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 over 200 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 However this is preceded by a section containing the full texts of a number of unpublished expressions of concern.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 in recent years. (These questions and contributions are from forty-eight Members of Parliament and from seven Members of the House of Lords.)

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. . ."

1.6. 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."

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 23@nhs-it.info. 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
Aylesbury
Bucks
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.

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."

3.2. 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. 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."

3.3.18. 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. . ."

3.3.19. 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. . ."

3.3.20. 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. . ."

3.4. 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.

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. . ."

3.5. 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. Publicly Reported Breaches in EPR Confidentiality (13 Sep 2005)

Jeremy E. Rogers, Manchester University

http://www.cs.man.ac.uk/mig/people/jeremy/Confidentiality.html

" An e-mail error led to confidential information about 92 patients being distributed by Melton, Rutland and Harborough Primary Care Trust to 35 local organisations including the local press and local government representatives."

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. 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."

3.6. 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. . ."

3.7. 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. . ."

3.8. 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. 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. . ."

3.8.5. 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."

3.8.6. 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."

3.8.7. 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."

3.8.8. 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."

3.8.9. 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]

3.8.10. 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."

3.8.11. 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]

3.8.12. 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? . . ."

3.8.13. 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."

3.8.14. 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."

3.8.15. 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"

3.8.16. 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."

3.8.17. 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."

3.8.18. 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. . ."

3.8.19. 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."

3.8.20. 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."

3.8.21. 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'."

3.8.22. 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?"

3.8.23. 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]

3.8.24. 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. . . "

3.8.25. 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."

3.8.26. 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. . ."

3.8.27. 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. . ."

3.8.28. 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. . ."

3.8.29. 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]

3.8.30. 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."

3.8.31. 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. . ."

3.8.32. 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. . ."

3.8.33. 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. . ."

3.8.34. 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. . ."

3.8.35. 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. . ."

3.8.36. 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. . ."

3.8.37. 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

3.8.38. 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."

3.8.39. 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. . ."

3.8.40. 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. . . "

3.8.41. 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. . . "

3.8.42. 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]

3.8.43. 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. . ."

3.8.44. 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

3.8.45. 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."

3.8.46. 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. . ."

3.8.47. 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. . ."

3.8.48. 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. . ."

3.8.49. 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. . . ."

3.8.50. 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. . ."

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]

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

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."

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."

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#06070077000412

" 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."

7.30. 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."

8.5. 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. . ."

8.6. 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. 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. . ."

9.2. 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. . ."

9.3. 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."

9.4. 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.)

9.5. 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.

9.6. 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. . ."

9.7. 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."

9.8. 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.**"**

9.9. 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."

9.10. 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."

9.11. 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."

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. . .”

11. NPfIT Specifications and Policies

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. 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."

11.9. 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. . ."

12. Other Documents

12.1. 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. . ."

12.2. 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.)

12.3. 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."

12.4. 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."

12.5. 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. . ."

12.6. '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]

12.7. The Spine, *an* 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."

12.8. 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."

12.9. 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."

12.10. 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. . ."

12.11. 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. . ."

12.12. 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. . .?

12.13. '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. . ."

12.14. 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."

12.15. 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. . ."

12.16. 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.)

12.17. 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. . ."

12.18. 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."

12.19. 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?"

12.20. '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)"

12.21. 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."

12.22. 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. . ."

12.23. 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?".

12.24. 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."

12.25. 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. . . ."

12.26. The Dossia consortium

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

12.27. 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. Other Websites

(Relevant websites and other online resources.)

13.1. 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

13.2. Health Informatics community web-site

http://www.informatics.nhs.uk/ - a large document repository

13.3. 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

13.4. 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).

13.5. 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

13.6. 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

13.7. NHS Confidentiality

http://www.nhsconfidentiality.org/

A campaigning web-site: " Protect your privacy and campaign against the government's NHS Care Records"

13.8. Patient safety

http://www.patient-safety.org.uk/home.htm

Website of the All-Party Parliamentary Group (APPG) on Patient Safety.

13.9. Yasnoff on e-Health

http://williamyasnoff.com/

An informative blog by William Yasnoff on issues to do with (mainly American) Health Information Systems.

13.10. The Big Opt Out

http://www.nhsconfidentiality.org/

" Protect your privacy and campaign to preserve medical confidentiality"

13.11. 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. 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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15. Appendix 2 - Initial Incorrect Version of the Agreed Statement, and Currently Available Text

15.1. 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.

15.2. 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.

16. 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.

17. 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 NPfIT's 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
Director, Information System Integrity Group
London School of Economics

David Bustard
Professor and Head of Computing
and Information Engineering
University of Ulster

Ewart Carson
Professor of Systems Science
Centre for Health Informatics
City University

Patrik O'Brian Holt
Professor
School of Computing
The Robert Gordon University

Roland Ibbett
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School of Informatics
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Uday Reddy
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Peter Ryan
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Martyn Thomas
Visiting Professor
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Colin Tully
Professor of Software Practice
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18. Appendix 5 - Letter to Mr David Nicholson (29 Nov 2006)

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David Nicholson CBE
Chief Executive of the NHS
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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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19. 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.

20. 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.