House of Commons

Public Accounts Committee

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

Second Report of Session 2008–09

Report, together with formal minutes, oral and written evidence

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The Public Accounts Committee

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Summary

The National Programme for IT is designed to reform the way the NHS in England uses information, and hence to improve services and the quality of patient care. The Programme's aims are ambitious, and its scale and complexity make delivery more challenging than similar projects elsewhere in the world. The Programme requires substantial organisational and cultural change to be successful and it is dependent on the deployment of systems in an increasingly devolved NHS.

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

Some systems are being deployed across the NHS. The Care Records Service, however, is at least four years behind schedule, with the Department's latest forecasts putting completion at 2014–15. At 31 August 2008, new care records systems had been deployed in 133 of the 380 Trusts. Trusts in the North, Midlands and East have been receiving an interim system and will have to go through a further deployment in due course to implement Lorenzo, the care records software for the North, Midlands and East, which has suffered major delays. By the end of 2008, Lorenzo had not been deployed throughout any Acute Trust and in only one Primary Care Trust.

The Programme started with four Local Service Providers—the main suppliers responsible for implementing systems at local level—covering the whole of England, but two have left the Programme. Only two remain, both carrying the responsibility for major components of the Programme. The Programme's high dependence on just two major suppliers has implications for the Programme's capacity and capability, and for the Department's leverage.

Fujitsu's contract covering the South of England was terminated in May 2008. Negotiations to reset the contract had failed because the two sides were unable to agree on the price and commercial terms. The future arrangements for the South remain under discussion, but the Department's intention is allow those Trusts which have not yet implemented a new care records system to choose between those offered by the two remaining Local Service Providers, BT and CSC.

The estimated cost of the Programme is £12.7 billion, including £3.6 billion of local costs, although this figure remains uncertain. In the event that Trusts decide not to deploy the Programme's systems, the Department is nonetheless obliged to make payments to the suppliers concerned. While the Department can direct NHS Trusts and Primary Care Trusts to take the systems, it has no such power over Foundation Trusts.

The Programme is intended to generate substantial benefits for patients and the NHS. The aim is for the care records software to be delivered in a series of releases with increasing functionality. Delivering the clinical functionality will be key to convincing NHS staff of the benefits of the Programme because what has been provided to date has not met their

expectations.

Keeping patient data secure is crucial to the reputation and success of the Programme, and the Department is confident that the mechanisms it is putting in place will provide a high level of security. Access to the Care Records Service will be controlled through Smartcards and passcodes, and access will be auditable. The security of the IT systems themselves is the responsibility of suppliers, with NHS organisations and their staff responsible for keeping secure the data they access. The Department is notified of serious security breaches, but less serious incidents are handled at local level.

The Committee first reported on the Programme in March 2007.[1] On the basis of a further report by the Comptroller and Auditor General,[2] we took evidence from the Department of Health and Fujitsu on the progress being made in delivering the Programme, including the termination of Fujitsu's contract as the Local Service Provider for the South.

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1   Committee of Public Accounts, Twentieth Report of Session 2006–07, *Department of Health: The National Programme for IT in the NHS,* HC 390

2   C&AG's Report, *The National Programme for IT in the NHS: Progress since 2006,* HC (Session 2007–08) 484–I

Conclusions and recommendations

1. **Recent progress in deploying the new care records systems has been very disappointing, with just six deployments in total during the first five months of 2008–09.** The completion date of 2014–15, four years later than originally planned, was forecast before the termination of Fujitsu's contract and must now be in doubt. The arrangements for the South have still not been resolved. The Department and the NHS are working with suppliers and should update the deployment timetables. Given the level of interest in the Programme, the Department should publish an annual report of progress against the timetables and revised forecasts. The report should include updates on actions to resolve the major technical problems with care records systems that are causing serious operational difficulties for Trusts.

2. **By the end of 2008 the Lorenzo care records software had still not gone live throughout a single Acute Trust.** Given the continuing delays and history of missed deadlines, there must be grounds for serious concern as to whether Lorenzo can be deployed in a reasonable timescale and in a form that brings demonstrable benefits to users and patients. Even so, pushing ahead with the implementation of Lorenzo before Trusts or the system are ready would only serve to damage the Programme. Future plans for deployment across the North, Midlands and East should therefore only follow successful deployment and testing in the three early adopter Trusts. This will mean that lessons can be learned before any decision is taken to begin a general roll-out.

3. **The planned approach to deploy elements of the clinical functionality of Lorenzo (release 1) ahead of the patient administration system (release 2) is untested, and therefore poses a higher risk than previous deployments under the Programme.** The Department and the NHS should undertake a thorough assessment of whether this approach to deployment will work in practice. No Trust other than the three early adopters should be invited to take the first release of Lorenzo until it is certain that release 1 and release 2 will work effectively together.

4. **Of the four original Local Service Providers, two have left the Programme, and just two remain, both carrying large commitments.** CSC is responsible for deploying care records systems to the whole of the North, Midlands and East after taking over Accenture's contracts. As well as deploying systems in London, BT is responsible for the N3 broadband network and the Spine. In the light of the experience of Accenture's and Fujitsu's departures from the Programme, it is vitally important that the Department assesses BT's and CSC's capacity and capability to continue to meet their substantial commitments. The assessment should consider the impact on the strength of the Department's position of having only two suppliers responsible for the Programme's major components.

5. **The termination of Fujitsu's contract has caused uncertainty among Trusts in the South and new deployments have stopped.** One option being considered for new deployments is for Trusts to have a choice of either Lorenzo provided through CSC or the Millennium system provided through BT. There are, however, considerable problems with existing deployments of Millennium and serious concerns about the

prospects for future deployments of Lorenzo. Before the new arrangements for the South are finalised, the Department should assess whether it would be wise for Trusts in the South to adopt these systems. Should either of the Local Service Providers take on additional commitments relating to the South, the Department should take particular care to assess the implications of the extra workload for the quality of services to Trusts in the Local Service Providers' existing areas of responsibility.

6. **The Programme is not providing value for money at present because there have been few successful deployments of the Millennium system and none of Lorenzo in any Acute Trust.** Trusts cannot be expected to take on the burden of deploying care records systems that do not work effectively. Unless the position on care records system deployments improves appreciably in the very near future (i.e. within the next six months), the Department should assess the financial case for allowing Trusts to put forward applications for central funding for alternative systems compatible with the objectives of the Programme.

7. **Despite our previous recommendation, the estimate of £3.6 billion for the Programme's local costs remains unreliable.** The Department intends to collect some better data as part of the process of producing the next benefits statement for the Programme. In the light of that exercise, the Department should publish a revised, more accurate estimate for local costs and, thereby, for the cost of the Programme as a whole.

8. **The Department hopes that the Programme will deliver benefits in the form of both financial savings and improvements in patient care and safety.** In March 2008, the Department published the first benefits statement for the Programme, for 2006–07, predicting total benefits over 10 years of over £1 billion. There is, however, a lot of work to do within the NHS to realise and measure the benefits. Convincing NHS staff of the benefits will be key to securing their support for the Programme, and the credibility of the figures in the benefits statement would be considerably enhanced if they were audited. We consider future benefits statements should be subject to audit by the Comptroller and Auditor General. The Department should also review achievements under the Programme so that lessons can be identified and shared where products and services are working well.

9. **Little clinical functionality has been deployed to date, with the result that the expectations of clinical staff have not been met.** Deploying systems that offer good clinical functionality and clear benefits is essential if the support of NHS staff is to be secured. For all care records systems offered under the Programme, the Department and the NHS should set out clearly to NHS staff which elements of clinical functionality are included in existing releases of the software, which ones will be incorporated in the next planned releases and by what date, and which will be delivered over a longer timescale.

10. **The Department has taken action to engage clinicians and other NHS staff but there remains some way to go in securing their support for the Programme.** To assess and demonstrate the impact of its efforts to secure support for the

Programme, the Department should repeat its surveys of NHS staff at regular intervals (at least every year) and publish the results.

11. **Patients and doctors have understandable concerns about data security.** However extensive the Care Record Guarantee and other security provisions being put in place are, ultimately data security and confidentiality rely on the actions of individual members of NHS staff in handling care records and other patient data. To help provide assurance, the Department and the NHS should set out clearly the disciplinary sanctions that will apply in the event that staff breach security procedures, and they should report on their enforcement of them.

12. **The Department does not have a full picture of data security across the NHS as Trusts and Strategic Health Authorities are required to report only the most serious incidents to the Department.** The Department's view is that it is not practical for it to collect details of all security breaches but at present it can offer little reassurance about the nature and extent of lower-level breaches that may be taking place. Given the importance of data security to the success and reputation of the Programme, the Department should consider how greater assurance might be provided through regular reporting. The Department should also report annually on the level of 'serious untoward incidents', on any penalties that have been imposed on suppliers for security breaches, and on the steps being taken to keep patient data secure.

13. **Confidentiality agreements that the Department made with CSC in respect of two reviews of the delivery arrangements for Lorenzo are unacceptable because they obstruct parliamentary scrutiny of the Department's expenditure.** The Department made open-ended confidentiality agreements in respect of these reviews, with the result that information will not be disclosed even after commercial confidentiality has lapsed with the passage of time. We believe this is improper. The Department should desist from entering into agreements of this kind.

1 Progress in implementing the systems

1. The National Programme for IT is designed to reform the way the NHS in England uses information, and hence to improve services and the quality of patient care. The Programme's aims are ambitious, and the scale and complexity make delivery more challenging than similar projects elsewhere in the world. The Programme requires substantial organisational and cultural change to be successful and it is dependent on the deployment of systems in an increasingly devolved NHS.[3]

2. At the outset of the Programme, the aim was for implementation of the systems to be complete by 2010. While some aspects, such as the N3 broadband network and the Spine, are complete or well advanced, the original timescales for introducing the Care Records Service have not been met. The Department's latest forecasts are that it is likely to take some four years more than planned—until 2014–15—before every Trust has fully deployed the new care records systems which will support the creation of Detailed Care Records. The introduction of the Summary Care Record is also behind schedule, though deployment in five early adopter areas began in March 2007.[4]

3. The Department pointed to three factors to explain why the original timescales had proved unachievable. These were the technically ambitious nature of the Programme; the need to agree how consent would be handled in order to retain public confidence; and customisation, where suppliers were having to do more to meet the needs of individual NHS organisations than was envisaged at the start of the Programme. Fujitsu agreed that the need to tailor the systems to meet local requirements had been a major cause of delay.[5]

4. The new care records systems are being deployed in Trusts, but much more slowly than originally planned. At 31 August 2008, a total of 133 deployments had been made, including 37 in Acute Trusts (**Figure 1**). In the first five months of 2008–09, just six deployments were made, two each in Acute Trusts in London and in the North, Midlands and East, and two in Mental Health Trusts in the North, Midlands and East. There were no further deployments in Primary Care Trusts or in the South.[6]

5. Cerner's Millennium product has been deployed in Acute Trusts in London and the South. Deployment of the first release began in December 2005 in the South and in July 2007 in London. Since April 2007, responsibility for developing plans for implementing systems in all Trusts has rested with the local NHS, working with the Local Service Providers. London has outline plans, but deployment of the later releases of Millennium will not be complete for several years.[7]

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3   Q 72; C&AG's Report, para 1

4   C&AG's Report, paras 5–6, 2.16

5   Qq 11–12, 150

6   C&AG's Report, para 2.14, Figure 1; Ev 29

7   C&AG's Report, paras 2.8, 2.15–2.16

Figure 1: Deployments of electronic care records systems under the Programme at 31 August 2008

Area	Local Service Provider	Acute Trusts		Mental Health Trusts		Primary Care Trusts	
		Number of Trusts	Number of deployments	Number of Trusts	Number of deployments	Number of Trusts	Number of deployments
London	BT	31	6	10	6	31	20
South	Fujitsu (to 28.05.08)	41	8	14	1	31	7
North, Midlands and East	CSC	97	23	35	15	90	47
Total		169	37	59	22	152	74

Notes
1. Two of the deployments in Acute Trusts in London pre-date the Programme but have since been integrated into the Programme, with services now provided by the Local Service Provider.
2. The deployments in the North, Midlands and East are of iPM, the interim solution, which will be replaced later by releases of Lorenzo.
3. This Figure does not include deployments of GP systems.

Source: Department of Health

6. Trusts generally experience some technical problems with the new care records systems, and the hospitals in London and the South which have deployed Millennium have had considerable problems. For example, in summer 2008 the Royal Free Hampstead NHS Trust identified problems associated with data entry, system processing, data management and reporting that were having a significant impact in relation to waiting list management and patient bookings, and on the finances of the Trust.[8]

7. Least progress has been made in the North, Midlands and East because the Lorenzo care records software, the strategic solution, has not been available. As a result, in the meantime Trusts have been deploying iPM, an interim system. To implement Lorenzo, these Trusts will have to go through a further deployment in due course, with the attendant substantial additional work. The Department acknowledges that the delivery of Lorenzo has not gone smoothly and has taken much longer than planned. In addition, the software developer, iSOFT, has experienced a series of financial, accounting and governance difficulties. In the light of concerns about progress, in summer 2007 the Department and CSC (the Local Service Provider) jointly commissioned two reviews of the delivery arrangements for Lorenzo. Among other things, the reviews drew attention to deficiencies in programme management, which has since been strengthened. The Committee requested copies of the reviews, but the Department responded that it could not release them because CSC had agreed to the reviews only on the basis of strict confidentiality agreements, advising that the information supplied was commercially sensitive to third parties.[9]

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8   C&AG's Report, para 3.85; Royal Free Hampstead NHS Trust, Chief Executive's Report to the Board on 6 November 2008, http://www.royalfree.nhs.uk/doc/061108/Appendix%20C.pdf

9   Q 44; C&AG's Report, paras 2.10–2.12, 2.14; Ev 24

8. Despite the delays, the Department is optimistic about the prospects for Lorenzo, which is now being demonstrated to the clinical community. At the time of our hearing in June 2008, the first release of Lorenzo was in pre-deployment testing in three early adopter sites. (The first release is solely clinical and functionality for the patient administration system will follow in the second release.) Trusts will not go ahead with a deployment until they are satisfied that the system will not put patient safety or the running of the hospital at risk. It can be very disruptive if a system is deployed too early and a Trust has to revert to clerical records. Decisions about 'go live' dates are therefore a matter for individual Trusts, rather than being determined centrally.[10]

9. The Department had expected that Lorenzo would be deployed first at University Hospitals of Morecambe Bay NHS Trust at around the end of September 2008. In the event, the planned 'go live' date at Morecambe Bay was not met, and the first Trust to deploy Lorenzo was South Birmingham Primary Care Trust, on 3 September 2008, where the system is supporting the podiatry service. Roll-out of the first release of Lorenzo across the North, Midlands and East, to follow implementation in the early adopters, was expected to begin later in 2008 but was not achieved. As for Millennium, further releases are planned to be implemented over several years.[11]

10. Progress on two other key components of the Programme—Choose and Book and the Electronic Prescription Service—is mixed. Choose and Book incorporates an electronic booking service, although not all Trusts can take direct bookings and utilisation has been lower than expected. Although on average around 98% of GPs use the Choose and Book system at some stage in a week, in total only around half of new outpatient appointments were being made in this way. Choose and Book involves significant change in the way people work and it is taking time to train, educate and support GPs to use the system. The Department is also planning to publicise patients' rights in order to increase awareness of Choose and Book.[12]

11. In relation to the Electronic Prescription Service, over 70% of GPs and pharmacies have the first release of the software, which enables them to handle electronic prescriptions. But as the GPs and pharmacies are not necessarily in the same areas, only around 40% of prescriptions are issued with readable barcodes. Paper prescriptions will continue to be required until the second release of the software is deployed, which cannot begin until GP and pharmacy systems have been accredited. The Department expects that most suppliers of GP systems will be accredited by the middle of 2009. After the introduction of the second release of the software, paper prescriptions will continue only in certain limited circumstances, for example, when a patient requests a paper prescription or when the prescription is a private prescription.[13]

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10   C&AG's Report, para 2.13; Qq 16–17, 46–48, 58

11   Ev 29

12   Q 31; C&AG's Report, paras 3.92–3.93, Figure 5

13   Qq 24–26; Ev 22–23

2 Managing the change of Local Service Provider in the South

12. The Local Service Providers are responsible for the local systems in different parts of the country, including the care records systems, and for ensuring that these systems integrate with the national applications and with local legacy systems. At the time of the Comptroller and Auditor General's report, there were three Local Service Providers—BT in London, Fujitsu in the South, and CSC in the North, Midlands and East—following Accenture's withdrawal in January 2007.[14]

13. On 28 May 2008, however, the Department terminated its contract with Fujitsu, following ten months of negotiations about resetting the contract. The aim of the resetting process had been to set a new baseline for development and deployment plans, and to agree changes to meet the local needs of the NHS. The two sides were unable to agree on price and commercial terms. Fujitsu considers it could not have afforded the terms that the NHS was willing to agree to, while the Department was not prepared to make payments ahead of delivery, as Fujitsu requested.[15]

14. While the basis for the contract termination is in dispute and likely to lead to mediation in due course, we asked the two parties for their general views on why an impasse had been reached. Fujitsu told us that the project had not run in the way that the original contract had envisaged. Delays in getting paid for deployments were frustrating and, in Fujitsu's view, the NHS had held back from approving payment to force Fujitsu to make further changes to suit the specific requirements of individual Trusts. Fujitsu regarded these changes as beyond its contractual requirements. It had received a total of 650 change requests.[16]

15. In the Department's view, however, most of what Fujitsu considers to be new requirements were in fact remedial and necessary to make the product fit-for-purpose for the NHS. Furthermore, the Department considered Fujitsu had not met its contractual obligations, which had caused delay to the Programme.[17]

16. At 31 August 2008 the position in the South remained under discussion. Under an arrangement which has been extended to May 2009, Fujitsu was continuing to support the eight sites in the South where it had deployed new care records systems, while negotiations continued between the Department and BT to transfer responsibility for maintaining these sites. The Department currently considers that BT is best placed to take on the maintenance as it is also deploying Cerner's Millennium system in London.[18]

17. There also remains a substantial number of Trusts in the South in need of improved IT systems. The current intention is to offer these Trusts a choice of either the Millennium

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14   C&AG's Report, paras 3.43–3.44

15   Qq 4–6, 184; Ev 21–22

16   Qq 142–144, 150; C&AG's Report, para 2.30

17   Q 145; Ev 21–22

18   Ev 29–30

system provided by BT or the Lorenzo system provided by CSC. The contracts with the two remaining Local Service Providers allow them to deploy systems outside their 'territory' at the same prices and under the same terms and conditions as in their home area. The Department considers that this approach will provide the most certainty and be the most cost-effective, but we consider that it would pose a serious risk were Trusts to enter into agreements before existing problems with the deployments of Millennium have been resolved and Lorenzo has been successfully implemented at the pilot sites.[19]

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19   Q 162; Ev 29–30

3 The costs and benefits of the Programme

18. The estimated cost of the Programme is currently £12.7 billion (at 2004–05 prices) (**Figure 2**). Value for money has yet to be established. There remains considerable uncertainty around the estimate of £3.6 billion for local costs, principally because the figure is based on business cases compiled by Trusts in 2003–04. The Department carries out an annual survey to establish how much the NHS has spent on IT, but is not able to separate the amount that Trusts have spent on the Programme from spending on IT for other purposes. The Department considers that the figure of £3.6 billion is probably an overestimate and, as part of producing the next benefits statement for the Programme, is to carry out research at a sample of sites to generate more accurate data on local expenditure.[20]

Figure 2: Estimated cost of the Programme at 31 March 2008 (at 2004–05 prices)

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

Source: Department of Health

19. The Programme's contracts were based on the assumption that all Trusts would take the systems at some point. If the Local Service Providers do not receive the expected revenue for reasons solely due to the Department (for example, where a Trust decides not to deploy the system), the Department is obliged to make payments to the suppliers concerned. At 31 March 2008, £36.1 million had been paid under these arrangements, of which £29.1 million will be deducted from the charges if the deployments go ahead and £7.0 million is irrecoverable. Most of the irrecoverable amount relates to two Trusts which declined to take the Picture Archiving and Communications Systems being provided under the Programme.[21]

20. We are not yet convinced that the Department secured good value for money by letting contracts which covered the NHS as a whole. It can direct NHS Trusts and Primary Care Trusts to take the systems, though the position on Foundation Trusts is less clear cut. While Foundation Trusts are not subject to direction, they are bound by Treasury rules which require them to take account of the impact of their decisions on the wider public sector finances. The Department considers that it would therefore be difficult for a Foundation Trust to put together a business case which involved rejection of the

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20   Q 27; C&AG's Report, paras 2.12, 2.24–2.26

21   Ev 24; C&AG's Report, paras 2.32–2.33

Programme's preferred systems. In any event, it expects all Trusts will want to take the systems when they see the prospective benefits. However, in the event that the problems with Millennium cannot be resolved or the Lorenzo system is not satisfactorily developed, it may be necessary to renegotiate or terminate the existing contracts with the Local Service Providers.[22]

21. The Programme is intended to generate substantial benefits for patients and the NHS—both financial savings and wider benefits such as improvements in clinical safety and the quality of patient treatment—though there is no baseline against which to assess the benefits actually achieved. The Picture Archiving and Communications Systems for digital X-ray has helped to reduce diagnostic waiting times, although picture archiving systems were already being introduced in the NHS prior to the Programme.[23]

22. Financial savings arise where Trusts no longer have to buy something or can buy it at a much reduced cost, such as the N3 broadband network and NHSmail. The first benefits statement for the Programme, for 2006–07, forecast estimated total savings of £1.1 billion over the 10 years to 2013–14, though the Department expects the total will prove to be considerably higher as more of the systems are fully deployed across the NHS.[24]

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22   Qq 19–23, 67–68; C&AG's Report, para 1.14

23   Q 74; C&AG's Report, paras 2.35, 2.39, 3.89

24   Q 28; C&AG's Report, paras 2.37–2.38

4 Securing the support of clinicians and other NHS staff

23. The success of the Programme will be largely determined by the support it enjoys among clinicians and other NHS staff who use the systems. The Department considers that the current levels of support reflect the fact that for many staff the benefits of the Programme are still theoretical.[25]

24. Delivering clinical functionality will be key to convincing staff of the benefits of the Programme. The aim is for the care records software to be delivered in a series of releases with increasing functionality, and the Department acknowledges that the clinical functionality delivered to date has not met the expectations of NHS staff. The new systems have required clinicians and other staff to change the way they work, without their seeing very much benefit and sometimes without consultation.[26]

25. The Department needs to accelerate the deployment of clinical functionality, such as order communications (the electronic ordering and reporting of clinical tests, linked directly to a patient's care record), especially in the South. Fujitsu highlighted, however, that order communications had been available as part of the first release of the Millennium care records software but that some Trusts had chosen not to take this functionality in order to limit the amount of change which the deployment would entail. To bring forward clinical functionality in the North, Midlands and East, the first release of Lorenzo is solely clinical, and administrative functionality will follow in the second release.[27]

26. The Department is continuing to take action to engage clinicians at national and local level, including appointing a Chief Clinical Officer for the Programme to provide clinical leadership and input to the development and deployment of the systems. At the time of our hearing, however, overall leadership of NHS Connecting for Health had been uncertain for some time, following the announcement in summer 2007 that the Director General of IT would be stepping down. The Director General of IT left his post in January 2008, and the Department has since made appointments to two new posts, a Chief Information Officer for the NHS and a Project Director for the Programme.[28]

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25   Q 30; C&AG's Report, para 3.31

26   Q 79; C&AG's Report, para 3.83

27   Qq 79, 152–153; Ev 24; C&AG's Report, para 2.18

28   Q 9; C&AG's Report, paras 3.2–3.2, 3.31

5 The security of patients records

27. Maintaining the security and confidentiality of patient data is crucial to the success and reputation of the Programme. The Department acknowledges that patients and doctors have concerns about data security. The Department has set out policies on secure processing, transmission and storage of patient data, and there are a range of controls to prevent unauthorised access to data.[29]

28. The Local Service Providers and other suppliers are required to implement security policies which, among other things, comply with industry good practice and meet any specific threats to the systems. The suppliers have to test their security policy, and the Department can witness and see the results of the tests, as well as carry out its own audits. Suppliers are required to notify the Department immediately in the event of a security breach, actual or attempted, and to take all reasonable steps to remedy the breach and prevent recurrence. Subject to the nature of the breach, suppliers may face financial penalties in the form of deductions against their monthly service charges, and in extreme circumstances a security breach could give the Department the right to terminate a supplier's contract.[30]

29. While suppliers are responsible for the systems themselves, NHS organisations and their 1.3 million staff are responsible for keeping secure any data they access. The Department stressed that confidentiality is a corner-stone of the NHS, with data security a key responsibility for all NHS Chief Executives. To help provide assurance about data security and confidentiality, the Department and the NHS have developed a 'Care Record Guarantee', which sets out the principles that will be applied in handling electronic care records. The Care Record Guarantee is reviewed each year to take account of developments in the Programme and in the NHS.[31]

30. Security incidents which relate to locally managed processes are dealt with by the local NHS and there is no requirement for the Department to be notified of all breaches. NHS organisations set out details of security breaches in their annual reports and Strategic Health Authorities publish information on the more serious breaches on their websites every quarter. The Department considers it is not practical for it to be notified of every security breach regardless of the severity, but Trusts and Strategic Health Authorities are required to report 'serious untoward incidents' to the Department immediately, for example, if a large number of care records are lost.[32]

31. Access to the Care Records Service is controlled through Smartcards and passcodes, though these are not yet in use in all Trusts because early releases of the care records software in London and the South do not support them and the Trusts concerned therefore continue to rely on passwords. To get a Smartcard, NHS staff have to produce evidence of identity, typically a passport, and of residence, typically a utility bill. If a Smartcard is

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29   Qq 115–117; C&AG's Report, para 3.21

30   Ev 28

31   Qq 29, 117–118; C&AG's Report, paras 3.20, 3.23

32   Qq 124–129; C&AG's Report, para 3.27

reported as lost, it is disabled immediately so that anyone finding the card is not able to use it even if they had the associated passcode.[33]

32. The Smartcards grant access to patient data based on an individual's role and level of involvement in patient care. In addition, they can provide an audit trail to show who has accessed which record, when and what they did, provided that the Smartcards have not been shared or left unattended in the reader when staff take a break, both of which are clear breaches of security.[34]

33. It is intended that patients should be able to exercise choices in relation to the Summary Care Record and their decisions will be influenced by how confident they are that data will be secure. Every patient will be sent a letter informing them that the NHS plans to create a Summary Care Record for them, and patients are assumed to be content unless they explicitly state otherwise. The Department has consulted patients and doctors about this 'implied consent' approach. One of our concerns is that patients who are difficult to reach and vulnerable would be least likely to provide explicit consent.[35]

34. Following our hearing, the Department decided that patients' consent should be sought at the point of care, before their Summary Care Record is viewed. This 'consent to view' approach is being used in other parts of the UK and has worked successfully in other countries.[36]

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33 Qq 66, 130–132; C&AG's Report, para 3.75

34 Q 123; C&AG's Report, para 3.79, Figure 15

35 Qq 14, 169–170; C&AG's Report, paras 3.13, 3.16

36 Qq 14–15, 170

Formal Minutes

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon	Mr Nigel Griffiths
Mr Ian Davidson	Mr Austin Mitchell

Draft Report (*The National Programme for IT in the NHS: Progress since 2006*), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 34 read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Monday 19 January at 4.30 pm

Witnesses

List of written evidence

List of Reports from the Committee of Public Accounts 2008–09

Oral evidence

Taken before the Committee of Public Accounts

on Monday 16 June 2008

Members present:

Mr Edward Leigh, in the Chair	Keith Hill
Mr Richard Bacon	Dr John Pugh
Mr Paul Burstow	Geraldine Smith
Mr David Curry	Mr Don Touhig
Mr Ian Davidson	Mr Alan Williams
Nigel Griffiths	Phil Wilson

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Mr Tim Burr, Comptroller & Auditor General, **Mr Michael Whitehouse,** Assistant Auditor General and **Ms Angela Hands**, Director, National Audit Office, gave evidence.

Ms Paula Diggle, Alternate Treasury Officer of Accounts, HM Treasury, was in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

THE NATIONAL PROGRAMME FOR IT IN THE NHS: PROGRESS SINCE 2006 (HC 484-I)

Examination of Witnesses

Witnesses: **Mr David Nicholson,** Chief Executive of the NHS, **Mr Gordon Hextall,** Chief Operating Officer and Interim Director for Programme and Systems Delivery, NHS Connecting for Health, **Professor Michael Thick,** Chief Clinical Officer, NHS Connecting for Health, **Dr Gillian Braunold,** Clinical Director of the Summary Care Record, Department for Health, and **Mr Peter Hutchinson,** Group Director UK Public Services, Fujitsu Services, gave evidence.

Q1 Chairman: Good afternoon, everyone. Welcome to this hearing on the latest report on the National Programme for IT in the NHS: Progress since 2006. We welcome David Nicholson once again to our Committee, who is the Chief Executive of the NHS, and the Senior Responsible Owner of the programme, and Gordon Hextall, who is the Interim Director for IT Programme and Systems Delivery and previously Chief Operating Officer of NHS Connecting for Health, and Mr Hutchinson, representing Fujitsu Services. Mr Hutchinson, I have a letter in front of me dated 5 March 2007, after we had summoned one of your employees who had lifted the lid on this programme, and you told me in your letter that he was expressing his personal views during his recent presentation and these views did not represent the views of Fujitsu. Of course, Fujitsu has now withdrawn from this programme. Have Mr Rollerson's warnings been borne out by events, Mr Hutchinson?

Mr Hutchinson: I wrote you the letter at the time because Mr Rollerson was not working on the project and had not been for a year, and he was being represented in the press as a senior executive of the company who was working on the project and I wanted to set that straight.

Q2 Chairman: Have his warnings been borne out by events? That was the question I put to you.

Mr Hutchinson: I think some of what Mr Rollerson said at the time was probably borne out, some was not.

Q3 Chairman: Mr Granger is no longer with us. What was wrong? Was it because he was bullying you into a contract that you simply could not sustain given the difficulties?

Mr Hutchinson: That is not the way I would characterise it, Mr Chairman.

Q4 Chairman: Why have you withdrawn? What has gone wrong?

Mr Hutchinson: As I think the Committee know, there has been a very long period of renegotiation called the contract re-set discussion, at the end of which the two parties were unable to agree on commercial terms for taking the project forward.

Q5 Chairman: We know that, yes, so why has all this happened? Now there is a gaping hole in this programme, is there not, for which you were responsible? We are a Parliamentary Committee charged with trying to find out what went wrong. Are you going to enlighten us or not?

Mr Hutchinson: If you want to be more specific, I am very happy to answer any specific questions.

Q6 Chairman: Make an attempt at answering the question I put to you.

Mr Hutchinson: The situation we have all found ourselves in is that the project has not run exactly the way that the contract originally envisaged that it would, that we worked together very hard in order to try to find a way forward that would be more effective. I think we got quite close to agreeing a way forward that would be effective, but we were unable to agree on the price and the commercial terms.

NHS

Q7 Chairman: I will leave it there and other Members will have to try and come in, if they wish. Mr Nicholson, Mr Granger announced his resignation a year ago now and we are still without a permanent head of this programme. What is going wrong?

Mr Nicholson: I do not think anything is going wrong in terms of—

Q8 Chairman: Why is Mr Hextall still Interim Director of what is the biggest computer project in the world?

Mr Nicholson: One of the things that we had started to do after Richard Granger announced he was leaving the scheme was to have a review of informatics in general across the Department and the NHS, and that is what Matthew Swindells, who was in that position, has been doing since then. He has subsequently left. Part of that review was to look at the way in which we manage informatics across the Department and the NHS and the programme, and we want to have a long, hard look at the way in which the programmes were being managed. We wanted to take our time over that to get it absolutely right.

Q9 Chairman: He announced his resignation a year ago, Mr Nicholson. When are we going to have a successor in place?

Mr Nicholson: We have interviews both for the Chief Information Officer for the NHS and the Department scheduled later this month, and a Project Director for the programme scheduled at the beginning of July, depending on who we appoint and their availability.

Q10 Chairman: Would you like to look at paragraph 2.15, which tells us that timetables the local service providers originally agreed with NHS Connecting for Health proved to be unachievable given the scale of the challenge. Why did they prove unachievable?

Mr Nicholson: The first thing I would say is that many of the elements of the programme have been achieved on time, and in fact some have been achieved ahead of time and have been achieved within budget. The issue that particularly is highlighted in the National Audit Office report is the care record.

Q11 Chairman: The patient care record is delayed until at least 2014, an absolute key part of the programme, so I am asking you why this plan proved unachievable.

Mr Nicholson: What I was saying was that quite a lot of the programme has been delivered. It is not the only part of the programme. It is an important part of the programme but it is not the only one. I think there are three things I would say about the delay. The first issue is the whole way in which we handle consent. One of the things I think we have learned from these kinds of projects internationally is that keeping public confidence in a patient care record is vitally important. The whole issue of the way you handle that, the way you handle consent, is very important, and it is true we have taken a lot of time

over getting the system, the programme, into the right place in relation to consent—I am sure Gillian can talk about that in a while—and we are piloting it and we are having independent evaluations of it to make sure that at every step we take the public with us, because we think that is crucial. Secondly, there is no doubt that this programme is incredibly ambitious and technically ambitious. Nowhere in the world delivers an IT system quite like the one that we want for the NHS.

Q12 Chairman: Which begs the question that perhaps it was too ambitious.

Mr Nicholson: It was technically ambitious but it was right for the NHS; for an integrated, publicly run system, it seemed to us the right thing to do. It was ambitious, and there is no doubt that our suppliers have had some difficulty delivering the product that is required to make it work, but I think we are in a much better place now, both with Cerner and with Lorenzo, to get much closer now to seeing the products that we can have. The third issue is the issue of customisation, where we have tried very hard over the last two or three years to listen very closely to the needs both of organisations and clinicians in terms of what kind of system they need. So the level of customisation that the suppliers are having to make for individual organisations is certainly more extensive than we imagined at the beginning of the programme.

Q13 Chairman: You mentioned consent. I would just like to ask a specific question on that. Why are you assuming that patients are going to be happy to have their summary care record created unless they explicitly state otherwise? Should there not be a positive involvement in this? I ask this question because there is increasing concern with this huge loss of data that we have seen over the last 12 months in other areas. People are very worried at the thought that their personal health records . . . It is bad enough if your address or your tax details are lost but imagine if there was a huge loss of healthcare records. Does this not concern you? Why do people have to explicitly opt out of this?

Mr Nicholson: Can I introduce Gillian Braunold, a GP who is the Clinical Director for the Summary Care Record, who will talk about the detail of that.

Q14 Chairman: I do not want a long technical answer.

Mr Nicholson: No, she will not give you a technical answer. In general terms what I would say the issue for us, to be honest—and we have been working through this with groups of patients, we are taking advice from clinicians and patients right the way through the process. We have not concluded yet the position that we are in, but I think the issue for us is those people that are difficult to reach and are vulnerable. It is very difficult for those groups, I think, to do the kind of positive consent that you have described, and in fact, in lots of ways they would be the very people who may not be part of the

programme if we went for a more positive thing, which is very important to us. I do not know if Gillian wants to add anything.

Dr Braunold: I would just like to add really that the independent evaluation of the summary care record programme, which was published on 6 May by University College, reinforced what we had found in our own work, which is that when we go out and ask patients, the vast majority of them are very happy to have a summary care record.

Q15 Chairman: That evaluation also showed that there was great ignorance about this whole process.
Dr Braunold: Indeed, but when asked, they are happy. What they have recommended that we look at, and that is what we are doing an impact analysis on at the moment, is asking their consent to view; the records are still set up under an opt-out basis but asking permission to access at the point of care, which carries a lot of trust with the clinician who is with them at the time. That is how it has gone on successfully in other jurisdictions.

Q16 Chairman: Let us go back to this roll-out. We have looked at paragraph 2.15, which looked at the initial timescales. We will now look at the revised outline plans, which is mentioned in paragraph 2.16. "Revised outline plans are now in place for London and the North, Midlands and East with deployment of the final releases of the care records software scheduled to span several years." Why should we be any more confident about these new timescales than we were about the last ones, which proved unachievable?
Mr Nicholson: Gordon is closer to the detail of the projects but there are two things I would say about that. First of all, I think we have more experience now, more knowledge and understanding, and we are working much better with certainly the two LSPs that are left and understand each other, I think, quite well, and have a level of trust and understanding based on a lot of detailed work of testing what people are saying. That is the first thing, and secondly, we have a product now, or are very close to having a product. I think some members of the Committee will have seen the Lorenzo demonstration. It has been very widely welcomed by the clinical community.

Q17 Chairman: Let me stop you there. Thank you for arranging that demonstration last week but let us remind ourselves that Lorenzo has not been deployed in a single hospital yet. It is one thing to show it to members of the Committee in Richmond House, and it works; it is quite different to deploy it into a busy hospital and have the thing not crashing. How much confidence can we really have in this? There have been so many delays up to now with Lorenzo. Convince us that you would be right to keep faith with it.
Mr Hextall: So, your question was why are we more confident now. I think it is because we have real systems rather than plans for systems. So the version of software that you saw last week is real. It is not a PowerPoint demonstration. It was linked to the live

service. That is a real product that is actually in pre-deployment tests now in the three early adopter sites. Those early adopter sites will take the product when they deem that it is fit for their use, for them to depend on in a live hospital sense. The products exist. We have also had closer and more intrusive collaboration with our prime suppliers and the subcontractors during the development both of Lorenzo and of the next versions of the Cerner product, so again, in the south the Cerner product is there, it is already live, and in London. The version that is there in the south has a package of upgrades that is, again, through the testing process and ready to be implemented.

Q18 Chairman: I want to briefly talk about liabilities. This is mentioned in paragraph 2.32. "The Programme's contracts were based on the assumption that all trusts would take the new systems at some point." What is the potential liability if an increasing number of trusts choose not to take the systems? What is the liability to you? I understand that, for instance, Newcastle are thinking about going it alone, are they not?
Mr Nicholson: No.

Q19 Mr Bacon: So is Royal Berkshire.
Mr Nicholson: Can I say the reason we did it in the way in which we did it—and this has been independently evaluated—is to get good value for money, and we think that by setting the contracts in the way that we did, to cover the NHS as a whole, saved something in the region of £4.5 billion. So there was a good reason for doing it this way. As far as NHS trusts and PCTs are concerned, of course, we can direct them to take the system.

Q20 Chairman: Newcastle is a foundation trust.
Mr Nicholson: I will come on to foundation trusts. As far as foundation trusts are concerned, the first thing about foundation trusts is that as part of their licence, whatever system they agree to take at the end of the day has to be connected to the main system. That is the first thing. Secondly, they are, like all of us, subject to Treasury rules, which are very clear about taking account of the impact on the wider public sector finances.

Q21 Chairman: So you are going to force them, are you? You are going to force the foundation trusts to take a system they do not want.
Mr Nicholson: We think the product that we are developing they will want to take.

Q22 Chairman: If they do not take it, the money is wasted, is it not?
Mr Nicholson: No.

Q23 Chairman: You have the liability if they do not want the system.
Mr Nicholson: They have to have a business case which sets out the benefits or otherwise of taking something alternatively, and I think it is a very difficult thing for them to be able to prove. In fact, I have not seen one that has done it yet. The example I

would give you is Bradford, where I visited recently. Bradford foundation trust went through a process of looking at alternatives and came to the conclusion that the Lorenzo option was the most cost-effective and beneficial service to operate. As far as Newcastle is concerned, they want to move quickly so they are looking at a Cerner solution, I think, as an interim solution but still staying part of the programme until the full solution in 2014.

Q24 Phil Wilson: In paragraph 13 on page 8 it talks about prescriptions and that the majority of GPs and pharmacies are able to issue electronic prescriptions but they still have to issue paper prescriptions until the pharmacies and GPs are accredited. First of all, how long is that going to go on for and what kind of accreditation do they need?
Dr Braunold: About 70% of pharmacists are now at level one of the electronic pharmacy EPS service and about 70% of GPs, but they are not all the same GPs and the same pharmacists in the same areas. About 30-40% of the prescriptions that are issued across the week in general practice come out with the barcodes on them but they are still paper. We are waiting for the second phase of the EPS before we can get rid of the paper in terms of it going electronically directly to the pharmacy, and then we can get some of the other benefits, the bigger benefits, in terms of business process benefits for patients in terms of repeat dispensing from the general practitioner. At the moment we are not getting as many dispensed as we would like because of the mismatch of where the pharmacists are and where the GPs are. Unless we get a steady stream of bar-coded prescriptions into the pharmacist, they have to switch on and switch off different business processes. Their training needs to be timely to when all those prescriptions are coming in. So we are in an interim stage until we get through all of that. My understanding is that we should by the end of this year have phase two beginning and by the middle of next year have most of the GP suppliers delivering EPS Release 2.

Q25 Phil Wilson: Does that mean by the end of next year we will not need paper prescriptions any more?
Dr Braunold: I understand there will still be a legal requirement for a signature, which might be printed out at the chemist's, but I will need to check exactly on that, but certainly the sending of the prescription to the pharmacist electronically is where we are aiming and certainly 2009 is when we are looking to achieve that.[1]

Q26 Phil Wilson: So you will still need a signature, which I understand, but you will not need a paper prescription?
Dr Braunold: You do not need the signature of the GP; the signature of the patient if they are claiming exemption from prescription charges will be required but I think that can be delivered at the pharmacy end.

Q27 Phil Wilson: Paragraph 14 on page 9 says you have no idea of local costs, apparently, Mr Nicholson. Obviously, we need to work out what the local costs are, and that will obviously be additional to the £12.7 billion or is it included in that figure?
Mr Nicholson: Within the £12.7 billion there is an element for local costs. It is true it has been quite difficult to get hold of an exact number. Both ourselves and the NAO have been working on all of that and I think we have a better process to do it, but interestingly, it is just over £300 million, is it not?
Mr Hextall: We have done an annual survey to establish how much the NHS spends on IT. That is a kind of one-off sample once a year. That gives us good indicative figures. What we are not able to do is separate out the amount that individual trusts spend on the programme as opposed to IT for other purposes. They have considered that quite an onerous task to try and do in the past. We have an exercise as part of the production of this year's annual benefit statement to try and do some sampling scientifically to try and establish the amount that is actually spent on the national programme. But it is absolutely within the £12.7 billion that the NAO reported on. It is down as £3.4 billion, I believe, which we believe is probably an overestimate and that includes costs for PACS, for example.

Q28 Phil Wilson: Apparently, this system at the end of the day is going to be producing a lot of savings for the NHS. How are we going to actually work out what the savings are if there is no baseline to compare it with? How do you know you have made the savings? That is pointed out in paragraph 21 of the report. The current estimate is £1.1 billion.
Mr Hextall: The programme was never expected just to produce financial savings. Many of the benefits of the programme are in improved clinical safety and the quality of patient treatment. Where it is possible to make financial savings is where an individual trust was buying something before that they are no longer buying or buying it at a much reduced cost. That is certainly the case with the broadband network, N3, with NHSmail. You can arrive at scientific calculations of financial benefits for those areas.

Q29 Phil Wilson: I will turn to a different section now, maintaining the confidence of patients, paragraph 31. There is something called a care record guarantee. How does that work and what is it exactly?
Dr Braunold: The care record guarantee is a living document that was drawn up under Harry Cayton's leadership and is something that is revisited once a year now. It was twice a year to begin with. It sets out a statement of how the Government and the Department promises to handle patients' records, who will have access to them and how they will be handled. The reason it is living is because clearly, as the programme evolves and new demands on the Health Service come around, it will need to be revisited.

[1] Ev 22

NHS

Q30 Phil Wilson: The next question is on staff and their involvement in the development of the system and the programme. The percentage figures on this survey in paragraph 32 are that 67% of nurses and 62% of doctors think this will improve patient care. On the face of it, obviously it is more than 50% but that, to me, still seems relatively low. I do not know whether it meets your expectations. Do you expect figure to increase?

Mr Nicholson: Our expectation is that that is the kind of figure you might expect. For lots of people some of this stuff is quite theoretical, if they have not actually seen the benefit in their own hands. We are taking a lot of action—Michael might say something about this—particularly to engage clinicians in all of this, both at a national and a local level.

Professor Thick: Yes, that is right. Given that 100% of GPs, more or less, use an electronic record and perhaps 20% of consultants at the moment have a card to use electronic records, it does seem a bit low. I would have expected it to be a bit higher. Certainly on the secondary care side, that reflects the fact that there is not very much clinical utility being deployed just yet, and therefore there is not much for them to do and therefore no reason for them to have a card. Nonetheless, we do think that engaging with senior clinical staff is critically important, and over the last two years since my appointment we have set up the Office of the Chief Clinical Officer in order to bring some clinical authority into the way the product is developed and rolled out and implemented in the Service. We have done that by virtue of the relationships that we have with the Chief Medical Officer, who has now become extremely interested in our clinical safety programme; with Professor Sir Bruce Keogh on his appointment and with the quality and monitoring activities that we are pursuing with him; we have relationships with the Royal Colleges, and with the Academy of Royal Colleges; we have specialty reference panels; we have frequent meetings with the specialty services; and with this great plethora of information that we get from the practising service, we think that we can unequivocally say that we do bring an authority that is worthwhile.

Q31 Phil Wilson: The next question is the Choose and Book system. I know the usage of that is rising; 6.7 million people are using it but the expected figure for January of this year was 39 million. There is a bit of a disparity there. Can you tell me why that is and what we are doing to improve it?

Mr Nicholson: There is no doubt that utilisation of the system is not as great and extensive as we had imagined it would be at this particular stage. Something like 90% of GP Practices at some stage in a week use the Choose and Book system but on average only just over half of appointments are made through this process. It was said that the way to develop this was to increase the financial incentives on general practitioners to use the system more. We have stopped the payments, as it happens, for Choose and Book, and in fact, the utilisation has still gone up so that is not a particular issue. I think there is no doubt this involves significant change in the way people work and interact with their patients in their clinical activity. Some people find it very easy and are attracted to it and use it a lot. Some people do not. It is just taking more time, I think, to train, educate and support people to make it happen. One of the things that we will be doing as part of the next stage review is to publicise the patient's rights in relation to all of this much more, so we can get much more of a patient push as well as the kind of pull that I have talked about.

Q32 Phil Wilson: Paragraph 25 of the report admits that the implementation of IT systems usually has problems, never mind how big they are. The Chairman has said that this is the biggest IT programme in the world. Do you not think, having read the report, the problem is around just setting arbitrary deadlines instead of being up front with problems you have been facing?

Mr Nicholson: We are obviously learning to develop this programme at the moment, and we did it against a background of not having a product that was there in existence, so it was always, I think, going to be quite difficult to do that, but I think we are in a much better place to do that now. I think we have the experience we have gained, particularly working with clinicians, particularly the experience we have already gained of implementing systems—and do not forget quite a lot of systems have been implemented across the scheme. We have learnt a lot from that and I think we will be much better at predicting where we are going to be in the future.

Q33 Phil Wilson: When can I expect the roll-out of this in County Durham, where my constituency is, since it seems to be a problem?

Mr Nicholson: I do not have that particular information. We will send you a note on that.[2]

Q34 Mr Bacon: Mr Nicholson, you said a minute ago we were dealing with products which were not yet in existence, and obviously we know there have been significant delays to Lorenzo in particular. If one looks at the iSOFT annual report, they said Lorenzo was ready in 2004. I have it in front of me. In the 2005 annual report and accounts to shareholders it said "available from early 2004". "Lorenzo was the first solution," blah, blah, blah, the first solution on the market; it is talking about it as something already available and on the market. We then had our report two years ago, where one of our conclusions was, based on the June 2006 hearing, "We are concerned in particular that iSOFT's flagship software product Lorenzo, on which three-fifths of the programme depends, is not yet available." That was two years ago; at least based on the hearing two years ago. Then we had the Health Committee, who looked at this more recently, and they say in paragraph 231, "In the remaining three clusters which are awaiting iSOFT's Lorenzo product delays drag on. Such delays have left many hospitals relying on increasingly outdated systems for their day-to-day administration" and

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[2] Ev 23

they say elsewhere that the ongoing delays to the delivery of the new hospital software are one of the most serious problems. This is paragraph 192. "The failure to deploy the Lorenzo system anywhere in the NHS is a particular concern." That was last year. Can you just remind us when the Morecambe Bay Hospital Trust was due to deploy Lorenzo? When were they due to go live with Lorenzo?

Mr Hextall: A planning date that was in the public domain was 16 June.

Q35 Mr Bacon: What date is it today?
Mr Hextall: It is 16 June.

Q36 Mr Bacon: They were due to go live today, were they not? I have it here. Just correct me if it is wrong. This is from *eHealth Insider* dated 12 June, a piece last week: "As recently as April"—that is April this year—"the Strategic Health Authority appeared confident." "Chief Information and Knowledge Officer, Alan Spours, told the SHA board on 29 April"—so recently—"Morecambe Bay is still scheduled to deploy the first release of Lorenzo on 16th of June." That is today. So we had concerns two years ago, the Health Committee had a concern last year, as recently as late April they were saying they were going to be deploying today, the company said it was available four years ago, and it is still not deployed, and you are asking us to believe this is going OK.
Mr Hextall: If I could address your point—

Q37 Mr Bacon: Let me make my point if I have not made it clear enough: I am asking you, why should we believe that things are going OK in the light of this record? What evidence is there that things are going OK?
Mr Hextall: The software is actually in the trust and being tested and, as I said to Mr Leigh earlier, when it is ready and when the trust is ready to accept it, it will take it.

Q38 Mr Bacon: Mr Hextall, the company said it was available in 2004.
Mr Hextall: I can find you many other references in Parliamentary Accounts reports that say—

Q39 Mr Bacon: I am not talking about Parliamentary Accounts reports. I am talking about a PLC that published statements saying the software was available four years ago. Mr Burr, can I just check something? I know there is a Financial Services Authority investigation that was launched because of the statements that the company made, and I think there was another one into the auditors by the Accountancy Investigation and Discipline Board. Do you know if those investigations have been completed yet?
Mr Burr: As far as I know, the position is still as in the report. The investigations are still ongoing.

Q40 Mr Bacon: They are still ongoing, are they? Why did they launch an investigation? Because of the statements by the company?

Ms Hands: Yes, I think so. It was all around their accounts, their financial position. There were financial issues that needed to be investigated.

Q41 Mr Bacon: There were, where there not? They stated that they made profits of £68 million and then they had to restate them and it turned out they made a loss of £340 million. They said here they had software which was available, which helped ramp up the share price, and then of course, all the directors sold their shares, but that is not our concern here. Mr Nicholson, could I ask you if you agree with Richard Jeavons. He was asked on 13 March—this was when he was still with us—at a Department of Health press conference "Would there ever come a point where you say, 'That's it, we've had enough, we are going to do something else'"? He replied, "I doubt it." Do you agree with him?
Mr Nicholson: In the context of what?

Q42 Mr Bacon: In relation to Lorenzo.
Mr Nicholson: It seems a fairly fruitless discussion really, on that basis, because no-one, certainly I would not sit here and say everything has gone absolutely smoothly and has been delivered in the way it was described to begin with. That is certainly patently not the case, but it seems to me that we are in a place at the moment, today, as we sit here, which is far better than we have been in the past, that we have a product which is in the hospitals being developed and worked on at the moment, and we have seen that is a place where we have not been before. We have had to, in the circumstances in the past, take the kind of suggestions from the company that you have just described.

Q43 Mr Bacon: In the Department of Health last week we were told that there were evaluations that have been done on Lorenzo. I think EDS and Mastek were mentioned. What did those evaluations say about Lorenzo?
Mr Hextall: They were joint reviews that Connecting for Health and CSC undertook last year as part of an assurance review, and, as I mentioned, there has been much more of an intrusive and collaborative closer scrutiny of the development process. That was both CSC and ourselves looking to give ourselves some assurance that the product was going to be delivered in line with the timescales.

Q44 Mr Bacon: What did they say?
Mr Hextall: They drew attention to a lack of programme management, insufficient programme management, which has since been strengthened.

Q45 Mr Bacon: When were these reviews done?
Mr Hextall: Last June, I guess, a year ago. So it is part of the action plan that was put in place that has led to Lorenzo actually being deployed. It was deployed in this country in May of this year. It is deployed, as I have said several times, in Morecambe Bay now and is being tested but I refuse to agree with any trust—

Q46 Mr Bacon: Sorry, can I just check. You said it has been deployed in Morecambe Bay. It has not gone live at Morecambe Bay, has it?
Mr Hextall: I refuse to agree –
Mr Bacon: Sorry, can I just check. You said it has been deployed at Morecambe Bay. It hasn't gone live at Morecambe Bay has it?
Mr Hextall: It has been deployed and is being tested.

Q47 Mr Bacon: So it hasn't gone live? I am just asking you to answer my question, Mr Hextall.
Mr Hextall: I am trying to answer it because -

Q48 Mr Bacon: Has it gone live? Yes? Has it gone live?
Mr Hextall: It has not gone live.
Mr Bacon: Thank you.
Mr Hextall: It will go live when the quality is right, and that, surely anyone would agree, is the right answer. You need to be date-driven as far as getting a product to a particular point in time but when you are heavily into the testing of it, towards the end, you turn from being date-driven to being quality-driven. I was in Morecambe Bay last week and they are a very committed management team and a very highly skilled IT team, and they will take that product when they are satisfied that it is going to work for them. They are not going to put patients at risk.

Q49 Mr Bacon: Mr Nicholson, there are trusts who have not been able to take Lorenzo yet because it has not been available, who have instead had an interim system deployed, iPM. When that is deployed does the local service provider get paid for installing it?
Mr Nicholson: Yes.

Q50 Mr Bacon: So when they later install Lorenzo, assuming the problems are fixed, will they be paid again?
Mr Nicholson: Yes, they will be paid again.

Q51 Mr Bacon: So they are being paid twice.
Mr Nicholson: No, no. It is within the total amount in the contract. It does not increase the total amount that we have identified in the contract.

Q52 Mr Bacon: It does not increase the amount they are paid altogether?
Mr Nicholson: No.

Q53 Mr Bacon: If during this deployment the trust finds that there is too little functionality for the system to be deployed economically or safely and decides to pull out, does the NHS have to pay penalties to the local service provider?
Mr Hextall: In the situation you have just described, if the functionality is not up to the original specification, the trust certainly does not have to pay penalties. The only situation in which penalties would be paid is if a deployment slot was not taken, which is reported on in the NAO report.

Q54 Mr Bacon: Can you explain why, if you are so confident that Lorenzo will eventually be sorted and delivered, CSC is hawking a Portuguese software system around?
Mr Hextall: I am not aware that they are hawking a Portuguese software system around.

Q55 Mr Bacon: Are you not? CSC people were on a stand selling or offering the Alert system from a Portuguese supplier, at the Harrogate IT health conference. You had a stand there yourselves, did you not? They are in negotiations with Epsom and St Helier trust right now, which is one of the iSOFT seven, as I am sure you are aware. Why would they be doing that if they had confidence that they could install Lorenzo?
Mr Hextall: I am aware that the Alert system is a very good e-prescribing system which can be adopted as an interim system by a trust if they are on a later path for taking Lorenzo, so there is a very legitimate reason why a trust might want to take the Alert e-prescribing element of their system.

Q56 Mr Bacon: The Australians, actually the Victoria Auditor General, in a study of the Australian system HealthSmart, which has some very similar characteristics and, curiously enough, uses both Cerner Millennium and has tried to use Lorenzo, has come to some similar conclusions about the problems. Have you looked at that and have you tried to draw lessons from it?
Mr Hextall: Yes, we have.

Q57 Mr Bacon: Can you send us a note about what those lessons were?
Mr Hextall: Yes.[3]

Q58 Geraldine Smith: I have a keen interest in the Morecambe Bay trust because it is my own health trust and my local hospital. I think it is a great to challenge you have in trying to get IT into the National Health Service in the way you are doing but I think it has to be done. Morecambe Bay acknowledges one of the reasons why they are so keen on this system is because of some of the problems they have had with manual records. I would take quite the opposite view to my colleague and say make sure you get it right. I do not care if it takes a little bit longer. What I am worried about is that those records are right and that everyone is sufficiently trained. Can you give me a little bit of information that will make me feel very confident that this is what will happen?
Mr Hextall: Morecambe Bay is spread over a number of sites, so they are looking for IT to be able to answer the needs to improve their treatment. They have an interim patient administration system at the moment which they took from CSC as part of the national programme, and they were at the forefront to upgrade to the Lorenzo product so they could get the clinical functionality that they do not currently have. I mentioned that they have a committed management team and an experienced IT team; they

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know what they are doing, I am comfortable with that, and they do not want to take the product until they are sure it will fit in smoothly and they will be able to do their normal business. If they get any kind of interruptions and they have to revert to clerical records, it is quite disruptive to the hospital. It is in their hands to sign that product off when they are satisfied it is working, which is why I am keen to have a date when it should go to the hospital for testing and for implementation but not keen that we should be predicting to them when it should go live. That is down to them.

Q59 Geraldine Smith: Do you have any idea? I went to the demonstration last week and I was given the impression that it would be around July.
Mr Hextall: They are optimistic about it being deployed before the end of July at the moment based on this weekend's experience.

Q60 Geraldine Smith: Can I also ask what sort of support they will get? They are obviously one of the first of three early adopters. What sort of help and support is there? It is a massive exercise for them in staff training.
Mr Hextall: It is. They have support from CSC, as the supplier, and iSOFT, who are keen to make sure that the product works. So they are getting a substantial amount of support. Connecting for Health has a deployment support team helping, and the way that the early adopters are doing it in the North, Midlands and East, the two who are next are going to be helping in the Morecambe Bay area so that they can learn the lessons from Morecambe Bay, for Bradford and South Birmingham, who are the next ones to go.

Q61 Geraldine Smith: I hope there are not too many lessons to be learned.
Mr Hextall: There are always lessons to be learned.

Q62 Geraldine Smith: I hope they get it right first time, because it does have such serious repercussions for patient care. Most of the problems we have had in the past in our area are down to poor administration so I think it is essential that we get it right. Is three months enough of a time gap before you start rolling it out to all the trusts? That does not seem very long to me.
Mr Hextall: If everything went well, it would be enough time. Again, we need to be quality-driven rather than date-driven as far as that release key milestone, that then will sign off the release for the remainder of the trusts to be able to take. If everything goes according to plan, the three months will be okay. It will be clearly monitored on a weekly basis during that period.

Q63 Geraldine Smith: From the demonstration last week, it did look very good. I hope it works as well as it appeared to in that demonstration. Can I ask, is it just going to be the hospitals that hold this information or is there that link with the GPs, or is it going to be gradual?

Mr Hextall: It will be gradual. There are four releases currently planned of the Lorenzo software and that is one thing that was a change, one of the lessons from the review that Mr Bacon enquired about that we commissioned last year. The four releases have increasing levels of functionality and the GP integration is in the fourth release, so it is right at the end.

Q64 Geraldine Smith: What sort of time delay is that? How long are you talking about?
Mr Hextall: I think it is 2010. I would need to check.
Mr Nicholson: Spring 2010.

Q65 Geraldine Smith: One of the things again from the demonstration that I found very useful was that there appeared to be an alert system as well, so there was a lot of information available for GPs who may be prescribing a drug that may interfere with someone's condition that they may not be immediately aware of.
Mr Hextall: They certainly have elements of prompts and decision support built into the system to try and prevent people doing the wrong thing, yes.

Q66 Geraldine Smith: Can I ask about security of data, because, of course, everyone is concerned about that. Can you reassure me?
Mr Hextall: Yes. As with all the Connecting for Health systems, patient confidentiality is ensured by anybody using the system having to access the system with a smartcard, and you can only get a smartcard on production of evidence of identity, typically a passport, and evidence of residence, typically a utility bill. Your smartcard would then contain details of your role-based access, and there are different roles that can be set into the card so you would only be able to use it for the purpose that it was given to you, and again, only if you have a legitimate relationship with the patient. That is the same kind of level of security which is known as e-GIF level 3 in government terminology, which is the highest that we could aspire to.

Q67 Geraldine Smith: Mr Nicholson, can I ask you, just changing the subject slightly. We touched on trusts doing their own thing, having different systems. I do not think they should be able to. We still have a National Health Service and I think if you have an IT system it should be linked nationally. One of the problems is if you have a great many different systems operating. That is bound to cause problems, I would have thought.
Mr Nicholson: The way that we are trying to operate is that they will all take the same system in a particular LSP area. I personally have a different constitutional relationship with foundation trusts than I do with NHS trusts. I cannot direct NHS Foundation trusts to take it but what I can do is to make sure that the processes are in place to make it much more likely that they will.

Q68 Geraldine Smith: Do you think you should be able to direct them?

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Mr Nicholson: All I would say on it is that the only place I have been where they have seriously looked at this is Bradford. They went through a process of looking at the alternatives and came to the conclusion that the national system was by far the best one for them, and they are absolute advocates for it now. By telling them to do something, you would not have got the kind of advocacy and the commitment they have to implementing that they have now. So I think if they come to it under their own conclusion, that is a much more powerful way of taking it forward.

Q69 Geraldine Smith: Can I just ask about how the Choose and Book system is going? It appeared a bit mixed in my own area. I think people like the booking part. I am not so sure they think there are real choices there or that they want the choice. I am getting into policy areas. How is the actual IT system going?

Mr Nicholson: The IT system itself works well. In fact, 90% of GP Practices at one stage or another use it. So it does work. I think some of the operational ways that people work underneath it are sometimes quite difficult. For example, if you want to book a date, the implication is that there is a clinic there for you to book, so the hospital has to be absolutely on top of the way that they manage and pre-book clinics. That is not absolutely in place everywhere and it just takes time to make that happen, but it does give you the opportunity, whether you take it or not, to have the kind of choice that people now have through free choice. As you know, people can now choose secondary care, can choose any hospital that will do services at NHS quality for NHS tariff in the country when you are making a referral. So whilst we do not force people, if they do not want to make that choice, it is available and increasingly I think people will take it up.

Q70 Geraldine Smith: In my experience, people just want their local hospital to be good. They do not want six choices or three choices. They just want their own hospital to be good. That is the priority for them.

Mr Nicholson: Yes, I agree.

Q71 Geraldine Smith: Finally, with Choose and Book, what is the feedback from GPs? Are they satisfied with it? Do they think it is going reasonably well?

Dr Braunold: From my understanding from my colleagues—and I have spent a lot of time talking to my colleagues about Choose and Book—there are those of us who are lucky enough to work in areas where our configuration of our services, our computers on our desks, are working well. Choose and Book is working well for us and I scream blue murder when it is down actually, because I do not like going back to the old system. I like the fact that I know about the different hospitals in London and the different services that are there, and my vulnerable patients, who do not speak good English, are able to leave the room with the date of their consultation with the clinician. We do not have any

of that coming back to me, "When is my appointment coming?" There are other colleagues for whom it is not working as well. The local configuration of their computers is not working so well or they have some kind of real objection to doing some of the extra work that I personally believe I advocate to do in my consulting room. I have spoken to a colleague, for instance, a friend of mine, who was actually very anti doing the work, but he was totally transformed by the relationship improvement with his patients of enabling them to get their appointment. So he feels that, even though it takes longer, he prefers to do that. It takes time to move the population of GPs along but the tool is working, the tool is deployed and it works.

Q72 Keith Hill: Mr Nicholson, this is obviously a fabulous and very exciting programme, which will presumably confer hugely valuable benefits on patients in England. Is it being attempted anywhere else in the world?

Mr Nicholson: I do not know whether it is. Certainly there is lots and lots of interest in it from Australia, from Spain, from the rest of Europe. We recently had some people over from France. There are lots of people very interested in the way we are doing it but I do not know whether there is actually anywhere else doing it in exactly the way that we are.

Mr Hextall: From the discussions we have had with other countries, I am sure that everybody is doing the same thing but nobody is doing it on the same scale. Typically, Australia and America are doing it on a state-based system and Switzerland is doing it on the canton-based system but the same functions of having patient information available, electronic booking and the electronic prescriptions . . .

Q73 Keith Hill: It is the sheer scale and centralisation of the National Health Service which makes it possible.

Mr Hextall: Yes.

Q74 Keith Hill: Personally, it seems to me very difficult to think of what else would be a more compelling thing that you would want to do for the National Health Service going forward into the 21st century.

Mr Nicholson: An interesting thing to me is if you take something like picture archiving, which is digital x-rays and all the rest of it. Four or five years ago we were quite behind the rest of Europe in terms of implementation of picture archiving. Now we are the first G8 country to have it completely implemented across the whole of the country, enabling digital x-rays and images to be moved between departments, between hospitals, and between services. We were able to do that because of the nature of the system, because of the way we were implementing it. We would never have been able to do that if we had left it to individual organisations to decide when to do it and how to do it.

Q75 Keith Hill: When I asked the question first, I deliberately referred to patients in England but we are a United Kingdom and we do still have

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reasonably porous borders. What are the opportunities going to be for Wales, Scotland and Northern Ireland?

Mr Hextall: Certainly Wales and Scotland have similar schemes. They were given an opportunity when we placed the adverts for the contract for procurement in 2003 to join in with the national programme for IT, and either were not able to respond quickly enough or had their own ideas. Certainly Wales and Scotland are doing very similar initiatives about making patient information available where it is needed and we are collaborating with both of those jurisdictions at the moment.

Professor Thick: I attend a European forum of those who are developing electronic records, and I think the general observation is that boundaries are very dangerous places because you go across, you get ill and how are your records going to follow? We are putting a great deal of effort into making sure that the standards that we implement are international, that the summary records that we develop are interoperable precisely in order to make patient safety the prime issue.

Q76 Keith Hill: This is all good news.

Mr Nicholson: I was recently, for a completely different reason, visiting the Armed Forces in Afghanistan. I was in a hospital in Helmand province where they were able to send digital images from the middle of Helmand province right into the University Hospital Birmingham, so that by the time the injured member of the Armed Forces got into the hospital all the images and all the details were with the doctors, which I thought was fantastic.

Q77 Keith Hill: It is fantastic. It is very sad about the individual soldier of course, but this is very impressive stuff. Let me take you into slightly more detailed questions now, because as the NAO remarks, this will only succeed if you can engage the support and enthusiasm of clinicians and other NHS staff. There are obviously issues which emerge from the NAO report about a certain dissatisfaction—I think you may have alluded to it earlier—about the realism of progress reporting and communications. How can you make progress reporting and communications about the programme more open and realistic to staff?

Mr Hextall: I must admit I was puzzled when I saw that comment originally in the report but I now understand it, because we have a plethora of information to be able to manage the programme, so from a programme management perspective there is not anything we do not know. What we are not particularly good at is making that available in lay terms so that the public can understand how individual trusts perhaps are progressing. It typically takes 12 months for a trust to prepare and then implement a patient administration system as part of the national programme. There is a lot of preparation, a lot of data migration that needs to happen. We have not been very good at being able to measure that to make it visible. For the future, taking that recommendation on board, we are looking at being able to turn the plethora of

information that we use to manage the programme internally into external facing information for the public.

Q78 Keith Hill: That is for the public but let me just put you an issue which is raised by the NAO about the surveys you do with staff and ask you if there is any significance in the fact that in the latest survey you carried out you decided not to ask staff about how favourable they were towards the programme.

Mr Hextall: That was the MORI survey, I think. We have done the MORI survey in three waves. In the first couple we asked the same questions virtually, I think. What happened between the first two waves and the third one was that we went through an NPfIT local ownership programme where we were putting more ownership and accountability on the NHS so that they felt they could pull the systems and they owned them rather than feeling that perhaps they were being delivered to them. As part of that process we consulted with the strategic health authorities on what they wanted out of the survey by way of stakeholder engagement and communication to inform their engagement and communications. So the questions were actually formed out of discussions with the strategic health authorities and shaped in that way. So if there was a question dropped, that would be why it was dropped.

Q79 Keith Hill: Let me turn to something which has already been raised, which is the issue of clinical functionality. How can you convince staff of the benefits of the programme given the limited clinical functionality currently available?

Professor Thick: You are quite right. In the first implementations in the south it has been disappointing perhaps that there is such a limited amount of clinical functionality in the Cerner product that was deployed. I think that has resulted in great expectations in the clinical community there which have been let down, so they feel cross. Also, if you put in a new PAS system into a hospital you necessarily change the processes of the way people work and, as far as the clinicians were concerned, they saw their everyday work being changed around in a way that they did not understand, and perhaps with a limited amount of consultation. So their perception inevitably was that the system did not work because it did not do what they normally do. We are going to have to turn that around considerably by accelerating the amount of clinical functionality that goes into particularly the south. It is not quite so true in the North because the clinical functionality is there in the first place. We are putting a great deal of effort into making sure it becomes available before then very quickly and in particular, order communications.

Q80 Keith Hill: When will the trusts in the south get meaningful clinical functionality?

Professor Thick: The start will be the next implementation which I think is in Worcester, it is certainly the West Country, and it will have order communications in it.

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Q81 Keith Hill: Finally, why is there no realistic training environment for Trust staff to use prior to deployment of the new care record system?
Mr Hextall: In the early deployments there was certainly a mismatch between the training environment that the Trusts were using to train and the system they eventually got, and given that there are differences during the test cycles with the release of software going in in little mini stages, it was inevitable that the training system that was being delivered to them for training, I do not know, three months in advance of the implementation was slightly different to the system they eventually got. With all of our suppliers we recognise that, and there is much less of a mismatch now between the training environment and the system that is being taken, and, where there is, then it needs to be supported by notes explaining where those differences arise.

Q82 Dr Pugh: All my questions really are about long-term running costs, value for money and lock-in, but I want to talk about specific aspects of the Programme with that focus on it. First, the national network itself. I note in the NAO Report the service contract comes up for renewal every three years, and is not a completely straightforward renewal because presumably in the core services you need to buy your hospital or whatever, and there are others you can choose to add on. I am correct in that, am I?
Mr Nicholson: Yes.

Q83 Dr Pugh: Who is the contract with?
Mr Hextall: The N3 broadband network is with BT.

Q84 Dr Pugh: If I earmark a hospital, I do not really have an option other than to go to BT for the core services, do I?
Mr Hextall: Well, it is important to recognise that the contract BT have to supply the N3 broadband network is not for them to supply a BT network; it is for them to act as an agent on behalf of the NHS and get the best price they can. So they do not deploy BT networks everywhere; they buy networks off the whole range of network providers.

Q85 Dr Pugh: What I am trying to figure out is what scope there is for re-negotiation or negotiation on the part of institutions when you are buying into the national network—and you cannot not buy into the national network?
Mr Hextall: That is correct.

Q86 Dr Pugh: There is limited scope?
Mr Hextall: There is no scope.

Q87 Dr Pugh: On the national data Spine, again you are using the Oracle database server platform for that, and presumably at some point in time that might become very expensive to use. Is it a realistic option to find another supplier?
Mr Hextall: Bearing in mind that we have an enterprise-wide agreement with Oracle to supply unlimited—within the parlance it is all you can eat—so as much of the Oracle products as you can buy at a fixed price.

Q88 Dr Pugh: That may be a very good deal, but if you do not like the deal you are offering is it realistic or sensible or highly disruptive to go elsewhere?
Mr Hextall: It would be disruptive. That particular decision as to which database platform they use is the supplier's, since they are getting it for nothing effectively.

Q89 Dr Pugh: So in one case you are stuck with BT, in the other you are stuck with Oracle. I am satisfied with those answers. In terms of the documents generated on the data Spine and so on, they are all presumably in some open European document format so if we did have to use Oracle or whatever, we could. Is that the case?
Mr Hextall: Yes. They would typically be XML documentation. You mention the servers and being open. 95% of the servers on the BT Spine are—some are Micro systems, Open Solaris.

Q90 Dr Pugh: So you are not locked into any particular format or suppliers. What is the running cost of the national data supply as opposed to the cost of implementing it?
Mr Hextall: I will have to give you a note on that.[4]

Q91 Dr Pugh: Moving on to Choose and Book, are there any central running costs to the NHS as opposed to the costs to the PCTs of actually running Choose and Book?
Mr Hextall: The contract with Atos is centrally funded so there are not any costs on the PCTs other than providing the GP systems.

Q92 Dr Pugh: So what is the annual year to year running cost of having Choose and Book?
Mr Hextall: The whole contract for seven years was £64.5 million.[5]

Q93 Dr Pugh: Can I just turn to Fujitsu for a second? One thing that is proven about Choose and Book is that GPs are allowed to choose their own systems, and that has been much appreciated by GPs. It did say, page 39, in paragraph 3.42 of our previous NAO Report that this had not been anticipated in the Fujitsu contract. I am right in thinking that, am I not? There is this kind of flexibility?
Mr Hutchinson: There was no demand for GP in the Fujitsu contract so it was always expected we would add that on later, and that was part of the re-set discussion.

Q94 Dr Pugh: The extra cost was estimated at £105.9 million?
Mr Hutchinson: Yes.

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5 The contract is for five years with an option to extend by two years. The £64.5 million is the cost of the core contract over 5 years. There was also a provision of £80 million over the same period, made at the time of the contract, to purchase services beyond the scope of the original contract, specifically to deliver additional services to support the Department's new policy requirements such as Extended Choice. Together these equate to the £144 million shown in the C&AG's Report.

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Q95 Dr Pugh: But that was not the deal breaker?
Mr Hutchinson: No.

Q96 Dr Pugh: So there was agreement reached on doing that?
Mr Hutchinson: That would not have been an issue, no.

Q97 Dr Pugh: After all this IT development—and there is a great deal of it—does the NHS own any software?
Mr Hextall: We certainly own the intellectual property rights, so the intellectual property rights remain with the NHS.

Q98 Dr Pugh: Do you have any access to the code of any software you license?
Mr Hextall: Yes, because we have given a free licence to the Rest of the World for the Microsoft common user interface, for example, because it is to the benefit of patients everywhere if the same interface with clinical systems is used.

Q99 Dr Pugh: You see, I am just thinking what happens if you do not have a happy relationship with the companies you currently have and you wish to find other companies. Can we turn to patient administration systems? There are a number of them, and obviously Millennium and Lorenzo are two of the better known ones. If I am in a hospital in the north and I have this very rich record listing all my ailments, prescriptions and so on, but I move south and I want a similar record but it would be sitting in a different patient administration system, is it a relatively straightforward process to import all this data, all these ones and noughts, from one system to another, and have you ensured that is the case?
Mr Hextall: It is not at the moment while both Cerner and Lorenzo are in development. Once both are fully deployed we would hope to be able to achieve transfer of patient records, in the same way we already do with GP records.

Q100 Dr Pugh: And you are insisting on it?
Mr Hextall: We are insisting on interoperability between the systems so that patient information can be available where ever it is needed.

Q101 Dr Pugh: That is a reassurance as well. In a sense, if you do get that kind of interoperability, there is not an enormous amount of merit in having everybody in the one area use the same system, is there?
Mr Hextall: There are different justifications, I suppose, in that case because one of the values of using a common system that is of good quality is that it is going to be resilient and have disaster recovery built in, so that hospitals that are open 24 hours a day seven days a week can be assured of 99.9% availability, all but 45 minutes in a 31 day period, so high standards of resilience, but also, every time you come to upgrade it, the fewer systems there are to upgrade the cheaper it is, and the less risky it is.

Q102 Dr Pugh: So the fewer people providing the care the fewer options you have got.
Mr Hextall: Yes.

Q103 Dr Pugh: NHSmail has not been taken up by everybody but it does say in the Report that "all will". Now, if they do not at the moment, how do you know all will?
Mr Hextall: All are expected to because (a) it is free—

Q104 Dr Pugh: They do not have to?
Mr Hextall: They do not, no. So (a) it is free and (b) when the upgrade to the Microsoft Outlook platform takes place later this year that will remove a number of barriers that some large-scale campus sites are seeking—

Q105 Dr Pugh: But if they do not wish to they can stay out. On GP to GP transfer, there are three firms at the bottom of the list on page 35 which are apparently quite small, and their accreditation is going to be much delayed. Why are you so prejudiced against small firms?
Mr Hextall: We are definitely not prejudiced.

Q106 Dr Pugh: Why are you delaying their accreditation then?
Mr Hextall: They are not able to be accredited yet.

Q107 Dr Pugh: That is only because you are not accrediting them.
Mr Hextall: As soon as they are able to be accredited, they will be.

Q108 Dr Pugh: But it says, " . . . accreditation will be delayed until the other suppliers have successfully delivered GP to GP transfer". It does not say they are not able to; it says they are back in the queue.
Mr Hextall: They get accredited the instant they are able to do it.
Dr Braunold: They are not ready with the system.

Q109 Dr Pugh: They have not proved they have done it.
Mr Nicholson: Yes.

Q110 Dr Pugh: Finally, I learnt there is a little firm called Graphnet in the Hampshire and Gwent areas who have implemented the electronic patient record to wholesale satisfaction. If that is the case, why has the National Programme had such difficulty?
Mr Hextall: I think there is a completely different scale. We have examined the Graphnet system and it is on a different scale with different security entry criteria to the ones we are operating.

Q111 Dr Pugh: It is less secure?
Mr Hextall: I am saying they are using different security input mechanisms.

Q112 Dr Pugh: But not worse, necessarily?
Dr Braunold: It is not to e-GIF Level 3 standard. It is against different security methods, and it has different amounts of data on there as well.

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Q113 Dr Pugh: But you assume the system they are using at the moment is not necessarily the higher standard but safe?

Dr Braunold: It has a lot of patient and clinician satisfaction with the system, and we have done a lot of learning from the Graphnet system in terms of how they have done patient participation and clinician participation, in particular, and how they have got patient buy-in in Gwent, which has been very interesting indeed.

Q114 Mr Touhig: Mr Nicholson, I see that in January 2004 you were awarded the CBE for services to the NHS. That is fact.

Mr Nicholson: I am sure—I think—

Q115 Mr Touhig: I think it should be for courage because anybody who would go on Radio 4, the *Today* programme, as you did just before Christmas last year, and state that the NHS care record service would be considerably more secure than internet banking is recklessly courageous. Why did you make that statement? What does it mean?

Mr Nicholson: It means the levels of security and the technical mechanisms we have make it more secure than internet banking.

Q116 Mr Touhig: I do admire your courage too! It is an impressive claim to make but can you understand that doctors and patients will have some doubt and some concern about security of their records in view of the breaches that have taken place in the past?

Mr Nicholson: Yes, I can perfectly understand why people will be concerned. That is why we have taken the time and the effort we have to get ourselves to where we are today.

Q117 Mr Touhig: We are not quite sure where you are today, are we? The Care Record Guarantee summarised on page 35, Fig 15, of the C&AG's Report also seems very impressive but so did Revenue and Customs' policy on data security before a massive data loss last year, and the MoD's before they lost the details of 600,000 applicants who planned to join the Armed Forces. The policy always sounds good, does it not, but is it deliverable?

Mr Nicholson: The NHS is a massive system, 1.3 million people work in it, a huge number of organisations; those organisations are responsible for the security of their data; it is hard-wired into people in the NHS around confidentiality, so it is one of the basic points that I think NHS staff operate under; we have a whole series of guidances and processes and procedures out there to ensure it; it is built in technically to the system we are developing through Connecting for Health, through the kinds of things that Gordon has been talking about in terms of the level of security: I think we are in a good place as far as security is concerned. There always will be circumstances, and when circumstances do take place then we need to make sure we react rapidly, and we do.

Q118 Mr Touhig: Revenue and Customs' policy was: "We use leading technologies and encryption to safeguard your data and operate strict security standards to prevent any authorised access to it", yet they still managed to lose 25 million people's records not because of any failure of the system but because people failed to follow proper procedures. What are you doing to ensure people follow proper procedures that have nothing to do with actually managing the system?

Mr Nicholson: You also need to make it easier to make the right decisions than the wrong decisions, so you need a set of technical systems and processes to underpin that to make that happen around encryption and all the rest of it, so it is not just about processes and procedures. We have issued a huge amount of guidance; we have put it high up on the responsibilities of all chief executives in the NHS; we have identified that if there are any kind of data breaches patients need to be told: we have said that people have to set it out in their annual reports if there are any and what lessons they have learned and what they have done about it, so we have significantly increased its significance to NHS organisations. We expect people to take action when it does go wrong.

Q119 Mr Touhig: But things do go wrong, and how often are staff reminded and warned about following proper procedures? We are not clear what has happened just recently but it is clear people have not followed proper procedures and have taken secret information away from the Cabinet Office that should not have been removed under those circumstances. We do not know the details yet. What are you doing to ensure every day that people are reminded that there are certain procedures they must follow?

Mr Nicholson: As I say, part of it is the design of the system itself so you cannot do the sorts of things you have described, but also training and education in the way in which we take forward the development of our people, and it is absolutely hard-wired into the kind of training and education that we have.

Q120 Mr Touhig: But it is not universal, is it?

Dr Braunold: There is an information governance toolkit that everybody within the Health Service is required to do that is part of the Statement of Compliance, and they have to demonstrate where they are and what they intend to do to achieve better standards over the next year.

Q121 Mr Touhig: That is across the NHS?

Dr Braunold: Yes.

Q122 Mr Touhig: How do you know that?

Dr Braunold: It is a standard that is there.

Q123 Mr Touhig: Paragraph 3.27 states that "Security incidents which relate to locally managed processes . . . are dealt with by the local NHS" and there is no requirement for NHS Connecting to be notified of any security breaches. So how do you know?

NHS

Professor Thick: Previously with manual records it was a favourite sport in secondary care hospitals for people to look up relatives' records and members of staffs' records and we had absolutely no way of checking whether or not it had been done. With our current security arrangements we have an audit trail so you can see who has been looking at what and when and for what purpose, and unless they have a legitimate reason for doing so then they will be called to account for doing it locally, and that is a massive advance on where we were before.

Q124 Mr Touhig: But does it not seem to make some sense that, if there are security incidents in a locality within a Trust, there is some warning to the centre that this has happened? How on earth do you know whether your processes are working otherwise?
Mr Nicholson: In terms of the NHS as a whole what we are saying is that they should identify them in their annual reports and publish them.

Q125 Mr Touhig: It is a bit late then.
Mr Nicholson: That the Strategic Health Authority should publish them on their website once a quarter, and that for those significant ones they should be reported on the system. It is simply impractical for us in the centre to deal with the day-to-day set of case notes going missing or whatever.

Q126 Mr Touhig: But if you are merrily working on a system that appears to be working fine with everything going swimmingly, and you have to wait for some Trust to produce an annual report to find out it has failed somewhere, that is a bit late, is it not?
Mr Nicholson: They obviously have to identify and set out for us if there is a serious untoward incident. If many records are lost or whatever they would have to report to us centrally, that is true, but for the day-to-day breaches in security of a relatively minor nature in terms of the scale we would not expect to identify every single one.

Q127 Mr Touhig: But if the central body is not even informed of all security breaches, how would you form a clear picture as to whether or not the security measures you are putting in place that you are have talked about are actually working?
Mr Nicholson: Because we can identify them through the annual report and the quarterly reports of the Strategic Health Authorities, and through the notification of the major system—

Q128 Mr Touhig: But are you saying that if there was an issue that cropped up you would then perhaps take some action, maybe six, eight or nine months after it had occurred because that is when the annual report has come out that you did not know about, but there was an requirement on any of the other trusts or bodies to inform the centre of the failure?
Mr Nicholson: But it is individual organisations. There are a large number of boards/organisations out there in the system who are responsible for that. They would have to report them to the Information Commissioner in the same way that we did. We cannot work on the basis that everything that

happens in the NHS gets reported to the centre for us to be assured that everything that is supposed to happen did happen. It is simply not practical.

Q129 Mr Touhig: Well, this is the key issue, is it not?
Mr Nicholson: What I am saying is that minor security they have to report in their annual report; medium issues the Strategic Health Authorities report quarterly; and if there are major security breaches they tell the centre straight away.

Q130 Mr Touhig: I am short of time so I would appreciate if you would keep your answers brief. I think you are putting your claim on the *Today* programme somewhat at risk by that approach. Paragraph 3.75 tells us that access to care records is controlled by Smartcards and pass codes. What valuation has been made of the risks to data security if a Smartcard is lost?
Mr Hextall: If a Smartcard is lost and reported as lost then it is disabled straight away, so that anybody finding that card would not be able to use it. Before they could use it effectively they would also need the pass code, so they would need both.

Q131 Mr Touhig: Paragraph 3.75 also tells us that the software in some NHS Trusts does not actually support the use of Smartcards.
Mr Hextall: If it is an existing piece of software then it would not.

Q132 Mr Touhig: What security measures would be in place then?
Mr Hextall: Typically passwords, that is the history, but they are not systems that have been delivered through the National Programme for IT.

Q133 Mr Touhig: Is it your ambition that all the record systems would be Smartcard compliant?
Mr Hextall: Yes. Patient records.

Q134 Mr Touhig: Is there a target date for that?
Mr Hextall: It would be when the systems are fully deployed so at the moment, based on the information in the Report, it would be 2014.

Q135 Mr Touhig: You have had a bit of a problem, the Chairman touched on it, with some of the people you deal with, and Mr Hutchinson was questioned a bit earlier. In January '07 you switched from a contract with Accenture to one with CSC for the north east and east, and in May this year you terminated your contract with Fujitsu because of unacceptable delays. Are you simply a bad customer or do these people just take you for a ride?
Mr Nicholson: I do not think we are either, but these are very difficult and complicated issues that we are trying to tackle. This is an extraordinarily ambitious programme, as we said before, and in order to make it work it means a very close working relationship between a private sector partner and the NHS. It is working extremely well with BT and CSC—
Mr Touhig: But not with Fujitsu. I am sorry but I have run out of time.

NHS

Q136 Mr Burstow: Mr Nicholson, could you tell us how many revisions there have been so far to the target date for delivering the patient record?
Mr Hextall: It was always envisaged that the patient records would be delivered over a ten-year period and there was a ten-year programme that was announced in 2002, so there were revisions on an almost weekly basis with individual suppliers about individual milestone dates.

Q137 Mr Burstow: But what about delivering a fully operational system? My understanding is it has been revised in broad terms at least three times: it was originally to be delivered in 2005, then 2008, then 2010 and now 2014–15. Is that a fair assessment of the numbers?
Mr Hextall: No, because that mixes up the start and the finish. Some of these dates are the start of delivering and some are the finish of delivering it, and the date in the report, the 2014–15 date, is the finish of it, not the start.

Q138 Mr Burstow: Now that we have, through this set of questions, defined what we are talking about, how many times has that date been revised? The date is currently 2014–15. How many times has it been changed to get to that date?
Mr Hextall: At that very high level probably three times.

Q139 Mr Burstow: So the figure I quoted turns out to be still correct, three revisions to date. How many more revisions would be acceptable?
Mr Hextall: That is an impossible question to answer because, on the one hand, you would say no revisions are acceptable but, on the other hand, this is not a programme that is the equivalent of paint by numbers. Some elements are, so delivering PACS and the N3 broadband connections are what I would describe as paint by numbers, you do the design and then you know how to do it repeatedly. This is more of an expedition where you have some expertise setting out to do the expedition—

Q140 Mr Burstow: It is an interesting analogy. As an expedition, do you have a map the compass?
Mr Hextall: Absolutely, and you have to overcome the problems you are going to encounter on the way, and you have to work collaboratively with the suppliers on the NHS to be able to do that.

Q141 Mr Burstow: I am going to have to think about that analogy a bit further and come back to it, if I may. Why has it taken so much longer to settle each payment with Fujitsu in respect of the deployments? The figures as at 31 March suggest it was taking 219 days to settle a payment for Fujitsu. Why was that?
Mr Hextall: These are the deployment sign-offs which are done at a local level by the individual Trust, so following a deployment within the contract there is then a 45-day period where you would expect the Trust to say, "This is not working" and supplier to be able to implement a deviation plan to fix it.

Q142 Mr Burstow: Pausing for a second, Mr Hutchinson, why was it taking you so long to get the money out of the NHS?
Mr Hutchinson: There were a lot of delays in getting paid for things which were quite frustrating, and there is no question that local Trusts withheld agreement to payment in order to force us to make further changes to the system and keep us under pressure?

Q143 Mr Burstow: What sort of changes were these? Were they contractual changes?
Mr Hutchinson: These were changes to the contracted requirement to suit the specific requirements in particular Trusts.

Q144 Mr Burstow: So you had a contract to deliver something and they wanted something extra?
Mr Hutchinson: And that has been a feature of this all the way through. So far we have received 650 change requests.

Q145 Mr Burstow: Is that characterisation a correct one, Mr Nicholson? Would you accept that is the case? That there has been a lot of attempts to have contract creep on the part of the NHS?
Mr Nicholson: There has certainly been a lot of discussion between ourselves and Fujitsu about what constitutes contract change and what constitutes non-delivery on the contract, and my guess is that is going to be subject to a whole series of discussions between ourselves and Fujitsu in the next period.

Q146 Mr Burstow: A whole series of discussions which have been going on for quite a long time and are going to go on—
Mr Nicholson: Yes, and not ones we have had with BT or CSC.

Q147 Mr Burstow: Just in terms of that, as I understand it, Fujitsu were paid £317 million upfront as part of the contract and are due to repay £143 million, as set out in the NAO's report, and in an answer to a PQ last week it was suggested we would learn in the period ahead just quite what the financial consequences of terminating Fujitsu's contract would be. What does the period ahead actually include? How far into the future might we have to look before we get an actual figure for the costs of this termination?
Mr Hextall: The figure of £143 million and the £340 million[6] were both related to advance payments that are allowable within the Treasury rules to enable a supplier to use cashflow without having to borrow on the open market, so it is better for the taxpayer to do that. A proportion of the £143 million that was quoted in the report has already been repaid and there is currently £67 million outstanding which is due to be repaid by the end of June[7]. The financial consequences you then talk about, beyond that, will

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6 The advance payments to Fujitsu were actually £388 million.
7 The Department confirms that repayment was subsequently made on time.

be part of the transitional arrangements that we are now discussing with Fujitsu to be able to enable them to transition out.

Q148 Mr Burstow: So these are payments for the on-going servicing of the deployed sites so far?
Mr Hextall: Yes. They will be different payments.

Q149 Mr Burstow: Moving on to the contract itself with Fujitsu, just to be clear, the Cerner software that was being deployed in the south I think Professor Thick described as very limited in terms of its clinical functionality. Is it the case that this was a rather limited, one-size-fits-all package that was being delivered?
Mr Hutchinson: No. When we set up the Cerner project it was very clear we would deliver functionality in four releases, Release 0, 1, 2 and 3. Release 0 was essentially the United Kingdom version of Millennium running successfully at two hospitals in London, and we would move rapidly on to Release 1; and Release 2 was the real star release from the point of view of additional clinical functionality. Release 0 has been the subject of many changes and that is what has delayed the arrival of the later releases.

Q150 Mr Burstow: Is that also where the payment disputes have been?
Mr Hutchinson: The payment disputes were a side effect of that but the need for change was the fundamental effect, and this is really where the fundamental issue of standardisation versus localisation comes in, and, in the real world we live in, deploying systems, and the reason why there have been more changes in the south is because we have deployed more systems and we have set up more projects with more Trusts with the strategic system. The constant need to change systems to meet local requirements, which was not originally envisaged in the contract, has been the major cause of delay.

Q151 Mr Burstow: So the intention had been from those who contracted with you to have a one-size-fits-all, and that is not what the customers wanted?
Mr Hutchinson: Ruthless standardisation was the watchword, yes.

Q152 Mr Burstow: On the re-set negotiations it has been suggested that the intention was to get the full product as a result of that. Is that the case? It was going to be the full singing product?
Mr Hutchinson: Part of re-set was a movement towards a greater level of local flexibility in order to meet the local needs of the Trusts, so that was a fundamental part of it. I would also say that there was more clinical functionality in Release 0 than most Trusts actually used, but the Order Comms functionality that some people say is missing is actually there and one of the Trusts is using it.

Q153 Mr Burstow: Why do you say Trusts were not using that which was already there? What was the problem?

Mr Hutchinson: Because the change process that has been noted is very onerous on Trusts and is a very tough change to go through, and most Trusts decided to be less ambitious and employ less functionality than was available.

Q154 Mr Burstow: I want to ask a little bit about what happens now for the south where systems have been deployed. What happens for those earlier adopters? What support has been put in place to ensure they know what happens next?
Mr Hextall: There are eight live sites currently, or families of sites, and they currently continue to be supported by Fujitsu whilst we look to arrange for an alternative supplier to take responsibility for those live sites, so that is a priority, to keep those sites running, and Fujitsu agreed to co-operate during that transition.

Q155 Mr Burstow: How long will that interim arrangement be?
Mr Hextall: As quickly as possible for all parties. I do not think it is any secret we are talking to BT at the moment about BT taking responsibility to maintain those live sites. Clearly BT will need to do some due diligence before they take responsibility for something like that, and it is likely to be a month, I would guess, before that due diligence is complete.

Q156 Mr Burstow: And, just so I understand, what was the rationale behind having local service provider contracts in the context of the software itself? It has meant during this period no one could go directly to the software supplier for any support.
Mr Hextall: The advantage of local service providers being the world class systems integrators they are is to be able to take a product that has got great clinical functionality but then needs to be engineered so it can be available 24 hours seven days a week with the right levels of recovery and resilience to back that up. So the LSP is bringing expertise and programme management, expertise in systems integration on a large scale, because typically an acute hospital has between 20 and 40 existing systems all having to interface with the new product, so not a trivial task, and also having the financial ability to bear that level of financial risk.

Q157 Mr Burstow: Do you think the model has been tested to destruction in the last few months?
Mr Hextall: It has certainly been tested—not to destruction. It has been tested to show it works.
Mr Burstow: Finally, you said the Choose and Book contract is for seven years and £64 million. The contract ends in 2009. What happens after 2009? Are we back to this process of expedition?

Q158 Chairman: Briefly, please.
Mr Hextall: There is an option within the contract to extend for two years and we will tell the supplier by the end of 2008 whether we wish to exercise that option.

NHS

Q159 Mr Williams: My first question overlaps the last answer and concerns the practical impact on your plans and the falling out between yourselves and Fujitsu. If I understand it correctly, the process is that it will take you about a month, you think, to find a replacement for Fujitsu, is that what you said?
Mr Hextall: That is for the eight sites that are currently live.

Q160 Mr Williams: But what about the rest of the programme? What is the impact there?
Mr Hextall: There are options available to the Trusts in the south of England.

Q161 Mr Williams: Before you tell us what the options are, what is affected by the fact that they dropped out, just so we understand the problem you have to address?
Mr Hextall: There is still a substantial number of acute trusts, community trusts and mental health trusts all in need of improved IT systems, so it is a question of arranging to meet those needs.

Q162 Mr Williams: Fine. So when you are talking about a month to find a replacement as the main substitute for Fujitsu, at the same time what you are saying is there are a lot of ancillary impacts that could take a lot longer to resolve. What is your assessment of (a) the timing impact of this decision and (b) the cost impact, if any, of this decision?
Mr Hextall: It is genuinely for the south to make a decision about what they want to do for the future. The National Programme local ownership programme that took place last year not only gives the south a voice but gives them a decision-making voice as well, so the options that are available are that we have two extant contracts, one with BT and one with CSC, to deploy products so that there will be a known product at a known price. The contracts enable all suppliers to deploy their systems outside their home territory at the same price, so we have known product, known supplier, known price, and known terms of conditions of contract. So those Trusts in the south can choose to take a system from either CSC, the Lorenzo system, or from BT, the Cerner system. They could also in the community and mental health area choose to take one of what BT is offering. BT deploys RiO and has deployed around 20 RiO mental health and community health systems in London successfully, because it has been acclaimed by the Trusts that have taken it, and I know there are some Trusts in the south of England who will be keen to take the RiO system. Similarly CSC have TPP SystmOne community system, and they are equally able to deploy that. As with the ambulance systems there are credible ambulance systems able to be deployed, so some of those can be deployed quicker than had Fujitsu tried to deploy RiO, which is one of the options we were talking about—
Chairman: Can we have briefer answers, please?

Q163 Mr Williams: So, in effect, what you seem to be saying and explaining in detail, and I asked for detail so it is my fault, is that it will have a fairly minimal impact on cost and timing?
Mr Hextall: It depends on the choices the south take. They could also choose for us to do a procurement through our additional supply capacity and capability framework, a relatively recent framework contract, but that would take time and the price would be unknown.

Q164 Mr Williams: Thank you. That is helpful. Mr Nicholson, the Strategic Health Authorities I gather have been carrying out a review of data security. Is there any early information available as a result of that inquiry?
Mr Nicholson: It has all been published on the strategic health authority websites, so all the work they have done and what they have found is in the public domain.

Q165 Mr Williams: Access to the care records is controlled, as have you explained, through a Smartcard and pass codes, but of course in many of the Trusts that is not in use yet. The Smartcard code system is not operating, but is there a guarantee that the security is strong enough, or as strong as that you are hoping to get through the Smartcard?
Mr Nicholson: This is a really difficult issue for us to deal with because a lot of these systems, particularly, for example, in the community, are absolutely vital for delivering services for patients. The danger is to take a very prescriptive position from the centre where you might have a whole series of unintended consequences and midwives will not be able to do their work properly or whatever, so what we have said to individual organisations is they have to make their own assessments on all of this, they have to make a judgment, a trade-off, between security on the one hand to the level we have talked about here, against delivery of services for patients, and they have to make that explicitly to their boards and make a judgment about what they are going to do.

Q166 Mr Williams: So what you are saying is it really is a trade off, a trade down, and it is a less secure approach?
Mr Nicholson: These are existing systems and existing arrangements which have gone on for years, and it is absolutely true that if you took a very strict position from the centre and said: "All of this must be in this way and all must be in that way" there would be a whole series of consequences for patients, and it is true that individual organisations have to make those judgments about what is in the best interests of their patients, but they should do it transparently and openly and explain to their population what they are doing.

Q167 Mr Williams: So will patients have a say in whether they have signed up or not signed up? Whether they have opted in or out? Are they given a specific choice?

Mr Nicholson: I do not think this bears any relation to the summary care records. These are individual operational systems that staff might take. For example, if you are a community midwife and you have a laptop with a whole set of information about your patient, you could not make a judgment that no one takes the laptop out of the building. That is, for example, what has been said nationally for civil servants as part of the Cabinet Office Review, and we could not do that in the NHS. If we did do that then the consequences would be that community midwives would not be able to organise their work and see their patients, and it is not practical in those circumstances to consult individual patients about all of that but it is a judgment that organisations have to make.

Q168 Mr Williams: So the patient does not have a say in it at all? We were talking about consent, but you are saying it would be impossible to consult, are you?

Mr Nicholson: No—this is not about consent about patient records. This is about operational systems to run services, and it is true that for those that are outside the existing Connecting for Health system there is a trade-off.

Q169 Mr Williams: So going back to a question you were asked right at the beginning by the Chairman, are patients given a specific choice: "You can or you need not sign up to this"? Because we are told that patients are assumed to be content for a record to be created and shared unless they state otherwise, but nowhere does it say that anyone has to ask them that question. Do they have to ask that question?

Mr Nicholson: We do ask that question. What happens, and we are piloting this at the moment in Bolton and Bury, is that every patient gets a letter setting out what we plan to do and there is a pre-paid envelope[8] in it for them to send back.

Q170 Mr Williams: If it is so notable in Bolton and Bury, what it is like in the rest of the country, that you remember those two?

Mr Nicholson: That is where the pilot is. We are learning how to do it and then we will roll it out across the system as a whole, so we go through that process, so people do get the individual letter and they can respond as part of that. The process we have taken has been described as one of opting out as opposed to opting in, and that is what we have been piloting and that is what the evaluation looked at. The issue that came out of that, then, was if you have an opt-out system should you have an extra consent before an individual gets to see your record. What is that described as, Gillian?

Dr Braunold: We could call it "permission to access" or "consent to view", which is what is happening in other parts of the United Kingdom, so rather than asking patients before you load their records on to the Spine, which would mean you would have to go through many years before you would get the benefit

because we know how long it would take to address it with each patient, the other jurisdictions that have done it successfully have done it under implicit consent, which is the model that Mr Nicholson is describing, where we write to all the people, tell them what is going on as we do with all the other NHS transactions about patient data, and give them the opportunity to say no. If they do not want a summary care record, they do not have to have one. At the point of care what we are impact analysing at the moment is asking them before we look at the record, and that is not what we have been doing in Bury and Bolton, or the other early adoptive PCTs, but that is what we are considering doing now, and the decision around that will be made by the Summary Care Record Advisory Group and the CRS Programme Board in July.

Q171 Mr Williams: The Information Commissioner has asked for a penalty for data theft. What is your response to that and, if you were positive to it, what sort of scale of penalty would you envisage being involved?

Mr Nicholson: We responded to the consultation very positively, and we support his demands to increase that level.

Mr Hextall: It is £5,000 now, which is not sufficient a deterrent.

Mr Williams: Thank you very much.

Q172 Mr Bacon: Mr Nicholson, is it possible for you to send us a couple of notes? Firstly, you mentioned the evaluation of Lorenzo done I think you said jointly with CSC, with the consulting firms EDS and Mastek. Could you send us that, and any other evaluations of Lorenzo as well?

Mr Hextall: Could I just explain that we did not disclose the names of those suppliers because there are non disclosure agreements between the four parties—

Q173 Mr Bacon: You did not disclose which suppliers?

Mr Hextall: The ones you mention.

Q174 Mr Bacon: They were mentioned to me by the Department of Health last Wednesday in that meeting. I was told by a Department of Health official, so the answer to your statement is incorrect. You did disclose them to us there last Wednesday.

Mr Hextall: But there is a written non disclosure agreement with all those parties so I need to take legal advice on that.

Q175 Mr Bacon: Could you send us those evaluations that you are able to send us?

Mr Hextall: Yes.[9]

Q176 Mr Bacon: Secondly, there are some Trusts which, for one reason or another, either have got fed up or can not wait for this strategic product to be delivered by one of the LSP software suppliers and have gone out and bought their own thing. Can you

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[8] The prepaid envelope enables the patient to request additional information if required. It is not to enable them to state their consent, which is implied unless otherwise stated

[9] Ev 24

send us a list of which Trusts have bought non NPfIT products and for which purposes and applications? In other words, maternity or radiology or whatever?

Mr Hextall: If we have that information centrally, yes.[10]

Q177 Mr Bacon: Thirdly, Mr Hextall said it was always envisaged that this would take ten years. Now, I do not suppose Mr Hextall was around at the time but originally, when Sir John Pattison was the original senior responsible owner, it was agreed at the February 2002 meeting which kicked off the National Programme that delivery would take two years and nine months from April 2003, in other words, it would be completed by December 2005, so it is not true to say it was always envisaged it would take ten years, although later it became envisaged that it would take ten years. Could you send us a note explaining, as it were iteratively, how it got from being envisaged that it would take two years nine months to how it was envisaged that it would take ten years?

Mr Hextall: Yes.[11]

Q178 Mr Bacon: Mr Nicholson, do you think it would have been wise to have gone ahead with a completely independent review which was suggested by the 23 academics who wrote an open letter to Downing Street suggesting that should take place? Do you wish you had done that now?

Mr Nicholson: We met all of those people,[12] all the people who had criticisms of the programme, about 18 months ago in the same room and there was no coherent argument for us to have it. The most important thing that people said is you should get on and get something done and delivered, and that is exactly what we have been focusing our attention on.

Q179 Mr Bacon: Arthur D Little did a completely independent study of the National Air Traffic Service, which was quite useful.

Mr Nicholson: I know. I have seen it.

Q180 Mr Bacon: Do you not think there is a case for doing something similarly, completely independent, in other words independent by American standards, with no connection at all with the Programme?

Mr Nicholson: Various bits of the Programme—

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[10] Ev 24
[11] Ev 25
[12] Note by witness: After the publication of their open letter to the Health Select Committee in March 2006, the 23 Academics were all invited to a meeting with the Department of Health to discuss their concerns. Six of them attended. Subsequently, the Department held a further conference in January 2007 to review concerns raised by a range of critics of the Programme, including the 23 Academics. The 23 Academics were invited to send representatives and two of them attended.

Q181 Mr Bacon: The whole thing?

Mr Nicholson: No, I do not believe that is sensible at all. The most important thing now is to deliver. The Service is crying out for this product and we need to deliver it.

Q182 Mr Bacon: Indeed they are. Mr Hutchinson, quickly, just to clarify the sequence of events, the NHS terminated your contract but that was after you had withdrawn. You withdrew, and then they terminated the contract, in that order, that is correct, is it not?

Mr Hutchinson: We withdraw from the re-set negotiations. We were still perfectly willing and able to deliver to the original contract.

Q183 Mr Bacon: Good. That is very clear. In other words, you were not sacked; you withdrew from the re-set negotiations, you said you were up for delivering the original contract, the NHS said no, and, therefore, that was curtains and they issued the termination contract. It was not that you were sacked; you withdrew from the negotiations for the re-set?

Mr Hutchinson: To be honest, I was not in the room and there are people here who were, but I think there was a mutual understanding that the discussions had exhausted themselves. So I think there was more mutuality—

Q184 Mr Bacon: Could you say why exactly Fujitsu withdrew from the contract re-set?

Mr Hutchinson: We had tried for a very long period of time to re-set the contract to match what I think everybody agreed was what the NHS really needed in terms of a contractual format. In the end the terms that the NHS were willing to agree to we could not have afforded and, whilst we have been very committed to this Programme and put a lot of our time and energy and money behind it, we have other stakeholders that we have to worry about, including our shareholders, our pension funds, our pensioners and, indeed, all the staff who work in the company, and there was a limit beyond which we could not go.

Q185 Mr Bacon: Finally, Mr Nicholson, plainly there have been some things that have gone better than others in the programme, we have talked about N3 broadband, and PACS which was added later to the programme, but it is clear that the biggest single problems have been around the big LSPs, these huge contracts and their software suppliers. It is quite clear they have breached sufficient of their contractual obligations to you, never mind what you may have done to them, that you probably would be able to reach an accommodation and you would not end up in court. This structure with the huge LSPs and their software suppliers, almost a monopoly restriction, has basically not worked. Why not just dump them?

Mr Nicholson: I do not accept they have not worked.

Mr Bacon: You have not deployed a single working PAS for Lorenzo, and it is four years after the company said it was available. How can you say it is working?

NHS

Q186 Chairman: No more questions now.

Mr Nicholson: CSC have deployed quite a lot. We have deployed a significant amount in the mental health service; we have deployed 136 PASs across the country as a whole, albeit only just over 30 from acute hospitals, but mental health and PCTs have worked well.

Q187 Mr Bacon: I was talking about Lorenzo actually.

Mr Nicholson: But we are in a position now where Lorenzo have a product that can be deployed. It would seem to be ludicrous at this particular moment in time to dump that when we have the opportunity to do something that we have been trying to do for several years.

Mr Bacon: I am out of time.

Chairman: Mr Burstow?

Mr Burstow: Can you give us a note explaining the contractual arrangements in respect of Choose and Book, what happens after seven years and what happens after the two years extra, firstly, and, secondly, in terms of understanding the three local supply contracts for London, south and north, can you give us some detail about the levels of functionality supplied in each case and whether they are comparable? I would like to see a note that talks us through that to see whether we are comparing apples and pears.[13]

Chairman: And I would like a note on what happens to a supplier if there is a security breach, please, and that, Mr Nicholson, you will be relieved to hear, concludes our hearing. We wish you well in your endeavours.

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[13] Ev 25

THE NATIONAL PROGRAMME FOR IT IN THE NHS

ESTIMATED COST OF THE PROGRAMME AND EXPENDITURE TO-DATE AT 31 MARCH 2008

1. The table overleaf, requested by Richard Bacon MP, brings together two sets of data from the C&AG's report on *The National Programme for IT in the NHS: Progress since 2006 (Volume 1)* and *Project Progress Reports (Volume 2)*.

2. We did not present the material in this format in the report as the two sets of data are not comparable in that:

— the estimated total costs are un-indexed and shown at 2004–05 prices; the final outturn will be higher due to impact of price inflation in years subsequent to 2004–05 (paragraph 2.21 and Figure 6 on page 25); and

— the expenditure to date figures are resource outturn figures (paragraph 2.27 on page 26 and Volume 2).

Category	Estimated total cost (from Figure 6) £ million (at 2004–05 prices)		Expenditure at 31 March 2008 £ million
Core contracts			
London	1,021		191
South	1,104		81
North East	1,035		214
East	930		200
North West and West Midlands	1,042		185
Spine	889		585
N3 network	530		423
Choose and Book	144		103
Amount retained by Accenture	110		(49)[1]
Total for core contracts		£2,005	1,934
Products added to the scope of the Programme		666	346
Other central costs		1,599	499
Total for central costs		9,070	2,778
Local costs (estimated)		3,586	772
Total		**12,656**	**3,550**

[1] Note 1: Part of Accenture's repayment of £69 million (the £179 million it had received previously less the £110 million retention—paragraph 3.47).

Source: NHS Connecting for Health

June 2008

Memorandum from the Department of Health

NHS NATIONAL PROGRAMME FOR IT: CONTRACT WITH FUJITSU SERVICES LIMITED

1. This note, a draft of which has been shown to Fujitsu Services Limited (Fujitsu) and takes their comments into account, is designed to provide a factual account of the events leading to the termination of the Project Agreement between the Department and Fujitsu on 28 May 2008. It should be appreciated that as the basis for the termination is in dispute, in due course this will need to be the subject of a formal dispute resolution process and/or settlement negotiations. As such, both parties would be placed in an extremely difficult position, if they are compelled to disclose:

— legal advice surrounding the termination and concerning the strengths and weaknesses of the parties' respective positions in any future formal dispute resolution process and each party's prospects;

— the parties' future plans and tactics regarding negotiations and any future formal dispute resolution process; and

— likely settlement parameters and terms.

2. The Comptroller and Auditor General's second review of the NHS National Programme for IT was completed before the negotiations between the Department and Fujitsu were concluded. The Department holds the contracts on behalf of the NHS. The aim of the negotiations had been to reset Fujitsu's contract as Local Service Provider to the three Strategic Health Authorities in the South.

3. The contract with Fujitsu, originally signed in January 2004, comprised the provision and maintenance of the local NHS Care Records Service to all NHS care settings in the South as well as the provision and maintenance of the Picture Archiving and Communications Systems (PACS) and Radiology Information Systems (RIS). By the time of the first C&AG's Report, published in June 2006, it had already been reported that Fujitsu had replaced its main subcontractor, IDX, with Cerner and that delivery of the care records service had been delayed. The reset Fujitsu contract, with Cerner as the main subcontractor, was signed in September 2005 and the first Cerner Millennium patient administrative system was deployed at Nuffield Orthopaedic Centre in December 2005.

4. Although more deployments of Cerner Millennium have been made, these are, as the C&AG's Report shows, at a slower pace than planned originally. The NHS has also raised concerns about the quality of the systems deployed. The key events leading to the notice of termination of the contract were:

(i) *July 2007*: Fujitsu and the NHS, recognising that the contracted schedule had not been met and that the solution approach needed to be revised, jointly signed a Memorandum of Understanding to achieve a further contract reset to re-baseline development and deployment plans to reflect reality for the future. In the following months, discussions centred on a new approach to development and deployment, taking account of experience to date.

(ii) *January 2008*: The Memorandum of Understanding expired but the negotiations continued and focussed largely on establishing affordable costs and a greater level of detail relating to the development and deployment approach.

(iii) *February 2008*: Breach Notices were served on Fujitsu on 20 February 2008 and 29 February 2008 to the effect that among other things, Fujitsu had not met key contractual milestones, including deploying to the NHS sites or meeting timetables agreed. These did not terminate the contract but gave Fujitsu five days to produce a remediation plan that would remedy the breaches. A remediation plan served by Fujitsu was rejected by the Authority.

(iv) *March 2008*: Fujitsu's best and final proposal required the NHS to find substantial new money, which the NHS did not consider was justifiable.

(v) *April 2008*: A series of further Breach Notices in similar terms was served on Fujitsu for its failure to deliver under the original contract (as reset in September 2005). In return, Fujitsu challenged the validity of the Notices and has alleged that the termination of the Agreement by the Department is unlawful. A formal legal dispute exists between Fujitsu and the Department as to termination of the Agreement.

(vi) *22 April 2008*: Fujitsu made a revised offer that was considered in principle to be financially acceptable to the NHS.

(vii) *27 May 2008*: It became clear that Fujitsu's offer was conditional on payments under the contract being made earlier than the principles of payment on delivery permitted. Because agreement could not be reached, Fujitsu having previously stated that it was withdrawing from further negotiations, the decision was made by the Department to terminate the contract on 28 May 2008.

5. One particular area of difficulty in the negotiations was the cost of what Fujitsu termed "new requirements." The NHS' position was that the majority of these requirements were remedial and were necessary to improve the current IT product and make it fit for purpose. Furthermore that the delay to the

programme was as a result of Fujitsu's failure to meet its contractual obligations. The Fujitsu position was that all the requirements were new and incremental to the existing contract and therefore needed new NHS funding. Fujitsu's view was that the Department had caused delay to the Programme as a result of, amongst other things, substantial changes required to the solution and that Fujitsu should be paid where the solution was being used by Trusts.

6. Fujitsu's proposal on 22 April 2008 still required additional funding but this was believed to be justifiable in return for the delivery of new requirements identified by the NHS and for an extended period to the contract that was also included.

7. On 27 May 2008 both parties met with senior representation to work through the remainder of the issues to enable the Heads of Agreement to be signed. Towards the end of that meeting it was clear that, although the overall price in the revised offer remained affordable to the Department, Fujitsu's expectation of revenue recovery to offset against costs in the early years of a reset contract could not be met by the profile of payments that would be legitimately earned for products and services delivered. There were no grounds to alter the financial risk principle in the contracts that protects the taxpayer by making payments dependent on the delivery of systems that are fit for purpose, especially as similar provisions apply to the other Local Service Provider contracts. Although efforts were made to resolve the different revenue/payment profile expectations, this proved to be insoluble unless either Fujitsu relaxed their financial constraint and recovered costs in line with payments over the life of the contract or the NHS relaxed the principle of payment being related to delivery in protection of the taxpayer.

8. In the circumstances and with regret, the Department decided that there was no alternative but to end the contract and issue a termination notice on 28 May 2008.

9. Looking to the immediate future, without prejudice to either party's legal arguments, both parties are discussing working together to maintain the live services to those trusts with a Cerner Millennium solution and to discuss achieving a transition to an alternative supplier.

10. Alongside this, the Department is examining its options for the continued implementation and support of the care records service in the South. These include contracting with either one or both of the other Local Service Providers, whose contractual terms allow them to deploy systems outside their "territory" at the same prices and under the same terms and conditions as in their "home" territory. The Department is also considering the options available under the new framework contracts that were put in place for contingency purposes and new requirements earlier this year.

11. The termination of Fujitsu's contract was with the knowledge and agreement of the Chief Executives of the three SHAs in the South (who, under the NPfIT Local Ownership Programme, are accountable for delivery of the National Programme for IT in their SHA areas) as well as the NHS Chief Executive as Senior Responsible Owner for the National Programme, Ministers, the Office of Government Commerce and The Treasury. The SHAs in the South will be parties to the decision making on the way forward.

12. Fujitsu has delivered PACS in full and it is generally working well. Although there was a single contract covering both the Care Records Service and PACS and the termination of the contract therefore covers both items, the intention of both Fujitsu and the Department is that Fujitsu will continue to deliver PACS' and RIS' services in the South, subject to contract, at least in the short term prior to a general transition to an alternative supplier subject to the agreement of terms. Without prejudice to Fujitsu's legal rights, Fujitsu continues to provide these services pending confirmation by the Department of commercial cover.

13. The Department remains committed to the successful delivery of the National Programme but value for money has also to be achieved. Whilst the loss of Fujitsu is regrettable, the original approach to the contracts was designed to cope with such events.

10 June 2008

Supplementary memorandum from the Department of Health

Question 25 (Phil Wilson): *The circumstances where paper prescriptions will be required after Release 2 of the Electronic Prescription Service is introduced*

After the introduction of Release 2 of the Electronic Prescription Service, paper prescriptions will continue only:

— where a patient requests such a prescription;

— when controlled drug medication is prescribed;

— when the prescription is a private prescription; and

— in the initial phase of implementation of Release 2, where the patient has not nominated a dispensing contractor.

Where a patient's or their representative's signature is required in connection with the payment for the prescription, for example to claim exemption, this will be collected at the pharmacy and will not require the issue of a paper prescription by the GP or other prescriber.

Question 33 (Phil Wilson): *In respect of Local Service Provider deployments of patient administrative systems, can I expect the roll-out of this in County Durham, since it seems to be a problem?*

There are four NHS Trusts in County Durham and Darlington.
County Durham and Darlington Foundation Trust implemented an interim Local Service Provider (LSP) solution for Clinical Management (iCM) in November 2006. This supports the electronic ordering of tests, publication of the results from those tests, electronic prescribing for take-home medications and the electronic production of discharge summaries. It is widely used by the clinical community and has yielded a wide range of clinical benefits arising from improved legibility, reliability and accessibility of the information which is critical to the progression and decision making associated with diagnosis and treatment.

The Trust is currently working with the LSP and NHS Connecting for Health, with a view to upgrading the interim LSP Clinical Management solution (iCM) to the strategic LSP solution (Lorenzo), as a potential Early Adopter. In the first instance this would focus on the LSP functionality for Clinical Management as the Trust has no pressing business need for a replacement of the current legacy Patient Administration System (PAS), which is the predominant reason why it has not been necessary to deploy an interim LSP PAS. However, as the LSP strategic solution provides a comprehensive electronic care record, covering both clinical and administrative functions, it is anticipated that the strategic LSP PAS elements will be implemented as soon as they have been fully tested and proven in service. The enhancement to the clinical functionality is expected during 2009.

Tees, Esk and Wear Valleys NHS Trust is currently deploying a LSP solution (PARIS) to replace its two current patient information systems, with the first user-groups due to start using the system during July 2008. The Trust plans to move to the Lorenzo solution when the system is fully tested and proven.

County Durham PCT and Darlington PCT have both identified a LSP solution (TPP SystmOne) as their strategic solution for Primary Care. Currently this is being used in 29 of 86 GP Practices; three of four Urgent Care Centres; one of four prisons; and by several community based teams (such as Dermatology). It is also being deployed to all Health Visiting and District Nursing staff, which is due for completion in November 2008. The system is already providing rich clinical information through the availability of a single patient record across primary care settings and data to support commissioning.

Each of the four NHS Trusts is currently moving to LSP solutions that will provide further system integration across health settings. The key challenges are in gaining increased understanding of the significant capabilities provided by the integrated solutions across the Local Health Community and gaining clinical buy-in of the potential patient benefits.

In addition, County Durham and Darlington Foundation Trust, County Durham PCT and Darlington PCT have agreed recently to implement a Community of Interest Network (COIN) supplied by the National Programme for IT. This will connect the whole of the County Durham and Darlington Local Health Community (all acute hospitals, community hospitals, community health centres, PCT premises and GP practices) in a private and fully resilient broadband network. This network will provide robust and secure access to existing and future national and local IT applications. The project is due for completion later this year. It will provide the infrastructure to enable reconfiguration of services into any care setting, in particular moving services closer to the patient and electronic information sharing between healthcare professionals where that is in the interests of patient care.

Question 56–7 (Mr Bacon): *What lessons have been learned from the Australian system "HealthSmart?"*

At the Committee's hearing on 16 June 2008, all four Departmental witnesses referred to programmes to introduce electronic health records in other jurisdictions and evidenced the sharing of information across boundaries. There has been a free exchange of information since the Programme's inception, including exchange visits.

HealthSMART is a Programme in Victoria, Australia and, as an IT enabled change programme designed to bring clinical benefits to patients, does have some similarities with the NHS National Programme for IT.

Some of the functionality is similar, including patient administration systems, clinical systems (including e-prescribing and ordering and reporting of clinical tests) and shared infrastructure services.

The major difference between HealthSMART and the NHS National Programme is the sheer scale. The population of Victoria is around 5 million (ie considerably smaller than Greater London and about twice the size of the West Midlands conurbation) of which around three quarters live in Melbourne. There are just 15 health authorities, 42 major hospitals and around 15,000 users of the systems.

Some of the delays experienced by HealthSMART have been avoided by the NHS. In particular the procurement was run to a tight timetable and there was a centralised approach from the outset that moved gradually towards more local ownership. Interestingly, the initial voluntary approach taken in Victoria was subsequently revised.

In both cases, the development of the clinical functionality has taken longer than anticipated and deployments have needed to be re-planned. This does demonstrate the huge development required to build IT support for healthcare, or to adapt existing systems to the particular needs within a jurisdiction, emphasising the need for realism and flexibility in future plans.

Question 90 (Dr Pugh): *What is the running cost of the national data supply as opposed to the cost of implementing it?*

The C&AG's Report (Volume 2, Page 12) shows expenditure on the National Data Spine as £585 million at 31 March 2008. Of this, £412 million related to capital and development costs and £173 million related to operational costs.

Questions 172 to 175 (Mr Bacon): *"You mentioned the evaluation of Lorenzo done I think you said jointly with CSC, with the consulting firms EDS and Mastek. Could you send us that and any other evaluations of Lorenzo as well?" (In the light of the Department's initial response that the reports were covered by confidentiality agreements, the member asked that the Department should supply what it could)*

Although the Department does not have a direct contractual relationship with iSOFT in respect of Lorenzo, NHS Connecting for Health does keep in touch with iSOFT, as the C&AG's Report noted, including through regular visits to their development sites. The primary purpose of these visits, either by NHS Connecting for Health directly or by contractors on their behalf, has been to review progress on the development of the Lorenzo product.

The main contractor, CSC, has agreed to these reviews only on the basis of strict confidentiality agreements, advising that the information supplied is commercially sensitive to third parties. This confidentiality requirement has been extended to the contractors undertaking the reviews.

The Department is therefore unable to release the reports but the key findings included:
— iSOFT's software engineering capability was well managed and very capable.
— The Lorenzo architecture was well conceived.
— Some improvements were necessary in programme management, including strengthening programme assurance.

The following action was taken:
— Lorenzo would be introduced in four releases rather than two.
— The first release would comprise clinical functionality, with the patient administrative functionality following in the second release.
— An action plan was developed to monitor progress in the areas where improvements were required.

NHS Connecting for Health continues to work closely with CSC and iSOFT through joint governance arrangements. The Department remains confident that Lorenzo will meet the requirements of the NHS.

Question 176 (Mr Bacon): *Which Trusts have bought non-NPfIT products and for which purpose and applications?*

The Department would be made aware of the procurement of non-Programme products only in the event that the procurement was such that the system available under the Programme was not required.

Two Picture Archiving and Communications Systems (PACS) have been declined, one in the Heart of England NHS Foundation Trust and the second in the Worcester Acute Hospitals NHS Trust. In the case of the latter, there was good reason as the Trust was tied into an existing PFI deal which made taking the Programme solution uneconomic.

There have been reports that Newcastle Foundation Trust has declined a Programme solution. Our understanding is that the Trust has signed a contract with Pittsburgh Medical Centre in the United States for a Patient Administration System, including clinical functionality and order communications. This is a non-anglicised Cerner product and the aim is to install it across their three sites. The Trust has told us that the contract is for five years with an option to extend for two years and they regard it as an interim solution until they migrate to the Programme's solution around year 2013–14.

In his oral evidence, David Nicholson explained that NHS Trusts are directed to take the Programme solutions and although Foundation Trusts are not subject to direction, they are subject to Treasury rules and required to take account of the impact on the wider public sector finances. It would therefore be difficult for a Foundation Trust to build a business case involving rejection of the Programme solutions.

Question 177 (Mr Bacon): *Could you send us a note explaining how it got from being envisaged that the Programme would take two years nine months to how it was envisaged that it would take 10 years?*

There has never been a plan to deliver the Programme within two years and nine months. It would have been unusual for the Prime Minister not to have been involved personally in such a large investment decision. However, the Prime Minister's seminar in February 2002 was not a planning meeting nor was it the sole, or even the most important, event leading to the National Programme for IT. 10 years of policy development in the field of NHS IT was embodied in the document *Delivering 21st Century IT Support for the NHS*, published in June 2002.

The timetable set out in *Delivering 21st Century IT Support for the NHS* envisaged completion by December 2010 though plans beyond December 2005 were described as "tentative."

Question 187(1) (Mr Burstow): *Can you give us a note explaining the contractual arrangements in respect of Choose and Book, what happens after seven years and what happens after the two years extra?*

The Choose and Book services were contracted initially for five years (until December 2009) with provision in the contract to extend for a further two years (until December 2011). Decisions have not yet been made on how the service will be provided from December 2009. Following consultation with the NHS, NHS Connecting for Health will prepare a business case that will evaluate the options, either to extend the existing contract or to re-compete it.

Question 187(2) (Mr Burstow): *In terms of understanding the three local supply contracts for LPfIT, SPfIT and NMEPfIT, can you give us some detail about the levels of functionality supplied in each case and whether they are comparable? I would like to see a note that talks us through that to see whether we are comparing apples with pears.*

The functionality specified in all the Local Service Provider (LSP) contracts was based on the original Output Based Specification and is therefore similar. However, the way the functionality is delivered, and its phasing, varies between Programme areas. This is a factor of both the LSP approach and negotiations with the NHS on their priorities.

The table below summarises the key elements of the Programme and shows which releases of the products contain (or will contain) the functionality. The following should be noted:

— The general approach with Cerner Millennium is that solutions incorporate basic functionality when released initially (ie in the release shown in the table). The functionality then increases in each subsequent release. For Lorenzo, the solutions generally incorporate the full range of functionality in the release stated.

— North, Midlands and East: where an item is asterisked, then for many Trusts this function is provided currently by interim iSoft solutions such as the i.PM PAS and i.CM order communications systems.

— South: The table excludes functionality that was planned to be delivered in future releases but for which the contract has now been terminated.

— Picture Archiving and Communications Systems (PACS) and Radiology Information Systems (RIS) are not listed as they are fully rolled-out across all three Programme areas.

Functionality	Definition	Lorenzo (North, Midlands, East)	Millennium (London)	Millennium (South)
Acute Trusts				
Patient Administration System	The administrative system that contains essential non-clinical data, such as patient demographic details, and patient attendance lists, appointments and waiting times.	Release 2.0*	Release 0	Release 0
Hospital Pharmacy System	The integrated information management application that allows all aspects of hospital pharmacy practice to be managed and tracked within a single system.	Release 2*	London Configuration 2	–

Functionality	Definition	Lorenzo (North, Midlands, East)	Millennium (London)	Millennium (South)
Pathology	A computerised management tool designed to increase the operational efficiency within the pathology department.	No formally contracted solution	Release 2	–
Order Communication	Enhances communication between departments, allows users immediate online access to order details and results eg laboratory tests and x-rays, and view results and reports from patient electronic medical records.	Release 1*	Release 0	Release 0
Theatres	A computerised management tool designed to increase the operational efficiency within the Operating Theatres Department.	Release 3*	Release 0	Release 0
Maternity	An integrated element of the Care Records System which will record, track and analyse the whole timeline for maternity (throughout the entire pregnancy and beyond, supporting comprehensive management of maternity care from booking, through delivery, to postnatal care.)	Release 3*	Release 0	Release 0
Accident and Emergency	A computerised management tool designed to increase the operational efficiency within an Accident and Emergency Department.	Release 2*	Release 0	Release 0
Decision Support	Helps clinicians make clinical decisions to enhance patient care. It can range from simple facts and relationships to best practices for managing patients with specific disease states, new medical knowledge from clinical research, and other types of information.	Release 1* (basic but expanded in each subsequent release)	London Configuration 3	–
Clinical Assessment Documentation	Functionality to support the documentation of a patient encounter, especially for the case management of patients and secure sharing of the documentation between relevant teams of clinicians.	Release 1*	Release 0	–
Scheduling (Theatres, Clinics, Beds, Diaries)	This enables scheduling and optimal utilisation for operating theatres, outpatient clinics structures, and consultants' diaries.	Release 2*	Release 0	–
Access to Management Information	Access to data extracts and reports from the other functional areas, allowing hospital clinicians and managers to manage the efficient running of their clinics and hospitals (eg local reports on waiting times etc).	Release 1*	Release 0	Release 0

Functionality	Definition	Lorenzo (North, Midlands, East)	Millennium (London)	Millennium (South)
Bed Planning and Scheduling	This searches for free beds, allocates beds to patients and plans and monitors bed occupancy for the Trust.	Release 2*	Release 0	–
ePrescribing	Offers clinicians up-to-date medication information for their patients at every stage of the medicines-use process, offering computerised guidance on things like the correct medication for specific indications, dosages and drug interactions and alerts about possible allergic reactions, and an end to the problem of interpreting illegible or incomplete prescriptions.	Release 2* (part) and Release R3* (full)	London Configuration 2	–
Hand-held Devices	Enabling clinicians on the move around the care setting to access clinical records securely via a hand-held device.	Release 4*	London Configuration 2	
Mental Health Trusts				
Mental Health Patient Administration System	Provides patient administration functionality for Mental Health Trusts (see Patient Administration System)	Release 2*	RiO Version 4	–
Primary Care Trusts				
Single Assessment Process	Standard designed to ensure that older people receive appropriate, effective and timely responses to their health care and social care needs, and that professional resources are used effectively.	Release 3*	eSAP Version 1	–
General Practice System	Supports the administration of patients and patient information in the GP Practice. This is an Integrated Primary Care product. Using a single electronic record, it enables collaborative working across Primary Care settings.	Release 4*	INPS Version 3	–
Hospice System	The system draws together a variety of teams into a single virtual team, where all members are able to share information and track patients efficiently, regardless of role or location.	Release 4*	–	–
Prison System	GP System which supports the administration of patients and patient information in the Prison. Tailored for the use in a prison environment.	Release 4*	–	–
Child Health System	Supports business requirements for child health departments including child register, immunisation, pre-school health, school health, dental screening, audiology and vision screening, child protection, special needs and statistical requirements.	Release 4*	RiO Version 5 replacing interim system	–

Functionality	Definition	Lorenzo (North, Midlands, East)	Millennium (London)	Millennium (South)
Community Patient Administration System	Provides patient administration functionality (see Patient Administration System) for community hospitals. This allows patient information to be shared electronically and in real time between community nurses and a broad range of Allied Health Professionals (AHPs) including Health Visitors, Dieticians, Phlebotomists, Podiatrists, plus PCTs and GP practices. AHPs can record complete assessments in their area of expertise.	Release 2*	RiO Version 4	
Ambulance Trusts Emergency Care System	The Emergency Care Systems supports paramedics at the scene by drawing on key patient data, and allowing them to register patient information for rapid dissemination to the hospital.	Release 2*	–	–

Question 187(3) (Mr Burstow): *What happens to a supplier if there is a security breach?*

CONTRACTUAL SECURITY REQUIREMENTS FOR LOCAL SERVICE PROVIDERS (LSPs)

The LSPs are bound contractually to provide a level of security which is:

— in accordance with good industry practice;

— meets any specific security threats to the system; and

— complies with ISO/IEC 17799:2000 and BS7799-2:2002.

The LSPs are required to develop, implement and maintain a security policy which adheres to the above principles as well as a range of other provisions set out in the LSP contract.

There are also contractual requirements for LSPs to conduct tests of the security policy. The Department has the right to see the results of these tests and to witness the tests. In addition, the Department has the right to carry out regular audits or to commission independent audits.

LSPs are liable for all breaches of security against the contractual requirements described above.

WHAT HAPPENS TO A SUPPLIER IF THERE IS A SECURITY BREACH?

A "Breach of Security" is defined as the occurrence of unauthorised access to, or use of, the Premises, the Sites, the Services, the System or any Information Communications Technology or Data (including the Department's Data) used by the Department or the Contractor in connection with the contract.

In the event of a breach of security either party shall notify the other immediately upon becoming aware of the breach. This includes an actual or attempted breach, or threat to, the security policy and/or the security of the system. All incidents are then actively monitored until they have been satisfactorily resolved.

Upon becoming aware of a breach of security the LSPs shall immediately take all reasonable steps necessary to (a) remedy such breach or protect the system against any such attempted breach or threat and (b) to prevent an equivalent breach in the future. Full details of these activities then need to be reported by the LSPs to the Department.

Subject to the nature of the security breaches, LSPs may face financial penalties in the form of service deductions against their monthly service payments. Under the service deduction regime LSPs can loose 100% of their monthly service charges.

Furthermore, security breaches could be considered a contractor event of default which would mean the Department could have the rights to partially or fully terminate the LSP's contract.

Similar provisions are in place for the Programme's National Application Service Providers.

Further supplementary memorandum from the Department of Health

This note sets out the three questions asked by the Committee in the letter from the Clerk dated 2 July 2008, together with the Department's responses.

Question 1: *Update of Figure 1 of the C&AG's Report to show the number of deployments of care records systems at 31 August 2008*

Revised Figure 1: Deployments of electronic care records systems under the Programme at 31 August 2008

Area	Local Service Provider	Acute Trusts		Mental Health Trusts		Primary Care Trusts	
		Number of Trusts	*Number of deployments*	*Number of Trusts*	*Number of deployments*	*Number of Trusts*	*Number of deployments*
London	BT	31	6	10	6	31	20
South	(Fujitsu)	41	8	14	1	31	7
North, Midlands and East	CSC	97	23	35	15	90	47
Total		**169**	**37**	**59**	**22**	**152**	**74**

Notes:

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

2. The deployments in the North, Midlands and East are of iPM, the interim solution, to be replaced later by releases of Lorenzo.

3. In addition to the deployments shown in Acute Trusts in London and the South there are seven iSOFT systems (five in London and two in the South) deployed prior to the Programme that have been incorporated into the Programme for the provision of live services and technical upgrades. These will be replaced in due course. One of these was incorrectly recorded in the NAO Report as a Programme deployment in the South.

Question 2: *Details of the progress made at 31 August in deploying Lorenzo at the three early adopter sites and the likely timetable for full roll-out in the North, Midlands and East (paragraph 2.13 of the C&AG's Report)*

The C&AG reported that the first release of Lorenzo had been demonstrated to NHS staff, had received a positive reception, and was expected to be available for deployment in the three early adopter Trusts in Summer 2008, with full roll-out planned from Autumn 2008.

The purpose of the early adopter phase is to ensure the solution can be safely deployed in an NHS environment and that it meets the clinical and business requirements of the NHS. In evidence to the Committee, Gordon Hextall said that the early adopter sites would take the product when they deemed that it was ready for their use. The process would be quality-driven and not date-driven. This remains the policy and CSC has been working closely with the NHS to ensure the quality of the product.

The current position in the three early adopter sites is:

— *South Birmingham NHS Primary Care Trust*: Lorenzo Release 1 was signed-off as meeting the go-live acceptance criteria on 29 August 2008 and, after data migration, and went live on 3 September 2008. The full clinical team is using the system to support their work for the podiatry service.

— *University Hospitals of Morecambe Bay NHS Trust*: Lorenzo is expected to be implemented around the end of September 2008.

— *Bradford Teaching Hospitals NHS Foundation Trust*: Lorenzo is expected to be implemented shortly after the implementation in Morecombe Bay.

National rollout will follow implementation in the early adopters. Deployment plans will be determined by the NHS and implementation is expected to commence later in 2008.

Question 3: *Details of the position in the South at 31 August following the termination of Fujitsu's contract, including progress towards establishing replacement arrangements and in reaching agreement with Fujitsu on the terms of the termination*

1. Maintenance of live services to Trusts with a Cerner Millennium solution provided by Fujitsu:

Fujitsu continues to provide live services to those Trusts in the South to which they had deployed Cerner Millennium. This was provided initially under a new "Short Form Agreement" for the period to 28 November 2008.

Negotiations are underway with BT for a transfer of the service. BT already has a contract with the Department to deploy and maintain a similar version of the Cerner Millennium software in London and is therefore best placed to understand the requirement to maintain the live services in the South. A proposal to maintain and support the live services is expected from BT by the end of September 2008.

In the circumstances, and recognising the need for the services to be continuously maintained, the Short Form Agreement with Fujitsu has been extended for up to a further six months (to May 2009) to enable a smooth transition.

2. Trusts in the South awaiting deployments:

For those Trusts in the South that have not yet been provided with the strategic solution, the intention is to offer a choice through the National Programme of either Cerner Millennium (provided by BT) or iSOFT Lorenzo (provided by CSC).

The contracts with the current Local Service Providers allow them to deploy systems outside their "territory" at the same prices and under the same terms and conditions as in their "home" territory. This approach therefore provides the most certainty and is the most cost-effective.

To inform the choices, BT and CSC are making presentations to the Trusts involved, including holding detailed discussions about their future requirements.

3. Terms of the termination:

Fujitsu disputes the validity of the termination of the contract and issued a Procedure Initiation Notice (PIN) on 5 August 2008, to which the Department has responded. This is part of the formal dispute process set out in the now terminated contract. The dispute procedures survive the terminated agreement and will be adhered to by both parties.

The current dispute process is likely to lead to mediation in due course. In the event that mediation is not successful, the next process would be a determination by either arbitration or the courts.

15 September 2008

Memorandum from the British Medical Association

The following briefing provides the BMA's views on the National Audit Office's report and recommendations on the National Programme for IT.

Key Points

— Delays in delivering the NHS Care Record Service (CRS) have damaged confidence in the programme. Realistic timescales must be set and NHS staff must be kept updated on progress.

— Recommendations to improve communications about the NHS CRS including deployment, performance and costs are supported by the BMA.

— The BMA welcomes the recognition that NHS staff should be fully engaged and facilitate knowledge sharing.

— The BMA agrees that rigorous testing of the shared record systems should be carried out in the early adopter sites. The testing should not focus on the capability of the system alone but also explore the impact of multi-contributory records on patient care.

— The BMA notes the delays in delivering the Summary Care Record (SCR) but welcomes NHS Connecting for Health's commitment to act upon the findings of the recent independent evaluation despite the further delays this will cause in rolling out the programme.

— A "consent to view" model would help better inform patients about the SCR and help generate confidence in the programme.

Background

The National Programme for IT comprises of a number of components; however the main deliverable is the NHS Care Record Service with each patient having an electronic care record by 2010. The NHS Care Record Service consists of a Summary Care Record and a Detailed Care Record. Demographic details are held on the Personal Demographics Service (PDS) and patients can view their SCR via Healthspace; an online health portal.

BMA RESPONSE TO NAO RECOMMENDATIONS

42(a): *There is considerable uncertainty about when the care records systems will be fully deployed and working across the country*

Delays in delivering shared record systems, particularly in Trusts, have been damaging to the programme. Slipping deadlines for new IT systems and the premature release of systems that are not fit for purpose have been deeply frustrating for NHS staff leaving many doctors disillusioned with the programme. The BMA fully supports the NAO recommendation that NHS CfH and SHAs should communicate deployment plans and these must be realistic and transparent to users.

42(b): *The North Midlands and East Area does not yet have the strategic system to support its care record service because of the time taken to develop Lorenzo*

The BMA supports the NAO recommendation that care record systems should be rigorously tested in early adopter sites to ensure that they work as required. However, experience in the South has demonstrated that a successful system in one Trust can cause significant disruption in another and this needs to be factored into any implementation plan. We fully support the recommendation that lessons learnt from the early adopter deployments should be made visible to staff. Staff, working with the IT team, are often in the best position to predict if something is not going to work well in their particular Trust even though it may have worked well in another Trust. The rigorous testing should not just focus on the technical aspects of the system but the significant changes in practice that multi-contributory records will bring. There have already been difficulties, highlighted by clinicians, where multi-contributory records have been implemented in the North, Midlands and East Cluster and the BMA is concerned that the impact of multi-contributory records has not yet been fully explored.

42(c): *It is difficult to report reasonably precisely the state of play on many different elements of the Programme*

There is certainly a need for better communication about deployment and performance. It is often easier to find out information about deployments from the media rather than NHS CfH communications. We agree that some areas of the national programme are communicated about much more openly and the same needs to apply to the NHS CRS.

42(e): *The Programme's emphasis on benefits realisation is increasing but not yet sufficiently comprehensive across the whole programme*

The BMA welcomes the recognition that success of the programme is dependent on the commitment of NHS staff. The NAO reports that NHS staff are key in advising how systems can support the Trust's operations so that benefits can be realised. Staff who are appointed to carry out this role must be properly supported and arrangements should be put in place to ensure that they can be released by their Trust when required. This recommendation recognises that success should not be measured on getting systems in place on time but on ensuring that the benefits are realised to improve patient care.

42(f): *Early experience with the Summary Care Records indicates that patients have a high level of confidence that their personal data will be secure, but security lapses could easily undermine that confidence and reduce the benefits of the Programme*

The BMA agrees that data protection should be a priority. The BMA has recently produced guidance to doctors on protecting electronic patient information and supported the Information Commissioner's calls for penalties for data theft. The NAO report recommends that levels of public confidence in security should be monitored. The evaluation of the SCR early adopter sites found that patient awareness was very low despite a public information programme. The BMA believes that a consent to view model, where SCR are created on the basis of implied consent but can only be accessed with explicit consent will help ensure that patients are better informed about the SCR. This model has been successful in Scotland, Wales and Hampshire.

The BMA has recommended that there should be no further roll out of the SCR until the issues identified in the UCL independent evaluation have been addressed. These include the need to review the consent model and a tighter definition of the SCR. Whilst increasing delays these changes will gain the support of the profession and help generate confidence in the SCR. The BMA has been pleased by NHS CfH's commitment to act upon these findings in a timely way.

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