Can the new “electronic highway” for the NHS have a smooth launch?

Geoff Watts *London*

The NHS in England is getting serious about information technology. It has to. Size, organisational complexity, and burgeoning knowledge are all driving in the same direction: a new “electronic highway” linking all parts of the NHS. The new system will provide “seamless care for patients through GPs, hospitals, and community health services.” That, at any rate, is the hope.

Typically for Britain, many innovations in NHS computing have been the brain children of talented enthusiasts. The GP, the registrar, or the manager who could see a better way of referring patients, retrieving their records, or juggling available bed space have all made their mark. But the day of the amateur geek, however inspired, is over.

Like other branches of government that spend taxpayers' money, the Department of Health likes to emphasise the measure of its task. Hence the talk of 300 million GP visits annually, five million hospital admissions, and so on. Richard Granger, joint director of the NHS National Programme for

IT, has pointed out that by the time the new network is up and running, 850 000 staff will have access to it. Only the system operated by the United States's defence department can boast more users.

The present system has grown piecemeal, often to link buildings or departments in a single trust. The replacement programme was formally established in October 2002, but the awesome task of designing and installing the infrastructure takes time.

N3, the new network due to replace the existing NHSnet, will be national but will be run by five suppliers, each covering a different area and each able to compete on price. N3 will not just handle data, emails, and the like but will also act as the NHS telephone network and offer rapid transmission of x ray films and other images.

The engineers claim that it will mesh smoothly with systems already in place. If an old system is due for renewal or cannot be integrated, it will—after local consultation—be replaced.

Security is an issue with any computer system, and the national programme planners say that this was a priority requirement in all the contracts. “Access to the system and what users can see and update will be determined by the user's role,” a spokesman told the *BMJ*. “For example, a receptionist will not have access to clinical information.”

The programme is ambitious, but the implementation of computer systems in the UK public sector has a dismal record. Will

this one be any different? The organisers claim to have learnt the lessons of past failure and say that they have “broken down the procurement and implementation into achievable bite size chunks.” By phasing the system in gently, the planners believe they can minimise disruption.

Perhaps. But the recent resignation of Professor Peter Hutton, chairman of the project's National Clinical Advisory Board, is seen by some as a hint of troubles yet to come. The wording of Hutton's resignation statement was less than explicit, but it's generally assumed that what prompted his

departure—after only six months—was some dissatisfaction with staff consultation over impending change. There was some surprise when, in March, Professor Aidan Halligan became joint director general of the programme with responsibility for ensuring clinical involvement. It is possible he and Hutton do not agree over how best to proceed.

The success of innovative information technology depends on more than connecting the right wires. If the organisers of national programme don't already know that, they soon will. □

Paper prescriptions will soon be distinctly “last season”

Geoff Watts *London*

Paper prescriptions will soon be history as a system of electronic transmission of prescriptions is to be phased in from early in 2005 in England.

Currently the doctor writes or prints a prescription for the patient to take to the pharmacist, who reads and dispenses it before adding it to the pile destined for the Prescription Pricing Authority. Here it's read again to determine who should be paid, how much, and for what. Given that a majority of prescriptions

are already prepared on a computer, messing around with bits of paper is logically indefensible. The information required by the people who need to read what's on the prescription is already stored electronically—but it's not delivered to them in this form.

The new system will be accessible in all GP surgeries and community pharmacies, and it will be designed to meet the professions' own standards of confidentiality and security. Patients will be able to choose which

pharmacy to collect their medicines at, and the system will incorporate safeguards to prevent duplicate supplies being dispensed. Nurse prescribing won't initially be part of the system, but it's assumed that they too will eventually join in.

So much for the dream. To test the new system, three private sector consortiums—each with expertise in computing and pharmaceuticals—have run pilot studies of three different systems.

The pilots were launched in summer 2002 and intended to last six months, but early recruiting difficulties forced them to run for longer than planned. In the end, more than 30 000 prescriptions were issued by 34 gen-

eral practices and handled by 23 pharmacies.

An evaluation by Sowerby Centre for Health Informatics at Newcastle upon Tyne reached carefully measured conclusions. It found the scheme “technically viable,” adding: “Patients, GPs and pharmacists are on the whole likely to find ETP [electronic transmission of prescriptions] acceptable, and may come to appreciate the benefits in time.”

As that last phrase hints, the pilots seem not to have left users howling for immediate implementation. But the report attributes certain “negative attitudes” to what it describes as “temporary difficulties encountered with new software and business processes.” □