Digital Transformation in the NHS
10 June 2022

Executive summary:

In response to this call for evidence on Digital Transformation in the NHS by the Health and Social Care Committee we provide evidence and policy recommendations in relation to the following questions (from the terms of reference):

- 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?

Key findings:

- Lack of inter-operability of health records across professionals delivering end-of-life care in the community. This prevented shared access to patient data across professional groups and was a significant issue that delayed patient access to important medicines.
- Inequity in access to electronic prescribing systems, with many nurse prescribers delivering end-of-life care in the community unable to access and use these.

Based on these findings, we make the following recommendations:

- That healthcare provider organisations are required to commission or re-commission IT systems to ensure these are compatible across the different organisations locally that employ health professionals delivering care, including compatibility with local hospice IT systems.
- That future policy development in this space addresses the inequities in access to digital technologies between different professionals delivering care.

Response authors:

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Sue Latter is Professor of Health Services Research, and leads the Medicines Management Research Group in Health Sciences, University of Southampton. For the last 20 years Professor Latter has led a research programme that focuses on large-scale, nationally funded studies, working with policy makers and health care professionals locally, nationally and internationally, to disseminate findings, and generate impact which has shaped health care professional policy, education and practice. Her research programme has included over 30 funded studies, from peer-reviewed Government, charity and industry funding bodies. She has led interdisciplinary teams of world-leading academics, delivering complex, large scale studies which have resulted in a sustained record of international quality publications and generation of knowledge exchange and global impact.

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Natasha Campling is a Lecturer and Senior Research Fellow in Health Sciences, University of Southampton. She is the School of Health Sciences lead for pre-registration nursing palliative and end-of-life care education. She has significant expertise in qualitative and mixed methods research in the context of end-of-life care, including evaluation of end-of-life medicines-related issues. She was a Co-Investigator and the Senior Research Fellow for the NIHR funded ActMed Study (Accessing medicines at end-of-life: a multi-stakeholder, mixed method evaluation of service provision) and co-led one of the study phases.

About the Medicines Management Research Group:

Our inter-disciplinary, international research aims to provide evidence to support effective management of medicines by patients, carers and health professionals so they are prescribed safely and used by informed patients and carers to manage symptoms and maximise health and well-being. Effective prescribing and patient management of medicines requires good communication and information about medicines, and is an important part of self-management of many conditions. We aim to understand patient and carer experience of managing medicines and health professional – patient interactions about medicines and build on this to develop and evaluate interventions to support best quality medicines management.

Our research includes understanding and evaluating patient-centred interventions to optimise medicines use in co-morbidity, polypharmacy and long term conditions, as well as studies evaluating interventions and experiences of medicines management for patients nearing the end of their lives. A further focus is on understanding and promoting safe and effective prescribing of antimicrobials in hospital, primary, community and out-of-hours settings in order to contribute to global antimicrobial stewardship.

Research in the Medicines Management group is inter-disciplinary: we collaborate with leading academics and clinicians from medicine, pharmacy, psychology, paramedicine and health economics, to deliver important new evidence to influence policy and practice on a critical health care issue. Our studies include systematic reviews, qualitative research, large scale surveys, mixed methods research and feasibility trials.

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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?

1.1 Evidence from our recently completed research (Latter et al, in press) into experiences of accessing medicines in the community in the last 12 months of life (end-of -life) indicated that lack of inter-operability of health records prevented shared access to patient data across professional groups. This was a significant issue that delayed patient access to important medicines.

1.2 Professionals involved in providing end-of-life care in the last 12 months of life include GPs, community nurses, specialist palliative and end-of-life care nurses and community pharmacists. They work within a combination of organizations: GP practices, primary care, community services providers / Trusts, hospices and community pharmacies. Patients may receive prescriptions for medicines from a GP or any nurse or pharmacist who is qualified to independently prescribe medicines.

1.3 In our survey of health professionals providing palliative care in the community (Latter et al 2020), variable access to shared records was reported and many expressed dissatisfaction with a lack of access to shared records to support their role in providing patients with medicines.

Those based in GP practice (GPs and primary care pharmacists) had relatively high levels of access. However, Clinical Nurse Specialists in particular reported limited access to others' records, whether paper or electronic: 44% reported no access to GP records and 66% were unable to access GP out-of-hours records.

Satisfaction with access to shared records to facilitate medicines access reflected these results: 39% of respondents overall were either 'Not At All' or only 'Slightly satisfied'. Clinical Nurse Specialists and community pharmacists were especially likely to rate access as 'Not At All' satisfactory, with half of all Clinical Nurse Specialists (50%) reporting that they were either 'Not At All' or only 'Slightly satisfied'.

1.4 In addition, the majority (58% 142) of prescribing nurses and pharmacists were not able to use an electronic prescribing system (whereby details of prescribed medicine/s are entered electronically and where scripts can be sent direct to a pharmacy for dispensing to the patient). This means many prescribing nurses and pharmacists can only hand-write paper prescriptions which the patient needs to physically take to the pharmacy. Clearly, this requires time and effort for patients and their families at what may be a distressing time, and is likely to delay their access to medicines that are important for controlling symptoms such as pain.

1.5 Our research (Campling et al 2022) in the case of General Practice highlighted that lack of access to shared records hindered medicines access (particularly best practice in relation to prescribing and interdisciplinary working required for this). Community pharmacists were only able to access brief, summary patient details (Summary Care Record), community nurses had no access to specialist palliative care nurse records and vice versa, and the general practitioners could not view the community nursing or specialist palliative care records or general practitioner out-of-hours records.

1.6 We found that community palliative care clinical nurse specialist prescribers were not able to prescribe electronically and were not able to prescribe from their work base. They were only able to hand a paper prescription to the patient, which the patient or their family would then need to take to a pharmacy. Electronic prescribing would have enabled the nurse prescribers to send the prescription direct to the pharmacy speeding access to a delivery or collection of medicine.

1.7 In the 24-hour 7-day-a-week end-of-life telephone support line we investigated, the value of access to shared records was highlighted. Staff delivering advice on the telephone support line were able to access patients' medical records for each service where the patient was registered. These records were essential for recording and checking relevant clinical history (*e.g.* types and dosages of medicines prescribed, co-morbidities and allergies, carer information, services accessed) and allowed healthcare professionals to plan next steps in co-ordinating services to access medicines. The telephone support line used the “task” instant messaging feature of the patient record to request input from other services (*e.g.* tasks a general practitioner to request prescription or home visit) and also from other telephone support line staff (*e.g.* nurse tasks a non-clinical call handler to delegate an appropriate duty related to that patient). Tasks became part of patients' clinical records and provided details of what work needed doing and what had already been done with specific patients and aided planning, co-ordination and follow-up of medicines issues.

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References

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