NHS Connecting for Health

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The **NHS Connecting for Health** (**CFH**) agency was part of the UK [Department of Health](https://en.wikipedia.org/wiki/Department_of_Health_(United_Kingdom)) and was formed on 1 April 2005, having replaced the former [NHS Information Authority](https://en.wikipedia.org/wiki/NHS_Information_Authority). It was part of the Department of Health Informatics Directorate, with the role to maintain and develop the NHS national [IT infrastructure](https://en.wikipedia.org/wiki/IT_infrastructure). It adopted the responsibility of delivering the **NHS National Programme for IT** (**NPfIT**), an initiative by the Department of Health to move the [National Health Service](https://en.wikipedia.org/wiki/National_Health_Service_(England)) (NHS) in England towards a single, centrally-mandated electronic care record for patients and to connect 30,000 [general practitioners](https://en.wikipedia.org/wiki/General_practitioner) to 300 hospitals, providing secure and audited access to these records by authorised health professionals.

On 31 March 2013, NHS Connecting for Health ceased to exist,[[*citation needed*](https://en.wikipedia.org/wiki/Wikipedia:Citation_needed)] and some projects and responsibilities were taken over by [Health and Social Care Information Centre](https://en.wikipedia.org/wiki/Health_and_Social_Care_Information_Centre).

History[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=1)]

Contracts for the NPfIT spine and five clusters were awarded in December 2003 and January 2004.[[1]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-EHI_588-1)[[2]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-EHI_591-2)[[3]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-EHI_606-3)[[4]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-EHI_632-4)

It was planned that patients would also have access to their records online through a service called HealthSpace. NPfIT was said by NHS CFH to be "the world's biggest civil information technology programme".[[5]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-:0-5)

The cost of the programme, together with its ongoing problems of management and the withdrawal or sacking of two of the four IT providers, placed it at the centre of controversy, and the Commons [Public Accounts Committee](https://en.wikipedia.org/wiki/Public_Accounts_Committee_(United_Kingdom)) repeatedly expressed serious concerns over its scope, planning, budgeting, and practical value to patients.[[6]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Telegraph_070417-6)[[7]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-7)[[8]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Public_Accounts_2009-8) As of January 2009, while some systems were being deployed across the NHS, other key components of the system were estimated to be four years behind schedule, and others had yet to be deployed outside individual [primary care trusts](https://en.wikipedia.org/wiki/Primary_care_trust) (PCTs).[[8]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Public_Accounts_2009-8)

[*The Guardian*](https://en.wikipedia.org/wiki/The_Guardian) noted that the announcement from the Department of Health on 9 September,[[9]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-9) had been "part of a process towards localising NHS IT that has been under way for several years".[[10]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-10) In 2011 remaining aspects of the National Programme for IT were cancelled, and most of the spending would proceed with the Department of Health seeking for local software solutions rather than a single nationally imposed system.[[11]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-11) On 31 March 2013, NHS Connecting for Health ceased to exist,[[*citation needed*](https://en.wikipedia.org/wiki/Wikipedia:Citation_needed)] and some projects and responsibilities were taken over by [Health and Social Care Information Centre](https://en.wikipedia.org/wiki/Health_and_Social_Care_Information_Centre).

In August 2018, NHS launched a healthcare finance innovation initiative to identify solutions which could streamline financial operations.[[12]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-12)

Structure and scope[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=2)]

The programme was established in October 2002 following several Department of Health reports on *IT Strategies for the NHS*, and on 1 April 2005 a new agency called NHS Connecting for Health (CfH) was formed to deliver the programme.[[13]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-13) CfH absorbed both staff and workstreams from the abolished [NHS Information Authority](https://en.wikipedia.org/wiki/NHS_Information_Authority), the organisation it replaced. CfH was based in [Leeds](https://en.wikipedia.org/wiki/Leeds), West Yorkshire. By 2009, it was still managed nationally by CfH, with responsibility for delivery shared with the chief executives of the ten [strategic health authorities](https://en.wikipedia.org/wiki/Strategic_health_authority).[[8]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Public_Accounts_2009-8) The programme represented a significant shift to national priorities over local priorities.[[14]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-14)

Reviews[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=3)]

The refusal of the Department of Health to make "concrete, objective information about NPfIT's progress [...] available to external observers", nor even to [MPs](https://en.wikipedia.org/wiki/Member_of_parliament), attracted significant criticism, and was one of the issues which in April 2006 prompted 23 academics[[15]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Signatories-15) in computer-related fields to raise concerns about the programme in an open letter to the [Health Select Committee](https://en.wikipedia.org/wiki/Health_Select_Committee).[[16]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-CW20060412a-16)[[17]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-CW20060411b-17) On 6 October 2006 the same signatories wrote a second open letter[[18]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-CW20061010a-18)

A report by the [King's Fund](https://en.wikipedia.org/wiki/King%27s_Fund) in 2007 also criticised the government's "apparent reluctance to audit and evaluate the programme", questioning their failure to develop an ICT strategy whose benefits are likely to outweigh costs and the poor evidence base for key technologies.[[19]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Wanless_2007-19)

A report by the Public Accounts Committee in 2009 called the risks to the successful deployment of the system "as serious as ever", adding that key deliverables at the heart of the project were "way off the pace", noting that "even the revised completion date of 2014–2015 for these systems now looks doubtful in the light of the termination last year of Fujitsu's contract covering the South", and concluding "essential systems are late, or, when deployed, do not meet expectations of clinical staff".[[20]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-20)

The initial reports into the feasibility of the scheme, known to have been conducted by [McKinsey](https://en.wikipedia.org/wiki/McKinsey_%26_Company), and subsequent reports by IT industry analyst Ovum among others[[21]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-21) have never been published nor made available to MPs.[[22]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-CompWeekly-22)

Costs[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=4)]

Originally expected to cost [£](https://en.wikipedia.org/wiki/Pound_sterling)2.3 billion (bn) over three years, in June 2006 the total cost was estimated by the [National Audit Office](https://en.wikipedia.org/wiki/National_Audit_Office_(United_Kingdom)) to be £12.4bn over 10 years, and the NAO also noted that "...it was not demonstrated that the financial value of the benefits exceeds the cost of the Programme".[[23]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-NAO_2006-23) Similarly, the British Computer Society (2006) concluded that "...the central costs incurred by NHS are such that, so far, the value for money from services deployed is poor".[[24]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-BCS_2006-24) Officials involved in the programme have been quoted in the media estimating the final cost to be as high as £20bn, indicating a [cost overrun](https://en.wikipedia.org/wiki/Cost_overrun) of 440% to 770%.[[25]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-25)

In April 2007, the [Public Accounts Committee](https://en.wikipedia.org/wiki/Public_Accounts_Committee_(United_Kingdom)) of the [House of Commons](https://en.wikipedia.org/wiki/British_House_of_Commons) issued a damning 175-page report on the programme. The Committee chairman, [Edward Leigh](https://en.wikipedia.org/wiki/Edward_Leigh), claimed "This is the biggest IT project in the world and it is turning into the biggest disaster." The report concluded that, despite a probable expenditure of 20 billion pounds "at the present rate of progress it is unlikely that significant clinical benefits will be delivered by the end of the contract period."[[6]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Telegraph_070417-6)

In September 2013, the Public Accounts Committee said that although the National Programme for IT had been effectively disbanded in 2011, some large regional contracts and other costs remained outstanding and were still costing the public dearly. It described the former National Programme for IT as one of the "worst and most expensive contracting fiascos" ever.[[26]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-bbc-pac-2013-26)

The costs of the venture should have been lessened by the contracts signed by the IT providers making them liable for huge sums of money if they withdrew from the project; however, when [Accenture](https://en.wikipedia.org/wiki/Accenture) withdrew in September 2006, then Director-General for NPfIT [Richard Granger](https://en.wikipedia.org/wiki/Richard_Granger) charged them not £1bn, as the contract permitted, but just £63m.[[27]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Kablenet-27) Granger's first job was with [Andersen Consulting](https://en.wikipedia.org/wiki/Andersen_Consulting),[[28]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Observer-28) which later became Accenture.

Deliverables[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=5)]

The programme was divided into a number of key deliverables.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Deliverable** | **Since** | **Name of software** | **Original delivery date** | **Progress 2007**[[19]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Wanless_2007-19) | **Progress 2009**[[8]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Public_Accounts_2009-8) |
| Integrated care records service | 2002 | [NHS Care Records Service](https://en.wikipedia.org/wiki/NHS_Care_Records_Service) (NCRS) / [Lorenzo](https://en.wikipedia.org/wiki/Lorenzo_patient_record_systems) | 2004 | "Real progress only just beginning", no go-live date specified | "Recent progress...very disappointing", completion date of 2014–2015 now looks unlikely following withdrawal of Fujitsu, arrangements for South region not resolved, Lorenzo still not live in a single acute Trust |
| Electronic prescribing | 2002 | [NHS Electronic Prescription Service](https://en.wikipedia.org/wiki/NHS_Electronic_Prescription_Service) | 2007 | Implementation began in early 2005, used for 8% of daily prescriptions | 70% of GPs and pharmacies had 1st release of software, but only 40% of prescriptions issued with readable barcodes |
| Electronic appointments booking | 2002 | [Choose and Book](https://en.wikipedia.org/wiki/Choose_and_Book) | 2005 | Take-up slow, system reliant on outdated technology, GPs dissatisfied, target of 90% of referrals on system by March 2007 missed | Mixed, around half of new appointments made using system, additional training and time required |
| Underpinning IT infrastructure | 2002 | [New National Network](https://en.wikipedia.org/wiki/N3_(NHS)) (N3) | March 2002 | On schedule, with 98% of GP practices connected |  |
| Medical imaging software |  | [Picture Archiving and Communication System](https://en.wikipedia.org/wiki/Picture_Archiving_and_Communication_System) (PACS) |  |  |  |
| Performance management of primary care |  | [Quality Management and Analysis System](https://en.wikipedia.org/wiki/Quality_Management_and_Analysis_System) (QMAS) |  |  |  |
| Central e-mail and directory service |  | [NHSmail](https://en.wikipedia.org/wiki/NHSmail)\* |  |  |  |

\*NHSmail was renamed to *Contact* in late 2004,[[29]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-29) before being reverted to NHSmail in April 2006.[[30]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-30)

**The Spine (including PDS and PSIS)**[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=6)]

The Spine is a set of national services used by the NHS Care Record Service. These include:

* **The Personal Demographics Service (PDS)**, which stores demographic information about each patient and their [NHS number](https://en.wikipedia.org/wiki/NHS_number). Patients cannot opt-out from this component of the spine, although they can mark their record as 'sensitive' to prevent their contact details being viewed by 831,000 staff.
* **The Summary Care Record (SCR)**. The [Summary Care Record](https://en.wikipedia.org/wiki/Summary_Care_Record) is a summary of patient's clinical information, such as allergies and adverse reactions to medicine.
* **The Secondary Uses Service (SUS)**, which uses data from patient records to provide anonymised and pseudonymised business reports and statistics for research, planning and public health delivery.

The Spine also provides a set of security services, to ensure access to information stored on the Spine is appropriately controlled. These security measures were queried during the early stages of Spine development, with leaked internal memos seen by the [*Sunday Times*](https://en.wikipedia.org/wiki/Sunday_Times) mentioning "fundamental" design flaws.[[31]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-31) In addition, government spokeswoman Caroline Flint failed to dispel concerns regarding access to patients' data by persons not involved in their care when she commented in March 2007 that "*in general* only those staff who are working as part of a team that is providing a patient with care, that is, those having a legitimate relationship with the patient, will be able to see a patient's health record."[[22]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-CompWeekly-22)

The Spine was migrated to a new system in August 2014.[[32]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-32)

**Exceptions**[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=7)]

The NHS in [Wales](https://en.wikipedia.org/wiki/Wales) was also running a national programme for service improvement and development via the use of information technology – this project was called [Informing Healthcare](https://en.wikipedia.org/wiki/Informing_Healthcare). A challenge facing both NHS CFH and Informing Healthcare was that the use of national systems previously developed by the NHS Information Authority were shared by both of these organisations and the Isle of Man. Separate provision needed to be made for devolution, while maintaining links for patients travelling across national borders.

NPfIT was focussed on delivering the NHS Care Record Service to GPs, acute and primary hospitals, medical clinics and local hospitals and surgeries. While there were no immediate plans to include opticians or dentists in the electronic care record, services are delivered to these areas of the NHS.

**Clusters and local service providers**[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=8)]

The programme originally divided England into five areas known as "clusters": Southern, London, East & East Midlands, North West & West Midlands, and North East. For each cluster, a different *Local Service Provider* (LSP) was contracted to be responsible for delivering services at a local level. This structure was intended to avoid the risk of committing to one supplier which might not then deliver; by having a number of different suppliers implementing similar systems in parallel, a degree of competition would be present which would not be if a single national contract had been tendered. Four clusters were awarded in two tranches on 8 and 23 December 2003,[[1]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-EHI_588-1)[[3]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-EHI_606-3) with the fifth on 26 January 2004.[[4]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-EHI_632-4) However, in July 2007 [Accenture](https://en.wikipedia.org/wiki/Accenture) withdrew from their 2 clusters, and in May 2008 [Fujitsu](https://en.wikipedia.org/wiki/Fujitsu) had their contract terminated, meaning that half the original contractors had dropped out of the project. As of May 2008, two IT providers were LSPs for the main body of the programme:

* [Computer Sciences Corporation](https://en.wikipedia.org/wiki/Computer_Sciences_Corporation) (CSC) – North, Midlands & Eastern (NME) cluster
* [BT Health London](http://www.globalservices.bt.com/uk/en/industries/Health) (formerly BT Capital Care Alliance) – London cluster
* [Accenture](https://en.wikipedia.org/wiki/Accenture) had full responsibility for the North East and East/East Midlands clusters until January 2007, when it handed over the bulk of its responsibilities to the CSC, retaining responsibility for [Picture archiving and communication system](https://en.wikipedia.org/wiki/Picture_archiving_and_communication_system) (PACS) rollout only.
* [Fujitsu](https://en.wikipedia.org/wiki/Fujitsu) – had responsibility for the Southern cluster until May 2008 when their contract was terminated.[[33]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Guardian_080529-33) Most of their responsibilities were subsequently transferred to BT Health except for PACS which was transferred to the CSC Alliance.

**Local ownership**[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=9)]

In the first half of 2007, [David Nicholson](https://en.wikipedia.org/wiki/David_Nicholson_(civil_servant)) announced the "National Programme, Local Ownership programme" (known as "NLOP") which dissolved the 5 clusters and devolved responsibility for the delivery of the programme to the ten English [strategic health authorities](https://en.wikipedia.org/wiki/Strategic_health_authority) (SHAs).[[34]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-34) Connecting for Health retains responsibility for the contracts with the LSPs.[[35]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-35)

Under NLOP, staff employed by CfH in the clusters had their employment transferred to the SHAs, with some being recruited to revised national CfH posts.

**National Application Service Providers**[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=10)]

In addition to these LSPs the programme appointed National Application Service Providers (NASPs) who were responsible for services that were common to all users, *e.g.* [Choose and Book](https://en.wikipedia.org/wiki/Choose_and_Book) and the national elements of the NHS Care Records Service that supported the summary patient record and ensure patient confidentiality and information security. As of October 2005, the NASPs were:

* [BT](https://en.wikipedia.org/wiki/British_Telecom) – [NHS Care Records Service](https://en.wikipedia.org/wiki/NHS_Care_Records_Service) and [N3](https://en.wikipedia.org/wiki/N3_(NHS))
* [Atos Origin](https://en.wikipedia.org/wiki/Atos_Origin) and [Cerner](https://en.wikipedia.org/wiki/Cerner) – Choose & Book
* [Cable and Wireless](https://en.wikipedia.org/wiki/Cable_%26_Wireless_Worldwide) – NHSmail

**Changes to service providers**[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=11)]

In March 2004, [EDS](https://en.wikipedia.org/wiki/Electronic_Data_Systems) had their 10-year contract to supply the NHSMail service terminated.[[36]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-36)[[37]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-37) On 1 July 2004, Cable and Wireless were contracted to provide this service, which was initially renamed *Contact*.[[38]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-38)

IDX Systems Corporation was removed from the Southern Cluster Fujitsu Alliance in August 2005 following repeated failure to meet deadlines.[[33]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Guardian_080529-33) They were replaced in September 2005 by [Cerner Corporation](https://en.wikipedia.org/wiki/Cerner).

In early 2006, ComMedica's contract for supply of [PACS](https://en.wikipedia.org/wiki/Picture_archiving_and_communication_system) to the North-West/West-Midlands cluster was terminated, and they were replaced by GE Healthcare.

In July 2006, the London region started the contractual replacement of IDX (which had been bought out by GE Healthcare in January 2006) as its supplier. Systems for secondary care, primary care and community and mental health services are proposed by BT to be provided by [Cerner](https://en.wikipedia.org/wiki/Cerner), INPS (formerly in Practice Systems) and CSE Healthcare Systems, part of the CSE-Global group of companies, respectively.[[39]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-39) This is subject to contractual negotiation known as 'CCN2'.

In September 2006, the CSC Alliance, Accenture and Connecting for Health signed a tripartite agreement that as of January 2007, the CSC Alliance would take over the responsibility for the majority of care systems the North East and Eastern clusters from Accenture, with the exception of [PACS](https://en.wikipedia.org/wiki/Picture_archiving_and_communication_system). As part of the handover process, around 300 Accenture personnel transferred under a [TUPE](https://en.wikipedia.org/wiki/Transfer_of_Undertakings_(Protection_of_Employment)_Regulations_2006) process to CSC, and CSC took over the leases for some of Accenture's premises in [Leeds](https://en.wikipedia.org/wiki/Leeds). Accenture now retains only a small presence in the city for the delivery of its PACS responsibilities.

In May 2008 it was announced that following the failure to conclude renegotiation of the contract for the Southern Cluster, CfH terminated the contract with Fujitsu.[[40]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-40) The majority of the Southern Cluster care systems were subsequently transferred to BT Health except for PACS which was transferred to the CSC Alliance, aligning with the technology deployed by each company.

Criticisms[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=12)]

**Failure to deliver clinical benefits**[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=13)]

The 2009 Public Accounts Committee (PAC) report noted, that the NPfIT had provided "little clinical functionality... to-date".[[*citation needed*](https://en.wikipedia.org/wiki/Wikipedia:Citation_needed)] The PAC report of 18 July 2011 said it failed to deliver clinical benefits.[[41]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-41)

**Data security risks**[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=14)]

NPfIT has been criticised for inadequate attention to security and patient privacy, with the Public Accounts Committee noting "patients and doctors have understandable concerns about data security", and that the Department of Health did not have a full picture of data security across the NHS.[[8]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Public_Accounts_2009-8) In 2000, the NHS Executive won the "Most Heinous Government Organisation" [Big Brother Award](https://en.wikipedia.org/wiki/Big_Brother_Award) from [Privacy International](https://en.wikipedia.org/wiki/Privacy_International) for its plans to implement what would become the NPfIT.[[42]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-42) In 2004 the NPfIT won the "Most Appalling Project" [Big Brother Award](https://en.wikipedia.org/wiki/Big_Brother_Award) *because of its plans to computerise patient records without putting in place adequate privacy safeguards*.[[43]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-43)

The balance between the right to privacy and the right to the best quality care is a sensitive one. Also there are sanctions against those who access data inappropriately, specifically instant dismissal and loss of professional registration[[*citation needed*](https://en.wikipedia.org/wiki/Wikipedia:Citation_needed)].

A January 2005 survey among doctors indicated that support for the initiative as an 'important NHS priority' had dropped to 41%, from 70% the previous year.[[44]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-44) There have been concerns raised by clinicians that clinician engagement has not been addressed as much as might be expected for such a large project.

Concerns over confidentiality, and the security of medical data uploaded to the Spine have also led to opposition from civil liberties campaigners such as [NO2ID](https://en.wikipedia.org/wiki/NO2ID) the anti-database state pressure group and The Big Opt Out who provide patients with a letter to send to their doctor so that their records are withheld from the database.[[*citation needed*](https://en.wikipedia.org/wiki/Wikipedia:Citation_needed)]

**Reservations of medical staff**[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=15)]

As of 5 August 2005, research carried out across the NHS in England suggested that clinical staff felt that the programme was failing to engage the clinicians fully, and was at risk of becoming a [white elephant](https://en.wikipedia.org/wiki/White_elephant). The Public Accounts Committee observed in 2009 that "the current levels of support reflect the fact that for many staff the benefits of the Programme are still theoretical".[[8]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Public_Accounts_2009-8)

Surveys in 2008 suggested that two-thirds of doctors would refuse to have their own medical records on the system.[[*citation needed*](https://en.wikipedia.org/wiki/Wikipedia:Citation_needed)]

**Impact on IT providers**[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=16)]

According to the Daily Telegraph, the head of NPfIT, Richard Granger, 'shifted a vast amount of the risk associated with the project to service providers, which have to demonstrate that their systems work before being paid.' The contracts meant that withdrawing from the project would leave the providers liable for 50% of the value of the contract; however, as previously mentioned, when Accenture withdrew in September 2006, Granger chose not to use these clauses, saving Accenture more than £930m.[[27]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Kablenet-27)

The programme's largest software provider [iSOFT](https://en.wikipedia.org/wiki/ISOFT) has been seriously affected by this process and is under investigation by the UK [Financial Services Authority](https://en.wikipedia.org/wiki/Financial_Services_Authority) for irregular accounting.[[45]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-45) On 28 September 2006, the consultancy [Accenture](https://en.wikipedia.org/wiki/Accenture) announced its intention to withdraw from £2bn of 10-year contracts with NPfIT, which were taken over in January 2007 by the CSC Alliance – both Accenture and CSC laid blame with iSOFT, although CSC has said it will be retaining iSOFT as its software provider for all its clusters.[[46]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-46) Earlier in the year Accenture had written off $450m from its accounts because of 'significant delays' in the programme. iSOFT announced in March 2011 that trading in its shares would be suspended pending a corporate announcement. Subsequently, in April 2011, the company announced that it was recommending a cash offer from CSC. CSC acquired iSOFT in August 2011.

In September 2018 it was reported that [Fujitsu](https://en.wikipedia.org/wiki/Fujitsu) was to be paid "hundreds of millions of pounds" in settlement of a legal dispute stretching back to the National Programme for IT when their £896 million contract was terminated. Substantial payments had also been made to CSC.[[47]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-47)

Implementation[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=17)]

The first trusts in the London and Southern clusters to implement the new [Cerner](https://en.wikipedia.org/wiki/Cerner) system found it problematic, with [hospital trust](https://en.wikipedia.org/wiki/Hospital_trust) board minutes revealing a catalogue of errors. Difficulties with the system meant that:[[48]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Observer_10-08-2008-48)

* 2007: [Enfield](https://en.wikipedia.org/wiki/London_Borough_of_Enfield) [PCT](https://en.wikipedia.org/wiki/Primary_care_trust) were unable to obtain vital data on patients awaiting operations and were obliged to delay 63 patients of the [Barnet](https://en.wikipedia.org/wiki/Barnet_Hospital) and [Chase Farm](https://en.wikipedia.org/wiki/Chase_Farm_Hospital) hospitals. Further, 20 patients were not readmitted for treatment within 28 days towards the end of the year because the surveillance system for tracking them "was not operational in the new ... system". [Buckinghamshire Hospitals NHS Trust](https://en.wikipedia.org/w/index.php?title=Buckinghamshire_Hospitals_NHS_Trust&action=edit&redlink=1) found that problems with the system had meant potentially infectious patients with [MRSA](https://en.wikipedia.org/wiki/Methicillin-resistant_Staphylococcus_aureus) were not isolated for up to 17 days, requiring six weeks work by staff to update them manually.
* April 2008: Enfield PCT found that the system had failed to flag up possible child-abuse victims entering hospital to key staff, "leaving the responsibility to the receptionist"
* May 2008: Enfield PCT found that 272 elective operations were cancelled at the last minute for "non-clinical reasons"
* May 2008: [Barts and The London NHS Trust](https://en.wikipedia.org/wiki/Barts_and_The_London_NHS_Trust) blamed their failure over the preceding six months to meet targets for treating emergency patients within four hours on staff not being familiar with the new computer system. The same report cited "breaches of the two-week urgent cancer access guarantee" and delays in assessing 11 patients with possible cancer as being due to the computer system.
* July 2008: the [Royal Free Hampstead NHS Trust](https://en.wikipedia.org/wiki/Royal_Free_Hampstead_NHS_Trust) said 12,000 patient records had to be manually amended over a three-week period due to the system, and noted that "The outpatient appointment centre has experienced a significant increase in the time taken to process individual patient appointment bookings. This has had a consequent and negative effect on call-answer performance."

Management team[[edit](https://en.wikipedia.org/w/index.php?title=NHS_Connecting_for_Health&action=edit&section=18)]

The NHS appointed a management team, responsible for the delivery of the system:[[49]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-49) In October 2002, [Richard Granger](https://en.wikipedia.org/wiki/Richard_Granger) the former Director General of IT for the NHS, took up his post before which he was a partner at [Deloitte Consulting](https://en.wikipedia.org/wiki/Deloitte_Consulting), responsible for procurement and delivery of a number of large scale IT programmes, including the [Congestion Charging Scheme for London](https://en.wikipedia.org/wiki/London_congestion_charge). In October 2006, he was suggested by [*The Sunday Times*](https://en.wikipedia.org/wiki/The_Sunday_Times_(UK)) to be the highest paid civil servant, on a basic of £280,000 per year, £100,000 per year more than then-Prime Minister Tony Blair.[[50]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-50) Granger announced on 16 June 2007 that he would leave the agency "during the latter part" of 2007.[[51]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-51) In February 2008 Granger left the programme .[[52]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-52) His credentials were questioned by his own mother, a campaigner for the preservation of local health services in her area, who expressed her amazement at his appointment, criticising the whole scheme as "a gross waste of money".[[28]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Observer-28)

In 2009, overall leadership of CfH was described by the Public Accounts Committee as having been "uncertain" since the announcement that Richard Granger would be leaving the project.[[8]](https://en.wikipedia.org/wiki/NHS_Connecting_for_Health#cite_note-Public_Accounts_2009-8)

<https://en.wikipedia.org/wiki/NHS_Connecting_for_Health>

## Like many men, I don't go to the doctor very often. The last time I did, I was with my GP for 25 minutes: five minutes discussing my symptoms and 20 minutes helping her to understand how to use her new computer system to record my symptoms, her diagnosis and book the next appointment. Together, we experienced a system that was slow, cumbersome, insufficiently explained and poorly implemented.

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By

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Published: **13 Sep 2010**

##### by Alistair Maughan, partner [Morrison & Foerster (UK) LLP](http://www.mofo.com/)

Like many men, I don't go to the doctor very often. The last time I did, I was with my GP for 25 minutes: five minutes discussing my symptoms and 20 minutes helping her to understand how to use her new computer system to record my symptoms, her diagnosis and book the next appointment. Together, we experienced a system that was slow, cumbersome, insufficiently explained and poorly implemented.

That experience seems to sum up the massively ambitious NHS National Programme for IT (NPfIT, subsequently re-christened Connecting for Health) which the government has announced has finally been cancelled. Since NPfIT, as it was originally conceived, has widely recognised to have been dead in the water for some time, this coup de grâce is long overdue.

Given the amount of taxpayer money that's been spent on this project over the past seven years, it should give no-one any satisfaction that the problems of the NPfIT stem back right to the start of the project. You almost feel sympathy for those in the Department for Health whose role has been to try to salvage something from the project over the past three to four years - and also for service providers who invested a lot of time, resources and money in pursuing and attempting to deliver on contracts that were aggressively drafted but poorly specified.

Many of the lessons that can be learned from the failure of NPfIT are no more than commonsense. Indeed, many of the mistakes have been obvious almost since Day 1 - but the lessons appear not to have been learned, or at least not until too late.

### 1. Motives

"Top-down" projects are much more likely to fail than "bottom-up" projects, and NPfIT was top-down project par excellence. I identify a top-down project as one done for political reasons: and this can be both genuinely Political with a capital P in the public sector or a "vanity" or CEO-inspired project in the private sector. The history of public sector ICT and outsourcing is littered with politically-inspired projects that failed: the £1.5bn project to computerise benefit payments at post offices was the classic 1990s example.

The motivation to commence NPfIT came from Cabinet level and it's hard to argue against the fact that many of its aims were entirely laudable. But there is a big gap between laudability and deliverability. The decision to commence any project - let alone one which will transform a fundamental building block of a nation's healthcare system - must be made by the right people who really know about the issues involved. It's unfortunate for civil servants and the departments they run that they have to carry the can for projects devised by ministers that often only make sense on the political drawing board and are almost impossible to translate into reality.

### 2. Buy-in

Surveys regularly report that more than 30% of ICT project failures are as a result of poor strategy and business planning. This includes a failure to understand and align the commercial drivers and what value is intended from the project. Rarely is a project ever just an IT project; generally it should be viewed as a broader process to deliver business benefits.

It is a hallmark of successful ICT and outsourcing projects that there should be good consultation with all stakeholders involved, including particularly end-users. Ever since NPfIT began, there have been concerns expressed by key stakeholders within the health system, especially doctors and GPs, about the accessibility and utility of the planned system.

In particular, it was not clear even from the outset of NPfIT exactly what was going to be delivered to the ultimate end-users. Add to that the entrenched interests in NHS trusts about loss of control over their own systems and you have an inherently suspicious, if not downright hostile, user base. Few projects can succeed over the outright opposition of the proposed users.

### 3. More haste, less speed

One so-called innovation for which NPfIT was originally praised was the speed and efficiency of its procurement and contracting process. That process has subsequently become a mill-stone around the project's neck.

NPfIT rushed to award contracts in almost indecent haste with insufficient planning, particularly for such a large contract. Contract scope was unclear and much work needed to be done after contract award to agree key contract parameters such as scope and deliverables. At the time, this was felt by many to be a sign of success and the model for how future procurement should be done.

No-one could argue that there must always be a desire to procure and award contracts as efficiently as possible. But this can't come at the sacrifice of agreeing all appropriate contract terms up-front, rather than retrospectively once the contract has been put in place. Nor is this a substitute for doing appropriate due diligence before the contract is awarded and actually writing clear statements of work and requirements.

One of the lessons that should be learned is that projects will always run into trouble if they try to complete the contractual paperwork before actually working out the scope of what a project is about, what its deliverables will be and how they will be implemented.

### 4. Poor contracting process

The NPfIT procurement model called for a drastic cut in timescales, with no negotiation allowed, contracts offered on a "take-it-or-leave-it" basis and a very aggressive approach to legal remedies against service providers. NPfIT and its advisers appeared to forget the golden rule that these contracts involve a long-term relationship; so a hyper-aggressive approach to supplier management is counter-productive.

One of the issues that bedevilled the project from the outset was the extent to which the NPfIT was attempting to force service providers to accept onerous and one-sided contracts. Negotiation was a dirty word and NPfIT used heavy-handed tactics to ram through contract terms that were considerably harsher than had ever been seen within a government (or even private sector) context before.

It is worth noting that some of these provisions (for example, in relation to what happens on financial distress of a service provider or in relation to clawback of prepaid milestone payments) have found their way into standard practice within government - not always with entirely successful results.

The combination of the implemented payment provisions (under which service providers had to do all the work upfront with no payments until successful delivery) and the harsh termination and liability provisions, meant that the risks being absorbed by service providers were extremely high.

While many may say that service providers make a healthy margin and, therefore, ought to absorb risk, no service provider is a bottomless pit able to accept enormous costs and risks of delivery, particularly where the customer is in a position of being able to re-interpret and add requirements during the course of delivery. A number of significant service providers have fallen by the wayside during the course of the NPfIT project simply because of the difficulty of delivering what NPfIT wanted within its timescales and risk profile, and against a moving timeframe.

Hopefully, one lesson government will learn from NPfIT is that there needs to be a balance of risk and reward in negotiating contracts even for very large projects. It is notable that the standard paradigm for public sector contract terms has moderated significantly since NPfIT was initiated. Many might wish that there had been more reasonable voices involved in the original project who could have argued for putting in place a more moderate, deliverable contract that didn't force service providers to take on so many contractual risks that their own internal business cases became unstable.

### 5. Multisourcing

NPfIT was certainly innovative in its structure of making different service providers work together by awarding work in a series of lots. Part of the rationale for this approach was that different regional service providers could be swapped in or out if and when other regional service providers failed.

At least this has meant that, as some service providers have had their contracts terminated over the past few years, there have been others prepared to pick up the slack. But it does illustrate that anything other than a "one customer, one service provider" structure is very difficult to operate.

This doesn't mean that it cannot be established in this way - as the current swathe of multisourcing contracts has shown. But it does mean that there needs to be much more careful thought and planning in advance about how different service providers will be incentivised to collaborate - not forced to co-operate almost against their will and without some "script" or plan as to how disputes will be resolved.

### 6. Accountability

Finally, the termination of NPfIT also illustrates what I call the Mastermind factor - that is, there is a tendency amongst people involved in a project which isn't going well to adopt the "I've started so I'll finish" approach, circle the wagons and not step back and take the inevitable decision at a more appropriate stage.

Good managers on ICT and outsourcing projects are always asking themselves whether the original course of action is correct and whether adjustments are required - and they are prepared to take the ultimate decision at the right time and not delay the inevitable.

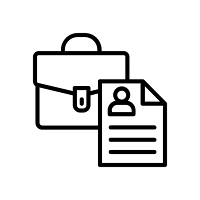
NPfIT was run by a very strong project director with a powerful personality. Maybe that was the best way to give the project a chance of success. Unfortunately, once the project ran into trouble there much less room for manoeuvre and few supporters outside the core team. Clear accountability is fine (indeed, essential) but accountability needs to be in the right hands and with the right checks and balances. If the public sector learns anything from NPfIT, let's hope that it will be how to identify and implement those checks and balances from the outset.

<https://www.computerweekly.com/opinion/Six-reasons-why-the-NHS-National-Programme-for-IT-failed>

Jan**20**2019

* **Labels:** [Case Studies](https://www.henricodolfing.com/search/label/Case%20Studies), [Project Failure](https://www.henricodolfing.com/search/label/Project%20Failure)

[Case Study 1: The £10 Billion IT Disaster at the NHS](https://www.henricodolfing.com/2019/01/case-study-10-billion-it-disaster.html)

[](https://1.bp.blogspot.com/-JGbq9WEscHc/XUcYW9hZBsI/AAAAAAABQS8/bU0SESMncpg3KnW7eFaEKNzyK6WflSIpgCLcBGAs/s200/project_failure_case_study.png)

The National Program for IT (NPfIT) in the National Health Service (NHS) was the largest public-sector IT program ever attempted in the UK, originally budgeted to cost approximately £6 billion over the lifetime of the major contracts.  
  
These contracts were awarded to some of the biggest players in the IT industry, including Accenture, CSC, Atos Origin, Fujitsu and BT.  
  
After a history marked by delays, stakeholder opposition and implementation issues, the program was dismantled by the Conservative-Liberal Democrat government in 2011, almost 10 years after Prime Minister Tony Blair initiated it at a seminar in Downing Street in 2002.  
  
The core aim of the NPfIT was to bring the NHS’ use of information technology into the 21st century, through the introduction of integrated electronic patient records systems, online ‘choose and book’ services, computerized referral and prescription systems and underpinning network infrastructure.  
  
Despite the failure of many of these services to be delivered, the government, and ultimately taxpayers, incurred significant costs for the program, including contract transition and exit costs which continued to accrue to a total amount of more than £10 billion.  
  
Since NPfIT was a public-sector program, there is a large amount of documentation and press about the case available. If you are interested in reading more about it, I have collected many of these documents [here](https://drive.google.com/open?id=11eyVkSufGYX5wGmegufqrkX5TalSgSac).  
  
**Before we continue with this case study...**  
 **>**For an overview of all case studies I have written please click [here](https://www.henricodolfing.com/p/project-failure-case-studies.html).

Timeline of Events

**2002**  
  
**>** NPfIT starts with Richard Granger being the appointed NHS IT director.  
  
**2003**  
  
**>** BT awarded contract for the national data spine  
**>** Local service provider 10 year contracts awarded (CSC for North West and West Midland cluster; BT Capital Care Alliance for London cluster; Fujitsu for Southern cluster; Accenture for North East and Eastern England clusters.  
  
**2004**  
  
**>** BT awarded N\* (NHS broadband network) contract  
  
**2005**  
  
**>** NHS Connecting for Health (NHS CFH) set up to deliver NPfIT  
**>** Contract reset 1 (BT) for “interim solutions” in London  
  
**2006**  
  
**>** Accenture withdraws as local service provider  
**>** CSC awarded 9 year contract for Accenture’s former clusters  
  
**2007**  
  
**>** NPfIT Local Ownership Programme (devolves responsibility for local delivery of the program from NHS CFH to groupings of strategic health authorities  
**>** Replaces original five clusters with three program areas: Southern (local service provider Fujitsu), London (local service provider BT), and North, Midlands and East (local service provider CSC).  
**>** Contract reset 2 (BT) for “best of breed” London solutions  
  
**2008**  
  
**>** Fujitsu contract for local service provider in Southern area terminated; legal dispute continues  
**>** Contract reset negotiations 3 (BT) for new delivery model in London  
**>** Richard Granger, head of NHS CFH, leaves in January  
**>** Gordon Hextall, acting head, leaves in April  
**>** Christine Connelly and Martin Bellamy appointed to jointly lead NHS CFH in September  
  
**2009**  
  
**>** BT awarded additional contract to take over eight trusts formerly with Fujitsu, plus 25 trusts for RiO and four additional acute trusts in Southern area.  
**>** Other Southern trusts given choice of local service provider solution from BT or CSC or from various suppliers in Additional Supply Capability and Capacity List (ASCC)  
**>** Martin Bellamy, director of programmes and systems delivery, NHS CFH, resigns  
**>** NHS CFH, headed by Christine Connelly, is integrated with Department of Health Informatics Directorate  
**>** Parliamentary announcement of contract negotiations with BT and CSC - seeking NPfIT costs savings  
  
**2010**  
  
**>** New memorandum of agreement signed between BT and NHS CFH, including reduced number of deployments in acute trusts in London  
**>** Contract discussions with CSC continuing  
**>** UK general election in May - new coalition government  
  
**2011**  
  
**>** The National Programme for IT has finally come to an end, although the bill for the enormously expensive and controversial project will continue to be paid for years to come.  
**>** The deadline to exit NPfIT national contracts in the North, Midlands and East passed on 7 July, marking the end of the final chapter of the £12.7 billion attempt to bring the NHS into the digital age.  
**>** Around £2.6 billion of actual benefits had been identified as of March 2011

What Went Wrong

In order to bring some light on all the things that went wrong I follow the structure of Oliver Campion-Awwad, Alexander Hayton, Leila Smith and Mark Vuaran. You will find their case history document in the directory mentioned above. It identifies three main themes: rush, design, and culture/skills.  
  
**Rush**  
  
In their rush to reap the rewards of the program, politicians and program managers raced headlong into policy-making, procurement and implementation processes that allowed little time for consultation with key stakeholders and failed to deal with confidentiality concerns. This resulted in:  
  
**>** An unrealistic timetable  
  
**>** No time to engage with users and privacy campaigners  
  
**>** Inadequate preliminary work  
  
**>** Failure to check progress against expectations  
  
**>** Failure to test systems  
  
**Design**  
  
In an effort to reduce costs and ensure swift uptake at the local levels, the government pursued an overambitious and unwieldy centralized model, without giving consideration to how this would impact user satisfaction and confidentiality issues. This resulted in:  
  
**>** Failure to recognize the risks or limitations of big IT projects  
  
**>** Failure to recognize that the longer the project takes, the more likely it is to be overtaken by new technology  
  
**>** Sheer ambition  
  
**>** The project being too large for the leadership to manage competently  
  
**>** Confidentiality issues  
  
**Culture and skills**  
  
The NPfIT lacked clear direction, project management and an exit strategy, meaning that the inevitable setbacks of pursuing such an ambitious program quickly turned into system-wide failures. Furthermore, the culture within the Department of Health and government in general was not conducive to swift identification and rectification of strategic or technical errors. This resulted in:  
  
**>** A lack of clear leadership  
  
**>** Not knowing, or continually changing, the aim of the project  
  
**>** Not committing the necessary budget from the outset  
  
**>** Not providing training  
  
**>** A lack of concern for privacy issues  
  
**>** No exit plans and no alternatives  
  
**>** A lack of project management skills  
  
**>** Treasury emphasis on price over quality  
  
**>** IT suppliers that depend on lowballing for contracts and charge heavily for variations to poorly written specifications

How NHS Could Have Done Things Differently

This case study contains several lessons useful for project managers, IT professionals, and business leaders.

**Understanding the problem**  
  
"Top-down" projects are much more likely to fail than "bottom-up" projects, and NPfIT was top-down project par excellence. I identify a top-down project as one done for political reasons: and this can be both genuinely Political with a capital P in the public sector or a "vanity" or CEO-inspired project in the private sector. The history of public sector ICT and outsourcing is littered with politically-inspired projects that failed.  
  
The motivation to commence NPfIT came from Cabinet level and it's hard to argue against the fact that many of its aims were entirely laudable. But there is a big gap between laudability and deliverability. The decision to commence any project - let alone one which will transform a fundamental building block of a nation's healthcare system - must be made by the right people who really know about the issues involved. It's unfortunate for civil servants and the departments they run that they have to carry the can for projects devised by ministers that often only make sense on the political drawing board and are almost impossible to translate into reality.  
  
See "[Understanding Your Problem Is Half the Solution (Actually the Most Important Half)](https://www.henricodolfing.com/2018/05/understanding-your-problem-is-half.html)" for more insights on this topic.  
  
**Stakeholder engagement**  
  
Rarely is a project ever just an IT project; generally it should be viewed as a broader process to deliver business benefits.  
  
It is a given of successful technology projects that there should be good consultation with all stakeholders involved, including end-users. Ever since NPfIT began, there have been concerns expressed by key stakeholders within the health system, especially doctors and GPs, about the accessibility and utility of the planned system.  
  
In particular, it was not clear even from the outset of NPfIT exactly what was going to be delivered to the ultimate end-users. Add to that the entrenched interests in NHS trusts about loss of control over their own systems and you have an inherently suspicious, if not downright hostile, user base. Few projects can succeed over the outright opposition of the proposed users.  
  
See "[10 Principles of Stakeholder Engagement](https://www.henricodolfing.com/2018/03/10-principles-of-stakeholder-engagement.html)" for more insights on this topic.  
  
**Start slow in order to run fast later**  
  
One so-called innovation for which NPfIT was originally praised was the speed and efficiency of its procurement and contracting process. That process has subsequently become a mill-stone around the project's neck.  
  
NPfIT rushed to award contracts in almost indecent speed with insufficient planning, particularly for such a large contract. Contract scope was unclear and much work needed to be done after contract award to agree key contract parameters such as scope and deliverables. At the time, this was felt by many to be a sign of success and the model for how future procurement should be done.  
  
No-one could argue that there must always be a desire to procure and award contracts as efficiently as possible. But this can't come at the sacrifice of agreeing all appropriate contract terms up-front, rather than retrospectively once the contract has been put in place. Nor is this a substitute for doing appropriate due diligence before the contract is awarded and actually writing clear statements of work and requirements.  
  
One of the lessons that should be learned is that projects will always run into trouble if they try to complete the contractual paperwork before actually working out the scope of what a project is about, what its deliverables will be and how they will be implemented.  
  
See "[Your Projects Should Start Slow in Order to Run Fast Later](https://www.henricodolfing.com/2019/06/start-projects-slow-run-fast-later.html)" for more insights on this topic.  
  
**Balancing risk and reward**  
  
The NPfIT procurement model called for a drastic cut in timescales, with no negotiation allowed, contracts offered on a "take-it-or-leave-it" basis and a very aggressive approach to legal remedies against service providers. NPfIT and its advisers appeared to forget the golden rule that these contracts involve a long-term relationship; so a hyper-aggressive approach to supplier management is counter-productive.  
  
One of the issues that bedevilled the project from the outset was the extent to which the NPfIT was attempting to force service providers to accept onerous and one-sided contracts. Negotiation was a dirty word and NPfIT used heavy-handed tactics to ram through contract terms that were considerably harsher than had ever been seen within a government (or even private sector) context before.  
  
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Hopefully, one lesson government will learn from NPfIT is that there needs to be a balance of risk and reward in negotiating contracts even for very large projects. It is notable that the standard paradigm for public sector contract terms has moderated significantly since NPfIT was initiated. Many might wish that there had been more reasonable voices involved in the original project who could have argued for putting in place a more moderate, deliverable contract that didn't force service providers to take on so many contractual risks that their own internal business cases became unstable.  
  
**Multisourcing**  
  
NPfIT was certainly innovative in its structure of making different service providers work together by awarding work in a series of lots. Part of the rationale for this approach was that different regional service providers could be swapped in or out if and when other regional service providers failed.  
  
At least this has meant that, as some service providers have had their contracts terminated over the past few years, there have been others prepared to pick up the slack. But it does illustrate that anything other than a "one customer, one service provider" structure is very difficult to operate.  
  
This doesn't mean that it cannot be established in this way - as the current hype of multisourcing contracts has shown. But it does mean that there needs to be much more careful thought and planning in advance about how different service providers will be incentivised to collaborate - not forced to co-operate almost against their will and without some "script" or plan as to how disputes will be resolved.  
  
**Checks and balances**  
  
There is a tendency amongst people involved in a project which isn't going well to adopt the "I've started so I'll finish" approach, circle the wagons and not step back and take the inevitable decision at a more appropriate stage.  
  
Good managers on technology projects are always asking themselves whether the original course of action is correct and whether adjustments are required - and they are prepared to take the ultimate decision at the right time and not delay the inevitable.  
  
NPfIT was run by a very strong project director with a powerful personality. Maybe that was the best way to give the project a chance of success. Unfortunately, once the project ran into trouble there much less room for manoeuvre and few supporters outside the core team. Clear accountability is fine (indeed, essential) but accountability needs to be in the right hands and with the right checks and balances. If the public sector learns anything from NPfIT, let's hope that it will be how to identify and implement those checks and balances from the outset.

Closing Thoughts

The Public Accounts Committee (PAC) calls the saga one of the “worst and most expensive contracting fiascos” in public sector history, and adds: “Although the Department told us that the National Programme had been dismantled, the component programmes are all continuing, the existing contracts are being honoured and significant costs are still being incurred. The only change from the National Programme that the Department could tell us about was that new governance arrangements were now in place.”  
  
The estimated costs of the scheme rose from £6.4bn to £9.8bn, but ongoing costs arising from legal battles and other issues will keep dragging this figure higher, the MP said, especially the price of terminating the Fujitsu contract in the south of England, and the ongoing costs of Lorenzo in the north, Midlands and east.  
  
Committee member Richard Bacon MP said the fact that only 22 trusts are now expected to take the Lorenzo system – despite the original contracts with CSC totalling £3.1bn – is another indictment.  
  
Let’s hope the whole public sector has learned something from this disaster. It is our money that is wasted.

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