

PPA CONFERENCE 2003 : 27 FEBRUARY 2003

NICK SCHOLTE, CHIEF EXECUTIVE SPEECH

“TOWARDS A MODERN NATIONAL PRESCRIPTION SERVICE”

Good morning (Lord Hunt) Ladies and Gentlemen. I'm glad to see so many old and new faces at this the first PPA conference.

The theme today is about working towards a MODERN National Prescriptions Service.

I think most people attending today would agree that a National Prescriptions Service already exists - GPs prescribe, Pharmacists dispense and the PPA reimburses. To complete the loop the PPA feeds back data on prescribing to those in the NHS that are required to manage it.

Although this national system is effective most people would also agree that the system is ripe for modernisation.

Those in the audience as old as I am will be able to recall the days when the only way to get cash out of your bank was to go to a branch, wait in a queue, write out a cheque, and have the money counted out to you.

How different it is now? You can pay bills by phone or through the internet and to draw cash you go to any cash machine in the country. I've forgotten where my bank branch is or even whether its still open.

Does that bother me? No. Because I have something I didn't have before...the convenience of obtaining cash and paying bills when I like, where I like.

In my view the prescription service as it is at the moment is overdue for modernisation of the type that occurred in personal banking services. The arguments for such a shift are compelling and the technology is no barrier....what's needed is a will to change by all those with a stake in the system.

The sessions we have arranged for today's event major on the strands of activity that will be required to enable us to achieve the goal of modernising the national prescriptions service.

I hope you find the plenary sessions informative and thought provoking. Perhaps however the most important part of today's sessions will be the afternoon workshops...I would urge you to attend these sessions because we want to hear from you with ideas as to how modernisation might be best achieved.

Before I introduce that theme I should perhaps say a few words about the PPA and some of the very real pressures upon the organisation. Hopefully that will explain why we are so keen on modernisation.

We are a Special Health Authority within the NHS with offices across the North of England. Our core functions are to process every prescription that is dispensed at NHS expense in England, pay pharmacists and other dispensing contractors and authorise payments to dispensing doctors. Some 10,000 dispensing contractors are paid monthly to an accuracy of over 99.8% month in month out.

As a by product of that service we recut dispensing data into prescribing data which we provide to PCTs and other health bodies to enable them to manage prescribing costs and trends in their locality.

We also run the NHS's Patient benefits schemes such as Pre Payments Certificates, Low Income Scheme, Medical and Maternity exemption schemes and provide a finance and Human Resources support service to other central NHS bodies where the cost of setting up their own support departments would be unnecessarily expensive.

In essence by undertaking these functions centrally we are able to take the burden of administration away the front line of the NHS enabling them to concentrate on delivering effective patient services.

And it is indeed some administration. The volumes involved are staggering.

For example, last year we processed over 600 Million prescription items. To put that into context by the time you have left this venue this afternoon we will have processed about 2.5 Million items. Still can't visualise it? By the time I've finished my speech we will have processed over 113,000 prescriptions. For each member of staff engaged on processing that's a prescription processed every 6 seconds.

Our operating costs are approximately 1% of the total primary care medicines bill which last year totalled £6.4 Billion which we are responsible for paying out or authorising for payment. It may surprise you to know the NHS spends approximately 12% of its entire budget on medicines dispensed in the community.

No wonder that Primary Care Trusts and Strategic Health Authorities want to have accurate and reliable information on the volumes and cost of prescribing.

That information enables those in the NHS responsible for prescribing activity to manage prescribing trends and costs locally. These services such as epact.net, Prescribing Toolkit and PCT Board reports get comprehensive information on prescribing straight to the front line as soon as we have finished processing each months batch of prescriptions.

These electronic information services are used extensively across primary care. Some 87% of PCTs use ePACT.net and 59% use Toolkit according to The Latest National Primary Care Tracker Survey.

On top of all this our management of all the governments patient benefits schemes puts us into direct contact with over 2.5 Million patients each year who are entitled to receive help with their health costs as a result of their financial position, their medical condition or because they are heavy prescription users. When entitlement is linked to tax credit status that figure is likely to rise by a further 4 Million.

Imagine the cost and potential inconsistency of each PCT running separate schemes for reimbursement, remuneration, management information on prescribing and patients benefits!

As a result of this broad portfolio of national services to a range of stakeholder groups we are in a good position to consider how these services might be best integrated within a MODERNISED National Prescriptions service.

Before I set out my view on what that means, I should perhaps explain what I see are the issues and challenges with the environment we have at the moment.

Firstly and somewhat parochially I confess to being worried about the impact of the inexorable growth in prescription volumes will have on my organisation. Prescription volumes are now growing at 6% per annum, nearly double the rate of a few years ago. The repeats policy is likely to add a further 14% or so on top of that growth rate.

Unless we re-engineer and modernise the system it will mean I have to open up more offices, recruit, train and deploy more people and invest in more IT kit to do more of the same.

Frankly I'd rather concentrate our efforts on re-engineering the process so that we get data in electronically, in a form that can be installed directly onto a database and validated where possible by computer rather than by human effort.

At first glance the PPAs business looks relatively straightforward, rather like a high volume invoice processing business or a pure data entry operation.

What makes it more complicated than it first appears is that GPs can prescribe virtually anything in any quantity and therefore the drug reference data set we have to hold is very large, some 250,000 products at the last count and rising. And it has to be kept up to date to reflect pricing changes.

The lack of defined data standards for describing drugs consistently, exacerbates the complexity of the reimbursement and remuneration framework as we have to design rules and routines that enable us to cope with ambiguous and occasionally missing prescribing and dispensing data in order to make the correct payment.

For these reasons the PPAs core task is not simple..... it is currently as much about data interpretation and validation as is it about pure data entry.

If we are going to have a Modernised National Prescriptions service we must get to the point where the primary care drug dictionary is fully deployed to ensure that there is interoperability between GP systems, Pharmacy Systems and the PPA.

If we want a modernised system that replaces the vast volumes of paper with standard electronic messages then we need to have a systems and network infrastructure that can firstly cope with the volume of messages and secondly can generate standard messages, send them to the right place and be read as they were intended to be read.

Finally any modernised service must provide patients with real benefits otherwise I suspect they would prefer to have things stay as they are. It is not enough for any system to be built solely around the requirements of the PPA or the pilot consortia or because it preserves pharmacy business interests. It has to provide patients with greater convenience so that the benefits are visible and they will want to participate. So what do we mean by a MODERN National Prescriptions Service?

I think the traditional view, if that's the right word in this context, is that it means replacing the paper prescription with electronic messages sent and received to defined standards be that for drugs, message format or encryption.

Whilst those elements are clearly important, my view is that that is too narrow a description.

In the context of modernising the service we also need to look at ways in which the reimbursement and remuneration framework can be simplified.

We must also understand how better quality prescribing information can be derived from the richer and more standard data that the NHS can have at its disposal once messages are transmitted electronically.

Most importantly we need to understand the impact on patients, not just in the context of ETP and what that might mean for them but also how they access benefits schemes.

This is not simply a technology issue. If we are to Modernise the service we need to recognise that this really is a business change issue involving everyone with a stake in the service.

If we can't produce wins for Patients, GPs, Pharmacy and the PPA then it is unlikely that we will have succeeded.

So let's look at each component in a bit more detail in the context of what it may mean for the PPA and other stakeholders.

The three ETP pilots have now been running for some time and although they got off to a slow start volumes of prescription messages coming through the pilots have increased recently, although not to the level that we would have liked.

There are basically two models being piloted.

The push model involves messages being sent directly to the Pharmacy of the patient's choice be that a bricks and mortar pharmacy or an internet based pharmacy.

The relay model involves all messages being sent to a relay and made available to any ETP enabled pharmacy to pull down from the relay when the patient arrives at the pharmacy.

We have learnt a number of valuable lessons from the pilots but perhaps the most important one is that it has become apparent that none of the pilot models is suitable for national roll out on its own.

It has also been recognised that for full implementation to be achieved there is a real need for GP and pharmacy systems to be upgraded to be capable of sending and receiving data in a standard format and for NHSnet to have the capacity to cope with expected message volumes.

These issues are being addressed by the wider national IT programme for the NHS and I hope that they will shortly be resolved.

In the meantime a considerable amount of effort is being put in to define the right approach for the NHS and Patients.

By right for the NHS I mean an approach that does not disenfranchise health care professionals because it is more cumbersome to operate than the current paper based system.

It also has to be an approach which represents value for the investment that will need to be put in so that the service does not waste money that could otherwise be spent on improving patient care.

There is also a need for the approach to compliment the wider aims and objectives of the 21st Century IT Strategy in particular the Electronic care record stream. Indeed ETP has the capability of recording and storing a record of most primary care transactions and could therefore become the kernel of any Integrated Care Record service.

The common model being currently worked on is hybrid of piloted models in that it contains the best elements of all of them from the point of view of patient convenience and professionals workflow and minimises the cost of message transmission to the NHS.

The idea is to provide patients with a full range of choices about how they access medicines.

Some patients will know which pharmacy they want to collect their medicines from as they generally go to no other. They still have to physically go to the pharmacy but the prescription can be prepared prior to the patient arriving thus reducing waiting time.

In Denmark which has had an operational ETP system since 1993 this is seen as such a benefit that patients are willing to pay 1 Krona to have their prescription sent electronically to the Pharmacy of their choice.

Some people, however, will not be able to predict which pharmacy they will get their medicines from, perhaps because they go to their GP near home but pick up their medicine during their lunch break. For them the model has to enable any pharmacy to dispense their prescription.

Other patients, perhaps the elderly or infirm or those that live some distance from a pharmacy outlet might wish to avail themselves of the facility to order medicines over the phone or through the internet and have them delivered to their door.

The model being worked on encapsulates all these options to maximise patient convenience.

For pharmacy it supports the policy objectives described in *Pharmacy in the Future* by providing some savings in pharmacy workflow that can be reinvested in patient care. These could derive from pharmacy no longer having to collect prescriptions from surgeries and also automatic install of patient data on the pharmacy system thus avoiding rekeying.

From the point at which ETP was first mooted the PPA recognised that for it to be successfully implemented there needed to be in place a standard way of uniquely describing drug products that all participants of the National Prescription Service would use.

The design of the dictionary has ensured that the product supports key use cases in primary care be that prescribing, dispensing, reimbursement or decision support.

Its extensibility into secondary care settings is being tested by the NHS Information Authority in the context of the UK Clinical Product Reference source project. Initial results from these exercises are very positive.

The good news is that first release of the NHS Primary Care Drug Dictionary was made available by the PPA earlier this year on time and to cost. The current release contains products that meet 99% of primary care prescribing, all drug tariff appliances and all borderline substances.

The response to its release has been most encouraging. Some 100 organisations, including major systems suppliers, and database providers now have access and we are continuing to encourage organisations to adopt and embed the dictionary within their systems. Those to whom this is new can pick up a copy of the Dictionary demo disk from our stand.

In terms of its future development I can assure delegates that we will continue to populate the dictionary with the less commonly prescribed products and as and when new products become available for primary care prescribing.

In the meantime the dictionary, as the first deliverable of the UKCPRS project, is in the process of being submitted for Information Standards Board approval which will establish the dictionary as a defacto standard for use across the NHS.

This is an important development for the PPA as well as the rest of the NHS.

For us, when fully deployed, it means we will get unambiguous and complete prescribing and dispensing data enabling us to automate the processing and pricing of prescribing and dispensing data.

The Dictionary is equally as important for the medicines supply chain with whom we are also actively working to encourage manufacturers and others to adopt the dictionary codes in their systems so that the code is available on medicines packs.

This would enable products to be tracked from manufacture to administration but most importantly it would help to reduce patient medication errors as it would enable pharmacy systems to be set up to alert the dispenser when a product about to be dispensed does not match the prescription order.

Although the deployment of the dictionary removes some of the complexity in the reimbursement framework it won't solve all the issues with it.

The rules are so complex that a simple reading of the drug tariff, which I don't recommend as it's about as scintillating a read as a telephone directory, won't necessarily tell you what you want to know.

The reason for this is that the tariff is reflective of a reimbursement policy "that contractors should be reimbursed fairly overall".

In practice, of course, each contractor wants to be reimbursed accurately for the items they have dispensed and in response to this procedures exist (that aren't in the drug tariff) because operationally the PPA has to scrutinise each individual prescription form to ensure it is priced accurately.

This diversity of approach explains why the current reimbursement framework is so complex - the rules have to reflect both the policy framework and the contractors' legitimate need to be reimbursed accurately.

I wonder whether the time is now right to have a fresh look at how pharmacy is reimbursed?

One idea that we have been considering is to move away from the concept that the reimbursement price for a particular medicine should vary according to manufacturer or pack size. Why not a unit price per pill for example? In effect that is what we have when there is only one pack size in the Drug tariff.

This is of course only one of a range of possible solutions that will help to simplify the reimbursement system. In developing our thinking on the range of options we have identified as meriting further consideration it is our intention to engage fully with the PSNC to test out the feasibility of new approaches.

Any such move to a simpler reimbursement system could be allied to a simpler method of remuneration too. At the moment remuneration is based on payment per item dispensed with add-ons here and there to reflect late opening and the requirement to undertake point-of-dispensing checks and so on.

We should ask whether this remuneration regime encourages pharmacy to accept the challenge of providing an increasing range of services for patients or constrains it?

I suspect it acts as a constraint and wonder whether it is time, perhaps in the context of the negotiations on the New national pharmacy contract to look at a simpler remuneration framework which properly rewards pharmacy for the services it provides to the NHS perhaps at different levels according to the quality or diversity of services on offer.

I confess to having an interest in simplification of the current reimbursement and remuneration frameworks. A unit cost solution to reimbursement would reduce considerably the reference data set that the PPA needs to keep up to date and remove a large part of the process of interpretation and validation of each prescription item.

A monthly contractual payment for services provided would also enable efficiencies to be made to the validation and payment process at the PPA

For pharmacy these moves would also allow greater transparency of pricing so that pharmacists would know what they were entitled to when submitting claims.

To build towards this objective I can tell you that we have now commenced a project to provide the drug tariff electronically on - line. As a first stage we want to find out from drug tariff users what they use it for and , if it was provided in a searchable format what facilities they would like to see provided. I would encourage pharmacy to get involved with that initiative so that we can provide a solution that will give real benefits to the tariffs users.

Turning now to our prescribing and other management information services.

The one thing apart from accuracy that our information users want is timely delivery. When that's not achieved the job of many people in the NHS with the task of managing prescribing is made that much more difficult. After all a wide range of users rely on our systems to manage prescribing budgets and to detect out of norm prescribing patterns.

Doctors themselves have access to information on their own prescribing practice through the PACT reports which are currently provided on paper, although a number of GPs have access to their prescribing data electronically.

ePACT.net and Prescribing Toolkit provide NHS users with on-line access to three years data held on the NHS prescribing database. Users can analyse practice prescribing using a range of patient denominators and cut the data in many ways to assess performance against budget or by comparison to other areas.

A new facility for PCT's is the electronic PCT prescribing report developed in collaboration with a number of expert organisations. This report is available electronically and is aimed at PCT Boards who use it to monitor trends on cost and volume of prescribing especially in those clinical areas which have been identified as high priority such as National Service Frameworks and NICE guidance.

We recognise that the implementation of the initiatives associated with Pharmacy in the Future will mean that demand for our prescribing information services will increase as a wider range of health professionals are empowered to prescribe. Our plans for providing prescribing data so that these initiatives can be monitored are well advanced and management information systems will be made available as new prescribers come on stream.

The implementation of ETP will itself enable us to provide richer and more timely management information as it will allow us to store data we currently don't enter onto our systems and enables us to collate data in real time and provide it earlier than current monthly batch driven process allows.

A further plank of information strategy is to try to eliminate the forest of paper reports by providing users with greater access to management information over the internet. This is an environmentally friendly approach and fits in neatly with e-government strategy.

I should mention that Pharmacy is not being forgotten. We have made a number of improvements to the management information we provide pharmacy. Historical schedule data can now be made available on line and we have provided the facility for amalgamated schedules for pharmacy chains so they do not have to manually consolidate accounts from their many branches.

We have been running the NHS Low Income scheme for some time but in October last year we took on responsibility for managing Prepayment certificates and medical and maternity exemption schemes.

From the outset we were able to offer patients the NEW facility of being able to apply for a prepayment certificate by telephone and a renewal reminder service, both of which have been well received by patients country wide.

We recognise there is still much to do in this area which has suffered from a lack of modernisation whilst service provision was split amongst the old Health Authorities. In particular we understand that these benefits schemes have not always been well promoted and have not been particularly accessible for those who need assistance.

To counter this we will be undertaking a range of measures to improve the visibility and accessibility of the patient benefits schemes we manage.

We will consider ways in which patient benefits schemes can be better promoted to those who are entitled to relief from charges. Amongst improvements in the pipeline are encouraging other health web-sites used and accessible to the public to link to our site for on line applications.

We will review the application forms and redesign them to make the process of applying easier and less time consuming.

To improve the accessibility and convenience of the service to patients we intend to encourage more pharmacies to sell Pre payment certificates over the counter and to report a sale to the PPA on-line so that we can keep our database of patient entitlements up to date.

We are also going to make available the facility for patients to make an application for a PPC over the internet.

Finally as the PPA will host most of the patient benefits databases it is our intention, as the NPS develops, to develop systems that enable on line checking of eligibility at the pharmacy in real time. If that can be achieved then the overhead attaching to the current methods of checking eligibility after the event will no longer be needed except in special cases.

So why is the implementation of a modernised national prescription service so important for the PPA?

As I referred to earlier we are facing an unprecedented period of growth in the number of prescriptions we are required to process and it shows no sign of slowing down. We cannot simply carry on expanding our workforce, premises and equipment. We need to harness new technology so that the cost of providing the service does not expand at the same rate as prescription volume.

In essence we want to receive prescription data electronically rather than on paper as this will enable us to install that data directly onto our data base thus eliminating the data entry part of the core task.

We then want to be in a position to have computers validate that data automatically thus reducing the need for human intervention in the process.

The extent to which we can achieve that will depend on the extent to which the NHS Primary care Drug Dictionary is implemented within GP and Pharmacy systems and the degree of simplification of the reimbursement and remuneration rules that can be achieved.

That is why we are working hard to get to the position where the drug dictionary is in common use throughout primary care and discussing simplification options with our colleagues in the department of health and PSNC.

So how might the roll out of a modernised national prescriptions service be achieved?

Well firstly it is important to be clear about why it should be done, what the business drivers are. I guess there are a number of pretty important ones here....

Firstly the need to enable the PPA to re-engineer to cope with prescription volume growth and lower the unit cost of prescription processing.

Secondly to provide workflow benefits to GPs and Pharmacy so that the time saved can be deployed on service improvement.

Third to provide patients with greater options for accessing medication thus providing them with greater convenience.

And lastly lets not forget that if this volume of paper is converted to electronic messages then it goes some considerable way to meeting the governments targets for transactions to be electronic rather than paper based.

There are however a number of dependencies which will need to be progressed before a national electronic prescription service can be fully deployed.

We need to decide whether patients have to opt in or opt out of the electronic service. We need the NHS Primary Care Drug Dictionary deployed in GP and Pharmacy systems. We need an NHS net that can cope with the volumes of messages that the system will generate. We need to determine how pharmacy will connect to the NHS net and we need an agreed approach to authentication and encryption.

We also need to decide on the model that is right for deployment for the NHS and patients and last but not least we need to decide what needs to be procured and the shape of any Prime or regional service provider involvement in the programme.

Most importantly we need to engage with the service, suppliers, professional groups and patients so that we can create a project environment that provides gains all round. We will then have a much greater chance of succeeding.

This engagement has already started in some key areas of our work.

Groups have been established comprised of stakeholders or potential stakeholders in relation to taking forward the Electronic Transmission of Prescriptions Pilots towards a common model that is right for the NHS and patients.

We are working collaboratively with the NHS Information Authority, within the context of the UK CPRS project, to engage fully with those with an interest in implementing the NHS Primary Care Drug Dictionary.

We want now to continue that momentum by providing an opportunity for front line users of our key current services to shape their future development.

To that end I can announce that we are setting up three stakeholder forums to help inform our thinking about how our contractor, patient and information services can be best improved to meet the needs of those on the front line of the NHS.

Those of you who would like to contribute are invited to register your interest at our stand in the room adjacent to this one. Your involvement will help us to develop and deliver better services.

In conclusion I just want to stress that this programme is not just about releasing efficiencies at the PPA and developing our services to match users needs.

That is important.... but it is just as much about ensuring there are gains all round in improving GP and Pharmacy workflow, reducing cost by reducing patient medication errors and most of all its about making services more convenient for patients.