

From Ben Bradshaw MP, Minister of State for Health Services and  
Minister for the South West



Richmond House  
79 Whitehall  
London  
SW1A 2NS

Tel: 020 7210 3000

PO000000229840

Dr Hamish Meldrum  
Chairman of the Council  
British Medical Association  
BMA House  
Tavistock Square  
London  
WC1H 9JP

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26 SEP 2007

*Dr Hamish*

Thank you for your letter of 1 August about the National Programme for IT (NPfIT). I apologise for the delay in responding.

I appreciate that you are able to state publicly the British Medical Association's (BMA's) wish to see the National Programme succeed.

The NPfIT is here to enable NHS-wide access to integrated, high quality health information. I know that the BMA has been calling for better health IT for many years now and has been working closely with the Programme, particularly through the national clinical leads.

I attach an appendix with some initial responses to the concerns raised in your letter. Many of the issues you raise are complex and not all may be easy to resolve in the short term. However, they set an agenda and I believe it would be helpful for us to meet to discuss these issues in more detail.

In relation to the broad themes that you have identified, I agree that clinical engagement with the doctors who are already using, and will continue to use, the programme's systems and services is vital for successful implementation and to secure the changes in clinical practice and delivery that will make real improvements in the quality of care. I welcome any offer of help to this end and hope the BMA will be able to work with the Office of the Chief Clinical Officer in NHS Connecting for Health, and with the newly appointed National Clinical Directors, Dr Mark Davies and Dr Simon Eccles, both of whom are well known to you.

I think you are right to highlight in particular the issues affecting secondary care. Responsibility for engaging with local clinicians in a hospital as it plans to deploy the new IT rests with the local service provider, with the Strategic Health Authority and the particular hospital Trust itself. The NPfIT Local Ownership Programme has been implemented specifically to strengthen this local element. Dr Eccles would be happy to work with you to achieve assurance that in doing so, the best possible methods are

adopted for securing the confidence and understanding of staff at all levels across secondary care.

There is no doubt that the success or failure of the summary care record depends crucially on our being able to establish public and professional confidence in the confidentiality with which the personal health data it will contain is treated, and in the security of the arrangements which protect it. I can assure you that there are no plans for deploying the summary record beyond the existing early adopter sites until we have understood the lessons from the independent evaluation from University College London. We would like to work with the BMA to make sure the evaluation is meaningful, not least in that it is based on sufficient professional input to learn all the right lessons for national rollout. You may know that Dr Gillian Braunold has recently been appointed the Clinical Director for the summary care record and I know she has already established a close working relationship with the BMA and local medical committees in the early adopter areas.

Lastly, I think it is widely recognised that data that will flow from the secondary uses service has the potential to a valuable research tool for health improvement. It is imperative that the public understand, and have confidence in, plans for their data, and that the right safeguards are in place.

I look forward to meeting with you, and the opportunity to take these important matters forward in the near future.

With best wishes,



**BEN BRADSHAW**

**Appendix PO00000229840**

***(I) Renewed engagement with system users***

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

The NPfIT Local Ownership Programme (NLOP) was introduced in response to a perceived need to improve and strengthen local ownership and governance of the National Programme, and to address the need for better clinical engagement and greater public understanding of, and confidence in, the Programme. We share the BMA's aspiration for it to fulfil these purposes. The essence of NLOP is that control over key programme activities and associated resources has explicitly been given to the NHS through Strategic Health Authorities (SHAs). Specific to the issue of renewed engagement with system users, NLOP makes Information Management and Technology (IMT) planning, and the 'requirements/design/build/test' cycle the responsibility of the NHS under the control of the SHAs and the Local Programme for IT.

Whilst NLOP is still in its early days (resources formally transferred with effect from 1 July), the opportunity to drive a change in behaviours and priorities by engaging local NHS users even more in the system development process now exists in reality.

We welcome the BMA's support in capitalising effectively on this opportunity, and will continue to seek its input to developments as they emerge.

**2. Introduce an open, two-way reporting mechanism, which allows users to highlight problems with systems and suppliers to feed back what steps are being taken to address these issues and within what timeframe.**

As part of NLOP, we have reviewed the way in which programme requirements are specified to Local Service Providers (LSPs), including ensuring that this remains a process which supports the objective of continual improvement and the changing needs of a modern NHS.

The model process has always been that requirements for each LSP release are defined by NHS managers and clinicians. These are then developed by the LSP, and implemented across the NHS. However, there has previously been limited opportunity to revise or refine the requirements and it has often been a challenging process to engage NHS clinicians to fully and clearly articulate their requirements. Going forward, therefore, it is proposed that in addition to these arrangements, the NHS will introduce the concept of 'user groups' whose constituency will include all