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HOUSE OF COMMONS

ORAL EVIDENCE

TAKEN BEFORE THE

PUBLIC ACCOUNTS COMMITTEE

NATIONAL PROGRAMME FOR NHS IT

MONDAY 23 MAY 2011

PATRICK O'CONNELL and SHERI THUREEN

CHRISTINE CONNELLY and SIR DAVID NICHOLSON

Evidence heard in Public Questions 1 - 319

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Oral Evidence

Taken before the Public Accounts Committee

on Monday 23 May 2011

Members present:

Mrs Margaret Hodge (Chair)
Mr Richard Bacon
Stephen Barclay
Stella Creasy
Jackie Doyle-Price
Justine Greening
Chris Heaton-Harris
Mrs Anne McGuire
Austin Mitchell
Nick Smith
Ian Swales

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Amyas Morse, Comptroller and Auditor General, and **Mark Davies**, Director, NAO, gave evidence. **Gabrielle Cohen**, Assistant Auditor General, and **Marius Gallaher**, Alternate Treasury Officer of Accounts, were in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
The National Programme for IT in the NHS: an update on the delivery of detailed care records systems (HC 888)

Examination of Witnesses

Witnesses: **Patrick O'Connell**, President, BT Health, and **Sheri Thureen**, President, UK Healthcare, Computer Sciences Corporation, gave evidence.

Q1 Chair: Can I thank you both very much for attending? This first session is going to be very tight. We got half an hour, so we really want to use this to inform our questioning of those officials who are responsible for the programme. So if you could keep your answers as tight as possible, it is really to try and get some information that can help us do the main session as best we can, but I am very grateful to you both for coming. I am a non-IT person, but when I read this Report and looked at the previous Report it seemed pretty clear to me that you might have taken a position at the start that this ambitious Report was undeliverable. You are the professional experts; I will start with you, Mr O'Connell and then come to you Ms Thureen: why did you sign a contract committing to deliver something, which we now know you cannot deliver, but which I think you as professionals might have taken a view back in 2003 was undeliverable?

Patrick O'Connell: Personally I was not here in 2003, but, to answer your question, I would guess or speculate that in 2003 the needs of the user—as perceived at that time—the policy of the Department, the state of technology, the trade-off between costs and schedule were believed to be doable at that time. As time has progressed, many things have progressed and evolved, and it has brought us to a different solution. I do not know that it necessarily means it was not doable at day one.

Q2 Chair: So if you had been around in 2003 would you have told Government, "This is not doable"?

Patrick O'Connell: In 2003? I do not think I would have said such a thing in 2003. It is more a matter that there are a lot of factors I am unfamiliar with from 2003, but the principle of it—

Q3 Chair: You know more in 2011, but in 2003, seeing the technological difficulty, the extent of the number of players who would have to come to the system, the fact that you had a whole range of different systems up and down the country—this was never deliverable. I cannot understand why professionals signed it in 2003 saying, "We can deliver."

Patrick O'Connell: One of the things that has changed is the need of the users. In 2003, if one had built the system that was envisioned versus the system that is needed today—in the sense of a centrally-located system versus a clinically-led system—I think they would have approached it differently. It looks like the need has evolved.

Q4 Chair: I am not sure that I accept that, but given the shortness of time, Ms Thureen. Am I pronouncing your name right?

Sheri Thureen: Yes, thank you. Based on my experience of running very large Government contracts that span 10 to 12 years, the contract, as it was set out, was not unusual. And these components, when you have such a large organisation that has very specific requirements, will go through a process, in the beginning, where you are asking the suppliers to make a very significant investment up front—in our particular case to build a product that incorporates the specifications of the NHS into it. It does take some time before you start to see the benefits realisation. So I think we are on a track that we still can deliver the programme, and, as my experience has been in the past, this is the point in the programme where we have the base functionality in place, and it will start to pick up through the ensuing developments.

Q5 Chair: What? You believe that you can deliver a fully integrated, electronic care records system, available to all, at all times, in all NHS settings, by 2016?

Sheri Thureen: I believe that we have made significant progress to date.

Q6 Chair: Can you deliver it?

Sheri Thureen: I believe that it is common knowledge that our contract as it stands today is being evaluated for both the scope and the volume to adjust to some of the conditions that we have encountered so far.

Q7 Chair: Can you deliver by 2016, which is the end of the contract, a fully integrated, electronic care records system, available to all, at all times, in all NHS settings?

Sheri Thureen: I believe we will have the foundation to provide for much of that through a connected approach versus a replace-all—moving to a connect-all versus a replace-all.

Q8 Mr Bacon: So we are paying for foundations? This £11 billion or £12 billion programme—I know the number has moved a lot—is buying us some foundations, a sort of first step to get us off the mark, is it?

Sheri Thureen: I believe it is buying some core components, you are correct. I believe that we have made significant progress. For example, in the North Midlands and East,

10 years ago, 97% of the population did not have electronic patient records; today 20 million electronic patient records are in place.

Q9 Mr Bacon: This is using the interim system?
Sheri Thureen: It is not an interim system that is providing that.

Q10 Mr Bacon: It is true, isn't it, that you have implemented far more interim systems than you have Lorenzo?
Sheri Thureen: It is true that we have—

Q11 Mr Bacon: It that true, yes or no?
Sheri Thureen: Yes it is.

Q12 Mr Bacon: It is. In fact, it is 81 interim systems that you have implemented, because Lorenzo was not yet ready. Is that correct?
Sheri Thureen: Yes—

Q13 Mr Bacon: It just needs a yes or a no. Is it correct? It may be 82, it may be 79, I don't know. Is it correct you have implemented 81 interim systems, because Lorenzo was not yet ready?
Sheri Thureen: We have implemented more than 81 interim systems; it is 130 plus.

Q14 Mr Bacon: It's a higher number. So be it. What's the number actually?
Sheri Thureen: And we did that in the interim—

Q15 Mr Bacon: So what's the number?
Sheri Thureen: 130 plus.

Q16 Mr Bacon: 135 interim systems. Now, it is true also, isn't it, that these interim systems were not what was contracted for; in fact, they were rejected back in 2002 as being unfit for the national programme? That is true, isn't it?
Sheri Thureen: I believe that it was always our intention to provide—I don't believe that's true.

Q17 Mr Bacon: I'm not asking you what your intention was. I'm asking you if the interim systems that you're now deploying were rejected in 2002 as being unfit to deploy as part of the national programme. Yes or no?
Sheri Thureen: No. I am not aware that that was ever the case.

Q18 Mr Bacon: You do not think that that was the case?
Sheri Thureen: I do not.

Q19 Mr Bacon: Well, the Report itself says that that is the case. Are you disagreeing with the Report?
Sheri Thureen: Our contract was started in 2003, and part of our contract was always to take a look at what systems were in place, to enhance those that could be enhanced and also to deliver some new systems. Lorenzo is one of those new systems.

Q20 Chair: Mark, can you help us, because Richard is right. Where is the reference that says that it was considered that all existing systems had to be replaced?

Mark Davies: The origin was that Lorenzo was going to be the basic system that CSC was going to implement.

Chair: There is somewhere in the Report a reference—

Q21 Mr Bacon: It is paragraph 18; obviously the 81 is now slightly out of date perhaps, but this Report was only published last week. Because of the delay in developing Lorenzo, "CSC has also delivered 81 interim systems to Trusts whose systems needed to be replaced urgently. These systems were not previously considered by the Department to meet the aims of the programme and under the terms of the current contract will need to be replaced", because they did not meet the aims of the programme. I was right, was I not? The interim systems that you are deploying now were not seen as suitable in the initial stages—as suitable for the national programme. That is correct, isn't it? Just like it says here.

Sheri Thureen: I believe that those systems, perhaps, in the beginning were, but they have been enhanced, and some of those interim systems will go forward, because they are fully capable, and they are providing—

Q22 Mr Bacon: This was not what you were contracted for. What interests me is that you have just bought iSoft, have you not?

Sheri Thureen: We are in the process of acquiring iSoft.

Q23 Mr Bacon: So, once you have iSoft—assuming all the regulatory hurdles are cleared and you get it, as it were, under your belt—you will have this large portfolio of old, profitable legacy systems where all the development work is already done. Why on earth would you continue pouring good money after bad, trying to make Lorenzo work?

Sheri Thureen: The acquisition of iSoft is a strategic decision of CSC to expand our global healthcare sector business.

Q24 Chair: Do you think Lorenzo will ever work?

Sheri Thureen: Lorenzo today is implemented in production; it is supporting 10 Trusts with 3.3 million patients being supported and 8,000—

Q25 Mr Bacon: That is version 1.0 in most of those, isn't it?

Sheri Thureen: It is release 1.9.

Q26 Mr Bacon: In how many of those 10 is it release 1.9?

Sheri Thureen: Four.

Q27 Mr Bacon: In four?

Sheri Thureen: In three; sorry three.

Q28 Chair: One Mental Health Trust pulled out of the contract completely, because it had no confidence in it. So, out of your 97 Trusts that you are trying to deliver this in, you are playing around with it in three; you wanted to put it into four, and one pulled out. What on earth gives you the confidence, having said it was ready in 2003 to 2004, nine to 10 years later, that it is ever going to be ready, and certainly within the terms of this contract?

Q29 Mr Bacon: It was actually the software supplier, iSoft, that said it would be ready, to be fair, Chairman; it was iSoft that said it was available from 2004. What confidence do you have that you can make it work?

Sheri Thureen: As I said, it is in production today for those three early-adopter Trusts on release 1.9. They have 8,000 users, supporting 3.3 million patients.

Q30 Chair: But hang on a minute. Unless our Report is wrong, our Report says you tried to introduce it in four; the Mental Health Trust—which Trust was that?

Mark Davies: Pennine.

Mr Bacon: Pennine.

Q31 Chair: Pennine has rejected it and is funding its own IT solution. The three have not yet accepted the software that you have given them; they are still waiting to accept it. I am just trying to have a little bit of common sense in this. Nine years on, you are experimenting with it in only three out of four—one has rejected—and in those three, nobody is yet satisfied with the software to be able to roll it out within their organisation.

Sheri Thureen: It has been accepted at one of those Trusts. The second Trust, Bury, has accepted—

Q32 Chair: When?

Sheri Thureen: Last week we had acceptance on that.

Q33 Mr Bacon: At the rate of deployment, how long do you think it is going to take you to deploy it across all the other sites where you are supposed to deploy it under the contract?

Sheri Thureen: As I believe is common knowledge, we are going through a restructure of our contract, which is discussing reduced volumes and scope. So I would not be able to talk to the details of that contract or deal, because it is under current evaluation.

Q34 Chair: I am going to ask both of you this question, but I will start with you. It would just be helpful for us to know how much you have been paid so far, how much you are owed and how much is left in the contractual commitment. Can you give us those three figures?

Sheri Thureen: So we have received £800 million to date for the whole programme. That is not Lorenzo; Lorenzo is only 3% of that. The top value of our contract is $3.1 billion.

Q35 Mr Bacon: Pounds?

Sheri Thureen: Pounds, sorry.

Q36 Chair: And how much do you believe you are actually owed—that is the contract—out of work done to date?

Sheri Thureen: Well, the payment on this contract is only received once we have successfully deployed a system and it has been accepted.

Q37 Mr Bacon: Yes, but because you have not declared any losses, you must have a value for your work in progress, mustn't you? What is that?

Sheri Thureen: You may have seen a couple of weeks ago that the company is in the process of closing out its fiscal year, and we did issue new guidance that talked about a reduction in inception-to-date profit on this programme.

Q38 Mr Bacon: But what is the current value of your work in progress?

Sheri Thureen: I do not know that number.

Q39 Stephen Barclay: What is the value of the termination clause of the contract? If the Department decided it wanted to stop work on this, what would be the termination cost?

Sheri Thureen: I am not aware of what that cost is.

Q40 Stephen Barclay: Not even an estimate

Sheri Thureen: I am not.

Q41 Stephen Barclay: You are in negotiations with the Department without knowing what the termination costs would be.

Sheri Thureen: We have a deal on the table today that we believe is a good deal, and I am confident that that is the right deal to have in place. We have been focusing on moving forward versus expecting to terminate the contract.

Q42 Chair: And this deal takes £500 million out of the contract because the Department is trying to reduce it by £500 million. Am I right in that?

Sheri Thureen: It is at least $500 million, and I cannot go into any specific—

Q43 Chair: Dollars? Is it all in dollars?

Sheri Thureen: Pounds, sorry.

Q44 Chair: Pounds, okay. So £500 million out of the contract at least—it could be more?

Sheri Thureen: Potentially.

Q45 Chair: It is more. And presumably that is because you are reducing scope and functionality?

Sheri Thureen: I would not be able to talk to the terms of that deal as it is still under evaluation.

Q46 Chair: Well, I think we do need to know. I can understand there is a bit you have to do commercially, but we need to know. Presumably, in reducing scope and functionality, can I just know whether you are reducing the number of Trusts you are going to deliver to?

Sheri Thureen: It is general knowledge that it is a reduction in the volume.

Q47 Chair: By how many?

Sheri Thureen: I would not be able to tell you that today.

Q48 Mr Bacon: And it would be a reduction in the scope as well. The functionality would be cut, correct?

Sheri Thureen: That is correct.

Q49 Mr Bacon: When Mike Laphen met the Minister for the Cabinet Office on 22 December, with the Chief Information Officer for Health, Christine Connelly, by what date did he say that Pennine would be implemented?

Sheri Thureen: I believe that was 7 February.

Q50 Mr Bacon: And was it implemented by then?

Sheri Thureen: It was not.

Q51 Mr Bacon: No, I did not think so. What really worries me about this is that you have your foot in the door: you are now three-fifths of the NHS. Accenture walked away declaring—we will say dollars, because they are American quoted—losses of $450 million, which was the equivalent of £270 million, and it walked away without really paying very much. There was a £60 million penalty, but, given what the contract said, it got off extremely lightly. It was glad to be out of it, which, given how much Government work it does, was an eloquent comment on the state of the programme. You then came along, you were one-fifth of the programme and you took on both their contracts, so you became three-fifths of the NHS. And in seven years you have deployed it in three hospitals and it has caused chaos: in Bury, in Morecambe and in Birmingham Women's. Pennine now, we were told, walks away. And the NAO tells us that if you are to be successful you now have to do at least two sites—two hospitals—per month for the next four years.

Why should we have any confidence that you are going to do this? Having now got your foot in the door and having bought iSoft so you can control it—there is somebody nodding over there, which is always dangerous, but I think this is correct—you are basically using it as a way to control the marketplace. You are going to get yourself into a position where it will be difficult to get rid of you because hospitals become dependent on you, even if they are with old legacy systems, and you will be a monopolist. Is that basically your strategy?

Sheri Thureen: To be clear, for the 50% of the programme that is not Lorenzo, we have implemented over 1,800 solutions. For the portion that is the Lorenzo side, we have implemented Lorenzo in 10 Trusts to date—

Q52 Mr Bacon: Yes, this is a bit of a red herring, isn't it, because you are talking about release 1.0? I mean, that is so basic that it is a red herring. You have done it in three, nearly four, and then Pennine basically told you to take a running jump. It is really three, isn't it, not 10?

Sheri Thureen: Look at some of the clinical benefits that are coming out of Morecambe Bay today, where last month it was able to issue 1,800 immediate discharge summaries directly to the GP. That came right from the acute system into the GP system with a standard set of information, and it was delivered on the next business day. This is something that the GPs have been asking for for 10 to 15 years. So I do believe that for the Lorenzo system the core part of the solution is available, it is in production and it is very much starting to prove out the benefits.

Q53 Chair: One more question, then I am afraid, Mr O'Connell, we are going to have to ask you some questions.

Patrick O'Connell: That's okay.

Sheri Thureen: Come on in.

Q54 Chair: Sorry about this: this is one of the worst examples that we have had to deal with, I am afraid, of very, very questionable value for money for the taxpayer. The final question: what I just do not get is that you said in 2003-2004, "Lorenzo is ready to be rolled out". We are now in 2011, where you are sitting here arguing with Richard, and probably me, about the readiness of Lorenzo, even in the very limited sites in which you have introduced it. I just do not understand, first, how you have managed to have those years and years and years where you have failed to deliver, and, secondly, what on earth gives you the confidence that you could deliver it between now and 2016 even in a more limited range of sites.

Mark Davies: Chair, can I just offer one word here? The contracts were put in place in 2003 to 2004. Concerning delivery of those contracts—whether it was BT or anybody

else—they were due to be all in place by 2007, with full implementation in 2010. So there was a bit of time to get it developed.

Q55 Chair: Just answer that very briefly, and then I think we have some questions for Mr O'Connell.

Sheri Thureen: As I said, part of the programme, however, delivered the 1,800 systems. On the Lorenzo side, we absolutely acknowledge there were delays in the development.

Q56 Chair: Huge, crazy, crazy. I mean, you have just called them delays. You know, this is amazing stuff. This is not a year or two, which is pretty awful.

Sheri Thureen: So we acknowledge those delays; some of those delays were as a result of issues we had with our supplier, where we had to step in to address them on their financial and managerial issues, and as we have already talked about we are now in the process of acquiring. We also had to adjust for the complexity of the NHS, so we have moved to a more modular approach, and to allow more configuration at the local level, so it can address the unique needs of the Trusts.

Q57 Chair: Why did you not suggest that in 2002 to 2003 when you signed the contract? That is one of the things that hits me in the face: why did you not suggest that then? You might have had something deliverable then.

Sheri Thureen: As is not uncommon in programmes of this type, the initial development and deployment goes through an early adopter process, and it is really not until you have got to that point where they have exercised the solution that you have a true understanding of whether or not the usability and the capability of the system are there.

Q58 Chair: I have to say to you—I will do it as a comment, because otherwise we are going to run out of time—that is a scary comment to make, because what it suggests is when Government signs a contract for a policy such as this, it is almost writing an open cheque, because you are not signing for a clear specification. And therefore, even with £11.5 billion—I can't remember what the figure was—you start off knowing you will not deliver, and that is what you are actually telling us. We signed an open cheque with you in 2002-2003.

Sheri Thureen: I am not saying that. We signed a contract that identified—

Chair: Which was undeliverable

Q59 Mr Bacon: One quick question: it is true though, isn't it, that CSC knew in February 2006 that Lorenzo was a complete dog? Scott Logan wrote a report—it was an Accenture and CSC joint review of Lorenzo—which said, "There is no well defined scope and therefore no believable plan for releases". You have known that Lorenzo was hopeless for over five years, have you not?

Sheri Thureen: I am not aware of that particular comment. I have talked about acknowledging that there were delays and that we did have to step in with iSoft to address both financial and managerial issues, which we did do.

Q60 Mrs McGuire: One very quick question: I have read your—what we would call—CV, and it is very impressive. And I am just wondering whether or not you are happy to sit here in front of this Committee and defend millions of pounds of taxpayers' money going in on the basis that 1,800 discharge statements have been made in Morecambe, because that, frankly, is what is coming across.

Sheri Thureen: Well, I think that is just the beginning of the benefits that are coming out of Lorenzo, but we have implemented 1,800 other programmes. We have 20 million electronic patient records that are providing real value today, and that is the direction that this programme was going; it was to put the electronic patient records in place.

Amyas Morse: Can I just ask you? You are renegotiating at the moment, and I do not want to enquire into the details of that, but is that renegotiating because you cannot really deliver what was originally planned, or because there is not enough budget to cover it? Which one of those is it?

Sheri Thureen: I believe we have a joint understanding that the contract as it stands today is not working for anyone.

Amyas Morse: So it cannot really be delivered the way it is now?

Sheri Thureen: There is a demand portion of that, and there is a delivery portion of that, and I think what we have said is both of those—the demand and the delivery—are not working for either side.

Q61 Chair: I am going to move to BT. On page 24 of our Report, Figure 9, it shows the renegotiation of the contract with you in 2010. It is about £1 billion. You are going to be delivering some sort of IT into just over 50 settings. That, in my very crude reckoning, is £20 million a setting, and some of that is off the shelf RiO stuff. How on earth can you think that is value for money?

Patrick O'Connell: I think that CCN3 is value for money and has moved the programme—

Chair: Sorry, I'm afraid you are going to have to speak up. The acoustics are really poor here.

Patrick O'Connell: I guess we think that CCN3 has moved the programme to a position of value for money by moving from a monolithic solution that is centrally led to a moderate solution, to produce localism in health. Even though there has been a reduction in the number of overall Trust settings, it is the same amount of work that is being done differently, in the sense that moving from monolithic to modular is quite a challenge to do, and quite an extensive amount of work. The design is different, the deployment is different, the service is different, the number of domains is different, they bought different kit, the capability is different. So we have changed the game.

Q62 Chair: It might have changed the game, but, at the end of the day, from the point of view of the taxpayer, this investment is going to produce an IT-based system to help better health delivery to patients in just over 50 settings for £1 billion. That is crudely £20 million per setting. Is that value for money?

Patrick O'Connell: Well, there are actually over 100 major systems in BT's data centres right now; there are 62 RiO systems, there are 15 acute systems, there are 21 PET systems—

Q63 Chair: Yes, but in the end it is a care record. What we are dealing with here, right, is the detailed care record system—part, I accept, of your IT system. You can tell me this—is this figure wrong, Figure 9 on page 24? It basically says £948 million, and then if you look up there you have cut the Acute Trust, you have taken out all the GPs, you have cut the community health services a bit and the Mental Health Trusts, and you are using RiO, which I understand is an off-the-shelf, rather cheapish system, for most of it. So we—the

taxpayer—are spending nearly £1 billion to get an IT system to support healthcare in just over 50 healthcare settings. Is that value for money?

Patrick O'Connell: I think the benefits the system is producing are equivalent to the value for money that you started out with before: it is rearranged into a different setting that will not only produce value for money, but will produce more value for money going forward. The modular systems, and the ability to configure the systems today, allow the clinicians and the administrators to tailor their systems to move their systems in a way that is required by clinical care today.

Q64 Chair: If you were sitting in the Department of Health as the official, would you sign a contract that meant an investment of, on average, £20 million to get to where we are going to get to by 2016?

Patrick O'Connell: Knowing what I know, yes. I think it is value for money.

Q65 Chair: You think that is value for money?

Patrick O'Connell: It is.

Q66 Chair: Is it value for money for the new contract that you have signed for those bits of the South for which you are now responsible, where the cost is 47% higher than it is for this, for me, extraordinarily expensive contract for London? So the costs in the South are 47% higher.

Patrick O'Connell: No. I think the South is value for money, but I think we are mixing what I will call some significant one-offs with business as usual. When BT went into the South to take over the Fujitsu sites, there were significant one-offs that have added to the cost of the entire programme in the South, for example—

Chair: Well, I assume somewhere in this the taxpayer has also had to pay Fujitsu for something. So that's not incorporated. They are still arguing in the courts, aren't they?

Mr Bacon: Not in the courts.

Chair: They are still arguing over that. So your cost is on top of a sunk cost to Fujitsu?

Patrick O'Connell: I am not familiar with Fujitsu's story, but we had to take over the Fujitsu sites in situ and move them to the BT sites; we TUPE'd their people over, then we did the business-as-usual upgrade. If you take a look at apples to apples, the cost in London is higher than the cost in the South, as you would expect it to be, and it is value for money. It was a unique circumstance in the South.

Q67 Ian Swales: I would like to explore the basics of this. I am sure that—I do have some experience in this field, by the way—the people in this room could design the systems that we are talking about here in a few days. In fact, they probably could not, because there are probably too many people in this room, and I think that is part of the issue that I see with these NHS IT systems: we seem to have built this massive superstructure that is never likely to deliver clear, simple, straightforward systems to the NHS.

My question is that I do not think this is really so much a software problem as a management problem, and I would like to know your views on how the costs have ramped up here in terms of how clearly the programme has been run and how clearly the customer interface has been operated. I am not sure why the DoH actually made it so complicated at the start, but presumably it is getting ever more complicated as every Trust treats itself as different, every doctor says, "I am different from the doctor down the hall." And I would like to know your views about the management of all of this—not the software, but the

management of the programme—because, let us face it, that's where most of the money is. The software costs are quite trivial in all this, we know that, or they should be anyway, with today's technology.

Patrick O'Connell: You mean the BT management of it?

Q68 Ian Swales: The management of the project—yes, the BT management, the CSC management, and how you see the management by the Department and by the Trusts, and so on, because that is where most of the money must be in all this. It cannot possibly be the software; a teenager in their bedroom can automate an e-mail from one system to another, or to a mobile phone; all that is trivial these days. This is about the management of some kind of superstructure that is going wrong—badly wrong.

Patrick O'Connell: I think it is more than that. Maybe we have not done a good job of explaining the complexity. This is a huge, huge; it is considered the largest civil IT programme in the world. The Spine, the N3, the LSP—there are three different parts there. There is a huge amount of industrial-strength robustness, availability, disaster recovery, that you cannot get someplace else. This is quite an unusual—

Q69 Ian Swales: This has never been attempted anywhere in the world. Neither of your companies has ever done anything like this in the world.

Patrick O'Connell: No. This is entire—

Q70 Ian Swales: So were we right to ask for it, then?

Chair: I don't think Mr. O'Connell would have signed the contract in 2003, from what he said earlier.

Patrick O'Connell: I think the company believed the contract was executable in 2003, at that time.

Q71 Ian Swales: Can you answer my question? The management from the public sector in the UK and your companies, the interface in that—how well has that been going, and how much has it been the source of the cost and the delays in this project?

Patrick O'Connell: I do not think that is really the issue. I think that, if you are asking about the NHS staff, we have found them to be professional, committed, dedicated, and to have worked extraordinarily hard to try to advance healthcare in a very evolving and changing environment.

Q72 Ian Swales: So the delays are all down to your companies, then?

Patrick O'Connell: No, they are more than that. It is the need of the users and the community. The users and the community today, the clinical people today, want a modular system: they want to be able to do it. They want a domain per Trust. I do not know if you know what a domain per Trust means.

Q73 Chair: Why did you not know that in 2003?

Patrick O'Connell: In 2003 there was only one domain. There was only one domain ordered in 2003.

Q74 Chair: Yes, but presumably the user community at that point wanted the same sorts of things as it wants today. I do not think clinicians have changed.

Patrick O'Connell: Today we have Facebook, we have Twitter. In 2003 there were only so many possibilities with technology. Today, 2011, with Facebook, all these things, more possibilities—

Q75 Stephen Barclay: That does not explain the lack of basic management information. I mean, the Report says at paragraph 9 on page 7: "Our findings are presented in the context of a lack of clarity between the Department and its suppliers about basic management information." This is notwithstanding the £820 million spent on project management. What is your view as to why there is such a basic lack of management information?

Patrick O'Connell: There is not a basic lack of management information on our part. I think that we work well with the NHS; we reconcile our figures. One of the things you have when you look at figures from other folks is that you have economic conditions, and the fact is that I happened to work in 2009 to 2010 and many Reports were done in 2004. Secondly, when you look at the average cost, there is no average cost because every Trust costs something different. The arithmetical average is not really a measure of the cost. Thirdly, there are things such as one-offs, and then there is business as usual. In the South there were a lot of one-offs. There were three different things—

Q76 Stephen Barclay: With respect, you are not answering my question. There may well be one-offs, but, as the Report says, "For example, information, we"—the NAO—"received from suppliers on Friday 13 May does not reconcile with information provided by the Department the previous day." So you have a situation where the Department is sending information on 12 May, which is different from the information provided the following day by suppliers. Would either of you like to comment on that?

Patrick O'Connell: I think, from a BT standpoint, we have no issue in terms of reconciliation of our numbers with the NHS. It could be that the questions that were asked in terms of two different people asking two different questions, but our numbers reconcile with the Government's.

Q77 Stephen Barclay: So the NAO has failed—

Q78 Mr Bacon: Did you just say your numbers reconcile with the Government?

Patrick O'Connell: Sorry, with the NHS.

Q79 Mr Bacon: Because we were getting the distinct impression that that is not the case. The Department last week was giving the numbers to the NAO, and the NAO was then going to you and saying, "What do you think?" And BT was saying, "We do not recognise those figures". Mr Davies, would you like to comment?

Mark Davies: That is correct. That is absolutely correct.

Patrick O'Connell: I accept the fact that we do not recognise some numbers from the NAO; I was making a comment—

Q80 Mr Bacon: No, the NAO is merely passing on the figures given to it by the Department of Health. Let us be clear about that. Am I right Mr Davies?

Mark Davies: Yes, absolutely. Our figures were sourced from the Department of Health.

Q81 Stephen Barclay: Does that not raise questions over the—

Q82 Mr Bacon: Sorry, can I just pursue that? You said a minute ago your numbers reconciled with the NHS. That is not correct, is it? It is not necessarily your fault Mr O'Connell—it may be because the Department of Health is shambolic and you keep good records; that is a possible explanation for this—but it is not the case, is it, that your version of events and the Department of Health-CFH version are the same?

Patrick O'Connell: The BT numbers and the NHS numbers, in the way that we discuss the numbers, work. As people do a lot of "what ifs?" to me, there is a chance that some of the numbers would be out of context. So out of context is a likely case in the complexity.

Q83 Stephen Barclay: But if there is a lack of clarity on basic management information does that not raise questions over any renegotiation?

Patrick O'Connell: If that were true, yes. But I think, as I said earlier and I repeat, that our numbers were reconciled with the NHS.

Q84 Mr Bacon: Mr O'Connell, I just wanted to ask you briefly about RiO. Could I ask you to turn to page 29 of the Report? You will see there that it says the delivery of RiO at Mental Health Trusts and the community health services, including service management, until 2015 is £224.3 million. That is for 25 sites, isn't it?

Patrick O'Connell: Yes.

Q85 Mr Bacon: So that works out at £8,972,000 per site. That is right, isn't it?

Patrick O'Connell: It depends on the economic conditions; you usually guess about right.

Q86 Mr Bacon: But basically just under £9 million per site. Now, it says in paragraph 3.14 on the next double spread, on page 31, that in London, "Prior to the Department agreeing for RiO to be provided as the strategic solution for 37 sites in London, BT purchased software and services from the supplier of RiO in 2006", and I have just checked this with the National Audit Office, "amounting to £46 million". That was for 37 sites, and it cost £46 million. That is about £1.24 million per site there; £8.9 million per site for the 25 sites in the South on the previous page. Try as I might, I cannot find a way to account for the discrepancy between the two: you are charging the taxpayer nearly £9 million per site for something that costs less than £2 million and a bit above £1 million, depending on the circumstances, to deploy. Why?

Patrick O'Connell: That is the part of the numbers that I cannot reconcile. By my own numbers, we charge basically £8.5 million, roughly, in London for a RiO site; we charge £6.5 million in the South for a RiO site. If one does apples to apples—the reason I say apples to apples is because what is required in London is a little bit different, and the reason the South is cheaper than London is because things such as programme management are not duplicated—from my standpoint, our costs are relatively straightforward. They follow the basic idea that the second time round should be cheaper. They have been audited by Ernst & Young, they have been audited by Gartner, they have seen OGC assurance, so our costs are reasonable. Part of the issue is that costs often get taken out of context.

Q87 Mr Bacon: With all these different things you are talking about—the domains and whatnot, and the programme management—you are asking us to believe that the cost of that is something like £6 million or £7 million, between the roughly £1 million to £2 million it costs to go out there and buy RiO and what you are charging the Government?

Patrick O'Connell: To buy a RiO á la carte, and buy it in the package sense, are two different things. You buy it á la carte, you buy it from somebody in a pub, you are not going to get—

Q88 Mr Bacon: You are not going to buy it from somebody in the pub; you can buy it directly from its supplier, CSC Healthcare, which makes it. You can buy it directly from it, can you not?

Patrick O'Connell: Yes, you can—

Q89 Mr Bacon: And they do not charge £9 million do they?

Patrick O'Connell: That is an á la carte offering. We are having a package offering. If you add disaster recovery in, if you add the things in that are required for this programme, you get to the cost that it costs us.

Chair: Á la carte means it costs more; it is not less.

Q90 Mr Bacon: I have just met with CSC Healthcare, and they tell me that it varies, of course it does—

Patrick O'Connell: Of course.

Q91 Mr Bacon: And companies are always sensitive about their costs, as well. But they confirmed to me that for a typical Mental Health Trust—not a very, very, very small deployment, and not an enormous unusual one, but a typical run of the mill deployment—a number somewhere between £1 million and £2 million, depending on the bells and whistles, including, typically, five years of service and support, would be typical. You are charging £9 million and no matter how you cut it, no matter which bells and whistles you pretend to add on, or which number you divide it by before adding the number you first thought of, it is impossible to me to see how you get to £9 million as a value for money number. It just does not make sense. This is a relatively straightforward system.

Patrick O'Connell: No, it does. Disaster recovery, the amount of SLAs that we have to add to it—

Q92 Mr Bacon: I would hope there was disaster recovery anyway. I mean, this is standard; everybody has disaster recovery if they have any sense.

Patrick O'Connell: No, they do not. They have backup. Backup means that within some weeks you can stand a system up; disaster recovery means that in two hours you are back and up running just like it was before with no data lost. It is a very industrial strength, highly robust system with significant failovers in it—

Q93 Chair: Which justifies that scale of difference? We are going to have to move on folks, so I am just going to ask you what I asked Ms Thureen: how much have you been paid so far under the contract?

Patrick O'Connell: Approximately £2.8 billion.

Q94 Chair: How much is left as contractually committed?

Patrick O'Connell: Approximately £1.3 billion.

Q95 Chair: And how much do you reckon is the value of the work you have done so far that you're owed?

Patrick O'Connell: I am not sure about that. I do not want to guess on that, so I would prefer to—

Chair: Are you bidding for the other South contract, the second contract to deploy some sort of IT in the South? We haven't covered it all.

Patrick O'Connell: Well, we have a contract with what is labelled the greenfields.

Q96 Chair: One—and then there is another contract, which needs to be let pretty soon if it is going to be delivered by 2016.

Mark Davies: The ASCC

Patrick O'Connell: That is competitive. But the greenfields was a—

Q97 Chair: And are you bidding for the competitive one?

Patrick O'Connell: Some elements of it, yes.

Chair: Thank you.

Q98 Mr Bacon: Can I very quickly ask Ms Thureen, you mentioned 20 million records?

Sheri Thureen: Yes.

Q99 Mr Bacon: What system are they on?

Sheri Thureen: TPP.

Q100 Mr Bacon: Is that the GP system?

Sheri Thureen: GP and community health services.

Q101 Mr Bacon: Yes. So those 20 million are not hospital records—that is correct, isn't it?

Sheri Thureen: Community health services connected to GPs.

Q102 Mr Bacon: They are not hospital records?

Sheri Thureen: They are not acute.

Q103 Mr Bacon: That is what I meant—they are not hospital records?

Sheri Thureen: They are not acute.

Q104 Chair: Thank you very much. We will move on now.

Examination of Witnesses

Witnesses: **Christine Connelly**, Director General for Informatics, Department of Health, and **Sir David Nicholson KCB CBE**, Chief Executive of the NHS in England, NHS, gave evidence.

Q105 Chair: Welcome to you, Sir David, and welcome to Christine Connelly. I just want to contextualise how we are going to deal with this afternoon. This is a programme that was launched in 2002-03. It was a programme the aim of which was to improve the quality of care, in case we forget that, by a radical change in the use of IT. As I understand it, central to that was a fully integrated care record system, which you wanted, or intended, to be available to all, in all settings, at all times, right? And I think we all accept that that is a very worthwhile ambition, which probably has proved beyond the capacity of your Department to deliver. Now, what we are going to try and do this afternoon is firstly look at why you cannot achieve that aim that you had in 2003; secondly, your progress in delivering to date; and, thirdly, the future. Just to say to you, I think we all understand there are other issues around the detailed care records system where you have delivered. So we are taking that as read and do not want to go back to it—the broadband and the electronic delivery of x-rays and scans.

We are trying, in the time available this afternoon, just to focus on the care record system. Is that okay?

Context. So I am going to start you off, take your pick who answers: was the vision too ambitious?

Sir David Nicholson: Having an integrated care record for patients in the NHS seems to me a laudable ambition, and, as you know, at the time a huge amount of work was done around working out how you might put that into practice. I think the issue with the way that the programme was set up was there were some big risks in the middle of it, and I think what I would say is that since then you have seen the working through of those risks in the way that we have tried to manage and adapt that vision to the circumstances that we found ourselves in over time. So, two examples: the first one is that part of the vision was to have a standard, relatively inflexible product, for the acute hospitals, that would essentially be implemented across the whole country, acute hospital by acute hospital. That has proved, right from the beginning, to be very, very difficult to do, and no doubt we will go through the reasons why it was—

Chair: Impossible, impossible.

Sir David Nicholson: Very difficult to do. And, indeed, if you look at the way we have tried to manage the programme since then, we have been trying to move from that very top-down approach to the delivery of the programme to one where the individual Trusts and clinicians are in the lead, and many of the decisions that we have taken have been a part of that process. And the second bit, which has been the risk that we have dealt with, is that for quite a lot of the service in the acute sector—I think you are absolutely right, the acute sector is about 20% of the totality of the programme, so we have 80% of the programme over here—the product to meet the specification we set out did not exist. So going into a process where there literally is not a product to deliver it is inherently risky, and those two things that started off in 2002 at the heart of the programme have been, in a sense, what we have been managing and trying to get into the right place since then.

Q106 Chair: So I take that to say you should never have signed the contract in 2002?

Sir David Nicholson: No, I am saying that—

Q107 Chair: It is a lot of money; it is a heck of a lot of money. I will just do you a crude stat—we all do our little crude things: £1 billion buys you about 20,000 nurses. That is what we are talking about.

Sir David Nicholson: No, no. Absolutely, but the point I would make as well is that the total amount of money we are talking about now spending on the programme is less than we were talking about the last time.

Q108 Chair: Sorry, I got that wrong—it is 50,000 nurses. We are talking about £4.3 billion buying you over 200,000 nurses.

Sir David Nicholson: I cannot remember the point I was trying to make. Oh yes, as we sit here today, the amount of money we spent on the programme, projected, is less than we were when we sat here last time at the Public Accounts Committee. It is £11.4 billion we are talking about now, as opposed to the £12.6 billion at the time. So it is less; we are projecting less money now.

Q109 Chair: But you are never—

Sir David Nicholson: We spent about 20% of that resource on the acute sector. The other 80% is providing services that literally mean life and death to patients today, and have

done for the last period. So the Spine, and all those things, provides really, really important services for our patients. If you are going to talk about the totality of the system, and you have just divided one by the other, you have to accept that 80% of that programme has been delivered.

Mark Davies: Can I just make a point here? That we are focusing on the care system here.

Chair: Care system, yes.

Mark Davies: We have spent £2.7 billion, and the estimate is another £3.4 billion—

Chair: It is a £7 billion programme.

Mark Davies: We have spent on the care records system.

Chair: Please, because we can talk about Spine and all that stuff—

Q110 Mr Bacon: Sir David, the title of this Report that we are taking evidence on is "An update on the delivery of detailed care records systems", not something else. So let us talk about detailed care record systems, shall we?

Sir David Nicholson: I am absolutely happy to do that, but if you are going to use the total amount of money—the £12.6 billion—let us talk about it.

Q111 Mr Bacon: You are right, let us concentrate on the £2.7 billion and the £4.3 billion.

Sir David Nicholson: Fine.

Chair: So, £4.3 billion, just to say to you, buys you 200,000 nurses.

Q112 Stephen Barclay: Sir David, your Health Minister called this an expensive farce on the radio last Wednesday. Do you agree with your Minister?

Sir David Nicholson: I think in terms of trying to deliver a top-down programme, spending huge amounts of taxpayers' money for no benefit, anyone would describe something like that as a farce. The particular position we are talking about here in relation to the local service providers and that contract is, I think, moving us towards a position where we will be able to deliver value for money for patients and improvements for them.

Q113 Stephen Barclay: Who is the senior responsible owner for this project, and when were they appointed?

Sir David Nicholson: Me.

Q114 Stephen Barclay: And when did you become the SRO?

Sir David Nicholson: Sometime during the end of 2006-07.

Q115 Stephen Barclay: Right. And how much time do you spend a week, would you say, as the senior responsible owner on this project?

Sir David Nicholson: It would vary, depending on where we were, because there are some parts of the programme where I would spend a lot of my time on it, when we are renegotiating.

Q116 Stephen Barclay: Absolutely, but since 2007, on average how much time would you say as SRO?

Sir David Nicholson: That is quite a difficult thing for me to calculate. I would have to go back.

Q117 Austin Mitchell: You said, Sir David, the problems came from the middle range, but surely they were implicit from the start, because this project was rushed into. The Prime Minister was very keen, the delivery unit was very keen, it was very fashionable to computerise things like this. An appendix indicating the cost would be £5 billion was missed out of the original report as published, so you have a very high estimate there in the first place. Then, Richard Granger, the Director of IT, rushed through, without consulting the professions. This was a kind of computer enthusiast's bit, was it not? The professionals who were going to have to work it were not consulted, because consultation would have made it clear that they were going to ask more from it and expect more from it, and then contracts for £1 billion were let pretty well straightaway, in May 2003. That was very quick. Now, why were the contracts let before the professionals were consulted?

Sir David Nicholson: Well, we had to start the work, and we had to start to work with suppliers to get us into a place where they could start to deliver.

Q118 Austin Mitchell: But you would not know what you were going to deliver on unless you had consulted the professionals.

Sir David Nicholson: Well before the specification was delivered to the contractors there was consultation with the professions, albeit certainly in hindsight not enough.

Q119 Austin Mitchell: Well, the professionals say not, and you have had to cut down what information is required to a simplified form of five pieces of information instead of the wider range of information, and the profession is still not agreed on what those five should be.

Sir David Nicholson: No, absolutely. As I said right at the beginning, this idea that you could have a one-size-fits-all to every hospital in the country, I think, was a massive risk for the programme to take at the beginning, and it has proved unworkable in that sense.

Q120 Chair: Can I put it on the record that we are not going to get a care records system that is available to all, at all times, in all NHS settings. Yes or no? No?

Sir David Nicholson: No. We will get what you have just described, but, of course, it means different things to different people. So, for example, what you will not get is one type of medical record which covers everything, for everybody in the country, available everywhere. You will not get that, you absolutely will not get that. You will get different mechanisms in different parts of the country, because that is, in reality, where most of the requirement for clinical information is. But on top of that you will get the summary care record, which will do exactly what you have just described. So in an emergency, anywhere in the country, at the end of this process, your doctor, your physician, will get access to some basic information about you to enable you to be treated safely.

Q121 Chair: But we will come back to the summary record—£180 million out of £7 billion.

Christine Connelly: Could I perhaps add something to that description in terms of what we will get from this? We will get lots of locally owned information that is owned by the clinicians who go through their working practices, and we will have an infrastructure that connects those sources together, as opposed to drawing all the data out of that and putting it into some big, single system. So the shift that we have made is to move away from an idea of a very small number of very large data sources to a networked environment where we have many data sources that will fit particular standards and will technically be capable of joining together.

Q122 Chair: But that was not the purpose of the system.

Christine Connelly: I guess it is whether you describe the purpose of the system as the technical architecture that delivers it or the purpose to provide the information to the clinician.

Chair: No, the purpose of the system was what everybody says: if you are in Barking or Bournemouth or Birmingham, whichever setting you end up in, they have access.

Q123 Ian Swales: It is about driving choice as well: if I want to have my knee replaced in my local acute hospital, I expect the records to be available if I go and have it done in the next town or the next county. That was the original idea.

Christine Connelly: Certainly, and the architecture that we are working with will allow that to happen. It is not an expectation that your data will be trapped on a particular site. The question was asked earlier, why was that not the architecture in 2002?

Q124 Ian Swales: So it is one system?

Christine Connelly: No. It is not a monolithic system. It is a networked architecture where forces will exist around that network, and the ability to join them together will be there. A key requirement of that is that all the systems identify you in the same way, and the piece of data they will use for that is your NHS number. So, as long as the system that is holding your record identifies you with the same unique identifier as any other system, the technology will be in place to join that together. And the question was asked earlier as to why we did not do it that way in 2002. In 2002 the maturity of the technology to allow those connections to happen at the level of risk that the Health Service could accept just was not there. So an alternative structure about large data stores—half a dozen or so of them that would be joined up—was the way forward. By 2011, or certainly by 2009-10, when we were looking at this again, we said, actually, the technology had moved forward.

Q125 Chair: Hang on a minute, this system was supposed to be in place by 2007. I am going to ask everybody, although I know it is really irritating, because everyone wants to talk—let us keep tight, tight, tight, or we will be here all evening.

Amyas Morse: Can I just say, to avoid being misleading, in fact the plan is that local Trusts will get issued with a connectivity toolkit that they need to make work. Is that not right?

Can I just ask you something, Sir David? Sorry, just before we get away from the broad picture, it must put you in a very difficult position when you start with a very ambitious contract and you then have to negotiate, so to speak, downward with the providers all the time. So you have actually already contracted for a very substantial delivery, a lot of money, and then you are always having to try and modify and negotiate down. Does it not put you in a position where it is very hard to walk away, or to, sort of, draw stumps and start again? Does it not put you in a very tough position to have started with that hand of God?

Sir David Nicholson: Well, there are two bits of answer to that. The first one I am sure I should not say, but I will do anyway, which is, most of it is actually working fine, and actually the contracts have worked, and we have delivered on time and on budget. On the bits that you are particularly talking about, one thing I would say about it—the thing that we have always had in this contract, which is really, really important for us—is that you do not pay unless delivered. So the bit of the environment you did not talk about is the fact that we pay when they deliver.

Amyas Morse: What happens if you cancel?

Sir David Nicholson: Absolutely right that, in a sense, what we committed to in 2002-03 is to work in partnership with BT, with CSC and the other people during that period,

and we do work together; we work closely together to enable it to happen. If I felt at any time that we were unable to get value for money out of that, we would clearly look seriously at the option of cancelling the contract. Any sensible people would do this.

Chair: We will come to the future. I am trying to get people to focus.

Q126 Mr Bacon: Just very briefly, before you do, Sir David, you said something I did not hear. You said most of it is working fine.

Sir David Nicholson: Yes.

Q127 Mr Bacon: What is "it" in that sentence?

Sir David Nicholson: The Spine. All those things that I am not allowed to talk about.

Q128 Mr Bacon: It is a Report about the detailed care record, isn't it?

Sir David Nicholson: Yes, I know, but Amyas was talking about the contracts as a whole, so I was just making that clear. So the idea that we cannot run a contract—we can, and there are lots of good examples.

Q129 Ian Swales: Can I ask how you feel about the number of professionals you had on your side of the desk, or the table, when these contracts were being put in place, and how you feel about the fact that much of the software you were contracting for did not exist, and you are now getting some software that was judged inappropriate at the time, some half-baked software, some that will never be completed? How do you feel about the contracting that you did at the start, and the risks that you were taking? Did you have the right professionals on your side of the table?

Sir David Nicholson: Clearly, based on the evidence of what we have seen, doing it in the way that you have described added to our risk. So if you are asking me do I wish we had had more clinical buy-in at the beginning of this process, of course I wish we had had more clinical buy-in, and it would have made it easier to deliver the products.

Q130 Ian Swales: That was my other point, the clinical buy-in. To what extent do you think that we have now allowed open season in all the different areas, to the point where the IT suppliers can now go in treating each new setting as a clean sheet of paper, and charging us an arm and a leg for doing so?

Christine Connelly: So I think it is important to understand that we did a large engagement exercise in the middle of 2008 following on from the Next Stage Review that went out and talked with large numbers of clinicians about what they wanted from their IT systems. What came back was a very rich set of requirements that we then looked at, which we talk about as the Clinical Five. Because there are five things and five headings, we should not think of that as five cells in Excel. It is not that level of functionality. So that was a very large exercise. We have since then used that as a significant input to look at the scope of the contracts that we have, focusing our suppliers on delivering the Clinical Five, plus some other key departmental systems—things like maternity—that are critical policy areas for the Government, but did not come up through that exercise.

When we did that, we then looked at the delivery mechanism that we had in the contracts, and we have to balance up this idea of consistency through that delivery and local configuration, and we are very clear that we talk about local configuration and not software customisation. So we do not drop into the product and change it. We configure the product, making use of the capability that came with a product like Cerner. When we do that, if we look at the way we are doing that in London, we have created a menu of modules that a particular Trust can then look at and say, "These are the things I want and in this order." We

have managed now to put into the contract all the Cerner product, which was not there before. We then get to a situation where a particular Trust configures the product for themselves, and places that configuration in a configuration library so that when the next Trust comes along, the first place that they go is the configuration library, so they start from that place and then say, "If I am going to take this module, which is the same as the module that the Royal Free took; if I am going to take that module, which is the same as the module that Kingston took. By taking them together, do I need to do something slightly different, because they did not take it in that mix?" And then from there that would go back into the configuration library.

Ian Swales: But the consultation was five years too late, that is the only trouble.

Q131 Chair: Ian, I am trying to keep this in an order. First, before we get to the operability, Anne is this on this?

Q132 Mrs McGuire: Yes, it is on this. Sir David, on I think about four or five occasions you have mentioned the word "risk"—"big risk" and so on. Can I ask you, what risk assessments were actually undertaken before the contract was placed?

Sir David Nicholson: Yes. I am sure that if you look at the documentation there is extensive risk assessment done around it, but the big issue is payment by results. In a sense that was the bottom line in all this. We do not pay until we have a functioning system in place.

Q133 Mr Bacon: Can you tell us what the total value of the advance payments has been through the life of the programme?

Christine Connelly: No. Advance payments run during a year, and then they all get called back to the Department at the end of the year.

Q134 Mr Bacon: I was not asking you about when they get called back; I was asking for the total value of advance payments. You have just said you only pay for delivery; advance payments are something different from that. What is the total value of advance payments that have been made during the course of the programme?

Sir David Nicholson: I have not got that piece of information.

Christine Connelly: No, I am sorry; we do not have that with us. But in terms of what an advance payment is—

Q135 Mr Bacon: It is at least £443 million, isn't it? And that is a very old figure. Actually, to pursue the point that you were trying to make with Mrs McGuire, it is not actually true to say you have just been paying for delivery, is it?

Christine Connelly: It is true that we have only been paying for delivery; what an advance payment is—

Q136 Mr Bacon: In that case, why were you making advance payments?

Christine Connelly: Perhaps I could explain what an advance payment is.

Q137 Chair: Very quickly, please.

Christine Connelly: Thank you. So it is an amount of money—

Q138 Mrs McGuire: I want to deal with this issue of risk and what efforts were made to evaluate risk at the beginning of the contract, not with the retrospection we are hearing just now, very admirably, from Christine Connelly.

Christine Connelly: Chair, so an advance payment is an amount of money that goes to the supplier that is covered by a bond. If the supplier does not meet their deliverables within that year, the money comes back to the Department. If at any time during that year the supplier fails to meet any of the criteria set by the Treasury or ourselves, the bond is called back.

Chair: Right, risk.

Q139 Mrs McGuire: Perhaps Mr Bacon might come back to that. Who undertook the risk assessments?

Sir David Nicholson: The Department of Health will have done that.

Q140 Mrs McGuire: What professional technical advice—not clinical advice—did the Department of Health, who were pretty new into this game, frankly, take on board when they were undertaking those risk assessments?

Sir David Nicholson: I have not got that detailed information with me, but there was extensive technical advice, from consultancies and others.

Christine Connelly: During the original procurements third-party experts were included, and in particular KPMG, Gartner, and Partnerships UK were consulted on the original procurements. So they were the third-party people who came in.

Q141 Mrs McGuire: I think you may well just have destroyed the reputation of the organisations that you have mentioned given the situation that we are facing now. Were Ministers made aware of the risk? Everybody who has dabbled in technology thinks it can do wonderful things, but we have just been told by one of the previous witnesses here today that this is the biggest IT project in the whole world, if not the universe, yet we appear to be in a situation where, if a risk assessment was undertaken, it certainly does not appear to have been particularly valid.

Sir David Nicholson: Well, those risk assessments were taken, I can absolutely assure you.

Q142 Mrs McGuire: Were Ministers aware of the risks?

Sir David Nicholson: Ministers would have been aware of those risks.

Q143 Mr Bacon: Sir David, can you remind us, what was the risk score in the original document, "21st Century IT"?

Sir David Nicholson: I have not got that.

Christine Connelly: I have not got it with me, sorry.

Q144 Mr Bacon: It was 53 out of 72, which makes it very high risk.

Sir David Nicholson: Right.

Q145 Mr Bacon: That was in one of four appendices, and I do not know if the Ministers saw the appendices, but in the published version, can you confirm that there were not four appendices, only three, and that the risk profile was removed? Can you confirm that now?

Sir David Nicholson: I cannot confirm that.

Q146 Mr Bacon: Why not? I mean, you ought to know this; you have been living and breathing it for five or six years, and you have been the SRO since 2006. Why not? You should know this stuff. I do, and I have 50 other things to do. I look at a lot of other projects;

this is just one of them. The members of this Committee, who just joined the Committee since May last year, have done 40 or 50 hearings on 40 or 50 different projects. I happen to be rather long in the tooth and I have been here for 10 years, so I have done probably 400 or 500. I remember your becoming the Senior Responsible Owner, I remember seeing "21st Century IT", which was produced by Sir John Patterson after the February 2002 breakfast meeting where he was given 10 minutes to present, and he was asked how long it was going to take, and he drew his breath, and he said, "Maybe three years". And the Prime Minister of the day said, "How about two?" This is what happened, and you are telling me you do not know the risk score? Why not?

Sir David Nicholson: No, you have asked me whether I knew whether the risk score had been taken out of the final document.

Q147 Mr Bacon: Actually, I asked you what it was. With respect, my first question was, what was it?

Sir David Nicholson: Yes.

Q148 Mr Bacon: You said you did not know, and then I got on to, did you know that it had been removed?

Sir David Nicholson: I did say that I thought the system and the contract were high risk, and you have reinforced that by what you have said. So I knew it was risky—

Q149 Mr Bacon: But it was hidden, it was concealed—

Sir David Nicholson: When I took it on. What I did not know—

Q150 Mr Bacon: My point is just how risky it was was concealed at the inception.

Sir David Nicholson: I cannot comment on that.

Q151 Chair: I want to move this on to the actual programme with Stephen. I just want to ask one final question, because we are still on the purpose. At the end—2016—how many Trusts are going to end up with the full range of functionality as agreed, and as priced, in the original contract?

Sir David Nicholson: It is quite difficult to make that comment on the basis that what we have focused our attention on is the clinical files. That was what the clinicians told us were important in functionality terms for the NHS going forward. Our expectation is that that functionality will be available across the whole NHS. It will be delivered in a whole set of different ways to those perhaps originally perceived in the contract, but will be available to people across the NHS.

Q152 Chair: And what will the benefits be? What has changed? As briefly as you can.

Sir David Nicholson: What happened? The way this particular bit of the system was explained was in terms of what the computer system would look like in an individual organisation. What we found in our conversations with clinicians was it was very difficult to talk about that specification to them; they did not understand it.

Q153 Chair: They should have been in there designing it.

Sir David Nicholson: They should have—well, let us put that to one side. What we said then in those circumstances was, "What are the big clinical benefits that you think you want?" They came up with five big areas they thought were important.

Q154 Chair: What are they?

Sir David Nicholson: The first one is a patient administration system—a system in a hospital which enables bits of your information to go around that hospital and outside it when required and helps you doing appointments, all that sort of thing. The second area is discharges—being able to communicate discharges from hospital to hospital, from hospital to community, from a hospital to GPs, and that coded in a way that you could use your unique identifier, as Christine says, with a diagnostic coding. So everyone would know what your condition was as it went through the system. The third area is order communications—I am looking at you as a patient, I think you need an MRI scan and a blood test, or whatever, I have a mechanism by which I can there and then, on your computer, order those tests and get them straight back to you, so that is the third. The fourth one is scheduling, really important—scheduling outpatients and scheduling operating theatre sessions are really significant. Then the final one was e-prescribing: the ability to be able to prescribe, and for pharmaceutical information to be available. Now, if you add all those five things together, you get, for an individual patient, the potential for an integrated record.

Q155 Chair: Well, you get something. You get something, but it is very different from the original vision.

Sir David Nicholson: You get what clinicians regard as being the most significant sets of information and knowledge for them to make decisions about your care.

Q156 Chair: But not shared from Torquay to Newcastle.

Sir David Nicholson: Certainly to be shared across your local health community.

Q157 Chair: Yes, not shared from Torquay to Newcastle?

Sir David Nicholson: Well, potentially they could be shared between those places. It is absolutely right that you could sit in an out-patient clinic in Newcastle and call up the results somebody had had from somewhere else, but there are a lot of ethical and complicated discussions to be done before we get to that place.

Q158 Chair: Okay. Let us move onto costs and progress.

Q159 Stephen Barclay: You have been talking today about some of the benefits; notwithstanding the concerns of this Committee, you failed to comply with a previous recommendation to produce a benefits statement.

Sir David Nicholson: Yes.

Q160 Stephen Barclay: Why was that?

Sir David Nicholson: All I can say on that is to apologise to the Committee. We said we would do it, and we did not do it. I can talk about the mitigations and reasons for that, but absolutely we should have done it, and we did not.

Q161 Stephen Barclay: So you only produced it the week this Report came out, on 11 May.

Sir David Nicholson: Yes.

Q162 Stephen Barclay: Over a year late.

Sir David Nicholson: Yes. I am sorry, I do not want to give an excuse, and I am absolutely sorry for not having delivered it to the Committee.

Q163 Stephen Barclay: Okay. Is the benefits statement up to date now? Does it run up to 11 May?

Sir David Nicholson: No, the benefit statement that you have is for 2009-10.

Christine Connelly: Yes.

Q164 Stephen Barclay: So it is a year late and it is a year out of date when produced?

Sir David Nicholson: Absolutely. The only mitigation I can say is that we did the work, and we did produce it on time; however, it got mixed up, I have to say, with a whole set of discussions around the new Government coming in, the review of the IT programme as part of that, the major projects review plan and all that. But that is an excuse; we should have produced it, and I apologise to the Committee for not doing that.

Q165 Stephen Barclay: Could we then look at the central programme costs? As of May 2011, they are estimated at a staggering £1.19 billion. How much of those central costs consist of legal fees?

Christine Connelly: Sure. I do not have the number specifically for legal fees. We can go away and find that.

Q166 Stephen Barclay: Perhaps we can have a note on that.

Christine Connelly: Certainly.

Q167 Stephen Barclay: Could you give us a breakdown of that £1.19 billion as you understand it, or perhaps Sir David, as the Senior Responsible Owner, may wish to do so.

Christine Connelly: The major part of those central programme costs are staff that we have in the centre. We have, as a result of the work that we have been doing in the last year, taken out a significant part of those central programme costs compared with the last Report that this Committee saw, where the expectation was that they would be £1.6 billion in total. For the costs still to go in the programme, we have taken out half the internal costs that were here, which is this piece.

Q168 Stephen Barclay: With respect, that was not my question. My question was a breakdown of the costs. What I was hoping for was some broad figures. We have a figure here. I am sure that you prepared for the Public Accounts Committee hearing. You have a figure here of £1.19 billion. It is not an unreasonable question to ask for a breakdown of that figure. Can you give us a sense of what it has been spent on?

Christine Connelly: I shall give you a note of it specifically. The key categories are about our people, our internal staff, our external contractors and consultants. There would be professional fees. There would be the cost of the buildings that those people work in.

Stephen Barclay: Okay, fine.

Christine Connelly: There will be the cost of the IT that they use for themselves.

Q169 Mr Bacon: When you say your external contractors, you mean central administrative cost contractors rather than the contracts?

Christine Connelly: The people that we use to come in and do work in our offices for our work day to day. As a programme of work, we do not use permanent staff to do all the work, because this is not something that will last for ever.

Q170 Stephen Barclay: On that, could you clarify a previous note you gave the Committee? At a previous hearing we discussed spending on consultants. You will recall

that the Department of Health is one of the two highest-spending Whitehall Departments on consultants. In your note to the Committee, you said that spending on consultants would go down, but also hidden in there it said that spending on contractors would go up, and I was a little confused as to the distinction between the two. Perhaps you can clarify that.

Christine Connelly: In this programme we look at consultants and contractors together, because we bring them in to do pieces of work. Sometimes we talk about it as a work package. Sometimes it is somebody coming into a team to fill a job on a temporary basis. We do look at that together here.

Q171 Stephen Barclay: So when we were looking at the £1.5 billion spent by Government on consultants, you drew a distinction between consultants and contractors. What you are saying today is that actually there is no distinction.

Christine Connelly: I am not saying that. I am saying that for this particular programme I have a line in my management reporting that shows me the amount for consultants and the amount for contractors. They are both inside the central programme cost.

Q172 Stephen Barclay: Perhaps in the note we could bring out the two figures.

Christine Connelly: Certainly.

Q173 Stephen Barclay: Could I come on to a related issue, which is around the security of the detailed records on this system? Could you clarify how many members of staff will have access both to the high-level record and to the detailed patient records? How many members of staff will be able to access those?

Christine Connelly: By the high level record, do you mean the summary care record?

Stephen Barclay: Yes.

Christine Connelly: Thank you. The summary care record is being created for any patient in England who chooses not to opt out of the system. To date we have about 6 million records. We have written to over 30 million patients. The expectation is that, when a patient presents themselves out of hours, which is the more common time, at that point—

Q174 Stephen Barclay: No, how many staff will have access? I am not asking how many patients' records there will be. What I am asking is, how many staff will have access to the high-level record and to the detailed medical record?

Christine Connelly: At that point, when the patient presents themselves, the member of staff who is treating the patient will ask the patient for permission to see their record, and only those clinicians who are given that permission can then see the record.

Q175 Stephen Barclay: Again, you are not answering my question. I used to work in financial crime prevention. One of the issues there was the concern of staff, often on very modest salaries, being bribed to reveal confidential information. It is not a new issue. It is one I assume, in your risk assessments, you have looked at.

Christine Connelly: Certainly.

Q176 Stephen Barclay: We have just had news around the hacking issue. What I am trying to get to is how many NHS staff will potentially have access to detailed financial records? Do you have any sense—

Christine Connelly: Detailed financial records?

Stephen Barclay: Detailed medical records.

Christine Connelly: Detailed clinical records.

Stephen Barclay: Yes.

Christine Connelly: Okay. Clinical staff who are treating a patient will be given access to their detailed record.

Q177 Chair: How many thousands?
Christine Connelly: How many people are currently registered on the system?

Q178 Chair: No, not people with records. How many staff—
Christine Connelly: No, no, I mean clinicians. Today there are 800,000 clinicians registered with smart cards on the system, and in March we had 380,000 unique logins to the system.

Q179 Mrs McGuire: How will you protect the access? If I am sitting as a patient with a clinician, and I say no, what safeguard do I have that that clinician cannot make a unilateral decision to access my medical records? Do I have a password that I keep in my head?
Christine Connelly: No. The record is opened up as clinicians are added to the clinical team, so people then get added, with the exception of the summary care record, which is available should you need to see it. The summary care record is a very minor record.

Q180 Mrs McGuire: Maybe I am not explaining myself properly here, but how do I have protection delivered to me for my records if I do not wish to give permission to someone who has a smart card that can access the system? Do I have a PIN that I need to keep in my head so that I can give that to the clinician who wants to access my records?
Christine Connelly: No, you do not have a PIN that you need to keep in your head.

Q181 Mrs McGuire: Right. Explain to me what happens if a clinician wants to access medical records without a verbal positive comment from a patient.
Christine Connelly: The clinician is placed on the clinical team looking after that patient, and those clinicians can access the record. Only people on that team can see the detailed record.

Q182 Mrs McGuire: But if I say, "I do not want you to see my records," then how—
Christine Connelly: Then nobody would be put on the team.
Ian Swales: But they might not do anything for you.
Mrs McGuire: Am I the only one who does not quite understand this?
Stephen Barclay: It is totally unsecure.

Q183 Ian Swales: Going back to Mr Barclay's point, you were saying that roughly one in every 50 adults in this country will have access to this system—800,000 people. It is a legitimate question to ask about security of data, isn't it?
Christine Connelly: It absolutely is a legitimate question.
Chair: *The News of the World* may be very interested in the clinical records.
Christine Connelly: That is the number of people who have access to the system overall. There is then another level of security about the records for particular patients, where those patients are assigned to a clinician's list. As the patient gets assigned to the clinician's list, the record goes with that. In the same way, if your paper record moved and you went to have treatment, your paper record would be called up from a file somewhere in a store, and the paper record then, if everything went well, would work its way through the system and move to the clinicians who were treating you.

Q184 Chair: The difference here, however, is that if you are a clinician, you can take it off and then sell it on.

Christine Connelly: You cannot take it off. It is very difficult to take it off.

Q185 Chair: You can write it down. You have access, you write it down, you sell it on.

Christine Connelly: You can do the same thing on a paper record. If you have legitimate access to the paper record—

Q186 Chair: Much more difficult.

Christine Connelly: In the same way that you can have legitimate access to the electronic record, you can take things out, and you can photocopy them, and you could send them away. By putting this on an electronic system, we have an audit trail of everybody who has ever accessed the system. If there was to be some kind of leak, it would be very clear who the community of people were who had accessed this system in a way that we would not have with paper records.

Q187 Chris Heaton-Harris: I do not want to get too confused about the gateways to the privacy of people's records, but I really wanted to ask Sir David, you are the Senior Responsible Owner of this project and you are dealing with a great period of change within the NHS. I do not expect you to be spending days upon days upon days on this, but I wanted to know the structure of your team beneath you, and how many people in the Department of Health are helping you on this project.

Sir David Nicholson: I have a Director-General, the Chief Information Officer, Christine Connelly, an extraordinarily experienced individual doing this kind of thing, who heads it all. She has a whole team of staff working for her—

Christine Connelly: 1,300 people.

Sir David Nicholson: She has 1,300 people working for her, who are managing this system. Within the governance arrangements we have a Programme Board, which oversees the programme, which is chaired by my deputy, who is also the Director of Finance, Performance and Operations for the NHS, and that has three Strategic Health Authority Chief Executives on it, the three leaders of the individual patches. That is Bill McCarthy, who is the Chief Executive from Yorkshire and the Humber, who looks after North Midlands and East; Candy Morris, the Chief Executive from the South East Coast, who looks after the South; and Ruth Carnall, who is the Chief Executive of London. They look after the individual geographic patches for me as part of this system.

Q188 Chair: I had two more questions on costs and progress in the current period, then I want us to go to the future. You say in page 14, paragraph 28, "Money spent to date has not been wasted, and will potentially deliver value for money." That is your claim.

Sir David Nicholson: Yes, yes.

Q189 Chair: I just want to test that against two things that we talked about with the contractors. If we can take BT first, you renegotiated that contract in 2010.

Sir David Nicholson: Yes.

Q190 Chair: Crudely, as I have said, you are still spending £1 billion. You have not saved anything, because you are spending money outside the contract on delivering

something for GPs. You have taken out the GPs. You have taken out half the Acute Trusts. You have taken out the Ambulance Service. We are left with £1 billion for 53 sites.

Sir David Nicholson: Yes.

Q191 Chair: How on earth can you say that is value for money?

Sir David Nicholson: The first thing is that if you take the GP and the Ambulance one, that is a relatively tiny amount of money—important, but relatively tiny.

Q192 Chair: That makes me even more scared, because I then think you thought at some point £20 million was—

Sir David Nicholson: The bulk of this issue is moving essentially from 31 hospitals to 15 hospitals. That is essentially the bulk of it all. The point of that is that, first, all hospitals in London will have access to the Spine, and all those other things that I cannot talk about. They get all those. So nobody is outside the programme in that sense. The difference is essentially twofold. One is that the 15 hospitals that you are left with are by far the biggest and most substantial in London, so significantly more than half the patients of London will be treated. You will get more than it appears by going from 31 to 15 in coverage. That is the first thing. The second thing is the functionality has significantly increased for those. If you add those two things together, it is perfectly possible to calculate that you do get value for money out of this.

Q193 Chair: But £20 million? I know I have averaged it out, and some will be more, and some will be less.

Sir David Nicholson: Yes, yes.

Q194 Chair: I am looking at Figure 9 on page 24, which tells me that 53 cost you £948 million.

Sir David Nicholson: Yes.

Q195 Chair: You are saying that an average of £20 million, with the increased functionality—which is very different from the original functionality, but nevertheless what clinicians want—is good value for money. Is that what you are saying?

Sir David Nicholson: Yes, yes.

Q196 Chair: Can I then ask you how you justify the costs in the South being 47% higher?

Sir David Nicholson: They are not, and we do not accept those figures at all in the document.

Q197 Mr Bacon: Can I just stop you there? I have been discussing this with the NAO for quite some time, and I am sure the NAO will want to come in. The whole point is that we do not like hearings where you do not agree the figures with the NAO. We like hearings where the figures are agreed and signed off. The NAO has been sweating blood to try to get some sensible numbers out of you. Even though you have known that this Report has been in the pipeline since last September, you gave one set of numbers to the NAO last Thursday, and BT says on the Friday, "We do not recognise these figures." This Report is replete with references to the fact that you do not know what is going on.

Sir David Nicholson: I do not accept that.

Q198 Mr Bacon: Can I just finish, Sir David?

Sir David Nicholson: I do not accept that.

Q199 Mr Bacon: Can I just quote from the Report?

Sir David Nicholson: Yes.

Q200 Mr Bacon: On page 7, it says, "Our findings are presented in the context of a lack of clarity between the Department and its suppliers about basic management information." Over the page it says, "The Department has not stated what impact these reductions in the scope will have on the expected benefits of the Programme." Then on page 9, "The Department has also been unable to provide us with a full breakdown of the cost implications of these changes." Just one more. This is page 23. It is relevant to what we were just talking about, actually: the cut-down that has taken place in London: "The Department has been unable to provide us with a full breakdown of the costs of the revised £948 million contract." This is not what we expect the NAO to have to report, but it is because you do not appear to have had a firm grasp on the numbers.

Sir David Nicholson: That is not the case. As you know, I do many Public Accounts Committees, so, like you, I hate the idea that we would come with a different set of numbers from the NAO, because it is not the most productive way of spending our time together. There is no doubt that there was a significant breakdown of the process operating between the Department and the NAO around this Report. We can have a debate about why that was and how it happened, but the reality is that it happened. I do not think there was any surprise when you talk to BT about their problem about their figures. You were talking about figures—

Mr Bacon: They did not have a problem.

Sir David Nicholson: Being shared with the NAO on 13 and 14 May, which was three or four days before—

Q201 Mr Bacon: They kept on moving, Mr Nicholson. I have been talking to the NAO about this for months, and the expression they used to me several months ago was, "The trouble is that the numbers keep swinging and swaying." You have known about this, and the need to get hard figures, since last September.

Sir David Nicholson: I agree. I cannot remember a Report for which I have been at the Public Accounts Committee in the last five years where we have been in that position. I cannot remember a time, and I, like you, do not want it to be like that. We can answer each of those issues as you want.

Chair: Speak to the 47% increase in the South.

Mark Davies: Can I just pick up on that. The 47% is derived from figures that were sourced from Department of Health papers.

Sir David Nicholson: Of course. There are lots of sources, you can add one against another. The problem they have here is that you have essentially tried to compare apples with oranges. You have tried to do an average across a set of organisations, which are simply not average, so you have come up with a figure that I think is nonsense.

Mark Davies: I do not understand why the figure is nonsense, because we are taking the global figures—sourced, as I say, from the Department of Health—in terms of London costs, and comparing them with the costs of the three acute greenfield sites in the South.

Sir David Nicholson: In a sense that is part of the problem: you do not understand it and neither do I. Sorry, no, I absolutely understand our own figures, and we are very clear that our figures tally exactly with those of BT and of the suppliers.

Q202 Chair: I am sorry to rush you, but it is half-past 5. If we go to the South—I understand it is apples and pears, and there is a bit of that in it, but I think you can overplay that card—BT are delivering 35 out of 90 sites there for £454 million. You are expecting to introduce, for the rest of the South, IT support for some sort of patient information, 55 sites, for £470 million. Now, that is 57% more systems for 3.5% extra cost. Is this cloud cuckoo land?

Christine Connelly: In terms of how we are looking at the South, it has been broken up into a number of different categories to procure, rather than continuing with the idea of a large single supplier.

Q203 Chair: Can I just say to you, you try and complicate it? It seems to me we have sites, we have money. You do not accept that it is 47% extra in the South? I am now drawing to your attention to it that you are trying to deliver 57% more systems for 3.5% costs in the South. Have I got that wrong? Have I read it wrong?

Christine Connelly: So in terms of what that number means for us, we will deliver systems that will be in service for significantly less time than the time that the other systems will be in service around the LSPs. So in terms of how the costs are constructed, there is a deployment cost for any system that we have under these contracts, and then there is an ongoing service cost. We have market tested each of the component pieces, and we believe that we can deliver the systems in the South for that number.

Q204 Chair: So if I have you back in a year's time, if you are still working in that job, you will have delivered the 55 extra sites at £470 million, full stop.

Christine Connelly: In terms of where we will be in a year's time, we will not have delivered all those things because the contracts will run for four years, and we will only pay an amount of money as the system is deployed, then pay annually when the system is serviced.

Q205 Chair: Every time you renegotiate you pay perhaps the same, but you pay for less.

Sir David Nicholson: That is not true.

Q206 Chair: That is true. That is true. You are paying for fewer sites in London.

Sir David Nicholson: We are paying for significantly more functionality; that is what we are paying for.

Q207 Chair: Not for more functionality than you had at the beginning.

Christine Connelly: Yes, we are.

Q208 Mr Bacon: Let me just quote from a briefing that was prepared for a very high-level meeting. You were present at a meeting mentioned in this briefing. It is talking about the negotiations with CSC and that while the offer, which will involve the saving of £500 million, may be superficially attractive, it is, in fact, unattractive, and, indeed, that the health commercial team are not approaching it in the best way. And, "This is because the unit price of deployment per Trust, under offer, roughly doubles the cost of each deployment from the original contract". Are you telling me this is wrong?

Sir David Nicholson: I don't recognise the source.

Q209 Mr Bacon: I did not tell you the source. Are you telling me that is wrong?

Christine Connelly: Or the context. So, we do not know which paper you are talking about.

Mr Bacon: You know perfectly well it is correct.

Q210 Stella Creasy: I am sorry, you just said that you are delivering for 15 sites in London, and that is going to cover about 50% of the patients. What about the rest of them?

Sir David Nicholson: No, I said we would cover more than 50% of the patients, because the hospitals that we are going to be dealing with—

Q211 Stella Creasy: 60%, 55%, 52%? How many do you think will actually be covered by this at the moment, and what are you going to do about the rest?

Sir David Nicholson: No, the point of all this is we have moved from a situation where, at the beginning of the process, we decided that we would replace all the systems in all the hospitals.

Q212 Stella Creasy: Yes.

Sir David Nicholson: We have changed, we have gone away from that and we have said we will have a system where we connect all the systems together. But for some of the hospitals, for obvious reasons, because their individual systems were coming to the end of their natural life, or they were moving to new accommodation, or whatever, they are going to get replacement systems. The other hospitals will not get replacement systems, but they still will have systems, and they will be connected to the national arrangements.

Q213 Stella Creasy: So there will be two tiers of patients. There will be the patients who get the new system, and the patients who get the old system?

Sir David Nicholson: Absolutely not, absolutely not. The functionality will be very similar, but these organisations do not—

Q214 Stella Creasy: Very similar? Will the functionality be the same? Will every patient in London get the same level of service under this system?

Christine Connelly: Patients will get the same level of service. The technical footprint to deliver that service will be very different across the landscape, and that is what choice is about. If hospitals were asked to take exactly the same system we would be back to the original model that we all agreed we did not want.

Q215 Stella Creasy: As a patient, if I go to my hospital in London, I will be offered a technical choice about the kind of system—

Christine Connelly: No you will not. As a patient you will be offered a service that will be the same.

Q216 Stella Creasy: So how will I have choice in this system, then?

Christine Connelly: The patient will be offered a service; the service will be the same. The organisations providing that service will choose the technical footprint they want to have to support their working practices to deliver that service. The systems as they run there—the kind of systems we are talking about under this piece of the programme—will not be in evidence to the patient themselves, other than when they sit with their clinician—the clinician showing them data; the clinician showing them x-rays, which I know we are not allowed to speak about; the clinician bringing back their tests in an ordered form; and the clinician communicating with the patient. But the patient would not know if they were doing that through a Cerner or Lorenzo system, or anything else.

Q217 Stella Creasy: Heaven forbid, one of my constituents in London, on holiday, has an accident in Bournemouth, and there is a different system—

Christine Connelly: There is the summary care record.

Q218 Stella Creasy: And they need, because of their medical conditions, access to all that information. You do not think there is a risk that, because they are a London patient and they are not in that 50%, that data will not be there? There is no assessment of any risk there?

Christine Connelly: The risk is no different between the Cerner system supplied under this programme and the systems supplied independently through the Trust themselves.

Q219 Chair: So why are we spending money on the programme?

Stella Creasy: So why are we spending all this money on this new system, then? If they are not going to get a better quality of service, why are we spending all this money?

Christine Connelly: They absolutely will get a better quality of service, and the point is, where Trusts already have systems that deliver the required level of service, what would be the value in us just ripping those systems out for the sake of it? It takes a hospital in London between 12 and 18 months to replace their patient administration system. If they consider already that they have a system that is modern, fit for purpose and meets the technical standards required to connect into this environment, why would we go in and just replace it?

Q220 Stella Creasy: Why start this process at all? My constituents would really like those nurses Margaret pointed out. Why start this process at all if the standards are already there?

Christine Connelly: Because for the hospitals that do not have a system, or did not have a system all those years ago, we had to do something to give them a system. For those people who are in the other Trusts in London—

Q221 Stella Creasy: Sorry, so when you started this process, at that very point, Sir David, you said we had this lofty ambition at the start, a high risk process. You are now saying actually that was not what this was all about; it was about trying to do with a patchwork system. Which is it?

Christine Connelly: You have asked me two separate questions: what will happen to me now if I have a different system?

Q222 Stella Creasy: With respect Ms Connelly, I am responding to what you are saying—

Christine Connelly: So that is one set of questions—

Stella Creasy: And I am deeply concerned as a London taxpayer and a London user of the service whether I am in the 50% either way. I do not know that, but what you are telling me is that this was not a system that you brought in to deal with a qualitative improvement in service; it was about dealing with gaps in service. Is that fair?

Christine Connelly: I am sorry, that is not what I meant to say.

Q223 Mr Bacon: What you meant to say is you are paying for a Rolls-Royce, but getting a second-hand Datsun. That is what you meant to say.

Christine Connelly: That is not at all what I meant to say, Mr Bacon, and you would know that.

Chair: Right, I am going to move this to the future.

Q224 Mr Bacon: Can I just briefly, before we go on to the future, come on to one issue on cost, because we discussed this with BT, Sir David, and I would like to discuss it with you? If I could ask you to look at paragraph 3.14; this is on page 30. It is about the cost of RiO. It says, "The Department has stated that it determined their average £9 million cost"—that is the cost of the RiO systems—"on the basis of the costs agreed for RiO systems in London in 2007, but despite repeated requests has not provided us"—that is the NAO—"with any evidence of the work it undertook to assess the value for money of the prices agreed for London". Now, will you send us a clear, written account, or do you not have one, of the work that was undertaken?

Sir David Nicholson: We will send you a clear written account.

Q225 Mr Bacon: Why were you unable to give it to the NAO? You do not understand?

Christine Connelly: We believe that we presented it, but clearly we did not present it in a way that the NAO understood.

Q226 Chair: Mark, can you comment on that?

Mark Davies: I am sorry. I think I have to stand by exactly what we say in this Report—that we were not provided with evidence of the work. It is as simple as that, and this Report has been in clearance discussions with the Department, so I will stand by what we say in this Report.

Q227 Chris Heaton-Harris: Let us try: the CSC representative who was here described that, essentially, Community Trusts had 50 sub-optimal, non-Lorenzo products placed in them. If you had bought those sub-optimal products off the shelf from them at the very start, how much money would you have saved?

Christine Connelly: I think what happened with interim systems was that when we took those systems they were then invested in, in a way that the supplier had not intended, to allow the systems to be connected into the broader environment.

Q228 Chris Heaton-Harris: I am not convinced that was the question I asked you.

Christine Connelly: I am sorry then.

Q229 Chris Heaton-Harris: I just want to know, if you had bought those interim systems as System 1 or whatever it was called—

Christine Connelly: IPM.

Q230 Chris Heaton-Harris: Yes, how much would we have saved?

Christine Connelly: So the systems as they stood off the shelf would not have worked in the integrated environment that we had. So IPM, for example, is a system that is supplied by iSoft and is in use in Community Trusts and in Acute Trusts, and we have some 83 implementations of that. And that system, at the start of this programme, was not able to do things like interact with Choose and Book, connect with the Spine. All that development work was done then with the supplier to allow it to operate as an interim system in this programme.

Q231 Mr Bacon: That is why it was rejected—because it was unfit for the programme—yet you now have 81, or 83, or however many of them it is, and CSC is now in the position of being virtually a potential monopolist. Did you take legal advice on what

might happen if CSC were to succeed in buying iSoft, if it all goes through, and then just basically drop Lorenzo, and carry on with other interim systems, and carry on updating them. Having got their enormous size 12 foot through the door, they are going to have you over a barrel, are they not?

Christine Connelly: Well, we do not believe so. We believe that our commercial agreements are good for us, and we believe that they are fair to our supplier. So we think that we are in a good position with that. We would say that in terms of the IPM systems the suppliers were required to bring them in as interim systems, to upgrade those systems, to make them interact with the rest of the national programme systems: the Spine, Choose and Book and so on. So the supplier then invested in those systems in a way that they had originally not intended.

Q232 Stephen Barclay: You just said that you thought the CSC systems were good for us.

Christine Connelly: I said the CSC contract.

Q233 Stephen Barclay: However, the Report says, "The Department is considering all options, including termination or a significant reduction in both scope and functionality". This is in reference to CSC.

Christine Connelly: And I said that I thought the contract was good for us.

Q234 Stephen Barclay: What is the maximum exposure of the Department to both CSC and BT?

Christine Connelly: So, in terms of the contracts that we have today if we decided to terminate for convenience—I do not want to run through a set of numbers that, if we put them out into the public domain, we could find ourselves in a commercial discussion where our suppliers come back and say, "Well, you said that you would expect to pay this to us if we were in that situation," particularly given where we are with CSC at the moment, and we are exploring all our options with CSC. But in terms of what we would expect to see in the supplier discussions, there are contractual caps in the contract, where we would be required to pay a certain amount depending on the period of time, for how long the service is not supplied. So we would expect that contract, if we were talking about CSC, to be several hundred million pounds in terms of what we would have to pay to terminate for convenience.

There then is the potential that the supplier may then come to us and seek damages based on the work in progress that they have on their balance sheet today, with a view—not that I am saying at this point that we would share it—that we have impacted their ability to get return on that asset that we were holding. So they may come to us and seek damages as a proportion of that balance sheet value. Again, that may be several hundred million pounds.

From that point on we would have to look at the cost of transitioning the systems out of the national programme to some other supplier, and I am not talking about what it costs in terms of running those other systems, but there would be a cost if we decided no longer to have Lorenzo or IPM or whatever. We would have to take the people who are currently using those systems and move them to something else; that would be a transition cost. There then is likely to be a period where we would still be running the systems that we had now terminated. If you look at what happened to us in the South with Fujitsu, Fujitsu increased the cost of supporting the systems. They almost doubled the cost compared to the contract that we had. So for the period before we had transitioned the systems across, we would expect to pay some premium on that support and obviously we would seek not to do that, but given that we would then be over a barrel, because we are running systems that one supplier has provided and we have now terminated, if we do not manage that well that could be a very difficult position. So

potentially, if you ask me about the absolute maximum, we could be exposed to a higher cost than the cost to complete the contract as it stands today.

Q235 Stephen Barclay: It is an interesting contrast with our hearing last week. We had a hearing last week with the Department for Transport which, on the East Coast, entered into a £1.4 billion contract, yet the termination clause from the company concerned, which was allowed to be a stand-alone company, was just £120 million. So when a contract ends for the benefit of the private contractor there is very little cost. Here, where we have the boot on the other foot, you have actually negotiated yourself, by the sounds of it, into a very difficult situation. Have you shared up-to-date figures on your assessment of the termination costs with the NAO?

Christine Connelly: Well, there were certainly figures in the paper that was presented to the National Programme Board on the CSC contract negotiations, which were legally privileged, that were available to the NAO, because we made all the papers that went to the National Programme Board available. I do not know if the NAO picked up and looked at that paper, and I do not know if they only looked at the minutes of that, but certainly I can evidence that that paper went forward to the National Programme Board and has been to the Board twice definitely, maybe three times—I would need to go back and look at it—where the Programme Board asked us to explore different sets of options.

Chair: Really quickly, and then I am really moving to the future.

Q236 Mr Bacon: Very quickly, I just wanted to pursue this point about the cost of RiO, which I did with Mr O'Connell from BT, where you are paying BT £224.3 million to install RiO in 25 sites. Have you now ascertained the cost of obtaining RiO outside the national programme?

Sir David Nicholson: Yes.

Christine Connelly: Yes.

Q237 Mr Bacon: And what figure were you given?

Christine Connelly: I have looked at a particular example of that. You wrote to me about this last Thursday night, Mr Bacon, so based on that we looked at the example of Bradford District Care Trust, which is a Mental Health Trust, which has procured RiO outside the contract. It procured RiO under the ASCC arrangement and we looked then at the terms provided to it as well as the services provided as part of that contract, and we looked to compare both.

Chair: And what came out of that, sorry?

Mr Bacon: What was the amount, by the way? I am assuming it is going to be a pretty high number, but go on—how much is it?

Christine Connelly: So in terms of the total cost of RiO at Bradford where they have a 59-month contract duration, the cost is £1.3 million over that 59 month duration.

Q238 Mr Bacon: Right, so it is actually within the bounds of what you would expect.

Christine Connelly: It is inside what you have quoted

Q239 Chair: And the comparison?

Christine Connelly: Okay. So the comparison: in terms of the services that we provide, there are a whole set of services that are not within that £1.3 million that are inside the LSP contract. Earlier somebody said, "Well, doesn't everybody have disaster recovery." Well, actually, no, and at this Trust only 25% availability is provided in their local

arrangements, which are not included in these costs. So we have a cost in terms of the BT LSP in the South for the same period, which includes the hardware, the support, the disaster recovery at 100%, the Spine connectivity, all of which are not supplied inside this Bradford system. If we looked at those costs through BT's cost profile, it would be valued at £2.5 million. Our cost compared to Bradford is £2 million more.

Q240 Mr Bacon: Yes, but the—

Christine Connelly: So it is £1.3 million compared to £3.3 million.

Q241 Mr Bacon: Can I pursue this point? It is the comparison with the £8.9 million figure that interests me, because the company itself says it can do it between £1 million and £2 million and it depends on the size of the project, including hardware and including support. You gave the example of £1.3 million and then there are certain add-ons for services that are provided on top of that. I still cannot understand how you get something under £2 million up to £8.9 million? What is it that you get from the £2 million to £3 million, the £3 million to £4 million, the £4 million to £5 million, the £5 million to £6 million, and so on? What do you actually get for it?

Christine Connelly: So first there is the period, so we need to take a look at the average period that you would expect to be there, because we pay a one-off deployment charge and then we pay a monthly charge. So in terms of the figure that you quote, it is generally for about a four-year period, and the figure we quote is generally for about a six-year period, sometimes a little more. I think what we get is 24/7 support. We get full disaster recovery. I think it is fine to say, "Oh, anybody has that." The cost of full disaster recovery is significant, when you look at the costs that BT have; we invited an external auditor to go look at the cost build-up, and they have audited these costs. We looked at BT's profit margin, and they have taken a significant reduction in their profit margin between the original contract and the contract that we have today.

Q242 Mr Bacon: But it is not the taxpayer's fault if BT has unbelievably high costs. The way to do this is to get a software supplier talking directly to a potential buyer, but the company that supplies this product—which for all I know is a perfectly good product; I have not heard complaints about the product itself—said to me in a meeting this afternoon, "We are not allowed to talk to our customer." That is the problem with this structure; it is like having you over here, and the customer over there, and an enormous thicket, a forest of lawyers in between. I said, "Is that right?" and he said, "Yes, except you have to factor in that you have to translate it into two different languages as well." That is why it is so expensive, and most of that is unnecessary, isn't it?

Christine Connelly: The structure of the programme in the past was that the Trust talked to BT, BT talked to the suppliers. One of the most significant of the changes that we have made to this programme is that you will see suppliers of product on site talking to Trusts themselves. In London and the South, for RiO, they have created a user group to bring together all the Trusts so that the Trusts can work together and work with the supplier of the product. In Cerner's case, Cerner worked directly with each Trust as they went through the deployment. That was a significant shift in the model post-the Royal Free. So before the Royal Free we had an arm's length relationship between the Trust and the supplier.

Q243 Mr Bacon: When you say post-the Royal Free, can you just remind everyone? That was the one where the system was giving double doses of radiation, wasn't it?

Christine Connelly: That is not true. That is absolutely not true.

Q244 Chair: Okay. Can I ask a final question on this one? Are you satisfied that the extra costs that are incurred through BT running this for you, as the accounting officer, are value for money? It's just a yes or no, so I can move on.

Sir David Nicholson: What we have said is it is too early to tell.

Q245 Chair: And then can I ask one final thing: can you also give us a note on why you disagree with the 47% extra costs?

Sir David Nicholson: Yes.

Q246 Chair: Now can we move to the future? There is £4.3 billion left in this contract; again, every £1 billion is about 50,000 nurses. Should we drop it? Should we save our money and spend it elsewhere, particularly with your £20 billion challenge?

Sir David Nicholson: We should always have in our minds—

Q247 Chair: What is your view? You are the SRO, so what is your view, given the disasters to date?

Sir David Nicholson: As I say, we are talking about 20% of the programme; 80% of the programme is fine, all those sorts of thing.

Q248 Chair: No, please, there is £4.3 billion now on care records. That is a heck of a lot of money.

Sir David Nicholson: Yes, it is.

Q249 Chair: Is it right to carry on or should we cut our losses?

Sir David Nicholson: We think that in London now we have a product that can be delivered and professional clinical support to make it happen. We believe it is the right thing to do to continue with that.

Q250 Chair: £4.3 billion?

Sir David Nicholson: However much for London.

Q251 Chair: London is £1 billion.

Christine Connelly: From the end of March this year to the end of the contract, the remaining cost for London is £504 million.

Q252 Chair: I imagine that is the same sort of story—you are contractually committed.

Sir David Nicholson: When you look at the option of cancelling it, why would we? We now have a product, which is being delivered, and we can see the benefits across London.

Q253 Chair: Not this Lorenzo rubbish?

Sir David Nicholson: No, this is London. It's London. For North Midlands and East, which is Lorenzo, we are involved in a set of negotiations with CSC about the future of this contract, the structure of it, the way it is delivered, the functionality and the kind of penetration that we get through it. We hope that that will come to a satisfactory conclusion, but the alternative in all that, inevitably in those circumstances, is to think about the cancellation. That is not what we are applying to do at the moment, because we think the negotiations will happen, but we will make that part of our decision-making, and similarly with the resetting of the arrangements with the South, the ASCC, we are in the position at this

moment in time where we could make a decision to cancel if we thought that was the right thing to do. As I sit here at the moment we are confident that those negotiations—

Q254 Chair: Sorry, is this the BT contract in the South?
Stella Creasy: The Millennium contract?
Christine Connelly: The BT contract in the South has £241 million still to run. The ASCC in the South is the programme that we were talking about earlier that has £470 million.

Q255 Chair: So you could cancel that?
Christine Connelly: So we would say the same about the BT part of the contract in the South as we would of London.

Q256 Chair: You are contractually committed and coming out of it would cost you more than staying in?
Sir David Nicholson: But we also think we have got a product with BT.

Q257 Nick Smith: I want to talk about the future governance and costs. We all know that we are on a pause at the moment, but the project is going to roll on until 2016, possibly longer. It is supposedly managed by Connecting for Health and the 10 SHAs, which look like they are likely to be abolished. There is a question mark over Connecting for Health. So, in terms of future governance, who is going to manage the contracts? Who is going to measure and report on the benefits, given this is an eye watering amount of money? And given that the contract is probably going to go on beyond 2016, how are you going to make sure that Trusts, or GP consortia, or whoever is next decided at the pause, are going to be able to manage this eye watering amount of money?
Sir David Nicholson: I mean, there are a whole set of issues there because the programme is not a monolith; there are bits of the programme that sensibly are being managed by different bits of the system.

Q258 Nick Smith: But at the moment it is sort of centrally managed?
Sir David Nicholson: It is.

Q259 Nick Smith: Yes, so what is going to happen in this new atomised future?
Sir David Nicholson: Well, we are obviously working through all this at the moment—as you know we are going through the listening exercise—but obviously we are trying to think about how we can make it—

Q260 Mr Bacon: I thought it was full steam ahead, Sir David. I thought the whole point of the listening exercise was that under the undergrowth everyone was told to paddle furiously. Was that not your last missive to everyone?
Sir David Nicholson: I think that is a distortion of what I was saying.

Q261 Mr Bacon: I must have got that wrong.
Sir David Nicholson: Okay.

Q262 Chair: Actually, there is a serious point here. On the assumption that the reforms go ahead, what would the governance arrangements be for this programme?
Sir David Nicholson: Yes, okay, you are absolutely right. Central to the reforms going ahead is this idea of a purchaser-provider split, where you will have the commissioning system over here, and the providers all being individual providers as Foundation Trusts

responsible for their own governance and future. And that makes it quite difficult to shift a system like that into that environment, because what you want to get to, at the end point, is that each individual Foundation Trust will have its own relationship with the supplier over the things that it does. But the contractual arrangements still end up with the Department as it stands at the moment. So what we may have to do is think about an interim step—a transitional body of some description, looking very similar to Connecting for Health, to enable us safely to transit from where we are at the moment to a place where individual organisations take responsibility.

Q263 Chair: Within your commissioning empire?
Sir David Nicholson: No, no. Sorry, I said that badly. This is a provider issue.

Q264 Chair: So it will be a new quango?
Sir David Nicholson: Well, we are looking at how we could do it.

Q265 Nick Smith: Given the high risk, what you are saying is you are going to have a quango, because it is very high risk isn't it?
Sir David Nicholson: I think either the Department could do it directly in the new environment, or you could have some other arrangement, but you need some transitory arrangement safely to transfer it. We cannot just go from where we are now to one where—

Q266 Stella Creasy: What if the GPs say no?
Sir David Nicholson: But most of it is very little to do with the GPs; this is about individual hospitals.

Q267 Stella Creasy: But they are going to be connected to it as well.
Sir David Nicholson: Yes, but these will be—

Q268 Stella Creasy: They are going to be the purchasers, are they not?
Sir David Nicholson: Yes, but regarding the bit of the programme we are talking about now, which is the hospital systems, it is not a matter for the GP about the technical way in which a hospital resolves its problems.

Q269 Stella Creasy: But it will be a matter for the GP who connects into this system, will it not?
Sir David Nicholson: Well, obviously there will have to be connectivity between the hospital and the GP system, but we have made that very clear, whatever the arrangements are. What we are talking about here is the implementation of this and holding the contracts. And that would not be a matter for the GPs or the GP commissioners; that would be a matter for the individual organisations going down the road.

Q270 Stella Creasy: So there could need to be more bits of technology to make all these different bits work together?
Sir David Nicholson: No. There is something called the—
Christine Connelly: Interoperability toolkit.
Sir David Nicholson: That is the one, which is the bit that connects it all together, which will continue nationally. And the issue for us is how we make sure that work continues in an environment where you are splitting the commissioning and provider part of the system. I think we have not come to the conclusion of that, but it seems to me some transitional body will be required that will be able safely to manage that. Going from where we are now to

essentially splitting up all the contracts within the individual organisations seems to me to be adding huge amounts of risk to what is already a very risky transition.

Q271 Stephen Barclay: You just mentioned a transition body. Will you continue as senior responsible accounting officer for this project?

Sir David Nicholson: I am the chief executive of the commissioning board designate. When I become the chief executive to the commissioning board, subject to all this listening—if we have a commissioning board at the end of it—I would not be the accounting officer for this particular—

Q272 Stephen Barclay: So will that change happen? When will there be a change of accounting officer, and who is it likely to be?

Sir David Nicholson: I think that is the issue. I think that is part of what we are trying to work through.

Q273 Nick Smith: When will we know about these transitional arrangements for this £4 billion, five-year, many-people organisation?

Sir David Nicholson: We will know when the Government has responded to the listening exercise.

Q274 Nick Smith: Have you had many responses on this part of the listening exercise, and what are they?

Christine Connelly: Around the national programme? No.

Q275 Nick Smith: No responses yet?

Christine Connelly: I am not aware of that.

Sir David Nicholson: At none of the meetings I have been at.

Q276 Nick Smith: Can you give us a note on the responses you have had around this at this moment in time?

Sir David Nicholson: Yes.

Q277 Nick Smith: Given it is £4 billion over five years.

Christine Connelly: I think it is important for us to talk about the breakdown of that £4 billion, because part of that breakdown is in the local costs that are about deploying the systems. Part of it is in the contracts that we are talking about with the LSPs. And, as we have said already, in terms of the costs to go, we have about £2.2 billion to £2.3 billion inside those contracts. The other costs are things like the interoperability toolkit and like the ASCC in the South, which are being managed in a very different way. So the Child and Community Health Programme for ASCC in the South has each individual Trust that signs up to the programme take the contract, so they will have the contract as soon as we let it, and they have written already to guarantee that they will provide the benefits statement on what they do. So the constructs that we are creating within that £4 billion that you are discussing differ depending on where we are in which part of the programme. We are still talking about a very significant amount of money.

Q278 Nick Smith: We are talking about a very chunky organisation with much risk, which, in the middle of the pause, you have had little response from clinicians or others on, on which you are going to decide in how long—by when?

Sir David Nicholson: Well, we have already done quite a lot of work on looking at what the options would be and looking at how we might put them into place; it very much depends on the timetable that comes out, for example, of the listening exercise as to how quickly or slowly we will move.

Q279 Chair: But Sir David, you are looking for £20 billion—I cannot quite work it out—but out of the £4.3 billion left, how much do you think you are stuffed because you are in there and how much is available for taking out of it? Have you got a figure?

Stephen Barclay: Zero.

Chair: Well, zero on a bit of it, yes. There is £4.3 billion left. On how much do you reckon you are so contractually committed it would be too expensive to get you out, and how much do you think you have free spending, out of £4.3 billion?

Sir David Nicholson: It is quite difficult for us to answer that.

Q280 Chair: Give us a crude oversight?

Sir David Nicholson: A crude figure would give the suppliers an indication as to what we would be prepared to pay if we cancelled it, and I am reluctant at this moment in time, given what we are trying to deliver here, to say that out loud.

Q281 Mr Bacon: I have 120 pages—I did not have time to read it out this afternoon, but I will send in a potted—

Stella Creasy: Shame.

Mr Bacon: Well, I always could, Stella.

Sir David Nicholson: Please feel free.

Q282 Mr Bacon: This is full—full of broken promises going back many, many years; not one or two years, but five or six. And some of the stuff about Lorenzo is just hilarious—the things that people have said, including you, about what is going to happen and then has not happened. So plainly, although the NHS has not helped itself by being a fairly bad client and has kept on moving the goalposts, and has negotiated for the down-scoping in various places—behind the backs, I might say, of the NHS Hospital Trust Chief Executives who are supposed to be the beneficiaries of all that—it is still also the case that the suppliers have failed as well. They have failed big time. Now, I am not asking you to get all macho and cojones-istic, if there is such a word, but surely to goodness, certainly in the case of CSC, they have delivered so well.

Chair: Badly.

Mr Bacon: They have delivered so little with this product Lorenzo, which is itself the subject of a huge scandal, as you know, because it was sold in as a product that was available from 2004, there was basically a stockmarket ramp of the company iSoft, four directors then sold tens of millions of pounds worth of shares—at least £76 million, and probably more like £90 million—and went off and bought football clubs and things. As you know, four of those former directors are now the subject of criminal prosecution for false accounting, which they deny, and you have this company that for years was trying to implement and install the unimplementable, and you are saying, "Well, we just have to be careful of the contract, we have to pay them billions of pounds." It really ought not to be that simple, should it?

Sir David Nicholson: And it is not that simple, and first, without going through it, your overall analysis I do not accept. That is the first thing.

Q283 Mr Bacon: You mean about the football clubs or about the criminal prosecution?

Sir David Nicholson: Before you got to that—the way you characterised the relationship between the programme and the NHS I do not accept. I do not accept that.

Q284 Mr Bacon: It is certainly true—I was talking specifically about Lorenzo—that Lorenzo was sold into the programme as a great new shining hope. It was called the great strategic product by iSoft, and it had not even been written.

Sir David Nicholson: I can absolutely assure you, we have had these conversations more recently, in the last three or four weeks, with the—whatever he was—President of CSC—

Q285 Mr Bacon: Mike Laphen.

Sir David Nicholson: In words of one syllable that anyone can understand, what our expectations are around all that. We think there is the possibility of getting something really good for the NHS out of this, but having said all that, we are going to be pretty hard nosed about all this, because you are absolutely right: on the one hand, it is not that we have huge amounts of growth going into the NHS; we have not. So we need every penny we can use of taxpayers' money; we are not going to make a cavalier decision based on what we think we were trapped in in the past, and genuinely, if we have to make that decision, we should absolutely make it. I do not feel that we are emotionally connected and that just because we had a contract in the past we should have one in the future, but we need to be hard nosed about it. At the moment, as you know, we have those contractual discussions coming to a conclusion, we have a major projects review being undertaken, and we have to submit all this to the Cabinet Office. So it is not just the Department; this is a broader Government question to tackle, and we absolutely will.

Q286 Stella Creasy: My local hospital is already looking at having to find savings, and looking at reconfiguration, yet you are saying that you think that they would still be more likely to buy into these changes in the computer system than they would be to investing in, say, front-line clinical staff?

Sir David Nicholson: Well, one of the things about these clinical—

Q287 Stella Creasy: Is that the trade-off you think they are going to have to make? Because as much as it is about the contract you will have to renegotiate at a national level, it is about the local modules they are going to have to buy, isn't it, to fit into this system?

Sir David Nicholson: They will make any payments they want to make; their judgments are based on what is in the interests of their patients and their organisation. They will have to take hard-headed decisions about all that. If you look at the Clinical Five—

Q288 Stella Creasy: For the contracts that you have renegotiated, which cost an extra 18% in London, for example, on the 50% of patients who are covered, where they will have to buy in the modules to get the functionality that you are talking about. That is right, isn't it? They will have to buy in the modules to make it work with their system locally; they are going to face the increase in costs, are they not? They are going to have to fund it themselves.

Sir David Nicholson: There is the group of hospitals.

Q289 Stella Creasy: Because nobody has the functionality that you are saying that you want at the moment, have they? Nobody has the level 3 Millennium functionality at the moment, do they?

Sir David Nicholson: No.

Q290 Stella Creasy: No. So nobody can make the system work in the way that you want it to at the moment, can they?

Sir David Nicholson: No.

Christine Connelly: The only piece of functionality that is not in use that comes as part of the Cerner product is e-prescriber. Now that piece of functionality, we say, does not exist, because we have not implemented it in the national programme yet. It is in train in a number of Trusts, for them to go look at it, they have started their projects to deploy it. Cerner, as a supplier, would say that that product does exist, because they are running that system in lots of other hospitals around the world. We take a view that until it has been deployed as part of the programme in one Trust, the functionality itself is not there. That is quite a hard-edged view.

Q291 Stella Creasy: What assessment have you made of the capacity of Trusts in London to make up the difference in funding that this new model will require?

Christine Connelly: That assessment would have been made by the London Programme Board as they came to a view on the mix that they thought was the best view for London. So they took a view that said, "We want to have much more flexibility and much greater functionality in this contract," and a number of Trusts then were saying, "We do not want to move forward with Cerner; we would rather keep the system we have already and enhance that system and join it up with the other Trusts who have Cerner."

Q292 Stella Creasy: Let me try this question the other way round: do London NHS Trusts have the money to pay for this system in the future? Yes or no?

Sir David Nicholson: It is a matter for them, their choice.

Q293 Stella Creasy: No, it is a matter for all of us, isn't it? Because you are paying, you are renegotiating the contract at national level, and they are picking up the pieces at local level. Do they have the money?

Sir David Nicholson: When we went through this process, we said to every Trust in London, "Do you want to come in or not?" and 15 said they wanted to come in, the rest of them did not want to. So it is not that there is a queue of people wanting to come in and do this.

Q294 Stella Creasy: I bet there isn't at these costs.

Sir David Nicholson: Because they are very happy with the arrangements that they have at the moment, and they think that by incremental changes they can get the functionality that is required. That is a judgment that they took about their own financial circumstances, which seems to be right.

Q295 Stella Creasy: When you are looking at the future of these contracts, and their deliverability, you have made no assessment of any variation in the component that local Trusts will pay?

Christine Connelly: So the idea of this is that local Trusts add to their environment to fit in with the working practices that they want to have with the new technologies that they want to use.

Q296 Stella Creasy: But do they have the money? They do not have the money to do that.

Christine Connelly: But they have the money for the specification that they want and the capability that they want. Every Trust in London was invited into the programme and 15

chose to come in, and then the functionality that they wanted was what we negotiated in this contract.

Q297 Stella Creasy: So the rest of those Trusts that were not part of that conversation will not be able to buy into it?

Christine Connelly: It is not true that they were not part of that conversation. They chose not to come into the contract.

Q298 Stella Creasy: So their patients—those 50% of people, or the less than 50% who will not be covered by this, whose Trusts will not be able to buy the functionality—what impact would that have on that service, on the ability for everyone in London to benefit from this scheme?

Christine Connelly: The point is that people in London will benefit from the scheme, because the systems will join together.

Q299 Stella Creasy: But they will not, because their Trusts will not be able to buy the modules to fit in with this, will they?

Christine Connelly: But the Trusts might already have what they want. Not all Trusts want all modules, and some Trusts have invested in their IT over the last few years.

Q300 Stella Creasy: Why at a national level are we paying for the development of modules that Trusts at a local level then are not going to buy?

Christine Connelly: Because a series of Trusts do want to have them, and we then moved into a world where we said we would offer choice to Trusts, and whether I think they should or should not have done this, it was their choice to come in or not.

Q301 Chair: Well, you were in a contract. I think what happened was BT was about to walk away at a huge bloody expense and you renegotiated down by de-scoping—

Sir David Nicholson: I am sorry, that just simply was not the case.

Q302 Chair: Well then, I do not know why you did not walk away from it instead of renegotiating.

Sir David Nicholson: It simply was not the case; what we wanted was a set of systems to be implemented that would improve services for patients, and they were unable—

Q303 Chair: But Sir David, do you know what I would have done in 2010? If you could have walked away in 2010, and you had nearly £1 billion to play around with, and you had gone to the idea that people would go modular and they would find their local solution and you would have just this little bit of interoperability, I would have given £10 million to each Trust, or something like that. They could have achieved a heck of a lot more on this, or chosen to spend it on nurses, than we are getting out of this contract.

Q304 Mr Bacon: This is exactly what the Chairman is describing; this is more or less exactly what was with GP systems of choice, whereby the Department of Health basically encouraged GPs to up the quality of their IT, and contributed financially towards it, and that model—that approach—would have worked much better than the National Programme for NHS IT, would it not?

Sir David Nicholson: The National Programme for IT is much bigger than just this.

Q305 Mr Bacon: You kept on saying that the detailed care record was only 20% or something; £7 billion on £11.5 billion or on £12 billion is about 60%, isn't it?

Sir David Nicholson: 40% of the total spend of the National Programme for IT is on the LSPs. Of the LSP about half that figure—a total of 20%—is on the acute sector. The rest of it is providing services in the community, mental health and for GPs.

Q306 Chair: £7 billion, either through you or through local PCTs, is being spent on this programme. That is the figure. Unless this figure is wrong, that is the figure, which is a heck of a lot of dosh.

Sir David Nicholson: I am not underestimating it; it is a huge amount of money. But I would just point out to you what happened before the National Programme for IT, where we had a situation that the National Programme team responded to, which was essentially every hospital could do their own thing. And we had huge issues with that.

Chair: But they are doing their own thing anyway.

Stella Creasy: There is also the impact assessment in London about subsidising an IT system that only 15 Trusts can use.

Chair: Yes.

Mr Bacon: King's College Hospital is not in and UCL is not in. They are not part of the National Programme. They are huge hospitals.

Q307 Jackie Doyle-Price: Could I bring us back to the CSC contract, if I may? Obviously CSC has not delivered the goods against its obligations on that contract, and you started to begin renegotiating with it in December 2009, is that correct? What has taken so long?

Christine Connelly: We started our negotiations with CSC in December 2009. We worked through and created a memorandum of understanding that the Department and CSC were prepared to commit to, but we would only commit to that when they had delivered Lorenzo Release 1.9 working in four Trusts. So we had built all that, and we discussed that, as Mr Bacon mentioned, with the Minister for the Cabinet Office in December last year.

Q308 Mr Bacon: I did not actually mention the Minister for the Cabinet Office.

Christine Connelly: Sorry, I thought you did.

Q309 Mr Bacon: No, I just said a high-level meeting.

Christine Connelly: I am sorry. There was a meeting between me, Mike Laphen of CSC and the Minister for the Cabinet Office and the fact that meeting has taken place is already in the public domain. That happened last Christmas. Given the delays we had had with CSC, the construct around that memorandum of understanding was predicated on delivery of those four Trusts, and we were still waiting at that time for Pennine, the Mental Health Trust, to deliver, which was due in February. That was late by then and we would not sign the MOU until that had happened. And we stated at that point that, if that Trust did not deliver, the shape of the MOU that we had agreed would move off the table, and we would then look to replace it with something else or nothing at all. But since then we have negotiated another structure of a MOU, which a CSC representative referred to earlier today, and that MOU has been put on the table for evaluation, and we are evaluating that proposition now.

Q310 Justine Greening: But ultimately they are in breach of contract, so why not just cancel it?

Christine Connelly: CSC disputes the fact that it is in breach of contract. We have informed it of our viewpoint, it has informed us of its viewpoint, and we are taking advice on what that looks like and where the balance of probability lies. So while we claim it is in breach of contract, and clearly we do, CSC itself does not accept that.

Q311 Justine Greening: I find this incredible. We have just listened to a representative from CSC, and she was very confidently giving a very good account of herself, but ultimately the facts are there. They are in breach of contract. How long does it take before the NHS wields its power in these situations? You are the customer. You have the obligations there.

Sir David Nicholson: And we did it with Fujitsu.

Q312 Justine Greening: How long does it have to be, and how much money has to be wasted, before you actually call time on this?

Christine Connelly: We do not believe that any money has been wasted because we only pay for systems when they are live and working in Trusts. In terms of where we are with the CSC contract, we agree that the current position is not at all what we would want to have, and we have said that we believe that CSC is in breach. CSC disputes that, and we then have to follow our process through. We are looking at options around that, and as the Prime Minister said in his response to Mr Bacon's question in the House, all those options are still being considered, including termination. What we must do is ensure that we get the best value for the taxpayer moving forward, and deliver systems into the NHS that are fit for purpose.

Q313 Justine Greening: And you are looking at taking £500 million out of that contract. Given their performance to date, what confidence can you possibly have that they will deliver against a reduced fee?

Christine Connelly: At the minute, we talk about the amount we are taking out of the contract as at least £500 million. So in terms of the deal that CSC has proposed, it understands that number, and the Chief Exec met with Sir David and discussed a different view of how they could take this programme forward. So we are evaluating that proposal.

Q314 Nick Smith: Following on from that, according to our brief there are over 3,000 places still to receive a system. Most of them are in the Midlands, the North and the East. That is where CSC is operating. You are now giving it a hard time, looking to take money out. What is likely to be the impact on those areas in terms of functionality and services from these systems?

Christine Connelly: In terms of the 3,000 people, the majority of that is in GPs. As was referred to earlier, what we have done in London and what we would seek to do in the North, the Midlands and East is to move the GP systems from the LSP contracts to GP systems of choice, with the exception of those that are already provided through the TPP SystmOne.

Q315 Nick Smith: Specifically about CSC, are you planning to try to get £500 million to spend it on other suppliers to deliver what is needed in the Midlands, the North and the East, or are they likely to get less functionality from the deal that you eventually do?

Christine Connelly: What we intend to do with any supplier agreement that we have is focus our functionality on the Clinical Five plus the key departmental systems. One of the things that often happens on very large IT programmes is that people over time inflate the

scope of the programme, and it is quite important regularly to go back and review that. That is one of the things that we have done through the engagement process that happened in the middle of 2008 to clarify exactly what was the relevant and appropriate clinical functionality in the systems that this programme provided. So we would seek to focus the CSC contract, if we take it forward, on that clinical functionality, the Clinical Five and the key departmental systems.

In terms of the GP functionality, our view at this stage is to do what we did in London and move the GP functionality to the GP systems of choice, with the exception of those GPs who have already signed up for the product delivered under the CSC contract, and CSC is happy with that position on GPs.

Q316 Austin Mitchell: I would have thought it would be cheaper right from the start to let the Trusts sign their own contracts with their own suppliers, and use what system they want to provide, and it is agreed nationally, instead of asking them to act through the contracts of four regional monopoly suppliers. That is just a passing thought.

My real question is, including London, what will be the total cost for the Trusts? There was an estimate earlier that the Trusts would have to pay £3.4 billion out of a total bill of £12.4 billion. That total bill might well be higher now, so what will the Trusts, in the desperate situation they are in, trying to impose these efficiency savings, have to pay at the end of the day?

Christine Connelly: The total cost inside the £11.4 billion of local deployment costs is almost £2.1 billion. So far, they have spent £882 million, so I guess the remaining value of that is something like £1.1 billion.

Q317 Austin Mitchell: And they have to find that at a time of huge efficiency savings?

Christine Connelly: That is what they estimate it would cost to deploy these systems.

Q318 Mr Bacon: Ms Connelly, you rightly said that I wrote to you last Thursday, and obviously we have not had time to cover all the answers by any means. Would you mind writing to the Committee with answers so that we can include them in the Report? Also, I will probably be writing to you again in the next couple of days with some more questions. If you could turn around these questions and the imminent ones very quickly that would be very helpful.

Christine Connelly: Certainly we have researched the answers to the set that you wrote to me last Thursday, and I have them with me today. I am happy to read them out or send them to you.

Q319 Chair: Thank you for your patience. It has been quite a long session. I take it from this that the purpose has changed. You may think it is valid, the current purpose. The purpose has changed from the original intent, and I think we will want to comment on that. I think we all agree that the costs have escalated for what you are getting in terms of Trusts covered or health settings covered for the money spent. While I accept the difference in view between the NAO and you on figures and value for money, I think we are left with a huge question mark on how much we can salvage from the £4.3 billion to spend elsewhere on front-line services within the NHS. Thank you very much indeed.