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The UK NHS IT Modernisation Programme

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The UK public healthcare IT programme [National Programme for IT (NPfIT)] is a classic example of a top-down grand plan for a public IT system that will not deliver but will cost up to £20 billion. This is due to the familiar inability of these 'grand projects' to actually involve those on the ground at the initial planning stage and to subsequently believe all remains well until it is too late to turn back.

Here I will recollect my personal involvement in the project, which reflects the bigger picture reported elsewhere. I was extremely keen to be a clinical champion of IT that works and have ended up as someone who is deeply saddened that an opportunity to bring UK healthcare into the 21st century has been squandered.

Shiny, New and Hardly Efficient

The plan for NPfIT arose from the desire to bring together all the potential benefits of having a country-wide joined-up healthcare IT system, with shared patient records and the ability to transfer information rapidly between, for example, the family physician and the hospital. In the predominantly public healthcare system in the UK, this could have delivered truly great efficiency gains. Unfortunately it was dreamt up by IT management consultants employed by the Labour Government without any real understanding of how things actually worked. They delivered a shiny new project that the politicians loved - a centralised, top-down, big, bold and, critically, brand-new IT system.

Prior to the project, the IT that existed in the UK healthcare system was piecemeal but very efficient - each family practice had had approximately a decade to implement IT systems specific to their needs and hospitals also had the freedom to choose systems according to need.

Because of the complexity involved in hospital care, the majority of hospital systems were Patient Administration Systems, with clinical records being paper-based. In primary care (family practice), however, great steps had been made in designing and refining IT systems that could deliver both administrative and clinical roles. These IT systems, in some practices, truly delivered (and continue to deliver) a paperless clinical and administrative system. Though not compatible with one another, there were examples where novel open architecture solutions (e.g. XML) could deliver useful communication between family practices and hospitals.

A PowerPoint Tour-de-Force

I attended one of the first conferences on this new IT system in 2002, prior to any of the contracts being awarded.

I believe, of the 300 or so delegates, I was the only clinician there. At the end of the conference, which was a PowerPoint tour-de-force of vague 'big ideas', I asked Richard Granger, who became the Director General of NHS IT, what involvement there had been from the end-users i.e. the clinicians such as myself who would actually have to use the system.

His reply - that he had discussed the project with the heads of the clinical Royal Colleges and that was more than enough involvement – filled me with concern.

Subsequently, it has been shown that even this clinical engagement was not followed through - for example, the main hospital system specifications were developed without any further meaningful clinical engagement or scrutiny.

Core Competency = Domain Knowledge

Following on from the conference, the announcement of the various franchises to design and deliver this project were revealed. There was a very clear decision to start afresh - all the IT knowledge that had gone into making the family practices have effective IT systems would be ignored and the plan was to go for a top-down new system, which would be custom-designed. England was to be split into 5 franchise areas, called Clusters.

Each franchise would have a sole supplier (service provider) who would deliver a combination of hardware and software that would be built to work according to NpfIT's still-to-beclarified specifications.

The suppliers were Accenture (twice), BT, CSC and Fujitsu, none of which, frankly, had much experience of delivering clinical IT systems in the UK. However, they were big corporations who could deliver big solutions, knew how to converse with politicians and were adept at delivering profitable contracts for their shareholders. As can be seen from the subsequent delays and problems with software suppliers such as iSoft, they did seem to have problems with delivering anything worthwhile.

Still keen to help, I joined one of the so-called Clinical Advisory Groups that were designed to provide some clinical input to each cluster. We were approximately 20 IT-minded clinicians and met every 2-3 months to give feedback to the plans of the Southern Cluster (primary supplier Fujitsu), relating to our own sub-region. None of us were paid to do this and our employing hospitals allowed us leave on the understanding that it would bring future benefit – there never was any funding for real clinical input.

Nonetheless, we were praised along the way - the Southern Cluster was acknowledged as having the most involved clinical input. Given the non-funding of the clinical input, it was unsurprising to learn that there was no meaningful clinical input in the 3 Northern Clusters and only some input in our Southern Cluster and in the London Cluster. Our involvement proved very frustrating over the years – we would be asked to review large documents with very little notice to sign them off as being fine, from a clinical point of view.

Teething Problems or More

The best example though, exposed the fact that the project was not merely going through some initial difficulties but had deep-seated defects in its design. This was the logon for the system. For the project, each user would have a log-on card and PIN number, to be keyed in at every log-on.

Imagine a busy Intensive Care Unit or Emergency Department, where clinical staff would be going from the computer to the patients many hundreds of times per shift: the card forces a log-off as you have to take it with you. We, as a clinical advisory group, were very clear that the log-on time had to be less than 2 seconds, otherwise this system would be nothing more than a glorified administrative system, with clinical records being kept on 'instant-access' paper.

The initial log-on times they delivered, which fulfilled all the contracts agreed at the outset, were of the order of 90 seconds! After a lot of work, it still remains at 20-25 seconds and so I fear that the system will never really work. It should be noted that the suppliers were very proud of the log-on times that they had, reflecting their complete ignorance of the clinical realities.

Parliamentary Committee Issues Warning

Subsequently, our Clinical Advisory Group has been disbanded following a recent NHS re-organisation with a promise that 'clinical engagement would be by a new mechanism'. This was over seven months ago and the new mechanism remains unfunded and still to be delivered. Thus the possibility of using clinicians to inform this system, to support patient care, safety and clinical governance, is now on hold. Sadly, the powers-that-be still remain intent on pursuing this to the bitter end, rather than admitting that there are great problems with the system and trying to fix things, which can only be done if an admission is made that there are problems.

This may seem to be an excessive review of the project but it reflects both my own experience and the April 2007 report of the UK House of Commons Committee of Public Accounts. The Committee, an independent arm of the UK Parliament, put it very clearly: there is no clear date for delivering a patient clinical record, there is no control over expenditure, there is poor communication with clinicians and 'it is unlikely that significant clinical benefits will be delivered by the end of the contract period.'

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