Minutes for the Community Pharmacy IT Group (CP ITG) Summer 2024 meeting held via videoconference

About CP ITG: The Group was formed in 2017 by Community Pharmacy England, NPA, RPS, CCA, and IPA. Members representing these five organisations attend the meetings, as do representatives from pharmacy system suppliers, NHSBSA, NHS England's Transformation Directorate, NHS England pharmacy team, DHSC, and PRSB. Further information on the group can be found on the Community Pharmacy England website.

Present

Matt Armstrong (Chair), Boots and CCA
Dan Ah-Thion (Secretariat), Community Pharmacy England
David Broome (Vice Chair), Stancliffe Pharmacy
Ursa Alad, NHS England
Joanne Angell, NHS North of England CSU
Mark Anyaegbuna, Community Pharmacy (CP) Kent
Dane Argomandkhah, Cohens Pharmacy
Steve Ash, Day Lewis Pharmacy
Suzanne Austin, CP Cheshire & Wirral
Jay Badenhorst, NPA
Rita Bali, CP Cambridgeshire
Mohit Bhardwaj, Asda Pharmacy
Gemma Binns, Cegedim
Luke Bolton, Cegedim
Shiné Brownsell, Community Pharmacy England
Alastair Buxton, Community Pharmacy England
Louis Clementson, Positive Solutions
Karen Cox, CP Cambridgeshire & Peterborough
Drew Creek, CP Cornwall
Victor Crudu, Logifect
Phil Day, Pharmacy2U
David Dean, CP Thames Valley
Darryl Dethick, Peak Pharmacy
Daniel Edmonds, PRSB
Kingsley Ejeh, PRSB
Matthew Ellis, Positive Solutions
Denise Farmer, NHS England Health and Justice
Jon Flitcroft, Albert Wilde Pharmacy
Phil Galt, Cegedim
Sanjay Ganvir, Greenlight Pharmacy
Leanne Garland, NHS England
Fintan Grant, NHS England
Leanne Hackett, Cegedim
Martin Hagan, NHSBSA
Caroline Hayward, CP Humber
Jo Hendry, Boots Colombus
Timothy Hill, EMIS health
Claire Hobbs, NHS England
David Hollick, Logifect
Kelly Holman, CP Devon
Allison Hornshaw, NHS England North East & Yorkshire
Julian Horsley, Clanwilliam /RxWeb
Nick Hunter, CP Doncaster
Khurum Hussain, Boots Pharmacy
Adam Irvine, CP Cheshire & Wirral
Sima Jassal, EMIS Health
Dalveer Johal, CP North East
Gareth Jones, National Pharmacy Association (NPA)
Shelley Johnston, NHSE's TD
Richard Judge, Kamsons Pharmacy
Sandie Keall, CP Tee Valley
Mandeep Khaira, Camascope
Grant Kobrin, EMIS Health
Ylan Kunstler, BeWell
Yvonne Lamb, CP Somerset
Jason Lestner, Living Care Pharmacy
Michael Levitan, Middlesex Group
Rhys Lloyd, Pharm Appy
Rajshri Owen, CP Leicester & Rutland
Anthony Maguire Clanwilliam
Helga Mangion, NPA
Mark Merry, Positive Solutions
Paul McGorry, CP Humber
Dave McNamara, Hallo Healthcare Group
Geraint Morris, CP North East-North
Wahid Muhammad, Invatechhealth
Kevin Noble, EMIS Health
Al-Dairi Noor, Boots
Amit Patel, CP South West London
Hema Patel, Community Pharmacy Essex
Mayank Patel, Pearl Chemist
Mark Pedder, Hub Rx
Darren Powell, Weldricks Pharmacy, NHSE's TD
Artur Pysz, CP South Central
Shanel Raichura, Apotec
Gemma Ramsay, NHS England pharmacy team
Sian Retallick, Shiphay Pharmacy
Tracey Robertson, Cegedim
Tahmina Rokib, NHS England
Rupal Sagoo, Tesco Pharmacy
Annie Sayer, NHS England
Lauren Seamons, CP Norfolk
Suraj Shah, Community Pharmacy England
Harjeet Sian, EMIS Health
Rahul Singal, NHSE's TD, Digital Medicines
Jeff Shelley, Invatechhealth
Charis Stacey, NHS England
Ian Swales, Pharmacy2U
Antania Tang, NPA
Rosie Taylor, Community Pharmacy England
Sue Taylor, CP Devon
Nick Thayer, Company Chemists Association (CCA)
Faisal Tuddy, Asda Pharmacy
Gabriele Vickers, Community Pharmacy England
Caline Umutesi, Community Pharmacy England
David Vanns, Weldricks Pharmacy
Iqbal Vorajee, Cohens Pharmacy
Gary Warner, PharmOutcomes & Regent Pharmacy
Jon Williams, RxWeb
Leah Wolf, CP Devon
Janson Woodall, Well Pharmacy
Heidi Wright, Royal Pharmaceutical Society
Zhouli Yap, Pharmacy team member
Andre Yeung, NHS England North East and Yorkshire
Fawwad Zafar, Nuchem Pharmacy

Item 1: The Chair welcomed the group

Item 2: Apologies for absence from voting members: Nick Kaye (NPA), Fin McCaul (Community Pharmacy England), and Graham Phillips (NPA).

Introductions, minutes of previous meeting and matters arising

Item 3: The minutes of the previous meeting were agreed upon.

Item 4: The remaining actions were carried into the paper's 'next steps' for this 5th June 2024 meeting. Outstanding actions are listed within the minutes.

Minutes

Item 5. Current pharmacy IT priorities

Overview

- Appendix CPITG 01/06/23 sets out related updates. Charis Stacey (NHSE's TD Head of Product for Digital Primary Care) presented slides and provided an update.
- The NHS England team updated on the digital supplier capability for the Pharmacy First service; at launch, the consultation record was sent as an interim PDF back to the patient's record.
- The key thing they have been focusing on is working with GP IT suppliers and community pharmacy IT suppliers to connect pharmacists and GPs. The NHS England team touched on work being done on three capabilities:
    - Booking and Referral Standards (BaRS): streamline referrals,
    - NHS Direct Care APIs Access Record (also sometimes called GP Connect Access Record): give pharmacists additional access to clinical information and
    - NHS Direct Care APIs Update Record (sometimes called GP Connect Update Record): streamline that information going back into the patient's NHS record.

NHS Direct Care APIs Update Record

- Update Record allows the healthcare organisation's system, in this case pharmacy systems, to send back information to the patient's record held in the GP system of the patient's registered GP practice. This is the first use case for Update Record has been pharmacy. NHSE's TD is working with the four pharmacy system suppliers that support Pharmacy First service, NHS Blood Pressure Check Service (Hypertension Case-Finding Service), and Pharmacy Contraception Service.
- The service specification details what is included as part of that Update Record message, but essentially, it is the same information currently shared from pharmacy to GP practices in a more manual way (e.g. by PDF). This technology can change how that message is delivered to the practice and how it 'lands' in the practice. Instead of a PDF emailed across, it is a structured message standardised as per the Professional Record Standards Body (PRSB) community pharmacy data specification.
- The message is fully coded, meaning the GP systems receiving it can consume that information more intelligently. It's not an attachment; it goes directly into the patient record and is linked to patient records via Patient Demographic Services. The message appears in the patient's consultation record at the GP practice. This minimises work for the practice as they don't have to transcribe that information or add any details from a PDF or an email.

Is the data auto-filed into the GP record?

- Some key questions to the Update Record team have been: are these messages auto-filed, and how will the GP practice process these messages? The answer is a bit complicated

because both EMIS and TPP, the two leading GP system suppliers that have done this work, have taken different approaches.

- For TPP, the default setting is auto-file. Any message sent to a TPP practice will automatically be filed to the patient record. NHS England has asked IT suppliers to ensure that records flow as expected. The GP practice can change the setting and manually file messages, and nothing is added to the patient record until someone at the practice has reviewed that message first.
- With EMIS, they have opted to implement slightly differently for their GP practice users; any medication information in the message is auto-filed, but any other details in the message are set in a provisional state until someone at the practice has reviewed that message.
- In both cases, the message may generate a workflow task in the GP system, which appears in the global workflow that the practice manages.
- The group asked NHS England to continue exploring how the NHS Direct Care APIs Update Record might be expanded to other areas, such as emergency medicine supplies. Emergency medicine supply notifications are sent via a previous solution NHSE deployed (DigiMeds). This sends updates into the GP workflow but is still a PDF with some coded information.

Information available via Patient Facing Services

- Pharmacists must consider that when sharing information back to the GP, it is directly added to the patient record. The information will be available to GPs, other health and care providers, and patients (and their proxy users) via Patient Facing Services.
- This is important to consider as there may be scenarios where the patient does not want others to access their information. The first thing to consider is whether the GP should receive the information. Does the patient wish for their GP to receive the information? The second element is whether that information should be visible through patient-facing services.
- Pharmacists should work on the basis that if they share information with the GP, that information may be available to patients via patient-facing services. So, if there are any concerns where that information shouldn't be made visible, then that information should not be shared with the GP practice. That is the safest way to stop that information from being made available.
- EMIS and TPP have again taken two slightly different approaches:
    - EMIS: entries are visible via Patient Facing Services once a user files a message at the practice.
        - Medication details are available immediately as this is auto-filed.
        - Users at the practice can change the setting to hide this information if required.
    - TPP: entries by default are automatically marked as hidden from online services
        - A user from the practice must review and mark the event for sharing with Patient Facing Services before this is available in online services.
- The group asked if there was a clinical risk of not sharing information with the GP and if the patient had been supplied medication. Arguably, there is a clinical risk for the contraception service within the service specification; NHS England has stipulated that patients can opt out of sharing their information with the GP. This makes it comparable to other community and sexual health services, whereby the information won't be shared with the GP. In this scenario, there is a 'benefit versus risk' in wanting patients to have accessible services without being deterred because their information will be shared. This is specific to the contraception service. For other services, as part of service provision, the patient has to consent to their information being shared with the GP. If they don't want their information shared with the GP, then unfortunately, the patient can't access the service because it's implied that they have to share their information as part of service delivery.

Update of Summary Care Record (SCR) through Direct Care APIs Update Record

- Update the Summary Care Record (SCR); information, once filled out, is available via SCR.
- Implementation:
    - EMIS:

        - Medication details are auto-filed and uploaded to Spine once an approved user is logged in at the practice using a valid Smartcard.
        - The remaining information in the message is held in a provisional state; this is uploaded to Spine once filed, and a user is logged in at the practice using a valid Smartcard.
    - TPP:
        - If messages have been auto-filed, SCR will update once an approved user is logged in at the practice using a valid Smartcard. This will trigger upload to Spine.
        - If messages are manually filed, information is uploaded to Spine once a user has filed the message and is logged on using a valid Smartcard.
- The key thing to note about the Update Record is the whole premise is that it's sending a summary of the consultation back to the patient's record held by the GP. What it isn't designed to do is be used to communicate urgent action or referrals. The reason is Update Record messages cannot be flagged. Pharmacy teams cannot highlight that this message contains an urgent action or urgent information.
- Pharmacists must not use the Update Record to communicate safeguarding information to GPs. If a major concern arises and support is required from the GP, the pharmacist or pharmacy team member should follow their standard local procedure and contact the GP using a two-way form of communication, e.g. telephone or instant messaging
- The group asked whether pharmacy systems clearly "flag" the refused Update Record. The pharmacy system receives a rejection message, triggering a fallback to email. This process varies depending on the pharmacy supplier, so TD advises checking with individual supplier guidance. Pharmacy users will not see the rejection and won't be aware unless they need to take alternative action.
- Both EMIS and TPP went live on April 3rd, 2024. The GP practice could turn off the Update Record. They are working with EMIS and TPP on this functionality.
- NHSE's TD is working with a cohort of GP practices that have turned off the functionality. The system supplier default is that this is sent as a message back to the pharmacist, and they need to take action to send that update via e-mail following the consultation. This capability is being removed. They wanted to flag this as possibly coming up.
- NHSE's TD has shared the volume of Update Record messages since this went live. The live pharmacy suppliers are Positive Solutions and Cegedim Pharmacy Services. As of 3rd June 2024, over 31,000 structured updates to the patient records using Update Record have been sent since April.
- NHSE's TD continues to work with other pharmacy suppliers, such as PharmOutcomes and Sonar. Sonar is within testing and assurance.

Streamlining referrals from GPs to pharmacies (BaRS)

- An update was provided on Booking and Referrals Standards (BaRS), a commitment to streamline referrals into community pharmacies from general practice for Pharmacy First.
- BaRS is another IT standard. It sets out structured information that needs to be transferred from the GP system into the community pharmacy workflow.
- BaRS is already live in the Urgent Emergency Care (UEC) space; this is the first time it is being expanded to a community pharmacy.
- GPs use three main systems to refer patients: NHSmail, PharmRefer, and EMIS Web Local Services, which are currently developing to the BaRS standard.
- This means referrals sent from PharmRefer and EMIS Web Local Services can be received directly into the four pharmacy system workflows.
- Existing NHSmail solutions can still be used to make referrals, but these will not go directly into pharmacy systems' workflows.
- With the Directory of Service (DoS), the referrals will go into the same system as the NHS111 referrals. This ensures that when pharmacies want to switch or update DoS, it is all done in one system that would need to be updated. Within the BaRS, there is a local DoS that the system takes a copy of and uses to send on the referrals.

- When pharmacies change ownership or switch suppliers, there is a business-as-usual switching process. Work is being done with community pharmacy suppliers as part of the quality assurance before BaRS goes ahead to simplify the process and a switching timeline.
- The group fed back that the change of ownership switch process is still prolonged, with some pharmacy owners stating that it took over two months.
- The group asked if anything looked different from the user's perspective and if it would require extra training. It was confirmed that from a user perspective, they will not see anything different; the only difference is the referrals that were previously coming in via email; when using BaRS, those referrals will now be coming into the pharmacy system workflow. Regarding the pharmacy's solution to manage or send the referral, there will be nothing different from the user's perspective.
- The group also asked what the BaRS referrals 'look like' from the community pharmacy end and whether this will be the same or different. Each supplier develops information for their customers to show them what is changing. NHSE's TD is working with Cegedim, Positive Solutions, and Sonar to collate a link to all the information in one place so they can share this with regions and ICB leads to support pharmacies. The key is for pharmacy owners to look at the information their supplier provides and update their local SOPs.
- The group asked when the other community pharmacy IT systems might be live. Suppliers will contact their customers, and the NHS England team will keep regional colleagues informed alongside the wider Community Pharmacy England team. They will communicate when the supplier is near the point of receiving approval for the national rollout.

Direct Care APIs Access Record: Providing more access to the patient's record at the GP

- Currently, all pharmacy professionals have access to patient records via Summary Care Record (SCR) / National Care Records Service (NCRS), which provides the patient's past, current, and repeat medication and allergies. Access Records provides a richer view of the patient record and ensures direct access to it as it is in the GP record.
- This means pharmacies can access medications, allergies, consultations, immunisation information, and investigation to support clinical care. It will also include uncategorised data, which includes observations, blood pressure, and urine dip samples.
- This will be rolled out in phases, with the first phase focusing on medications, uncategorised and investigations.

Actions:

- NHSE's TD is working with all four pharmacy-first clinical services systems to develop this; suppliers are in testing and assurance.

Independent prescribing IT

- The group asked NHSE's TD when Cleo Solo will be ready for the community pharmacy IP Pathfinder program. Cleo Solo was assured of EPS. However, compatibility testing needs to occur, e.g., with PMR systems and pharmacy infrastructure, as it has not been deployed in a community setting. Work is continuing with Cleo to progress this as quickly as possible.

Item 6. EPS and Original Pack Dispensing IT

EPS team updates

- **Appendix CPITG 02/06/23** sets out related updates. Fintan Grant (NHSE's TD Associate Director for Medicines and Pharmacy) presented **slides** and provided an update.
- The EPS team continues to extend the use of EPS into additional settings, such as within secondary care.
- There is a revised EPS onboarding approach for IT system suppliers that operate in community pharmacies. NHSE's TD has been working on revising the structure of how they manage system suppliers through the onboarding process.

- There are new APIs that system suppliers can use to align to EPS. These may also be used by new suppliers onboarding to EPS. The idea was to open EPS to a set of suppliers that hadn't previously integrated.
- There is more demand for EPS onboarding; NHSE's TD have some constraints on their capacity to take system suppliers through that EPS onboarding process.
- Work is continuing to deliver patient prescription tracking via the NHS App. A detailed update on this will be provided at future CP ITG meetings.
- NHSE's TD wants to modernise and expand the use of EPS to reduce the burden on healthcare staff and give patients a better experience.
- Summary of what has been achieved:
    - The first phase in the modernisation of EPS is complete. Focused on the development of technology which enables EPS to integrate with a new set of IT system suppliers, supporting the expansion of EPS.
    - Integration of EPS with the NHS App with the introduction of the digital prescription barcode.
    - Seven hospitals live with at least one department using EPS.
- The focus for the next year:
    - Increasing the number of EPS system suppliers who can provide EPS systems for secondary care.
    - Increasing the number of EPS prescriptions sent by non-GP care settings, currently at 35-37%, trying to increase that to 50% by the end of this year. This includes community settings, urgent care centres and secondary care.
    - Tackling the broader considerations relating to EPS use in secondary care.
    - Further integration of EPS with the NHS App will support enhanced prescription tracking.
- EPS in secondary care: there are different levels of complexity depending on various use cases. The current focus is on existing paper FP10 onto EPS prescriptions. That will give patients a better opportunity for a remote/virtual outpatient experience. Particularly for mental health trusts, it takes the burden of trying to get prescriptions to patients.
- Future use cases have greater complexity:
    - Request to GP
    - Outpatient Consultation
    - Inpatient Discharge Medications
    - Homecare Service Prescribing
- Midlands Partnership Foundation Trust was the first trust to use EPS. They used the 'Cleo' system, a stand-alone system that can be used alongside other systems.
- It takes a long time to go through the EPS assurance process for system suppliers starting from scratch, with the secondary care supplier, two suppliers that should be ready by September 2024, and then two every six months following that. It takes at least a year for a supplier to go from the start to the point where they have developed EPS against the instruction manual and all the prerequisites.
- The group asked EPS in secondary care whether this could lead to an expected increase in prescriptions into the global sum and how that affects the distribution of fees.
- That's one of the complex problems that needs to be tackled. Potentially, if trusts fully exploited EPS, community pharmacies would receive more prescriptions because things that the trust would have previously dealt with would start flowing to the pharmacy. That could be a scenario. This has a community pharmacy sector funding implication and would be for NHS England and the Department of Health and Social Care with Community Pharmacy England to consider.
- It is predicted that by March 2026, 50% of systems already used by secondary care will have the capability built into their system to offer EPS.

EPS and secondary care: discussion

The group were asked to answer the following questions about EPS use in secondary care.

Q. What do you see as the most significant potential benefits?

The themes within the answers are set out below.

Overall: More Service integration and efficiency between primary and secondary care. For example:

- Sharing of information between primary and secondary care. Supporting direct referrals in the future.
- Reduction in 'lost' prescriptions which are not dispensed.
- Better streamlining of processes.
- Remote clinics and domiciliary care can be sent straight to the pharmacy rather than via the GP practice.
- Greater transparency on prescribing costs to the taxpayer relating to secondary care.

Patients:

- Potential for coherent and seamless patient journeys (and experience) across care settings.
- Improving the choice of patients.
- Improved timelines for patients to obtain their medication. The patient journey becomes more efficient, especially when needed for in-hospital stays.
- Receiving care closer to home.
- Continuity of care for the patient, E.g., the New Medicine Service (NMS) and generally exposure to their ability to speak to their local pharmacist about their medication and treatment, etc.
- More patient options and possibly quicker discharge would work well as part of the Discharge Medicines Service (DMS).
- Patients will find the convenience of picking up their meds locally helpful.

Pharmacy impact:

- Removal of transcription errors (improved safety).
- Releasing pressure from pharmacy outpatient teams.
- Improved workflow planning by pharmacy staff.
- Able to see if there is a Rx (as opposed to trying to chase someone at a hospital).
- Potential for more removal of (paper prescription printed by trusts) paper from within community pharmacies.
- Enables a generic approach to dispensing across more prescriber setting types.

Secondary care/prescribers:

- Increased efficiency for the Trusts.
- Clarity in prescribers' intention.
- Complete and current drug list for patients in real-time for community pharmacy.

Q. What do you see as the challenges to overcome?

The themes within the answers are set out below.

Overall:

- It is essential that volumes now and over time are analysed and transparent to ensure the prescriptions can be handled appropriately across the sector and to support their capacity within community pharmacies for dealing with more prescriptions per year
- Getting it adopted nationally.

Patient expectations and meeting those

- Depending on guidance for trusts, pharmacies and patients, there could be an expectation to reorder medication without an adequate process.
- Hospital prescribers issue a prescription directly to the community pharmacy without any 'fine tuning' from the hospital pharmacy department.

- Comparability issues: dose vs quantity: being able to get prescriptions amended where incorrect.
- Variation from trusts in any engagement with primary care - different patient pathways depending on which hospital to go to.
- Risk of complex medicine regimens without support.

Guidance to support trusts

- Ensuring that secondary care prescribers consistently know what needs to be done and how concerning EPS prescriptions.
- Ensuring all information needed is written correctly. This has been a problem with handwritten prescriptions.
- Trusts understanding of EPS after implementing, timescales for hospitals to adopt vs their other priorities.

Community pharmacy

- Route to access the prescriber if there is a query about the prescription. How can prescriber details be obtained? Is there a route suitable for the pharmacy and the prescriber to deal with those cases that need querying? At present, this is not consistent across different trusts. Unable to contact the prescriber. Specialist or prescribing outside licensing indications.
- Could prescribers have their contact info within NHS Service Finder – where that is not already the case?
- Prescription arriving in PMR queue without being prompted that this might be a new outpatient with missing prescribing history.
- Drug Tariff inclusion of certain meds. The cost of drugs is not in line with the cost of hospitals obtaining them.
- Workload.
- Stock holding versus stock to be obtained. Will more space be required to hold additional stock? Pharmacies will stock an increasing range of medicines. This will impact wholesale bill costs (Specialty meds). National and Regional contract pricing of medicines unavailable in the community will also be affected.
- Patient waiting time – particularly for those medicines rarely dispensed.

Guidance and communications for patients

- Communication with patients—There may be situations where the same hospital offers a combination of paper and EPS, causing confusion.
- Increased expectations for community pharmacy management of patient care without access to information or any extra time to deal with those.
- The risk of ordering a high-cost drug and then wishing to collect elsewhere. Patient expectations must be managed—if they use a nominated pharmacy, the patient is expected to collect from that pharmacy.

Next steps for EPS and secondary care

Actions:

- The EPS team is going to set up a working group. They already have several trusts and want a community pharmacy IT representative to join the group. Pharmacy reps that would like to put themselves for taking part with this can email **it@cpe.org.uk**.

Item 7. EPS and the detained estate

- **Appendix CPITG 02/06/23** sets out related updates. Denise Farmer (NHS England Health and Justice) presented **slides** and provided an update.

- NHS England commissions healthcare services for people who are detained. They commission GP, primary care, mental health, public health and pharmacy services for people in prisons, immigration removal centres, children and young people's estates.
- They also commission community-based services, which support people diverted from the criminal justice system, and reconnect services, which support people released from prison with complex health needs.
- The focus is that there are a lot of people who move from a detained environment and back into the community.
- The HJIS team has a single clinical IT system (TPP); all the practices use this. They have a pharmacy workforce working in their settings. They have a policy where people are expected to be released with at least seven days of their medicines when they leave.
- Most medicines are prescribed in the health justice practice using an internal prescription form dispensed by the commissioned pharmacy service for the site, which might be in prison or outside of the prison.
- The same medicines available to the general public (as part of healthcare provided by the NHS) are also available in the same way to detained people.
- At the moment, FP10 paper forms are used to provide urgent medicines that are not available at the site. These are also used for unplanned releases.
- The NHS England regional commissioning budget funds the FP10 reimbursement costs; they are not paid for by ICS or ICBs.
- TPP already provides EPS functionality in primary care; they have a known and approved approach to providing EPS prescriptions; the implementation stage is now for people released from detained estates and urgent medicines.
- The full timeframe for the implementation is still being finalised, still at the pre-first of-type phase, in terms of trying out the functionality in a real-life scenario.
- The first of type implementation will be in July 2024 at earliest, with some follow-on site testing.
- The His Majesty's Prison (HMP) Exemption code has been 'unhidden' in the options menus of Patient Medical Record systems.
- NHS England Health and Justice envision that the EPS prescription that will be issued will be non-nomination as detainees will not always know which pharmacy they will approach to collect their medicines - but advise on nominations approach for their GP post-release. Group pharmacy representatives suggested this continue to be further explored as to whether some patient segments can be offered the opportunity to use one-off or standard nominations. That can provide an enhanced patient experience because steps are avoided in which the patient must ask the pharmacy to look them up, use EPS Tracker, obtain a prescription reference, download a prescription (and contact the prescriber if the prescription is inadvertently not yet created or has an issue). Prescriptions that go through the nominated process result in lesser waiting time, and the pharmacy can obtain and prepare medicines before the patient comes to collect them.
- Current guidance suggests that where prescribers issue non-nominated prescriptions, the prescriber must ensure the patient has relevant information, e.g., the prescription ID reference.
- The implementation of EPS prescriptions for people released from detained estates and urgent medicines is still being finalised.

Actions:

- The first of type implementation will be in July 2024 with some follow-on site testing.
- The HJIS team seeks to engage more widely with the group and colleagues.
- Communications will be issued as the rollout progresses.

Item 8. Original Pack Dispensing IT

- **Appendix CPITG 02/06/23** sets out related updates. A CP ITG subgroup meeting about this topic was held on November 15th, 2023.
- This current expectation is that OPD could be required to be ready to use by pharmacy teams by 1st January 2025.

- At least one supplier workshop will be held to try and clarify everything involved. Suppliers will be able to request testing from BSA to do testing. Suppliers were recommended to take up this opportunity.
- As discussed at previous meetings, the alternative to the new endorsement flag would be to use the existing dispensed quantity field.
- If the pharmacy owner dispenses more or less than 10% of the prescribed quantity, they will be reimbursed as prescribed.

Actions:

- DHSC to clarify whether controlled drugs are in scope on schedules 4 and 5. CP ITG pharmacy representatives and system supplier representatives suggested it would be helpful from an IT and simplicity perspective if OPD had Schedule 4 and 5 CDs within scope. This will help systems use dm+d CD flags to more automatically determine items in or out of OPD scope so that the pharmacy team can be directed within their system interface to treat these items as such.
- DHSC will instruct NHSBSA to host a supplier workshop.

Item 9. Vaccination IT

- **Appendix CPITG 03/06/23** sets out related updates. Matt Armstrong (CP ITG Chair) presented **slides** and provided an update.
- The CP ITG group touched on this briefly in the previous meeting. Past feedback emphasised the need for the following:

1. Appointment Accessibility
    - Patients can view and modify appointments using both the NHS App and pharmacy apps.
    - The integration of Pharmacy & NHS systems into BaRS ensures that these appointments are seamlessly managed.
    - NHS National Booking Service appointments are also part of this integrated system.

2. System Integration
    - The BaRS system is expanded to incorporate appointments, IT standards, and its acts.
    - Pharmacy systems and NHS systems are integrated, streamlining appointment management and communication.

3. Supplier Diversity:
    - Multiple system suppliers contribute to the development of vaccination service modules.
    - This diversity ensures flexibility, innovation, and continuous improvement in vaccination services.

This view emphasises patient empowerment, efficient appointment handling, and collaboration across healthcare systems and providers.

Vaccination IT: discussion

The group discussed methods (digital or otherwise) to update the GP practice for local vaccination.
How might these methods update the NHS App and other patient apps?

- Ideally, the ability to update directly into patient's records
- IT platform. Update Record could be used

- For COVID and Flu via PharmOutcomes only. There is no local provision for private notification
- NHS Direct Care APIs via PharmOutcomes would be better than NHSmail
- Using PharmOutcomes/Sonar
- PharmOutcomes for NHS Vaccine Paper/email for private
- PDF sent to go by system

Other comments:

- The group suggested that the pharmacy may be unable to obtain vaccine supplies through the wholesalers and needs a stock ordering system that works for its operations.
- The NHS App is there for NHS services, but with flu, many people have it privately, so having an integrated booking system will allow a single journey for patients, depending on whether it is free or paid. NHS Direct Care APIs Update Record will allow more collaboration between pharmacy teams and GP practices because there will be greater clarity regarding which patients will / could receive vaccinations.
- Is there a way to add some form of recall to the community pharmacy's toolkit, whether that is identifying patients from PMR records, GP records or summary care records?

Item 10. Future pharmacy IT

- **Appendix CPITG 04/06/23** sets out related updates. Matt Armstrong (CP ITG Chair) and Dan Ah-Thion (CP ITG Secretariat) presented **slides** and provided an update.
- In an initial meeting, NHSE's TD, Community Pharmacy England, and the CP ITG Chair discussed some points for future IT development.
- The group were asked for feedback on access to clinical records, including NHS Direct Care APIs and BaRS.

Views on NHS Direct Care APIs Update Record

Group comments on the future potential for Update Record:

- This should, over time, enable all services, interactions, and medicine dispensing (even private to ensure a full record) to be saved in the patient's record for future care of the patient.
- It could provide a standardised mechanism that could reduce GP practice workload.
- Ability to escalate or identify a patient to relevant teams, for example, a 'falls prevention' team
- Linkages to anywhere using similar systems, e.g. care home teams.
- Electronic Prescription Service status into GP format.
- Vaccinations - updated info is essential.
- Enhances hybrid working.
- Independent prescribing pathways.
- It will enable greater structured information, which will, in turn, allow data-driven insights in proactive prevention models, including medicine optimisation and compliance.
- Clarity is helpful on how NHS Direct Care APIs Update Record, Shared Care Records (ShCRs), and other records standards / APIs will interoperate over time.

Views on NHS Direct Care APIs Access Record

- Updating test results from in-pharmacy tests.
- Genomics.
- Vaccinations.
- All information relating to pharmacy workload.
- Pharmacodynamics and personalised medicine therapy.
- Reduce the need to go and use the separate portal (NCRS or ShCR) in more scenarios.
- Access Record could further drive automation and use Access Record data for clinical decision support.

- Improved patient care and outcomes.
- Local, not just national, services incl, including vaccines.

Views on the potential priority of future Booking and Referral Standards (BaRS) applications

- Greater integration of community pharmacy in primary care
- Information exchanged in a quicker and safer timeline
- Potential for BaRS appointment standards - potential for more seamless integration into the booking systems within the Patient Medical Record and elsewhere.
- Enable community pharmacies to make referrals to NHS clinics without going via the GP practice.
- Assists medicines optimisation by enabling structured referral into and out of community pharmacy
- Urgent treatment centres (UTCs) / emergency departments (EDs) to be able to refer patients under Pharmacy First to a community pharmacy booked appointment
- Independent prescribing related referrals.
- Adding the facility in the booking system/standard to allow booking as a group on behalf of family and friends together can improve the vaccination uptake
- Referrals to testing, e.g. blood, and podiatry from pharmacies for enhanced diabetic and long-term condition management
- Able to escalate patients and book them directly into GP practice following a specific Ambulatory Blood Pressure Monitor (APBM) reading
- Booking an appointment for Pharmacy First/ pathfinder appointments directly from surgery at present, the process is not efficient for patients where they are referred to a pharmacy and then asked to come back at a booked time as the pharmacist cannot see them straight away, especially independent prescriber appointments - they need dedicated time and should not only be ‘slotted in’ as a walk-in service, appointments are essential for best care.
- Allowing independent prescribers to refer patients for therapeutic drug monitoring (TDM) and other blood tests.
- For booking into the Hypertension Case-Finding (NHS Blood Pressure Check) Service, Pharmacy First service, Pharmacy Contraception Service, and any future services, community pharmacies could use BaRS to book patients into GP appointments or ‘tasks’.
- Calendar integration, so don't need to run multiple calendars
- Referrals to optician or dentist
- Streamlined referrals catching end-point data
- NHS 111 can book a Pharmacy First consultation appointment.
- A universal booking platform for flu.
- Onward referral from CP for red flags where a GP appointment is needed.
- Ensure standardisation of requests through a uniform channel and interoperability between systems, providers and suppliers.
- Existing services to use BaRS standardise NHS care.

Other comments on pharmacy IT future developments

- Linking the vaccination recording systems with the vaccine supply system in real time can help save time.
- Develop repeat ordering via the NHS App so that GP practices can see the benefits of Electronic Repeat Dispensing (eRD).
- Various systems should consider workable multi-factor authentication methods.
- Efficient technology use is required for all pharmacists to receive safety alerts, protocols, and patient group directions (PGDs), especially as pharmacists become independent prescribers.

- Patients can notify community pharmacies when they need their next batch of prescription items.
- Local Pharmaceutical Committees need access to outcome data in a singular form rather than chasing different providers to support pharmacies and NHS pharmacy service provision. The publication of BSA data involves too much time lag (typically several months).

Actions:

- The group was asked to share ideas on future priorities by contacting **it@cpe.org.uk**.

Item 11. Artificial Intelligence

- **Appendix CPITG 04/06/23** sets out related updates. Matt Armstrong (CP ITG Chair) and Dan Ah-Thion (CP ITG Secretariat) presented **slides** and provided an update.
- The group were asked to consider the following:
    - What are the things that the group need to think about with AI?
    - Where do we think the benefits are, and what are some of the areas of consideration?
    - What are the unintended consequences?

Artificial Intelligence: discussion

Group comments:

- Ethical considerations in terms of impact on the workforce. AI should enable the workforce to do tasks. Also, consider the benefits of utilisation of data, e.g., what's in the Patient Medical Record system. What can be leveraged there to engage with patients more and enhance their care and outcomes?
- AI is excellent on big data. Machine learning can help with repeatable processes in the dispensary and prompting colleagues.
- A challenge to overcome is continuing to meet the highest standards regarding data assurance, security, and accuracy.
- How can we use machine learning to remove tasks and prompt when a human needs to take a look, prompting for interventions which would benefit patients?
- Digital Capabilities: Upskilling pharmacy workforce: Help pharmacy teams understand how the current AI models work and the considerations about AI's appropriate and ethical use.
- Appropriate care and consideration for how the human fits in the loop—human decisions with AI assistance, AI decisions with human verification, and AI full automation. Ensure you are joined up with other professional bodies on such. Ensure all security PoVs are considered.
- A national Pharmacy strategy - we should feed data into a central location to support AI with areas such as:
    - Drug development
    - Predict hotspots of illness
    - Predict outcomes
    - Inventory management\seasonal demand
    - Monitoring for bias
    - Predict shortages
- Machine Learning is great for the local pharmacy.
- Transcription would be fantastic as an integrated part of a clinical system, but commercial/free products are not there yet.
- Need regulation in the sector; open AI models such as ChatGPT as these are open to the public. Do the groups lie with supporting regulators in developing these regulations and standards? The potential is vast, and we must use AI and automation to drive value. Value in the interaction with the patient to personalise care.

- Royal Pharmacy Society mentioned that they are developing a position statement on AI that will be principle-based.

AOB

National Care Records Service (NCRS) user research in mid-June
Pharmacy teams can email it@cpe.org.uk if they can feed in for interviews regarding NCRS development

Pharmacy services IT user research.
Please email it@cpe.org.uk to the pharmacy team members using Update Record / Access Record / Booking and Referral Standards (BaRS) who wish to share feedback (or speak with NHSE's TD user research team members). NHS researchers will also visit those pharmacy teams using the Update Record in the London and Manchester area during the spring/summer of 2024.

Future meeting dates

Weds 18th September 2024
Weds 13th November 2024
Weds 5th March 2025
Weds 4th June 2025 (to be confirmed)