

This guidance has been drafted by the Company Chemists' Association and the National Pharmacy Association for use by all community pharmacy contractors and is correct at the time of publishing (26 March 2020).

However, as it is subject to updates, please use the hyperlinks to confirm any information you are disseminating to the public is accurate.

Continuity of Pharmacy Services Planning Guidance

Covid-19 Pandemic 2020

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This guidance covers the considerations that can be made for the full transition from business as usual to managed closure.

At the time of publication, the community pharmacy network has already moved through to stage 3 and so we recommend focus is now centred around maintaining stage 3 and planning for moving to stage 4.

Scope of this document

This guidance is intended to act as a guide that all community pharmacy contractors can use to support them as they provide pharmaceutical services during times of crisis. By having a single set of principled guidance for all contractors the networks across England, Scotland, Wales and Northern Ireland, will be better placed to work collaboratively in order to maintain the supply of essential medicines and services to the public. The consistency of this approach will also help the public to understand what is happening, what to expect and where to go for their medicines and healthcare needs.

The principles in this document will serve 'worst case scenario' planning across pharmacy businesses in the event of a major emergency or major incident.

The guidance identifies the major stages of a managed cascade of maintaining pharmacy services for both individual pharmacies and for pharmacies working together to ensure the continuity of provision in a local area.

The triggers for enacting this guidance are outlined below

- A major emergency is declared, or a major incident has occurred **and**;
- The emergency or incident impacts the ability of contractors to deliver essential and non-essential services **and**;
- Contractors are unable to deliver essential or 'core' services within their own businesses **and**;
- The disruption to delivering core services lasts longer than 24 hours **and**;
- This disruption is likely to last for longer than two weeks.

The key principles behind the process steps for this guidance are:

1. Any contingency plans will be utilised when the triggers for enacting this planning guidance are engaged.
2. Company business continuity leads, whether local, regional or national, will need to decide when the triggers are engaged.
3. The redeployment of staff and stock will be agreed:
 - a) Among contractor businesses (considering any local measures that were agreed before the business continuity leads collectively agreed that the triggers were engaged), and then:
 - b) With other bodies including NHS.
4. Distribution of services will be recorded, and mutual aid agreements and reimbursement agreed (via PSNC/CPW/CPS/PSNI) once the major emergency is declared or a major incident has deceased, or at an appropriate opportunity (whichever is sooner).
5. The relevant NHS bodies (Area/Regional Team or Health Board) will be notified that a continuity plan has been actioned
6. All staff in each pharmacy will be aware of any contingency plan and the relevant contacts (see the separate example contacts template).
7. Contingency plan lead in each pharmacy will report to the Business continuity lead, regional leads (where applicable) and agree local continuity plan and agree which provisions can be shared across a local geography or an ask for provisions including staff resource and stock.

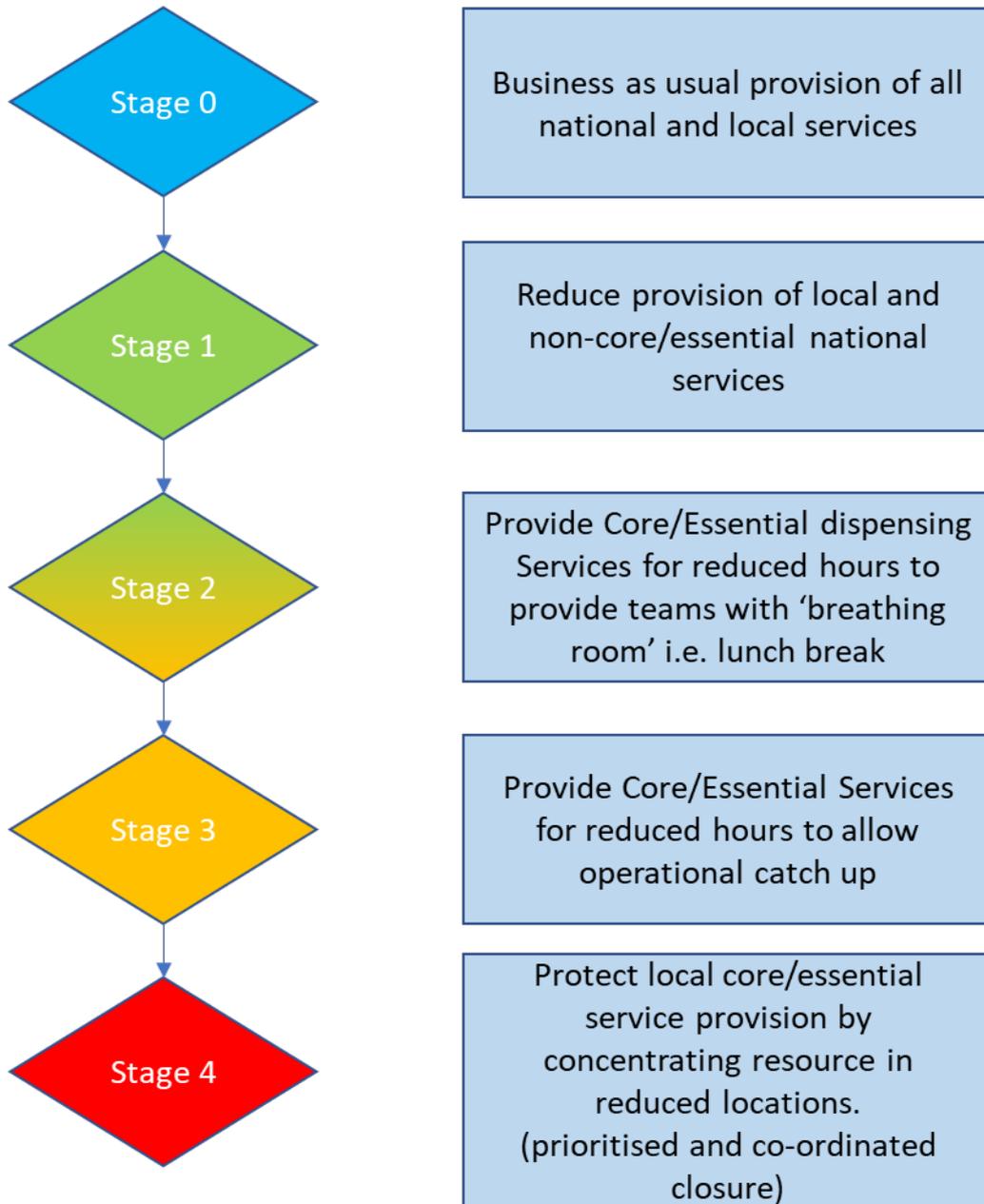
8. A risk assessment should be conducted, and resources shared only where deemed appropriate.
9. When decisions are being made regarding the sharing of resources consideration should be given to parameters based around locality and access. This may be based around the following:
 1. Health Centre/GP surgery pharmacies to be priority
 2. pharmacies serving large populations and with facilities for differentiated access (i.e. longer hours and locations that can offer sites suitable for pickups and testing such as supermarket car parks)
 3. Pharmacies that are close to another pharmacy that is offering better coverage to the local population and pharmacies that are unable to open even with additional resource or where there is no resource to facilitate opening.

This planning guidance **DOES NOT**

- Replace the need for pharmacy contractors to have and maintain their own Business Continuity Plans.
- Provide guidance on all aspects of contingency planning specifically relating to Covid-19
- Supersede any additional advice from GPhC, DHSC, NHSE, HSCB, PSNI, SG, WG etc

This planning guidance is intended to support the community pharmacy network by providing a consistent and coordinated approach to dealing with the significantly increased demand and reduced capacity caused by national emergencies and local major incidents.

Cascade of Pharmacy Service Provision



Stage 0: Full Service Provision

In order to maintain a full provision of services and care for customers and patients, pharmacies can consider the following.

Staff

- Pharmacy businesses should utilise all staffing resource available to them to deliver all services i.e. locum pharmacist, changing days off, changing agreed annual leave, increasing hours.
- Risk assess your pharmacy team based upon your knowledge of individual circumstances and latest guidance from Government and the NHS
 - Personal isolation
 - Family isolation
 - Caring responsibilities
 - Increased working pressures
 - Other reasons such as non-Covid related illness, holidays and days off
- Identify minimum staffing requirements for the delivery of each level of service provision (Core/Essential, National and Locally commissioned services) and refer to local guidance where available.
- When reviewing staffing levels in pharmacy consideration should be given to the utilisation of non-frontline staff, including registered professionals and other non-registered staff in support roles
- Identify roles and tasks that do not require the direct input from a pharmacist and ensure that the correct training and support is in place to allow others to step in, for example, but not limited to.
 - Taking in of Rx
 - OTC sales
 - Queue/customer management
 - Delivery drivers
 - Handling of delivery
 - Putting deliveries away
 - Call handling for non-clinical enquiries

Service

- Maintain full service provision
- Consider innovative methods of working, specifically using modern mobile and digital technology to enable the delivery of patient care and the safe and legal assembly and handing out of prescriptions.

Operations

- Identify all tasks that are not directly involved in the provision of services and consider delay or stopping

Communication

- Establish 2-meter exclusion between customers and staff
- Consider restrictions on numbers of customers allowed in the premises

- Produce clear communications and guidance for customers to explain operational changes
- [standard signage to be produced/shared]

Stage 1: Partial Service Provision

When it is no longer possible to maintain the full provision of all services pharmacies should review the non-core/essential contracted services they provide, prioritising them by customer need and ability to deliver.

Staff

- Prioritise deployment of staff to ensure service demand can be met
- Consider intra company sharing of staffing resource if applicable

Service

- Prioritise services based upon patient need and ability to deliver (with available resource)

Priority	Service examples and suggested actions
Category A - must continue	AMS e.g. dispensing of prescriptions; MAS, over the counter sales. PHS e.g. EHC. Palliative care, Rota and OOH. Will extend waiting times and ask patients to request urgently required prescriptions only
Category B – can be postponed for up to 24 hours	e.g. supervised administration – may postpone supervision for stable (all) patients for 24 hours and will inform Addiction Services
Category C - can be postponed for up to 72 hours	e.g. Smoking Cessation, supply only will postpone counselling (could suspend for longer depending on emergency?)
Category D - can be postponed for up to 7 days	MDS – ordinary dispensing for one week depending on emergency. BP monitoring
Category E - can be postponed for up to 28 days	Re-dispensing of medication into MDS for Care Homes. Weekly supply of prepared MDS trays for community dwelling patients - will give two or four prepared trays at a time to those patients with a carer (requires shared care risk assessment)

- Guidance available at <https://psnc.org.uk/the-healthcare-landscape/covid19/business-continuity/>
- and for Northern Ireland at <http://www.hscbusiness.hscni.net/pdf/Supervision%20Arrangements%20letter.pdf>

Operations

- Review cleaning procedures and ensure consultation rooms and chemist counters are clear and regularly cleaned.

Communication

- Update the correct contracting authority (for example, DoS in England or CP contract team at your Health Board)

- Clearly communicate with customers and patients which services are no longer available and which are being prioritised. Where services are no longer being provided customers and patients should be signposted to alternative locations for receiving care
- Inform local NHS area team of change to service provision (Possibility of National reporting systems solution to directly update NHS service databases in England)
- Inform local pharmacy network (via local pharmacy structures) of where usual service provision has been suspended

Stage 2: Maintaining Core Trading Hours

In order to support teams as they cope with increased demand pharmacies can consider adjusting their trading hours, for example closing for lunch and/or reducing supplementary hours (extended non-core hours). Supplementary hours may need to be reduced seeking agreement from NHS regional teams to reduce hours as quickly as possible (the normal notification period is 3 months).

Staff

- Ensure all staff have planned and enforced breaks to allow them to rest and recuperate.
- Consider condensing shifts to provide improved coverage throughout core hours
- Share staff with other pharmacies where they are needed if applicable
- Approach recent leavers to see if they are able to return on a temporary basis
- Consider recruitment of new temporary staff.
- In many local areas volunteer groups and networks are being established. Consideration can be made as to the suitability of engaging with these groups for support.
- Postpone all training (except that for new temp staff)

Service

- Continue to deliver core/essential dispensing services as well as critical advanced and enhanced service such as Common Ailments (Wales), the Community Pharmacist Consultation Service (England) and Pharmacy First (Scotland).
- Consider how a Responsible Pharmacist could support the provision of care in other locations (GPhC have said that they will support people making judgements in patients' best interests Click [here](#) to link to GPhC website)
- Approach local voluntary groups for support with deliveries

Operations

- Inform local NHS area teams of any changes to trading hours, whether temporary (24 hrs) or medium term in length, outside those agreed by government (devolved)
- Inform wholesalers of changes in opening hours and any access requirements if a delivery is due to arrive outside of new operating hours.

Communication

- Proactively engage with customers to update on pharmacy trading hours and signpost to locations where care is available outside of new hours
- Update the correct contracting authority (for example, DoS in England or CP contract team at your Health Board)

Stage 3: Scaled reduction in Trading Hours

Once the staffing resource available to a pharmacy business is insufficient to maintain the core trading hours for the delivery of essential services, then contractors should consider partial closures. This could mean either late opening and/or early closing, whilst maintaining assembly operations whilst the pharmacy is closed. In addition, pharmacies should consider coordinating lunchtime closures, to allow staff to have a suitable break and to help customers and patients understand when they can and cannot obtain pharmaceutical services (i.e. all pharmacies in a locality close for lunch between 1pm and 2pm)

Any closed door working, or full closures, outside of the current (subject to change) core hours agreed at a national level with national NHS bodies will need to be reported in accordance with normal reporting processes.

Staff

- Ensure all staff have planned and enforced breaks to allow them to rest and recuperate.
- Consider condensing shifts to provide improved coverage throughout core hours
- Consider increasing operational hours outside of trading hours
- Approach recent leavers to see if they are able to return on a temporary basis
- Consider recruitment of new temporary staff.
- Postpone all training (except that for new temp staff)

Service

- Continue to deliver core/essential dispensing services as well as critical advanced and enhanced service such as Common Ailments (Wales), the Community Pharmacist Consultation Service (England) and Minor Ailment Scheme (Scotland).
- Consider how a Responsible Pharmacist could support the provision of care in other locations (GPhC have said that they will support people making judgements in patients' best interests)
- Approach local voluntary groups for support with deliveries

Operations

- Update the correct contracting authority (for example, DoS in England or CP contract team at your Health Board)
- Consider reviewing and amending SOPs where appropriate
- Define which core services can be halted
- Inform wholesalers of changes in opening hours if deliveries are likely to arrive while no-one is at the pharmacy

Communication

- Recommend that NHS regional teams are informed with all reasonable promptness of any changes and for how long they will be in place
- Display signage highlighting reduced hours and reasons why. [See Appendix C]
- If possible, inform local GPs and the local LPC

Stage 4: Coordinated closures

Once a situation has been reached that pharmacy businesses can no longer offer core, or reduced trading hours of essential services then the view must be taken to work alongside pharmacies within the local area to pool resources of premises, people and products, in order to maintain the provision of essential pharmaceutical services for local communities.

Local pharmacy structures and company field teams can play a coordinating role in these situations, to ensure that priority premises are identified based upon geographical location and population served.

When establishing the priority of where to deploy share staffing resource consideration should be given to;

- Patient need. Pharmacies with highest existing patient demand should be supported, where capacity allows.
- Capacity – size of building/facilities and ability to scale up operations to meet increased demand
- Intra and inter organisational sharing of resource were appropriate and applicable
- Accessibility – can the premises be easily accessed by most of the local community
 - Consideration must also be given to natural and manmade barriers, such as rivers and motorways
 - Accessibility for staff, especially for those from other pharmacies and organisations
 - Accessibility for deliveries of medicines and stock
 - Capacity for deliveries to at-risk patients in isolation
- Population need- what is the patient demographic, how mobile is the local population
- NHS regional team/ Health Board guidance – does the local NHS regional team have a view of the distribution of pharmaceutical care
- Other

When a pharmacy is closed, for any significant period of time (>24hrs) consideration should be given to making provision for the existing business and resource to be transferred, temporarily, to another contractor. This transference will include staff, stock and data. Keyholder details for each pharmacy to be shared with local pharmacy structure (LPC/HB/HSCB)

Staff

Consideration should be given to

- Training
- Indemnity Insurance
- Access to premises
- Passporting (acknowledgement of third party accreditation)
- Acknowledgment of training
- Access to other businesses' premises
- Pay and other benefits
- Use of non-pharmacy staff (from other areas of the business)
- Access to GPhC/PSNI recently returned emergency register

Operations

- SOPs for new staff (people joining the pharmacy from third party organisations)

- New SOPs for new processes for existing and new staff
- Turn off automatic downloading of Rx from the spine
- In England, upload un-dispensed prescriptions back up onto the NHS spine
- Consider the managed and accounted re-distribution of stock either intra or inter organisation
- Consider the use technology to allow remote sign-in of Responsible Pharmacist (Click [here](#) to link to GPhC website)
- Confirm operating status daily to Head Office and local pharmacy structure
- Inform the Wholesaler that the pharmacy has closed so they do not make a delivery

Communication

- Display signage showing opening hours of the open pharmacy
- Display signage on the closed pharmacy signposting patients to the open pharmacy
- Inform local GPs and the local pharmacy structures

Decision making

For all movement between the stages as illustrated above, from ‘business as usual’ to ‘coordinated closures’, there need to be clear lines of delegated decision making. For some pharmacy contracts the business owners (contractors) works directly on their premises, for other contracts the owner or delegated decision maker can be remotely located.

The network needs to establish a suitable vehicle to enable the decision making required in such situations to be made in a timely manner, both at a very local level and at a wider, regional and national level.

For national/regional operators a single point of contact could be shared across the network. Local Pharmacy structures (LPCs/HSCB etc) could hold the contact details and coordinate business to enable decisions to be made.

Pharmacy Name	ODS Code	Pharmacy owner	Decision maker name/position	Contact details