Written evidence submitted by the National Community Pharmacy IT Group (DHS0018)

Introduction

This is the Community Pharmacy IT Group's formal response to the Parliamentary Health and Social Care Committee's consultation about "Evaluation of Government commitments made on the digitisation of the NHS".

About Community Pharmacy IT Group

The group is formed of community pharmacy sector representatives. It works to outline the sector's digital priorities and to encourage the sector to engage with upcoming digital changes.

The Group was formed in 2017 by the Pharmaceutical Services Negotiating Services (PSNC), National Pharmacy Association (NPA), Royal Pharmaceutical Society (RPS), Company Chemists' Association (CCA) and the Association of Independent Multiple Pharmacies (AIM). The group's meetings are attended by members from these organisations and from pharmacy clinical IT system suppliers, NHSBSA, NHS Digital, NHS England, and the NHS Transformation Directorate. Further information about the group is available on the CP ITG webpage.

The objectives of the group include:

- developing and communicating a shared vision for the optimum use of digital technology within community pharmacy in England;
- providing a forum to discuss new digital technologies which may have impact community pharmacy practice in future;
- supporting the development of user-led recommendations to be considered by suppliers;
- providing a credible, respected forum for sector-wide engagement with NHS organisations and other national bodies on the vision, strategy and operational plans for delivering optimum use of digital technology in community pharmacy;
- developing an implementation strategy for delivering optimum use of digital technology in community pharmacy and overseeing a joint work-programme to deliver this; and
- through its member organisations, providing recommendations and advice to community pharmacy and other healthcare organisations.

About the consultation

The Health and Social Care Committee's Independent Expert Panel seeks feedback about the Government commitments made on the digitisation of the NHS.

About CP ITG's consultation response

The CP ITG response relates only to those areas concerning NHS community pharmacy.

Policy Area and commitment	**Policy Area and commitment**	**Was the commitment met overall?** or (in the case of a commitment whose deadline has not yet been reached) Is the commitment on track to be met?	**Was the commitment effectively funded** (or resourced)?	**Did the commitment achieve a positive impact for patients and service users?**	**Was it an appropriate commitment?**
1	Care of patients and service users Commitment: 1. Our aim is that, by 2024, 75% of adults will have registered for the NHS App with 68% (over 30 million people) having done so by March 2023.	**1. Does the commitment have a clear and fixed deadline for implementation?** Yes **2. Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?** We'd like to see alongside NHS App usage growth, development with	**3. Do healthcare stakeholders view the funding as sufficient?** Community pharmacy stakeholders would like to see further NHS App development for greater features [see answers within column to left]	**1. What was the impact on equity of outcome different groups?** The growth of NHS App is welcomed but it should take place alongside the development of NHS Application Programming Interfaces (APIs) and other integration, for example of the NHS Booking and Referral Standards (BaRS) standard so that in due course when patients book a pharmacy or GP appointment, the main GP and pharmacy systems	**2. Is the commitment wide enough in scope? Does it cover interoperability?** We'd prefer a larger focus on wider types of interoperability which could be interconnected with use of NHS App. One example is set out within columns to left e.g. a. interoperability in regards to appointment booking standards – the interface used by patients, and the interfaces and systems used by health care providers such as pharmacy contractors

		healthcare provider IT development. For example a. the NHS App could be developed so that any patient can book an NHS flu vaccination with <u>any</u> community pharmacy providing NHS flu vaccines [subject to further developments and integrations with NHS Booking and Referral Standards (BaRS)]. b. Nominated dispensers to view patient medicine reorder requests made via the NHS App: Visibility will ensure that pharmacy staff confirm that they can fulfil requests effectively and reconcile items as needed. Patients assume that community pharmacy already has access to the medicines ordered and may query with the pharmacy where they have		can easily align to Booking and Referral Standards (BaRS) and NHS App also aligns to BaRS. This would mean there is a proper marketplace of appointment IT providers for GP / pharmacy.	b. points such as Electronic Prescription Service next generation development resource being guaranteed and progressed so that NHS App prescription/medicines readiness can better improve over time. **3. Is the commitment specific enough?** Arguably it may be too focussed only on NHS App. See answer above. **6. Is the target contained in the commitment an effective measure of policy success (if applicable)?** We think the digitisation policy streams should be more strategic and focus on a number of streams including digital IT used by healthcare providers, instead of a significant focus only on the usage of the tool.

		ordered a medicine, but it has not yet been prescribed. c. Development of Electronic Prescription Service and speedier progress with NHS Electronic Prescription Service will in turn 'unlock' an ability to re-explore and set out new fully standardised medicine statues (e.g. 'medicine to be collected from pharmacy', 'medicine to be delivered', 'medicine delivered'). In turn new statuses could be used within NHS App to give a deeper understanding about medicines status, whilst medicines are being obtained and dispensed. d. See further suggestions about NHS App on CP ITG's NHS App wishlist			**7. Was the commitment addressing an identified need and relevant to the problem?** NHS App along with other apps e.g. pharmacy apps, can provide a number of needs e.g. access to information by the patient.
	Care of patients and service users	Outside of CP ITG's	**3. Do healthcare**	Outside of CP ITG's	**1. Was (or is) the commitment**

	Commitment: 2. By increasing digital connection and providing more personalised care, we can support people to monitor and better manage their long-term health conditions in their own homes, enabling them to live well and independently for longer.	scope or knowledge to comment.	**stakeholders view the funding as sufficient?** CP ITG would like to see greater resource allocated towards a 'Pharmacy IT Futures' framework, learning lessons from the 'GP IT Futures', and to boost the IT standards expected to be used by pharmacy apps and NHS App pharmacy features. **4. Was any financial commitment a 'new' resource stream? If not, did reallocation of funds result in any unforeseen consequences/undesirable 'work arounds' at local level?** We were not aware of new revenue streams which could support the direct digital relationship between pharmacy and their patients.	scope or knowledge to comment.	**likely to achieve meaningful improvement for service users, healthcare staff and/or the healthcare system as a whole?** More specific commitment would seem to be needed. **2. Is the commitment wide enough in scope? Does it cover interoperability?** It seems too loose to genuinely push forward genuine interoperability within NHS IT. **3. Is the commitment specific enough?** No.
	Care of patients and service users	**1. Does the**	**1. Were specific funding**	**1. What was the**	**1. Was (or is) the commitment**

	Commitment: 3. Roll out integrated health and care records to all people, providing a functionally single health and care record that people, their carers and care teams can all safely access, enabled by a combination of nationally held summary data and links to locally held records, including shared care records.	**commitment have a clear and fixed deadline for implementation?** The commitment should do more to specify the sectors which require access to information, for example mandating the need for the community pharmacy sector to be able to have easy access to relevant information to ensure that medicines dispensing and services delivery is as safe as it should be. **3. To what extent has the NHS's Covid-19 response affected progress on targets?** The pandemic has demonstrated the importance of those providing direct care having access to the right information. We believe the pandemic has shifted public attitudes to being even more supportive of	**arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and where were they made?** There should be a clear national specific funding arrangement for deployment of ShCR towards: 1. Technological updating [coded IT standards] 2. Community pharmacy sector deployment. We are not aware that this is arranged yet. **2. Who was involved in determining the funding arrangements? Who was ultimately responsible for this decision?** Unclear to CP ITG at present. **3. Do healthcare stakeholders view the funding as sufficient?** No as per other answers	**impact on equity of outcome different groups?** Patients who happen to have a pharmacy with proper access to ShCR [small minority of pharmacy patients] could be at lower risk of negative clinical consequences. A case study by a pharmacy using ShCR set out all kinds of advantages for the patients using the pharmacy, and the pharmacy – Dorset Care Records website case study. Pharmacy ShCR access is in line with NHS Long term plan, Department of Health and Social Care (DHSC) data security policies, which propose all health care professionals have access to the information they need, when they	**likely to achieve meaningful improvement for service users, healthcare staff and/or the healthcare system as a whole?** CP ITG welcomes the growth of Shared Care Records (ShCRs). Within some areas pharmacies are already accessing ShCRs. In many areas planning is underway to try and make ShCRs available to pharmacy teams. There is a need for information to be integrated into clinical systems. There is little appetite from clinical IT software suppliers to integrate with multi local ShCR systems each with a different setup. The processes and IT across ShCRs and the GP Connect Access Records standards programme need to be standardised. The Professional Record Standards Body should be commissioned by NHS England to further outline the Core info

		clinicians caring for them having access to relevant information which best supports their care and outcomes. **4. How has this commitment been interpreted in practice at trust/patient level?** We have seen each Integrated Care System (ICS) / Integrated Care Board progressing ShCR. However there is still a limited amount of standardisation of protocols and systems and IT standards to support community pharmacy onboarding. This has led to blockers within some areas. Almost every community pharmacy must deal with patients from across more than one ICS area. Around half of community pharmacies are within organisations with 9 or fewer pharmacies. But a	within this section, we think greater work is needed to support records interoperability, and deployment of records access. It seems like significant funding has been applied locally, but inadequate resource applied to setting national protocols, guidance and technical recommendations / levers. NHS England's Transformation interoperability Directorate, Professional Record Standards Body, NHS England pharmacy IT team, and appropriate others require appropriate resource to progress the records agenda in the best way, and they are not adequately resourced at present for progressing towards the aspiration of all community pharmacies being able to access and record into ShCRs within the medium term. **4. Was any financial commitment a 'new'**	need it. **2. Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment?** We anticipate pharmacies using ShCRs to rise, but at the current speed, progress will be too slow, unless of further changes and clarifications to policy, timelines and interoperability planning and implementation. **3. Will (or have) patients and service users benefit(ted) directly, indirectly or both?** Yes – see question 1 in this cell.	standard relating to the ShCR standard and a community pharmacy subset and to enable GP Connect and ShCRs to align under the same IT standards framework. The CP ITG welcomes the work by PRSB to develop the Core Information Standard, which aims to create a standard that others could use when setting out electronic health record structures. The NHS Digital 'GP Connect' IT standards system (and GP Connect Access Record programme) was originally setup for use within the GP Sector but its scope has been broadened and other parts of health and care can now integrate with these records. GP Connect should be re-branded e.g. as Healthcare Connect or equivalent. GP Connect records IT standards should be aligned to those IT standards used by Shared Care Record (ShCR) systems. The Professional Record Standards Body should with

		segment of the sector operate across larger distances or across England. Being able to deal with tens of versions of ShCRs with limited standardisation is challenging. **5. Does data show achievement against the target (if applicable)?** The progress within community pharmacy sector is very limited to certain geographic patches (e.g. Dorset, East London, Greater Manchester) in which pharmacies have begun using the ShCR. If greater IT standards are created, endorsed, and used, and operated underneath ShCRs and underneath other NHS records, then a further measurement could become the % which	**resource stream? If not, did reallocation of funds result in any unforeseen consequences/undesirable 'work arounds' at local level?** As per other answers within this section. **6. Who made commissioning decisions (local budget allocation)?** As per other answers within this section.	**4. What category of patients and service users have benefitted? And why?** See question 1 in this cell.	partners, including the NHS England's Transformation Directorate interoperability team and NHS Digital, seek to code the ShCR standards so that suppliers can more easily align and integrate into ShCRs. Shared Care Records (ShCRs) systems should follow aligned IT standards that should be mandated to follow the expected PRSB and coded standards. Shared Care Records (ShCRs) systems should follow aligned processes and health, and care workers should follow the same IG processes, training and sign-up procedures regardless of the geographic setting of the Shared Care Record. **2. Is the commitment wide enough in scope? Does it cover interoperability?** See other answers within this section. **3. Is the commitment specific enough?**

		have access to 'integrated records'. I.e. not a need for access via a separate clunky internet records portal [an added login barrier for time poor frontline clinicians], and instead the records information is displayed intelligently within the clinical systems and the health care providers (e.g. pharmacy's) own Patient Medical Record system.			No. See other answers within this section. It should be made clear that community pharmacy should be able to have integrated access to ShCR, and be able to read and record into ShCRs. Additionally commitments must ensure ShCR projects, Summary Care Record (SCR), GP Connect records, other NHS records, and clinical IT suppliers all can align to the same coded new standard underlying NHS records [an expanded Professional Record Standards Body Core information standard] **4. Has the commitment had any unintended consequences?** The commitment has led to local Shared Care Records (ShCRs) developing ways that differ in nature amongst each other (technical arrangements, authentication arrangements, IG protocols, integration protocols / standards) . It would be better if ShCR aligned to national guidance (or mandates) so that there is less

					of a postcode lottery for patients and healthcare providers. **6. Is the target contained in the commitment an effective measure of policy success (if applicable)?** The target should be expanded to include: - % of 11,300 community pharmacy contractors with access to ShCR portal at minimum Then an aspiration to expand to: - % of 11,300 community pharmacy contractors with access to ShCR – integrated within their clinical system. **7. Was the commitment addressing an identified need and relevant to the problem?**

					Yes there was and is need to grow ShCRs. The progress is welcomed even though the responses within this report highlight some further areas to look at improving the process for ShCR projects, healthcare providers, NHS IT assurers, and clinical IT software suppliers. **8. How has working to those commitments affected other aspects of care?** We're not aware of ShCR related work so far having any significantly negative impact on other aspects of care.
2	The health of the population Commitment: 4. Through the Data for Research and Development programme we will invest up to £200 million to transform access to and linkage of NHS health and genomic data sets for data-driven innovation and inclusive clinical trials, whose results will be critical to ensuring public confidence in data access for research and innovation	Outside of CP ITG's scope or knowledge to comment.	Outside of CP ITG's scope or knowledge to comment.	Outside of CP ITG's scope or knowledge to comment.	**1. Was (or is) the commitment likely to achieve meaningful improvement for service users, healthcare staff and/or the healthcare system as a whole?** We believe that genomics information should begin to populate NHS records, and that health care providers including community professionals (i.e. pharmacists and pharmacy technicians regulated by the pharmacy regulator General

	purposes.				Pharmaceutical Council (GPhC)) with access to that information. This would require interoperability between standard health records and genomics health records. Community Pharmacists are key professionals working on the front line of healthcare and are the experts in medicines. Their unique training in science and healthcare, enables them to articulate complex medicines issues in a patient-friendly way. International evidence demonstrates diverse opportunities for Community Pharmacists in Genomics across community pharmacy. An NHS commissioned medicines genomics service of the future could involved the pharmacy team being involved with: •Raising awareness and promoting the use of Genomics in the healthcare setting •Members of multidisciplinary teams for better integration of Genomics use •Identifying patients who

					would benefit from Genomics testing, e.g. during medication reviews •Providing information and advice to patients and the public on Genomics due to their accessible position at the patient interface •Establishing, choosing, recommending, and ordering Genomics tests •Performing Genomics sampling and testing •Genomics data collection, analysis and management •Making recommendations on pharmacotherapy based on Genomics results •Medicines optimisation, therapeutic drug monitoring and dose adjustment based on Genomics results •Providing advice to patients on how their genetic material will be used and how test results may affect current or future treatments •Educating other healthcare professionals on Genomics •Developing and interpreting Genomics processes, guidelines and other publications •Supporting, contributing and leading Genomics research

					•Contributing to Genomics networks and committees •Helping the development of infrastructure and creating Genomics technologies for implementation in the healthcare sector. **2. Is the commitment wide enough in scope? Does it cover interoperability?** See question above. **3. Is the commitment specific enough?** See answer to question 1 above.
	The health of the population Commitment: 5. NHS Digital will develop and implement a mechanism to de-identify data on collection from GP practices by September 2019	**N/A.** This question is not appropriate for consideration by the CP ITG.			
3	Cost and efficiency of care	CP ITG would like to see reasonable investment into NHS IT including to facilitate a marketplace of clinical IT			

	Commitment: 6. We will streamline contracting methods both to leverage NHS buying power and simplify the process of selling technology to NHS buyers (ongoing).	system providers which have met relevant IT criteria for example alignment to standards such as Professional Record Standards Body Community Pharmacy Data standard, PRSB Core information standard, alignment to Community Pharmacy Contractual Framework (CPCF) services expectations [alignment to NHS technical toolkits], alignment to relevant NHS Digital standards etc. The pharmacy IT supplier market services a small population of 11,300 NHS community pharmacies, and we'd like to see the development of a proper 'Pharmacy Services IT Futures' [learning from the 'GP IT Futures' programme]. NHS England's Transformation Directorate, along with other departments at NHS England, NHS Digital and the NHSBSA, must be adequately resourced to conduct work to enable community pharmacy IT professionals to have sufficient IT infrastructure in place ahead of the launch of new NHS pharmacy services which have rolled out during recent years. Doing so will free-up more time for pharmacists to spend with patients, which will help ease the pressure on other parts of the health service in the long run.
	Cost and efficiency of care Commitment: 7. We will consolidate routes to market and strengthen our commercial levers for adopting standards through a new target operating model for procurement. This will include embedding standards as part of procurement frameworks, supporting NHS procurement teams to prioritise adherence to standards. Consolidation of the number of frameworks will encourage market entry and more choice in some markets, incentivising vendors to follow NHS standards.	See our answers relating to the commitment above.

4	Workforce literacy and the digital workforce Commitment: 8. We will co-create a national digital workforce strategy with the health and care system setting out a framework for bridging the skills gap and making the NHS an attractive place to work.	We'd like to see easy access to digital literacy training available to all NHSmail users working on the frontline – to include pharmacy team members with NHSmail accounts. This does not seem to be available in this way, and clinical staff can sometimes be very pressed for time, and therefore quick access to high quality training would have great benefit across the healthcare system.
	Workforce literacy and the digital workforce Commitment: 9. We will enable recruitment retention and growth of the digital, data, technology workforce to meet challenging projected health and care demand by 2030 through graduates, apprentices and experienced hires creating posts for an additional 10,500 full-time staff.	**N/A.** This question is not appropriate for consideration by the CP ITG.