English Pharmacy Board 2 July 2008 **PUBLIC BUSINESS**

Developments in Healthcare IT

Purpose
To note the update on developments in healthcare IT

Strategic objective domain
The public recognise and use pharmacists as the professionals with expertise in medicines

Background
The National Programme for IT in England is split into 3 areas:

London Programme for IT (LPfIT)
North, Midlands and East (NME) Programme for IT (NMEPfIT)
Southern Programme for IT (SPfIT)

NHS Connecting for Health (CfH) liaises with the Strategic Health Authorities (SHA) in each region on the various IT programmes. Below is a summary of the programmes that have a direct impact on pharmacy.

Electronic Prescription Service (EPS)

Release 1 (RI)
The most recent statistics presented at the last Pan-Pharmacy IT meeting were:

- Approximately 79% of GP surgeries and 80% of pharmacies are now EPS R1 technically enabled.
- 20-30% of daily prescriptions are being issued using the service.
- 6-11% of prescriptions issued using the services are being downloaded by pharmacies.
- Usage of the system has roughly doubled in the past few weeks.

The pharmacy bodies have continued to encourage pharmacists to use the EPS service to dispense prescriptions where practical so that problems with the systems can be identified and hopefully be resolved before EPS becomes business critical.

Problems associated with workflow that have been identified so far include:
- Unacceptable download times (the download time for the prescription should ideally be within 3 seconds, and certainly not beyond 10 seconds, but times much greater than this have been reported. Some systems also did not allow multiple downloads.
- Some system suppliers lagging behind with software development for R2.

Release 2 (R2)
The functionalities added to EPS Release 2 will mean that an electronic signature is applied to the prescription which will be the legal entity; patients will be able to 'nominate' a pharmacy for their electronic prescription signal to be sent; electronic repeat dispensing will be enabled; prescribers will be able to 'cancel' the electronic prescription; and pharmacists will be able to submit endorsement messages of e-prescriptions back to the spine where the Prescription Pricing Division (PPD) can pick up the signals electronically for reimbursement.

The signed copies of prescribing or dispensing token (depending on where it has been printed) that shows either payment has been made or that the patient is exempt, will still need to be posted back to

the PPD with a FP34c claim form for reimbursement. Therefore, even with Release 2, the prescription service will not be totally paperless but CfH envisage that there will be a significant reduction in the use of paper scripts as 70% of prescription exemptions are for patients who are age exempt.

Release 2 implementation will occur in 2 waves, the first wave will include 5 PCTs:
Berkshire East; Leicestershire County & Rutland; Liverpool; Southwark and Sunderland.

The second wave involves 12 more PCTs. CfH has produced a new leaflet for healthcare professionals on the benefits of EPS Release 2 and this is available via the CfH website.

NHS CfH is continuing to support the suppliers through the process of testing to ensure that systems meet a range of technical and safety criteria before they are used in a live environment. Pharmacy bodies have set up a group recently to work on a road map, stating the priorities that need to be met, so that CfH and suppliers are made fully aware of the issues. To date, no pharmacy system has begun testing for R2 yet. When GP systems are R2 enabled, prescriptions will not be generated by these systems until PCTs give the go-ahead.

The key message is to encourage pharmacists and pharmacy organisations to use the electronic service so that problems can be identified and reported to the relevant groups.

In addition to the issue of accuracy checking, other potential problems in business processes that have been identified include: confusion for patients over the nomination function; the printing of tokens being transferred from surgeries to pharmacies as patients are still required to sign the declaration; not all medicines are prescribable via EPS which could result in incomplete prescriptions and confusion to the patient.

Some pharmacy organisations are also concerned with the problem of having to obtain consent again from patients who are already registered for a collection/delivery service. It is also unclear as to what the process will be for PCTs to ‘switch on’ the EPS R2 functions for surgeries as this may have a locality effect on pharmacy businesses.

Dictionary of medicines and devices (dm+d)

This is the common vocabulary system for medicines and devices used in the NHS. It was originally driven by the Prescription Pricing Division, and the program is now part of CfH. The dm+d feeds into the prescribing and dispensing systems of the EPS program. It consists of a primary care model, a secondary care model and a medical devices model. Development to the primary care model is almost complete while the secondary model is still undergoing final changes.

The model concept consists of 5 sub-sections and there is a set of entries for each section:
Virtual Therapeutic Moiety (VTM) e.g. atenolol
Virtual Medicinal Product (VMP) e.g. atenolol 50mg
Actual Medicinal Product (AMP) e.g. atenolol 50mg tablets
Virtual Medicinal Product Pack (VMPP) e.g. atenolol 50mg tablets x 28
Actual Medicinal Product Pack (AMPP) e.g. atenolol 50mg tablets x 28 (AAH Pharmaceuticals Ltd)

The problem that has been created by this model is that when a clinician prescribes at the AMPP level, the name of the product on the prescription will include the supplier / manufacturer. Under the current Code of Ethics, pharmacists should dispense that particular product and should not substitute with an alternative ‘brand’ i.e. should not dispense ‘atenolol 50mg tablets (Generic UK Ltd)’ for a prescription that states ‘atenolol 50mg tablets (AAH Pharmaceuticals Ltd).

This issue is being considered by the Ethics Committee and it is likely that a consultation will be drafted in the near future on clarification on the terms for substitution.

NHS Summary Care Records (NHS SCR)

Currently the information (medication, allergies and adverse reactions) held in the NHS SCR is created from the GP records. It does not contain information of hospital admissions or discharge notes. It is a resource intended for use in emergency or unscheduled care settings. So far, it has been developed in conjunction with Healthspace, an internet based product. The recent report on the Early Adopter sites by the UCL group (led by Professor Trisha Greenhalgh) has recommended several priorities for the programme.

The main problem highlighted was the consent model that had been chosen – implied consent. The results showed that the majority of patients prefer to give consent at the point of care i.e. consent to view model, as already adopted in Scotland and Wales. The National Clinical Reference Panel (NCRP) which is the multidisciplinary group that advises on developments of the NHS SCR is now addressing the consent issues.

The group is aware of the limitations to the medication information that is held within the SCR e.g. only prescribed drugs are documented and not those dispensed; no information on discharge medication or from out-of-hours care; and no information on self-care drugs. It is likely that these will be scoped in the near future so that the medication history is as accurate / useful as possible (or allowable within chosen systems).

Patients will be able to see their own SCR through the website, Healthspace. Access to a patient's SCR is at present, limited to doctors or emergency care clinicians but it is recognised that access will need to be extended to other healthcare professionals, including pharmacists. Interestingly, most patients interviewed during the UCL project had thought that multi-professional access was already happening.

Smartcards and NHSmail

For security, access to the EPS and SCR will require the use of smartcards. These will be issued to healthcare professionals via PCTs and have to be renewed every 2 years. Currently, there are problems with the request and renewal of smartcards and the smartcard model for R2 is still being discussed.

Approval has been given for community pharmacists and pharmacies to be granted access to NHSmail. The CfH NHSmail team are keen to standardise roll out of the service to pharmacies and have organised a number of pilots to review arrangements for account provision, help desk support and to investigate the pharmacy activities can be used within the system, e.g. transmission of the MUR forms.

Results of the pilots are due towards the end of the year. Below is a summary of the key benefits of NHSmail (compared to other existing work-related email clients):

- Access from any internet connection - at work, home or on the move
- Use of an NHS Directory containing contact details for over one million NHS staff
- Ability to send free SMS and fax messages directly from email
- Same email address throughout one's NHS career, regardless of one's NHS organisation
- Approved by the BMA and Department of Health for exchanging clinical data
- A helpdesk is available 24 hours a day, 7 days a week

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