PSNC Service Development Subcommittee Agenda

For the meeting to be held on Wednesday 22nd May 2019

At 14 Hosier Lane, London, EC1A 9LQ

Commencing at 3.30pm

Members: Richard Bradley, Clare Kerr, Sunil Kochhar, Prakash Patel, Faisal Tuddy, Gary Warner (Chairman)

1. Welcome from Chair
2. Apologies for absence
3. Conflicts or declarations of interest
4. Minutes of the last meeting (pages 2-5) (**Appendix SDS 01/05/2019**)
5. Actions and Matters Arising

Action

6. General Pharmaceutical Council consultation on guidance for pharmacist prescribers (pages 6-8) (**Appendix SDS 02/05/2019**)
7. Reducing the climate change impact of inhalers (pages 9-10) (**Appendix SDS 03/05/2019**)
8. Vaccination and Immunisations Review (pages 11-20) (**Appendix SDS 05/05/2019**)

Report

9. Update on NHS IT projects (pages 21-25) (**Appendix SDS 06/05/2019**)
10. Any other business

Minutes of the PSNC Service Development Subcommittee meeting held on Wednesday 6th February 2019 at 14 Hosier Lane, London, EC1A 9LQ

Present: Richard Bradley, Sunil Kochhar, Prakash Patel, Faisal Tuddy, Clare Kerr, Gary Warner (Chair)

In attendance: Sian Retallick, Alastair Buxton, Rosie Taylor, Zainab Al-Kharsan, Margaret MacRury, Adrian Price, Mike Pitt, Fin McCaul, Indrajit Patel, Jay Patel, Alice Hare, Tricia Kennerley, Mike Dent

Item 1 – Welcome from Chair

Item 2 – Apologies for absence

2.1. No apologies for absence were received.

Item 3 – Conflicts or declaration of interest

3.1. No new conflicts of interest were declared.

Item 4 – Minutes of the last meeting

4.1. The minutes of the subcommittee meeting on 9th October 2018 were agreed.

Item 5 – Actions and Matters arising

5.1. Following a request at the October meeting for further proposals on including mental health in the next Quality Payments Scheme, Marc Donovan provided some suggestions, which have been included in the list of potential future quality criteria ideas.

5.2 Alastair Buxton provided an overview of his recent discussions with NHS England on the proposed new consent requirements and wording for the consent forms for MURs and NMS. Some information governance issues had been raised and discussions are ongoing between the pharmacy and IG teams within NHS England.

5.3 Rosie Taylor had communicated the subcommittee's views on the Quality Payments matters to NHS England as discussed at the previous meeting. NHS England agreed that contractors would only need to include bank holiday dates for 2019 until the end of May 2019. The option of allowing contractors to go back into their declaration on MYS after they had submitted it and make alternations was not, in the end, possible for this scheme.

Item 6 – SDS priority areas for 2019

6.1. No additions or amendments were proposed to the suggested priorities for the work of the Services Team and SDS during 2019, but it was noted that priorities for negotiations may also include prevention/public health services and the development/protection of MURs.

6.2 The chair noted that it would be unlikely that the Services Team would be able to spend much time on priority 4 (Developing PSNC's support for local services development, commissioning and implementation) due to current capacity and resource.

6.3 The subcommittee considered and agreed the suggested priorities for the work of the Services Team and SDS during 2019.

Item 7 – Quality Payments – discussion on the future

7.1 The subcommittee considered and agreed a set of principles to inform the future development of the scheme.

7.2 A thorough review of the potential future quality criteria included in the agenda was undertaken with suggested changes and removal of some of the options.

Item 8 – Seasonal Influenza Vaccination Advanced Service

8.1 The subcommittee considered whether any changes are necessary to the service for the 2019/20 season.

Item 9 – Developing a patient safety strategy for the NHS - Proposals for consultation

9.1 Alastair Buxton advised that he had already discussed providing a joint response with the other community pharmacy organisations, through the CCA hosted community pharmacy patient safety group.

9.2 The subcommittee agreed that a joint response to this consultation with other community pharmacy organisations would be appropriate, alternatively the views of the community pharmacy patient safety group should inform the development of PSNC's response.

Action 2: Continue the discussions with the community pharmacy patient safety group and the CCA around the potential for a joint or aligned response to the consultation (AB).

Item 10 – GPhC consultation on initial education and training standards for pharmacists

10.1 The Subcommittee agreed that PSNC's response should be aligned with the views of the CCA hosted workforce group.

Action 3: Speak to Marc Donovan to see if he would be happy for the CCA hosted workforce group's draft response to be shared with the Committee for comment, to feed into the PSNC response to the consultation (AB).

Report

Item 11 – Update on NHS IT projects

11.1 Alastair Buxton provided an update on discussions with DHSC on our request that maternity exemption data should continue to be provided to pharmacy teams via the

Real-Time Exemption Checking (RTEC) system. Janice Perkins had participated in a recent discussion of the issue with DHSC and NHS Digital. DHSC had concluded that the case for provision of the data had not been made, as there were other ways in which the information could be obtained by pharmacy teams. Once RTEC is rolled out, guidance will be issued to contractors to highlight the issue and the need to put in place mitigations once the information is no longer available from the patient's signed declaration.

Action 4: Discuss with the Community Pharmacy Patient Safety Group options to mitigate the risk of removal of the maternity exemption information when RTEC is introduced and issue appropriate guidance to contractors (AB).

Item 12 – Falsified Medicines Directive (FMD)

Item 13 – Any other business

13.1. There was no other business.

Return to agenda item

Subject	General Pharmaceutical Council (GPhC) consultation on guidance for pharmacist prescribers
Date of meeting	22nd May 2019
Committee/Subcommittee	SDS
Status	Public
Overview	This paper introduces the GPhC's proposed guidance for pharmacist prescribers and lists the consultation questions.
Proposed action	Read the GPhC's consultation on guidance for pharmacist prescribers ahead of the subcommittee meeting. At the meeting, provide thoughts on the GPhC's proposals to inform PSNC's response to the consultation.
Author of the paper	Rosie Taylor

Introduction

In March 2019, the General Pharmaceutical Council (GPhC) launched a Consultation on guidance for pharmacist prescribers; the consultation closes on 21st June 2019.

The consultation is on proposed guidance for pharmacist prescribers to make sure they provide safe and effective care when prescribing.

The guidance sets out nine key areas that relate to the provision of safe and effective prescribing. Pharmacist prescribers should consider the first eight areas when prescribing, to ensure safe and effective care. These are:

1. taking responsibility for prescribing safely;
2. keeping up to date and prescribing within your level of competence;
3. working in partnership with other healthcare professionals and people seeking care;
4. prescribing in certain circumstances;
5. prescribing non-surgical cosmetic medicinal products;
6. remote prescribing;
7. safeguards for the remote prescribing of certain medicines; and
8. raising concerns.

Section 9 deals with information for pharmacy owners and employers of pharmacist prescribers.

Consultation questions

The GPhC has asked for views on the following questions in their consultation document:

Key areas for safe and effective prescribing

1. Have we identified all the necessary areas for ensuring safe and effective care is provided?
2. For each of the nine key areas, do you agree or disagree with the guidance we have proposed?
3. Please explain your responses to the two questions above.

Prescribing safely

4. Do you agree or disagree that these are circumstances when a pharmacist prescriber must decide whether they can prescribe safely for a person?
5. Are there any other circumstances when a pharmacist prescriber must decide whether they can prescribe safely for a person?
6. Please explain your responses to the two questions above and describe any additional circumstances that should be considered.

Prescribing and supplying

7. Are there any other circumstances where you think a pharmacist prescriber should be able to prescribe and supply?
8. Please describe any additional circumstances that should be considered.

Safeguards for the remote prescribing of certain categories of medicines

9. Are there any other safeguards that should be put in place to make sure certain medicines are prescribed safely remotely?
10. Please describe any additional safeguards you think there should be.
11. What kind of impact do you think our proposals will have on patients and the public?
12. What kind of impact do you think our proposals will have on pharmacist prescribers?
13. What kind of impact do you think our proposals will have on other pharmacy professionals?
14. What kind of impact do you think our proposals will have on employers or pharmacy owners?
15. Please give comments explaining your responses to questions 11 to 14.

Equality impact

16. Do you think our proposals will have a negative impact on certain individuals or groups who share any of the protected characteristics listed below? Please tick all that apply.

Age	Race
Disability	Religion or belief
Gender reassignment	Sex
Marriage and civil partnership	Sexual orientation
Pregnancy and maternity	None of the above

17. Do you think our proposals will have a positive impact on certain individuals or groups who share any of the protected characteristics listed below? See table above - please tick all that apply.
18. Please describe the impact on each of the individuals or groups you have ticked in questions 16 and 17.

Subcommittee actions

Read the GPhC's consultation on guidance for pharmacist prescribers ahead of the subcommittee meeting. At the meeting, provide thoughts on the GPhC's proposals to inform PSNC's response to the consultation.

Return to agenda item

Subject	Reducing the climate change impact of inhalers
Date of meeting	22nd May 2019
Committee/Subcommittee	SDS
Status	Public (but SDU draft paper is confidential until it is finalised and published)
Overview	This paper introduces work that the NHS Sustainable Development Unit (SDU) has been undertaking on the use of inhalers and their impact on climate change. PSNC has recently been invited to participate in this work, by joining the SDU's working group on reducing the climate change impact of inhalers. The RPS is already a member of the working group. The invitation for PSNC to join the group follows work the subcommittee has previously discussed on the development of a national inhaler recycling scheme. The SDU has drafted a document on behalf of the working group on its aims and plans for the future; this was partially drafted in response to the scrutiny of F-gases undertaken in 2017 by the UK Government's Environmental Audit Committee.
Proposed action	Consider the SDU's document and whether PSNC can support the aims and proposals.
Author of the paper	Alastair Buxton

Introduction

In May 2018, the Committee considered a proposal that a national inhaler recycling scheme should be developed, working with the pharmaceutical industry and NHS England. This pharmaceutical industry proposal had been given added momentum by Parliament's Environmental Audit Committee, which had expressed concern at the lack of a recycling scheme being available across the country.

PSNC agreed that this proposal was worth pursuing and with other stakeholders, it was invited to participate in the development of a pilot project in Greater Manchester. Due to changes in commissioning staff in Greater Manchester, NHS England has not yet been able to provide practical support for the development of a pilot, but pharmaceutical industry partners are continuing to explore options.

Work on reducing the climate change impact of inhalers has also been undertaken at a national level by the NHS Sustainable Development Unit (SDU); the SDU is jointly funded by, and accountable to, NHS England and Public Health England to ensure that the health and care system fulfils its potential as a leading sustainable and low carbon service.

Last year, the SDU formed a working group on reducing the climate change impact of inhalers, with representation from a wide range of NHS and professional bodies, including the Royal Pharmaceutical Society. Following the work in Greater Manchester, the SDU invited PSNC to join the working group.

The SDU has drafted a document on behalf of the working group on its aims and plans for future activity across the health and care sector; this was partially drafted to provide a response to the scrutiny of F-gases undertaken in 2017 by the Environmental Audit Committee. This draft document is appended to the agenda as a separate PDF document (**Appendix SDS 04/05/2019**).

Further work is being undertaken by the SDU to identify how different parts of the health and care system can play their part in reducing the climate change impact of inhalers. Community pharmacy's initial role would be to continue to provide a recycling service to patients (where already offered as part of the GSK or TEVA schemes) or to accept back pMDI inhaler canisters from patients for safe disposal via the usual waste medicines disposal service.

Recycling canisters is a better environmental option than safe disposal, but disposal via incineration is still preferable to disposal via domestic refuse, as it is highly likely that F-gases in inhaler canisters will be released to the atmosphere when disposed of via that route.

Subcommittee actions

The subcommittee is asked to review the draft working group document and to advise whether PSNC can support it.

Return to agenda item

Subject	Provision of other vaccinations from community pharmacies
Date of meeting	22nd May 2019
Committee/Subcommittee	SDS
Status	Public
Overview	PSNC has been invited to join the advisory group for NHS England's review of Vaccination and Immunisation; the initiation of the review was agreed with the General Practitioner Committee (GPC) of the BMA as part of the last round of negotiations on the GP contract. The review provides an opportunity to push for a wider range of vaccines to be available via pharmacies as part of the NHS vaccination programme. The advisory group will also consider how a more collaborative approach to flu vaccination could be implemented by general practice and community pharmacy. This paper describes the UK vaccination schedule and hence the full scope of potential vaccination opportunities for community pharmacy to participate in.
Proposed action	Consider which vaccinations should be considered for discussing with NHS England and Public Health England, as vaccines that community pharmacists could potentially administer.
Authors of the paper	Alastair Buxton and Rosie Taylor

Introduction

PSNC has been invited to join the advisory group for NHS England's review of Vaccination and Immunisation; the initiation of the review was agreed with the General Practitioner Committee (GPC) of the BMA as part of the last round of negotiations on the GP contract.

The review provides an opportunity to push for a wider range of vaccines to be available via pharmacies as part of the NHS vaccination programme. The advisory group will also consider how a more collaborative approach to flu vaccination could be implemented by general practice and community pharmacy.

The Vaccination and Immunisation Review

The recently announced *Investment and evolution: a five-year framework for GP contract reform to implement The NHS Long Term Plan* included a commitment on the part of NHS England and the GPC to undertake a review of vaccination and immunisation contractual arrangements and outcomes in 2019 with a view to making recommendations for consideration in contract negotiations for 2020 and 2021.

This review will replicate the structures and collaborative, co-design model successfully utilised by the recent QOF Review. The approach therefore will be to work with the medical profession and other stakeholders to develop proposals for change which will deliver value to patients through the promotion of an increased uptake of vaccinations, reduce health inequalities, help prevent supply issues and support the resilience and sustainability of general practice. It will also take account of the wider context of primary care and specifically 1) the movement to at-scale working, 2) the contribution of community pharmacy, and 3) the recommendations of the Richards Review of screening where parallels can and should be drawn.

The Review will conclude in Autumn 2019 with its outputs used to inform subsequent negotiations, led by NHS England, with GPC England, on the GMS contract and between DHSC/NHS England and PSNC on the community pharmacy contractual framework. Recommendations for change will be developed assuming fixed system resources.

To ensure the views and expertise of key stakeholders are brought to bear throughout the process of the review, NHS England has invited representatives from GPC, PHE, PSNC, RCGP, NICE, DHSC, NHSCC, RCN, NPAC and a patient representative to participate in an Advisory Group. However, the output of this group is advisory and will not bind negotiating parties, nor predetermine future negotiations.

Scope of the review

This review will address the following issues in relation to the main vaccination programmes:

- How to ensure that contractual arrangements promote achievement of high uptake rates of immunisations, with improvements in all areas and a narrowing of regional variation. This will include consideration of barriers to uptake and potential mitigating activities.
- The detail of incentive and payment arrangements, including reimbursement, with a view to improving their incentive effect and simplicity including:
    - The childhood vaccines and immunisations additional service

  - The childhood immunisation scheme Directed Enhanced Service
  - The influenza and pneumococcal immunisation scheme Directed Enhanced Service
  - Other vaccination and immunisation programmes set out in the SFE and in NHS England enhanced services
  - Incentives for influenza immunisation in the Quality and Outcomes Framework
  - Vaccines outside of central procurement
- Guidance to practices including clarification of expectations around call/recall for immunisations, scheduling, vaccine procurement and recording uptake to improve delivery and reduce administrative burden.
- Specifically, a review of arrangements for community pharmacy and general practice delivery of flu vaccination to ensure synergy.
- Contractual arrangements for outbreaks, catch-up and mop up programmes and post-exposure vaccinations.
- Review of the list of chargeable travel vaccines.
- Contractual and funding implications for both general practice and community pharmacy arising from any move to central influenza vaccine procurement.
- The management of hepatitis B vaccination and immunocompromised patients.
- The contractual implications of the recommendations of the NHS England Review of National Cancer Screening Programmes (interim report April 2019, final report summer 2019) and parallels with the immunisation programme where they should and can be drawn.

The opportunity for community pharmacy

The review presents an opportunity for community pharmacy to argue for an enhanced role in delivery of the UK vaccination programme, as a means of improving the convenience of access to vaccination to patients, which may then support improved vaccination rates.

Practical issues would have to be addressed in relation to the vaccines within the programme which are centrally procured and distributed by PHE. The current ImmForm system and vaccine distribution process is not designed to allow distribution to over 11,000 community pharmacies.

There is, however, an opportunity to consider which vaccines it may be practicable for community pharmacy to play a role in provision. PSNC has previously agreed to seek the commissioning of a catch-up service for paediatric nasal flu vaccination from community pharmacies to cater for the needs of children who miss the vaccination in school; this will be raised with NHS England as part of the review.

Subcommittee action

The following tables contain information on the UK vaccination schedule. Consider which vaccinations should be considered for discussing with NHS England and Public Health England, as vaccines that community pharmacists could potentially administer.

The table below, taken from Chapter 11 of The Green Book, shows the schedule for the UK's routine immunisation programme (excluding catch up campaigns).

- centrally supplied vaccine

Age due	Vaccine given	How it is given	Relevant statistics
Eight weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B (DTaP/IPV/Hib/HepB) #	One injection	• There were **550,454** children who were 1 year old in England in 2017/18 (*Ref: NHS Digital, Childhood vaccination coverage statistics – England 2017-18*). • Rotavirus was the only vaccination to increase coverage in 2017/18, rising 0.5% to **90.1%** (*Ref: NHS Digital, Childhood vaccination coverage statistics – England 2017-18*). • In 2017/18, **93.1%** of children reaching their first birthday were reported to have completed their primary DTaP/IPV/Hib course (three doses) (*Ref: NHS Digital, Childhood vaccination coverage statistics – England 2017-18*). • The European Region of the World Health Organization (WHO) currently recommends that on a **national basis at least 95% of children are immunised against diseases** preventable by immunisation and targeted for elimination or control (specifically, diphtheria, tetanus, pertussis, polio, Hib, measles, mumps and rubella) (*Ref: NHS Digital, Childhood vaccination coverage statistics – England 2017-18*).
	Pneumococcal conjugate vaccine (PCV) #	One injection	
	Meningococcal B (MenB) #	One injection	
	Rotavirus #	One oral application	
Twelve weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B (DTaP/IPV/Hib/HepB) #	One injection	
	Rotavirus #	One oral application	
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B (DTaP/IPV/Hib/HepB) #	One injection	
	Meningococcal B (MenB) #	One injection	
	Pneumococcal conjugate vaccine (PCV) #	One injection	
One year old (on or after the child's first birthday)	Hib/MenC booster #	One injection	• There were **550,454** children aged 1 year in England in 2017/18 (*Ref: NHS Digital, Childhood vaccination coverage statistics – England 2017-18*). • In 2017-18, DTaP/IPV/Hib coverage at 12 months declined for the fifth year in a row, decreasing 1.6% since 2012/13 and is at its

			lowest since 2008-09. However, coverage at 24 months has remained **above the 95%** target since 2009/10 (*Ref: NHS Digital, Childhood vaccination coverage statistics – England 2017-18*).
	Pneumococcal conjugate vaccine (PCV) booster #	One injection	• Reported figures show that **93.3%** of children in England had completed a primary immunisation course of PCV at 12 months in 2017/18, a decrease from 93.5% the previous year (*Ref: NHS Digital, Childhood vaccination coverage statistics – England 2017-18*).
	Meningococcal B (MenB) booster #	One injection	• MenB coverage is reported as a national statistic for the first time this year and achieved **92.5%** at 12 months (*Ref: NHS Digital, Childhood vaccination coverage statistics – England 2017-18*).
	Measles, mumps and rubella (MMR) #	One injection	• Coverage for the Measles Mumps and Rubella (MMR) vaccine as measured at two years decreased in 2017/18 for the fourth year in a row. Coverage for this vaccine is now at **91.2%**, the lowest it has been since 2011/12. (*Ref: NHS Digital, Childhood vaccination coverage statistics – England 2017-18*).
Eligible paediatric age groups annually (programme phased in over several years; see Chapter 19)	Live attenuated influenza vaccine (LAIV)#	Nasal spray, single application in each nostril (if LAIV is contraindicated and child is in a clinical risk group, give inactivated flu vaccine; see Chapter 19)	• There were approximately **660,700** two year old patients registered with a GP practice in England in 2018/19; **43.8%** were vaccinated (43.6% were not in a clinical risk group and 54.5% were in a clinical risk group). • There were approximately **637,600** three year old patients registered with a GP practice in England in 2018/19; **45.5%** were vaccinated (45.5% were not in a clinical risk group and 56.9% were in a clinical risk group) (*Ref: PHE, Seasonal flu vaccine uptake in GP patients: monthly data, 2018 to 2019 - Data is provisional and*

			represents 96.7% of all GP practices in England responding to the main survey).
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio (DTaP/IPV or dTaP/IPV) #	One injection	• There were approximately **637,600** three-year-old patients registered with a GP practice in England in 2017/18. • In 2017/18 **87.2%** of children in England received their first and second dose of MMR vaccine by their fifth birthday (*Ref: NHS Digital, Childhood vaccination coverage statistics – England 2017-18*).
	Measles, mumps and rubella (MMR) #	One injection	
Twelve to thirteen years old	Human papillomavirus (HPV) #	Course of two injections at least six months apart	• There were approximately **307,000** eligible females in England in 2017/18. • **83.8%** of Year 9 females completed the two-dose HPV vaccination course in 2017/18 (*Ref: PHE, HPV vaccine coverage annual report for 2017 to 2018*).
Fourteen years old (school year 9)	Tetanus, diphtheria and polio (Td/IPV) #	One injection	• There were approximately **567,000** eligible children in England in 2017/18. • Average vaccine coverage for the LAs that delivered the Td/IPV booster to Year 9 students in 2017/18 was **85.5%**, compared to 83.0% in 2016/17 and 83.5% in 2015/16 (*Ref: PHE, Vaccine coverage estimates for the school based tetanus, diphtheria and polio adolescent vaccination programme in England, to 31 August 2018*).
	Meningococcal ACWY conjugate (MenACWY) #	One injection	• There were approximately **567,000** eligible children in England in 2017/18. • Average vaccine coverage for the LAs that delivered the MenACWY vaccine to Year 9 students in 2017/18 was **86.2%**, compared to 83.6% in 2016/17 and 84.1% in 2015/16 (*Ref: PHE, Vaccine*

			coverage for the school-based MenACWY adolescent vaccination programme in England, to 31 August 2018).
65 years old	Pneumococcal polysaccharide vaccine (PPV)	One injection	• There were approximately 9.9 million patients aged 65 years and over registered with a GP in England (approximately **561,000** were aged 65 years) in 2017/18. • Coverage of PPV in adults aged 65 years and over, vaccinated any time up to and including 31 March 2018, was **69.5%**, 0.3% lower compared with 2016/17 and 0.6% lower than 2015/16 and 2014/15. • The proportion of adults aged 65 years who were vaccinated in the last 12 months was **11.8%**, compared to 16.3% in 2016/17. • A national shortage of PPV vaccine is likely to be the main contributor to these decreases (*Ref: PHE, Pneumococcal polysaccharide vaccine coverage report (England) April 2017 to March 2018*).
65 years of age and older	Inactivated influenza vaccine	One injection annually	• N/A as community pharmacy is already commissioned to provide this vaccination.
70 years old	Shingles	One injection	• There were approximately **649,000** patients aged 70 years registered with a GP in England in 2017/18. • There were approximately **337,000** patients aged 78 years registered with a GP in England in 2017/18. • Shingles vaccine coverage in the routine cohort (aged 70 years on 1 September 2017) was **44.4% in 2017/18** and the catch-up cohort (aged 78 years) to **46.2% in 2017/18** (*Ref: PHE, Herpes zoster immunisation programme 2017 to 2018*).

The table below details four other non-routine immunisation programmes, which are detailed in the Green Book.

Vaccination	Programme information	
Pertussis vaccination for pregnant women	A temporary programme for the vaccination of pregnant women against pertussis was introduced in October 2012. Pregnant women should be offered dTaP/IPV # vaccine between weeks 16 and 32 of each pregnancy (for operational reasons, vaccination is probably best offered at, or after the foetal anomaly scan at around 20 weeks). Pertussis vaccine can be given at the same time as influenza vaccine but, to avoid compromising the passive protection to the infant, this should not be used as a reason to give pertussis vaccination outside of the recommended period.	• There are approximately **609,000** pregnant women each year eligible for the vaccine. • Pertussis vaccine coverage in pregnant women averaged **71.7%** across the quarter (Oct-Dec 2018), 1.9 percentage points lower than coverage for the same quarter in 2017. However, coverage in each month this quarter remained above 70% for the first time since March 2018.
MenACWY catch-up programme	In August 2015 a MenACWY # catch-up programme began for all children aged 14-18 years of age and those less than 25 years of age attending university for the first time. The MenACWY vaccine provides important protection, and all teenagers born between 1st September 1998 and 31st August 1999 are advised to arrange vaccination now with their GP. In addition, anyone born on or after 1st September 1996 who missed their routine school vaccination in school years 9 and 10 or the catch-up MenACWY vaccination can get the vaccine from their GP up to their 25th birthday.	• Publicly available data could not be identified.
Other selective immunisation programmes	There are a number of selective immunisation programmes that target children and adults at particular risk of serious infections, such as hepatitis B, hepatitis A, influenza, Hib, meningococcal and pneumococcal infection. Other vaccines, including BCG, HPV, hepatitis B and hepatitis A, are also recommended for individuals	

	at higher risk of exposure to infection, due to lifestyle factors, close contact or recent outbreaks in their community.	
Vaccination of individuals with unknown or incomplete immunisation status	This includes: • Any individual born in the UK who has not completed the routine immunisation programme as appropriate for their age should have the outstanding doses as described in the relevant chapters. • Children and adults coming to the UK do not have a documented or reliable verbal history of immunisation; they should be assumed to be unimmunised and a full course of required immunisations should be planned. • Individuals coming from areas of conflict or from population groups who may have been marginalised in their country of origin (e.g. refugees, gypsy or other nomadic travellers); where there is no reliable history of previous immunisation, it should be assumed that any undocumented doses are missing and the UK catch-up recommendations for that age should be followed. • Children coming to the UK may have received a fourth dose of a diphtheria/tetanus/ pertussis-containing vaccine that is given at around 18 months in many countries. Booster doses given before three years of age should be discounted, as they may not provide continued satisfactory protection until the time of the teenage booster. The routine preschool and subsequent boosters should be given according to the UK schedule.	

The table below details the travel vaccinations that are allowed (free of charge) at NHS expense.

Vaccination	How it is given	Relevant statistics
Polio (given as a combined diphtheria / tetanus / polio jab	One injection	• Publicly available data could not be identified.
Typhoid	Either one injection or three capsules to take on alternate days.	
Hepatitis A	One injection. Extra doses of the vaccine are recommended after 6-12 months if the patient needs longer protection.	
Cholera	The vaccine is given as a drink. For adults, two doses (given 1 to 6 weeks apart) can provide protection for up to two years.	

Return to agenda item

Subject	Update on NHS IT
Date of meeting	22nd May 2019
Committee/Subcommittee	SDS
Status	Public
Overview	This report provides an update on the following NHS IT topics: NHS App, EPS Phase 4 and EPS utilisation, EPS Controlled Drugs, Real-time Exemption Checking, Local Health and Care Record Exemplars and NHSX.
Proposed action	None
Author of the paper	Daniel Ah-Thion

NHS App

The NHS App roll-out, which began at the end of 2018, will continue across England throughout 2019. An NHS App team representative presented to the Community Pharmacy TI Group (CP ITG) at the group's March 2019 meeting.

Some of the NHS App functionality is similar to the GP online services which have been available to patients for some time. Individual GP practices will need to review some of their system settings before patients can access the full NHS App functionalities. NHS England has said it hopes to have all GP practices connected to the NHS App by July 2019 and this is reflected in the recently agreed amendments to the General Medical Services contract. Around one third of GPs are already signed-up so their patients can use the app.

Some GP practices went live with testing the app during September to December 2018, with 3,000 patients using it. NHS Digital has recently published a summary of the key lessons from the pilot. Findings included that repeat prescription ordering via the app was positively reviewed, with 87% of people using the feature saying they found the ordering process easy and convenient.

The NHS App is available on the Google Play store and the Apple App store. The last two GP system suppliers (Vision and Microtest) are expected to be on-boarded during May 2019, so they fully integrate with the app. NHS England expect the app to be a universal offer for patients, whichever GP practice they happen to use; a full launch, with an associated publicity campaign is expected to commence in July 2019.

NHS England and the NHS App team are planning to add a biometric login method as an early enhancement and they are continuing to consider further items for their development roadmap. Future enhancements will include patients being able to change their EPS nomination via the app and being able to view the status of their EPS prescription, e.g. repeat issued, prescription with pharmacy and a notification when the items are ready to be collected. The NHS App team also hope to link into the national NHS e-referral system within 12 months, allowing patients to book an outpatient appointment after a referral from their GP.

The NHS App team are keen to undertake more work with PSNC and a working group of the CP ITG to consider future developments of the NHS App which could support the provision of pharmacy services. PSNC and the CP ITG will continue to work with the NHS App team and NHS England's Empower the Person domain to support their work.

EPS Phase 4 and EPS utilisation

NHS Digital began piloting EPS Phase 4 at the end of November 2018. Sixteen GP practices have been able to use EPS for patients without an EPS nomination: patients are given a paper Phase 4 token with a scannable barcode, instead of a signed paper prescription. The pilot sites are spread across the country (including within Greater Manchester, Essex, South-east London, Leeds and Devon).

Prescribers in the pilot have successfully issued over 50,000 Phase 4 prescriptions which have been dispensed by almost 1,000 dispensers. Some of the pilot GP practices were also part of

the pilot for EPS Controlled Drugs (CDs) and in these sites, EPS usage has been seen just short of 90% of all prescriptions.

No significant issues have been identified with the pilot from a community pharmacy perspective, but some pharmacies have found that they have initially mistakenly tried to dispense against the token rather than the electronic prescription. The pilot has identified several issues in GP clinical systems, which the system suppliers have been working on to improve the efficiency of the prescribing process.

NHS Digital proposed an extension to the pilot, which is now commencing. This involves a further 40 GP practices joining the pilot, with the aim of this supporting the identification of further issues which need to be addressed before or as part of the full rollout of Phase 4. The additional GP practices are to be split into two sub-groups of around 20 GP practices each – half will be "simple" profiles, i.e. no branch surgeries, high existing EPS use and no dispensing patients, and half will be more complex practices. This extension to the pilot will allow the testing of a "communications-only approach" in the simple sites, i.e. allowing practices to rollout with guidance and remote support, but without any visits from NHS Digital or others at the point of moving to Phase 4.

Work will continue with NHS Digital to support the pilot and to identify learnings from the pharmacies involved.

Recent analysis by NHS Digital suggests that even without Phase 4 rolled out, many GP practices which previously used EPS at a low level are starting to make greater use of EPS. Data from the last six months shows:

- less than 400 GP practice sites now have an average EPS utilisation less than 40%; and
- less than 250 of those have an average EPS utilisation of less than 30%.

EPS Controlled Drugs

NHS Digital began to pilot the prescribing and dispensing of EPS Schedule 2 and 3 CDs in England from October 2018. Roll-out plans occurred on a GP practice supplier-by-supplier basis. Around 60 GP practices tested the functionality for several months through to early 2019.

Pharmacy teams, including those within EPS CD piloting areas, reported into PSNC and NHS Digital that they wanted wide roll-out speedily given the changes to the scheduling of pregabalin and gabapentin, which came into effect on 1st April 2019.

Some GP system and pharmacy system technical issues were encountered during the pilot which required fixes to be implemented in software. Following an overall successful pilot, in March 2019, NHS Digital granted approval for full roll-out of EPS CDs for those GP practices using EMIS, Vision and SystmOne (TPP). Full roll-out for those systems took place during March and April 2019. The large majority of GP practices can now prescribe EPS CDs.

NHS Digital is working with the other GP practice supplier, Microtest, to confirm dates for a pilot with its Evolution system. PSNC and CP ITG will continue to keep a watching brief on the Microtest EPS CDs roll-out, and feed into NHS Digital where required.

Real-time exemption checking (RTEC)

The RTEC system will be rolled out in phases. Phase One will comprise maternity, medical, pre-payment, low income scheme and HMRC exemptions. The first piloting for Phase One began with several pharmacy contractors that use the Positive Solutions Ltd (PSL) PMR system – from late February 2019.

The initial feedback from the test pharmacies has been very positive, with pharmacists pleased with the simplicity and ease of use, noting they would like to see the Department for Work and Pensions (DWP) exemptions included within the system in the near future. Further rollout for pharmacy contractors that use PSL is expected over the next few months.

Other system suppliers are planning to develop RTEC functionality for their systems over the summer.

PSNC will continue to work with NHS Digital, DHSC and NHS England on the planning for this change in process within pharmacies.

Local Health and Care Record Exemplars (LHCREs)

NHS England previously announced five areas chosen to become LHCREs. LHCREs are a group of organisations working in collaboration and intending to create a safe, secure and trusted information-sharing environment for use by health and care professionals and organisations. These partnerships received funding to put in place an electronic shared local health and care record which makes relevant patient records available more quickly to those involved in that patient's care and support.

The partnership areas are: Yorkshire and Humber (covering West Yorkshire, South Yorkshire, North Yorkshire and Humberside), Thames Valley and Surrey (covering Buckinghamshire, Oxfordshire, Berkshire and Surrey), Greater Manchester, Wessex, and "One London".

The Professional Record Standards Body (PRSB) is working with NHS England and others to support LHCREs. This work includes the creation of a standard for the core information that is shared in a local health and care record.

NHSX

In February 2019, DHSC announced the creation of NHSX, which is a new joint organisation for digital, data and technology. It will draw staff from NHS England, DHSC, NHS Improvement and NHS Digital.

DHSC said that the CEO of NHSX will be tasked with having strategic responsibility for setting the national direction on technology across organisations. The CEO will be accountable to the Secretary of State for Health and Social Care and the chief executives of NHS England and NHS Improvement.

NHSX's additional key responsibilities include:

- setting national policy and developing best practice for NHS technology, digital and data - including data-sharing and transparency;
- interoperability;
- setting national strategy and mandating cyber security standards; and

- championing and developing digital training, skills and culture so NHS staff are digital-ready.

Matthew Gould has been announced as the new CEO of NHSX. The former government director for cyber security will join NHSX in the summer to coincide with the organisation's July 2019 launch.

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