All PSNC members can attend this meeting and may speak with the permission of the Chairman.

PSNC Service Development Subcommittee Agenda

for the meeting to be held on Tuesday 8th October 2013

at Devonport House, King William Walk, Greenwich, SE10 9JW

starting at 11.30am

Members: Stephen Banks, David Evans, Elisabeth Hopkins, Margaret MacRury, Indrajit Patel, Janice Perkins, Alan Robinson, Gary Warner (Chairman)

1. Apologies for absence

At the time of setting the agenda, no apologies for absence had been received.

2. Minutes

The minutes of the meeting held on 9th July 2013 were shared with the subcommittee and can be downloaded from PSNC's website.

3. Matters arising

4. Work Plan

The 2013 work plan is set out at **Appendix SDS 02/10/13** for consideration by the subcommittee.

ACTION / RATIFICATION

5. Monitored Dosage Systems

A request has been made that the subcommittee considers reviewing monitored dosage systems in particular raising concerns about the funding for the service. The subcommittee needs also to consider the service implications, particularly in light of the reference to the Royal Pharmaceutical Society's guidance published recently. The chairs of SDS and FunCon decided that this matter should be discussed at this subcommittee. Background information is set out at **Appendix SDS 03/10/13**.

6. Pharmacist Workforce and HEE/HEFCE consultation

The Centre for Workforce Intelligence recently published a report (A strategic review of the future pharmacist workforce – Informing pharmacist student intakes) which had been commissioned by DH to inform the work on workforce planning of the Modernising Pharmacy Careers (MPC) programme (which now sits within Health Education England (HEE)).

The report forecasts and analyses the future supply and demand for the pharmacist workforce in England between 2012 and 2040. It recommends intervention to bring the supply and demand of pharmacists into balance and that this is undertaken using a staged approach. The Executive summary of the report is set out at **Appendix SDS 04/10/13.**

As a first stage, HEE and the Higher Education Funding Council for England (HEFCE) are consulting on the supply of pharmacy graduates in England. The consultation, Ensuring a sustainable supply of pharmacy graduates, follows work undertaken over the last few years by the MPC programme. Points for discussion are set out as **Appendix SDS 05/10/13**.

REPORT

7. New Medicine Service (NMS)

NHS England agreed to extend the commissioning of the NMS until the end of December 2013. Commissioning to the end of the financial year will continue to be an element of the wider discussions on amendments to the CPCF between PSNC, DH and NHS England.

The commissioning of the service in 2014/15 will be influenced by the outcome of the University of Nottingham/UCL evaluation which is expected to present its initial report to the DH steering group (which Gary Warner and Alastair Buxton are members of) by the end of February 2014.

8. HEE MPC Consultation & Communication Skills task and finish group

The MPC proposals for the reform of post-registration career development of the pharmacy workforce included developing the pharmacy workforce to be able to work with patients, other health care professionals and members of the public to improve quality, value and outcomes from medicines through medicines optimisation and enhancing their skills in the delivery of public health interventions.

The *Consultation skills in pharmacy practice working group*, jointly chaired by Chris Cutts, Director of the Centre for Postgraduate Education (CPPE) and Clare Howard, Deputy Chief Pharmaceutical Office, NHS England, has met four times. Drafts of the following have been produced:

- A 'vision' document for consultation skills in pharmacy practice;
- A set of professional standards based on the Royal College of General Practitioners' (RCGP) curriculum statement, which outline the competencies that pharmacists and pharmacy technicians need to achieve in order to conduct consultations effectively. These standards represent the basic competencies that will be expected of all patient-facing pharmacy professionals in the future;
- A pathway to encourage self-assessment of current consultation skills. This is directly linked to the Medicines Related Consultation Framework. This will also provide advice on using patient feedback (review form being developed, based on RCGP example) and peer feedback;
- A learning pathway, consisting of several options and methods for undertaking learning to develop skills needed for pharmacy consultations. Advice is also being provided to trainers and employers;
- A formative assessment framework using an online assessment; and
- A positive encouragement step to encourage reflection and continued improvement.

These draft documents are currently being professionally edited and compiled into a suite of key resources for a proposed national model for enhancing the consultation and communication skills of pharmacy professionals. When published, the documents will be made available on a dedicated website with open access to all pharmacy practitioners, and the expectation is that it will be co-branded by the Royal Pharmaceutical Society (RPS), the Association of Pharmacy Technicians UK (APTUK) and the Centre for Pharmacy Postgraduate Education (CPPE), and that the NHS logo will be included.

The next steps for this work are to:

- progress detailed elements of the learning pathway, including mailing to all pharmacy professionals with a CPPE open learning programme (Patient Centred Care);
- produce a model for summative online video based assessment – a separate project group has been set up to take this work forward, with a final output expected by March 2014;
- produce a website to host the key outputs outlined above, and to act as the central point for all information around pharmacy consultation skills, including specific branding;
- carry out stakeholder engagement testing;
- commence communications and PR activity to inform professionals of the work and to encourage early adopters to get involved;
- develop and implement champion/lead recruitment and training;
- pilot the model;
- produce an evaluation of the pilot to inform recommendations for a wider national roll out; and
- plan for national launch in March 2014.

9. Urgent and Emergency Care

The office has worked with Pinnacle Health Partnership to develop a minor ailments service business case for use by LPCs (which is available on the PSNC website). This has been supplemented by a PSNC Briefing on urgent and emergency care in order that LPCs are kept up to date with the work NHS England is carrying out at a local and national level on this subject.

It is clear from the contract negotiations with NHS England and DH that there will not be an opportunity to introduce a national minor ailments service in the next year, but progress could be made at a local level working with CCGs. NHS England officials have commented that this is a sensible approach for the current time and it is expected that the eventual outputs of the urgent and emergency care review will be supportive of the role of community pharmacy in addressing this challenging agenda.

As part of PSNC's lobbying at the three main party political conferences, a roundtable event has been held at each conference under the auspices of the Health Hotel. At the roundtable events PSNC and the Dispensing Doctors Association discussed the role of community pharmacy and general practice in managing the current demands on A&E and urgent care services with health Ministers and a member of the shadow health team. A flyer on urgent and emergency care was developed to use at the conferences and this has also been made available to the LPCs to use in local lobbying of commissioners.

10. Sustainable Development Consultation

PSNC responded to the consultation on Sustainable Development during the summer. The Sustainable Development Unit has issued a summary of the responses which indicates the approach that will be taken in the development of the strategy due to be launched on the 29th January 2014. It is expected that the strategy will take a wider approach both to the organisations it will cover, to include providers of NHS services and therefore community pharmacy, and the aspects, which will be broader than carbon reduction. There are some issues that will impact on community pharmacy as models of care, the supply chain, pharmaceuticals and procurement are all highlighted for consideration. The main points from the consultation summary are set out at **Appendix SDS 07/10/13** for information.

11. EPS Release 2 Update

An update on current NHS IT projects is set out at **Appendix SDS 08/10/13** for information.

12. Supporting Carers in community pharmacy

As part of work to develop our 'support for independent living' service domain, PSNC is working with the Carers Trust to consider how community pharmacies could identify and provide more support for informal carers (i.e. not paid carers). This is part of a wider DH funded project that the Carers Trust is undertaking across primary care.

A brief description of the initial plans is set out in **Appendix SDS 09/10/13** for information. A number of Carers Centres across the country have volunteered to take part in the project and they have been or will be paired with the corresponding LPC. A workshop to plan the activity that will be tested is due to be held prior to the PSNC meeting with the Carers Trust, PSNC, four LPCs, Carers Centre representatives, CPPE and the University of Leeds (who are evaluating the main project).

13. Falsified Medicines Directive Update

An update of the work on this Directive has been submitted by Raj Patel and is set out at **Appendix SDS 10/10/13** for information.

14. Consultation on the NHS England Mandate and the Vulnerable Older People's Plan

The response made by PSNC to the Department of Health consultation on Refreshing the Mandate to NHS England: 2014-2015 can be found in the PSNC's Work section of the website.

15. Department of Transport consultation on drug driving

PSNC and Pharmacy Voice have jointly responded to this consultation and the response can be found in the PSNC's Work section of the website.

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16. Any other business

Appendix SDS 02/10/13

2013 Work Plan for the Service Development Subcommittee

The 2013 work plan for the Service Development subcommittee covers all items agreed at the November 2012 planning meeting.

Key for RAG coding
Red – needs attention / not started / high risk
Amber – underway / in progress
Green – completed / no further attention

Target Plans	Target date	Comment / Update on progress	R/A/G
In 2013 PSNC will develop recognition of the value and potential of community pharmacy service provision in meeting the health needs of our population. We will support development of strong and productive relationships with the NHS Commissioning Board at local and national level. We will ensure that developments in technology support the community pharmacy service and will work to ensure that regulations and their administration meet contractor needs. • PSNC will work to develop models for service delivery in all four domains (medicines optimisation, minor ailments, public health and supporting independent living) ensuring they support the achievement of elements of the health and social care outcomes frameworks. Medicines optimisation services may focus on a specific patient cohort where day to day care of the patient's LTC is managed by the patient in partnership with their pharmacy. • PSNC proposals for the four domains will include robust and manageable quality and outcome measures, where possible aligning with those for other primary care service providers, notably GPs. • PSNC will seek to ensure the continued commissioning of NMS, and make progress towards the integration of tMUR and NMS as fully funded Essential services. • PSNC will seek to persuade the NHS CB and / or Public Health England to develop national standard specifications for a range of services in order to facilitate the commissioning of services at a national or local level.			
Review the management of common long term conditions in order to assess which could be most appropriately managed within community pharmacy.	March	The results of this review will be discussed at the May meeting of the subcommittee.	Green
Develop a business case and supporting documentation / resources to support the commissioning of medicines optimisation services.	August	Following the presentation and discussion on options for future medicines optimisation services undertaken at the May meeting, PSNC's vision narrative document was written which describes the options for development of services in the CPCF. This has been published and has received a considerable amount of publicity. The concepts on LTC service development within the vision narrative have been	Amber

		used in discussions on service development in the ongoing negotiations with NHS England and DH. Work on developing a value case for some of the service elements being discussed has also been started.	
Develop a business case and supporting documentation / resources to support the commissioning of public health services.	November	A business case for seasonal flu vaccination has been circulated to LPCs. Options for development of services at a national level are being considered by the office and the Chairman of SDS for discussion with PHE.	Amber
Develop a business case and supporting documentation / resources to support the commissioning of services to support independent living.	November	A project to support the identification of carers is being taken forward with Carers Trust (see report on October 2013 agenda).	Amber
Develop a business case and supporting documentation / resources to support the commissioning of self-care/minor ailment services.	August	A business case for MAS has been provided for use by LPCs. A PSNC Briefing and flyer provides supporting materials to use in wider conversations with commissioners on urgent and emergency care.	Green
Continue to collaborate with DH on building the case for the re-commissioning of NMS.	Ongoing	Following submission of the PharmOutcomes NMS evaluation, discussions with DH and NHS England resulted in an agreement to extend the service for six months. NHS England agreed in September to extend the service until the end of the year. A decision of commissioning beyond that point is likely to be agreed in principle in the ongoing negotiations, subject to the DH funded evaluation providing a positive report on the impact of the service.	Amber
Continue to collaborate with the DH appointed academic team evaluating NMS to support the provision of timely information to assist in future negotiations on the extension of the service.	Ongoing	Alastair Buxton and Gary Warner attended meetings of the NMS Evaluation Advisory Group in February and July. AB has also had bilateral meetings with a member of the research team to provide assistance on recruiting more pharmacies to the research. Regular contact with the research team is being maintained and assistance was been provided to them on the organisation of their stakeholder event in June.	Amber
Continue to develop contacts at the NHS CB and PHE and discuss development of standard service specifications once appropriate individuals are in post.	Ongoing	Initial discussions with new contacts at NHS England have been followed up with meetings with colleagues in the commissioning development, medical, nursing and operations directorates. Close relationships are continuing to be maintained with NHS Employers, who will continue to have a role in negotiating changes to the contract on behalf of NHS England. The commissioning development directorate have suggested that the development of standard service specifications may be something they would	Amber

		consider once the current negotiations are concluded. Alastair Buxton, Barbara Parsons and Sue Sharpe had a meeting with Prof Kevin Fenton (PHE) in June to open discussions on the role of community pharmacy in public health.	
• PSNC will work to ensure amending regulations and implementation of changes for administration of pharmacy services are effective for contractors and LPCs (working with LIS). • PSNC will work to ensure that Market Entry and PNA regulations are implemented effectively (working with LIS).			
See the LIS work plan for action points related to the above issues. If problems with implementation are identified SDS will consider the appropriate action to be taken in partnership with LIS.			
• PSNC will work to ensure implementation of EPS will incorporate full protection of risks to contractors, including protecting patient choice, and be managed to avoid any distortion of the market (working with LIS).			
Work closely with DH to ensure patient choice is protected during the implementation of EPS Release 2.	Ongoing	Guidance has recently been issued to LPCs on the NHS re-organisation. A particular concern is the loss of the duty on PCTs to proactively monitor use of the EPS nomination functionality however NHS England will continue to be obliged to respond to complaints.	Amber
Monitor the implementation of EPS closely to identify problems arising and support sharing of lessons learned to feed into discussions with DH on ensuring the system works effectively for pharmacies.	Ongoing	Continuing to work to collate feedback. A few new issues have arisen linked to changes in the message broker used by some system suppliers – however there is consistency in the majority of issues that are being reported.	Amber
Work with DH to agree guidance to support minimising the risk of system failures occurring and their impact and ensure that there is recognition in the funding arrangements of changes in business risk.	Ongoing	Discussions are on-going on business continuity guidance and the funding linked to this. It is hoped that this will be resolved soon.	Amber
• PSNC will support LPCs to develop their relationships with Local Authorities, Health & Wellbeing Boards and Clinical Commissioning Groups, and promote the commissioning of community pharmacy services at a local level (working with LIS).			
The LIS workplan contains a range of activities to support LPCs in line with the above action point. LIS will oversee the development of support materials and resources as appropriate and will seek the input of SDS on service related matters.			

Monitored Dosage Systems

Background

In 2004 PSNC agreed with the Department of Health that the 7th Essential service would be 'Support for people with disabilities'. This would involve an assessment by the pharmacist of the patient's needs where the patient has a disability within the meaning of the Disability Discrimination Act 1995, then the provision of support – level 1 - large print labels, easy open containers, reminder charts and medicines administration records; or of level 2 - supplying medicines in a multi-compartment compliance aid. The PCT could then carry out a verification exercise, and give instructions to the pharmacist not to provide further support if the PCT disagreed with the adjustment.

However, legal advice obtained by the Department of Health confirmed that the PCT would be unable to direct pharmacists not to make adjustments, as the obligation to comply with the Disability Discrimination Act 1995 rested with the provider, and it would conflict with this obligation to have a third party over-riding the pharmacist's decision.

The Department of Health had commissioned the development of a DDA toolkit, to assist pharmacists in identifying patients who had a disability, and in making decisions as to what adjustments may be reasonable under the Act. Even though the Essential service was not incorporated into the regulations, the Department agreed that NHS PCC could publish the DDA toolkit, with the qualifier that its use was not mandatory, and that other methods could be used by pharmacists to determine the adjustments required.

The funding for this service had already been agreed by the time the legal advice was obtained, and so the Department of Health and PSNC agreed that the funding would be distributed on a pence per prescription basis, on the assumption that the greater the number of prescriptions dispensed, the higher the likely number of patients requiring support. The total amount of funding was not based on statistically valid research, but instead, a sum of money proposed by the Department of Health. On the prescription volume at that time the payment amounted to 5.5 pence per item (total items, not just those for patients with a disability). When the Disability Discrimination Act 2005 came into force (which included for the first time, additional patients who suffered from a mental condition that was not medically recognised), the remuneration was increased to 6.6 pence per item.

The total amount paid has therefore increased with prescription volume and on the basis of 1 billion items, now amounts to £66m per year (an average of £5,700 per pharmacy per year).

MDS was initially provided free of charge to care homes, but over time, there has been an increase in the requests for a domiciliary service. Some of the demand has been led by carers (including professional carers) who require medicines to be dispensed in MDS to make the administration easier. In care homes, MDS may allow lesser qualified staff to carry out drug rounds.

Prior to the new contractual framework in 2005 some PCTs commissioned an MDS service, but once the funding was made under the Disability Discrimination Act, most PCTs discontinued the service.

Legal Advice

In 2006 PSNC took legal advice on the adjustments made under the Disability Discrimination Act. Counsel expressed concern that the DDA toolkit might be used not to identify patients with a disability and the most appropriate adjustment, but to identify people for whom an adjustment need not be made – in other words a toolkit to exclude persons from the DDA support.

Counsel also considered the dispensing service, and the potential adjustments that might be required under the Act, and observed that there would be very few patients who would satisfy the DDA conditions and benefit from dispensing in monitored dosage systems.

The lawyer also expressed concern that providing medicines in an MDS may give patients, their carers and relatives a false sense of security, if they think the adjustment will overcome the disability, where in fact the patient would benefit more from increased supervision by carers and relatives.

Previous review of the arrangements

PSNC considered the method of distribution and quantum shortly after the legal advice had been obtained. This was informed by an analysis of workload / costs carried out in a pharmacy with a substantial number of MDS clients. The Committee decided at that time not to pursue any change in the distribution of funding.

Professional Guidance

The Royal Pharmaceutical Society has recently issued professional guidance 'Improving patient outcomes: The better use of multi-compartment compliance aids'

The Executive summary states:
The use of multi-compartment compliance aids (MCA) has become regarded as a panacea for medicines use and is often integrated into practice and service policy without giving due consideration to the alternatives available.

This report aims to help continue the journey to improving patient outcomes with the better use of medicines, through the provision of knowledge and information to pharmacists, healthcare professionals and other stakeholders involved in health and social care. There needs to be a better understanding of the selection of an MCA as one adherence intervention amongst many, the evidence-base with the use of MCA, the practice considerations and the benefits and risks.

Although MCA may be of value to help some patients with problems managing their medicines and maintaining independent healthy living, they are not the best intervention for all patients and many alternative interventions are available. The evidence-base indicates that MCA should not automatically be the intervention of choice for all patients.

Not all medicines are suitable for inclusion in MCA. Furthermore, all stakeholders should recognise that the re-packaging of medication from the manufacturer's original packaging may often be unlicensed and involves risks and responsibility for the decisions made.

With the limited evidence base currently indicating a lack of patient benefit outcomes with the use of MCA, it is a recommendation of the RPS that the use of original packs of medicines, supported by appropriate pharmaceutical care, should be the preferred intervention for the supply of medicines in the absence of a specific need for an MCA in all settings. This is in line with the findings of the RPS working group looking at pharmaceutical care in care home settings in Scotland, in their report Improving Pharmaceutical Care in Care Homes.

A patient-centred approach to identifying the best intervention must be through a sustainable and robust individual assessment of both the level of care required by the individual, the reasons for both intentional and non-intentional non-adherence and the most suitable solution.
The RPS recognises that patient-facing pharmacists cannot fully implement the recommendations within this document on their own and that an integrated approach between health and social care, between commissioners and service providers, and amongst pharmacy bodies is required on the continuing journey to improve patient outcomes.

This summary confirms that MDS should not automatically be considered to be the adjustment of choice, and that other adjustments should be considered. Special consideration should also be given to the suitability or otherwise of the MDS for some medicines, and reminds pharmacists that removing medicines from their original containers is not without risk.

In the light of the recent professional guidance, the Sub-committee is asked to review the position taken on the impact of the Equality Act on the adjustments most pharmacies are required to make, and whether a request should be made to NHS England that an alternative distribution model be considered.

Executive summary from 'A strategic review of the future pharmacist workforce – Informing pharmacist student intakes'

The Centre for Workforce Intelligence (CfWI) was commissioned by the Department of Health (DH) to undertake a review to forecast and analyse the future supply and demand for the pharmacist workforce in England between 2012 and 2040. The report will support the DH, Health Education England (HEE) and wider Government in policy decision making to secure the pharmacist workforce of the future and the number of pre-registration trainees required.

Shape of the review

This review was driven by the need to provide sustainable, high-quality pharmacy services in a complex and evolving environment. The work was set in the context of the ongoing rise in pharmacist student numbers (more than doubling from 1999 to 2009 (MEE, 2011a)), and the Modernising Pharmacy Careers (MPC) Professional Board recommendation that the four-year pharmacy masters degree and pre-registration training year should be integrated into a single five-year course. Following ministerial consultation, it was agreed that this process should also consider the risks of an oversupply of MPharm graduates compared with the demand for qualified pharmacists and supply of pre-registration placements. (MEE, 2011b and DH 2012).

The purpose of the review is to consider how a complex set of factors interrelate to impact on the supply and demand of the future workforce. Short-term decisions may have a significant impact on the long-term availability of pharmacists in the workforce. Additionally, any immediate decisions by employers to reduce the number of funded training places could compound an imbalance between graduates and available training places. Therefore, it is important that local workforce planning is undertaken to inform decisions that may affect variations in supply and demand. In the short term, the focus is to support the MPC Professional Board's wider review of pharmacy training. In the longer term, the CfWI future pharmacist workforce review has a more strategic remit: to provide the evidence base for sustainable improvements in planning for the pharmacist workforce of the future, looking ahead to 2040.

Project approach

In this report, we share the results of a system dynamics model developed by the CfWI to forecast the supply and demand of the pharmacist workforce in England against a set of stakeholder-generated scenarios. The steps involved in this work include horizon scanning, scenario generation and workforce modelling. Our modelling shows the likely impact of certain variables on both the supply and demand of the pharmacist workforce. We used MPharm student data, pre-registration year data, and registered pharmacist data to forecast supply and demand based on a set of plausible scenarios facing the pharmacy workforce up to 2040 (a list of all data sources used in this project can be found in Appendix D).

The factors that work together to affect supply include MPharm student numbers and evidence-based attrition rates. We also looked at other factors for pharmacists joining and leaving the profession, including retirement.

There is a complex set of factors affecting demand. Our work reviewed changes in population growth and ageing, combined with trends in participation rates, and modelling assumptions informed by a Delphi process1 for each of our scenarios.

Stakeholders developed four plausible future scenarios describing the possible shape of the pharmacist workforce in 2040. These scenarios were chosen as they had the least predictability and the highest potential impact on the workforce. Whilst plausible, no single scenario is intended to be a direct prediction of the future. As a set of four scenarios, however, they produce a reasonable boundary within which the

future is likely to unfold. Two scenarios describe a future where technological advances result in pharmacists assuming a broadened role in healthcare, and two describe a future where technological advances result in pharmacists assuming a narrowed role in healthcare.

Key findings

In all four scenarios, supply is forecast to exceed demand, regardless of the pharmacist's role in healthcare. Therefore it is likely that there will be a surplus supply of pharmacists in the future. The possible range of oversupply by 2040 across all the plausible possible futures is between 11,000 and 19,000.

Recommendations and options for change

The CfWI recommends intervention to bring the supply and demand of pharmacists into balance. Given the likely oversupply of pharmacists in the future, it would be prudent to implement changes to the system that will optimise the output from education and training, with a view to reducing any potential unemployment risks that may accompany oversupply in the workforce. If there is no active policy intervention, future pharmacist numbers will be driven by market forces. Given the current planned changes to the training programme overall, and the potential for pharmacists to play a crucial wider role in community-based healthcare in the future, it is important to consider the risks associated with no active policy intervention at this stage.

The CfWI recommends a staged approach to balancing supply and demand to secure high-quality pharmacy services into the future. A staged change applied across multiple years can be used as a flexible, adaptive tool to bring supply and demand into balance. This would provide the greatest flexibility to manage the balance of supply and demand and reduce the risk of undersupply in the future. However, balance between the size and duration of the staged intervention is paramount.

This report considers a range of options, including initiating an active policy intervention aimed at optimising student numbers:

- at the entry point to university MPharm degrees
- at the entry to pre-registration.

The CfWI recommends on-going monitoring and periodic review of supply and demand, with a continued drive to improve data around the pharmacy workforce. The broad range of forecasts for the long-term future of supply and demand suggests it would be sensible to continue to monitor and review supply and demand, and any system changes affecting their balance in the medium-to-long term.

Additionally, the CfWI recommends a review of this work at least every five years with yearly monitoring, to ensure the impact of any intervention and emerging risks can be appropriately tracked. To improve the reliability of future modelling it would be advisable for a new pharmacy workforce census to be undertaken, as current modelling uses data from the most recent census in 2008.

Ensuring a sustainable supply of pharmacy graduates

Health Education England (HEE) and the Higher Education Funding Council for England (HEFCE) are seeking views to inform their response to a potential oversupply of MPharm graduates through one of, or a combination of, the following three main options:

- Allow the market to determine outcomes;
- Introduce intake controls; or
- Create a break point during study.

The aim is to secure a sustainable supply of MPharm graduates for the future, and the deadline for responses is the 15th November.

PSNC's main concern would be in any potential change to the funding which we negotiate for pre-registration places. We made our views clear during the MPC process that pre-reg funding is a PSNC matter. We would not normally comment on the number of graduates or student intake and did not respond to the previous consultation on student number controls (2014-15) which ran in May/June 2013.

This consultation has no specific funding proposals and therefore the first points to consider are:

- Does PSNC have the expertise to make the decision over whether a curb in numbers would a more effective measure over time than the other two options or whether leaving it to market forces would be better? And therefore:
- Should PSNC make a response or not?

Other points for consideration include:

- The effective curb on numbers is surely the number of pre-reg places so no matter how many students there are that is the restrictive point;
- Contractors and employees, and especially self-employed locums are expected to have opposing views. We represent contractors and therefore the first option with no limit, resulting in a larger workforce which would facilitate, for example, two pharmacists per pharmacy/ easy access to locums would be preferred;
- If the MPC recommendations to extend the MPharm course to five years and include the pre-reg year go through then this will also severely restrict intake numbers into courses unless there is a break point before the pre-reg point, for example at 3 years. This would make the third option favourable but with the following questions to be answered:
    - If a break was agreed, would it be made by student choice (possibly a favourite with foreign students), and/or exam results (the top x% going on to pre-reg year)?
    - What would these graduates come out with at the break point and how they would fit into the system as currently there is not a role for them as such?
- Would the profession appear less appealing to prospective students in the future if lower pay rates and large graduate numbers continue?

Appendix SDS 07/10/13

Sustainable Development Strategy Consultation Update

The Sustainable Development Unit, which works across the NHS, Public Health and Social Care system, has published a formal summary of responses from the consultation and engagement exercise to produce a sustainable development strategy. This strategy will be published in January 2014 and set out a clear vision and ambitions for the system through to 2020.
The key points are:

- The strategy will not just focus on reducing carbon but will have a broader scope and incorporate other aspects of sustainable development across an integrated and aligned NHS, Public Health and Social Care system;
- The overarching strategy document will be supported by a number of modules, one of which will be on leadership, engagement and development;
- These supporting modules will enables local health and care systems to select applicable areas and actions that match their locally determined priorities;
- The possibility of whether there could be national measures to assess sustainability across the health, public health and social care system will be explored;
- Carbon reduction will remain the driver and core indicator and monitoring of the NHS 10% carbon emissions reduction by 2015 will continue. However, a broader carbon footprint for the health and care system will be included in the strategy with the possibility of a waste/recycling metric;
- The most frequently recommended high-priority areas from respondents were:
    - Models of care
    - Commissioning
    - Pharmaceuticals

  It should be noted that Public Health and Local Authorities rated pharmaceuticals as their highest priority, whereas the NHS, Royal colleges and CCGs rated models of care highest;
- Staff engagement and training, procurement and travel were also identified as important areas for consideration in relation to reducing carbon emissions and indicators may be included in the modules supporting the overarching strategy;
- A whole system approach involving all organisations was strongly reinforced, and the need to engage and influence suppliers and the supply chain to behave more sustainably will be considered in the strategy;
- Respondents agreed that a priority for the strategy is to be measurable, achievable and realistic;
- A scorecard approach to measuring progress is to be considered which may include outcome measures linked to other outcome frameworks across the whole system to obtain a wide perspective of progress;
- Funding and resources to carry out many of the proposed changes has not been identified.

The Sustainable Development Unit is looking for case studies, especially those with community, social care or public health involvement, and any examples should be submitted to charles.kitchin@nhs.net.

Details of the consultation can be found at:
http://www.sdu.nhs.uk/sustainable-health/engagement-resources.aspx

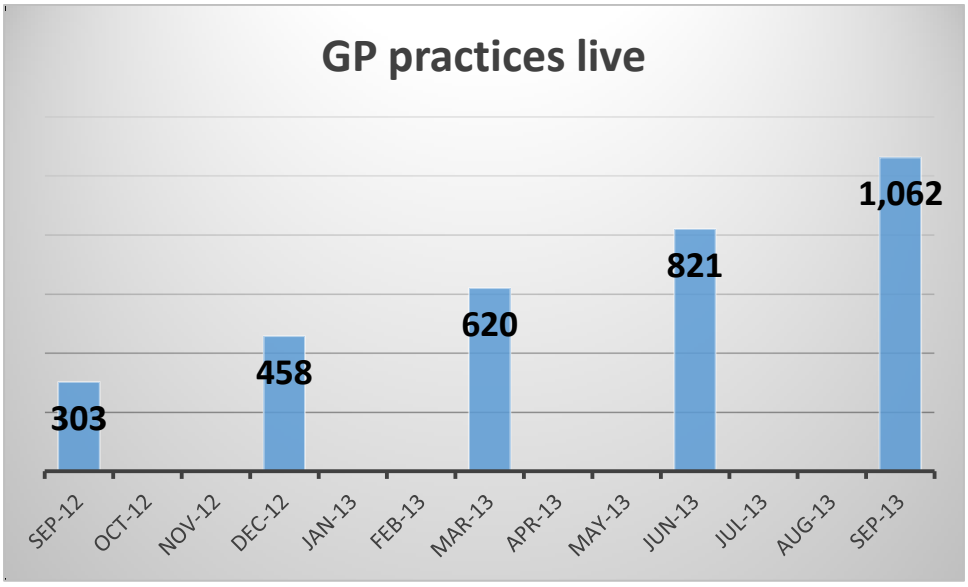
EPS Release 2 update

Seven pharmacy systems now have EPS Release 2 full roll-out approval, AAH Proscript Link, Cegedim Nexphase, Cegedim Pharmacy Manager, Helix Health, Positive Solutions Analyst, RX Systems Proscript and the Lloyds Compass system. An update from Pharmasys in July advised the company is still working towards achieving compliance: It has recently completed the development stage, and have moved into the final stage of accreditation. Since PharmaSys has been acquired by Helix Health, PharmaSys customers have had the option of transferring to the EPS R2 compliant Helix Health system while PharmaSys is still passing through the approval process.

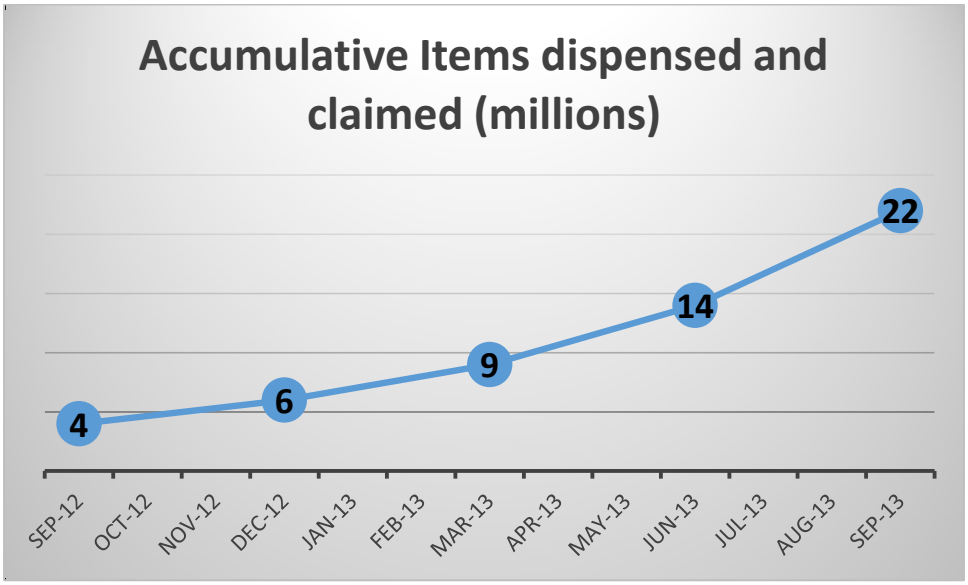
Four GP systems, EMIS Web, InPractice Vision, TPP SystmOne and Microtest Evolution 11 have been granted EPS Release 2 roll-out approval. In a trading update released in July, Emis Group said 174 former iSoft practices have migrated to Emis systems during the first half of 2013 and Emis expects to have obtained approximately two-thirds of the iSoft estate before support for the products ends next March. CSC said last September that it was withdrawing former iSoft products from the primary care market. The company said at the time that it would continue to provide support for the systems until at least 31 October 2013 for practices in England.

Authoritative information on the Release 2 development status of GP and pharmacy systems can be found on the Connecting for Health website (http://systems.hscic.gov.uk/eps/).

EPS Release 2 Deployment Statistics (Extracted 20th September 2013)	
EPS R2 enabled GP practices	1,062
EPS R2 enabled pharmacies	10,244
Number of R2 prescription messages to date	9,556,260 prescriptions containing 22,193,183 items have been dispensed
Number of patient nominations set	3,192,241



HSCIC are currently trying to significantly increase the number of GPs which are EPSR2-enabled. Under the 'new NHS', GPs can start to use the service when they wish rather than waiting for the PCT to go live as was previously required. As a result of this, there have been further increases to the number of GPs going live and an acceleration in the number of items having been claimed via EPS.



LPCs have been feeding back information on the status of local transition planning, and were invited to take part in a July survey. The results suggested an improvement since the previous survey on the same subject:

- 75% of respondents were confident that there would be a smooth transition; the remainder of LPCs were either concerned or declared they did not have enough information to know.
- All respondents said that transition was in progress, or had taken place, and half said an EPS lead had been appointed at the Area Team.

Issues arising from EPS Release 2 sites: There are consistent on-going issues arising from EPS R2 sites including inadequate training, and usability issues with PMR systems. Problems arising linked to the design of the EPS R2 system include inefficiencies linked to CD prescriptions not being able to be sent electronically. Particular issues are being reported linked to prescribers adding information to dosage instructions which would not be taken into account for pricing. Some problems can be resolved through guidance – in other cases there is a need to look at the design of the system, for example 'pushing' acute prescriptions to pharmacies rather than waiting for the pharmacy to check for these items on the spine.

A significant challenge to date has been inconsistency in local Registration Authorities ensuring locum pharmacists are able to gain appropriate smartcard access. National Operating Guidance issued earlier in the year, says that RAs must assure the Area Team that they can manage locum pharmacy staff and that this "is likely to include the use of the virtual organisation 'National Locum Pharmacy' with the organisation code FFFFF." However some LPCs have reported continued difficulties. As NHS England will ultimately be responsible for the provision of RA support, it is anticipated that there will be improved consistency in the application of RA policy.

Background information on EPS R2 can be found online at www.psnc.org.uk/EPS

Using community pharmacy to identify unpaid carers

Introduction

Carers Trust is the UK's largest charity for carers, with a network of carers centres and Crossroads schemes across the UK. It is managing a DH-funded project in partnership with the Royal College of GPs and Carers UK as part of the implementation of the National Carers Strategy. The programme aims to increase the identification and support of unpaid carers within primary care so that carers receive support before they reach crisis point.

Over recent years a number of carer-identification initiatives have been developed that have involved community pharmacies and Carers Trust network members. These have made use of the accessibility of community pharmacies to identify unpaid carers and refer them on to sources of local support and advice.

This work clearly fits with the aims of Carers Trust and its network partners, but it also fits with PSNC's vision for community pharmacies, which includes them providing support for people to enable them to live independently.

- 99% of the population – even those living in the most deprived areas – can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport;
- An estimated 1.6 million visits take place daily, of which 1.2 million are for health-related reasons;
- 84% of adults visit a pharmacy at least once a year, 78% for health-related reasons; and
- Adults in England visit on average 14 times a year.

Building on this work

Carers Trust and PSNC would like to see whether this local activity could be replicated in other areas of the country, where local pharmacies, Local Pharmaceutical Committees (LPCs) and carers centres are willing to cooperate in identifying and supporting unpaid carers. If the impact of such work can be assessed, this can add to the evidence base for community pharmacy services and their role in supporting people to live independent lives in the community.

This activity would form part of the signposting service within the community pharmacy contractual framework (CPCF), where people are referred to other sources of help and advice, beyond the pharmacy. It could be a topic for a public health campaign, which could also be undertaken at the same time by other health and social care providers.

What would it look like?

Community pharmacy teams would seek opportunities to identify unpaid carers and would discuss whether:

a) they were aware of local support for carers; and
b) whether they access any of the support that is available.

Identification of carers could be undertaken based on pharmacy knowledge of their patients, particularly where patient's representatives regularly collect a patient's prescriptions. Use of posters and leaflets in the pharmacy could also prompt identification of carers.

Carers would be provided with written information about local support available to them and where they wish to access that support, a personalised written referral note would be given to them by the pharmacy staff.

Previous experience suggests that referral notes personalised with the person's details can result in a higher number of people acting on the referral note. Referrals could rely on the carer approaching the carers centre, or the pharmacy team could pass a copy of the referral note to the carers centre to allow

them to proactively approach the carer. Both approaches could be options to use, depending on the view of the individual being referred.

The referral note would include details of the referring pharmacy and a unique reference number to allow assessment of the number of referred carers that actually had contact with the carers centre as a result of the pharmacy referral. This data could be reconciled from pharmacy and carers centre paper records, or an electronic solution could be used where the PharmOutcomes system is being used by pharmacies in the area.

The number of people being referred and the percentage of the total actually making contact with the carers centre would be the key outcome measure for community pharmacies.

Ideally the pharmacy team would receive feedback on whether the referred carer had accessed the support of the carers' centre, in order to provide positive reinforcement of the value of making referrals and to allow pharmacy follow up with the carer, if they are a regular visitor to the pharmacy.

EU Falsified Medicines Directive (2011/62/EU)

The Falsified Medicines Directive was adopted in July 2011. The Directive introduces a number of requirements across the supply chain:

1. In order to facilitate the authentication of the medicines it proposes the introduction of safety features on the packaging of medicines. All Prescriptions Only Medicines are within scope and all Over the Counter medicines are out of scope, unless a risk assessment determines otherwise. Repackagers will be integrated into this system;
2. It increases the transparency of the activities carried out by the intermediate agents of the distribution chain (wholesaler distributors, brokers and parallel traders);
3. It establishes certain measures in relation to the internet supply of medicines (such as a pan-European pharmacy logo and public awareness campaign);
4. It strengthens inspections of manufacturers of active substances (API), as well as increases the control of APIs exported from third countries;
5. It establishes stricter rules for inspections of agents involved in the distribution chain (apart from pharmacies), and also enhances the role of the EMA in those inspections; and
6. It increases the transparency of the information regarding certain agents involved in the distribution chain: an EU database managed by the EMA will publish certificates of good distribution practice issued for wholesalers following inspections, and a register of importers, manufacturers and distributors of active substances.

A number of key elements will not be implemented until the European Commission has published detailed technical rules under the "Delegated Acts" procedure. In relation to the system of safety features, the delegated acts will be published during Q3 2014, and member states will be required to implement the system at national level in late 2017.

There are a number of key questions for pharmacy:

- Will the Directive require authentication of products within pharmacy?
- If it will, could they authentication be performed at entry to pharmacy, or at the point of dispensing;
- Will all dispensary medicines be included?
- Will authentication delay the dispensing process?
- What costs will be incurred in implementing the system within pharmacy? (it should be noted that the manufacturers are responsible for the costs associated with providing a database – but not the costs associated with the process of authentication)
- Who will own the data generated by the system?
- Does this system offer wider benefits to pharmacy? (e.g. better stock control, fewer dispensing errors, lower risk of dispensing expired or recalled stock).

Management and governance of databases

Two organisations have put themselves forward as potential candidates to run the system of safety features and authentication:

EDQM (Council of Europe, Directorate for the Quality of Medicines and Healthcare)

The Council of Europe (NB, this is a completely separate organisation to the EU) is arguing that it is essential that a public governmental organisation provides the system of safety features and authentication. The EDQM has developed a system which could operate across 36 states, so its reach is further than the EU alone. Detailed technical and costing information is not available for this model, although it will rely on a unique serial number. Authentication will take place in pharmacy, with the option for others in the supply chain, including the patient as the final user, to run their own check.

ESM (European Stakeholder Model)

The ESM is a consortium of pan-European representative bodies EFPIA (branded manufacturers), PGEU (community pharmacies), GIRP (wholesalers) and EAEPC (parallel traders). This group argues that the existing supply chain is best placed to run an efficient system of serialisation and authentication. This consortium encompasses pharmaceutical companies (including Pfizer, GSK, AZ, Sanofi, Roche, etc.), pharmacy associations from all 27 EU member states (including NPA, RPS and PSNI) and wholesalers (Celesio and Phoenix). The major playing missing from this group is the European Generics Association, and work continues to seek a common position with them. This group has already appointed a provider to develop a central EU-hub, through which all individual product codes will enter the EU market. The EU-hub will download data to the relevant regional/national database, which will interact with pharmacies and remove serial numbers as items are dispensed.

UK Government position

The MHRA position on implementation of the safety features is not aligned with the current statements from the European Commission. The MHRA believes that only minimal work will be required to meet the requirement in the Directive to introduce safety features. For example, it believed that only very high-risk products (such as the 15 on its counterfeit watch list) would be included within mass serialisation. There are considerable risks to pharmacy if the MHRA and European Commission do not accept a common interpretation of the Directive in the near future.