Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Health Information and Standards

Statement of Outcomes

Public Consultation on Draft Recommendations for a National, Community-based ePrescribing Programme in Ireland

September 2018

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland. HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered. HIQA's ultimate aim is to safeguard people using services and improve the safety and quality of health and social care services across its full range of functions.

HIQA's mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, HIQA has statutory responsibility for:

- **Setting Standards for Health and Social Services** — Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.
- **Regulation** — Registering and inspecting designated centres.
- **Monitoring Children's Services** — Monitoring and inspecting children's social services.
- **Monitoring Healthcare Safety and Quality** — Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment** — Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.
- **Health Information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Overview of the HIQA health information function

Healthcare is information-intensive, generating huge volumes of data every day. Health and social care workers spend a significant amount of their time handling information, collecting it, looking for it and storing it. It is therefore imperative that information is managed in the most effective way possible in order to ensure a high-quality, safe service.

Safe, reliable healthcare depends on access to, and the use of, information that is accurate, valid, reliable, timely, relevant, legible and complete. For example, when giving a patient a medicine, a nurse needs to be sure that they are administering the appropriate dose of the correct medicine to the right patient and that the patient is not allergic to it. Similarly, lack of up-to-date information can lead to the unnecessary duplication of tests — if critical diagnostic results are missing or overlooked, tests have to be repeated unnecessarily and, at best, appropriate treatment is delayed or at worst not given.

In addition, health information has a key role to play in healthcare planning decisions — where to locate a new service, whether or not to introduce a new national screening programme and decisions on best value for money in health and social care provision.

Under section 8(1)(j), HIQA is charged with evaluating the quality of the information available on health and social care and making recommendations in relation to improving the quality and filling in gaps where information is needed but is not currently available.

Information and communications technology (ICT) has a critical role to play in ensuring that information to drive quality and safety in health and social care settings is available when and where it is required. For example, it can generate alerts in the event that a patient is prescribed medication to which they are allergic. Further to this, it can support a much faster, more reliable and safer referral system between the patient's GP and hospitals.

Although there are a number of examples of good practice, the current ICT infrastructure in Ireland's health and social care sector is highly fragmented with major gaps and silos of

information which prevents the safe, effective, transfer of information. This results in people using the service being asked to provide the same information on multiple occasions.

In Ireland, information can be lost, documentation is poor, and there is over-reliance on memory. Equally, those responsible for planning our services experience great difficulty in bringing together information in order to make informed decisions. Variability in practice leads to variability in outcomes and cost of care. Furthermore, we are all being encouraged to take more responsibility for our own health and wellbeing, yet it can be very difficult to find consistent, understandable and trustworthy information on which to base our decisions.

As a result of these deficiencies, there is a clear and pressing need to develop a coherent and integrated approach to health information, based on standards and international best practice. A robust health information environment will allow all stakeholders, the general public, patients and service users, health professionals and policy makers to make choices or decisions based on the best available information. This is a fundamental requirement for a high reliability healthcare system.

Through its health information function, HIQA is addressing these issues and working to ensure that high quality health and social care information is available to support the delivery, planning and monitoring of services.

One of the areas currently being addressed through this work programme is the need to develop recommendations to support electronic prescribing (ePrescribing) across organizational boundaries. In 2012, HIQA completed an international review on ePrescribing to inform the adoption of appropriate standards in Ireland. This review was revised in 2018 and is available on www.hiqa.ie. Both reviews focused on the prescribing and dispensing of medication in the community rather than in the hospital settings. Countries researched in the international review initially focused on the electronic sharing of prescriptions in community setting and, following successful implementation, built upon this by implementing ePrescribing in other setting such as within hospitals outpatient departments, emergency departments and inpatient settings.

This is explained as a consequence of both GPs and pharmacists having similar processes with their peers and hence being able to support computerization of the process. By

contrast, hospital medication management processes are typically more complex, incorporate multiple processes, including medication reconciliation on admission, ward based dispensing, recording administration of medication to patients and discharge planning making standardisation and computerisation more complicated. Based on the findings of the 2018 review, this document contains Recommendations on the national, community-based ePrescribing programme in Ireland.

Contents

Chapter 1 Introduction and Background

In 2018, HIQA publish an international review of national, community-based ePrescribing programmes, to identify factors that contributed to the success of such programmes. This research found that other aspects, including governance, strategy and stakeholder engagement, of a national ePrescribing program were equally important to successful adoption and, if neglected, could derail the programme.[(1)] Following the completion of the international review, HIQA undertook to develop a set of recommendations to the Minister for Health, based on the findings of the review. As part of the Recommendations development process, HIQA made the Recommendations available for Public Consultation from 22nd June to 3rd Aug. This document provides an overview of the international review findings and how they informed the Recommendations, then analyses the feedback HIQA received through the Public Consultation.

1.1 Introduction to ePrescribing

The United States Centers for Medicare and Medicaid Services state that "ePrescribing is a prescriber's ability to electronically send an accurate, error-free and understandable prescription to a pharmacy from the point-of-care, an important element in improving the quality of patient care."[(2)] This definition captures the generation of the prescription, the transmission of the prescription from prescriber to pharmacy and the pharmacy's dispensing of the prescription.*

In a similar manner, the original Fifth Community Agreement between the Australian Department of Health and the Pharmacy Guild of Australia includes the following concepts: the prescriber's ability to generate an accurate prescription electronically, the electronic transfer of the prescription to a pharmacy and the pharmacist's ability to receive and dispense the prescription. It also states explicitly that the prescription must be signed digitally, transmitted securely and integrate with the pharmacy billing system.[(3)]

* Note that the US definition of ePrescribing refers to an ePrescribing system where ePrescriptions are transferred directly from GP to pharmacy. This differs from the proposed model, which transfers ePrescriptions using a central message repository.

The European Patient Smart Open Services (epSOS) initiative, which sought to develop an eHealth infrastructure that would enable seamless and secure access to patient health information across borders for European citizens, defined the ePrescribing process as having two parts:

- **ePrescribing** is defined as a prescriber's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point of care.[4,5]
- **eDispensing** is defined as the act of electronically retrieving a prescription and reporting on giving the medicine to the patient as indicated in the corresponding ePrescription.[5]

These international programmes reflect the general understanding that the term ePrescribing is used to describe all aspects of the generation and transfer of prescriptions electronically using a dedicated system, whether in paper or electronic from, rather than faxing or emailing the prescription.[6] The same sources consistently identify ePrescribing as taking place in primary care, which involves the generation of the prescription by GPs, the transmission of prescriptions electronically from GP to pharmacy over national networks and the pharmacy dispensing the prescription.

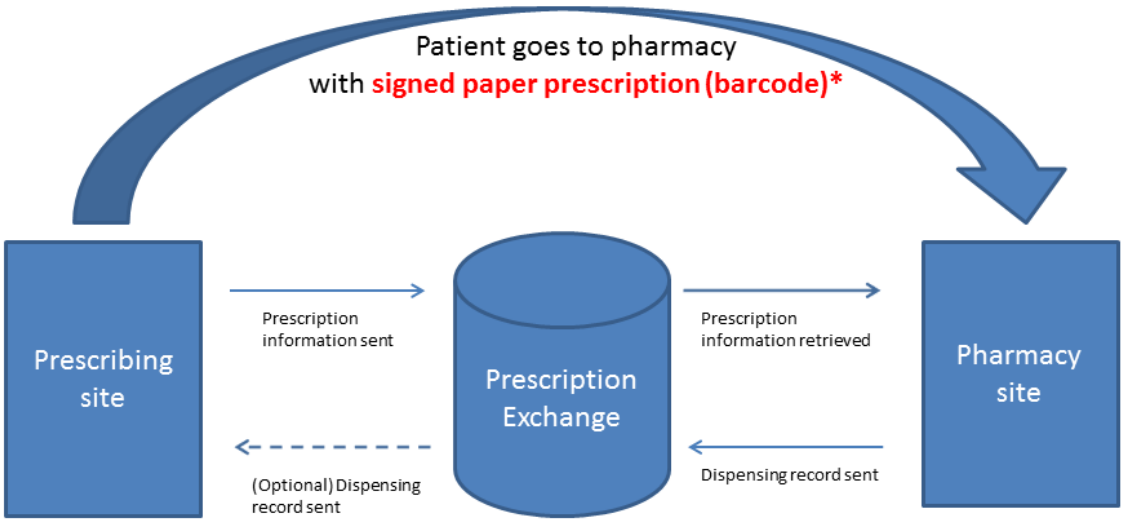


Figure 1. Three step ePrescribing process

In this scenario, ePrescribing mimics the paper-script-based business practice and the paper prescription remains the legal document, indicated in red with an asterisk (*):

1. **ePrescribing:** The prescriber generates a paper prescription with a barcode, which the prescriber signs. The barcode can contain either a unique identifier or all the prescription information.
2. **Electronic transfer of the prescription:** The electronic prescription is sent to the prescription exchange, where it is stored until it is downloaded and dispensed.
3. **eDispensing:** The pharmacist scans the barcode on the paper prescription, which contains either all of the prescription information or a unique identifier to retrieve the prescription information.

The pharmacist can optionally send an acknowledgement that the prescription items have been dispensed.

International programmes usually take a phased approach to implementation. A two-phased approach was adopted in England. During the first phase, a signed, barcoded paper prescription continues to be the legal document, with prescription information transferred electronically in parallel. This approach allows time for stakeholders to build skills and experience the benefits of ePrescribing as well as for the requisite legislative changes to be introduced. This provides a solid foundation for the second phase, when the digitally signed, electronic prescription is the legal document.

A two-phased approach was also adopted in Australia, with two similar levels of implementation levels supported — first, with the paper prescription as the legal document, and, second, with the electronic prescription as the legal and definitive document. Both levels assumed that prescription information was transferred electronically through a message broker. However, the Australian implementation approach supported direct transfer from GP practice to pharmacy as a temporary and interim measure.

These implementations, and ten others, are described in detail in the accompanying document, *ePrescribing: An International Review*. ePrescribing has been introduced, or is on the roadmap for introduction, in many more countries worldwide. ePrescribing has been shown to deliver significant benefits for patients and stakeholders alike.

1.2 Benefits of ePrescribing

A national, community-based ePrescribing programme can deliver significant benefits for patients, prescribers, pharmacists and others involved in the process.[6] In particular, ePrescribing can improve patient safety considerably, for example, by reducing errors of mistaken identity, incorrect dosage, incorrect medication and adverse drug interactions. It can resolve challenges concerning overlapping medications and improve medication practices. It can also reduce the number of pharmacist interventions significantly. ePrescribing can cost far less and take less time than processing the same prescriptions manually. Contributors to the public consultation also emphasised the benefits of ePrescribing in the management of repeat prescriptions and the reduction of transcription, both of which were considered problematic and time consuming.

1.2.1 Time savings and efficiency gains

Swedish physicians estimated that electronic prescribing saved them about 30 minutes daily.[7,8] Estonian physicians estimated that repeat electronic prescriptions took about 10–15 seconds, with new prescriptions taking about 30–60 seconds.[7,9] The manual processes had not been timed and so no comparison was possible, making these perceived rather than measured time savings.[9] UK physicians saw repeat prescriptions as one of the top advantages of ePrescriptions.[10] UK physicians' estimates of time saved differed, and while most GPs found it faster to generate prescriptions electronically, others found signed paper-based prescriptions faster.[11]

ePrescribing also resulted in efficiency gains for pharmacists, included better stock management and less paperwork at the end of the month.[12] In research from 2016, 55% of Swedish pharmacists felt that they saved time using electronic retrieval and dispensing.[12] However, UK pharmacists could wait up to 30 seconds for a prescription to be downloaded from the prescription exchange.[12] Evidence is mixed on whether ePrescribing reduced callbacks between prescribers and pharmacists: early UK studies showed a drop from 6% to 1%.[13] However, a review of more than 30,000 Swedish prescriptions showed that 2% of electronic prescriptions required a callback compared to 1.2% of paper prescriptions.[14]

NHS Digital estimated that, over the three years from 2013 to 2016, the 'transformative' electronic prescription service (EPS) saved the NHS £130 million.[15] Prescribers saved £327

million, while pharmacists saved nearly £60 million over the same period.[15] NHS Digital also reported significant time savings for prescribers, for pharmacists and for patients.[15] For example, pharmacists reported saving on average 54 minutes per day through faster dispensing and 43 minutes per day through fewer trips to GP practices to collect paper prescription forms.

1.2.2 Health and social benefits

Health benefits from ePrescribing included reduced medication errors, with approximately half of the 17% of patient hospitalisations through error being considered avoidable.[7] The Estonian Health Information Fund estimated that 80,000 (6%) of patients would benefit from the error reduction aspect of ePrescribing, while prescription errors were reduced by 15% in Sweden.[7] ePrescribing can make time-critical medications more readily available, for example, Estonian data indicates that increased availability of emergency contraceptives was correlated with use of ePrescribing.[7] ePrescribing can also provide useful data on patients' adherence (or otherwise) to prescribed medications, which can prompt policy measures to encourage adherence.[7] In the US, Surescripts reported that electronic prescribing drove a 10% increase in patient first-fill medication adherence,[†] which reduces hospital readmissions and improves patient care.[16,17]

Research also looked at the social benefits of ePrescribing.[7] In 2016, the percentage of patients who were satisfied with the ePrescribing service was high in Estonia (92%) and Nordic countries such as Sweden (85%).[12,18] However, patient satisfaction is often based on the improvement that patients experience, for example, before the introduction of ePrescribing, UK pharmacists often collected patients' prescriptions from the GP, so patients experienced no change in service.[7,19] Patient satisfaction may also be affected by the implementation, for example, in the second phase of the UK implementation some patients felt constrained by having the option to nominate a pharmacy, rather than being able to drop in wherever they wished.[7] ePrescribing may also reduce patients' involvement, for example, the patient may need a doctor or pharmacist to tell them where in the process

[†] Medication adherence indicates whether the patient has followed the course of treatment. First fill adherence means whether the patient fills a new prescription for the course of treatment, a prerequisite for medication adherence. Factors that influence a patient's medication adherence are of significant interest, as medication adherence has a huge impact on the success of the course of treatment.

their ePrescription is.[7] Finally, ePrescribing may provide financial savings for countries and improve social care for the elderly.[7]

1.2.3 Cost benefits

While Estonia saw the reduction of a small incidence of fraud thanks to ePrescribing, the benefits it realised in direct economic costs were far greater.[7,9] Printing costs for paper prescriptions dropped from €63,668 in 2009 to around €1,000 in 2010.[7] This meant that the country's investment in the ePrescribing system was almost completely offset by the savings on the printing and secure storage of the forms.[7] However, in the UK, the second phase of their solution potentially increased paper usage because GP printed prescriptions for patients who request them while pharmacists often print them to check.[19]

Any economic gains need to be offset against the implementation costs.[7] In Estonia, direct total implementation costs were estimated at €500,000 by 2016.[9] That figure includes once-off system implementation costs and annual maintenance costs but excludes large scale costs of project management, system integration and other operating expenditures.[7] However, Swedish numbers showed that these costs need to be viewed over several years.[20] By 2008, the cumulative investment costs over the eight years since nationwide implementation were estimated at €155 million, while the estimated cumulative benefits were estimated to be €330 million.[20]

However, ePrescribing does not always results in cost reductions. In spite of the combined effort of the Australian Commonwealth, the Australian Pharmacy Guild, and the two Australian prescription exchange operators, eRX and MediSecure, electronic prescribing remains a high cost for the Australian state. Under the Sixth Community Pharmacist Act (FCPA), Australian pharmacists continue to be paid 15 cents for each electronic prescription dispensed to offset the 15 cents that eRX and MediSecure charge for each digital prescription processed.[21] However, eRX reported dispensing 753,000 electronic prescriptions at a cost of AU$112,950 per day.

1.2.4 Transparency and fraud detection

When researchers investigated whether ePrescribing improved transparency, they found that prescribers were more accountable for what they prescribed in terms of adhering to

clinical guidelines, while pharmacists' practices around the medications they dispense and how quickly they dispense were more transparent.[7] The Estonian system displayed the active ingredient rather than the brand name to GPs, who must justify adding a brand name.[7] Prescriptions by active ingredient, rather than brand name, went from 50% to 90% of all prescriptions, which reduced patients' costs by about 25%, though the Estonian Health Insurance Fund's pharmaceutical costs were not reduced overall.[7]

ePrescribing can also counteract fraud, creating audit trails that make it more difficult to obtain or redeem multiple prescriptions, with faster detection of abuse and fraud.[22] Fraud reduction was the main driver behind the introduction of ePrescribing in Northern Ireland, where losses had been estimated as being more than £7 million.[7,23] In Estonia, ePrescribing revealed a small group of single doctors misusing their entitlements to obtain psychotropic drugs in collaboration with criminal groups.[7]

1.3 ePrescribing in Ireland

The vision for the Irish national, community-based ePrescribing programme is set out in the Department of Health's eHealth strategy. The goal of ePrescribing strategy in Ireland is to reduce medication errors, thereby reducing the associated costs and speeding up patient access to medication.[24] eHealth Ireland is responsible for realising this vision and, in June 2015, announced the National ePrescribing Programme, which included ePrescribing in primary care and the National Medicinal Product Catalogue among its projects.

The national, community-based ePrescribing programme also published its plan for a phased, standards-based implementation. The programme's phased approach included the development of the initial building blocks (phase 1), leading to an 'ePrescription' phase (phase 2), followed by the roll out of ePrescribing in primary care (phase 3). The adoption of a phased, pilot-based approach is in line with recommendations and best practices.

Research also indicated the importance of an interoperability framework for secure information exchange with other services, such as an electronic medical record system. A system to uniquely identify citizens was also a crucial component, along with the system to uniquely identify healthcare professionals such as GPs and pharmacists.[6]

As part of phase 1, eHealth Ireland worked with a number of organisations to develop a relevant interoperability framework based on national and international standards. HIQA, whose statutory remit includes developing national technical standards for health information, has defined and agreed the related standards for messaging and datasets, including:

- *ePrescription dataset and clinical document architecture standard* (March 2015)[25]
- *Data model for an electronic medicinal product reference catalogue – a National Standard* (March 2015)[26]
- *National Standard for a Dispensing Note including a Clinical Document Architecture specification* (January 2017).[27]

In November 2016, the Department of Health acquired a national licence for SNOMED when it became the 29th member of SNOMED International. Moreover, national health identifier legislation has been passed, permitting the creation and use of the Individual Health Identifier. As discussed, all successful national, community-based ePrescribing programmes used a national patient health identifier, which now has the legislative basis for use in Ireland.

ePrescribing pilot projects have also been undertaken. The first pilot, which transferred prescription information directly from GP to pharmacy, indicated that using a transaction broker was preferred. In the second pilot project, GPs sent the prescription information to the cloud and printed a legal paper script, which included a barcode. Pharmacists then scanned the barcode, ensuring the correct prescription information was downloaded.

The Slaintecare Implementation Strategy published in August 2018 identifies that "ICT has the potential to be the biggest and most effective driver of change and improvement for better patient outcomes across the health system."[28] The design and roll out of a range of primary- and community-based ICT services that will improve the lives of patients, including ePrescribing, summary care records and commence implementing telehealth solutions to support care in the community, was identified as a priority.

The Slaintecare Implementation Strategy lists the implementation of the ePrescribing service, together with summary care records, as part of the implementation of community care solutions, one of the ten key strategic actions that underpin the Slaintecare vision. The approach outlined in the Strategy '…centres around strong health service governance, leadership, accountability, a focus on clear outcomes, providing support to the frontline to drive change, and sustained stakeholder engagement…'.[28] These recommendations echo the key principles of this overarching approach and outline their applicability to a national, community-based ePrescribing programme in Ireland, as an exemplar eHealth service.

Chapter 2 Overview of the process

This section summarises the text of the Recommendations that were made available for consultation then outlines the process that was followed to develop them.

2.1 Recommendations development process

As part of the development process, and in line with its legal remit, HIQA set up an ePrescribing Recommendations Advisory Group, which advised on the Draft Recommendations. The Draft Recommendations were then made available for a six-week public consultation, running from Friday 22 June to Friday 3 August 2018. The consultation document, which was published on the HIQA website (www.hiqa.ie) also contains the text of the Draft Recommendations for Consultation.

HIQA asked for feedback through an online survey and an online feedback form, both of which included seven questions to prompt feedback:

- Do you wish to add anything to support Recommendation 1: Scope and legislative requirements?
- Do you wish to add anything to support Recommendation 2: Governance?
- Do you wish to add anything to support Recommendation 3: Data Privacy?
- Do you wish to add anything to support Recommendation 4: Stakeholder Engagement?
- Do you wish to add anything to support Recommendation 5: Standards-based Approach?
- Do you wish to add anything to support Recommendation 6: Implementation?
- Do you wish to add any other Recommendation to these Draft Recommendations?

All submissions received were analyzed and, where appropriate, individual comments originally assigned to one recommendation were reassigned to a more relevant recommendation. This Statement of Outcomes document presents the findings from the Public Consultation.

Chapter 3 Analysis of public consultation

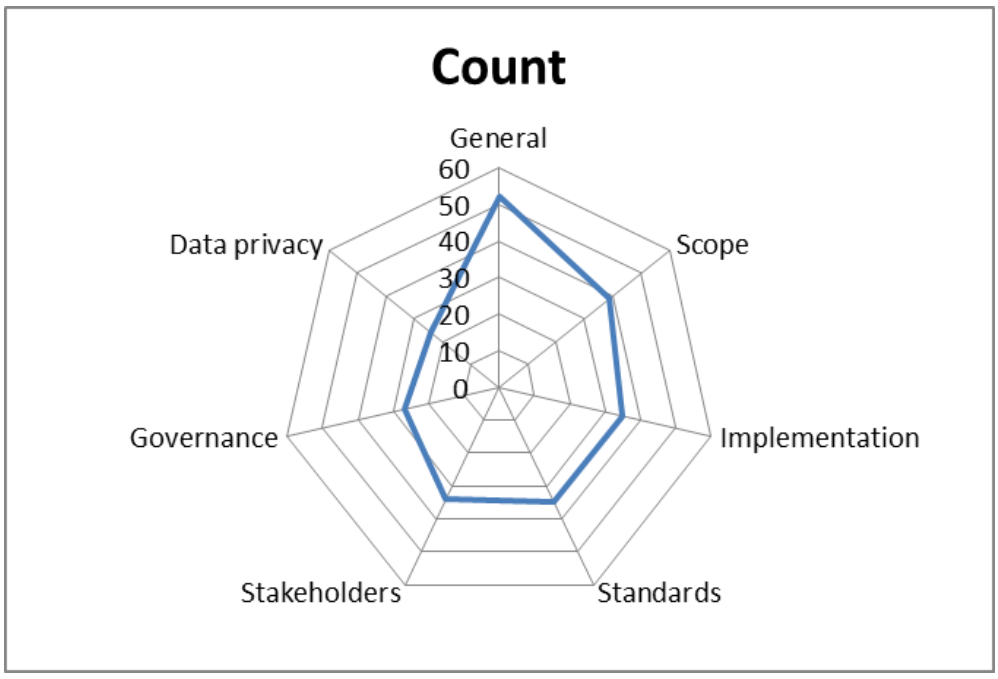
3.1 Description of responses

During the Public Consultation on Draft Recommendations for a national, community-based ePrescribing programme, 29 separate submissions were received – 18 through the online survey, 10 by email, and one by post. 20 submissions were made on behalf of organizations, listed in Appendix B, while nine were made by individuals.

Each submission was read in its entirety and broken down into individual comments. This yielded a total of 246 comments, each of which reviewed and its relevance to the recommendations assessed.

Figure 1 below illustrates the final count of comments for each recommendation and for the general comments category.

Figure 2 - Count of comments per category



The following table shows the distribution of comments:

Table 1 - Count of comments per recommendations

Recommendation	Count	Recommendation	Count
General	52	Stakeholder engagement	34
Scope and legislative requirements	39	Governance	27
Implementation	35	Data privacy	24
Standards-based approach	35		

The remaining sections provide an overview of the comments received for each recommendation. For each recommendation, a brief summary is provided first, followed by a sample of the comments—where appropriate, corrections have been made to punctuation and grammar of comments quoted in this report.

3.2 Do you wish to add anything to support Recommendation 1: Scope and legislative requirements?

The consultation feedback yielded 39 comments. From the comments several themes emerged. First, the Recommendation needs to identify where the ultimate responsibility and accountability for the programme lies. The Recommendation should clearly outline the scope of this programme with respect to secondary or tertiary care, to patient summary records, and to the related EU programme for Open National Contact Point (OpenNCP). The Recommendation text should clarify that the programme applies to both public and private prescribing, but to primary care only. Comments also noted the need for appropriate funding and for a formal review of existing pilot projects, with a view to developing and applying any lessons learned. They also recommended including the challenges likely to face stakeholders, as well as the expected benefits.

Finally, feedback indicated that consideration should be given to the legal requirements to implement the programme in the current legislative and regulatory environment and that supporting policy and legislative changes should be developed. Areas for consideration include the prescribing and supply of medicines and the replication of existing safeguards. Legislative changes should be outlined in the overall programme plan and developed in a timely manner.

Sample Comments

- *With whom does ultimate project management responsibility and accountability for this lie?*
- *The roadmap should clearly articulate that community-based ePrescribing is "the" scope of the project.*
- *Recommendation should outline the legislative changes needed to move from phase 1 to phase 2 and its timeframe from the paper prescription being the legal document to the digitally authorised electronic prescription being the legal document.*
- *A decision is required on whether the scope of the ePrescribing program includes both GMS and Private prescriptions in general practice.*
- *There may need to be a legislative basis to support the data processing aspects of the ePrescribing program.*
- *Acknowledging the need for legislative change, (We) would support striving for a paperless system. The proposed exception of retaining the current requirement for paper prescription and signature for controlled drugs, may in future be enabled for ePrescribing with appropriate legislative change.*
- *ePrescribing should be equally applicable to private and GMS patients.*
- *Scope needs to be realistic - there is some evidence that evolution rather than revolution enables stakeholders adjust.*
- *Can the scope be enhanced to include prescriptions created at discharge? Currently, the discharge prescription needs to be transcribed by the GP?*
- *(We) suggest that in addition to identifying the benefits expected for stakeholders, the challenges anticipated for stakeholders should also be outlined.*
- *Clarify if this programme covers the entire primary care sector as the HSE ePharmacy programme only covers the public sector.*
- *Also, for any developments in ePrescribing it is important that the public is protected and the current safeguards that exist in legislation are replicated or enhanced in any new systems that are implemented, to ensure the continued safe and rational use of medicines.*
- *The ePrescribing system proposed under the scope of this project must operate in compliance with the legislative requirements in place at the time of implementation, and with any future changes to legislation.*

- *Ensuring the effective and secure transfer of prescriptions between General Practice and Community Pharmacy has the potential to increase workload for medical practitioners and will require significant resources.*
- *A national ePrescribing system could also include a comprehensive medicines formulary that could support doctors in clinical decision making including information on adverse effects, drug allergy, drug/drug and drug/food interactions.*
- *Patients should be actively involved in defining the scope of the programme and in developing the roadmap and business case. Patients should be particularly involved in identifying the benefits of the programme and in designing metrics to objectively assess this impact. Patients should also review the successes or pitfalls of existing pilots and advise on the future integration of the programme with hospital-based prescribing.*
- *Clarify that this programme is for primary care only as Hospitals have closed loop systems and different requirements.*
- *(We) welcome the opportunity to share its views on the draft recommendations for the national, community-based ePrescribing programme in Ireland and broadly supports the recommendations to introduce electronic prescribing (ePrescribing) across organisational boundaries. (We) also supports the proposed collaborative approach in scoping an agreed ePrescribing programme roadmap with organisations and agencies involved in the programme but also those organisations which have direct experience of implementing ePrescribing.*

3.3 Do you wish to add anything to support Recommendation 2: Governance?

The consultation feedback yielded 27 comments and several themes emerged. First, the Recommendation should state clearly the organization to which the programme board should report. A programme sponsor who is accountable for the programme should be identified. Deliverable within the overall plan should have an appointed owner who is accountable and responsible for its delivery. Furthermore, the clinical leads should be clearly identified and clinical leadership should also be central to, and embedded in, the programme. Clinical leadership should be drawn from pharmacy and from general practice.

Sample Comments

- *To whom will this Board report?*
- *It is important to call out that clinical leadership should be central and embedded. Could this be stated more comprehensively to include clinical leadership for both the e-prescribing and the e-dispensing aspects?*
- *It could also be helpful to explicitly note the need for public and patient involvement (although this might be implicit in the stakeholder engagement).*
- *Key deliverable should have an appointed owner; responsible & accountable for it delivery.*
- *The governance should identify the HSE agency that is the business owner for the ePrescribing program and should identify the program sponsor or responsible individual and the clinical lead. There should be linkages to the EHR program as a stakeholder for future data sharing.*
- *It is important to avoid potential or perceived conflicts of Interest that encourage the prescribing physician to choose or recommend sending ePrescriptions directly to a particular pharmacy – a possibility if the system is set up as push rather than pull. The current situation where the patient chooses their preferred pharmacy must be maintained.*
- *Responsibility for maintaining up-to-date national medicines reference catalogue should lie with a non-commercial entity.*
- *We see ePrescribing as a Project within an ePharmacy programme of work and as such it will have its own Project Board.*
- *(We) have concerns that the governance structure as outlined in the recommendations is unclear and potentially weak as regards assigning clear responsibility for leadership and direction. We would suggest that further detail be provided on the governance structure and on the board of governance, including who will be responsible for directing and overseeing the delivery of a national ePrescribing program.*
- *The governance group should be spread equally to enable a scope beyond GPs and Pharmacists to be heard and evaluated.*
- *Patients should be equal partners in the governance of the programme and the governance board should include the appointment of at least two patient representatives (together with several alternates to account for periods of absence or illness). Patients have unique insights to share and they are able to make an*

important contribution to the understanding of local community e-prescribing needs. Patients are also very keen monitors and evaluators and they are constructive in their criticism as their interests are vested in developing a programme which delivers for patients.

- *(We) welcome the proposal that clinical leadership should be embedded within the programme with responsibility for the case for change, to the specification of requirements, through to the delivery phases of the programme. However, (We) also supports the integration of patient representation within the programme governance structure to ensure the patients voice and experience is accessed and heard at key decision points with the programme roadmap*

3.4 Do you wish to add anything to support Recommendation 3: Data privacy?

The consultation feedback yielded 24 comments. The feedback noted the 'critical importance' of 'appropriate data privacy' in realizing the maximum benefit from an ePrescribing programme. The Recommendation should specify consideration of the entire ePrescribing lifecycle and should extend beyond the immediate prescribing and dispensing processes. Comments also noted data privacy as being 'paramount' for patients and GPs, with breaches in other jurisdictions leading to subsequent reluctance on the part of patients to engage with electronic services. Lessons learned in these jurisdictions should also inform the Recommendation.

Sample Comments

- *The issue of appropriate data privacy is of critical importance in ensuring the maximum benefits can be realised. Many of the patient safety benefits derive from professionals (i.e. GPs and pharmacists) being able to access a complete medication history for a given patient over time e.g. 2-3 years as per a summary of care record.*
- *If the summary of care record is not already in operation when ePrescribing is commencing, the information sent should form the first component of the summary of care record and should be able to be accessed with patient consent and an explanation of the importance of this.*
- *The proposed consideration of the "entire ePrescribing lifecycle" is recommended. Data privacy considerations should extend beyond the purposes and processes involved with the immediate prescribing and dispensing processes, and should take a*

visionary view of the multiple potential purposes that this data could be used, to achieve both individual and societal benefits.

- *Recommendation should contain a process for how the patient/user requests his/her information at each stage of the process in line with GDPR.*
- *The data privacy assessment needs to consider the ICGP Guideline on data protection and in particular the approach that processing is necessary in order to protect the vital interests of the data subject. Relying on consent as the basis for processing may not be the correct approach.*
- *Reassurance regarding data privacy for GP and patient is paramount. In other jurisdictions where there have been data breaches, this has had a knock-on effect leading to patient reluctance to engage with electronic services. The relevant lessons learned from those experiences should inform the situation in Ireland.*
- *Clear basic guidelines in relation to GDPR, data privacy, data use and data retention are required for GPs, Pharmacists and patients to assuage the very reasonable concerns that may arise.*
- *Clarity is required on how GPs may access the data, for example for the purposes of audit. In addition, patient access to data held on their records requires careful consideration.*
- *This is a complex area and we must ensure the solution is usable by clinicians as well as meeting all data privacy requirements.*
- *It will not be enough to have robust authentication, monitoring and auditing. There will need to be a clear governance authority, probably separate to the project board, with appropriate penalties outlined for breaches.*
- *The patient should have access to their electronic prescriptions.*
- *Patients should be at the centre of data privacy decisions around e-prescribing, with their perspectives informing end-to-end privacy impact assessments. Patient information is sensitive personal data which must be safely stored and appropriately managed. Patients should help identify what information can be shared with whom, when and for how long and they should be extensively consulted around decisions to share data with third parties or to use data for secondary purposes.*
- *The need for explicit consent for particular health research purposes will be an important consideration. The independent committee being established by the Minister for Health to determine consent exemptions under health information legislation will be important to align with in this regard.*

- *The wider issue is electronic data sharing in primary care generally, and between primary care and secondary care, for example referrals to specialists and ordering diagnostics and receiving results. Most of this is still paper based in Ireland. Clarify how this programme will ensure that primary care ePrescribing will be GDPR compliant, technically secure and legally safeguarded. Clarify if there is a plan or intention to make the public aware of these privacy measures (as in similar projects in the leading countries?)*
- *In the context of ePrescribing and data privacy, practical consideration needs to be given as to how to leverage the existing Health Identifiers Act (2014) and integrate the promised registers of Individual Health Identifiers (IHI) and Health Services Provider Register (IHSP) to support not only the legality of the ePrescribing programme but to support the safe identification of patients and prescribers.*
- *(We) support the draft recommendation which suggests a thorough privacy impact assessment should be undertaken and made publicly available so that all data privacy risks are anticipated and controlled for.*

3.5 Do you wish to add anything to support Recommendation 4: Stakeholder engagement?

The consultation feedback yielded 34 comments. Comments suggested that the Recommendations around stakeholders be directed to the body with ultimate responsibility for the national ePrescribing programme, the Health Service Executive. They also suggested that time be allotted to familiarizing both patients and GPs with the new system and that relevant guidance documents be developed for all stakeholder groups at appropriate junctures in the programme lifecycle. Comments also mentioned potential stakeholder groups, such as software vendors and representatives from relevant regulatory bodies. Finally numerous submissions advised of the central role of patients to the programme and the need for patients to be involved in all aspect of the project.

Sample Comments

- *The views of service users and patients need to be understood and accommodated.*
- *The importance of the public awareness campaign to accompany ePrescribing cannot be underestimated.*
- *There may be a benefit of social marketing as an effective tool in raising awareness for patients, health professionals and others.*

- *(We) supports HIQA's view that stakeholder engagement and communication strategy will be fundamental to the success of a community-based ePrescribing programme in Ireland. (We) considers it important to be cognisant of how the healthcare system must function as a whole and not to focus solely on the primary healthcare system when developing an ePrescribing programme.*
- *Without the ability to access a patient's medication history e.g. as per a summary of care record, there are minimal benefits for GPs and pharmacists and stakeholder engagement will be more challenging.*
- *Don't forget to include end-users of data as stakeholders in the initial design of the system, including pharmacoeconomics and Health Intelligence: to ensure that the information can be translated into usable information in the end.*
- *It is important to understand the existing processes around reimbursement services undertaken by the Primary Care Reimbursement Service (PCRS).*
- *(We) welcomes the draft recommendation for an inclusive Stakeholder engagement approach and believes this approach is essential to ensure the successful adoption of ePrescribing.*
- *Although this is a project clearly defined as a GP to pharmacy project, a wider user base could include the patient. The medication record is asked for by clinicians in many, varied circumstances and enabling a patient to access a reliable list of their prescriptions would be a very valuable support to safety at the point of transfer of care between healthcare providers.*
- *The document rightly emphasises the importance of stakeholder engagement to the roll-out of a national community-based ePrescribing programme and how it must be well-designed for the business processes of stakeholders including GPs.*
- *Patient priorities and requirements should drive the solution and patients should be engaged throughout the design, implementation, monitoring and evaluation phases. Technical limitations or business requirements should not be allowed to unduly dictate the line of travel.*
- *There should be regular checkpoints established to verify that a patient needs are always at the heart of the programme's vision and decision-making processes.*
- *A patient-centred approach is essential to ensure that any future e-prescribing programme has a positive impact on the lives of patients and that it reduces or eliminates the practical challenges which patients face, for example patients may*

wish to only fill half a prescription or they may wish to switch pharmacies on a repeat prescription

- *(We) believe that patients can also be implementers and that the programme should consider nominating a patient implementing partner. Confining patients to only a governance or oversight or consultative function, we suggest, may limit the potential role they can play*
- *(We) supports a representative membership of the ePrescribing Advisory Group which we believe should include both participants from the independent health sector and organisations who have implemented ePrescribing and understand the challenges and opportunities it brings.*
- *The process involved in submitting ePrescriptions will have to be explained to each patient and GPs will be in the front line educating patients individually when the new system is available. This will add time to the GP patient consultation.*
- *As stated above in response to Consultation Question 3 regarding the Programme Governance, (We) supports the integration of patient representation within the stakeholder engagement process to ensure the patients voice and experience is accessed and heard at key decision points with the programme roadmap.*

3.6 Do you wish to add anything to support Recommendation 5: Standards-based approach?

The consultation feedback yielded 35 comments. Comments received acknowledged the importance of global standards, to facilitate interoperability, including clinical terminologies and classification systems. In particular, comments recognized the excellent work already completed with respect to GP messaging standards and ePrescribing datasets and Clinical Data Architecture (CDA) standard and suggest that consensus and agreement be reached on the common technical standards to be used.

Sample Comments

- *It is important that interoperability with hospital and community information systems be considered from the start. The information contained in the ePrescribing must be granular enough to support structural and semantic interoperability. In other words, other clinical systems must know what is being prescribed and dispensed.*
- *I would recommend that the standards include patient based recording of drug allergies and side effects, separately. Ideally this should link to IHI number, and be*

recorded at patient level to reduce the risk of prescribing meds to which the patient is allergic

- *….important to have comprehensive research and review regarding the potential messaging standards employed. Although HL7 2.4 is the version currently used in Ireland for most clinical messaging, has CDA been in use for the messaging between community pharmacy contractors and the HSE PCRS. The focus on this in the pilot is welcome, although pre-pilot might be better.*
- *Should there be something about ensuring the ePrescribing system facilitates: generic substitution; and, PCRS restrictions.*
- *There is no reference to any Recs about cloud vs on premises, perhaps too detailed at this level but a consideration just the same. Also, in the implementation phase, consideration must be given to supporting this environment for all stakeholders.*
- *The software packages in GP practices and pharmacies must be interoperable with ePrescribing.*
- *ePrescribing software / system should suggest medicines from the medicines management programme / generics to generate cost efficiencies. This will mitigate against the potential conflict of recommendations for more expensive medication options.*
- *Close cooperation is required between General Practice and hospital based prescribers regarding the clarity and appropriateness of medicines and ePrescribing is anticipated as an enabler for this cooperation.*
- *In this segment HL7 2.* and FHIR are referenced. The excellent work by HIQA around CDA ePrescription dataset and clinical document architecture standard, CDA should be referenced here as an option.*
- *The use of global standards will facilitate the interoperability of Ireland's ePrescribing solution with similar solutions implemented elsewhere and which are referred to in your draft recommendations document. (We) are a member of the Joint Initiative Council for Global Health Informatics Standardization (JIC) comprising major international standards organisations in the Healthcare sector…….As such, (We) will be ideally placed to provide advice and guidance on the implementation of these standards.*
- *Delivery of the NMPC is a dependency of ePrescribing - not a deliverable - hence detailed recommendations specific to the NMPC should not be listed as part of this document*

- *I agree with most of this. Interoperability is the key word. The use of standardised datasets and coding terms will deliver a robust structure that will facilitate further patient care improvements over time.*
- *Standards should be able to cope with all categories of community prescriptions as well as all types of transfer of the prescription or dispensed medication to other parties than the pharmacy.*
- *(We) believes that national, standards-based approaches are patient-centred approaches. The set of national standards adopted by the e-prescribing solution for community care should detail the minimum requirements for safe e-prescribing, and must aim to reduce the risk of prescription errors.*
- *The standards set adopted should be applied to all e-prescribing systems to ensure that all patients benefit from safe e-prescribing and can thus be seen as an exemplar for other areas of the eHealth ecosystem in Ireland.*
- *Where possible, standards compliance should be passed through a patient-centred lens. For example, patients should be involved in monitoring e-prescribing solutions against agreed standards.*
- *(We) strongly supports the draft recommendation that a standards-based approach is taken to support coherent ePrescribing Programme implementation decisions. These standards might include 1. The use of HL7 Messaging specification for Healthcare. The version of HL7 chosen needs to be determined not only by the normative versions available but by the maturity of the Irish interoperability landscape in healthcare.*
- *(We) has direct and relevant experience in managing the implementation of its EHR ePrescribing module within its organisation…..suggests that if the benefits of clinical decision support for ePrescribing are to be derived, there is a significant dependency on the availability of a standardised medicines reference data file.*
- *The potential for physiotherapists to be ePrescribers must be considered in any planning and development of the technology software and programming for ePrescribing so that it can smoothly facilitate the incorporation of physiotherapists as ePrescribers. The e-Prescribing technology needs to be sufficiently responsive to allow for extensions in the future in the Register of Medical Prescribers to prevent or minimise avoidable logistical barriers.*

3.7 Do you wish to add anything to support Recommendation 6: Implementation?

The consultation feedback yielded 35 comments. Comments outlined the need for a national, non-proprietary-based pilot, with clear life spans and phases, and that a further pilot be undertaken to evaluate three of the non-proprietary standards suggested: HL7 v2.4, HL7 FHIR, and CDA. Respondents also suggested that the ePrescription service be implemented as part of a 'family' of eHealth services.

Sample Comments

- *I note that the report states that ePrescribing is less effective if part of a piecemeal approach. This needs to feed into and form the basis of the summary of care record, with data protection issues reflecting this.*
- *Careful implementation re. setting of alerts to minimise "alert fatigue" and option to adjust locally.*
- *Lessons learnt are crucial from other countries and roadmap of options should be incorporated.*
- *There should be clarity around the life span of the pilot projects and the planned closure or transition to live status of the pilot projects.*
- *The ePrescribing program should not be vendor specific or proprietary.*
- *(We) recommend that ePrescribing be implemented in an incremental manner. In this regard, it is vital that the results of the pilot schemes and the lessons learned are made available. For example, the tech enabled pharmacies and GP practices with relevant expertise will have different experiences than others practices.*
- *The practices and pharmacies to be included in the next phases need to cover the full range to identify and address the difficulties that will arise, including but not limited to geography; rural/urban; single GP/multiple GP practices; patient profile; GP profile.*
- *In this segment HL7 2.* and FHIR are referenced. The excellent work by HIQA around CDA i.e. ' ePrescription dataset and clinical document architecture standard' CDA should be referenced here as an option.*
- *As per recommendations for Q1, implementation should informed by the formal review and lessons learned.*
- *A phased implementation is certainly the preferred option but whilst phased implementation by GP (prescriber) is possible, a phased implementation for*

community pharmacies may not. We learned this from our pilot. Once one eScript has been issued we cannot then control which pharmacy the patient will visit to have that script fulfilled. What we can control is the volume of eScripts issued by controlling the number of GPs that have ePrescribing enabled.

- *Also, in relation to selecting the best version of HL7, that debate is much broader than the ePrescribing project and we would not like it to become a dependency for the ePrescribing project alone to manage. Should this not be dealt with through a separate forum e.g. A2I Programme Board*
- *Recommendation 6 – Implementation With regard to the pilot based approach, (We) suggests clarifying that the implementation and pilot phase will be a national, non-proprietary based pilot.*
- *It is recommended that an ePrescription service be implemented as part of a 'family' of eHealth services.*
- *A successful introduction of a well working system will benefit all the citizens of Ireland.*
- *(We) welcomes the recommendation that a further pilot should be undertaken to ensure the implementation process is fit for practice and scalable. The advantages of a national community-based ePrescribing programme are numerous and include patient safety, cost-efficiencies, data collection, etc. However, a new programme will have cost implications for GPs in relation to IT software costs, training, and if not fit for purpose the costs could be significantly higher.*
- *In addition ePrescribing can facilitate better medicines management and substitution, however, it must be recognised that medication reviews take time and resources.*
- *Patients should review any of the pilots undertaken to 'test' the proposed e-prescribing programme. Feedback from patients must be prioritised and acted upon as e-prescribing must be fit for purpose, patients cannot be waiting longer to receive or fill prescriptions because of software glitches or delays or because of inaccurate or incomplete forms.*
- *E-prescribing should also seek to improve the efficiency and quality of the health service in general. For example, systems should be designed to alert general practitioners to prescribe available generics or biosimilars, where clinically appropriate.*
- *(We) believes that the e-prescribing programme should be supported by a wider e-health system. For example, patients should be able to view product leaflets online,*

as well as access high quality evidence-based information about various treatment options. The programme should link up with E-health Ireland's primary care division to ensure strategic and policy coherence with other work being conducted in this sphere.

- *(We) support the draft recommendation for the rollout of an ePrescribing training programme for all relevant individuals. We would support a multi-disciplinary rather than uni-disciplinary training approach which supports integrated learning.*
- *When choosing pilot sites for implementation, they should be reflective of the demographical, geographical and socio-economic diversity that exists within the country.*
- *Complexity, lack of leadership and lack of public engagement have played havoc with large top-down national eGov and eHealth projects such as eVoting and PPARS. Research suggests the emphasis in implementation should be to invest heavily in proving the concept (clinically, technically and legally) and then scale up quickly with appropriate incentives for adoption (as in the USA between 2010 and 2015).*
- *In addition, (We) believes the implementation approach should iterate from the Stakeholder engagement by identifying clear ePrescribing benefits to prescriber, dispenser and patient. These benefits will in turn clarify the targeted ePrescribing deliverables and the most appropriate implementation approach.*
- *(We) supports the completion of a further pilot but as stated in response to Consultation Question 1 regarding Scope and Legislation, the two ePrescribing Pilots should be formally reviewed and published in advance of further pilots to ensure learnings are integrated into the next phase of the ePrescribing programme. In addition, patient's views and experiences within existing and future pilots should be integrated into the Pilot Evaluation approach so that the programme can address the needs of the patient as a programme implementation priority.*

3.8 Do you wish to add any other Recommendation to these Draft Recommendations?

The consultation feedback yielded 52 comments. The scope of comments received in response to this general question spanned the recommendations and textual section of the consultation document.

Sample Comments

- *If ePrescribing is introduced it should be a pull system rather than a push system. The patient must dictate which pharmacy has access to the script.*
- *Note that in 1.2 many of the benefits (mistaken identity and incorrect medication) are referring to a hospital "closed loop" medication administration system using barcodes to identify medication and patient. Less relevant in this setting. There could be more emphasis placed on the benefits of managing repeat prescribing as per p 24 and reducing transcription as these are problematic and time consuming issues in practice and would potentially aid stakeholder engagement.*
- *A key point being made is that as hospital processes are more complex, e-prescribing should be developed in the community first and then adopted in outpatient, EDs, and other hospital departments. Hospital's ePrescribing systems would need to link both to an electronic drug administration recording system for nurses as well as electronic pharmacist approval and dispensing system whereas it's a simpler process in community.*
- *The biggest issues for GPs when prescribing are getting patients and hospitals to recognise the enormous risks in prescribing and to engage in systems to reduce that risk. The transmission of the prescription to the pharmacy is the least risky element.*
- *ePrescribing represents a step in the right direction for the Irish eHealth strategy and would serve as a great demonstration of the Individual Health Identifier (IHI) in action with added potential benefits in patient safety improvements.*
- *Ongoing research and audit of ePrescribing are essential to improve the quality of the initiative.*
- *ePrescribing data present research opportunities that, with careful consideration and transparent approaches, can be used to address key research questions. Outcomes from such research may contribute significantly to patient safety as well as leading to cost savings.*
- *Many of the 'benefits' that are enumerated in the many documents that are published about ePrescribing are illusory. They are based on the quaint vision that that doctors are beavering away with parchment and quill; the pharmacists are envisaged as peering over their half-moon glasses struggling to make sense of every prescription. This is compared with computers producing perfectly formed legible prescriptions that the pharmacist rapidly dispenses. This is a false dichotomy. The vast majority (>90% of community prescriptions are computer generated and*

printed. It is very rare that pharmacists call GPs because of legibility issues. Most calls are about pharmacological rather than editorial issues.

- *Before full implementation of an ePrescribing service, there will be a need to ensure continuity of the business as usual processes as part of the planned phased transition.*
- *At present pharmacies correct the errors on several hand written or printed prescriptions every day. Will there be a facility for pharmacists to correct errors on ePrescriptions? EPrescribing will not be the cure to all evils.*
- *The potential for transparency, fraud reduction and prescription error reduction as a result of ePrescribing are to be welcomed.*
- *(We) welcome the development of ePrescribing in Ireland and appreciates the many patient safety benefits and efficiencies that can be realised from the implementation of such a system.*
- *"EPrescribing can reduce errors of adverse drug interactions'. This already happens as most prescribing and dispensary systems have automated interaction checking facilities. There is an issue of 'alert blindness' if too many warnings are issued. In my view, prescribers and dispensers should use different drug interaction packages, a risk minimisation measure*
- *Use of the term 'Dispenser' in section 1.1 Introduction to ePrescribing the term 'dispenser' is used. This term is not defined in the document nor is it a legally recognised person in Ireland. The healthcare practitioners authorised in Irish medicines legislation to supply medicines to patients on foot of prescription are pharmacists. This should be reflected in the recommendations.*
- *I welcome this document, which puts flesh on many of the agenda items that will potentially drive a successful project.*
- *Thought should be given to the interactions for payments for prescribing and any links with national procurement processes.*
- *Over the last couple of weeks I have made contact with patients in other countries about their experience of e-Prescribing……This is only a snap shot of personal experiences.*

  Germany

  Only has e- prescribing in 1 region (Baden-Württemberg) this is a pilot project. It started in March 2018…..initial media reports of dissatisfaction in senior population.

…….

The Netherlands – Rob

ePrescribing only rolled out in some municipalities and he does not live in any of them.

……..

Norway

ePrescribing started with GPs and pharmacies and now expanded to hospitals. Patients have access to their data which is convenient to check if they need to visit the doctor for repeat prescriptions. Patients can click on the name of the drug and are then linked to the product information leaflet. Patients must bring formal identification to the pharmacy to collect medication. This is strictly enforced since e-prescribing came in and can be difficult if you usually need to ask someone else to collect your prescription. Older people without access to the internet prefer the paper based system.

……

Norway

E-resept is very useful when ordering from online pharmacies. Some people were sceptical at the start, especially the older population, of course. Now very well accepted. I'm not sure what he means by this but I'll include it in case it makes sense to you. But big tasks remain - such as "only one medicine list", i.e. same medicine list at nursing home, when they go to hospital etc. Lots of problems in that area.

- *A national ePrescription repository/database covering all items prescribed and dispensed for urgent/critical clinical, economic and research purposes should be a key objective. This could be legally mandated for all prescriptions regardless of source, as in the leading countries, and be easily captured and recorded as a copy of all prescription and dispensed transaction files. The key benefit is for clinical staff (A&E staff, GPs, paramedics, etc.) to check the most recent medicine dispensed quickly regardless of where it was dispensed and how paid. It is estimated that deaths in Ireland from polypharmacy are between 300-500 per annum, and the chief reason for this is the absence of complete up-to-date medication information readily available at the point of care.*
- *I have some concerns with the expansion of online medical services that patients could potentially access a number of services for prescriptions…. we don't prescribe a*

number of drugs as a result, including controlled opiates, benzodiazepines, sleeping tablets, tramadol, pregabalin and others. ePrescribing has the potential to be a solution for this but also to increase the chances of abuse if not implemented correctly

Chapter 4 Conclusion and next steps

The draft recommendations document was updated with all accepted comments. The updated draft recommendations were presented to the Advisory Group at the meeting on 14 August 2018. The final draft recommendations were then approved by the HIQA Executive Management Team. The final draft recommendations were presented to the HIQA Board for approval. Following the Board's approval, the final recommendations were then submitted to the Minister for Health and were published on the HIQA website.

HIQA looks forward to the implementation of these Recommendations through the establishment of a governance structure, which will support the implementation of the other Recommendations. HIQA looks forward to the definition of a clear programme scope and roadmap together with the ongoing engagement of all stakeholders over the lifetime of the programme. Additionally, HIQA looks forward to the adoption of a standards-based, phased implementation of an ePrescribing system within a clearly defined framework of legislative and regulatory requirements.

Appendix A Membership of the Advisory Group and HIQA project team

The following individual and organisations participated in the Advisory Group:

Karen Wynne	Access to Information Programme (HSE)
Yvonne Goff[‡]	Council of Clinical Information Officers (HSE)
Muiris O'Connor[§]	Department of Health
Niall Sinnott[**]	ePharmacy programme (HSE)
Dr Brian O'Mahony	General Practice Information Technology Group
Kevin Horan[††]	Health Products Regulatory Authority
Brian Kehoe	Hospital Pharmacists Association of Ireland
Rachel Flynn	Health Information and Quality Authority
Yvonne Costello[‡‡]	Irish College of General Practitioners
Dr Martin Varley[§§]	Irish Hospital Consultants Association of Ireland
Alan Reilly	Irish Pharmacy Union
Sheila Fitzgerald	Irish Platform for Patient Organisations, Science, and Industry
Olivia Sheil	Irish Platform for Patient Organisations, Science, and Industry
Niamh Earley	Pharmaceutical Society of Ireland
Carmel Burke	Primary Care Reimbursement Service (HSE)
Dr Tim Delaney[***]	School of Pharmacy and Pharmaceutical Sciences, TCD.

[‡] Dr Conor O'Shea attend both meeting on behalf of Yvonne Goff
[§] The Department was not represented at the first meeting. Anne Murphy attended the second meeting on behalf of Muiris O'Connor.
[**] Julie Bellew attended the first meeting on behalf of Niall Sinnott. Julie Bellew was in attendance at the second meeting. Brian Markey was in attendance at both Advisory Group meetings.
[††] Attended the first meeting of the Advisory Group.
[‡‡] Helen McVeigh attended both meeting on behalf of Yvonne Costello. Dr Tony Cox dialled in to the second meeting of the Advisory Group.
[§§] Attended the second meeting of the Advisory Group.
[***] Attended the first meeting of the Advisory Group.

Appendix B Contributing Organisations

This section lists the organisations that made submissions during the public consultation:

- Caredoc
- Digital Primary Care, Office of the Chief Information Officer, Health Service Executive
- DMF Systems
- General Practice Information Technology Group
- GS1 Ireland
- Health Informatics Society of Ireland, Nursing and Midwifery (HISINM)
- Irish Platform for Patient Organisations, Science and Industry (IPPOSI)
- Irish College of General Practitioners (ICGP)
- Irish Medical Organisation
- Irish Pharmacy Union
- Irish Society of Chartered Physiotherapists
- Quality Improvement Division, Health Service Executive
- Mental Health Commission
- National Immunisation Office
- National Rare Disease Office
- Office of the Chief Information Officer, Health Service Executive
- Pharmaceutical Society of Ireland
- Primary Care Reimbursement Service, Health Service Executive
- St. Patrick's Mental Health Services
- VideoDoc

Appendix C Public Consultation Feedback Form

Your views are very important to us. We would like to hear what you think about the developing a national, community-based ePrescribing programme for Ireland.
Your comments will be considered and will inform the development of recommendations in respect of a national, community-based ePrescribing programme, in conjunction with the Advisory Group.

The closing date for consultation is 5pm on Friday 3rd August 2018

You can email or post a completed form to us. You can also complete and submit your feedback online at http://www.hiqa.ie.

About you

First name:	
Last name:	
Contact Details: (Email, Phone)	
Date:	

I am responding:	as an individual	
	on behalf of an organisation	

Organisation: (If you are responding on behalf of an organisation)	

Feedback questions

We would like to know your views on the national, community-based ePrescribing programme. Please provide us with feedback on the Draft Recommendations, or alternatively you can provide us with general comments.

Consultation Question 1

Do you wish to add anything to support Recommendation 1: Scope and legislative requirements?

Consultation Question 2

Do you wish to add anything to support Recommendation 2: Governance?

Consultation Question 3

Do you wish to add anything to support Recommendation 3: Data Privacy?

Consultation Question 4

Do you wish to add anything to support Recommendation 4: Stakeholder Engagement?

Consultation Question 5

Do you wish to add anything to support Recommendation 5: Standards-based Approach?

Consultation Question 6

Do you wish to add anything to support Recommendation 6: Implementation?

Consultation Question 7

Do you wish to add any other Recommendation to these Draft Recommendations?

Thank you for taking the time to give us your views.

Please return your form to us either by email or post:
Health Information and Quality Authority
Technical standards consultation,
George's Court
technicalstandards@hiqa.ie

If you have any questions you can contact the consultation team by calling (01) 8147683.

Please return your form to us either by email or post before 5pm on Friday 3rd August 2018.

Please note that HIQA is subject to the Freedom of Information Acts and the Statutory Code of Practice regarding Freedom of Information.
HIQA takes every measure to protect information received and will only share information based on a legitimate legal reason.
To view your data protection rights please view our HIQA Privacy Notice at https://www.hiqa.ie/reports-and-publications/corporate-publication/hiqa-privacy-notice.

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