

Automating for Better Care Forum – Meeting Summary

14 September 2026

1. Welcome and Chairs Update

- Attendees were welcomed by Lord Carter of Coles (Co-Chair of the Automating for Better Care Forum).

2. Chairs update

- Yvette Cooper, the new DHSC Secretary of State is focused on improving workforce issues and providing steady leadership after a period of change.
- There was discussion about the NHS Modernisation Bill currently going through Parliament. Practical issues have surfaced with the move of NHS England functions to DHSC, and there has been discussion in the press of establishing a separate NHS focussed arm's-length body (ALB) or an NHS Executive. There is a policy tension between the more centralised approach of the NHS Modernisation Bill and the wider move towards devolution.
- There was discussion of the evolving role of ICBs. Feedback from one ICB suggests their role is clear with a focus on strategic commissioning and translating national direction into local commissioning priorities based on health needs of the local population. Neighbourhood teams will focus on delivery and local commissioning. Other ICBs are restructuring due to changes to the area they cover.
- A new NHS quality strategy has been published. Good financial management and good quality management need to go hand in hand — both need to function well together, underpinned by a clear forward plan on quality.
- Substantial NHS workforce expansion occurred during COVID but has not translated into productivity gains. This contrasts with trends in most other countries (Germany being a notable exception), where workforce numbers have decreased again after COVID.
- The House of Lords Public Affairs Committee Inquiry into Medicines Security expressed clear concern about the current UK approach. The House of Lords Committee recommended Government establishes a resilience scheme to secure medicines in emergency scenarios, but government has yet to commit to this.
- PRSB have received substantial funding from the Health Data Research Services to develop medicines data for research.
- The AI Commission recently reported their findings making 44 recommendations to which the government response is not yet published. The report combines forward-

looking and immediately actionable recommendations and is expected to have significant impact. The first AI liability cases are now with NHS Resolution.

- Despite a range of high-level organisational changes, on the ground, there was a view that most existing projects and programmes are expected to remain on track. However, in some organisations there is a lack of alignment between where pharmacy/medicines budgets sit and where pharmacy staff expertise sits, hindering joined-up decisions.
- In Wales, the new government has shifted strategic priorities creating uncertainty in digital strategy direction and impacting on planned work. The previous government had invested in a national data layer approach, without corresponding investment in data generation.
- In Scotland, there is a move towards reducing the number of health boards, reflecting a broader return to a more command-and-control model.

3. Update on implementation and evaluation at Liverpool and Plymouth

- There was an update on the A4BC Connected Medication Management (CMM) exemplar projects at Liverpool and Plymouth.
- In Plymouth the first study ward go-live is scheduled for last week of September with full rollout to four wards in total by end of November. Go-live was delayed due to an EPIC deployment at the trust. EPIC trainers are now supporting the BD Pyxis cabinet system roll-out.
- In Aintree, ongoing CPOE (Computerised Prescribing and Order Entry), with BD Pyxis cabinet roll-out is commencing in September with study wards following shortly after. Roll out is likely to be completed by end of November.
- A three-month embedding period will conclude late February/early March, after which post-implementation data collection begins. Initial publication of experiences of the implementation process is planned for mid FY26/27. Two further papers are planned (90 days post-implementation, and one year on). The aim is to address a gap in UK literature on how large-scale CMM programmes can practically be implemented and the impacts of these implementations.
- A CMM evaluation group has been established by BD, chaired by Keith Ridge. The group has a range of NHS representatives and will initially focus on developing a framework for benefits realisation when deploying medicines management automation. The intention is to publish this work in due course.

4. NHS England Update on technology, data and digital priorities for medicines management

- Rob Thompson, Chief Digital, Data and Technology Officer at DHSC and NHS England, has been in post for over 3 months. He is focused on delivery and

maximising adoption of existing products. His second area of focus is overall ownership of transformation programmes and their outcomes. The work of A4BC on implementation at scale (such as the CMM exemplar projects) could be helpful in understanding how oversight of these large-scale programmes works in practice.

- The Frontline Productivity programme received a red rating following a recent gateway review (a standard peer review process for large government projects). There is a key challenge around the investment model for the programme which combines nationally set standards with regional investment decisions. There have been learnings this year (the first year taking this approach), on funding and resource allocation which will inform the operational approach to delivery taken in Financial Year 2027/28.
- There could be opportunities for regions to invest jointly in technologies where multiple regions want the same capability, rather than regions negotiating separately. This could enable economies of scale and savings for regions, trusts and suppliers. There is currently no mechanism for this, but an approach is under discussion and support from the group may be sought.
- The Single Patient Record (SPR) is an emerging priority. The team has been established and has set priorities for the period ending March 2027. These priorities include medicines data for prescribing, dispensing and patient collection of medicines.
- Funding for digital medicines is now flowing directly to trusts and providers for the first time and suppliers have developed capabilities, but it has been hard to demonstrate the benefits that have been achieved from the NHS England funding. There could be a role for the group in supporting thinking about this. The group could also support thinking through the role of providers who are first adopters in supporting those who subsequently implement the technology. **Action: for smaller group to discuss and write paper for discussion at the next A4BC meeting on the potential role of A4BC in supporting NHS work on this area.**

5. Impact of automated medicines administration on nursing

- At the May A4BC meeting, there was a presentation from a pharmacists' perspective about the roll out of the Optimed single unit dose system on several wards at the University Hospitals of Leicester NHS Trust. This presentation provides feedback from nurses on that technology implementation.
- Traditional challenges around medicines management include medication administration errors, missed doses, time-consuming drug rounds, manual documentation, limited traceability and variable stock control. Administration errors represent a major proportion of medication incidents in hospitals. Traditional medicines management processes require a significant amount of nursing time to be spent on medicines-related activities.

- Feedback from nurses on the new system is that it is generally seen as easier and timesaving when working well. However, the new system is less popular with staff when not functioning properly and is seen as generating more waste from plastic packaging. There were some challenges when the system was initially introduced but staff have worked to overcome these.
- This automated system currently supports ~80% of medicines, with further work needed to expand coverage. The system cannot currently support medicines such as liquids, controlled drugs, or items unsuitable for automated storage.
- For nursing practice, the system:
 - Reduces the risk of wrong-patient and wrong-medication errors, supporting safer medicines administration.
 - Reduces medication administration errors and improved compliance with the “five rights” of medication administration.
 - Leads to fewer missed doses and improved medication adherence for patients
 - Reduces cognitive burden with less reliance on memory, helping nurses manage complex workloads more efficiently.
 - Provides greater traceability and better data with full traceability of medication administration actions and clearer audit trails. It also supports incident investigation, governance requirements and quality improvement initiatives.
 - More efficient drug rounds with faster medicine retrieval, reduced searching for medicines and improved stock availability.
 - Reduced medicines waste and medication expenditure.
- Barriers and challenges:
 - Workflow changes with new ways of working and initial disruption to established routines. Increased medication administration time during early implementation as staff adapt to new processes.
 - Staff concerns with resistance to change from established practices and perception of increased workload during initial implementation period.
 - Training requirements with need for comprehensive staff training before implementation and a need for ongoing education and refresher sessions. Support is needed to build confidence and competency in using digital medicines management systems.
 - Technical issues around the reliability of automated dispensing cabinets, the availability and functionality of patient wristbands for barcode scanning, maintaining appropriate stock levels within cabinets (e.g. for drugs used in high levels on particular wards) and technical functionality and performance.
 - Physical constraint as not all wards can accommodate large cabinets like the ones needed for the Optimed system.

- Maximising success needs nursing leadership to provide strong clinical leadership, early nursing engagement, clear communication of benefits, adequate staffing during implementation, and continuous training and support. People are key to successful implementation.
- This study reflects a single technology approach in one hospital, and this approach may not be appropriate for all settings and hospitals. No two hospitals are the same and benefits are context-specific and not necessarily transferable between organisations. Resource to introduce this technology needs to be balanced against prioritising the introduction of other technological advances.
- Medication administration is a relatively small (though safety-critical) part of the broader nursing role, which must be balanced against other care responsibilities.
- There is a need to engage medical staff/prescribers around implementation of these technologies alongside nurses and pharmacists, given medication administration responsibilities sit partly with doctors.
- The nursing profession is raising concerns about hazardous substance handling (i.e. cancer drugs) and this concern is coming to the attention of parliament and at a European level. Technologies such as this could be part of addressing the issue.
- Given the benefits for nurses and patients, there could be a role for the nursing profession in championing technology for digitising and automating medicines management.

Action: PRSB to engage with nursing professional bodies to offer support in championing accelerating use of these technologies.

6. Digital Medications at the Bedside

- The group heard personal reflections on 35 years of progress from paper records to real-time electronic visibility of patient medicines.
- Hospitals are dynamic environments with a flow of patients coming in, undergoing treatment and then leaving hospital. When patients come into the hospital there is a need for medication reconciliation for the medications the patient has taken into hospital with them. When patients leave hospital, there are often different elements to their treatment in hospital held on different systems and the information from all those systems needs to be shared with primary care at discharge.
- The administration of medicines at the bedside requires the right patient, drug information, and medicine. Environments vary significantly, and integration with the wider patient record is essential. As an example, medications administered during labour need to be recorded and may have an impact on the child. Information about the medications administered should automatically form part of the patient discharge information.
- When designing workflows for digital medicines technologies, the following factors need to be considered:

- Not all sites have electronic drug cabinets.
- Not all organisations want to move away from manual drug rounds.
- Which barcodes are on the medicine packaging (2D vs linear) and do they correspond with the readers available for ward rounds.
- There may be practical issues (such as patient wristbands wearing out) that need to be considered for procurement of consumables.
- For some patients and medications there may be physical and environmental constraints (e.g. side rooms, isolation patients, limited space for equipment within small patient rooms, controlled drugs, multi-drug vials, and fluid/additive bags lacking barcodes).
- Patient drug charts should be easy to access and view.
- Continuous infusion management (multiple syringes/drivers with complex dosing) needs to be considered.
- There can be barcodes on medicines packs arriving with patients which are not recognised by the hospital system.
- Retrofitting into existing environments can sometimes be used to overcome barriers. One site addressed missing barcodes using a barcode replicator to retrofit vials previously only barcoded at box level.
- Need to balance financial, operational, functionality, staffing, and system integration factors to make "the simple thing the right thing to do."
- From a midwifery perspective, on the ground integration of different electronic systems can be useful e.g. electronic prescribing and medicines administration integrated with electronic patient record enabling full incident traceability. Practical adaptations also need to be considered for the environment e.g. moving from wired to wireless scanning near infant care equipment.
- Often sites are using many closed-loop medicines administration processes but not for all steps, with the medicines administration step often not being fully closed-loop. It is important to take incremental steps in the right direction to improving medicines management rather than aiming to introduce a perfect system from the beginning.
- Internationally, the US introduced unit-dose in the 1960s for theft prevention, cost recovery, and safety; today the US uses a mix of unit-dose and packs rather than pure unit-dose. The US adoption was driven partly by 1990s legislation mandating pharmaceutical industry production of unit-dose packs. The UK by contrast has historically requested multidose packs. These multidose packs can be repackaged as unit dose packs but that requires time and specialist supervision and equipment. More widely, adoption varies internationally: Spain is moving toward unit-dose; the Middle East is increasingly employing repackaging staff and; Australia is considering their approach.
- It was suggested implementation of closed loop technologies could be prioritised through risk stratification. Oncology day units were flagged as high-risk areas which

do not currently have closed-loop systems in all hospitals. This could represent a potential safety-focused starting point.

- Consensus that the UK will not move to full unit-dose systems "overnight" and full unit dose coverage is unrealistic, but there is scope for a range of technologies to drive improvement.

7. Update on Medicines Barcoding Advocacy work

- There was an update from GS1 UK on the medicines barcoding advocacy work.
- An MHRA/DHSC consultation on barcodes on medicines packs was expected in July but was delayed. The timing of the consultation is currently unknown, likely in part due to the recent changes in government. It is currently unclear whether the consultation will cover falsified medicines or not.
- In the meantime, there is a need to build the evidence base on the scale and impact of missing barcodes on medicines packs. This is being taken forward in several ways:
 - [GS1 UK report](#) setting out the findings of their survey on this issue.
 - The "Scan for Safety" evidence report due for publication shortly which be circulated to forum members when published.
 - Working with BD and the East of England region to pull data from BD robots about the scale of the issue in hospitals.
- The [European Association of Hospital Pharmacists \(EAHP\)](#) and the [European Federation of Pharmaceutical Industries and Associations \(EFPIA\)](#) published joint guidance on single-unit medicines barcoding. The guidance considers issues such as paediatric medicines and bottles.
- MHRA has updated their best practice [guidance on labelling and packaging of medicines](#).
- A date has not been set yet for the upcoming House of Lords debate on Medicines Security.
- The A4BC briefing on barcoding has been drafted and should be circulated to a range of stakeholders as soon as possible. This will help to make the case for the MHRA consultation on barcodes to be launched.

8. Closing remarks

- Attendees were thanked for their input.
- The next meeting of the group will be held on 8th December with further details to follow.

Annex 1 – Attendees

Name	Role	Organisation
Dr Keith Ridge CBE	Co-Chair	Former Chief Pharmaceutical Officer for NHS England
Lord Carter of Coles	Co-Chair	House of Lords
Simon Noel	Deputy Chief Nursing Information Officer	NHS England
Rahul Singal	Chief Pharmacy & Medicines Information Officer & Senior Responsible Owner for Digital Medicines	NHS England
Raliat Onatade	Group Chief Pharmacist and Clinical Director for Medicines Optimisation	Barts Health NHS Trust
Paula Beckles	Digital Midwife	Imperial College Healthcare NHS Trust
Sam Coopey	Integration & Connectivity Solution Manager - Hospital Automation	BD
Rebecca Jones	Policy and Advocacy Consultant	PRSB
Georgina Lawton	Head of Healthcare	GS1 UK
Tanya Serebryanska	Market Development and Access Manager - MMS	BD
Patrick Singh	Lead Pharmacist for Digital and Informatics	Cwm Taf Morgannwg University Health Board
Sarah Thompson	CCIO (Pharmacy and Medicines)	University Hospitals of Liverpool Group
Pippa Roberts	Chief Pharmacist	University Hospitals of Liverpool Group
Ron Pate	Independent Consultant working with Deenova	Independent Specialist
David Campbell	Clinical Director of Medicines Optimisation	Northumbria Healthcare NHS Foundation Trust
Tony Davies	Northern Europe Hub Director – Medication Management Solutions	BD

Holly Kearn	Digital Manager	PRSB
Michael Pace	Managing Director (formally managing director of NHS London Procurement Partnership)	ZCJ Consulting
Dipak Duggal	Director of Medical Affairs International	BD
Colin McCreath	Business Development Executive	BD
Hannah Flint	Senior Nurse for Medicines Management and Optimed	University Hospitals of Leicester NHS Trust
Heidi Wright	Policy and Practice Lead, England	Royal College of Pharmacy
Julia Asplin	Assistant Director of Procurement, Pharmacy	East of England NHS Collaborative Procurement Hub
Karen Payne	UK Nursing Information Officer	Royal College of Nursing
Hannah Kooner	Optimed Project Manager	University Hospitals of Leicester NHS Trust