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The NHS programme for information technology

This massive natural experiment needs evaluating and regulating

The NHS National Programme for IT in England is one of the largest information technology programmes in the world.[1] The programme has been subjected to hostile media coverage in its four year history, and it has been difficult to know how much of this is justified. The publication of the National Audit Office report on the programme gives both supporters and critics food for thought.[2] The audit office finds that elements of the programme are progressing well, but also points to key challenges over the next few years—in ensuring that the promised systems are delivered and that NHS staff are engaged with the programme.[3]

The report contains a wealth of detail, but doctors should pay particular attention to two issues. Firstly, the report notes that the Department of Health has failed to show benefits of the programme that will justify its costs and that the Treasury accepts this and is content for the programme to proceed. The difficulty in identifying benefits is not surprising, given that systematic reviews show relatively modest benefits associated with information technology projects,[4 5] and the audit office stresses the need for high quality empirical evidence about the programme. To place the issue in context, the audit office estimates that the total costs of the programme to 2014 will be around £12.4bn. This is a big number but equates to only about 1-1.5% of NHS expenditure a year. Doctors need to judge, therefore, whether the programme will improve services and patient outcomes by an equivalent amount.

From a researcher's perspective, the programme is a massive natural experiment which offers a unique opportunity to capture good observational evidence about the costs, risks, and benefits of large scale investments in information technology. It is not necessary to stop the programme—this is not practicable now anyway—but the Department of Health should move quickly to commission studies that will generate robust, useful results in the next 12 months and beyond.

The second issue concerns the ways in which doctors and other clinicians engage with suppliers in the new electronic environment. In the early phase of the programme centralisation was justified. The audit office concluded that the processes for central procurement of infrastructure were well managed and that contracts have been managed in a way that protects NHS interests. Individual NHS organisations—and private firms providing NHS services—do not typically have the skills or the political clout to manage large contracts for building infrastructure. There are outstanding questions about the technological solutions favoured by the programme, but a review—prompted by an open letter from 23 academic computer scientists to the House of Commons Health Committee[6]—should provide a better understanding of those issues.

The process had relatively little clinical involvement early on, and this has led to criticisms that the programme is not doctor friendly. Staff working on the programme nationally now seem to appreciate that clinicians and suppliers need to work closely together if the more ambitious elements of the programme—notably the shared electronic health and social care record—are to be successful. The NHS does not want or need products imposed on it, whether on time or years late, and then be locked into them until a company chooses to develop replacements. Rather, a key objective over the next two or three years is to create a dynamic environment for research and development within which doctors can work with suppliers and others on the new electronic services, can continue to innovate after the initial services have been delivered, and can, if necessary, take part in decisions to amend or stop unsuccessful developments.

Staff working on the programme face a dilemma, however. How can they retain the advantages of the central procurement arrangements while at the same time encouraging localism? The answer may be for Connecting for Health, the agency responsible for the programme, to become a regulator. The agency could stop directing implementation centrally and could become responsible for encouraging good working relationships between suppliers and clinicians. In this way the agency would retain its role in monitoring compliance with multibillion pound contracts while letting clinicians and suppliers get on with development. It would also have an ongoing role in protecting the wider public interest on matters such as patient confidentiality. This arrangement might help to allay some clinicians' natural fears that their concerns will not be taken into account in the rush to computerisation.

Competing interests: None declared.

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