

# **Letter from Hamish Meldrum to Ben Bradshaw, Minister of State for Health Services, on the National Programme for IT**

**August 2007**

The National Programme for IT (NPfIT) is an important but contentious aspect of health policy. I would like to take this opportunity to express the BMA's hopes, to raise our concerns and to suggest recommendations as to what the programme should deliver to support patient care. I hope this will help inform debate at this crucial time for re-defining the future of the programme.

The BMA wants to see the programme succeed. We recognise that there have been some successes. We believe that with a change in leadership it is an appropriate time to review progress and set out a clear strategy for the future of the programme.

At the BMA's recent Annual Representatives Meeting, doctors from both primary and secondary care expressed their frustration about the programme. Doctors called for a public inquiry to review the problems encountered by Connecting for Health (NHS CfH), the cost to the tax payer and whether this has been a cost effective use of public funds.

The BMA believes there are some essential steps that must be taken to sustain successful delivery.

## **(i) Renewed engagement with system users**

1. Provide greater clarity about the NPfIT Local Ownership Programme, how it will improve engagement and what it will mean for clinicians and patients.
2. Introduce an open, two-way reporting mechanism, which allows users to highlight problems with systems and suppliers to feed back what steps are being taken to address these issues and within what timeframe.
3. Renew engagement and confidence by delivering some quick wins, focusing on areas which are proving successful and holding a series of secondary care roadshows to listen to feedback and address misconceptions
4. Work with the BMA to address the continuing issues with Choose and Book.

## **(ii) Generate confidence in the Summary Care Record**

5. No further roll out of the Summary Care Record (SCR), beyond the six early adopter PCTs, until the independent review has been completed and ways forward have been agreed by the Summary Care Record Advisory Group.
6. Work with the BMA to agree a code of practice/service level agreement for uploading information onto the SCR.

7. Seek a definitive legal opinion on the issues raised during the Health Select Committee hearings concerning the legality of the SCR and the Data Protection Act in relation to EU directives that can be agreed with the profession and patients alike.
8. Work with the BMA, Medical Defence Organisations and patient organisations to agree the final Public Information Campaign material so that together we can persuade PCTs to use an agreed standard package of information.

**(iii) Tackle implementation issues in Secondary Care**

9. Negotiate a choice of systems for secondary care within an agreed framework.
10. Establish a national implementation checklist, which must be completed before the implementation of any PAS.
11. Incorporate information governance and electronic records into the medical student curriculum and allow medical students access to the SCR.

**(iv) Provide clarity about the Secondary Uses Service**

12. Provide clarity about the Secondary Uses Service (SUS) including creating an area on the new NHS Choices website where patients can view details of how data is used for Secondary Uses.

I have provided further detail in the enclosed paper. I hope that these recommendations provide a helpful insight into our concerns, and that they inform your discussion. I would welcome your view on how we might work together on these recommendations.

I look forward to hearing from you.

Dr Hamish Meldrum  
Chairman of Council

# **BMA Recommendations on the National Programme for IT (NPfIT) - Paper sent to Ben Bradshaw, Minister for State for Health Services**

**August 2007**

- Renewed engagement with system users
- Generate confidence in the Summary Care Record
- Tackle implementation issues in Secondary Care
- Provide clarity about the Secondary Uses Service

## **Renewed engagement with system users**

1. Provide greater clarity about the NPfIT Local Ownership Programme (NLOP), how it will improve engagement and what it will mean for clinicians and patients.

NLOP could be a vehicle for greater local engagement and a means of renewing confidence. Clinicians want to know what is being delivered in their area and they need a mechanism for reporting back to SHAs where there are issues. NLOP could be the vehicle to make this happen. However, there needs to be clarity about the practicalities of this programme and how it will change the nature of engagement. What obligations do Strategic Health Authorities have to deliver and what impact does this have on Trusts, clinicians and patients? Will NLOP be properly resourced? What are the mechanisms for clinicians to feed into these developments? If we understand these processes we may be able to work better together to help ensure clinicians are engaged.

2. Introduce an open two way reporting mechanism, which allows users to highlight problems with the systems and suppliers to feedback what steps are being taken to address any issues and within what timeframe.

A clear two way reporting mechanism should be introduced. This will allow clinicians to highlight problems and potentially avoid a repetition of the recent incident where clinicians published a letter in the Times as a way of highlighting serious concerns with the system. It will also allow suppliers and Trusts to give clinicians information about how their concerns are being dealt with, the priority level and the estimated time for changes to take place as a result of their feedback.

3. Renew engagement and confidence by delivering some quick wins, focusing on areas which are proving successful and holding a series of secondary care roadshows to listen to feedback

and address misconceptions.

Delivering some quick wins will help regain confidence. This could include electronic discharge summaries and letters following an out-patient attendance and greater support for GP2GP transfer. As outlined above, prioritising local rather than national development will help define the priorities or quick wins in each area.

The series of roadshows, which were successful in primary care could be repeated in secondary care. This would allow doctors to voice their concerns and provide NHS CfH with an opportunity to address misconceptions about the programme. These need to be targeted at doctors who have not been engaged to date but have been influenced by the negative media coverage.

NHS CfH should also continue to focus on areas of the programme which have been welcomed by clinicians e.g. GP2GP transfer, Electronic Prescribing and the Electronic Transfer of Prescriptions.

4. Work with the BMA to address the continuing issues with Choose and Book  
Clinicians continue to express their concern about the Choose and Book system finding it unfit for purpose. The BMA recommends that we continue to work together to address these issues, many of which are associated with local policies, rather than the system itself, such as enforced use and inability to refer to named consultants. The BMA will issue guidance, which we hope will inform users of how the system should be implemented so that pressure can be placed on Trusts to use it as it was intended.

### **Generate confidence in the Summary Care Record**

5. No further roll out of the Summary Care Record (SCR), beyond the six early adopter PCTs, until the independent review has been completed and ways forward have been agreed by the Summary Care Record Advisory Group.

One of the prime concerns about NPfIT is in relation to security and confidentiality controls. Doctors are responsible for ensuring the confidentiality of the information provided to them by patients. Despite NHS CfH informing doctors that the security arrangements meet the highest standards, doctors remain cautious until they, or their colleagues, have experienced this themselves and can address firsthand any concerns patients may have rather than passing on assurances provided by the government.

The early adopter phase is the first step in providing this opportunity and we welcome the commitment to conduct an independent review. The SCR must not be rolled out beyond the six early adopter PCTs until the results of the independent review have been made public and ways

forward have been agreed by the Summary Care Record Advisory Group. A delay of a few months will not make much difference to the roll out of the programme but could make a real difference in terms of NHS CfH being seen to listen. This in itself will generate greater confidence. The BMA will advise its members, who are not involved in the early adopter phase, against uploading information onto the SCR until the review has been published so that lessons can be learnt before further roll out.

Role Based Access Controls and alerting processes have not yet been fully incorporated into the Early Adopter phase and we would welcome clarity about how these processes will be rolled out and piloted.

6. Work with the BMA to agree a code of practice/service level agreement for uploading information onto the SCR.

Changing the way information is managed presents a new challenge for the NHS. Staff are unsure of what is expected of them. Questions remain unanswered about multi-contributory records which does not generate confidence. For example, what data will be contained in a SCR? How often should data be uploaded? The BMA recommends that a code of practice or Service Level Agreement is agreed between NHS CfH and the BMA, with input from the Medical Defence Organisations. This should set out what is expected from doctors in relation to uploading and sharing information. This will help prevent misunderstandings which could put patient care at threat and help us work through the information governance questions, which remain unanswered.

7. Seek a definitive legal opinion on the issues raised during the Health Select Committee hearings, concerning the legality of the SCR and the Data Protection Act in relation to the EU Directives that can be agreed with the profession and patients alike.

At the recent Local Medical Committee's Conference, GPs voted in support of seeking complete clarity in relation to the legality of the SCR. There is concern that by uploading patient data to the NHS Care Records Service doctors could be in breach of the Data Protection Act and GMC guidance on patient confidentiality. There is also concern about the recommendations of the European Article 29 Data Protection Working Party, which if adopted, some legal experts believe would conflict with the Programme. Seeking a definitive legal opinion will reassure clinicians and staff that they are acting lawfully when uploading patient data and consequently help generate confidence in the NHS Care Records Service.

8. Work with the BMA, Medical Defence Organisations and patient organisations to agree the Public Information Campaign material so that together we can persuade PCTs to use an agreed standard package of information.

Consent in relation to uploading information onto the central spine has been a difficult area. The crux of the issue is the extent to which patients are properly informed, understand how their information will be shared and what choices they have if they wish to restrict sharing. In relation to the early adopter sites the MDU has advised that GPs have a responsibility to consider the effectiveness of the public information campaign and whether they can rely on implied consent. The BMA has been forwarded an example of locally tailored material, from the early adopter sites, which was felt to be inappropriate. Following the evaluation of the effectiveness of the public information campaign in the early adopter practices, the BMA recommends that NHS CfH engages with the Medical Defence Organisations and the BMA to agree a final version of the material. The BMA, the MDU and hopefully other defence organisations will advise their members to insist that PCTs use the agreed version. This will ensure that the material meets an agreed standard and will help prevent patients receiving substandard information due to local tailoring. It will also provide doctors with greater confidence that their patients have been properly informed of the changes.

### **Tackle implementation issues in Secondary Care**

#### **9. Negotiate a choice of systems for secondary care within an agreed framework**

The GPSoC agreement has been one of the successes of the programme. The original position of the government was that LSP contracts would make it impossible to continue to offer GPs a choice of systems. Following some careful negotiations a way forward has been agreed. This has set out a clear progressive strategy for the government, the profession and suppliers.

We recommend that a similar model is adopted in secondary care. Initially England was divided into geographical clusters with LSPs responsible for each cluster so that if one supplier failed it would not cause the whole programme to collapse. We are now in a situation of 3, rather than 5 clusters or programmes and secondary care PAS implementation is dependent on two systems: iSOFT's Lorenzo and Cerner's Millennium. Reports suggest that Lorenzo is still not even close to being implemented and Cerner has encountered difficulties in implementing the Millennium system. The pressure on suppliers to deliver is largely driven by finance, as they do not get paid until they deliver to a minimum standard, rather than customer satisfaction.

If Trusts had a choice of systems, there would be greater competition between suppliers. Suppliers would need to improve their products to stay ahead of the market. There could also potentially be greater acceptance of systems, as a choice could enable involvement of clinicians in that decision. As in primary care, this should not be an open choice but set in a clear progressive framework so that systems meet progressive standards and are interoperable with national programmes. Once systems are interoperable NHS CfH could place more emphasis on sharing information via messaging rather than storing large amounts of data centrally.

Whilst providing a choice of systems in secondary care would require a review of the LSP contracts, it is achievable as demonstrated in primary care. This would work in harmony with NLOP by moving decision making to a local level. NHS CfH has already taken steps to widen the range of available suppliers in secondary care with the catalogue of suppliers. We recommend that this is taken one step further.

10. Establish a national implementation checklist, which must be completed before the implementation of any PAS.

It has become clear that some of the negativity towards the programme has shifted from primary to secondary care. NHS CfH needs to demonstrate that benefits are being delivered. The delays and difficulties in implementing PAS have been widely reported and doctors are understandably sceptical. Doctors need to see that PAS implementations can be successful and have improved working practices.

The same mistakes are being repeated with implementations especially in secondary care for example, the PAS implementation in Nuffield followed by the problems in Milton Keynes. Whilst ultimately Trusts and suppliers are responsible for implementation there must be a clear mechanism for sharing lessons so that mistakes are not repeated. We recommend a national implementation checklist which must be completed prior to the commencement of any implementation. This should cover preparation required before the switch to the new systems and procedures once systems are in place in the short and long term including contingency planning in the event of teething and long-term problems. This should be an evolving document which reflects lessons learnt after each implementation. This will help promote best practice for future implementations.

11. Incorporate information governance and electronic records into the medical student curriculum and allow medical students access to the SCR.

The BMA recommends that information governance is included as part of the medical school curriculum so that medical students become familiar with how electronic records are used and how information is shared using best practice examples. Medical students should also be provided with access to the SCR as part of this training.

### **Provide clarity about the Secondary Uses Service**

12. Provide clarity about the Secondary Uses Service including creating an area on the new NHS Choices website where patients can view details of how data is used for Secondary Uses.

There needs to be complete clarity for both clinicians and patients about how data will be used for secondary uses. The BMA welcomed the establishment of the Care Records Development Board Secondary Uses Working Group but is concerned about the delays in publishing the report of this group. There remain many unanswered questions and concerns about the Secondary Uses

Service. We hope that this report will provide some answers and generate some open debate.

Section 60 of the Health and Social Care Act 2001 was introduced by Lord Hunt as a temporary measure until consent or anonymisation procedures were developed in the NHS. When debated in parliament, it was stated that section 60 would only be used in exceptional circumstances. Recently we have been extremely concerned about large amounts of identifiable data being made available under Section 60 following PIAG approval. This data has been subsequently made available to a private company without being fully anonymised. We also understand that PCTs have access to large amounts of patient identifiable data. Access to confidential data via the Secondary Uses Service will undermine even further confidence in the entire system.

We recommend that as part of the new NHS Choices website there should be a detailed page, which allows patients to see the way data is used for Secondary Uses, why and the benefits it brings.