nDCVP and dm+d Webinar 27/04/2023 - Transcript

Thank you for joining us tonight. My name is Nelson Kennedy. I'm associate director at Practitioner and Counter Fraud Services and I look after digital development. And one of my roles has been to support and work with the team that's been working on the development of the new DCVP. Its appreciated you could find the time from your business schedules to attend tonight. And we really, really appreciate that we've got about after an hour of your time.

We've got a presentation on nDCVP, but also on dm+d and once we've covered off that then we'll take some time to do question and answers. This event has been organised jointly with our colleagues from Community Pharmacy Scotland and I would really like to thank them for that. We will be starting off with Chris Leonard who is our Programme Manager, giving us a bit of a background on nDCVP.

And then soon after Chris has finished Barry Melia, our pharmacist from PHS, will be giving us a run through dm+d and the changes which will be coming through there with the transition from current DCVP and current evadis onto the new DCVP and dm+d. I'm hoping and looking forward to an interactive evening, exchanging ideas and finding ways how we can move forward as we now transition over from current business as usual process to the new system and the new payment module. So, without further ado, I will ask Chris to take the next step and walk us through the next set of slides. Thank you, Chris, over to you.

OK. Thank you, Nelson. And yes, as Nelson said, my name's Chris Leonard. I'm the Programme Manager for the nDCVP program within NSS. And as Nelson said, joined by a variety of colleagues from NSS, Public Health Scotland, CPS and from Atos, who we've been working with throughout the programme.

I absolute appreciate you're joining us tonight at relative short notice and we've arranged this webinar to try and some further context to the guidance document that we issued last week and provide some additional assurance to you all. That document, as many of you are already aware, is being updated to add some additional clarity and our intention is to circulate that as a package along with the recording of this meeting, the slides that we're presenting and any written up Q&A that we need to follow on with after the meeting. So that will all be distributed as soon as we can.

Hopefully you can all see the slides that are up on the screen. What we're going to do tonight is to try and add that little bit more context, as I said. So we'll touch on a little bit more background to nDCVP, why it's being delivered and similarly with dm+d, and how the whole thing works. Some of you may be very familiar with the whole pharmacy payments cycle. Some of you may be a little bit more limited in terms of being very familiar with your part of the system, as it were. So we'll try and give you that little bit of wider context how it works and then drill down ultimately into the bits that impacts yourselves.

In terms of a little bit of housekeeping, Anna's already put a message in the chat so please keep yourselves on mute just to eliminate background noise, the number of dogs barking and things like that you randomly get in these big events is amusing, but sometimes a little bit off putting. And if you can keep the questions to the chat that you may pick up as we go along, we'll endeavour to answer as many as them we can in the latter part of the session just depending upon the volume of course.

So just to get things started then. So new DCVP is the replacement for current DCVP and that stands for data capture, validation and pricing. Essentially, it captures all the data related to the prescriptions that are processed throughout Scotland and it validates all that data. It prices the items, and it initiates the payments back to the pharmacies to consolidate what you have dispensed to patients around the country.

Current DCVP has been there for the best part of 20 years. You'll all be very much aware of how IT technology has progressed in 20 years. And so that's a system that is very much built upon now unsupported components, unsupported software. There is a high level of manual intervention involved with running it on a day-to-day basis. Unfortunately, it is now at that point where the technology is such that it's at risk of failure. And I don't think any of us would be in a particularly comfortable position if it were to fall over, the process of payments would become somewhat of a challenge.

So, it has been a desire for a period of time now through NSS and P&CFS to deliver a new DCVP that is built upon supported software, modern technologies, more efficient process and very much is future proofed towards the wider NHS Scotland digital transformation goals and allows us to be in a position to take on some of those future enhancements around starting to move away from things like paper and so on. Those are the key drivers behind that and that piece of work has now been going on for several years and we are finally getting towards the end of it.

In tandem with this it was identified predominantly through policy decisions that Scottish Government that it made sense to use this as an opportunity to also move away from the legacy eVADIS pricing structure and move towards dm+d which is the UK wide pricing structure for drugs and medicines. This gives us an opportunity not only to align with the rest of the UK and to have a more up-to-date suite of items and prices.

It gives us an opportunity again, in a similar fashion to nDCVP, to replace some ageing side of things and move away from something that's not really supportable anymore. Barry will touch on that a little bit more when he comes to his section of the presentation.

So, in terms of new DCVP and how it plugs into the wider pharmacy payments process, some of you will be more familiar with this end of the cycle where prescription forms and prescription electronic messages are generated by the prescribers, whether that be in a GP practice or elsewhere. And that piece of paper, that of course the patient brings to you and your pharmacy. The scanning of that form and then the submission of your claim to be recompensed for what you have prescribed. What happens beyond then is the bit that is changing this first part of the process is not changing. You will submit your paper and electronic claims in the same way that you currently do.

What will change, and we'll come on to this, is what we're asking for in some aspects of that claim. In terms of what then happens after that, once the claims have been submitted both in paper and electronic form and disappear down their two channels towards us, obviously physical and electronic into the ePAY engine. What nDCVP does is it then takes those and if it's a paper and an electronic claim, it seeks to match those up. It has a whole suite of very complex validation rules to assess every claim individually and anything that needs human intervention gets human intervention. And ultimately, we come up with a pricing that then produces a payment schedule and extract to the data warehouse to provide a whole suite of information that can be used colleagues in Public Health Scotland and NSS, the health boards themselves, etcetera, to interrogate and pick out a whole suite of information for monitoring trends across the country.

Drilling down into the differences, this is the bit that you're all interested in the most, and what we have tried to articulate in the guidance document that was issued last week. In terms of changes that are driven solely by nDCVP, these are fairly limited and actually the relatively simple ones that are limited to these five here.

Rounding up to the nearest penny, which is obviously more preferable to yourselves then rounding down.

And the specific fact that we need the any out-of-pocket expenses fully endorsed with the reason codes.

We will now contact via e-mail rather than by phone.

Payment reports have been renamed

No longer the requirement for that VAT registration number.

So those are relatively straightforward, simple ones. Where we come to the more significant changes are those that are driven by dm+d itself. This holds data in a slightly different way eVADIS, we have a far wider, broader selection of items and pack sizes that we can choose from. And so as a result, we're able to use that that breadth of information to arrive at a claim response and prices that are much closer to what is actually dispensed. That should mean what we get more accurate payments associated with what you've claimed for. And again, as with current guidance, what we're asking you to do here is accurately claim in terms of identifying the specific dm+d that you have dispensed to the patient and provide any endorsement that you need. Doing that will ensure you're paid accurately.

The main difference, or the biggest difference I should probably say, and the one that I think we have received the most correspondence about, and probably the prime reason that we've put this webinar together this evening and we're updating the document, is around the quantities. So again, this is down to how items are held predominantly within dm+d and the fact that we have packsizes held in a slightly different manner and these are all based upon specific quantities such as doses for inhalers, bottles are held in mls, bandages are held in metres, etcetera. So, we're moving away from 1 inhaler to 200 doses etcetera.

What we are asking again here is that you ensure that you claim for the specific dm+d item on the pick list that will be demonstrated in mls or doses or whatever it may be, rather than 1 or 2.

The biggest concern that we have seen is ‘what happens if the prescription that we receive from a prescriber doesn't detail that specific quantity, such as mls or doses, and only gives us a quantity of 1 or 2 for arguments sake?

Ideally, we should see prescribing focusing on this detail as well and provide a prescription that says 2 X bottles of 200 mls. That's an easy one for 400 mls. And your claim would align with that.

When nDCVP validation sees the two of those coming together, it's a very simple automated process for it to match the two together and say yes, 400 mls was prescribed, 400 mls is what's been claimed. That's fine. You will be paid accordingly.

What the biggest concern is what happens if the prescriber can't do that and the prescription says 2, but you have claimed for 400.

Of course, what we've identified in the guidance is if you only claimed for 2, nDCVP would assess 2 as being smaller than the smallest bottle size available, and it would only pay for one bottle, so you'd be underpaid by 1.

What nDCVP does is it looks at those two and it says OK, you have claimed for 400 but you are only prescribed 2. That's not allowed. So we're going to fire that off to a keyer for human intervention. The keyer will take one look at that and go; OK, the intention here is correct. The prescription is not recognising the fact that it's mls rather than just a quantity of 2. It should be 400 mls and you'll be paid accordingly.

These items should be relatively few and far between. We know that they'll be limited predominantly to EMIS systems rather than Vision, and even then, in built within the majority of EMIS is a mapping process that seeks to consolidate anything that is only in a specific number of bottles or a specific number of inhalers into the correct dm+d item. So, as it says, there are roughly 98% of items that we're seeing going into ePAY are correctly being translated to a dm+d code. So, we shouldn't see a vast number of these, but any that do come through the net, nDCVP will take the appropriate action to fire that to a keyer for their intervention.

As you see at the bottom, if your claim has the correct dm+d item with the total quantity, you will be paid correctly.

I'm going to hand over to Barry just now who's going to focus in on some of the aspects of what Public Health Scotland have been predominantly focusing on around the Scottish Drug Tariff. So over to you Barry.

Thanks, Chris and lovely to see many familiar names in the sidebar. And again, just to reiterate, thank you very much for taking time out at the end of a busy day to come and join us – it's very much appreciated.

So my role is as principal pharmacist in Public Health Scotland and one of my roles is to manage the Scottish Drug Tariff on behalf of Ministers. I'm going to focus in this evening, particularly on Part 7, but just to reiterate what Chris has said, much of what you've been used to over the last many years and decades will remain exactly the same, so that should hopefully provide some reassurance.

OK, so a little part 7 history lesson for some colleagues who may be relatively newly qualified.

So Part 7 consists of four parts 7M or 7 main, 7B, 7S and 7U.

7 main or 7M is those commonly prescribed generic POM's in the main and the purpose of anything being in the drug tariff is really to set a standard price. So 7M you should all be familiar with.

7B originally was put in place in the time of the Minor Ailment Scheme, which of course has been now replaced by NHS Pharmacy First Scotland scheme. To add in some commonly prescribed generic descriptions of things like beclomethasone nasal spray.

We're going to see some changes in 7M and 7B and I'll come on to those in in subsequent slides.

Part 7S, which I always think refers to specials, provides standard price for items removing that need for pre-authorisation.

And 7U is really a little bit of a historical legacy issue. The lines in 7U were added at a time when we were seeing as a health service, some quite exorbitant out of pocket expenses being passed on to contractors. So it was about setting a price and ensuring the market was being reimbursed a reasonable amount.

So, Chris has already covered some of this. Why are we changing? We're not changing just for the fun of it. The eVADIS infrastructure, as Chris said, is no longer supported and that continued reliance on out-of-date technology, poses significant risk to payments and subsequently reporting.

What colleagues may not be aware of is that eVADIS in most part was reliant on companies advising us of the launch of new products and also all price increases or decreases. What we've seen even pre COVID was actually lots of companies were no longer providing information to us in Scotland and in many times we were having to proactively approach companies to get NHS list prices. It's remarkable how difficult that has been from certain companies historically. So, moving to the dm+d model will allow us to have more timely updates to pricing, ensuring new products are on file and support not only effective reimbursement but also effective reporting.

What we have seen at a UK level is actually the adoption of dm+d as the standard, and in our adoption of it in the next couple of days really it provides future proofing. dm+d is not going to go away anytime soon. So, adopting it now is very, very prudent. And as I said already, most companies, not every company, provides information to dm+d, but the vast, vast majority do, and they maintain it very, very well. So, the benefits of that will be realised by contractors and those interested in reporting.

What changes can you expect to see? Well, how we refer to products will change ever so slightly. The first, if you were looking in the Scottish Drug Tariff for April, you would have seen a line for fentanyl, 100micrograms, patches that looked something like the first line and then essentially the same thing, just in slightly different nomenclature for the dm+d description.

One of the changes we're having to make to ensure accurate reimbursement for products that are listed generically on the Approved List is to move them all to part 7B. We will have a business rule that checks against part 7B to ensure you're reimbursed if you're writing or prescribing or labelling whatever you want to call it, generically, the generic description is the one that appears in the approved list.

But to reassure you that although we're adopting a lot of dm+d, certainly for Part 7, Scottish prices will be set in Scotland. They remain to be agreed through Scottish ministers, so those very important roles that CPS play and those issues around concessions where maybe England haven't announced a concession; all of those processes remain as they are just now, and the decision as to whether to include a new product in Part 7, those processes that we've had for many, many years now will remain unchanged.

So, 7B I've already said things that are listed generically in the Approved List will all be listed in Part 7B. But what we've done up until now is also tried to expand 7B by having lots of essentially branded products, or AMPPs, in 7B as well. One of the things we've had to do in certain areas is actually think about how dm+d can be incorporated into some of our existing business rules because the business rules are important. So, for the purposes of the Approved List, Pharmacy First Scotland, the AMPP equivalent, those branded products will be removed from part 7B. But what we do in the background is those products or AMPP's as I've described or indeed products that are listed elsewhere in the tariff like some of our dressings and our eye products, etcetera will be flagged in a different way. You won't be able to see that. But we've been checking those flags very, very carefully to ensure those products and the way they are written reflect Scottish Government policy.

It's very, very important and I'm sure you know this already, apologies if I'm teaching you stuff that you already know, but it's really important you look at the current version of the Approved List. If it's

written generically on the Approved List, then label/prescribe it generically and claim as you would do normally.

So, part 7S for those of you who've been around for some time you will know that there's been a series of PCAs over almost the last decade around specials in Scotland. Earlier drafts of PCAs allowed a little bit of flexibility because we had flexibility within eVADIS, so if we had listed something like allopurinol suspension, we set a price and really that applied to suspension solution/sugar free/sugar containing/colourless etcetera, etcetera. And for the paraffin white soft paraffin, yellow soft paraffin, the base didn't really matter, we could set a price and that would be the price you would be paid.

However, with the constraints that dm+d put on our system, what we're having to do is specify each particular product. So, suspensions, solutions and also pack sizes and great thanks to my colleagues in CPS and others because there's been a lot of work going on in the background to ensure that the products that will be listed in Part 7S reflect the old list, the old Part 7 as closely as possible.

PCA 202317 was released earlier today and you may have seen that, it's on the CPS website and that that details the updated descriptions and pack sizes. However, it has not been possible to map existing 7S lines onto dm+d entirely, so only those products as before that are listed in Part 7S will be automatically reimbursed at those prices and using the existing business rules. So, if a product that you're supplying to your patient isn't on that list, then go through your local authorisation processes and it's for your local board.

Part 7U – I talked about the very historical nature of 7U because just like with part 7B, AMPP's will no longer be listed in Part 7. We've removed a lot of these lines and what the assessment around any financial risk has been that actually things have moved on considerably from when a lot of these lines were added and we're not expecting excessive out of pocket claims anymore. However, part of our due diligence is that we'll continue to monitor these and if this becomes an issue in future, we'll consider how we respond to that by possible re-addition to part 7.

But as I say, we don't anticipate this to be high risk.

So, what should you do if not already? And I put if not already on this slide, because actually most of you will not have to do a huge amount more if at all.

Number one, as an ex-community pharmacy manager, endorse. Ensure you're claiming for what was supplied to patients. Scotland has the most flexible business rules, but if something goes to a keyer, the information that you provide on your endorsement will really help them to ensure you get accurately reimbursed.

For Pharmacy First ensure you're keeping up to date with the current Approved List again, if it's listed generically, prescribed generically and claim appropriately.

Again check part 7S - there are some changes, so just make sure you're familiar with them and know where you may now need to see seek authorisation.

So just to reiterate, eVADIS really is no longer fit for purpose. The adoption of dm+d as the UK standard will provide resilience and future proofing for Scottish contractors and also as Chris said

earlier, that underpinning infrastructure and new DCVP taking that medicines information, actually operationalizing the pricing, that's our primary concern.

Keep a lookout for regular updates from NSS colleagues and CPS. What we're keen to do is to share with you our learning or any other issues that we think will help you and so keep an eye out.

And please remain reassured, the Scottish tariff remains exactly that. We will continue to decide drug pricing and the makeup of Part 7 in Scotland and any other issues that may affect other parts of the tariff. Again, we can 'Tartanise' where we need to.

Thank you again for your time. Back to you Chris.

OK. So just to summarise, bring this back around again to the to the key points that we were trying to make in the Key Differences guide, and hopefully as you've got a little bit extra assurance from this evening is with electronic claims please make sure you select the correct dm+d level from the pick list. You are going to see that greater suite of items to choose from, so that extra second just to make sure you select the correct one will ensure that correct and accurate payment.

If you select the correct item then that will include everything that we need in terms of the brand, packsize, manufacturer, etcetera so no endorsement should be required there. For paper, as Barry said, lots of endorsement there to ensure that you get accurately paid because those will go to a keyer and for human intervention. And if you have a paper plus electronic then please make sure that those match each other in terms of any endorsement and the dm+d items that's been selected.

In terms of the next steps for us. As I said, we're going to issue out that revised guidance hopefully as a package alongside these slides, the recording, once we've passed that over to our Comms team to tidy up into a YouTube link that is then shareable with all of you and anything that may have been dropped into the chat. I haven't had an opportunity to look at it in terms of Q&A. We can take an opportunity to address if there's anything that's sort of hanging over from this evening.

And aside from that, what are we going to be doing once nDCVP goes live? Well, we have a phase called Early Life Support. So once nDCVP goes into production, we will be maintaining our programme/project team around that for the first couple of what we're referring to as payment cycles to ensure that we can assess the performance of the system, not only for the people using it within NSS (the keyers and so on), but assessing it for yourselves and for our partners and Payment Verification to ensure that it's doing what we aim it to do. It's been through rigorous testing, we've undertaken what we've called the parallel run phase, whereby we've taken data that was processed through the current system a year ago and put it through new DCVP to make sure that we get what we expect out of it. But of course, once you go into production with anything, it's important to see how it plays out for that first period. And if we identify anything that needs to be addressed, then we'll take the necessary actions to do that and we'll have the opportunity with the team that we're maintaining around that, including our suppliers who've done all the development that's far above the capabilities of my technical brain.

Contacts for yourselves for any questions around claims will go to the usual NSS Helpdesk and they'll be triaged accordingly from there, depending upon the nature of them, of course.

I hope this has been a helpful session, thank you again for joining at short notice and appreciate that this is eating into people's evenings, or the first part of people's weekends perhaps given that it's a holiday weekend. But I hope it has been useful. Nelson, I don't know if you want to add anything at this point.

No, thank you very much Chris, and Barry, for walking us through that presentation very much appreciated and thank you very much. We've got a bit of time left here for this session and my intent was to open up to a few questions. The ones we can be able to respond to in the second-half of this hour. If there are any we can't deal with at this point in time, we'll take those away and we'll ensure to respond to each one of them.

So, Chris, if you could please stop sharing and then we can have a wider screen and we'll take and I don't know whether they're any questions immediately on the, on the chat side.

Yes, we've got a few so why don't I just take this in the order that they've come in

So, first of all there was a question about the e-mail address that will be used for queries so that's been posted in the chat so it's available in the chat as well as on the slides.

So next question, then is 'is it clear that the most important part of the electronic endorsement as the paper is hardly ever referred to, we have encouraged contractors to ensure electronic endorsing is accurate. As that is how it is paid.' So, is that a question or a comment? I'm not sure. Thank you.

Think it's a comment, but I'll bring in Glenn.

OK. Yep. So, nothing really changes in terms of what your pharmacy system is doing. Pharmacy system already sends claims in in terms of dm+d. So, the items that you pick, in 99% of the cases on your pharmacy system, say you've chosen a pack of 28 paracetamol tablets, whatever strength you've, chosen the manufacturer, you select on your system, it will send the dm+d claim. So in terms of electronic claims, you don't do anything different to what you do now. The electronic claim will come in and there's no change required to that. If you use an endorsement printer, that endorsement will be printed as it is now. And the reason why we also endorse the paper is just if anything goes wrong with electronic claim message, then you will be paid from the paper. I would say that hardly ever happens, if at all. It's always the electronic message if you send it, which is used. So, there's no real change to what you do in the PMR system. I think that just remains the same.

So, whatever you do now, keep doing it in terms of the PMR system, there's no change required whatsoever in terms in that aspect.

Thank you, Glenn. And the next one please.

So, this continues to be on the process. 'So, can I just clarify, there is no reason to send prescriptions back to the practice to be altered. The endorsing should match and where it doesn't, this will go to a keyer and be paid appropriately and for the majority of prescriptions, they will be absolutely fine. However, there may be the odd few where it's not prescribed in the manner required in, however prescribing systems and GP practice don't necessarily allow for this anyway.

Yeah. So, I'll just jump in on this one. Ideally of course we would like prescribers to provide in that that dm+d format, we're not expecting you to go back every time and say please can you change this. What we hope is that in time that will improve and actually as EMIS systems are phased out over the next few years that will happen anyway. I think the area that you are likely to see it is probably with repeat prescriptions that have been in place for a long period of time and that may be an instance that that you want to perhaps follow up on with the prescriber.

But yes, as we've said, if there is a mismatch there and because of the way it's been prescribed the system will pass that to a keyer who can address it accordingly. So, you will be paid correctly.

I'm just going say is that what you see in the prescription is in terms of EMIS is what we call the native prescribed product because EMIS isn't a native DMD drug dictionary. So, it's a EMIS system uses its own drug dictionary. What they have is they have that mapped to the dm+d equivalent products in 98 plus percent of the cases. So although the prescription you see in front of you might say 28 bottles, what you might have in terms of what's in the message, if you take this as being fortisip liquid at 200 mls a bottle, there will also be in that Electronic Prescription message, what we call the mapped medication, which says 5600 millilitres.

So that is coming in the message, your pharmacy system will send the claim back as being 5600 millilitres, assuming you dispense everything that's been prescribed. And they will be matched up perfectly because nDCVP will be looking for the mapped prescribed item and comparing that to what's being dispensed. So although what you see on the paper may say bottles, it may say something, one inhaler, etcetera in the vast majority cases behind the scenes it is also submitting an electronic message that says what it is in millilitres or dose as well and that is interpreted by your PMR system. For those PMR systems that sort of give you a virtual image of what the form is, the vast majority of those show you the native so that you don't look at the paper and then look at the screen and go there's something different here, it keeps them the same so you can see that both sides electronic and pay for are exactly the same. So just because it says something on the paper doesn't necessarily mean it's wrong in the background. There may be what's called this mapping in there. In terms of Vision systems then the native and mapped role are always the same because Vision systems is native dm+d, uses dm+d drug dictionary for prescribing.

Thank you. Thank you, Glenn,

Anna

Here's a question on what e-mail address will you send back to us on the e-mail as the PAY00 reports will not be appropriate?

Yes, so we can only send anything back that contains patient identifiable information, CHI numbers, etcetera to an nhs.scot or nhs.net e-mail address. So, anything that we need to come back to you on will go to your NHS e-mail address. As we move into production, we'll be going through a process to ensure that all e-mail addresses are correctly loaded into the system for those contractor contacts that we may need to have.

Thank you. Thank you, Chris,

Anna

OK, there's a comment from Diane just saying that they've tried to move away from paper endorsements for years now as it's paid electronically, comment only.

Then moving on to our next question, I noticed on Vision that those dressings, etcetera mainly have changed, but that something like protonson, irrigation solution still comes through as one bottle, also 350 mls is in description, would this therefore be sent to a keyer?

Barry – can you take first part and then we'll come the second part.

I'm not aware of what the specifics would be, but on the surface I think we could take this away and answer this Susan and get you a definitive answer but I think this would fall potentially back to a keyer but my colleagues in the service can confirm that and come back to you. Thanks.

Yeah, we could look up this specific dm+d item to check it. It may be that and obviously through all the testing got loads of different examples of scripts and things and and some of them do show 1 bottle. But as you say the 350 mls is in the description and what you may find is when that is actually selected it comes through as the 350 mls, but we can take a look at that one specifically, there may be the odd outlier. But again, If what you claim for is 350 mils, and for whatever reason it comes through as one bottle, it would go to a keyer

Thank you. Yeah, we'll take that away and get back to you and others directly through our response.

Thank you. Next one please. OK, what will happen when the prescriber writes one thing, then add notes which changes the request? For example specific generic manufacturer which is over DT price.

Sorry, can you repeat that?

Yeah, what will happen when the prescriber writes one thing, then adds notes, which changes the request, for example specific generic manufacturer which is over DT price?

OK, thank you. Glenn?

Thank you. So I think this is probably a case where you're talking about an item which is in the tariff and the GP prescribes generically but somewhere in that text says give out Brand X. Think that's what probably being referred to here. Now in theory what you should probably do is return the script back to the GP and ask them to prescribe it as the brand rather than as the generic item. There are other things you could do here, you could put a prescriber contact endorsement on there I guess to change it to say actually it was prescribed as X. Or you could put an OTH endorsement on, but to be honest this changes nothing to what happens now. You could just submit the paper and not claim electronically in this case, which I believe is what I've heard one pharmacy actually does. This has not changed, this happens now and if you think about the majority of stuff that's happening now is getting paid from the electronic message not what's on the paper anyways. So there's no change to that, it's just behind the scenes it's using dm+d rather than converting your dm+d claim from the pharmacy into eVADIS for payment.

So I would say do what you do now. If that's getting you the correct payment because it should be no change to that. But ideally you should be going back to the GP and saying they need to prescribe correctly because they shouldn't be doing this and they should be prescribing in what you actually need to dispense.

Thank you.

We'll take a few more as I think we still have a bit of time if there's more questions coming in.

Of course. Will payments move to one month in arrears now rather than three months since paper copies are almost never looked at and the system has been modernized.

I'll come on to that. The intent is to to move to a model where we are able to pay more regularly and that one month target has been our intent, but we need to go through a number of cycles to be assured of what the system is doing. We've moved away from batch processing for new DCVP and if the levels of automation increase then our intent is to get that point. But we'll not get there immediately with new DCVP, but we should get there sooner than would have with current DCVP.

Thank you, Anna. Next one please.

OK. So more on the kind of advice to prescribers. So are the prescribers, for example GP's and nurses being given guidance on prescribing quantities as they still very occasionally handwrite. Nurses more often handwrite unusually, quantity written is 1 box. At the moment this engagement is our first part of this transition and to maximize the benefit of the system to all of us. So I think that's a question and piece of work we can take forward. Chris. I know you've had conversations previously with ourselves and the team is there anything else we're looking at there?

I would just say that in this particular instance, what's key is what have you dispensed. So, was the box of whatever it is was it a 20 or something a 50, 100 or 200? Claim for the quantity you have dispensed, as we've said before if it's paper only, it would go straight to a keyer anyway and they would validate that. And if it's electronic and there's that mismatch that says hang on, it just says 1 on the prescription message, but you have claimed for 200 that would be spat out to a keyer as well who would be able to look at that and say, I see what's happened here, that's fine, you'll get paid for what you claim for. So I think that's the overriding key message, make sure you claim for what you have dispensed.

Thank you.

Thank you. Do you have any more Anna or?

Just a few more, so somebody seeking clarification on whether it's the clinical or personal nhs address that will be used. That varies as to what's on record depending upon the practices, the pharmacies that you're in, in some instances it is a personal one that's on record, sometimes it's a particular site or organization and it varies. So it will be whatever we have on on file for that and I would say if you have a couple, keep an eye on them and make sure that you monitor them and it will become clear which one we've obviously got on file for you. But if you're not sure, please do get in touch with us that's something we can check quickly and advise you what information is held. If you want that changed again that we can get that effected as part of the transition process.

Thank you, Anna. A few comments in the chat and we will obviously pick up all of them and and and and take them under advisement as well. But there's a question.

So will you be able to deal with serial scripts with no dm+d because that's how some of our errors are happening in Pharmacy First? So serial scripts with no dm+d. Sorry, it's two separate questions, it's two separate things.

So will you be able to deal with serial scripts with no dm+d? OK, so fine. Stick with that first of all.

I see. Yeah, Glenn.

I was going say I think this is probably where, if you like the GP over a 56 week period might have prescribed 12 inhalers and you'll see that come through as 12 inhalers and then the pharmacy will then dispense against that. So in theory if you look at what happens in terms of a claim for a serial prescription, it's no real difference what happens on a AMS acute medication script claim. So again if that came in as being what you'll see coming in there is there's no dm+d mapping the prescribed section would say 12 inhalers the pharmacy if it's a 200 dose inhaler and have given 1 would send a claim for 200 dose. That would then just find its way to a keyer it, as happens now, and the keyer would see it and would appropriately approve that payment for 1 inhaler, 200 dose. So there's no change there, that will display to the keyer on a virtual form if they need to have a look at it because

the quantity is different and the unit of measures would differ, the prescribed unit measure would be probably an inhaler of 200 dose. So we'd see the difference and go to a keyer to pay.

Thank you on this, but part two of that.

So the Part 2 is that's how some of our errors are happening in Pharmacy First and they give an example of 20 Bisacodyl going through as 20 x 20, 400 and not picked up by keyer.

OK, so Pharmacy First is a little bit different because both the supply product and the dispense products are supplied taken as written as all the equivalent of prescribed would be above coming from the PMR system and the PMR system if they've got those products within it, will be using dm+d for both sides of that. No one has reported that to us previously about any issues there, so it would be interesting to maybe see a little bit more detail about that if someone's got it because as I say both sides of the system are the same, supplied/written as and dispensed are botrh coming from the PMR.

Thank you. I think we can expand a bit more on that one for Pharmacy First, I know there's been correspondence earlier on so we can expand a bit on that in our wider response later on.

Thank you. Anna please.

So that's actually the actual questions all covered at the moment. Like I said, there are a few sort of more comments or statements in the chat which we will pick up.

Thank you. And any other final points from the team. Anything you feel we need to clarify at this point Chris?

I don't think so. I would just like to, you know, repeat what I said before and and thank folk for joining it relatively short notice in the middle of your evening. Our hope with the guidance document that we issued was that it would provide the information that you require, obviously it raised some concerns and and and a key learning for that was for us was to then address that as quickly as we possibly could and hopefully by doing this tonight we've managed to provide some reassurance and clarify some of those concerns that you had.

This has been a really useful session for us as well in terms of some of those additional questions coming through and we hope you found it and informative and useful. As I said, we'll package everything up in the coming days and and get this this out to everybody as a suite of slides, recording and updated guidance and and we would ask you to share that with any of your colleagues that have been unable to attend so that we make sure everyone's as informed as possible.

I would just like just to also add my thanks to Barry for coming along and providing some additional information, hopefully that was useful to you as well. This has been a long and complex program and we are getting very close to finally completing it and it's been a big undertaking. Thanks also to Michael and Emma from CPS, who helped us get this arranged for tonight and for all their input along the way in the program too.

Thank you.

Thank you, Chris. So thank you.

Thank you. But I just want to take this opportunity in the last few remaining few minutes to just invite our director for practitioner and counter fraud services, Martin Bell, to just say a few words in in partings so that we can stick to the one hour time.

Martin over to you. Thank you.

Yeah. Thanks Nelson. Thanks everybody, and thanks for the questions. Please if there are more questions, get them in, the team will go through them and answer them and get back out to you. Like Chris has said I want to thank everybody involved for those of you who have taken the time out this evening at your own time to get this update, those who have prepared the update and there's a plethora of people there from the program team themselves, CPS, our colleagues across the health Boards, special and territorial and contractors themselves out there, so the list is endless. Our appreciation is massive and we appreciate really how much effort this is going to require, but also I appreciate how much effort the teams have all put into this program again to get it to where we are today. We're nearly there and inevitably these things will have some grit in the ointment. But hopefully we will be able to iron those out quickly and get this up and running and as soon as possible having a resilient system that's fit for the next 20 years which is what we aspire to do.

And I think the point somebody asked about getting payments down to within a month; that's absolutely a long term aspiration. But as Nelson said, we need to get a walking first and then as soon as we can drive this machine, we will absolutely look to exploit all the benefit from it to make sure we can get contractors looked after accurately, effectively and ideally in a more timely way. So thank you all and have a great evening and yeah, look forward to seeing this one over the line in a couple months time. Thanks.

Thank you. Thank you, Martin, and thank you everyone and good evening and a good day tomorrow and I'll see you in correspondence later on. Thank you. Thank you again. Goodnight.

Thank you.

Thanks everybody.