Views on the next generation of Electronic Prescription Service (EPS)

Community Pharmacy IT Group (CP ITG) have collated views about the key priority items which could help EPS to progress NHSX missions and CP ITG's vision. Technology should be iterative and keep improving to help those who can benefit from the technology – ultimately the patients. EPS technology is no exception and CP ITG would support developments that build on the huge patient outcome successes of EPS to date. CP ITG have set out priority items categorised into four areas (which also align with NHSX missions): *Infrastructure and adaptability*; *Interoperability and security*; *Reducing burden*; and *Good use and enhancement of EPS*.

1. Infrastructure and adaptability

- *1a.* **Underlying structure was based on concepts from more than 20 years ago** and cannot easily be adapted to enable iterative enhancements and should be updated even if various systems would require alignment e.g. reconsideration of Fast Healthcare Interoperability Resources (FHIR) standards compatibility across EPS and its systems and potential benefits to grow adaptability.
- *1b.* **Current IT strategies outside of sector are moving to increasingly cloud-based solutions.**
- *1c.* **Spine to be made more adaptable.** Changes to Spine such as those that had begun to be made to Spine during the transition from Spine 1 to Spine 2 were intended to support making the wider EPS system more 'agile', and further changes enabling agility would enable more innovations.
- *1d.* **Improvements needed to burdensome streamline assurance process** for EPS changes so it is quicker, easier and cheaper for NHS Digital assurance teams and suppliers to progress EPS changes more quickly and introduce additional innovations but safely (the technical challenge and delay with enablement of EPS controlled drugs illustrates the challenge with EPS-upgrades).
- *1e.* **User comments should be sought prior to EPS changes** by wider circulation of drafted specifications for comment earlier during spec development (e.g. to CP ITG, PMR suppliers etc).

2. Interoperability and security

- *2a.* **EPS or health record compatibility with private prescriptions and over-the counter-medicines so the EPS or health record is more comprehensive in the patient interest**.
- *2b.* **Transparency of resilience metrics** (e.g. pharmacy systems metrics about availability could be published onto NHS Digital service status checker page and service status checker webpage moved to a www webpage instead of an nww one).
- *2c.* **Enable important EPS changes to be pushed out** to pharmacies without their need to manually choose to 'update' (where relevant stakeholders (e.g. CP ITG and NHS Digital) agree).
- 2d. **NHS Spine outages have potential to have significant impact on safe and legal supply of prescription medicines.** Spine has been resilient and strong measures are already in place, but as risk of failure has major impact, continued reinforcement is needed to maintain strong continuity.

3. Reducing burden

- *3a.* **The Smartcard process to securely access NHS systems is outdated when compared to processes outside of sector where biometrics are used** (e.g. smartphones / banking online etc.).
- *3b.* **Smartcard management and usage is time consuming.** Future improvements would enable admin efficiencies in both pharmacy and NHS.
- *3c.* **More standardisation of Smartcard Registration Authority (RA) policy implementation needed**.
- *3d.* **Enable paperless prescription processing (mobile devices in pharmacy)** including NHS Digital guidance for pharmacy contractors and pharmacy system suppliers to explain how that can be done securely, with EPS use being possible on mobile devices (an NHS Digital NHS Identity trial has been in progress for a while exploring SCR access on a mobile device within a pharmacy).
- *3e.* **Enable paperless prescription processing (electronic tokens developed and suitable guidance and standards in place)** (EPS Phase 4 prescriptions and NHS Digital token specification updated to specify electronic token requirements).

- *3f.* **Repeat prescription management (unless patients are signed up to digital ordering) is too often driven by paper requests,** more use of NHS App and other apps and pharmacy supplier integration with them could join up the process and improve the patient experience.
- *3g.* **EPS prescriptions have a limit of 4 items, pushing some patients' items onto multi prescriptions.** When these arrive at the pharmacy at different times, there is the risk some medicines but not all are passed to the patient. [A caveat: NHS Digital and system suppliers have advised major technical challenges with changing the limit, EPS may need to be more amendable for change].
- *3h.* **User testing of EPS changes should continue** e.g. NHS bodies should continue to work with EPS users such as those in the CP ITG and the wider pharmacy sector.
- *3i.* **Pharmacy teams do not have sight of sight of processed vs priced prescriptions in automated and end-to-end fashion.** Less time for claiming activities would allow extra time to support patients. There would also be less reliance on waiting for Pricing Authority schedules which arrive relating to medicines dispensed up to three months earlier. Solutions may involve NHSBSA or NHS Digital developing Manage Your Service system APIs and specifications and publishing these.

4. Good use and enhancement of EPS

- *4a.* **Clinical info should be displayed within or alongside EPS prescription** (Note: This may not require a big change to EPS itself given such information might be 'pulled' from elsewhere and displayed).
- *4b.* **Linear, constrained, electronic prescription information flow between GP to spine to specific pharmacy limiting flexibility**, e.g. a limited feedback loop such as dispensed information (e.g. 'not dispensed' status does not auto-flow to the GP practice system and the patient's record).
- *4c.* **Computable dose standards (dose syntax) standards are available but not yet used.** There is no alignment of GP and hospital standards for dosages. There is no dose standardisation from GP systems into pharmacy dispensing systems.
- *4d.* **Hospital discharge information and reconciliation currently happens outside of pharmacy system** adding complexity and increasing risk of info being missed in a patient care pathway.
- *4e.* **No toggle between manually download prescriptions or auto-pushed downloads** instead there is a focus on a manual 'pull' download system to download new EPS prescriptions into the pharmacy system. (Note: Pharmacy systems can enable a scheduled auto-download at set times.)
- *4f.* **EPS/systems should provide emphasis with supporting synchronisation of medicines in a smooth manner:** system support for medicine timings to be aligned to boost adherence efforts, systems that support synchronisation will support improved patient outcomes.
- *4g.* **eRD uptake is low and eRD improvements are needed to make eRD more flexible** (to make it easier to add or remove acute items or adjust treatment periods for prescriber and pharmacy).
- *4h.* **System safety warning messages (EPS ones and others) should be reviewed carefully on an ongoing basis to keep these displaying only where necessary** to ensure pop-up messages are kept to a minimum, so that when they do appear they are important and can be acted upon.
- *4i.* **The electronic 'right-hand-side' prescription area is frequently over-loaded with unnecessary / old information and the specifications relating to this part of the prescription should be improved.** New guidance would also be required if specification changes are implemented.
- *4j.* **Data portability needed for when pharmacies switch to a new system for continuity of care**.
- *4k.* **Frequently the EPS nominated pharmacy lacks the visibility of EPS medicines ordered** (via NHS APIs / NHS App) to address patient queries, e.g. when a medicine has not been prescribed in error.
- *4l.* **Some GP practices post-date some EPS items despite little guidance supporting this but pharmacies do not yet have early sight of these items.** This delays the time to obtain items within time e.g. for those medicines which are in shorter supply, that require more time to obtain.
- *4m.* **Limited NHS insight from EPS and dispensing data from NHS Spine transactions.**
- *4n.* **EPS and related systems should enable pharmacy teams to design their own reports in more and more ways** (e.g. age/medicines etc) to enable teams to innovate with patient care methods.
- *4o.* **Standardised EPS messages for 'to be collected' and 'delivered' so pharmacies can optionally use these statuses** (which must be easily recordable to keep burden low).
- *4p.* **Instalment Dispensing for Controlled Drugs not yet enabled for EPS (EPS MDAs).**

This list has been developed and collated by CP ITG and incorporates pharmacy team feedback and future versions can continue to do so. If you require further information about the list or items on it, or you work within a community pharmacy and want to suggest changes, please contact it@psnc.org.uk.