

CP ITG views on EPS NextGen (Summary)

Electronic Prescription Service (EPS) should evolve from an electronic prescription transfer mechanism into a connected medicines platform which supports safer care, reduced administrative burden, enhanced patient experience and improved interoperability across health and care.

EPS developments should support the ambitions of the NHS, community pharmacy, patients and the wider health and care system whilst maintaining resilience, safety and usability.

A. Adaptable and modern platform

Future EPS should be easier to change, extend and improve, allowing innovation whilst maintaining interoperability between prescribing, dispensing and NHS systems.

Priority areas

A1. Modernise EPS architecture and standards: Underlying structure was based on concepts from more than 20 years ago and cannot easily be adapted to enable iterative enhancements. Consideration should be given to modern interoperability standards and future architectural approaches. (*previous EPS future list ref - 1a*)

A2. Align with modern platform and cloud approaches: Current IT strategies outside the sector are increasingly moving towards cloud-based solutions. (*previous ref 1b*)

A3. Continue Spine modernisation: Spine should continue to be made more adaptable and agile to support future innovation. (*1c*)

A4. Streamline assurance and deployment: Improvements needed to streamline the assurance process for EPS changes so it is quicker, easier and cheaper for NHS assurance teams and suppliers to introduce enhancements safely. (*1d*)

A5. Maintain strong collaborative specification development: User comments should be sought prior to EPS changes by wider circulation of draft specifications earlier during development. (*1e*)

A6. Support timely deployment of nationally agreed changes: Enable important EPS changes to be pushed out to pharmacies where relevant stakeholders agree. (*2c*)

B. Connected medicines ecosystem

Future EPS should operate as part of a wider medicines and care ecosystem supporting interoperability, medicines optimisation and integrated records.

Priority areas

B1. Support structured medicines data: computable dose standards (dose syntax) are available but remain largely unused. Greater adoption would improve safety and interoperability. These standards are also needed to optimise reminders, help prevent missed doses, and improve information available through the NHS App. (*4c*) .

B2. Integrate with future NHS records: EPS should align with future Shared Care Record, Single Patient Record and GP Connect developments, allowing appropriate access to and contribution of medicines information.

B3. Improve information flow across care settings: Linear, constrained information flow between GP, Spine and pharmacy systems limits flexibility and feedback mechanisms. (*4b*)

B4. Improve hospital-community medicines integration: Hospital discharge information and medicines reconciliation currently happens outside pharmacy systems, increasing complexity and risk. System interoperability is required. Guidance and communication between hospital prescribers and community pharmacies are also critical. (4d)

B5. Improve visibility of medicines ordered digitally: Frequently the EPS nominated pharmacy lacks visibility of medicines ordered through NHS APIs and NHS App – including situations where a patient places an order but no prescription is issued due to an error. (4k)

B6. Improve data portability: Data portability is needed when pharmacies switch systems to support continuity of care. (4j)

B7. Improve use of structured identifiers: Greater use of prescription form and item identifiers could improve interoperability and medicines tracking. (4q)

B8. Make better use of EPS and dispensing data: Greater NHS insight from EPS and dispensing data should support service development and medicines optimisation. This would help realise the full benefits associated with B1 (computable dose standards). (4m)

C. Reduced burden

Future EPS should reduce unnecessary workload and administrative burden for pharmacy teams, prescribers and patients.

Priority areas

C1. Modernise authentication: Smartcard processes are outdated when compared with authentication methods used elsewhere, use NHS CIS2. (3a)

C2. Simplify user access and identity management: CIS profile management and usage remain time-consuming. (3b)

C3. Reduce variation in identity processes: Greater standardisation of Registration Authority policy implementation is needed. (3c)

C4. Support mobile and paperless working: Enable paperless prescription processing using mobile devices and secure handheld access. Enable regulatory changes that remove the requirement for ink signatures on tokens. (3d)

C5. Enable electronic tokens: Enable paperless prescription processing through electronic tokens and updated standards. (3e) Progress with NHS App token capability.

C6. Patient digital clarity about medicines across the whole journey: Utilise digital tools and greater interoperability to enable smoother flow of digital medicines (could be eRD now, but later may be less need for ordering and eRD if medicines flow intuitively). Improve management of electronic repeat dispensing (eRD), including prescription renewals, cancellations and changes to treatment. Over time, greater interoperability should support a more intuitive medicines journey for patients. This all links back to single item dispensing. (3f/4g)

C7. Improve reimbursement transparency: Pharmacy teams do not have sight of processed versus priced prescriptions in an automated end-to-end fashion. (3i)

C8. Improve workflow automation and flexibility: Models should better support pharmacy workflow preferences and automation, e.g. more automated downloading and the ability for EPS or pharmacy systems to queue prescriptions automatically. (4e)

C9. Improve operational reporting: EPS and related systems should enable pharmacy teams to create more sophisticated reports and analyses. (4n)

C10. Support appropriate automation and AI-enabled workflows: Future EPS development should support safe automation and administrative efficiency where this reduces burden and improves productivity.

D. Better patient and clinical experience

Future EPS should support safer care, medicines optimisation and a more transparent patient journey.

Priority areas

D1. Provide clinical context alongside prescriptions: Clinical information should be displayed within or alongside the EPS prescription where appropriate. (4a)

D2. Improve prescription journey visibility: Patients, pharmacies and prescribers should have appropriate visibility of medicines ordered, prescribed, dispensed, collected and delivered. (4k, 4o)

D3. Support medicines synchronisation: EPS and related systems should support synchronisation of medicines to improve adherence and patient outcomes. (4f)

D4. Enhance repeat dispensing: eRD improvements are needed to increase flexibility and improve uptake. (4g)

D5. Support pharmacist prescribing: EPS should support future pharmacist prescribing models, medicines optimisation and clinical workflows.

D6. Support controlled drug instalment dispensing: Instalment dispensing for controlled drugs has not yet been enabled within EPS. (4p)

D7. Single item prescribing: EPS prescriptions have a limit of four items, creating risks where medicines arrive separately and limiting flexibility. Consider moving to single-item prescribing or increasing the current item limit. (3g)

D8. Improve alert usability: System safety warning messages should be reviewed continually to minimise alert fatigue and maximise impact. (4h)

D9. Improve presentation of prescription information: The electronic right-hand-side prescription area is frequently overloaded with unnecessary information and could be improved. This will become increasingly important as systems undertake more clinical checking. (4i)

D10. Improve visibility of future prescriptions: Some post-dated prescriptions are not visible early enough to support effective medicines supply planning. (4l)

E. Resilience, safety and governance

Future EPS should remain safe, resilient, transparent and co-designed with users.

Priority areas

E1. Maintain and strengthen Spine resilience: NHS Spine outages have the potential to have a significant impact on the safe and legal supply of medicines and continued reinforcement is needed. (2d)

E2. Improve transparency of service performance: Greater transparency of resilience metrics and service status information would support users and suppliers. (2b)

E3. Business continuity EPS: Expand business continuity options for sites affected by incidents such as fire, flooding or loss of premises access. Enable EPS continuity arrangements where a pharmacy experiences system lockout.

E4. Continue user-centred design and testing: User testing of EPS changes should continue with pharmacy teams, suppliers and stakeholders involved throughout development. (3h)

E5. Maintain proportionate governance and assurance: Governance, assurance and safety processes should continue to support safe innovation and service evolution. (1d, 1e)

F. Implementation and operational considerations

These items remain important, but are more operational or implementation-specific than strategic direction. They may be better tracked through NHS delivery programmes, CP ITG workstreams or future detailed requirements papers.

Priority areas

F1. Review EPS item grouping limitations: EPS prescriptions have a limit of four items, pushing some patients' medicines onto multiple prescriptions which may arrive at different times. (3g)

F2. Reduce variation in Registration Authority operational processes: More standardisation of Smartcard Registration Authority policy implementation may be required. (3c)

F3. Support flexible prescription download workflows: Pharmacy teams may benefit from flexibility to choose between manual download, scheduled download and automated download workflows. (4e)

F4. Improve presentation of supplementary prescribing information: The electronic right-hand-side prescription area is frequently overloaded with unnecessary or outdated information and may benefit from improved standards and guidance. (4i)

F5. Consider management of post-dated prescriptions: Some GP practices post-date prescriptions but pharmacies do not currently have advance visibility of these items. (4l)

F6. Continue assurance process improvement: Detailed assurance process improvements should continue to be reviewed to support timely and safe deployment of EPS changes. (1d)

F7. Continue specification and stakeholder engagement improvements: Draft specifications should continue to be shared and reviewed with stakeholders during development. (1e)

This list has been developed and collated by CP ITG and incorporates feedback from pharmacy teams. Future versions will continue to be informed by user feedback. If you require further information about the list or would like to suggest changes, please contact da@cpe.org.uk.