/la-fi-kaiser15feb15,1,5401753,full.story?ctrack=1&cset=true

“Patients’ welfare is at stake in the electronic effort, experts say. Kaiser Permanente’s $4-billion effort to computerize the medical records of its 8.6 million members has encountered repeated technical problems, leading to potentially dangerous incidents such as patients listed in the wrong beds, according to Kaiser documents and current and former employees. At times, doctors and medical staff at the nation’s largest nonprofit health maintenance organization haven’t had access to crucial patient information, and system outages have led to delays in emergency room care, the documents show. Other problems have included malfunctioning bedside scanners meant to ensure that patients receive the correct medication, according to Kaiser staff. Concerns about Kaiser’s effort, called Health Connect, recently led the California Department of Managed Health Care to request information about the project, a first step before a possible formal investigation. The HMO’s problems come as it plans to expand the computerized system over the next two years to nearly three dozen more hospitals — most in California — where the sickest patients are treated and ensuring patient safety is most difficult. Currently, the system is fully rolled out only in two hospitals, Baldwin Park Medical Center and South Sacramento Medical Center. Kaiser’s effort, one of the largest and most ambitious electronic medical records projects in the country, is seen as a possible national model. With evidence suggesting that digitized recordkeeping can lower health costs and save lives, President Bush is pushing for every American to have an electronic medical record by 2014. But the glitches illustrate the difficulties a massive healthcare provider might encounter trying to implement a complex computerized system. . .”

13.43. Speaking Truth to Power (Mar 2007)

IEEE Software

http://www.computer.org/portal/cms_docs_software/software/content/promo/s2012_07.pdf

“Whenever I conduct an architectural assessment - well, really, I try to apply the following principle in all my dealings - I endeavor to speak truth to power: those with true power never fear the truth. That being said, sticking to that precept has gotten me kicked off at least two projects. In one case, I’d suggested to management that they simply cancel their project because it had a corrupt architecture and a dysfunctional process that were beyond repair. They eventually did cancel the project, but only after they had spent several more tens of millions of dollars of taxpayer money. In the other case, my recommendations were clearly contrary to the project manager’s political aspirations, so my papers were buried and I was shuffled out the door. Rumor has it that this project was also later canceled, but not before the manager in question moved up the ladder, leaving the morass and the resulting blame to his successor. . .” [Grady Booch]

13.44. Implementing Snomed CT within national electronic record solutions (10 Apr 2007)

CHIRAD - the Centre for Health Informatics Research

http://chirad.org.uk/paper_one.htm

"The experience and lessons learned from implementation projects have highlighted differences between suppliers, organisations and end users in what supporting SNOMED CT actually means, and the ability of existing solution architectures to support the advanced clinical documentation tool that SNOMED CT provides. In addition to the English Care record Service programme several other nations have "signed up" to utilising Snomed CT within their own national programmes, the most recent being France. One benefit of utilising Snomed CT is that if clinical data is input by clinicians at the point of care for clinical purposes then accuracy and detail should be improved for clinical care,

and be available for downstream reporting and decision support and care pathway functions. There is therefore an expectation that SNOMED CT will support the implementation of payment schemes including Payment by Results (PbR) and the Quality and Outcomes Framework QoF) within the English NHS. SNOMED CT itself is only a part of the solution to addressing the requirements for effective electronic clinical records as a terminology and on its own does nothing unless it is both implemented and used. The implementation of SNOMED CT requires software applications that exploit its features to meet the real and perceived needs of users. The users of SNOMED CT are not restricted to end-users who enter or retrieve clinical information and experience SNOMED CT through a configured application that uses the terminology. Users also include those who design, commission and configure software for use in a particular clinical environment. SNOMED CT is not 'just another coding system' and its implementation will take some time and require significant development of the solutions. The adoption of SNOMED CT across and within nations will, by necessity, be incremental. In this extended implementation period, solution providers will need to support workarounds such as maintaining separate clinical terming and classification coding processes. Therefore, there will be a mixed population of systems and users that either can or cannot support SNOMED CT. This presents new problems regarding reporting, mixing, sharing and migrating of data. . . As systems push the boundaries of how SNOMED CT can be supported (in terms of simpler user interfaces and exploiting the encoded information to support clinical decision support), there will always be legacy data which is difficult to migrate to an unambiguous new form and to the required level of detail. Additionally, some users will be in advance of others, making data sharing using the right detail difficult. Therefore supporting SNOMED CT within solutions requires new databases, new processes and workflow, new reporting frameworks and ongoing maintenance. These must ensure that SNOMED CT can co-exist alongside other 'codes' until every patient record is fully SNOMED CT encoded. . .The key risk to SNOMED CT implementations is that financially and politically costly user implementation and technology strategies are developed and implemented without a clear vision for the end point."

13.45. Computer Weekly's campaign for NHS openness awarded (14 May 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/05/14/223903/computer-weeklys-campaign-for-nhs-openness-awarded.htm

"Computer Weekly has won the publishing world's "Oscar" for campaigning journalism in recognition of our fight for an independent and published review of the NHS's £12.4bn National Programme for IT. It is the first time a magazine has won such an award twice for the same subject - in this case, the NPfIT. In 2004 the award citation said we had campaigned for a proper review of the NPfIT and had "battled against a strong climate of secrecy and suppression of dissent". That battle continues. There is still a minimalist approach to accountability - what the British Computer Society described as political pressure for officialdom to "deny problems and defend the indefensible". At the same time, the government wants everyone to applaud it for the achievements to come. But that would mean ignoring IT management in the health service, the BCS, leading academics, the NHS Confederation and several Royal Colleges. All have expressed profound misgivings about important elements of the programme. To this criticism the government has responded in the way we warned it would. In 2002, when the programme was launched, we accepted that it was announced with the best of intentions. But we questioned whether it was feasible and warned that the government would react to troubles by trying to head off perceptions of failure with statistics on the high numbers of transactions and registered system users. That is exactly what has happened. The government can stop our run of success in NHS campaigning. It can commission what the programme urgently needs: a genuinely independent review that is published in full and it can be open and honest about mistakes."

13.46. NHS IT: an open letter to Gordon Brown [by Robin Guenier] (26 Jun 2007)

Computer Weekly

http://www.computerweekly.com/Articles/2007/06/25/224998/nhs-it-an-open-letter-to-gordon-brown.htm

"Dear Prime Minister, I don't suppose that the NHS National Programme for IT (NPfIT) is high on your list of priorities. I suggest it should be: you have an opportunity now to make some simple changes that could transform the programme, benefit the NHS and make a real difference to clinical

care. Most informed people welcomed NPfIT when it was launched in June 2000, recognising the need for a comprehensive update of NHS IT systems. The project got fully started in April 2003 and, since then, around £2bn has been spent and much more committed. A lot has been achieved. Yet there are problems: key elements of the programme are years late, costs are escalating, suppliers are in trouble, users are disappointed and stakeholders feel neglected. The NHS insists all is well: a recent report for your predecessor is reported to have said, "Much of the programme is complete …" In contrast, an April 2007 Public Accounts Committee report did not expect significant clinical benefit before 2013/14 when current contracts end. My purpose is not to discuss which view is correct but to recommend three actions that could transform NPfIT. First, I propose that a full-time "senior responsible owner" (SRO), as defined by the Office for Government Commerce, be appointed with unambiguous responsibility for the entire project. . . Secondly I propose that, as recommended in April by the Public Accounts Committee, the business case for NPfIT be subject to an independent review in the light of progress and experience so far. . . Finally, I propose that a major exercise be implemented to engage NHS staff, especially clinicians, with the programme. . ."

13.47. Granger: The final word (6 Jul 2007)

CIO

http://www.cio.co.uk/concern/alignment/features/index.cfm?articleid=351

". . . For a man better known for savaging suppliers, with an apparent 'lead me, follow me, or get out of my way' attitude, 42-year-old Richard Granger, director general of IT, NHS, is surprisingly plaintive. We met in Whitehall a few weeks before he announced his departure at the end of this year after five years in what must be the biggest, highest profile civilian CIO job in Europe. Granger has heard a lot of domestic condemnation of his role over the past five years. Critics argue the project is too complex; that it should have a more localised approach; or one based on smartcards; and that his mismanagement of finances has resulted in a £12 billion bill that is fast rocketing to £50bn. . . NHS financing will haunt Granger for the rest of his career and it is unlikely the final cost will ever be apparent. The National Programme today is said to be running at around £12bn but Granger takes issue with the current calculations. . . Also, Granger says the scope of the current programme is far larger than the original plan, something with which few commentators would disagree. It is a clear and fundamental problem with NHS IT delivery. . . It would be reasonable to surmise there is a connection between Tony Blair's long goodbye and the announcement of Granger's departure at the end of the year. But in the field, Granger has been accused of riding roughshod over the requirements of the user base and local needs. "The distribution of cost/benefit is a difficult part of seducing people to take new systems. GPs for example, bore the brunt of collecting addresses but hospitals are more likely to see the benefits." Does that mean he thinks there should be a mandate for user buy-in with public sector contracts. "Our users are highly educated. They often have quite strong opinions. I think you can do something like that in a clerical environment, like the computerisation of social security and quite a lot of my team, including me, worked on that. You built a system, test it in some offices and then roll it out. If you were a clerk administering income support, that was the system you used. There was no alternative He says the NHS is a far more complicated situation. "We were not going from a clerical process to a computerised process in a nationally controlled organisation. These organisations are statutory independent bodies, especially if they are foundation trusts. They buy services from the private sector and they've been investing a billion pounds per year in computers. Two years ago that was money for at least a decade, if not longer. You've got a lot of existing assets you must sweat. "We get a lot of views from the end user community about what is right and what is wrong and we must have a mixture of products that hopefully makes their lives easier, although sometimes we fail to do that miserably." He adds: "Sometimes we put stuff in that I'm just ashamed of. Some of the stuff that Cerner has put in recently is appalling. It really isn't usable because they have been building a system with Fujitsu without listening to what the end users want. They have taken some account but they then had to take a lot more. Now they're being held to account because that's my job."

13.48. Granger says he is 'ashamed' of some systems provided (10 Jul 2007)

e-Health Insider

http://www.e-health-insider.com/news/item.cfm?ID=2854

"The departing head of the NHS IT programme Richard Granger has said he is ashamed of the quality of some of the systems put into the NHS by Connecting for Health suppliers, singling Cerner out for

criticism. Going further than he before in acknowledging the extent of failings of systems provided to some parts of the NHS - such as Milton Keynes – the Connecting for Health boss, said "Sometimes we put in stuff that I'm just ashamed of. Some of the stuff that Cerner has put in recently is appalling." He said a key reason for the failings of systems provided was that Cerner and prime contractor Fujitsu had not listened to end users. "It really isn't usable because they have building a system with Fujitsu without listening to what end users want. They have taken some account but they then had to take a lot more. Now they are being held to account because that's my job." The latest remarks, quoted in an interview in the current issue of CIO magazine, appear to make a nonsense of Granger's June statement that unless agreement was reached between Computer Sciences Corporation and iSoft over its acquisition by IBA Health, Cerner could wind up as the system used across the whole of the English NHS. In December 2005 Nuffield Orthopaedic Centre became the first NHS site to go live with Cerner Millennium under the NHS IT programme. It has since suffered a string of problems ranging from missing appointment records, to inability to report on wait times. The Millennium system – now installed at six NHS locations in the South – remains unable to directly integrate with Choose and Book or meet 18-week reporting requirements. . . Granger also cast further light on Accenture's departure from the NPfIT programme at the end of 2006, describing their relationship with sub-contractor iSoft as a failed marriage, in which they had failed to realise their co-dependency. He contrasted the relationship with iSoft with Accenture's performance on Picture Archiving and Communication Systems with Agfa as its sub-contractor. "When they work with a mature, high quality vendor that recognises Accenture as in charge and they're doing it their way, you get a quite good deal and they'll do the job." The CfH boss goes on to state that he has been careful to avoid Stockholm syndrome -identifying with suppliers' interests rather than those of the NHS - as problems have mounted. "One supplier asked for an extra £500m to deal with cost overruns. He received a succinct refusal but there are many places where the response would have been different; where threats of bad publicity and contract disputes would persuade an organisation to start bunging millions of pounds a month in addition to the existing contract, just to cover up," says Granger. Elsewhere in the in-depth valedictory interview carried out ahead of Granger announcing his resignation, he rounds on critics and erstwhile colleagues, saying. "Either people are really stupid or evil. It's difficult to be compassionate with people who claim that suppliers are going out of business because they are not getting paid or they were withdrawing from wishing to do business with the NHS. At the same time, they are saying they [the suppliers] have been bunged millions of pounds that weren't budgeted for. It's stupid or wicked." He reserves particular ire for so-called experts. "There is a little coterie of people out there who are alleged experts and who worked on this programme. They were dismissed for reasons of non-performance or in one case, for breach of commercial confidentiality. "He actually sent our financial model to a supplier and that's why we suspended him. He then resigned which is an answer in itself." Granger continued: "Who contributed evidence to the public accounts committees? For just about every figure quoted as an expert in this programme, I've got HR files on them. They generate a piece of opinion that often substantiates their world view."

13.49. Sensitive Downing Street papers on the NHS's National Programme for IT [NPfIT] may be released (21 Aug 2007)

Computer Weekly - Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/2007/08/the-information-commissioner-r.html

The Information Commissioner Richard Thomas has ordered the disclosure of "highly sensitive" papers about a meeting at Downing Street which led to the launch of the UK's largest IT-based project, the £12.4bn NHS national programme. The ruling is a breakthrough in favour of openness over how Whitehall and Downing Street take decisions which lead to the award of large contracts on large and risky IT-based programmes. And it vindicates Computer Weekly's campaign against excessive secrecy over the National Programme for IT - a complaint made by many in the IT industry including the British Computer Society. The ruling comes two and half years after Computer Weekly made a request under the Freedom of Information Act for details of a seminar on NHS IT at Downing Street in February 2002, which was chaired by the then Prime Minister Tony Blair. The meeting set in train events which led to funding for what became the NHS's National Programme for IT [NPfIT]. It was attended by several ministers, the Chief Secretary of the Treasury, the Secretary of State for Health, the Chief Executive of the Office of Government Commerce, the e-Envoy, business consultants and others. The Cabinet Office, on behalf of Downing Street, twice rejected our request for information about the meeting. It claimed the information was exempt from disclosure under the Act. We appealed to the Information Commissioner in July 2005. The Cabinet Office told Richard Thomas that some of the

information withheld was “used by the Prime Minister to reach decisions on the future role of IT in delivering NHS services”. . . Its arguments for secrecy resembled those the government has made to resist rulings by the Information Commissioner and the Information Tribunal that early gateway reviews on the ID cards scheme should be published. Gateway reviews are independent assessments of high-risk IT-based projects and programmes. The Cabinet Office said that disclosure would inhibit frank advice given by civil servants. The Information Commissioner Richard Thomas accepted some of the arguments of the Cabinet Office but decided that other factors outweighed them. He said the information we had requested was “historical”. We had made our request in January 2005, three years after the policy over NHS IT had been announced. . . He ordered the Cabinet Office to disclose the information requested within 35 calendar days of the date of his notice - 13 August 2007. Officials may appeal the decision to the Information Tribunal [link is to the Tribunal’s decision to order the publication of early gateway reviews on ID cards] within 28 days.

13.50. The biggest computer programme in the world ever! How's it going? (Sep 2007)

Journal of Information Technology (Sean Brennan)

http://www.palgrave-journals.com/jit/journal/v22/n3/full/2000104a.html

". . . In essence, the National Programme's content was agreed over the last 20 years of health IT with successive programme and projects agreeing a blueprint for the future development programme. This blueprint culminated in a clearly defined strategy for electronic records as articulated as the outcome of the national EPR Programme and the follow-up programme ERDIP. The Six Level EPR model was a reasoned pragmatic solution that was well received by both the NHS and Suppliers alike. The interactive CD Rom used to promote the model soon became a Health IT icon of its time. But its time may well come again. This comprehensive and complex programme cannot be delivered overnight and will not be delivered through a big bang. There needs to be an incremental plan and the old EPR model could be dusted off and tweaked. (The author still has copies of the original interactive CD Rom for those interested in reviewing it! For further information, visit www.eprarms.com) This model ensured the way to do it was simple and well understood. EPR would be built at a local clinical community level. It would consist of integrated clinical and administrative systems. These would produce a passive record, held locally. A national summary record (the EHR) would be fed from these local systems. 'Would be' implying that this is some future functionality and not a pre-requisite from day one. In my view, the NPfIT turned that simple approach on its head. NPfIT decided that the main objective of their programme was a single national electronic record. Most of the problems with the Programme can be traced to that fundamental re-interpretation of what the NHS needed. It might have been workable if this was allowed to evolve over time, so long as the programme's primary objective was left untouched – to put in place effective, workable local systems that support the way that healthcare professionals work in local organisations. Halfway into the programme, the LSPs have yet to convince the NHS that they really can deliver solutions and change effectively. Perhaps the scale of the challenge is just too big for them. There was a stage, in 2003, before the NHS in England was divided into five arbitrary clusters, when we all expected the delivery model to be much more local. As discussed previously, we had 28 SHAs back then, and we expected a process where 28 service providers would be appointed – one for each SHA. It is hard to escape the view that, if this had been the model, we would be looking at a Programme much closer to completion. Each local contractor would be dealing with less than half a dozen Trusts; work would have started much sooner; the relationships between Trusts and contractors would have been closer. Smaller contractors could have been lighter on their feet dealing with software delays. But multiply that up to the huge clusters that we have today, and the model becomes huge and unwieldy. Trusts who are in no hurry to move can bide their time. No one is in the spotlight. Maybe NLOP (NPfIT Local Ownership of the Programme) – due to come into force in September 2007, will change that. But even so, SHAs are much bigger now. It would not be easy to regenerate the enthusiasm for change that was so prevalent back in 2004. And will NLOP really mean a shift in decision making down to these re-defined SHAs or will the major decisions continue to be made behind closed doors and then the NHS expected to act on them? . . ."

13.51. A Computer Scientist’s Reactions to NPfIT (Sep 2007)

Journal of Information Technology (Brian Randell)

http://www.palgrave-journals.com/jit/journal/v22/n3/full/2000106a.html

“This paper contains a set of personal views relating to NHS Connecting for Health’s National Programme for IT (NPfIT), and in particular its Care Records Service, written from the point of view of a computer scientist, not a medical informatics expert. The principal points made are as follows:

Centralisation: Pulling lots of data together (for individual patients and then for large patient populations) harms safety and privacy – it is one by-product of excessive use of identification when in fact all that is usually needed is authentication. Large centralized data storage facilities can be useful for reliability, but risk exchanging lots of small failures for a lesser number of much larger failures. A much more decentralised approach to Electronic Patient Record (EPR) data and its storage should be investigated.

Evolutionary acquisition: Specifying, implementing, deploying and evaluating a sequence of ever more complete IT systems is the best way of ending up with well-accepted and well-trusted systems – especially when this process is controlled by the stakeholders who are most directly involved, rather than by some distant central bureaucracy. Thus authority as well as responsibility should be left with hospital and general practitioner trusts to acquire IT systems that suit their environments and priorities – subject to adherence to minimal interoperability constraints – and to use centralized services (e.g., for system support and back-up) as if and when they choose.

Socio-technical Issues: Ill-chosen imposed medical IT systems impede patient care, are resisted, result in lots of accidental faults, and lose user support and trust. All these points are attested to by rigorous studies involving expertise from the social sciences (psychology, ethnography, etc.) as well as by technical (medical and computer) experts – much more attention needs to be paid to such studies, and more such studies encouraged.

Constructive Reviews: A constructive expert review, working closely with Connecting for Health, could be very helpful, but should be evidently independent and open and thus essentially different in nature to past and current inquiries. A review of this nature could not just recommend appropriate changes of plan, and speed progress. It could also contribute to the vital task of helping to restore the trust and confidence of the public and the media in the programme and in the government officials involved.”

13.52. 'The biggest computer programme in the world...ever!': time for a change in mindset? (Sep 2007)

Journal of Information Technology (Chris Clegg and Craig Shepherd)

http://www.palgrave-journals.com/jit/journal/v22/n3/full/2000103a.html

". . . In this project, there is a strong emphasis on developing and implementing a large set of IT systems. In time, the intent is that these systems will provide the technical infrastructure enabling NHS staff to deliver better care to patients. But, at least for now, the focus is on delivering the IT. This is where the budget is spent. This is what is project managed. This is what companies and people are hired to do and rewarded for doing. Put simply, this is (at present) a technology project, and indeed this is reflected in its title. We believe this 'techno-centric mindset' may be misguided, and flies in the face of lessons learned from research and practice over the last 20 or so years. While it may be the biggest programme ever, we have doubts that this is a useful way of looking upon it. Put bluntly, we question whether the current strategy is the most appropriate way forward to achieve successful service improvements. . ."

13.53. Conflicting institutional logics: a national programme for IT in the organisational field of healthcare (Sep 2007)

Journal of Information Technology (Wendy L Currie and Matthew W Guah)

http://www.palgrave-journals.com/jit/journal/v22/n3/full/2000102a.html

"Abstract: This paper reports the findings from a 4-year study on the UK National Health Service on the introduction of a national programme for information technology.1 This is the largest civil IT programme worldwide at an estimated technical cost of £6.2 billion over a 10-year period. An institutional analysis of our historical and empirical data from six NHS organisations identifies growing fragmentation in the organisational field of healthcare, as past and present institutional logics both fuel and inhibit changes in the governance systems and working practices of healthcare practitioners. This is further complicated by new institutional logics that place the citizen at centre stage of the NPfIT, in a move to promote patient choice and public value."

13.54. Modernising healthcare – is the NPfIT for purpose? (Sep 2007)

Journal of Information Technology (Annabelle L Mark)

http://www.palgrave-journals.com/jit/journal/v22/n3/full/2000100a.html

"Abstract: This paper responds to the findings of the research by Currie and Guah on the introduction of the National Programme for Information Technology through an institutional theory perspective. It considers both the appropriateness and applicability of the method chosen in the light of what is already known about UK healthcare organisations and the complex and changing process that is involved in both the organisation and any research that takes place. This is further confounded by an unstable political environment both nationally and locally and a failure to understand the changing location, role and status of the medical record. Only when this is resolved will a transformational change occur, in line with the new patient-focused government agenda and the external world of technology that must engage with the emotional as well as the rational role that both technology and health play in people's lives."

13.55. Local sociotechnical system development in the NHS National Programme for Information Technology (Sep 2007)

Journal of Information Technology (Ken Eason)

http://www.palgrave-journals.com/jit/journal/v22/n3/full/2000101a.html

"Abstract: The National Programme for Information Technology is implementing standard electronic healthcare systems across the National Health Service Trusts in England. This paper reports the responses of the Trusts and their healthcare teams to the applications in the programme as they are being implemented. It concludes that, on the basis of the data available, it is likely that the emergent behaviour of healthcare staff will serve to minimise the impact of the systems. The paper looks at the opportunities within the programme to undertake local sociotechnical system design to help staff exploit the opportunities of the new electronic systems. It concludes that there are opportunities and offers one case study example in a Mental Health Trust. However, it concludes that there are many aspects of the technical systems themselves and also of the approach to implementation, that limit the opportunities for local sociotechnical systems design work."

13.56. Our Future Health Secured? - A Review of NHS Funding and Performance (Sep 2007)

Kings Fund (Derek Wanless, John Appleby, Anthony Harrison, Darshan Patel)

http://www.kingsfund.org.uk/publications/kings_fund_publications/our_future.html

". . . The NHS Care Records Service (NCRS) aims to provide an electronic health care record for every patient in England. The NHS Plan noted that this could become a reality by 2004, when 75 per cent of hospitals and 50 per cent of primary and community trusts would have implemented electronic patient record systems. However, controversy has seriously undermined this aspect of the NPfIT, partly due to the absence of any published plans for the design and implementation of NCRS. It is also unclear what information will be held on individual electronic health care records. Doctors and patient groups remain anxious about who will have access to electronic patient records and the associated risk to patient confidentiality. The government has now agreed to allow patients to 'optout' of having their records held by NCRS, although the details of the opt-out procedures have not been settled. Consequently, real progress is only just beginning. In the spring of 2007, a number of early adopters began creating 'summary care records' as a prelude to the national roll-out. These records are expected to include significant elements of a patient's care, including major diagnoses, procedures, current and regular prescriptions, allergies, adverse reactions, drug interactions and recent investigation results. However, this will be a challenge. National roll-out is expected to begin early in 2008, but it will be several years before coverage is complete. A date has not yet been specified for the system to be fully operational. . . A detailed review of NPfIT is beyond the scope of this report, but three factors seem likely to have an impact on the 2002 review's productivity assumptions. The first is the failure to develop an ICT strategy whose benefits are likely to outweigh costs. The NAO (2006) noted that'...it was not demonstrated that the financial value of the benefits exceeds the cost of the Programme'. This is a serious criticism, implying either the absence of an original business case for investment or investment made in spite of a business case that did not justify the spending. In similar vein, a report by the British Computer Society (2006) concluded that'... the central costs incurred by NHS [Connecting

for Health] are such that, so far, the value for money from services deployed is poor'. Surprisingly, systematic reviews of ICTs show that evidence for key technologies, such as NCRS and PACS, is lacking (Delpierre C et al 2004; Poissant L et al 2005). It is difficult to understand why Connecting for Health is being allowed to pursue a high-cost, high-risk strategy that cannot be supported by a business case. Second, while the 2002 review assumed that investments would be audited and evaluated, apart from the NAO report the necessary work is not being undertaken and it does not seem possible to obtain reliable data on NHS resources being committed to NPfIT. Connecting for Health has so far made negligible investments of less than £0.5 million in evaluation (a fraction of the projected £12.4 billion costs). There seems a real risk that the costs and benefits of NPfIT will never be accurately assessed. The third factor, which may turn out to be the most important, is that the NPfIT contracts risk creating monopolies in various areas of the programme. The House of Commons Public Accounts Committee (2007a) has noted that 'The use of only two major software suppliers may have the effect of inhibiting innovation, progress and competition'. Connecting for Health chose to award a small number of large contracts to consortia charged with designing and implementing the technologies. But they could instead have set out to create a competitive market for IT goods and services. Is it possible that a robust business case could be created, even now, with a focus on strategies for encouraging a healthy market? It is clear that there are considerable challenges ahead in modernising NHSIT systems, and continuing debate over the feasibility of some current NPfIT plans. The continuing uncertainty and delays have the potential to undermine the productivity gains envisaged by the 2002 review. . ."

13.57. Potential contributions to developing EHRs (2 Dec 2007)

BCS Health Informatics Now

http://www.bcs.org/server.php?show=ConWebDoc.16210

". . . Lincoln Moura Jr gave a snapshot of a city-wide electronic health record project covering 22 million people in Sao Paolo and the surrounding area. It has 400 primary care units, 160 polyclinics, 105 hospitals and 7 million patients. Open standards and open source code was being used where possible, and national standards were to be promoted if not fully complied with. The project team was assembled in January 2004, with deployment in September of the same year. New features were added up until March 2005. Currently 13 million people are registered and 30,000 appointments scheduled daily. The project's success is attributed to the software engineering principles used, an integrated project management process and some exceptional talent. . ."

13.58. Evidence from other shores can benefit UK (2 Dec 2007)

BCS Medical Informatics Now

http://www.bcs.org/server.php?show=ConWebDoc.16215

"What can the UK learn internationally in health informatics? . . . [Though] issues such as telemedicine and home monitoring are important, in most people's minds in the UK the key issue in health informatics is electronic records, and here the NHS has very specific policies - four of them, one for each home country. Can we really learn here? Surely the question must be considered the other way round: we expect clinicians to practice evidence-based medicine, so are not informaticians - and informatics policy makers - duty bound to practice evidence-based health informatics, and to ground their action on the best available evidence? It is here that it is clear that the UK could learn more from looking outside its shores - not in any sense of deference, but in one of scientific enquiry. Yet the policy evidence base of UK health informatics is not striking, with the four home countries not emphasising independent underpinning evidence, let alone collaborating on determining what is best in the UK situation. There is a strong tendency to look to the United States, where many vendors and regularly cited implementations are based, and where the influential Institute of Medicine's (IOM) study on the computer-based medical record1 was published. But the US health system and its commercial basis are very different to the UK's, and the IOM study has neither metrics nor costings - it is a vision, not a blueprint. But from the United States there is a considerable literature on barriers and enabling factors to clinician uptake of EPR systems, which seems to have been largely ignored as inconvenient. So in this case the learning has been of the wrong type - the conceptual and organisational-level material has been followed, even though the two health systems are very different, but the individual clinical behaviour which has much greater similarities has been ignored. So how can and should the UK learn internationally? One start would be to recognise that our greatest links are with Europe. Not least, all European health systems have strong values of equity, accessibility, and affordability at the time of need. . ."

13.59. Evidence from other shores can benefit UK (Dec 2007)

BCS Health Informatics Now

http://www.bcs.org/server.php?show=nav.9756

". . . there is much that can be learned, as well as contributed, by the UK in health informatics internationally. This can be to the benefit of informatics practitioners, but above all to systems, their implementing organisations and thus patients. It is time that this was seen as a legitimate - indeed required - activity, in a move to better informed and evidence-based informatics. Indeed there is some enlightenment, as exemplified by Wales specifically setting up an International Advisory Group to regularly review its health informatics progress. Is this the beginning of an age of enlightenment on learning from outside views and evidence?"

13.60. Data sharing on a par with nuclear radiation (Dec 2007)

BCS Health Informatics Now

http://www.bcs.org/server.php?show=nav.9756

"Given the dangers of highly sensitive medical data falling into the wrong hands, implementing the right controls to protect confidentiality are vital. As moves accelerate towards the nationwide sharing of records, four speakers at a BCS event looked at different aspects of making sure that private data stays that way."

13.61. Visualizing Electronic Health Records With "Google-Earth for the Body" (Jan 2008)

IEEE Spectrum

http://www.spectrum.ieee.org/jan08/5854

"Andre Elisseeff leads a research team at IBM's Zurich Research Lab that in September demonstrated a prototype system that will allow doctors to view their patients' electronic health record (eHR) using three-dimensional images of the human body. . . "You can think of it as being like Google Earth for the body," is how Elisseeff frames the mapper engine. "We see this as a way to manage the increasing complexity that will come in using computers in medicine." A major driver of that complexity is the push by governments worldwide to computerize paper-based medical records. "By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care," said President George W. Bush in his 2004 State of the Union address. In that speech he called for the computerization of the nation's medical health records. In April 2004 Bush issued an executive order to accomplish this by 2014. Although our ability to meet the 2014 date is highly doubtful, progress is being made toward defining the underlying standards necessary for creating a national, interoperable automated health-record system. The United States is following the lead of other countries, such as the United Kingdom, Australia, Canada, Finland, Germany, and Denmark, each of which has introduced national programs to eliminate paper-based medical records and replace them with some form of eHR. The UK's computerization effort, called the National Programme for IT (NPfIT), is considered by many to be the largest nonmilitary IT program ever undertaken. However, not all is well on the eHR front, not only because of the technological difficulties involved (for instance, the NPfIT implementation, like most national eHR efforts, has experienced both schedule slips and rising costs) but because of the resistance of both physicians and patients to the presence of computers in the exam room. Many doctors complain that eHRs have turned them into clerks, while patients say that doctors using these automated systems seem more interested in typing on their computer keyboard than in listening to their health problems. Instead of capturing unstructured data from a conversation between doctor and patient, "most of the electronic health record systems have been built as if physicians and clinicians were office workers entering in structured administrative data," says Elisseeff. This clerical approach to these system designs implicitly excludes the patient as an active participant and makes the computer an intrusive third party to what are often difficult personal discussions. . ." [Robert N. Charette]

13.62. Secrets of Blair briefing on NPfIT to be surrendered (4 Feb 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/02/04/229234/secrets-of-blair-briefing-on-npfit-to-be-surrendered.htm

The government is taking the unprecedented step of releasing papers on how policy decisions were taken at Downing Street before the launch of the NHS systems modernisation project - the world's largest civil IT-based scheme. The move follows a three-year campaign by Computer Weekly to force disclosure of the "Downing Street papers", using the Freedom of Information Act. The disclosures, which are expected to be made this week, will mark the first time Whitehall has made a major release of secret information on how policy decisions over large and risky IT projects and programmes are taken. In 2005, days after the Freedom of Information Act came into force, Computer Weekly formally applied for details of an IT seminar held at Downing Street in February 2002, chaired by the then prime minister, Tony Blair. Decisions at the seminar led to the launch of what became the £12.4bn National Programme for IT in the NHS. The government formally rejected Computer Weekly's request three times. The case was due to come before the Information Tribunal on 11 February, but last week the government's lawyers unexpectedly withdrew from the appeal. The Cabinet Office will now release the information. The NHS IT programme has been dogged by problems and Computer Weekly has sought information on whether the risks were sufficiently discussed and assumptions challenged. Papers now expected to be released include: A submission to the prime minister explaining the background to the meeting and giving him a steer on questions to raise; A record of what was said at the Downing Street meeting. Two months ago Computer Weekly submitted a paper to the tribunal setting out the public interest arguments in favour of disclosing the Downing Street papers. The tribunal decided formally to accept our evidence as part of the case, which appears to have been a factor in the decision of the Cabinet Office to withdraw its appeal.

13.63. Granger era ends as DG leaves CfH (7 Feb 2008)

e-Health Insider

http://www.e-health-insider.com/news/3454/granger_era_ends_as_dg_leaves_cfh

Richard Granger has left NHS Connecting for Health, the NHS IT agency responsible for the £12.4bn NHS IT programme, which he has led for the past five years. CfH staff and NHS chief information officers began to be notified of Granger's departure this morning. The announcement ends a period in which it has been unclear how closely involved Granger has been in running CfH. He had originally been due to quit by the end of 2007, after announcing in July that he would 'transition' from CfH. A DH spokesperson told E-Health Insider this morning that Granger will not be replaced by an equivalent director general, but instead by a new director of programme and systems delivery at CfH. A new role of Chief Information Officer will be created, based in the DH, covering both the DH and NHS. The spokesperson said: "We've just had Cabinet Office agreement that we can go ahead and start filling these roles." Until these recruitments are completed Matthew Swindells, who is currently leading the DH's Informatics Review, with act as the DH's CIO. Gordon Hextall, the chief operating officer of CfH will act as director of programme and systems delivery. . .

13.64. Google Health unveils electronic record pilot (22 Feb 2008)

e-Health Insider

http://www.e-health-insider.com/news/3496/google_health_unveils_electronic_record_pilot

"Google has teamed up with the prestigious Cleveland Clinic in the US to pilot a system which lets patients transfer their existing medical information to its new online Personal Health Record (PHR) service, Google Health. Once transferred to Google Health patients will then be able to manage and control access to their records, deciding who they want to share them with. In a keenly-anticipated announcement the internet search giant said it will manage the electronic health records for almost 10,000 Cleveland Clinic patients who currently use the hospital's online health records system. Patient participation is voluntary. The Google Health pilot will test secure exchange of patient medical record data such as prescriptions, conditions and allergies between their Cleveland Clinic PHR to a secure Google profile in a live clinical delivery setting. A Google UK spokesperson told EHI the service will only be made available in the US initially, with global expansion to be considered in the future. The ultimate goal of this patient-centered and controlled model is to give patients the ability to interact with multiple physicians, healthcare service providers and pharmacies. . . A Google spokesperson stressed to E-Health Insider that they have no plans to add providers to the pilot or to sell or share data without explicit patient consent. The system will initially run in the US, and global expansion will be considered in the future . ."

13.65. Majority of NHSmail accounts are inactive (25 Mar 2008)

Kable's Government Computing

http://www.kablenet.com/kd.nsf/FrontpageRSS/EA92D5EE0912651C80257412005FBFBC!OpenDocument

"The secure email and directory system for England and Scotland's health services has 153,000 active accounts, less than half the 337,000 registered users. The number of active users is a small fraction of the NHS employees within the two nations, which exceeds 1m. In April 2006, then director general of NHS Connecting for Health Richard Granger challenged health service organisations to turn off local email systems in favour of NHSmail. The figure for active users was provided by health minister Ben Bradshaw in a parliamentary written answer on 19 March 2008. The number has grown by 40% over the last 12 months, from 109,548 at the end of February 2008 to 153,073 on 29 February 2008. NHSmail is provided free of charge for all health service staff in the two nations, with staff able to retain their email addresses when moving between health service organisations. The system was originally run by EDS, but its contract was terminated after six months. NHSmail is now provided by Cable & Wireless, but last year, the system was moved from that company's Mirapoint email system to Microsoft Exchange 2007, as part of a widening of Connecting for Health's agreement with Microsoft."

13.66. Warning on Storage of Health Records (17 Apr 2008)

New York Times

http://www.nytimes.com/2008/04/17/business/17record.html

"In an article in The New England Journal of Medicine, two leading researchers warn that the entry of big companies like Microsoft and Google into the field of personal health records could drastically alter the practice of clinical research and raise new challenges to the privacy of patient records. The authors, Dr. Kenneth D. Mandl and Dr. Isaac S. Kohane, are longtime proponents of the benefits of electronic patient records to improve care and help individuals make smarter health decisions. But their concern, stated in the article published Wednesday and in an interview, is that the medical profession and policy makers have not begun to grapple with the implications of companies like Microsoft and Google becoming the hosts for vast stores of patient information. The arrival of these new corporate entrants, the authors write, promises to bring "a seismic change" in the control and stewardship of patient information. Today, most patient records remain within the health system — in doctors' offices, hospitals, clinics, health maintenance organizations and pharmacy networks. Federal regulations govern how personal information can be shared among health institutions and insurers, and the rules restrict how such information can be mined for medical research. One requirement is that researchers have no access to individual patients' identities. Under the current system, individuals can request their own health records, but it is often a cumbersome process because information is scattered across several institutions. As part of a push toward greater individual control of health information, Microsoft and Google have recently begun offering Web-based personal health records. The journal article's authors describe a new "personalized, health information economy" in which consumers tell physicians, hospitals and other providers what information to send into their personal records, stored by Microsoft or Google. It is the individual who decides with whom to share that information and under what terms. But Microsoft and Google, the authors note, are not bound by the privacy restrictions of the Health Insurance Portability and Accountability Act, or Hipaa, the main law that regulates personal data handling and patient privacy. Hipaa, enacted in 1996, did not anticipate Web-based health records systems like the ones Microsoft and Google now offer. The authors say that consumer control of personal data under the new, unregulated Web systems could open the door to all kinds of marketing and false advertising from parties eager for valuable patient information. Despite their warnings, Dr. Mandl and Dr. Kohane are enthusiastic about the potential benefits of Web-based personal health records, including a patient population of better-informed, more personally responsible health consumers. "In very short order, a few large companies could hold larger patient databases than any clinical research center anywhere," Dr. Mandl said in an interview. But the authors see a need for safeguards, suggesting a mixture of federal regulation — perhaps extending Hipaa to online patient record hosts — contract relationships, certification standards and consumer education programs. . ."

13.67. Newcastle chooses Pittsburgh for EHR (29 Apr 2008)

e-Health Insider

http://www.e-health-insider.com/news/3702/newcastle_chooses_pittsburgh_for_ehr

Newcastle upon Tyne Hospitals NHS Foundation Trust has partnered with the University of Pittsburgh Medical Centre (UPMC) to deploy electronic health record technology at Newcastle's hospitals. Under the 14-month implementation plan, a UPMC technology team will install and adapt five electronic health record (EHR) applications at five Newcastle hospitals, including the Royal Victoria Infirmary, Freeman Hospital and Newcastle general Hospital, with a total of over 2,000 beds. The five applications to be installed include inpatient order entry, patient administration, pharmacy management, accident and emergency services and operating room systems. Details of the applications to be used or the value of the deal were not disclosed. UPMC and Newcastle have also formed a joint venture to provide IT services to other UK hospital trusts. "Newcastle will be an important proving ground for this partnership," said Len Fenwick, chief executive of Newcastle Hospitals. "We are confident that others will soon see the value of what we are doing here and seek to replicate it." UPMC has regularly been voted one of the leading hospital groups in the US for its use of IT. Systems used by UPMC include: Epic System's EpicCare for outpatient electronic medical records, Cerner's PowerChart for electronic medical record management, Medical Archival Systems, Inc. for patient notes, Stentor for digital imaging, remote access tools and a physician portal. . . "The Newcastle contract is the first of what we hope will be many international agreements for our information etchnology services," said Dan Drawbaugh, chief information officer at UPMC. Donna McCormick, CIO of UPMC's international and commercial services division will be based in London to oversee the Newcastle project and other UPMC international technology initiatives. . . Explaining why it has gone outside the NPfIT programme the trust said "Because of its long-standing commitment to using advanced technology to improve patient care, Newcastle sought an outside technology partner to implement elements of an electronic health record. Through a competitive bidding process, it selected UPMC as its prime contractor. The new system is expected to be fully compatible with the UK's national programme for electronically connecting hospitals."

13.68. How a Sociotechnical approach can help NPfIT deliver better NHS patient care (May 2008)

Centre for Organisational Strategy Learning and Change, Leeds University Business School Malcolm Peltu, Ken Eason and Chris Clegg)

http://lubswww2.leeds.ac.uk/COSLAC/index.php?id=54

". . . This paper seeks to show how sociotechnical thinking and practice can be of practical benefit within NPfIT – provided the programme adopts a more holistic overall strategy that places social and organizational issues alongside technology concerns at the heart of its work. The methods recommended are based on sociotechnical design principles which have been successfully applied in many environments over more than fifty years. The optimists at the [7 Feb 2008 BCS] meeting claimed there are opportunities to use this knowledge to improve outcomes in many NPfIT implementations, although others expressed doubts about the extent to which this would happen. This paper starts by summarising the nature of NPfIT's current strategy and the main problems it has encountered. It then identifies key sociotechnical design principles relevant to overcoming such problems, explaining why the sociotechnical view is well positioned to address key barriers to the success of NPfIT. Guidelines on applying these principles offer a way of realising the enormous potential benefits which are made possible by the use of IT capabilities in delivering healthcare. . ."

13.69. Is the Treatment Working? (Jun 2008)

Audit Commission

http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/9F8B7F6A-214D-4165-BE65-716315270A82/IstheTreatmentWorking.pdf

"Since the government announced the NHS system reform programme in 2000 in the NHS Plan, the NHS has made significant progress. There are shorter waiting times and the quality of care overall, as measured by the annual health check, has risen. This report examines the impact of the system reform programme on the progress made. It concentrates on some key aspects of the reforms – patient choice, Payment by Results (PbR), practice based commissioning (PBC), foundation trusts (FTs), greater NHS use of the private sector through the introduction of independent sector treatment centres (ISTCs), and the impact that major workforce contractual changes have had on hospital efficiency. . . There have been significant delays in the roll out of electronic patient records as part of the National Programme for IT, Connecting for Health. Many of the organisations involved in our research were frustrated with the pace of implementation for Connecting for Health and that its structure, at times, was perceived

neither to match local needs nor offer an improvement to existing systems. Even PbR, the most fully implemented reform, has been hampered by a lack of supporting infrastructure, for example, in the provision of data. For example, as stated in The Right Result? (Ref. 10), the timeliness and quality of data available to PCTs through the secondary uses service (SUS)I for monitoring contracts and making payments under them need significant improvement. . . The necessary infrastructure is also not yet in place to enable choice to reach its full potential. The national roll out of Choose and Book, the electronic booking appointments system, was delayed. This has limited the choice that patients had over access to outpatient appointments. In addition, the NHS Choices website only went live in July 2007; the information it contains is still incomplete; and not all patients will have access to this medium. Chapter 3 explains how choice policy is being hampered by the lack of necessary information on patient care, although the DH are now addressing this. PBC is also yet to deliver significant change and the slow progress can be attributed at least in part to underdeveloped budgeting, data collection and information sharing and governance processes. . ."

13.70. Conservatives commission review of NHS IT (21 Aug 2008)

e-Health Insider

http://www.e-health-insider.com/news/4075/conservatives_commission_bcs_to_review_nhs_it

"The Conservative Party has commissioned an independent review of NHS IT policy. The review is intended to inform future government policy for the use of IT in the NHS, health and social care in England. The review will aim to establish a vision for IT in the NHS, health and social care and inform the policy actions the current and any future government should take. Chaired by Dr Glyn Hayes, the former chair of the BCS Health Informatics Forum, the new review has been commissioned by, and will report back to, the Conservative shadow health minister, Stephen O'Brien. Dr Hayes told E-Health Insider that the he only agreed to lead the review after being assured of its independent nature. "The BCS is apolitical," said Dr Hayes. He stressed that he intended the review to focus on developing a pragmatic blueprint to get the maximum patient benefit from IT and informatics in health and social care, and not to dissect the existing National Programme for IT in the NHS. He said the first requirement was to define a clear shared "vision of what the future holds for the next five to ten years". Dr Hayes said the roots of the review could be traced back to the Commons' Public Accounts Committee review of the national programme, which first recommended that such a review should be conducted. However, he said the review "may inform the development of Conservative party policy in this area." Dr Hayes said the review will not be retreading the ground covered by the recent Health Informatics Review, which was carried out by the Department of Health. He said it had really only looked at the way forward for the DH and NHS Connecting for Health. And he argued it had failed to consider a number of key areas in sufficient detail. While the review focused on information sharing across the health service, for example, Dr Hayes suggested that some of the greatest benefits came from ensuring information was available "at the point of patient care." The plan is to carry out the review rapidly, with all written evidence to be submitted by the end of September. This phase will be followed by oral hearings in October and November. A first draft is to be produced in December and the final report is to be published by the end of March 2009. "The review will be published as an independent review and then it will be for the Conservative party to decide whether to adopt some or all of the policy recommendations," said Dr Hayes. Secretarial support for producing the report will be provided by the Conservative party. The review group has already been formed, with members from primary and secomdary care already confirmed. It has issued an invitation for written evidence from individuals and organisations involved in health and social care. . ."

13.71. Newcastle NHS trust quits the NPfIT ship (10 Sep 2008)

Computer Weekly

http://www.computerweekly.com/Articles/2008/09/10/232272/newcastle-nhs-trust-quits-the-npfit-ship.htm

"Patrick Kesteven, a consultant haematologist at Freeman Hospital, Newcastle, is open and clear-minded when talking about why his trust board decided to break away from the £12.7bn National Programme for IT in the NHS. "The National Programme was taking forever," he says. He is not even sure that the National Programme for IT (NPfIT) - the UK government's biggest IT investment - will ever work as originally intended. Far from being a renegade, Kesteven is ensconced in Newcastle's medical establishment. He chairs a programme board which is planning for a system of e-records to start going live at three hospitals in Newcastle in May next year. Executives at the Newcastle Upon

Tyne Hospitals NHS Foundation Trust, which employs 11,000 clinical and administrative staff, have given up waiting for e-record systems from the NPfIT. They want as soon as possible to give doctors and nurses systems which, with a single log-on, provide an overview of patients' treatments and histories, who is supervising them, where they are in the hospital and whether, for example, they have just had an adverse reaction to a general anaesthetic. The trust also wants better information to ensure it is paid for all it does. When patients are given extra treatment unrelated to their initial problem, the work can go unrecorded on existing payment-related systems. The NPfIT was specified to provide the solutions, but the government promised it would be in place by 2006. When ministers announced the NPfIT in 2002, they promised that patients would have a national electronic health record by the end of 2005. That has not happened, nor is it expected to happen for years. The National Audit Office says it will be 2015 before a national e-records scheme will be rolled out across England, and believes even that date may be optimistic. So the Newcastle board has decided to buy its systems from the US University of Pittsburgh Medical Center, which has introduced an integrated e-records system at its 20 hospitals. The purchase cuts out CSC, the national programme's local service provider to NHS organisations north of Oxford. It also sidelines NHS Connecting for Health, the 1,100-strong bureaucracy in the Department of Health which is running parts of the NPfIT. Newcastle and Pittsburgh Medical Center have formed a joint venture whose directors hope to sell licences and implement systems to NHS organisations. Other foundation trusts have been inquiring about Newcastle's approach to major IT investment, says a report to the trust's board. Foundation trusts have the freedom to buy outside the NPfIT if they have good financial reasons for doing so. Non-foundation trusts must buy their main hospital system - the patient administration system - under the NPfIT, although there are exceptions. Monitor, the regulator of NHS foundation trusts, is aware of Newcastle's plans to buy outside the NPfIT. Newcastle's board has been told that Monitor "understood that the trust could not wait until 2012/13 for the national programme to provide the required systems". If many foundation trusts diverge from the NPfIT, the government's plan to supply England's NHS trusts through a small group of appointed IT companies - local service providers - will disintegrate further. Already, non-foundation trusts in the south of England are considering "interim" systems not supplied by the scheme's two remaining local service providers, BT and CSC the contract of the third provider, Fujitsu, was terminated. Tola Sargeant, an NPfIT expert at market analyst Ovum, says that the "lull" in the NPfIT, mainly in southern England, creates opportunities for suppliers other than CSC and BT. . . The Newcastle trust is the first organisation outside the US to invest in Pittsburgh Medical Center's Cerner-based e-records technology. Kesteven recognises that not all staff at Pittsburgh Medical Center are enamoured with all aspects of the system. "But would they go back to how things were before? They couldn't imagine it." There is also the challenge of making a US system work in the UK. Anglicisation will be the key, Newcastle has been told. If the Newcastle implementation goes badly - as did a basic version of the Cerner system when it was deployed at some NHS trusts in London in the south of London - health officials in Whitehall may say it serves the trust right for not waiting for the free (because centrally funded) NPfIT systems. But Newcastle's executives see the risks as worth running. They have learned the main lesson from the troubled installations of the NPfIT Care Records Service in London and the south of England: that the customer must be in control of the supplier, the contract, the software's functionality and the changes in the day-to-day working practices of doctors and nurses. . . Even with their own IT contracts in place, Newcastle's directors know it will be difficult trying to combine information on its patients, given that data is held in up to 100 legacy systems across its various sites. Andre Snoxall, e-record programme director at the Newcastle trust and a former CIO at trusts in New Zealand, says that even with the most favourable conditions and contracts it is still an enormous task to bring about a comprehensive view of a patient with a single log-on. "It takes an extraordinary amount of effort to try and get a full picture of a patient's history," he says. He adds that the biggest challenge for the trust is not so much technology as inspiring people, engaging them and "getting them working towards a common goal". And if achieving a single patient view at one large trust alone is hard enough, the government aims to do it for all hospitals across England. Standardised systems, no contractual relationship between most trusts and their suppliers, little customer control over changes to the software, and delays of at least four years so far are just some of the obvious problems. Kesteven will gain some sympathy from some NHS IT executives for his view that the NPfIT may never happen. That should be a prompt to the government to rethink the programme or conduct a high-level review, which it has so far repeatedly refused to do. . ."

13.72. E-records without a central database? (11 Sep 2008)

Tony Collins' IT Projects blog

http://www.computerweekly.com/blogs/tony_collins/2008/09/erecords-without-a-central-dat.html

"The Newcastle Upon Tyne Hospitals NHS Foundation Trust is considering an interesting product, dbMotion, which allows doctors and nurses to see a patient's medical history even when parts of it are in many different legacy systems, without establishing a central database. The product is among the healthcare IT systems sold by the University of Pittsburgh Medical Center, with whom Newcastle Upon Tyne Hospitals NHS Foundation Trust has a joint venture, outside of the NHS's National Programme for IT [NPfIT]. Clalit Health Services, the largest health maintenance organization in Israel, which has 32,000 employees, uses dbMotion at its 14 hospitals. It says the principles are:
- No central database. "All the information stays where, and in the same format, it was created" so there is "no need to replace any of the legacy systems":
- No single point of failure
- Rigid security and privacy
- Performance - average. response times, end to end of eight seconds or less.
- Use for viewing only - saving data not allowed
Clalit says of dbMotion that it "securely shares medical information, creating a virtual patient record by connecting a group of care providers and organisations without requiring data centralisation". Professor Brian Randell of the School of Computing Science at Newcastle University briefly summarised the way products such as dbMotion work in his paper "A Computer Scientist's Reactions to NPfIT". Randell is one of 23 computer scientists who wrote an open letter to the House of Commons' Health Committee calling for an independent review of the NPfIT. He said in his paper:". . . the concept of an EPR [electronic patient record] should be abandoned in favour of that of using an 'information broker' to enable the accessing of information that is gathered as appropriate for each particular purpose from multiple specialised record repositories. Such a broker can be regarded as implementing what are in effect 'virtual EPRs'. In fact, Connecting for Health already endorse one software system - Miquest - that works this way, extracting data from different types of general medical practice computer systems, and this is the approach taken very successfully in Israel by Clalit Health services."

13.73. Lib Dems urge immediate halt to NPfIT (17 Sep 2008)

Kablenet.com

http://news.zdnet.co.uk/itmanagement/0,1000000308,39489336,00.htm

The Liberal Democrat shadow health secretary Norman Lamb has called for an immediate end to further spending on the NHS National Programme for IT. He also pledged an independent inquiry into the £12.4bn project to computerise the health service, which he said had been "a shambles from the start". "We believe the gains possible from the use of IT would more likely be realised if the programme were decentralised and control given to local organisations who could instead work on improving connectivity between health and social care," Lamb said in a statement to GC News. His comments followed a speech yesterday at the Liberal Democrats' annual conference in Bournemouth, in which he said the party would create local health boards with a legal duty to deliver value for money in securing health care. Central imposition of private-sector providers would be rejected. "And it's goodbye to the National IT programme, which has and will waste billions of pounds," Lamb told the conference. "Besides — who would trust this government with a national database of our medical records?" In keynote speeches, party leader Nick Clegg and his treasury spokesperson, Vince Cable, both attacked the government's record on IT programmes. Both promised to an end to the National Identity Scheme; Clegg claimed a "computerised bureaucracy" had replaced face-to-face contract; and Cable said the party would also stop "the gravy train of management consultancy in government".

13.74. Computational Technology for Effective Health Care: Immediate Steps and Strategic Directions (9 Jan 2009)

Committee on Engaging the Computer Science Research Community in Health Care Informatics, National Research Council

http://www.nlm.nih.gov/pubs/reports/comptech_prepub.pdf

". . . The National Library of Medicine launched this study to support the engagement of individuals from the computer science research community in meeting two challenges posed by health care information technology: identifying how today"s computer science-based methodologies and approaches might be applied more effectively to health care, and explicating how the limitations in these methodologies and approaches might be overcome through additional research and development. The study described in this report was conducted by an interdisciplinary committee of experts in biomedical informatics, computer science and information technology (including databases, security,

networking, human-computer interaction, and large-scale system deployments), and health care providers (e.g., physicians who have worked with information

technologies). . ."

13.75. The Data Model That Nearly Killed Me (17 Mar 2009)

Syleum: Analysis From the Bottom-Up

http://www.syleum.com/2009/03/17/healthcare-data-model/

". . . During the last week of January 2009 a faulty electronic, networked, health information data model nearly killed me despite its vaunted status as a component of two state-of-the-art, health information systems at two of the world's most advanced medical facilities. This will come as no surprise to healthcare IT experts because health information is inherently complex, medical science develops extraordinarily rapidly, patient interactions are intensely personal, and the number of data types and sheer volumes of healthcare data explode prodigiously with new tests, instruments, and treatments. . . Medical personnel at urgent care and the hospital who interacted with me all used a version of the same electronic health information system (the "system"). It became clear that everyone was fighting that system. Indeed, they wasted between 40% and 60% of their time making the system do something useful for them. The system kept everyone from fulfilling their duties - the health information system did not help medical professionals perform their duties. . . The national health information network envisioned by President Barak Obama is a pipedream. That is, unless and until information technology (IT) professionals learn how to build systems and data models that meet end-user requirements (read, useful to medical professionals). My recent experience with an urgent care clinic and a major tertiary care hospital convinced me that the United States will require a long time before there is a consistent data model capable of recording a patient's health information, let alone a data model capable of accurately and reliably transmitting that information from one healthcare institution to another. . .

13.76. Newcastle prepares for go-live (16 Jul 2009)

e-Health Insider

http://www.e-health-insider.com/news/5035/newcastle_prepares_for_go-live

Newcastle upon Tyne Hospitals NHS Foundation Trust is preparing to go-live with the electronic patient record system for which it partnered with the University of Pittsburgh Medical Centre last year. Trust director of programmes André Snoxall told E-Health Insider that despite some minor delays the trust is "cautiously optimistic" that it will go live with the Cerner system at the end of August. "The main issue has been the extent and complexity of migration of data, which has placed a stress on the dates," he said. "There have also been issues with compliance with NHS Connecting for Health, which has really stressed us and has been far more complex than anticipated." In April 2008, Newcastle announced that a UPMC implementation team would help it to install and adapt five electronic patient record applications at five city hospitals. The trust's decision to award an EPR contract outside the National Programme for IT in the NHS came after it rejected the solution offered by its then-local service provider Accenture. Instead, it placed an advert in the Official Journal of the European Union. After monitoring developments following the appointment of a new LSP, CSC, it decided to continue its move outside NPfIT and partner with UPMC. Snoxall said: "It's the first time CfH have tried to engage with an individual trust, because usually they deal with large organisations as part of NPfIT. So far, every facet of what we have done has been investigated by CfH, with a single person managing every point of the contract." The trust intends to go-live with the new Cerner Millennium PAS at the end of August. This will include admission, transfer and discharge summaries, booking and scheduling of theatres and Choose and Book. "This will all go live across the whole trust, 1,500 beds and 11,000 staff," Snoxall said. At the end of September, the trust hopes to go-live with investigations ordering and results review, which will initially be rolled out at the Freeman Hospital. Electronic prescribing will be rolled out in phases until October next year. Snoxall said: "The roll-out will again begin at the Freeman Hospital and move from one area at a time until October 2010. We will then look at further changes and when those have been made it will be rolled-out in more delicate areas, such as intensive care." He added the trust is trying to strike a balance between going live on a specific date and going live when the system is right. "We are trying to be sensible by not sticking to particular dates and are continuing to fix the problems with data as we come across them. We're just taking things one step at a time in order to manage risk effectively and be well informed as to when we are ready to go-live," he said. Training began last month to ensure that all administration and nursing staff are fully trained before the

PAS goes live. Clinicians will receive online training, which is being developed. The trust is also issuing a newsletter and running open invitation sessions every two weeks to keep staff updated on the programme's progress. These are "extremely well attended." Snoxall said that around 25 people from UPMC and Cerner and are onsite all day, every-day, working alongside a 25 strong programme team, which is also working "flat out." He said: "The integrator, UPMC, has contracted Cerner into providing the support for us so this is a very much a fully engaged partnership, which is really helping us to get across the line."

13.77. Independent Review of NHS and Social Care IT (Aug 2009)

http://www.guardian.co.uk/politics/2009/aug/10/tory-medical-records-plan

Commissioned by Stephen O'Brien MP, Chaired by Dr Glyn Hayes

From the Executive Summary:

Since its inception in 2002, the Government's National Programme for IT (NPfIT) has remained the largest civilian IT project in the world. Not only is it unrivalled in scale, the complexities of healthcare data and information mean that the use of IT poses an infinitely greater challenge in the NHS than in other sectors where information is more objective and absolute. Nevertheless, there is universal consensus that, if this challenge is met, the use of information systems in the NHS will bring about significant improvements to the delivery of patient care. Patients can also benefit from the enhanced communication channels that IT can forge between health and social care. The National Programme for IT should not, therefore, be abandoned, as some are suggesting it should be. Rather, it must be adapted and recast to better meet the needs of patients. The Review Group has reached a number of conclusions as to how the National Programme for IT or a successor programme can best address the challenges posed by the NHS and deliver long-term improvements to patient care.

13.78. Newcastle set to switch on Millennium (6 Nov 2009)

e-Health Insider

http://www.e-health-insider.com/news/5368/newcastle_set_to_switch_on_millennium

The Newcastle upon Tyne Hospitals NHS Foundation Trust is planning for a "low-key" go live of its new Cerner Millennium electronic patient record system tonight. The trust has declined to confirm that it is planning of going live this weekend, but E-Health Insider understands the trust aims to go live this Friday. Newcastle is planning one of the largest ever hospital IT implementations in the UK when it switches over to a new Cerner Millennium system, to be run across five hospital sites, and initially be used by up to 4,000 staff. Newcastle is understood to be installing a fuller version of the Cerner Millennium product than the simplified version of the system bought under the NHS IT programme. Plans for a go-live on August Bank Holiday go-live at Newcastle were put on hold, and a revised late October go-live was also pushed back. Sources close to the trust say it has taken time to work through a series of problems, but is now sufficiently confident to attempt a go live. In testing, problems are thought to have been identified around reporting on 18-week waits, similar to those previously experienced at trusts including Barts and the London. Sources also indicate that up until last week staff involved had only received verbal instructions to prepare for this weekend's go-live date "due to concerns about any problems and slippage". One NHS source close to the project told EHI the project was going "exceptionally well". Once switched on the Cerner Millennium system will be used for order communications, initially for inpatients with outpatients to follow. Another EHI reader claimed the trust is suffering from "the same problems that have been experienced by other sites exposing the fact that the McKesson legacy system has more functionality suited to the way the NHS works". In August the trust decided to take more time to make sure the switch to the new system did not disrupt business processes. . . The care records system is being installed outside the NHS National Programme for IT in the NHS, under an April 2008 deal with University of Pittsburgh Medical Centre (UPMC). The delays are understood to be causing growing anxiety among UPMC staff, who are keen to move on to their next project at Royal Berkshire, which has also contracted to take Cerner outside NPfIT, in deal involving UPMC and Newcastle. UPMC is thought to have about 25 staff on site working on the Newcastle implementation project, these are currently "free" to the trust and not covered by a subsequent support and maintenance agreement. The trust plans to go-live with the new Cerner Millennium PAS. This will include admission, discharge and transfer summaries, booking and scheduling of theatres and Choose and Book. Eventually the implementation is planned to cover the whole trust, 1,500 beds and 11,000 staff. At the time of going to press, the trust had yet to respond to questions about its planned go-live date.

13.79. Tensions and Paradoxes in Electronic Patient Record Research: A Systematic Literature Review Using the Meta-narrative Method

Milbank Quarterly 87,4 (2009)

Trisha Greenhalgh et al

http://www.milbank.org/quarterly/8704feat.html

Conclusions: The findings suggest that EPR use will always require human input to recontextualize knowledge; that even though secondary work (audit, research, billing) may be made more efficient by the EPR, primary clinical work may be made less efficient; that paper may offer a unique degree of ecological flexibility; and that smaller EPR systems may sometimes be more efficient and effective than larger ones. We suggest an agenda for further research.

13.80. Fixing NHS IT: How to save £1Bn and get IT working for patients (22 March 2010)

2020health.org

http://www.2020health.org/health-topics/technology/index.html

An incoming Government could save at least £1 billion by realigning the troubled NHS computer programme and boosting its performance, according to a detailed new study from a leading health think-tank. 2020health.org have compiled an unprecedented dossier gleaned from extensive interviews with key participants of what has worked, what should be stopped and what next. . . This study, conducted by 2020health.org and written by NHS IT expert John Cruickshank, warns of a risk of "hiatus" for NHS IT after the election expected in May. It is based on confidential interviews with NHS officials and the private contractors tasked with upgrading NHS IT.

Key recommendations:

* Future national IT approaches should only be done in limited circumstances. Trusts should be free to set their own direction to meet local clinical priorities, provided nationally agreed standards are met.

* A course of national action and investment is needed in areas where IT is currently under-exploited in the NHS, notably telemedicine and collaborative technology, which are a focus in other countries such as in Scandinavia

* Those elements of NPfIT which are a valuable platform for the future should be developed. These include N3 (the NHS broadband network), PACS (the capture and communication of radiological and other images) and the Electronic Prescription Service.

* Action should be concentrated on addressing the care records service in acute hospitals where the failings are greatest. A series of tests are proposed and a plan of action should the model fail those tests.

* The roll-out of the controversial Summary Care Records project (part of the NHS Spine) should be halted and subjected to review.

* A radical reorientation and downsizing of the central IT organisation is needed for it to become more transparent and accountable to the NHS, in combination with a consolidation and strengthening of IT provision at the local level.

Full report at http://www.2020health.org/export/sites/2020/pdf/Fixing_NHS_IT_-_A_Plan_of_Action_for_a_New_Government_-_March_2010_-_Full_version_-_EMBARGOED_UNTIL_noon_220310.pdf

13.81. 2,500 Newcastle staff using Millennium (14 May 2010)

eHealth Insider

http://www.e-health-insider.com/news/5905/2500_newcastle_staff_using_millennium

Newcastle Upon Tyne Hospitals NHS Foundation Trust has completed the roll-out of the Cerner Millennium medicines management system across the Freeman Hospital. The trust went outside the National Programme for IT in the NHS to contract for a University of Pittsburgh Medical Centre implementation of Millennium. It went live with the first elements of the system six months ago and

has since been extending it across its three main hospitals. There are now more than 2,500 staff accessing the system at an average of four times a day, and Cerner and UPMC are no longer on-site. The trust started the medicines management roll-out at the beginning of December in a 30 bed nephrology inpatient ward, and has now deployed the system across 27 wards at a rate of 2-3 wards per week. On a visit to the trust earlier this week, Steve Leggetter, e-records programme director, told E-Health Insider: "We've been going live with three wards a week, looking at the medicines charts patient by patient and then working with the project leaders and pharmacists ward by ward." The is still using its McKesson PAS in 'enquiry only' format for a number of staff. It is also continuing to use some paper process alongside electronic medicines management until two remaining speciality areas, ICU and paediatrics, have gone live with the system. This is likely to happen over the summer. The trust has also completed the roll-out of order communications at the Freeman and started implementing the system across the Newcastle General Hospital earlier this week. It will go live with order communications and medicines management at the Royal Victoria Infirmary over the summer and will implement functionality to allow electronic signatures on results. "There is a six week point from where we make the decision to roll out and go-live to actually doing it in terms if readiness and getting training sorted," Leggetter said.

14. Other Websites

(Relevant websites and other online resources.)

14.1. e-Health Insider Document Library

http://www.e-health-insider.com/Document_Library.cfm

A *very* useful resource for accessing documents by and about NPfIT

14.2. Health Informatics community web-site

http://www.informatics.nhs.uk/ - a large document repository

14.3. UK's National Health Informatics Collection

http://www.bcs.org/server.php?show=ConWebDoc.7605?

Consisting of over 1,000 global titles and conference papers

14.4. Connecting Patients, Providers and Educators

http://stream.ncl.ac.uk/ramgen/Content/halamka.rm

Streamed video of lecture by John D. Halamka, of Harvard Medical School (2005).

14.5. NHS: The Real Story

http://www.computing.co.uk/computing/specials/2071854/nhs-real-story

A page providing links to Computing Magazine's coverage of NPfIT from April 2002 to April 2005

14.6. NHS IT

http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/06_06_06_nhs_it.pdf

Transcript of BBC File-on-Four radio documentary, 30 May 2006

14.7. NHS Confidentiality

http://www.nhsconfidentiality.org/

A campaigning web-site: " Protect your privacy and campaign against the government's NHS Care Records"

14.8. Patient safety

http://www.patient-safety.org.uk/home.htm

Website of the All-Party Parliamentary Group (APPG) on Patient Safety.

14.9. Bad Health Informatics Can Kill

http://iig.umit.at/efmi/badinformatics.htm

-"ICT can have positive impact on health care, but there are also examples on negative impact of ICT on efficiency and even outcome quality of patient care. Medical informaticians should feel responsble for the effects of ICT on patients and public. Systematic analysis of ICT errors and failures is the precondition to be able to learn from negative examples and to design better health information systems. This document contains summaries of a number of reported incidents in healthcare where ICT was the cause or a significant factor. For each incident or problem at least one link to a source will be provided. With the following list, we want to rise awareness on this important issue, and provide information for further reading" [Working Group for Assessment of Health Information Systems of the European Federation for Medical Informatics (EFMI)]

14.10. Yasnoff on e-Health

http://williamyasnoff.com/

An informative blog by William Yasnoff on issues to do with (mainly American) Health Information Systems.

14.11. The Big Opt Out

http://www.nhsconfidentiality.org/

" Protect your privacy and campaign to preserve medical confidentiality"

14.12. openEHR

http://www.openehr.org/

" openEHR is an international not-for-profit Foundation, working towards: Making the interoperable, life-long electronic health record a reality; Improving health care in the information society . . . by developing open specifications, open-source software and knowledge resources; Engaging in clinical implementation projects; Participating in international standards development. . ."

14.13. Our work for the NHS

http://www.bigwheel.org.uk/NHS.htm

By the Big Wheel Theatre Company. (Big Wheel is a major provider of training programmes and conference interventions for the NHS and associated institutions. most recently one on "Connecting for Health: Ethical issues relating to children".)

14.14. Tony Collins' IT Projects Blog

http://www.computerweekly.com/blogs/tony_collins/

By Tony Collins, Computer Weekly: "Against the Current: Exploring challenges involved in IT-based projects"

14.15. Down at the EPR Arms

http://eprarms.com/eprarms20012.html

Sean Brennan's monthly column on Electronic Patient Records from the British Journal of Healthcare Computing & Information Management.

14.16. CareGrid: Trust Domains for Healthcare

http://caregrid.org/

"A collaborative project between research groups at Imperial College London and The University of Cambridge. The aim of the project is to develop middleware for supporting decisions based on trust, privacy, security and context models in a healthcare application domain."

14.17. E-Health Forum

http://www.ama.com.au/web.nsf/doc/WEEN-6L76QJ

Australian Medical Association, Canberra, December 2005. ("The aim of the Forum was to raise the level of debate on E-Health beyond specific projects, pilots, activities or specific standards to one that focused on connectivity as the foundation for progress on E-Health, how the agreed "vision" might or should be financed and health sector and industry partnerships as the wave of the future to make the connected clinician a reality.")

14.18. EUROREC Institute

http://www.eurorec.org/index.cfm?actief=home

"An independent not-for-profit organisation, promoting in Europe the use of high quality Electronic Health Record systems (EHRs). One of its main missions is to support, as the European authorised certification body, EHRs certification development, testing and assessment by defining functional and other criteria."

14.19. Opting out of the NHS Database

http://www.neilb.demon.co.uk/

Website ofof Dr Neil Bhatia, GP and Caldicott Guardian for the Oaklands Practice

The End of NPFIT

15. The End of NPfIT

15.1. The future of the National Programme for IT (9 Sep 2010)

The Department of Health

http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_119293

A Department of Health review of the National Programme for IT has concluded that a centralised, national approach is no longer required, and that a more locally-led plural system of procurement should operate, whilst continuing with national applications already procured. A new approach to implementation will take a modular approach, allowing NHS organisations to introduce smaller, more manageable change, in line with their business requirements and capacity. NHS services will be the customers of a more plural system of IT embodying the core assumption of 'connect all', rather than 'replace all' systems. This reflects the coalition government's commitment to ending top-down government and enabling localised decision-making. The review of the National Programme for IT has also concluded that retaining a national infrastructure will deliver best value for taxpayers. Applications such as Choose and Book, Electronic Prescription Service and PACS have been delivered and are now integrated with the running of current health services. Now there is a level of maturity in these applications they no longer need to be managed as projects but as IT services under the control of the NHS. Consequently, in line with the broader NHS reforms, the National Programme for IT will no longer be run as a centralised national programme and decision making and responsibility will be localised. Health Minister, Simon Burns, said: "Improving IT is essential to delivering a patient-centred NHS. But the nationally imposed system is neither necessary nor appropriate to deliver this. We will allow hospitals to use and develop the IT they already have and add to their environment either by integrating systems purchased through the existing national contracts or elsewhere. "This makes practical sense. It also makes financial sense. Moving IT systems closer to the frontline will release £700 million extra in savings. Every penny saved through productivity gains will be reinvested to improve patient care." Director General for Informatics, Christine Connelly, said: "It is clear that the National Programme for IT has delivered important changes for the NHS including an infrastructure which the NHS today depends on for providing safe and responsive health care. Now the NHS is changing, we need to change the way IT supports those changes, bringing decisions closer to the front line and ensuring that change is manageable and holds less risk for NHS organisations."

15.2. NPfIT future is modular and locally-led (9 Sep 2010)

eHealth Insider

http://www.e-health-insider.com/news/6228/npfit_future_is_modular_and_locally-led

The National Programme for IT in the NHS' centralised and national approach is "no longer required" and trusts will instead be able to operate "a more locally-led plural system of procurement", health minister Simon Burns has announced. In a ministerial statement this morning, Burns said that a Department of Health review of the national programme had concluded that a new, "modular" approach to implementation should also be adopted. The statement said that the two changes together would allow "NHS organisations to introduce smaller, more manageable change in line with their business requirements and capacity." "Improving IT is essential to delivering a patient-centred NHS. But the nationally imposed system is neither necessary nor appropriate to deliver this," Burns said the statement. "We will allow hospitals to use and develop the IT they already have and add to their environment, either by integrating systems purchased through the national contracts or elsewhere." A spokesperson for the DH's informatics department stressed to E-Health Insider that the programme was not being "scrapped", since elements of it will be retained and its contracts honoured, although the key implementation of detailed electronic care records will be taken forward in a new way. Burns' statement says that the national infrastructure elements of the programme and applications such as Choose and Book will be retained, although "they no longer need to be managed as projects but as IT services under the control of the NHS." New arrangements for the oversight of these services will be in place by 2012. These may involve them moving to the NHS Commissioning Board, which is given responsibility for IT and information standards in the white paper, 'Liberating the NHS.' The changes to the programme will help to make additional savings of £700m to the £600m announced in labour's pre budget report. A further £200m will be taken off CSC's local service provider contract for the North, Midlands and East of England, while the other £500 will come from "local savings." The statement argues the reconfiguration is in line with the current Operating Framework for the NHS in

England, which stressed a new approach of "connecting all" rather than "replacing all". It also says that it is in line with the broader NHS reforms set out in the white paper. The Department of Health's director general for informatics, Christine Connelly, said: "It is clear that the National Programme for IT has delivered important changes for the NHS including an infrastructure which the NHS today depends on for providing safe and responsive health care. "Now the NHS is changing, we need to change the way IT supports those changes, bringing decisions closer to the front line and ensuring that change is manageable and holds less risk for NHS organisations." The statement does not mention any changes to the Summary Care Record, but says that a separate review is underway which will report at the end of September.

15.3. NHS National Programme for IT - the last of the government mega-projects (9 Sep 2010)

Computer Weekly Editor's blog

http://www.computerweekly.com/blogs/editors-blog/2010/09/nhs-national-programme-for-it.html

And so it came to pass - the £12bn NHS National Programme for IT (NPfIT) is no more, replaced by a decentralised approach that aims to save £700m. The clock has been ticking loudly for NPfIT for some time, and while the formal death knell has finally been sounded today, its demise has been inevitable ever since the government white paper in July that announced the coalition's radical reorganisation of the health service. The Department of Health has managed to come up with a smart compromise that avoids the risk of legal action from the two main suppliers to the programme, BT and CSC. The existing central contracts with both firms remain in place, but NHS trusts will have the freedom to determine when, how - and most crucially, if - they avail themselves of the applications on offer. The most contentious element of NPfIT, the Summary Care Records system that would put a national electronic patient records application in place, may yet be cut further, with a review underway that will report back by the end of September. Officially, NPfIT is being "reconfigured" - but the announcement today by health minister Simon Burns gives free reign to local managers to pursue their own IT plans. In effect, that means BT and CSC will have to compete for every deal they win in every NHS trust, instead of being rolled out automatically in the regions they were responsible for. "Localised decision making and responsibility will create fresh ways of ensuring that clinicians and patients are involved in planning and delivering front line care and driving change," Burns said in a written ministerial statement to Parliament. And therein lies perhaps the main reason why the over-ambitious National Programme floundered - clinician's anger at the lack of involvement they had in what they perceived as centralised decisions that took little consideration of their needs. That fundamental flaw was the common theme through all the problems that ensued. Project reports from the early days of NPfIT revealed poor relations with suppliers and concerns from clinicians. One of the original suppliers, Accenture, pulled out of the programme because it saw costs ballooning and profit shrinking. A second, Fujitsu Services, was sacked. BT was forced to make a £1.2bn write-off because of its contract to deliver NPfIT and had to renegotiate with the Department of Health. But it wasn't only the suppliers who suffered financially. In November 2008, the Royal Free Hampstead NHS Trust in London reported a £7.2m deficit as a result of problems with the rollout. NHS IT managers will undoubtedly be pleased to have regained control over their own systems, but within a national framework that looks to take advantage of common systems that have been delivered by NPfIT such as Choose and Book, digital imaging and electronic prescriptions. At the time the programme was initiated, way back in 2003, the concept of regional providers with some national applications was pitched as a compromise between total centralisation and complete decentralisation. In truth, it was what the technology available at the time was best at delivering. Since then, the internet has connected everyone, and if you started NPfIT today, it would be blatantly obvious that you set common standards, and allowed everyone to do their own thing with a standardised, interconnected infrastructure. For government IT, perhaps that is the most important thing to learn from the demise and debacle of the NHS programme. Technology changes faster than any such large-scale project can deliver, and putting in place a huge, 10-year programme based upon trends and technical limitations at its inception is doomed to failure. The future of government IT is smaller, decentralised, faster to implement, standardised, interconnected systems. The lasting legacy of the NHS National Programme should be that it is the last of the overblown, over-ambitious mega IT projects.

16. Appendix 1 - The Open Letter of 10 April 2006

THE NATIONAL PROGRAMME FOR IT IN THE NHS

The Select Committee may be aware of the concerns of health professionals, technologists and professional organisations about the £6bn NHS National Programme for Information Technology (NPfIT):

- The NHS Confederation has said " The IT changes being proposed are individually technically feasible but they have not been integrated, so as to provide comprehensive solutions, anywhere else in the world" .

- Two of NPfIT's largest suppliers have issued warnings about profits in relation to their work and a third has been fined for inadequate performance.

- The British Computer Society has expressed concern that NPfIT may show a shortfall of billions of pounds.

- Various independent surveys show that support from healthcare staff is not assured.

- There have been delays in the delivery of core software for NPfIT.

Concrete, objective information about NPfIT's progress is not available to external observers. Reliable sources within NPfIT have raised concerns about the technology itself. The National Audit Office report about NPfIT is delayed until this summer, at earliest; the report is not expected to address major technical issues. As computer scientists, engineers and informaticians, we question the wisdom of continuing NPfIT without an independent assessment of its basic technical viability. We suggest an assessment should ask challenging questions and issue concrete recommendations where appropriate, e.g.:

- Does NPfIT have a comprehensive, robust:

  - Technical architecture?

  - Project plan?

  - Detailed design?

Have these documents been reviewed by experts of calibre appropriate to the scope of NPfIT?

- Are the architecture and components of NPfIT likely to:

  - Meet the current and future needs of stakeholders?

  - Support the need for continuous (i.e., 24/7) healthcare IT support and fully address patient safety and organisational continuity issues?

  - Conform to guidance from the Information Commissioner in respect to patient confidentiality and the Data Protection Act?

- Have realistic assessments been carried out about the:

  - Volumes of data and traffic that a fully functioning NPfIT will have to support across the 1000s of healthcare organisations in England?

  - Need for responsiveness, reliability, resilience and recovery under routine and full system load?

We propose that the Health Select Committee help resolve uncertainty about NPfIT by asking the Government to commission an independent technical assessment with all possible speed. The assessment would cost a tiny proportion of the proposed minimum £6bn spend on NPfIT and could save many times its cost.

SIGNED

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17. Appendix 2 - Initial Incorrect Version of the Agreed Statement, and Currently Available Text

17.1. Initial Incorrect Version of the Agreed Statement (21 Apr 2006)

(In the agreed statement we were careful to say that we expressed our support for the overall goals of the programme AS EXPRESSED IN the meeting. The text below was placed on the Connecting for Health web-site shortly after the meeting, but replaced by a corrected version once we had pointed out the small but significant error:)

> At the meeting on 20 April between the six representatives of the 23 signatories and NHS Connecting for Health a constructive and fruitful dialogue occurred.
>
> The representatives expressed their agreement with and support for the overall goals of the programme in the meeting. There was agreement that a constructive and pragmatic independent review of the programme could be valuable. The parties agreed to meet again to consider further details of how such a review might best be conducted and its terms of reference.

17.2. Current Replacement Text on the CfH Web-Site (12 Oct 2006)

(Below is the text - in place of the agreed text - provided on the CfH web-site as of 12 Oct 2006. It is not known when the original agreed statement, which made it clear that both sides accepted that a " constructive and pragmatic independent review of the programme could be valuable" , was replaced by this text.)

> **Academics supporting agency's overall goals**
>
> At the meeting on 20 April between the six representatives of the 23 signatories and NHS Connecting for Health a constructive and fruitful dialogue occurred.
>
> The representatives expressed their agreement with and support for the overall goals of the programme as expressed in the meeting.
>
> Ministers are considering whether or not such a review would help progress this large scale programme.
>
> The parties agreed to meet again to consider further details of how such a review might best be conducted and its terms of reference.

18. Appendix 3 - Memorandum for Health Select Committee (14 May 2004)

(Sent 14 May 2004)

The need for an Independent Review of NPfIT.

As experts in complex systems, we are concerned that the NHS National Program for IT (NPfIT) is starting to show many of the symptoms displayed by large IT and business change projects that have failed in the past. We have a wide range of IT backgrounds and experience, and have studied many failed projects, as well as many that succeeded. Our professional opinion is that a constructive, independent review is urgently needed, to ensure that the risks to NPfIT are fully recognised and that appropriate actions are taken.

Most IT project disasters stem from problems with requirements or specifications. Either the requirements keep changing, or they do not take sufficient account of the need for consultation to ensure that all the users of the system will be able to adopt the new work practices. Unexpected changes in requirements always emerge; but when a project's requirements keep on changing, the project will be delayed, costs will rise and the project may get out of control.

The attempt to contain costs and to keep to milestones often reduces flexibility, as suppliers interpret their contracts ever more strictly to avoid " unnecessary" work. When milestones slip, the slips typically get concealed by re-interpreting the specification or the milestones: people often prefer to postpone the day of judgment, hoping that it will be possible to catch up later, or that someone else will be forced to announce a slippage first.

Sometimes, real technical problems arise - such as a wrong data model or a network that is insufficiently reliable. It often turns out that the designers had simplistic fault assumptions: the dependability criteria turn out to be wrong, or missed, or both. Even when a working system is introduced, if the specification does not fit the real needs, the users may need so many work-arounds that the project's goals are undermined.

In the case of NPfIT, we have heard reports of changing specifications, delays, cost escalation, dependability problems, and significant technical issues.

The Department of Health has acknowledged that the published specifications (which date from 2002 and 2003) are now obsolete; as the NHS changes, and CfH has learned more about the real requirements of users, the specification has evolved significantly. It has become clear that the system will require the clinical professions to work differently; we have heard many clinicians criticise this, or complain of a lack of information about the system's current goals.

Costs now appear much higher than anticipated; with suppliers issuing profit warnings, they will be tempted to focus on the cheapest possible reading of the specification. There is sharp technical debate about whether the proposed data standards (and a number of other aspects of the system architecture) are fit for purpose. Finally, early implementations (such as in Oxford) have been reported as insufficiently usable and dependable. We cannot be certain how serious the underlying problems in the project might be, but our experience suggests that the symptoms could be the early signs of a failing project.

Since publishing our open letter to you, we have been contacted by many people: from clinicians to health service managers to experts in computer companies. We also have met with the top NPfIT management team. The information we have gathered since our letter has reinforced and sharpened our concerns.

There are two possible ways of viewing NPfIT. The optimistic view is that the specification is now stabilising into something that can be built, and that will deliver benefits to the NHS. The pessimistic view is that things are running out of control.

We hope that the optimistic analysis is correct, in which case an independent review can help by improving communications and building stakeholder confidence. We fear that the pessimistic analysis may be correct, in which case an independent and constructive technical review can provide evidence and recommendations to help the project to recover.

Richard Granger and the NPfIT management team agree with us that a review at this time would be useful. We have also received many private communications that reinforce our belief that an

independent review is essential. We attach outline proposed terms of reference to indicate the nature of the review that we recommend. We also attach a short annotated bibliography to illustrate some of the published concerns about the NPfIT.

19. Appendix 4 - Letter to Lord Warner (12 Nov 2006)

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Lord Warner of Brockley
Minister of State for Reform
Department of Health
Richmond House
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London SW1A 2NS

12 November 2006

Dear Lord Warner

I am writing to you on behalf of the group of 23 professors of computing and systems, who have been expressing their urgent concerns about the National Programme for IT in the NHS (NPfIT).

Last April, we wrote to the Health Committee to say that we believed that the NPfIT was showing many of the symptoms that we had seen in major IT systems that had subsequently been cancelled, or overrun massively, or failed to deliver an acceptable service to their intended users. We asked the Health Committee to call for an independent review of the Programme and to publish the results. A group of us met Dr Granger and his team in April and explained our concerns; at that meeting Dr Granger agreed that a constructive independent review such as we were proposing could be helpful, but that it would require your approval. We understand that during your speech to the Health Service Journal Conference in London last Thursday, you said *"I do not support the call by 23 academics to the House of Commons Health Select Committee to commission a review of NPfITs technical architecture. I want the programme's management and suppliers to concentrate on implementation, and not be diverted by attending to another review."*

Since we first voiced our concerns we have been contacted by many inside the NPfIT programme, at all levels, giving us details of specific problems and strengthening our concerns about the programme. This also makes us confident that a review could quickly identify some of the underlying technical and managerial problems and help to provide solutions. Some of us have experience of technical reviews of major computing projects and we know that such reviews, when carried out professionally, more than repay the time taken up. When a programme is experiencing delays there is a natural tendency to focus more on the details, to increase the pressure on staff and suppliers to meet their deadlines, and to resist any outside assistance as diversionary. Such a reaction, though understandable, is almost always a further symptom of trouble ahead rather than good management. Please will you allow us a meeting at which we can explain our concerns to you, before you finally reject our call for a constructive review?

We are amongst the strongest supporters of the basic aims of NPfIT and as professionals in the field of informatics have long espoused the importance of ICT in furthering the aims of the NHS.

For the avoidance of any possible misunderstanding, I would like to make it clear that my colleagues and I are not seeking to review NPfIT ourselves. We are entirely independent of the programme and we are acting out of strong professional concern and, we believe, in the public interest.

Yours sincerely

Frank Land
Emeritus Professor in the Information Systems Group, Department of Management
London School of Economics

also on behalf of the following:

Ross Anderson
Professor of Security Engineering
Cambridge University

Ray Ison
Professor of Systems
Open University

James Backhouse
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David Bustard
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20. Appendix 5 - Letter to Mr David Nicholson (29 Nov 2006)

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David Nicholson CBE
Chief Executive of the NHS
Department of Health
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29 November 2006

Dear Mr Nicholson

We are writing to you on behalf of the group of 23 senior academics in computing and systems who have over recent months been expressing their urgent concerns about the National Programme for IT in the NHS (NPfIT).

In April we wrote to the Select Committee on Health to say that we believed that NPfIT was showing many of the symptoms we had seen in major IT systems that had been cancelled, had overrun massively, had failed to deliver an acceptable service to intended users or had failed to reach business benefit targets for their organisations. We asked the Committee to call for an independent review of NPfIT and to publish the results. A group of us met Dr Granger and his team in April and explained our concerns. Dr Granger agreed that a constructive independent review such as we proposed could be helpful.

Since we first voiced our concerns, subsequent problems, including those with suppliers, have increased our anxieties. People working within NPfIT, at many levels, have contacted us giving details of specific problems. It also seems clear that NPfIT has failed to gain the confidence and support of large numbers of the NHS community. We are confident, however, that an independent review would identify the main underlying technical and managerial problems, help provide solutions and bolster confidence. Our experience of technical reviews of major computing projects is that, when carried out professionally and dispassionately, they more than repay the time and cost involved.

We are delighted now to learn that the Select Committee has decided to hold an inquiry. It may be some time, however, before its results are published. We are also heartened, therefore, to hear via the press that you have commissioned a confidential internal review. We would be pleased to present evidence, written and/or oral, for submission to the review if you would find it useful, given that your review is likely to be completed in advance of the Committee's inquiry.

For the avoidance of any misunderstanding, we would like to make it clear that our group is not seeking to review NPfIT ourselves. We are entirely independent of NPfIT. We are acting out of strong professional concern and, we believe, in the public interest.

Yours sincerely

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Also on behalf of:

21. Appendix 6 - Article by Robin Guenier (25 Jul 2002)

Article published in Computer Weekly on 25 July 2002

There's no more pressing priority for the Government than improving the NHS. If possible, dramatically — and comfortably before the next election. It has less than three years. The money is available; although increased pay may absorb more than had been expected. How best to spend what is left? Surely to improve the lot of the patient?

Apparently not. The Government has chosen a course that is likely to make it worse: sweeping and massively expensive changes to NHS computing systems. We are told it is " the IT challenge of the decade" and " a Herculean task" .

Why don't people learn? Why are big IT projects seen as a badge of virility — a sign that we really mean business? They nearly always cause trouble: the bigger the change the bigger the trouble, especially in the public sector. Difficulties with this Government's earlier IT plans for the NHS (this is the third) demonstrate that the risk is especially great for such a uniquely complex organisation — employing 1.3 million people with over 50 million potential patients. Ambitious IT changes rarely deliver what is promised and commonly cause serious inconvenience for those they are intended to benefit: in this case, the patients. Surely anyone who wishes the NHS well would be striving to introduce the minimum necessary IT change, the smallest possible challenge?

This is not a Luddite rant. Computing systems are an essential part of healthcare delivery. There is undoubtedly a case for extension, innovation and improvement and extra funding is plainly needed. But, particularly for the NHS, plans for change, however desirable, must be balanced against risk — and, where there is serious uncertainty, doing the minimum necessary must be the best course.

In contrast, the recently published Department of Health plan, Delivering 21st Century IT Support for the NHS, sets out a massive programme involving massive risk. Yet the case for that programme is not, to use current medical jargon, evidence-based.

It starts with a " vision" . Vision, with integration and centralisation, is one of the most dangerous words in computing. Central control and " ruthless standardisation" will bring about a wonderful new world where health professionals and managers will have instant and simple access to a wealth of information (case histories, test results, research data, resource services, etc.) designed to support the patient " quickly, conveniently and seamlessly."

This dream requires a major new NHS-wide IT infrastructure, a new procurement strategy and centrally defined data and system standards, focusing initially on national health records, booking systems and prescriptions. It sounds splendid. But such plans always do, particularly when technically naive senior civil servants, in alliance with enthusiastic industry representatives, are painting an idealised picture for ministers. That's before the dull practicality of the real world intervenes. Four examples:

1. Ruthless standardisation means that perfectly good but non-standard local systems — often introduced after much trial and agony — that are at last working and serving staff and patients, will have to go. There are many such systems. Is dismantling them really a good idea? Is it desirable to pile new problems and " challenges" on health professionals and management — let alone the patient?

2. IT is constantly changing: it's salutary to recall that Bill Gates recognised the importance of the Internet only about seven years ago. A standardised system defined today with, as is proposed, a " limited portfolio" of " compliant" equipment could be wholly obsolete in just a few years. Yet the plan's full implementation will take eight years. In other words, the NHS could be setting out on a course of pain and disruption for a period going way beyond the foreseeable future, only to be left with a hugely expensive museum piece.

3. The NHS' IT skills are inadequate. Delivering 21st Century IT Support recognises this and, after considering various options for implementing the plan, opts for one that involves outsourcing many of its major components. But is it acceptable to put effective responsibility for much of our healthcare delivery into the hands of big computing and telecommunications businesses? What happens when, as seems likely, this proposal runs into opposition?

4. Electronic Patient Records (EPRs) are a critical component of the programme. The concept involves huge problems: health information is far more complex in nature and detail than, for example, financial information. The Government has already experienced difficulties: although 35% of NHS Trusts were supposed to have implemented EPRs this year, so far only a handful have done so and the target of 100% by 2005 looks increasingly difficult. And concerns about data privacy and human rights are a growing worry, particularly sensitive regarding such a personal matter as health. Recent ID card worries suggest that a centralised system for health records would exacerbate these concerns.

So an exciting vision risks damage and disruption for an already vulnerable healthcare service. The Government even recognises this: Delivering 21st Century IT Support notes that " significant risk will be involved" . And a senior Department of Health official recently described it all as " incredibly ambitious … we're betting the farm on this" . Why? Where is the evidence that such risk is justified?

What is envisioned would clearly be desirable. But, to justify a huge gamble with the nation's healthcare, the potential outcome must be more than desirable — there must be plain evidence of major and achievable benefit. No other test will do. Delivering 21st Century IT Support provides no such evidence. Perhaps that was not its function: it is a plan for action. For the strategy we must go elsewhere.

The Wanless report, commissioned by the Treasury to examine healthcare funding, gave prominence to the need for much greater investment in IT. Delivering 21st Century IT Support is the response to that. Key Wanless recommendations are that IT spending should be doubled (and protected to ensure it was not diverted elsewhere), that national standards for data and IT should be set centrally " and vigorously applied" and that investment should be aimed at " better integrated and more flexible" IT.

So far as funding is concerned, the principal justification is that spending per employee is lower than in other sectors of the economy and is less than is spent in overseas healthcare services. Doubtless true — but not of itself an argument for spending more. Clear evidence demonstrating the likelihood of major benefits coming from greater funding and supporting the centralise and integrate theory is needed. There is no such evidence.

Instead there is assertion: " The benefits of ICT [i.e. IT] will not come through significantly until the necessary infrastructure is built…" That is despite a statement towards the end of the Report that " decisions to invest in ICT need to be accompanied by firm evidence of the costs and benefits." Exactly.

Unfortunately, although it notes the " clear risk given the scale of such an undertaking" , the Wanless Report fails to provide that firm evidence. The closest it gets is its comment that evidence (coming from Kaiser Permanente, a Californian healthcare provider and currently controversial Government favourite) " suggests that significant benefits are achievable…"

In the light of the potentially damaging outcome of what is now planned, a mere suggestion is quite inadequate, confirming my fear that the Government is gambling with the future of the nation's healthcare. That would be unwise in any circumstances. To do so when the chances of success are low is irresponsible. To do so when the costs of even a successful outcome are high and its value uncertain must be foolish. We seem to be embarking on a course that is both irresponsible and foolish.

Wanless may be right about the inadequacy of NHS investment in IT. Probably greater expenditure is needed. If so, where would it be most beneficial in a reasonable timescale? My experience is that it is usually best to start from the bottom and work up — the antithesis of what is proposed. Identify the best local examples of effective IT-enabled healthcare delivery in the NHS (not in California) and build carefully on those. I'm no expert on NHS IT but there are many who are, including some clinicians — they should be heard. There may be some who believe that additional IT expenditure is not the best way of delivering a better service to the patient. They also should be heard. In other words, we need a debate.

Some months ago, the Chancellor spoke of his wish for a great debate about the future of healthcare in Britain. It hasn't happened yet. But, as the programme defined in Delivering 21st Century IT Support does not get fully started until April 2003, there is time for a widely based and informed debate about whether these proposals are a risk too far and, if so, what is the better course. Not consultation, debate. I believe it would be widely welcomed by NHS staff, healthcare professionals and the public.

July 2002

NOTE: Guenier is Chairman of iX Group plc a business that uses the Internet to provide services to the medical professional and pharmaceutical industry. In 1996, he was Chief Executive of the Central Computing and Telecommunications Agency, reporting to the Cabinet Office, and was subsequently appointed by the DTI as Executive Director of Taskforce 2000.

22. Appendix 7 - Plundering The Public Sector (2006)

How New Labour are letting consultants run off with £70 billion of our money

David Craig

with Richard Brooks of Private Eye

ISBN-13: 978-1-84529-374-1

[Extracts provided here with the author's and publisher's permission.]

CHAPTER 10

Welcome to Connecting for Health

We've seen some impressively big projects, each costing many hundreds of millions of pounds, each wasting hundreds of millions more and most failing to deliver anything like the levels of service that were originally promised. But nothing can compare with the NHS IT systems programme that has been going on since October 2002. Previously called the *National Programme for Information Technology* (NPfIT) this has been renamed *Connecting for Health* (CfH).

A successful CfH would have an immensely beneficial effect on healthcare in Britain. It would provide comprehensive, up-to-date and immediately accessible medical information on all patients, thus dramatically improving doctors' ability to diagnose and treat them. It would contribute to drastically reducing the annual 980,000 'patient safety incidents' and 2,000 deaths from medical and prescription errors. It would free up time for clinicians to spend looking after patients instead of looking for medical records. It would greatly reduce bean counting, administration and paperwork by hundreds of millions of pounds per year, which could then be channelled into patient care. And it would automatically provide a wealth of healthcare information to target and measure the progress of performance improvement initiatives and to assist future healthcare planning. Conversely, in terms of cost, scope, potential for wasting money and potential for having a catastrophic effect on the NHS, which is probably our most critical public service, CfH far surpasses any previous New Labour scheme for modernizing the delivery of public services. It is almost a hundred times larger than most other New Labour projects. So if it goes wrong, with the all too depressingly familiar sight of budgets and timescales spiralling hopelessly out of control, our government will have caused the largest haemorrhage of taxpayers' money from essential front-line services into the pockets of management and IT systems consultants in British history.

Connecting for Health: a Brief Guide

Between 1998 and 2002, a series of studies and reports identified the need for the NHS to drastically improve its use of IT systems. Perhaps the most significant was the April 2002 Wanless Report. It compared the inadequate use of IT in the NHS with the 'improvements in performance and efficiencies gained from new technology seen in other spheres of industry and in other health services'. It recommended 'an increase in IT investment; stringent centrally managed standards for data and IT; and better management of IT implementation in the NHS, including a national programme'. This led to a document called *Delivering the NHS Plan* which 'developed a vision of a service designed around the patient offering more choice of where and when to access treatment'. In June 2002 *Delivering 21st Century IT Support for the NHS - a National Strategic Programme* set out 'the first steps including the creation of a Ministerial Taskforce and recruitment of a director general for the National Programme for IT'. In October 2002 the *National Programme for Information Technology* (NPfIT) was formally established with (ex-Deloitte consultant) Richard Granger's appointment as the director-general of NHS IT. Its task was 'to procure, develop and implement modern, integrated IT infrastructure and systems for all NHS organizations in England by 2010'. In June 2004 another document, The *NHS Improvement Plan: Putting People at the Heart of Public Services*, detailed 'the priorities for the NHS, including the purpose of NPfIT'. A month later the NHS Information Authority was merged into the NPfIT creating one body for managing IT within the NHS. In April 2005 CfH was established. In addition to supporting existing NHS IT systems, CfH has six main 'products' that it plans to deliver. These are:

- NHS Care Records Service (CRS) - building a central database with electronic patient records. This will lead to one unified electronic medical record for each patient to replace today's inefficient mix of paper and electronic records often duplicating each other and often held in different places.
- Choose and Book (C&B) - an electronic booking system allowing GPs to offer each patient they refer to a hospital a choice of four to five hospitals and enabling them to make the booking immediately on-line. This is intended to replace the current process where patients often get a limited or no choice of hospital, where appointments are made by phone or letter and where the patient seldom gets much choice of a date and time that suits them.
- Electronic Transmission of Prescriptions (ETP) - allows prescriptions to be sent electronically from the prescriber to the dispenser and then to the Prescription Pricing Authority. This will reduce the reliance on paperwork for the over 325 million prescriptions issued each year.
- New National Network (N3) - this will provide IT infrastructure, network services and broadband connectivity to support the systems being implemented as part of CfH.
- Picture Archiving and Communications Systems (PACS) - this system will allow the replacement of film-based radiographic images by electronic images. Digital images will then become part of each patient's electronic medical record and there will no longer be any need to print on film and to file and distribute images manually.
- General Medical Services Contract, Quality and Outcomes Framework (QOF) - a data collection and management system allowing payment of GPs, analysis of information, targeting of improvement initiatives and measurement of hospital and GP performance.

What Will it Cost Us?

When looking at where the money for CfH will come from, for the sake of simplicity CfH can be divided into two main parts - the smaller of these by far is what the government pays from central funds in order to build up the basic infrastructure and systems. The larger part is what health authorities will have to provide to get the new systems up and working in their areas. The money from health authorities is money that is being taken from their local budgets, thus leaving less for patient care.

The government has already awarded around £6.5bn of contracts to a very small, select group of about seven consultancies - many of whom have placed their people in influential position within government or have been generous contributors to the New Labour cause. This £6.5bn is often quoted in the press as being a lot of money to spend on IT systems. However, it is fairly modest compared to the other associated costs of the programme. So far, we only have a number of estimates for the total cost - the government has never categorically stated precisely how much we will pay for the whole adventure. Most estimates suggest that individual health authorities will have to pay between four and five times the cost of the basic £6.5bn infrastructure - so around another £25bn to £30bn of money that could be used for front-line patient care - to upgrade and adapt their systems for CfH to function.[1] Management consultants are expecting about £10bn to come their way for 'change management projects to ensure the successful implementation of NPfIT'.[2] In addition, in 2003 the head of the NHS predicted huge training costs: 'there are recent articles indicating that other healthcare systems are investing six times the amount in training that they are in the IT systems themselves, and it will have to be in that sort of order if you take the true costs into account.'[3] By the beginning of 2006, the figure of £50bn was being mentioned as the likely total cost of the programme.[4]

The total annual budget of the NHS is around £70bn. So whatever the final cost of CfH, it means that over the next few years a huge amount of money is being taken out of, and will continue to be taken out of, patient care to fund the CfH programme. Assuming about one million employees in the NHS will be affected in some way by the programme, CfH is going to cost over £35,000 per employee - that

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[1] *Daily Telegraph* 30 October 2004, Accountancy Age 17 November 2004, http://www.theregister.co.uk 12 October 2004.

[2] http://www.topconsultant.com 16 June 2004 quoting British Computer Society estimates

[3] House of Lords Committee on Science and Technology 13 March 2003

[4] *The Times* 8 February 2006

is really quite a lot of money for management and IT systems consultancy. In fact, with CfH we are seeing consultancy support per health service employee that is almost on the scale of the £45,000 per employee paid to consultants during the catastrophic Child Support Agency programme.

This is already causing some concern and even turmoil at a local level, as health workers see their hard-pressed budgets being diverted from valuable hospital medical consultants to expensive but probably less essential IT systems consultants.[5] In October 2005, I had a meeting with the IT director of a regional health authority. He was at his wits' end. He had IT systems consultants from the huge multi-national consultancy that had the CfH Contract for his area crawling all over his department telling him what he had to do to prepare for CfH and continuously coming to him with demands for money to 'upgrade' or change his systems and data to make them 'compatible' with CfH standards. He was not allowed to see the contracts CfH had agreed with the systems consultants as these were apparently 'commercially confidential'. So he could not find out whether the consultants' requests for cash were justified or not. Additionally, he could not find out whether their hourly rates were appropriate, though he personally felt they were exorbitant and much higher than those of the local companies he would normally use. Yet under pressure from the CfH organization, he had to go to his chief executive and get the funds transferred from front-line patient care to pay the IT consultants whenever the consultants asked for more money.

As many hospitals faced funding problems in late 2005, the Health Secretary resisted demands to bailout NHS hospitals that were heavily in the red and avert a winter crisis. As one newspaper reported, 'dismissing calls for more money, she said, " No - there is more money going into the NHS than ever before.'" She went on to point out that if hospitals were in financial difficulties, it was probably because they were wasting taxpayers' money: 'I don't know whether Marx ever said waste is theft from the working class, but he should have done, because it is. We have asked them to pay higher national insurance contributions. We have got to give them maximum value for money.'[6] The Health Secretary clearly had no time for poor and wasteful management of public-sector money when she also said, 'I want to make it clear that inefficiency and poor financial management are not acceptable.'[7] Although there was no money available to help hospitals avoid closing wards and reducing patient care, the Department of Health did at the same time manage to find almost £100m to offer as financial incentives to various medical professionals who could show that they were using some of CfH's new IT systems, so that the government could claim that CfH was the stunning success it most clearly was not. In the same month, the Health Secretary also blamed doctors, rather than her own department, for a shortage of flu jabs to protect those who were most at risk.[8] So there seems to be an emerging pattern of government claiming that we are truly fortunate to have such a wondrously effective department as the Department of Health while asserting that all problems in the health service are due to wasteful hospitals and incompetent doctors. Such political posturing can ring a little hollow to the people on the ground who are experiencing cost-cutting, recruitment freezes, reductions in numbers of beds and corresponding reductions in numbers of operations.

Progress So Far

How is CfH progressing? Actually, it is difficult to say. Firstly, because although CfH issues an impressively shiny Business Plan full of such high-sounding fashionable management gobbledegook as its 'mission, values and strategy', the document contains many more photos of happy healthcare workers than figures explaining how much money is being or will be spent. Moreover, although the Business Plan details all the remarkable achievements of CfH, nowhere does it compare these achievements with an original schedule. So we cannot see if they are on target, behind or ahead. Not only is the Business Plan less than informative, but it is also almost impossible to get any information from the CfH organization about what is happening. A cult of secrecy seems to have descended over the project. This got so extreme that journalists from one of Britain's leading computer publications, which had been critical of the way CfH was being run, were allegedly banned from attending a CfH

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[5] *Computer Weekly* as reported on http://www.theregister.co.uk 12 October 2004

[6] *Independent* 21 November 2005

[7] *The Times* 12 December 2005

[8] *The Times* 23 November 2005

press conference.[9] Requests for information on whether the project is going off schedule are met with a stony silence or patronizing denials. Answers to parliamentary questions are also either singularly unenlightening or else consist of reams of figures detailing CfH's many achievements - reminiscent of Soviet newsreels claiming over-performance against the five-year grain production plan, while most people are going hungry. The suspicions that something truly horrible is happening behind the CfH iron curtain is not helped by the fact that the publication date of the NAO report on the project keeps getting put back. One journalist voiced their doubts about the length of time it was taking to produce the NAO report when they wrote, 'it is not unknown for government departments to deliberately spin this process out to delay what they perceive to be potentially embarrassing reports.'[10]

Most failed IT systems projects (and remember that a study of over 13,500 organizations showed that this is around 73 per cent of all IT projects) go through four well-known and exasperatingly predictable phases. First there is a huge ambition to 'revolutionize' and 'transform' the working practices of the lucky future system users. CfH certainly gave us that: 'We will deliver a twenty-first century health service through efficient use of information technology.' Then there comes pride as the leaders of the great venture mistakenly equate the sight of huge numbers of consultants, being paid huge amounts of money, with making real progress towards delivering a system that meets users' needs. Again, CfH has demonstrated this: 'The National Programme for IT has a strong record of achievement. For example, since our inception two years ago, we have mobilized a skilled workforce capable of meeting the challenge.' By this time tens of millions have usually been spent. Now the project can go two possible ways. Very occasionally, it delivers working prototypes and systems that match the original promises, in which case the worthies in charge are usually only too happy to continually advertise their tremendous achievements to anyone with the time and energy to listen. Alternatively, and much more frequently, endless problems start to surface: it is discovered that the business processes being computerized have not been fully understood; that the complexity of the system has been drastically underestimated; that the hardware is found to be inadequate; that response times are ludicrously slow; that the initial budgets look like pocket money compared to the fortunes that are now being poured into the consultancies' bank accounts. And those responsible eventually come to the horrible realization that, 'Oh, shit! We got it wrong. It's not going to work!' But by this time so much money has gone up in smoke and so many reputations are on the line, that there can be no turning back. The project is in a hole and in their desperation to try and sort out the mess, everybody just keeps on digging faster rather than pausing to check whether they are actually digging the right kind of hole in the right place. Meanwhile, the tens of millions turn into hundreds of millions as the consultants, who had previously apparently agreed a reasonably fixed price for the work, now start billing the client, in this case the government, by maintaining that every bug and inadequacy they fix is new work for which they need to charge extra. Anxious to avoid a bust-up with their suppliers which would leave them both high and dry and looking particularly inept, the civil servants are trapped and have to keep on handing over millions of our money in the hope that something can be salvaged from the wreckage so that their careers can be protected. This is when the third phase - secrecy - kicks in. Given the iron curtain that seems to have been erected around CfH to prevent anything but the official line leaking out, it's hardly difficult to guess that inside the monolith all is not light and joy and popping champagne corks.

Close to delivery, things generally change yet again for most of these kinds of projects, and *Connecting for Health* doesn't seem to be any different. By the end of 2005, one piece of the system should have been close to delivery - the *Choose and Book* system for GPs to make hospital appointments for their patients. Planned to cost £65m, this first system has now cost over £200m. In 2004, it managed to make 63 hospital appointments compared to a planned 205,000. In 2005, despite the fact that the Department of Health pulled £95m from front-line care to give to any doctors who used *Choose and Book*, only about 0.7 per cent of hospital appointments were made using the system and in most cases created extra paperwork that had not been required before. Of course, CfH denied that there were problems with the system, denied *Choose and Book* was over budget and claimed it was always intended to cost £200m. (It is odd that when the press first reported that *Choose and Book* would only cost £65m, the CfH press office didn't correct this apparent 'inaccuracy'.) In the light of the Health Secretary's comments about hospitals being in the red due to their own waste and mismanagement, it is interesting to note that the total budget deficit for NHS hospitals in the 2004/5 financial year was around £140m. Coincidentally, this almost exactly matches the current £140m overspend on *Choose and Book*. Though, of course, as

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[9] *Computer Weekly* 17 January 2005

[10] http://www.e-health-insider.com 26 January 2006

we know from CfH, this £140m was not overspend at all, it was always in the budget. This reminds one of the congenitally incompetent MoD bosses claiming that their £6bn overspend was not 'overspend' either, it was just a £6bn 'level of disappointment'. Let us hope that we do not get similarly huge, or even larger 'levels of disappointment' at CfH.

This brings us to the fourth phase of failing or failed IT systems projects - blame. This is when the original budget has been overspent by millions, tens of millions, hundreds of millions or even, as will be the case with CfH, billions. Years after the planned date, either nothing is yet installed or else some sort of system may be working, but it does incomparably less than was originally promised, is tortuously difficult to use and is probably costing more per transaction than the previous, largely manual way of doing things. At this point, those responsible for the system's implementation blame those who work with it for continually changing their requirements and for not using it properly. Although by November 2005 CfH was far from completion, a rather unsightly public spat had already broken out between the director of the programme and the head of the NHS. Richard Granger reportedly wrote to a senior civil servant at the Department of Health claiming 'Choose and Book's IT build contract is now in grave danger of derailing (not just destabilizing) a £6.2bn programme. Unfortunately, your consistently late requests will not enable us to rescue the missed opportunities and targets.'[11] So that's the predictable bit about changing user requirements being responsible for the cost increases and delays. Additionally, in an interview with a computing magazine, the director of CfH said, 'Low usage is not something I can do anything about.[12] And there we have the equally predictable criticism of users for not using the marvellous new system that has been developed especially for them.

When a complex public-sector project goes well, those involved are usually seen enthusiastically clapping each other on the back and smiling delightedly for the cameras as they contemplate their forthcoming knighthoods and lucrative positions as highly paid, top level advisers and directors - they are not usually knifing each other in the back by sending accusatory emails in an apparent attempt to shift responsibility for an impending disaster. This altercation could be seen as yet another sign that CfH is decidedly moving into the 'Oh, shit! It's not going to work!' period and is casting around for somewhere convenient to hang the blame, while everyone inside the project struggles to fix the unfixable before the outside world spots the meltdown. Of course, when talking to the press, CfH claim that all is well in the best of all possible worlds. But given the careful control on information from the project, one could suspect that there is an ever widening chasm between what is said by CfH spokespeople in public and what they really believe.

Learning from Past Mistakes?

The NHS and IT systems have not, in the past, been the happiest of bedfellows. There have been two major NHS IT strategies in recent memory. In 1992, the NHS developed a strategy to 'ensure that information and information technology are managed as the significant resources they are and that they are managed for the benefit of individual patient care as for the population as a whole'.[13] Despite its lofty intentions, it seems that the 1992 NHS IT plan turned out to be something of a damp squib when words had to be turned into actions. The PAC noted that: 'Design and implementation of the 1992 NHS IT Strategy demonstrated many of the key failings we have seen on public-sector IT projects generally. In particular: the absence of an overall business case; errors in business cases that were produced for individual programmes; failure to identify interdependencies between programmes leading to a lack of cohesion; and failure to set budgets for the full costs involved. The NHS executive decided not to set specific, measurable, achievable, relevant and time-related objectives for the six main projects and programmes. Neither did they consider how the projects related to one another.'

As part of the ill-fated 1992 plan, a project to standardize IT systems in the Wessex Regional Health Authority was abandoned after about £43m had been spent. A flurry of civil lawsuits and allegations of criminal fraud ensued. The NHS then waited four years before reviewing what had gone wrong, slightly limiting its ability to learn from the unfortunate experience. In 1990 following a severe attack of NIHS (see Chapter 1), the NHS decided that the US clinical coding standards were not suitable for Britain. It then went on to waste about £32m trying to develop its own new electronic language for health. By 1998, the NHS had given up and just adopted the US clinical coding standards after all. And

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[11] *Sunday Times* 13 November 2005

[12] ibid

[13] PAC Report *The 1992 and 1998 Information Management and Technology Strategies of the NHS Executive*

at least £10m was lost when the West Midlands Regional Health Authority supplies division junked their plan to set up an electronic trading system because 'proper market research was not carried out, suppliers were not consulted, estimates of supplier take-up were significantly overstated, potential customers were not consulted and the royalty projections were unrealistic'.[14]

In 1998, the NHS launched a package of new and existing IT projects and service aspirations called Information for Health - An Information Strategy for the Modern NHS 1998-2005. Reviewing the 1998 Strategy, the PAC felt that the NHS had learnt something from previous mistakes, but expressed its concern that, 'again the NHS chose consciously not to make the objectives specific or fully measurable, leading to a failure to clearly link targets' to objectives. There is no full business case for the strategy:' It was also felt that the 1998 Strategy 'risked a similar lack of cohesion' to the 1992 plan. Is CfH definitely and expensively heading for the same fate as virtually all other New Labour projects? Or could it still turn out to be a shining example of best practice showing that our Civil Service have, as they repeatedly claim, learnt from past mistakes?

One thing the government seems to have found out from their impressively long list of IT screw-ups is that civil servants are not capable of running major projects. So, in hiring Richard Granger for CfH, the government seems to have made the effort to find someone from the private sector who already had a track record of successfully delivering large, complex projects. As Sir John Pattison, then head of the NHS, said to a House of Lords select committee: 'What we have done is to secure for ourselves Richard Granger, who is Director-General of NHS IT. He comes from the private sector. He has experience of putting in large computer systems. We can look at the experiences of the Passport Office as one experience; we can look at the experience of what Richard Granger installed for congestion charging in London as another experience; and say that we may well have somebody who is capable of delivering on time and on price something that works.'

Sir John Pattison, who would have retired well before the results of CfH were apparent, for better or for worse, then went on to explain that the new Director-General had been drafted in due to a lack of capability in project management in the public sector: 'However, if I may just make a personal comment, I cannot exaggerate the value of Richard Granger to this programme, and the likelihood of its success. These are skills and experience which we simply do not, or have not had up till now in the Department of Health and the NHS. We are good, and we have introduced somewhere in the NHS everything that we want to install, but we have never done it on a scale that is implied as necessary and correct in order to support the National Health Service. So he is bringing in people who we would not automatically have brought in and did not know about, and I think that is increasing the likelihood of success of this enormous project.'

The other major change that shows CfH have learnt something from previous projects can be seen in the way they have structured their contracts with suppliers. For almost the first time on a government project, CfH have imposed major cost penalties on suppliers if they miss critical project dates. Moreover, they are also applying them. BT were reported to have paid £4.5m in penalties in 2004 and to be facing further fines in 2005. BT denied that the £4.5m had been a fine and insisted it had just been an 'adjustment of payments'.[15] The Director General of CfH, however, seemed fairly unambiguous in his views of BT's performance. He accused them of having made 'a very shaky start' to the contract and of being 'behind the original contracted schedule'. Moreover, he said, 'their project management wasn't good enough, the people they had on the job weren't good enough and they still have some distance to go there.'[16] Nevertheless, whether the £4.5m was a fine for late delivery or 'adjustments of payments', in theory this new tougher stance should push IT systems suppliers to perform better than they have done on previous programmes.

However, this approach has been derided within the IT industry. At a conference in November 2005, the chief legal counsel of one of the world's top three systems consulting companies explained that the problems on government projects stemmed from the limited management capabilities of the civil servants running the projects and so would not be solved by the imposition of fines: 'The changes in the style of the process were typified by the NHS NPfIT Programme procurement in 2003. This can be summarized as the " big stick" rather than the partnership approach to procurement. At a recent

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[14] PAC Report *Improving the Delivery of Government IT Projects*

[15] *The Times* 14 October 2005

[16] http://www.e-health-insider.com 14 October 2005

meeting of industry trade body Intellect's healthcare group, Richard Granger, Director-General of the £6bn NHS NPfIT told his audience that he wants to " hold suppliers feet to the fire so that the smell of burning flesh is overpowering" . Suppliers have expressed concern to the OGC that the Government is increasingly relying on punitive contracts and the inevitable fines (which have already begun at NPfIT), rather than developing its own programme management capacity and becoming the " intelligent customer" .' [17]

Of course, given the typical business practices used by the larger consultancies, one should take such protestations of innocence with a not inconsiderable pinch of salt. Too often, civil servants' inexperience and incompetence have suited the consultancies as they have enabled consultancies to double, triple and even quadruple their prices once they got their public-sector contracts signed. Some consultancies even boast that the way they make money from public-sector contracts is to submit a low bid, in the full knowledge that the government contract will be so full of holes that it offers the consultancy a captive client and an almost unlimited licence to raise prices once the project has begun. However, there is probably also some justification for the IT company's chief legal counsel at the conference going on to accuse the government side of, among other things, 'lack of clear senior management and ministerial ownership and leadership, lack of skills and proven approach to project management and risk management, lack of understanding of and contact with the systems supply industry at senior levels, too little attention to breaking development and implementation into manageable steps, inadequate resources and skills to deliver'. Failings from the government side that, as we have seen, seem to be a recurring feature of large public-sector consultancy programmes.

Sadly, as I review and also discuss with experts and insiders how CfH have designed and set up their programme, it seems that, apart from these two areas, they are taking exactly the same approach as previous catastrophic projects and so wilfully repeating the mistakes of the past. It is said that one sign of madness is to carry on doing the same thing and to expect a different result. Unfortunately for us taxpayers and for our health service, CfH seem determined to follow in the ill-fated footsteps of their unfortunate predecessors, while somehow expecting the results to be quite different.

CHAPTER 13

WHAT DO WE DO NOW?

Connecting for Health (CfH)

If Choose and Book is still not working, it should be put on hold for a few years and the money from the programme fed back into front-line patient care. An investigation should be conducted into the suppliers, Atos Origin, to understand if they are in any way responsible for either the delays or cost increases. If they are, the government should seek full compensation, which should also go straight back into patient care.

We should probably stop the CfH programme in its present form and cancel all the contracts with the Local Service Providers as they are against the public interest. Here, of course, there will also be much bluff and bluster from the consultancies and threats of legal action for breach of contract. But measures like whistle blowing rewards and the threat of investigations into whether they have defrauded public funds or have been complicit in doing so, and the possibility of subsequent prosecutions should help some of the consultancies understand that their longer-term interests lie in cooperation with government rather than confrontation. The only CfH consultancy contracts that should be kept should be those for routine maintenance of existing systems.

The board of CfH should all be removed and replaced - they have too much personal capital invested in the way the programme is currently being run to accept that it should be radically changed. CfH is so critical for the country that it should be treated as an issue of national importance rather than risking becoming a massive profiteering opportunity for just four huge companies. In the same way as we create a government of national unity in times of emergency, we need to transcend the interests of one party and four big companies and run CfH for the public and not for a few New Labour politicians and their consultants. A cross-party programme board of MPs should be set up. They should be allocated a sum of money - say £5bn. They should then invite the smaller and medium-sized specialist medical systems suppliers to form a consortium to propose how the useful elements of CfH can be implemented in a tactical, low cost way rather than the current high cost juggernaut approach. Re-use of existing technology, interoperability, distributed databases and market competition should be the guiding

[17] Society for Computers and Law 5th Annual Conference November 2005

principles rather than unnecessary reinvention, monolithic uniformity, centralized databases and monopolistic market control. The elements that should be implemented are electronic patient records, electronic prescriptions, electronic imaging and cost and management information.

We should set up a project management board made up mainly of clinicians representing the main groups of hospitals. Moreover, the useful systems should be developed at just a couple of test locations using an iterative prototyping development approach. Once the project management board was satisfied with the systems' effectiveness and robustness, they could be rolled out to other locations. We will probably find that this approach will give us a fully implemented CfH in a greatly accelerated time-frame for less than £5bn for the whole NHS, rather than the over £30bn that the existing approach will cost. This will get us back to the kind of figures that were mooted when the programme was originally launched. Moreover, rather than just enriching four already massive IT consultancies, this encouragement of many smaller companies to create a competitive market for medical IT systems will probably result in Britain developing a world-beating medical systems industry with massive export potential as other countries also inevitably move to improve the use of technology in their health services over the next few years.

An axe should be taken to NHS administration. The government should pass a law requiring non-medical and non-cleaning staff expenses in hospitals not to exceed say 10 per cent of overall staff costs by the end of 2006, 8 per cent by the end of 2007 and 7 per cent by the end of 2008. Any hospital breaching these targets should be found to be committing an offence of wasting public funds and the chief executive should be barred from any form of employment in the public sector for five years. Any employee reporting management fiddling the figures should be rewarded with a percentage of the savings made after the employee's reporting of the incident and the hospital chief executive should be automatically dismissed with loss of pension rights. Moreover, any communication departments or marketing departments should be closed, the people fired and the budgets returned to front-line care. If hospitals have something important to say, the clinical staff are probably quite capable of saying it.

Hospital cleaning should be brought back in-house with cleaning staff employed by the NHS and made to feel they are an important and integral part of a team providing safe medical and care services for the sick, rather than being easily disposable low cost labour for profit-maximizing outsourcing companies. This measure alone will probably lead to a halving of the annual 600,000 plus hospital-acquired infections and of the 5,000 plus deaths from hospital-acquired infections. The money to pay for the employment of hospital cleaners as NHS employees could come from the money saved from reducing hospital administration costs to the levels proposed above and from the savings from an almost immediate reduction in levels of hospital acquired infections. This new policy could be piloted in four or five hospitals and, when it is found to be at least self-funding (and probably generating a cash surplus that could go back into patient care), rapidly rolled out across the whole NHS.

23. Appendix 8 - Our Submission to the EPR Inquiry

15 March 2007

Submission to the Health Select Committee Inquiry

into

The Electronic Patient Record and its Use

Submitted by

Brian Randell

On behalf of the Group of 23 Senior Academics in Computing and Systems,
listed at the end of this document

Executive Summary

This submission addresses the issue: "Current progress on the development of the NHS Care Records Service and the National Data Spine and why delivery of the new systems is up to 2 years behind schedule". It draws on the Dossier of Concerns regarding NPfIT that we have assembled from a variety of sources, and recently made available to Members of the Select Committee. Despite the difficulty of assessing NPfIT's plans and progress, caused by the Programme's size and complexity, the secrecy regarding detailed system specifications, and the atmosphere of fear that prevents many NHS staff from expressing criticisms, our Dossier contains extensive evidence, some but by no means all anecdotal, that supports our assessment that the Programme is in serious danger. The huge range of problems, covering technical matters, methods of procurement, the lack of buy-in from stakeholders, privacy and security questions, delivery delays and spiralling costs, greatly complicate the task of correctly identifying the fundamental causes and most effective remedies. Hence **our recommendation that a detailed technical review of the Programme be commissioned**, a review that must be open and manifestly independent if public confidence in NPfIT is to be regained.

Introduction

1. We, a group of concerned senior academics in computing and systems, first wrote to the Select Committee last April, saying that we believed that NPfIT was showing many of the symptoms we have seen in major IT systems that had eventually been cancelled, overrun massively in terms of time and anticipated budget, failed to deliver an acceptable service to users or to reach business benefit targets for their organisations. We are pleased that the Committee has now agreed to hold an inquiry into the critical aspect of NPfIT, its support for and use of Electronic Patient Records (EPRs).

2. Since we first wrote we have compiled, and made available in printed form to all Members of the Committee, an extensive Dossier of Concerns. This has been assembled from nearly 600 published and unpublished sources, ranging from scholarly research papers to what might (unwisely) be dismissed as mere media rhetoric. Our submission makes numerous references to this Dossier — for convenience simply by indicating the relevant section number, e.g. "3.8.8", in the printed version of the Dossier, dated 18 January 2007. (This version can be found online, along with the current further-extended version, via our website at http://nhs-it.info.)

3. As one of the MPs we sent our Dossier to remarked to us, it is very difficult to obtain an adequate picture of NPfIT free of the "entanglements of political axe-grinding, professional jealousies and commercial interests". An even greater difficulty is the climate of fear in the NHS that has prevented many from expressing publicly the views that they have been willing to share with us in private. Nevertheless, even though much — though by no means all — of the evidence in our Dossier is anecdotal, and from secondary sources, we believe that it provides strong support for our assessment that NPfIT is in serious danger. What is significant about our Dossier is not just its size, but the range of problems noted, covering technical matters, methods of procurement, the lack of buy-in from a range of stakeholders, questions of privacy and security, delays in delivery and spiralling costs.

4. We have also attempted, as outsiders, to assess the technical merits of NPfIT, particularly those of direct relevance to the safety and reliability of the overall system. However many details of NPfIT (even the contractual integrity and availability requirements and specifications) are regarded as commercially highly confidential, making this task virtually impossible. (Such difficult-to-justify secrecy has, we are certain, also contributed to the lack of confidence that many working in the NHS have in the Programme [3.8.8].)

5. Our hope is that the outcome of the Committee's Inquiry will be the setting up of an open independent constructive technical review, ideally of NPfIT as a whole, but at least of the centrally-provided NHS Care Records Service (NHS CRS), and of the various systems being provided by the Local Service Providers (such as Patient Administrative Systems, Clinical Systems and Departmental Systems), that together support the creation, maintenance and utilisation of EPRs. Dr Granger and his senior colleagues publicly expressed support for such a review following our meeting with them last April. It is we believe the best way of arriving at a disinterested expert assessment of NPfIT and of significantly improving the chances of a successful, timely and well-accepted outcome of this major investment by the NHS. (The current refusal by NHS to contemplate such a review is worryingly reminiscent of management attitudes during London Stock Exchange's disastrous Taurus project [Drummond 1996].)

The Electronic Patient Record

6. Virtually all the claimed clinical advantages for patients of centralised EPRs (at cluster or national level) could be achieved by replacing paper records with electronic ones at the local (i.e. trust) level [2.6, 3.5.21]. The claimed importance of being able to access a central EPR directly when a patient requires treatment far from home is not supported by evidence [2.7]. Making what could have been local record keeping part of a cluster-level, leave alone an immense national-level, "system-of-systems" introduces system interdependencies that, because of their effect on system complexity, pose risks to system reliability and availability that in our judgement are likely to prove out of all proportion to any potential benefits [3.8.8]. Also the integration of EHR files at cluster, and certainly national, level greatly exacerbates the problem of maintaining patient confidentiality [Javitt 2005, 2.8, 3.5.3, 3.8.25].

7. Electronic records need to be generated as a by-product of relevant medical activity, and at the time of that activity, if they are to be of direct support to health care (for example in preventing possible clinical errors, such as related to drug dosage) [2.1]. If in contrast their generation has (perhaps because of usability or system performance limitations) to be undertaken as a supplementary time-consuming after-the-fact task, especially if it is one of little evident direct benefit to patients or clinicians, there will be much less incentive on the part of staff to undertake detailed record generation or to maintain quality control [Brennan 2005, 7.1.1].

8. Moreover, such are the differing circumstances from hospital to hospital that centrally-imposed standard EPR systems will often prove ineffective, and will not be used as intended, as Professor Eason, for example, has convincingly demonstrated in his study of mental health trusts [Eason 2007]. The clear implication is that it would be better to let local experts decide how best to satisfy local needs and circumstances, to identify minimum standards needed for interlinking local systems, and to defer such interlinking until after local systems have been successfully implemented and gained general support.

The causes of delayed delivery of the new systems

9. Many studies have reported significant time delays, cost overruns and, all too frequently, complete failures of projects that involve extensive software development or customisation. For example, a 1995 study [Jones 1995] of 164 software projects concluded that over 24% of projects were cancelled and that two-thirds experienced significant cost and time overruns. A 2001 survey [Taylor 2001] reported that of more than 500 development projects, only three met the survey's criteria for success. A 2002 survey of 13,552 IT projects [Standish Group 2002] reported that only 34% were completed on time and to budget and that 51% though completed and operational were over-budget, over the time estimate, and offering fewer features and functions than originally specified.

10. The ever-growing levels of ambition on the part of system builders and system commissioners are such that the situation is not improving: in 2007 a US National Institute of Standards and Technology report stated that: "By most estimates, over half of all large application development projects . . . end in failure — after all the time and money is spent, the product still cannot be used operationally".

11. Hence it is clear that the utmost care has to be taken to (i) avoid undue ambition, (ii) make sure that the most circumspect software acquisition processes are employed, (iii) minimise undue dependence on the continuous correct functioning of the complete system, (iv) evolve towards the intended overall system via a sequence of practical and cost-effective intermediate systems, and (v) avoid at each stage the trap of specifications that are vague, changing or in conflict [Curtis 1988, 3.8.25].

12. Many healthcare systems are necessarily large and complex, but the NHS is huge and organisationally highly intricate [Beynon-Davies 1994; Wyatt 1995]. A fully-integrated NHS-wide healthcare system is vastly larger and more complex than any previous healthcare system [Javitt 2004]. Indeed it is admitted to be the world's largest civil IT project ever. Thus NPfIT is by definition an undertaking that is inherently "at risk". Moreover, given the crucial and pervasive role played by EPRs, we believe much of this risk arises from the complex systems supporting cluster-level and national-level EPRs.

13. Adverse outcomes from large IT projects rarely can be linked to a single cause (Lyytinen and Hirschheim 1987). Indeed analyses have identified many different causes. Some we list here, with representative references to relevant sections of our Dossier, as a contribution to identifying problematic aspects of NPfIT.

- cryptic or concealed agendas [3.3.2, 3.8.31]
- not involving users or not incorporating organisational needs [2.1, 2.3-4, 3.4.1-3, 3.4.9-10, 3.4.12, 3.4.16-17]
- treating a project as an IT project rather than as a business change project [3.8.5, 3.8.8-9, 4.2]
- ill-defined, unrealistic or conflicting objectives [2.1, 3.1.18, 3.7.33, 3.8.29]
- suppression or mismanagement of risks and uncertainties [2.8, 3.1.21, 5.3.7]
- ineffective project or resource planning [2.2, 3.1.10-12, 3.1.14, 3.4.6, 3.7.8]
- planning for "big-bang" instead of evolutionary delivery and failure to plan for longer-term evolution [2.2, 3.8.13-14, 3.8.28]
- fixing objectives, timeframes or costs when excessive uncertainty still exists [1.2.5, 3.1.11, 3.7.28]
- ignoring costs of business change [2.2, 3.8.1, 3.8.8]
- insufficient political support [2.3, 3.4.18-19]
- over-dependency on, and/or failure to control, suppliers [3.1.14, 3.1.26, 3.3.10-13, 3.3.20, 3.7.27]
- excessive project size and complexity [3.1.12, 3.2.11, 3.3.17, 3.7.32, 3.8.15]
- unproven technology or approach, especially exceeding the limits of proven performance [3.1.25, 3.1.30]
- inadequate provision for data transfer and quality [2.6, 3.3.14, 3.8.9]
- lack of provision for information governance [3.8.26, 3.8.47-48]
- failure to identify or achieve relevant standards [2.6, 3.7.25, 3.8.26]
- failure to plan for necessary levels of safety, security or recovery [2.8, 3.3.19, 3.5.1-47, 3.6.1-23]
- lack of project or technical skills [1.6.4, 2.2, 3.1.14, 3.7.32, 3.8.21]
- undefined exit conditions [1.2.5]
- inflexibility, inappropriate aggression and machismo [3.3.13, 3.5.34-35, 3.8.34]
- loss of political support [1.6.5, 3.4.11, 3.8.33]
- resources not properly allocated [3.3.6-7, 3.8.44]
- failure to create effective partnership with contractors [3.2.2, 3.2.9, 3.8.22, 3.8.46]
- unreliable progress reporting [3.1.14, 3.3.9, 3.8.16]
- unrealistic timeframes or budgets [1.2.5, 3.1.11, 3.7.30, 3.8.21, 3.8.40]
- inattention to quality [3.1.14, 3.3.14]
- barriers to communication [3.8.17, 3.8.31]
- fear of failure [3.6.8, 3.8.14]

14. We find it quite remarkable, and extremely worrying, that our Dossier shows that *all* of the above lengthy list of generic system problems would appear to exist in NPfIT.

15. Our Dossier also provides extensive evidence of a number of further problems that are specific to, or particularly challenging in, NPfIT including:

- inadequate clinical engagement during system requirements analysis and specification [2.3-4, 3.4.3, 3.4.9, 3.4.16-17, 3.8.22, 5.3.9]

- replacement of existing successful well-trusted systems by standard systems that are perceived to be inferior [3.6.8, 3.8.9, 3.8.39]
- employing Patient Administration Systems that were designed for the very different US healthcare market [3.8.10]
- inadequate response to the medical profession's concerns regarding issues of patient confidentiality [3.4.5, 3.5.1, 3.5.11, 3.5.30, 3.5.34]
- excessive reliance on IT consultants and suppliers with little knowledge of UK healthcare and the NHS [2.4, 3.8.7]
- implementing a complex centralised system in a situation in which the NHS is constantly faced by changes in organisation, medical practice and even the law [2.6, 3.8.23, 9.3]
- identifying and managing the changes in NHS working practices needed to complement, shape, and exploit proposed new IT facilities [3.8.5, 3.8.8, 3.8.9]

16. The above exercise of identifying relevant references in a large collection of evidence, gathered mainly from the public (albeit mainly specialised) media, is a far from satisfactory way of assessing the real extent and seriousness of the issues which should be addressed if NPfIT is ever to succeed. We argue however that our analysis illustrates very dramatically the number, variety and complexity of the concerns surrounding NPfIT, and thus provides a compelling argument for commissioning a detailed review of the project, carried out by evidently-independent experts with full access to all relevant information and personnel.

17. It will, we believe, take such a review to pinpoint the most important causes of the present delayed delivery of the Programme, in particular those aspects related to EHRs. More importantly, such a review is needed to determine whether there are, as we suspect, strong reasons to assume that the Programme will actually fail, not just continue to over-run its schedule and budget, unless appropriate remedial action is identified and undertaken urgently.

Concluding remarks

18. A well-known aphorism in the IT industry is: "A complex system that works has evolved from a simple system that worked" [Gall, 1975]. Another hard-won insight is that the most successful highly-critical large IT systems, such as the worldwide VISA payments system [Stearns 2006], achieved their success through ruthless control of their complexity, and minimisation of the level of dependence that needed to be placed on them, as well as through high levels of hardware/software reliability. A further crucial insight concerns the criticality of employing evolutionary procurement methods, and socio-technical expertise, in order to determine precise specifications that meet the various stakeholders' requirements [2.2]. **A detailed constructive review of NPfIT in the light of these insights could, we argue, greatly increase the likelihood of the project's eventual success.**

19. The NHS has many good working systems, and NPfIT is planning and delivering others, but our and others' research and experience suggests that NpfIT's problems, especially those centred on EHRs, are daunting; our expert opinion therefore is that there is a high (but probably avoidable) risk that the Programme will fail. Hence our recommendation that an open independent technical review is an essential first step toward managing that risk in a professional manner. (In making this recommendation we are not seeking to review NpfIT ourselves – being entirely independent of NpfIT, we are simply acting out of strong professional concern and in the public interest.)

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24. Appendix 9: Electronic Medical Records for the Department of Health Services (2003):

The Future Lies Ahead, The Past is History

Daniel Essin, MD

Introduction

According to the popular notion of how medicine will be practiced in the future, omnipresent, intelligent systems will acquire and store all available information about what is going on in the healthcare environment. Healthcare providers will simply talk to the computer to provide their input. At any point in the process the healthcare provider will be able to ask a question or make a request. In response the computer will analyze all of the relevant facts and suggest the likely diagnosis and most appropriate treatment and set the provider's requests in motion. The same computer will monitor the status of all the patients even when the providers are otherwise engaged and will alert them if a patient requires their attention or if they have overlooked something. Such a system would be implicitly paperless. Unfortunately, such systems exist only in science fiction. The expectations that they engender are real and must be addressed for any project to be successful.

Buoyed by the technological optimism of the 1980's, the new LAC+USC Hospital was conceived as a paperless facility. In a bold move, the architects were directed to omit from the design storage space for medical records and administrative records as well as most office space for physicians. Provisions were made, however, to allow for a paper chart of each patient's current admission. In 1989 these assumptions seemed reasonable. The industry seemed poised to deliver systems that would be marvels of technological and medical innovation; unburdening the physician, improving the efficiency and safety of patient care and, in general, conforming to the collective hope for a future that is made better through technology. There was, it seemed, more than enough time to acquire such a system and eliminate the need for long-term paper storage as well.

The gap between our expectations and what is available today is large and may not diminish any time soon. There are reasons for this gap that can be analyzed and debated at length but that does not alter the fact that the gap exists and the gap is our problem. For years now, our unrealistic expectations have stood in the way of taking practical steps to achieve a way of doing business in the new facility that does not produce paper that required long-term storage. There are a variety of pragmatic solutions that will address this requirement in isolation and a smaller number that can also deliver some of the computerized functions that physicians associate with a computerized patient record.

The Immediate Problem

The most immediate problem is that most patient care is provided in an information vacuum. Patients are treated by various specialties at multiple sites. With portions of the records stored at different facilities, unfilled and misfiled documents, charts that are unavailable and "shadow charts" that are limited to a single specialty, an individual provider rarely has access to the patient's entire medical record. All of this information needs to be captured (either as data, text or images of documents) and stored in a way that they can be retrieved and viewed on a computer screen at any location within the healthcare network. The good news is that doing something about the paper storage problem will also have a large, positive impact on the quality and efficiency of patient care. The biggest impediments to achieving paperless operations within the replacement facility that we face in the short term are:

- Expectation management – Some are unwilling to focus on a pragmatic solution because it is incomplete or imperfect.
- Behavior modification – All staff at all levels will have to develop new work habits and practice styles. All will need to be held to new levels of accountability.
- Lack of experience – Our staff has not practiced in partnership with technology and lacks the experience to make sophisticated decisions about requirements. "Experience is what you get when you don't get what you want"
- Lack of responsibility – It is the organization's responsibility to craft the overall approach to these problems and take the responsibility for overseeing the integration of all the components to achieve the functional goals

- Lack of specialized staff – The adoption of any new technology in this area will place additional importance on quality control, computer and network technology, medical terminology, knowledge engineering and clinical workflow. The time to complete any implementation will be inversely proportional to the number of qualified staff available.
- Lack of important infrastructure – The proper functioning of an elaborate system that includes the "must have items" depends on the proper and unique identification of each patient. We would be well advised to avoid implementing too many systems in which an incorrect identification could lead to a disastrous medical outcome until we have implemented a Master Patient Index of some sort and have cleaned our existing files of duplicated entries.

Expectations are the biggest hurdle. The major expectations are that patient safety be enhanced, clinicians are able to work more efficiently and that paper storage be eliminated. While it will not be possible to fulfill every expectation completely, they all require some degree of attention in order to secure the support of the majority of clinicians that will be users of the system. Time is short and access to the existing paper charts will be required (immediately and for some time to come). This suggests that a hybrid approach will be required that can combine some of the functions normally expected from a computerized patient record system with a capability for document imaging.

The success of any scheme depends on its enthusiastic adoption by the staff. There are plenty of examples the vendor's or programmer's notion of what makes a usable system is out of sync with that of the intended audience – the medical staff and nursing staff.. It makes sense to introduce new technology gradually, placing the most vital components first. Every practitioner within the organization is familiar with the impending paper storage problem and should easily accept the fact that adoption of a paperless system is mandatory.

As people gain experience with new technology, their understanding and opinions evolve rapidly. Were we to perform an elaborate requirements elicitation now and then repeat it one year after the staff had been working in a paperless operating environment, their list of requirements and their priorities would be dramatically different. We should take advantage of every opportunity to provide the staff with hands-on experience as it will result in more discerning customers.

The effort to increase the utilization of computer technology in medicine is a long-term activity. The medical record itself, for example, must often be retained for more than 20 years and perhaps for a patient's lifetime. The time span is extremely long when compared to the lifespan of an individual computer system product. It is also long when compared to the lifespan of the average vendor. It is imperative that the organization take the overall responsibility for the determination of strategy, the selection of components and the integration of those components (as they come and go) so that the clinical computing environment provides a seamless, ever-increasing level of functionality to the practitioners.

The need for highly specialized staff increases dramatically at the time that we implement systems that contain "expert system" features to provide alerts and reminders. Individuals who are knowledgeable about the medical field in question and well as about knowledge engineering must configure these features for each medical specialty. Most organizations that have that implementing knowledge-based decision support systems is a multi-year activity spanning 5 to 20 years. The short time available in which to achieve a paperless operating environment means that the timetable for implementing alerts and reminders will have to be tailored to the available resources and may not be finished for some time after the replacement facility is occupied.

When the point is reached where automated systems are critiquing or making recommendations on medical treatment, it is vital that those systems have access to ALL the information that is related to the specific patient in question and ONLY information about the patient in question. Our current systems lack appropriate technology or safeguards to insure the accurate and unique identification of each patient. It would be dangerous to attempt to implement a sophisticated decision support system until the organization has implemented an enterprise-wide Master Patient Index and has identified the majority of the duplicate entries and merged the medical records of those patients.

The Long-Term Problem

Although we must be pragmatic about rapidly implementing a Paperless Operating Environment, we must do so in the context of a long-term framework. There are Enduring Business Themes (EBTs) that originate from the business of healthcare that will remain stable for years to come, even as the

technology that we use to implement actual components changes from moment to moment. EBTs are a form of design pattern. An example of an EBT is the need for accurate, non-duplicated identification and demographic information about each person that receives or provides services. This need will persist regardless of how it is implemented. There are two classes of EBTs, some address the principal business while others address the IT infrastructure needed to support the frontlist business. The following list presents examples of Healthcare Enduring Business Themes.

Principal Business Themes

Access to and Payment for Care (Patient Eligibility, Enrollment, Scheduling, Registration, Billing and Reimbursement)

Delivery of Care

Acute Care

Episodic Care

Coordinated Care

Request Management (superset of Order Entry) and Fulfillment

Documentation of Care

Retrieval of existing results and documentation

Creation of new documentation

Alerts and Reminders

IT Infrastructure Themes

Authentication

Person Identification

Policy and Guidelines (Superset of Permissions and Access Control)

Request Management (non-care related) and Fulfillment

Archival Storage (Text, Images, Multimedia)

Clinical Data Repository (primarily short-term storage and work-in-process)

Expert Advice (generates alerts and reminders)

Terminology and Nomenclature

Notary (Digital Signature)

Security, Privacy and Release of Information

Resource Allocation and Management (HR, Materials Management, Scheduling

This list conveys the notion that the number of Enduring Business Themes numbers in the tens, not the hundreds. Cline and Girou [1] have propounded a few principles that they have found useful in identifying EBTs:

- Avoid looking at the details since themes are abstractions
- Look at a business from the viewpoint of its customers, not its employees
- Today's requirements are not as important as future requirements
- Avoid centralized command and control approaches

The Challenge

The perennial challenge is to address the Principal Business Themes in an optimal manner at every point in time as the day-to-day requirements of business and the state of technology change. Translating this arcane statement into a practical strategy for the replacement facility, it means that we have to adopt a way of doing business (along with the technology to support it) that is sufficient to meet our immediate needs. It also means, to the extent possible, to select and assemble the solution in such a way that individual components can be replaced in an incremental fashion as needs and technology evolve.

The key lies in modularity. The strategy is necessarily one of incremental acquisition and evolution. Over time it will become apparent that the items listed as IT Infrastructure Themes each lend

themselves to being created as a "service" – a kind of black-box that receives requests, performs a particular set of internal operations and returns a result.

Thinking of Archival Storage as a service, its function would be to store information in a way that insured persistence, integrity and authenticity --- Some of the services, notably the Archive and the Master Patient Index, have few dependencies and can operate more-or-less on their own. The rest function at a higher level and depend on the existence of the core services to be able to perform meaningful work.

If, on the other hand, these services were to be specified as "requirements" of individual products rather than being acquired by the organization to be used as resources, the end-result will be the dreaded "silos" – a bunch of vertically integrated special purpose systems that contain whatever functionality they need to do their job. The end result, also called islands of information, can only be avoided if individual tasks are performed by applications tailored to the needs of each user or department that all use and share the services provided by the organization.

The creation of a Paperless Operating Environment is an incremental step toward this approach. It is a stepping-stone to establishing an Archival Service that can eventually be made available to all applications that generate information related to patients that requires storage. As the overall computerized healthcare computing environment evolves, this information will eventually be routed through the Notary that will challenge the user for their identity, verify it with the Authentication Service and then forward a signed copy to the Archive.

Each one of these services will be accessed through a well-defined set of data and communication standards that will hide the internal implementation details from its consumers. This will make it possible to upgrade any component in an orderly fashion, when it becomes necessary, without having to disturb the operation of the other services or the applications that use them.

Conclusion

Modularity provides a mechanism for the organizations to assert control in a consistent fashion throughout the enterprise while avoiding duplication of effort and inter-facility variations. It also provides a mechanism for orderly growth and predictability in budgeting. It minimizes the risk that is associated by making a multi-megabuck commitment to a single vendor for a single project.

In conclusion, addressing the short-term goal of providing a Paperless Operating Environment for the replacement facility is also an excellent first step toward achieving the long-term goal of a highly computerized patient care environment in which automated functions improve the quality and safety of patient care while providing the practitioners with a more satisfying and less tedious work experience.

[1] Cline, M and Girou, M. Enduring Business Themes, ***Communications of the ACM*** May 2000, Volume 43 Issue 5.

25. Appendix 10: NHS Mobile (2003)

This week's announcement of the NHS on line patient booking system reminded me of a unique preview I received a few months ago, courtesy of Virgin Trains West Coast Line. I had requested and received an Oxenholme-Euston ticket for the first-class quiet coach, hoping to work on the way. But Virgin forgot to include the coach and instead, I was treated to an episode in the life of government.uk from the man across the table, sorry desk, from me.

Small, balding and in his 40s, Richard G.* appeared to be an IT manager attached to the Department of Health probably, I thought, one of that twilight army of government special advisors. Non-stop high-volume input into his mobile and dictaphone demonstrated ad nauseam he was not one to use plain English when a managerial cliché was to hand. 'Emerging thinking'; 'in the frame'; 'operations domain'; 'hot desking'; 'gateway review' tripped readily off his tongue. The purest David Brent moment occurred when he speculated whether a female colleague, who had been out-sourced to Essex and begged not to be called an Essex Girl, might not have some 'gender issues'.

But Richard turned out to be much better connected than the Slough paper merchant manager ever was. Lord Hunt (Parliamentary Under Secretary of State, Department of Health), Sir John Pattison (Director of Research, Analysis and Information, ditto), Nigel at the Treasury - or was it the Cabinet Office? - all needed 'to be appraised of' his travel plans which were, since you ask, a three-day first- class trip to San Diego to attend a health IT conference, at a cost (to us?) of over £5,000.

Fortunately, thanks to modern technology, Richard could sift through the fore-log before leaving his desk. Having checked with his garage if he could post-date the MOT on his Range Rover, he dictated a thank-you letter to the BA travel shop in Leeds which was closing down, asked for the number of Interflora in Whitehaven, declared three glasses of wine under conflict of interest rules and claimed £10 for networking drinks, he got down to the serious business of NHS management.

You may be relieved to know that 'accelerated procedures' are being used to 'tune up core submissions' so that 'as small a forward column as possible is used in planning that area of the river-bed'. I am sorry I cannot tell you which part of the mighty NHS river we were swimming in here but I do know that NAO (National Audit Office) was hot on its trail. I can also reveal that the '25% uplift on framework procurement' was one of IA's (NHS Information Authority) stupid rules and could safely be ignored.

Entangled in the bureaucratic gobbledegook, a deeper administrative malaise was discernible, despite Richard's efforts to keep his colleagues in and systems on line. Most of his energy was spent reminding people to do what they had said they would do before Christmas. Richard did not want 'to go with the flow and reward dysfunctional behaviour' but his threat of 'professional competence assessments' as a prelude to dismantling whole operations rang hollow. He could barely cope with his own work load. Having calculated that he spent forty hours a week just clearing his in-tray, he confided to Sally (his - long- suffering - PA?) that he was not going to deal with it any more.

The previous Monday the entire EMIS (Egton Medical Information Systems, lead providers of Primary Healthcare 'medical informatics') for Lambeth and Lewisham, covering 23 general practices, failed. As Richard told an IA colleague, 'we should be seen to be doing something about it', it being run from a server shed in Leeds. He proposed first to congratulate the hapless victims on stripping out the old RT (possibly shorthand for SNOMED RT, Systematized Nomenclature of Medicine Reference Terminology) and looking to the future. But they were, he intimated, deeply unflattering about the entire IA contract. Rather than putting 'spider monitors' on the equipment - which might not be where the problem lay - he suggested calling a meeting to try and sort out the whole mess.

Not all was doom and gloom. Richard proposed a 'ground floor opportunity' to one supplier. The latest 'sexy' thinking from a consultant at the Maudsley was tele- psychiatry. With the help of a VC link, a patient in a dedicated room at a general practice in Tulse Hill (which had to be spelt out letter by letter like a remote flight destination) could now be put in touch with a consultant, thereby increasing productivity, decreasing patient disruption and cutting costs. This seemed to Richard a fertile area to 'explore as an exempla'.

Richard's mobile battery gave out at Milton Keynes, so he was reduced to feeding more items into his dictaphone and shuffling through his briefcase. But I must say I feel privileged to have been party, if only for three hours, to such a frank and fearless demonstration of open government in action. Would another Whitehall department care to volunteer a candidate to entertain me on my next journey north?

[*Richard Grainger, a partner with Deloitte Consulting, was appointed in September 2002 Director General of NHS IT on a salary of c.£250,000 a year. The journey this note refers to took place on February 4th 2003]

Celina Fox

26. Appendix 11: Supplementary Evidence on Independent Reviews (May 2007)

Introduction

1. At the Committee's second evidence session, Dr Richard Taylor asked Professor Brian Randell to provide a short note describing where independent technical reviews had previously helped major projects to succeed. This supplementary evidence has been prepared in response to that request.

Examples of independent reviews

2. In 1998, the project to develop the New En-Route air traffic control centre (NERC) at Swanwick was three years late, over budget, and facing continuous scrutiny by the press[5] and by the Parliament. Mrs Gwyneth Dunwoody MP, as Chair of the Transport Committee, called for an independent review of NERC, and this was carried out by DERA (now QinetiQ[6]) and Arthur D Little. The review reported that the project was likely to succeed if a number of technical and management recommendations were implemented[7]. One conclusion was that the Chief Executive Officer had such a powerful commitment to the success of the Project and this "very likely inhibited more open discussion at such meetings on project problems and possible Operational date slippage. This in turn stifled debate and helped reduce the effectiveness of the review meetings". The recommendations were followed and NERC came into service in 2002; it has proved very successful in operation.

3. In MoD there is an Annual Major Projects Review, which is published. It would make sense for all of the major programmes across Government to be included in an Annual Major Programmes Review similar to the MoD Major Project Review. This would get the facts about those programmes into the open on a regular basis for scrutiny and debate.

4. In the USA, the Office of the Undersecretary of Defense introduced a programme of independent project reviews in 1999 (the Tri-service Assessment Initiative). A status report[8] states that "As a direct result of the assessments conducted to date (19 since inception), Project Managers are implementing relatively low-cost post-assessment recommendations and realizing high returns."

5. A report by Jack Ferguson, director of Software Intensive Systems for the US Department of Defense[9] describes their independent expert programme reviews.

> At the DoD, our large development efforts face problems with the lack of software management expertise and of real data on the causes of problems. To address these issues, we are implementing independent expert program reviews (IEPRs) at appropriate points in the system life cycle. The Defense Science Board Task Force on Defense Software made this industry best practice its top recommendation. IEPRs leverage the scarce technical talent resident in government and industry to help DoD program managers better understand risks, problems, and best practices. Independent expert teams provide a comprehensive assessment of the programs, identify risks, and make recommendations for management and risk mitigation. Participation in these assessments is voluntary; program managers request assessments and control assessment report distribution. The review team and program staff jointly establish assessment scope and initial issue areas. They also establish a follow-up review schedule to evaluate actions taken as a result of the assessment. To date, 42 such IEPRs have been performed. Besides significantly reducing the overall risks on the programs reviewed, the IEPR results are giving the DoD stronger experience based insights that help software-intensive–system programs as a whole. Based on generic, systemic issues found across the assessments, IEPRs give feedback to DoD and senior acquisition managers, identifying recommended changes in policy, education, and training. These findings let us base risk mitigation and process improvement decisions on real data rather than

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[5] http://news.bbc.co.uk/1/hi/uk/politics/75220.stm

[6] http://www.qinetiq.com/home/case_studies/aviation/swanwick_air_traffic_control_centre.html

[7] http://www.publications.parliament.uk/pa/cm199899/cmselect/cmenvtra/586/586mem01.htm

[8] http://www.stsc.hill.af.mil/crosstalk/2000/11/baldwin.html

[9] IEEE Software, July/August 2001

anecdotes. They also provide information on the unintended consequences of well-meaning policy directives.

6. The MITRE Corporation and the Software Engineering Institute (SEI) in the USA both frequently review major programmes for the US Department of Defense. The SEI's publication on lessons learned from independent technical assessments[10] contains the following summary.

> All of the assessments summarized in this paper were on large scale, DoD (or related government agency) programs. All of the programs were in actual or perceived difficulty. Some of the recommendations were for substantial restructuring or cancellation of the effort. With this in mind, we look to some of the root causes of the problems uncovered, and attempt to compare and contrast them to similar works in the non-defense world. In doing this, we find that there are more similarities than there are differences. The most significant drivers to failure on these systems continue to be management and culture related, just as they are in commercial systems. Technological failings, while they exist, also have a strong management flavor, as they tend to cluster around failings in the systems engineering process. There are no technology "silver bullets," and anyone promoting any technology as a panacea should be viewed with suspicion. A recent Defense Science Board report states: "Too often, programs lacked well thought-out, disciplined program management and/or software development processes. ... In general, the technical issues, although difficult at times, were not the determining factor. Disciplined execution was.". There are numerous examples as to how this lack of disciplined execution manifests. Some deficiencies are related to human nature. Self-interest leads people to primarily consider their tenure on a job, cleaning up problems left for them by their predecessors and often not considering long-term consequences of short-term decisions. There is also a tendency to try to place blame on other organizations: customers and program offices cannot hold to a set of requirements; contractors don't live up to their obligations; vendor's products don't live up to their performance and capability claims. It is obviously someone else's fault. This is all a case of lack of discipline. We find that in programs in trouble, there are NO innocent parties. All stakeholders involved participated (at some level) in creating or abetting failure.

7. According to Dr Robert Charette (who was chief designer of the IEPR process referred to above), the US National Academy of Science and Engineering routinely carries out reviews of troubled programmes and makes recommendations to help them to succeed. Dr Charette has taken part in many reviews, including the post-Challenger shuttle review for NASA[11], and he is willing to provide personal evidence to the Committee if you request him to do so. Dr Charette is also author of a recently-published article reviewing American and other efforts to develop national healthcare IT systems[12].

8. I and other members of the UK Computing Research Committee have participated in many independent project reviews for public-sector and private-sector organisations. The systems reviewed include large (several million lines of software), distributed (many scores of processors), information systems processing large quantities of real-time data. Many have involved complex supply chains, with suppliers in the UK and overseas - mainland Europe or the USA - with complex, multi-party (including multiple government agency) procurement organizations. Several have had challenging programmes, with multiple deliveries and complex integration activities to carry out prior to delivery. On several occasions, these reviews have occurred late in programmes. Whilst there are more opportunities and alternatives for improvements early in a programme, our experience is that it is usually still possible to identify courses of action which significantly improve the likelihood of successful project outcome.

UK Policy

9. The Information Tribunal has recently ordered the Office of Government Commerce (OGC) to publish its Gateway reviews of the ID-card programme. In response to the decision, the information commissioner Richard Thomas said: "Disclosure is likely to enhance public debate

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[10] www.sei.cmu.edu/pub/documents/01.reports/pdf/01tn004.pdf

[11] Such reviews by the National Academies of Science are routinely published, and play an inportant part in restoring public confidence in troubled projects. *An Assessment of Space Shuttle Flight Software Development Processes*, R. Charette (Chairman). Commission on Engineering and Technical Systems, National Research Council, (National Academies Press, 1993), 194 pp. [http://books.nap.edu/openbook.php?isbn=030904880X]

[12] R. Charette, "Dying for Data: A comprehensive system of electronic medical records promises to save lives and cut health care costs-but how do you build one?," IEEE Spectrum, vol. 43, no. 10, pp.22-27, 2006. [http://www.spectrum.ieee.org/oct06/4589]

of issues such as the programme's feasibility and how it is managed". It seems likely that the same ruling would apply to NPfIT.

10. On 3rd April 2000, the Committee of Public Accounts published its Session 1999-2000 Thirteenth Report entitled "The 1992 and 1998 Information Management and Technology Strategies of the NHS Executive". This report concluded (paragraph 39 & 40)

> "Evaluation of the success of IT projects is essentially to identify lessons learned and avoid the same problems in future. We have previously expressed our concerns about the failure of the NHS Executive to evaluate important aspects of the 1992 Strategy in its reports on the Hospital Support Systems Initiative and Read Codes. .... The Executive assured us that they are committed to evaluation of ongoing projects .and of the 1998 Strategy. But they have yet to develop their plans in detail. We expect the Executive to produce a programme for these evaluations, and to let us see it as soon as possible".

11. Hence the Committee of Public Accounts recognised as long ago as the year 2000 that evaluation of projects while they were still in progress is a potentially valuable act. In response, the Department of Health commissioned two reviews of direct relevance to the Health Committee's enquiry. Between August and October 2001, Professor Denis Protti, School of Health Information Science, University of Victoria, Victoria, British Columbia, Canada was commissioned to review "the state of progress of Information for Health". His report (the Protti Report) contains many pages of detailed recommendations. It was undoubtedly critical. In response, in 2003, the Department of Health commissioned a report from the PA Consulting Group (Core National Evaluation of the Electronic Records Development and Implementation Sites). This report also made a number of important recommendations.

12. Between April and July 2003, the Department of Health commissioned a review "The Public View on Electronic Health Records", conducted by the Consumers' Association and the researchers they commissioned: Research Works Limited (qualitative) and BMRB International Limited (quantitative). This report's findings are fascinating and its recommendations are most interesting.

13. The difficulty is that Connecting for Health appears to have largely ignored the recommendations made in these reviews. If they have not done so, they should be invited to explain to the Health Select Committee which recommendations they have implemented and how they have implemented these recommendations.

Conclusions

14. The Health Select Committee may wish to address two issues: (a) having independent timely information, which can only come from a thorough independent review; (b) monitoring that the Department pays attention to the review report, through a continuous programme of Health Select Committee scrutiny of the Programme. In this context, it may be worth noting that the House of Commons Work and Pensions Sub- Committee (Report HC 311-II Published on 14 July 2004) (paragraph 26) says:

> "We recommend that, as formal evidence to Parliament, the Department should present an implementation assessment for each major IT project. We envisage that such an IT Implementation Assessment (ITIA) would be similar to a Regulatory Impact Assessment (RIA) that is currently required. An ITIA should set out in some detail the Government's justification for embarking on the IT programme, including purpose, timings, costs, IT requirements and major risks".

15. In many ways the review recommended by Professor Randell, on behalf of the 23 academics, would produce an independent IT Implementation Assessment similar to that proposed by the House of Commons Work and Pensions Sub- Committee, which together with the Department's response may move the National Programme for IT genuinely forward.

16. Please let me know if you would like me to provide the Committee with any of the reports or other documents referred to in this evidence.

Dr Martyn Thomas CBE
May 2007