Response

Digital transformation in the NHS

June 2022

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About the Company Chemists' Association (CCA)

Established in 1898, the CCA is the trade association for large pharmacy operators in England, Scotland and Wales. The CCA membership includes ASDA, Boots, LloydsPharmacy, Morrisons, Rowlands Pharmacy, Superdrug, Tesco, and Well, who between them own and operate around 6,000 pharmacies, which represents nearly half the market. CCA members deliver a broad range of healthcare and wellbeing services, from a variety of locations and settings, as well as dispensing almost 500 million NHS prescription items every year. The CCA represents the interests of its members and brings together their unique skills, knowledge, and scale for the benefit of community pharmacy, the NHS, patients and the public.

Executive summary

Community pharmacy is undergoing rapid change in practice, responding to changing demands of both the NHS and patients. Frequently, there are barriers to care, inefficiencies, or missed opportunities stemming from poor digital integration. Community pharmacy providers want to provide the very best clinical care, and this ever increasingly requires a modern IT infrastructure.

Key priorities for the government and the NHS should be setting out clear technical standards and specifications for all clinical records and transfer of care. Then providing the leadership to ensure these are adopted across the country, regardless of setting, provider, or location. The introduction of ICSs in England creates many opportunities for patient care, but also risks of duplication of effort (and associated inefficiency). Different requirements for 42 Shared Care Records are a key risk for future efficiency. Frameworks for digital innovation and development that apply universally across the country will enable businesses, clinicians, and the NHS to collectively enhance care everywhere.

- How can the Government communicate the benefits of digital approaches in healthcare to the public and provide assurances as to the security of their data?

The recent pandemic has seen changes to nearly all of society, including healthcare. Following the necessary changes in practice, patients and the public are much more accepting and expecting of digital care. There is an opportunity to talk about taking the learnings from Covid and retaining what has worked well, whilst returning to activity that was understandably deprioritised.

The use of a digital approach is not new to much of the public, and analogies can be drawn with large sections of modern life. Indeed, many parts of healthcare have a history of digital technologies. CCA members have introduced online consultation platforms, automated dispensing technologies, apps, text messaging, and many other innovations in recent years. Broadly the public are supportive where the benefit is clearly understood. Access to detailed information surrounding (for instance) data security is important to garner trust with the public. There is no need to proactively create engagement where none is desired, but to have the information needed easily accessible to those interested.

It is important patients and the public feel empowered and understand how their data is managed by the NHS and healthcare providers. A better awareness and confidence in data handling will lead to better sharing of data, and ultimately better patient outcomes. Combining this data will also enable the use of data in clinical research and population health analysis. Broader messages about the societal benefits as well as the individual benefits to data sharing are likely key to realising potential benefits. This is best achieved through concise information in layman's terms, rather than through long privacy notices or similar.

Finally, clarity between private/corporate innovations and NHS services must be clear. There are examples of corporate applications promoted by healthcare professionals and commissioners which give the impression that the offered service is either NHS developed, or NHS funded. This is not the case, causing disruption to local patient pathways. It is important that where commercial opportunities are implemented there is either a full and public tender process for an NHS contract, or patients retain full (informed) choice about how to access their care and are not 'locked in' to non-NHS technology.

- What progress has been made in dealing with the proliferation of legacy IT systems across the NHS?

Community pharmacies in England dispense over 90% of their prescriptions using the Electronic Prescription Service release 2 (EPSr2) system This has enabled electronic payment methods and a reduction in dispensing errors improving patient safety. However, the EPS system uses out of date infrastructure which no longer meets the needs of an evolving health system. We are encouraged by the NHS Digital “EPS Next Generation” programme to transition EPS to a modern architecture and data standards and urge this work to continue at pace.

Outside of England prescribing is not yet electronic. Both Scotland and Wales are currently engaging with stakeholders on the design of future ePrescribing systems. We would encourage not only speed in implementation, to reap the efficiency and safety benefits of these systems, but also standardisation across national boundaries. Standardising the infrastructure across the UK would reduce costs for the NHS, and for system suppliers. It also prevents cross-border challenges arising from patients accessing different systems with unique system architectures and platforms.

It is notable that electronic Repeat Dispensing (eRD), which was introduced in England in 2009, remains a small fraction of repeat medication. At least two-thirds of community pharmacy prescriptions could be prescribing using eRD but the usage is currently approximately 14% across England. eRD offers many benefits to patients, prescribers, and pharmacies, including significant time saving. There have been many attempts to increase uptake, especially during the pandemic when the process for gaining patient consent was simplified. However, for a variety of reasons uptake remains poor. This is one example of systems not fully implemented across the country, despite wide awareness of the benefits.

We cannot comment on legacy IT systems within NHS organizations as CCA member companies complete their own IT procurement. However, we note that recently designed services, whilst digital in design, rely on minimum standards. For instance, both the recently nationally commissioned Community Pharmacist Consultation Service and Discharge Medicines Service in England rely on NHSmail as the core data transfer system. Whilst there are examples of integrated platforms these are locally commissioned.

There is a need to revisit the information flows between different parts of the NHS regardless of the hardware or software in use. NHSmail is regularly used for commissioned national services despite a defined data set. This requires transposition to alternate systems risking copy errors. By ensuring the consistent use of digital standards regardless of the location, then clinicians can successfully and reliably refer patients across the system.

- How do IT platforms used in NHS hospitals in England compare with those used in hospitals in the United States?

No response.

- How can the Government effectively foster co-operation between the NHS and the private sector to both develop and implement innovation in healthcare?

Any innovation requires both funding and some certainty in likely futures. Community pharmacy is an excellent example of where year on year underfunding undermines the environment for investment. Since 2016 community pharmacy has seen 25% real terms cut in funding. Private sector organizations have different requirements for creating and meeting business cases. These include an open understanding of the likely benefits or volume of activity following any innovation, through clear and shared Performance Indicators.

Alongside this there is a need for shared solutions to problems. Clearly defining the problem and a measure of success before implementation and/or design allows different parties to work together to solutions. An innovation framework may be helpful, allowing organisations to innovate with fewer concerns about interpretations of existing legislation, Terms of Service, and guidance.

- What other functions could and should be performed on the NHS App?

We expect the NHS App to act as the digital ‘front door’ to the NHS, guiding patients to all the possible care they need. This should likely include the ability to ‘nudge’ patients to access less immediate care,

such as self-care options and similar, to improve their general health. Critically the NHS App should have the ability to refer the patient to the service they need. This requires open standards for all providers to link their own systems, with full interoperability.

Interoperability is important to ensure patients have the choice of how they engage with digital healthcare. For instance, some CCA members have existing digital platforms combining their NHS commissioned services and private healthcare. Seamless use of the NHS App and other healthcare solutions would be facilitated by data flow maps showing which systems are linked and integrated. With this is the need for a consistent method for sharing information with system providers and organisations engaged in digital transformation.

Within pharmacy a greater ability for patients to view the status of their prescriptions would offer benefits to pharmacies and patients alike. Similarly, whilst patients can order repeat medication, the ability to request synchronization prescriptions would simplify the administration of repeat medication for patients and general practice.

- What progress has been made in digitising health and care records for interoperability, such that they can be accessed by professionals across primary, secondary, and social care?

Shared care records have been an ambition for both health and social care for years, set out in the Long Term Plan to be in place across all ICS's by 2024. Shared records are key to interoperability and joint working, to enable effective and efficient care for patients across all settings. Previous work by the Professional Records Standards Body (PRSB) was a helpful baseline for the information that needs to be captured and made available. Technical and data standards are essential to enable interoperability and we fully support the Professional Records Standards Body (PRSB) in their work to define core patient information standards.

Despite some promising evidence from some health systems (for instance Integrated Care System for Devon) extensive roll-out across England remains lacklustre with significant variation. Moreover, current indications are that there will be 42 individual ways of accessing these records despite identical use cases. Standardisation (one way to access records regardless of location) will offer benefits to systems, clinicians, and ultimately the taxpayer through efficiency savings. Furthermore, there is a disconnect between enablers to care and the needed commissioned activity. Many stakeholders are agreed that better use of clinical skills within community pharmacy is not just desirable but essential to support the NHS. Many of the developments needed require Shared Care Records. However, there is no clarity on a commissioning timeline that could inform work from both NHS and community pharmacies to implement these records. There is a need for a joined-up approach, succinctly describing the need and value of shared digital records alongside the desired timelines.

Outside of Shared Care Records there have been promising steps made to input patient outcomes following influenza vaccination in community pharmacy to GP records using PRSB data standards. We would advocate this approach being developed further to share other community pharmacy services into GP records, reducing the administration burden for both pharmacy and GP colleagues. Locally, referral systems do not follow nationwide technical standards, meaning multiple different systems require checking for patient referrals based on the system chosen by the referrer. This inefficiency risks the timelessness of action in the pharmacy. We welcome the NHS Digital Booking and Referral Standard (BaRS) programme which should standardised referrals across the NHS. We would encourage this programme to begin implementation quickly, consider practical steps to engage all providers and encourage uptake of new standards, as well as to prioritise community pharmacy referrals – given their ability to directly improve access to GP appointments.

- What progress has been made on making data captured for care available for clinical research through digital transformation?

No response

- Specifically, have lessons been learned from the success of the streamlined and accelerated nature of the RECOVERY trial, as pioneered during the pandemic by Professor Sir Martin Landray?

No response

- What should be the timescale for incorporating genomic data into patients' medical records?

We are not currently able to give a specific response to this question. However, we are mindful that there should always be a balance between information and clarity. Genomic information should be included in patient records when it can be considered both clinically relevant and can lead to action by individual clinicians as part of regular care. This will require both an increase in the frequency of testing with patients (and greater access to this testing) as well as education for all healthcare professionals in interpreting this data. We can see a role for community pharmacists in undertaking this testing and supporting patients with the results, as seen in peer-reviewed trials from around the world. However, until there is a clear commissioned route for acting upon this information it risks obscuring other vital information.

- What are the principal considerations that should be taken into account in this context and what additional training of the workforce will be needed to achieve this?

No response

- How can the creation or exacerbation of digital inequalities be avoided when implementing digital transformation?

Digital patient pathways should provide the advantage of increased accessibility. Features such as auto-translate, and text subtitles should be considered wherever technology allows. Video consultations are a prime example of where commercial technology can be applied to promote increased access, and directly tackle inequalities. It can also provide support to people with mobility challenges, or to those who find attending external appointments difficult.

However, we are mindful of the risk posed by digital poverty. It cannot be assumed that all patients have access to digital hardware to access pathways, can afford the data needed for service often based online, or have access to the private/confidential space needed to receive healthcare. Digital services also raise additional considerations surrounding safeguarding and ensuring that clinicians and patients are able to effectively converse to reach patient-centred decisions, for example without other individuals in the room but out of view.

Digital transformation should be additive, not a replacement. Digital transformation should create bespoke pathways for some patient groups, whilst creating additional capacity in existing services. Similarly, it is important not to assume patients fall into a digital or non-digital group. Patients may choose digital or physical pathways dependent on many factors, with different decisions for different types of care, the location in their treatment journey, or even the day of the week. This requires a flexible approach to patient pathways, recognising that patients may switch the way they access care regularly.

There is also a need to consider how those not able or willing to access digital pathways can be supported. Community pharmacies are unique in that physical access increases with greater deprivation. This means commissioning activity from community pharmacy can directly target those patients most at risk of digital inequality. Part of the approach to achieving the many benefits of digital transformation includes early discussions with the sector/providers and system suppliers to shape strategy and policy to meet the needs of patients and the population.