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 9th July 2013

at The Grand Harbour Hotel, Southampton

starting at 1.30pm

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

1. Apologies for absence

No apologies for absence have been received.

2. Minutes

The minutes of the meeting held on 14th May 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 02/07/13** for consideration by the subcommittee.

ACTION / RATIFICATION

5. Pharmacy consumer survey

Over the next few months NHS England is developing a strategy for the NHS and a primary care strategy. In order to influence the development of these strategies and to support future negotiations with NHS England, it is proposed that a short survey of consumers be undertaken in volunteer pharmacies in order to capture views on the services consumers would wish to see commissioned in community pharmacies. If data is collated in time, it could also be used as part of lobbying at the three political party conferences.

More work needs to be undertaken to develop the concept, but the subcommittee is asked whether it would support the principle of undertaking a consumer survey.

6. Rural Working Group

Following the decision at the May meeting of SDS to appoint the chair and members to the Rural Working Group, a further communication was sent to all LPC Chief Executives to inform them of the appointments and to seek further nominations in areas where there was no appointee. A further two nominations have been received; neither is opposed:

North East: Rob Pitt, Independent member and Vice-Chair of County Durham and Darlington LPC
North West: Mark Stakim, Independent member of Cumbria LPC

Both have the support of their LPCs and as these are uncontested positions the subcommittee is asked if it wishes to appoint these members.

7. PSNC's vision for community pharmacy

Following the discussion at the last meeting of SDS on service development approaches that could be taken for medicines optimisation, a submission based on the outputs of the discussion was written and sent to the RPS Commission on the future models of care for pharmacy. This document has been further developed to provide a narrative that describes how PSNC's vision for community pharmacy (agreed in

2012) could be implemented within the CPCF.

It is intended that this document can be used in discussions with NHS England, DH and other NHS stakeholders and it can also be published to help contractors visualise how the CPCF could develop over the next few years. The draft document is set out at **Appendix SDS 03/07/13** for consideration by the subcommittee.

8. Public Health England

PSNC recently met with Prof Kevin Fenton, Director of Health and Wellbeing at PHE, to discuss the role of community pharmacy in public health. He is ambitious to make a difference and is supportive of community pharmacy's role in public health.

A report of the meeting is set out as **Appendix SDS 04/07/13.** As a result of this meeting, and in pursuance of the tasks set out in the SDS work plan, the office is developing, in conjunction with the Chairman of SDS, some options on how commissioning of public health services could be undertaken at a national level.

9. PSNC Evidence Awards proposal

It is important to continue to expand the evidence base for community pharmacy to support more commissioning of services. To encourage LPCs to submit existing evidence and to support LPCs and contractors to improve their evaluation techniques, it is proposed that PSNC launches an Evidence Awards. A proposal is set out at **Appendix SDS 05/07/13** for consideration by the subcommittee.

10. EPS – Change of pharmacy ownership and patients' consent for nominations to carry over

PSNC has previously been involved in agreeing guidance on EPS nomination, including the requirement that where there is a change of pharmacy ownership, nominations must be confirmed with patients within six months of the change taking place. Further changes to the nomination guidance have now been suggested by the HSCIC IG team, but these could have implications on workload for new pharmacy owners. The proposed changes were shared with the subcommittee for discussion.

11. Developing quality measures for inclusion in the CPCF

The Committee has considered quality measures on a number of occasions over the last 12 months. Following the last discussion group session in January and discussions with the negotiating team, a paper was sent to DH illustrating how the quality measures previously considered by the Committee could make up a four-year programme which included gradual implementation of the different measures.

We expect that discussions on this topic will shortly recommence with NHS England and DH and as a consequence the confidential paper previously sent to DH is set out in **Appendix SDS 07/07/13** (which remains confidential) for review by the Committee in the SDS discussion session on Wednesday morning.

The discussion session will consider whether the options previously suggested to DH are still appropriate and whether there are additional proposals which could be included in particular as a result of the recommendations in the Francis report. The summary of the Francis report included in the May 2013 meeting papers is set out at **Appendix SDS 08/07/13** for ease of access.

PSNC invited the NPA, AIMp, CCA, IPF, GPhC and RPS to a meeting on 2nd July to discuss their ideas on quality indicators which could be incorporated into the contract. Once the suggestions have been collated, these will be shared with the Committee.

REPORT

12. Monitor review of GP services

Following its Fair Playing Field review, Monitor is to examine the commissioning and provision of GP services in England to see if there are barriers preventing patients from securing access to the best possible care. The health sector regulator wants to hear from patients, GPs, commissioners and other providers of primary and secondary care. They are particularly keen to receive evidence on:

- Patients' ability to access GP services, including their ability to switch practices;
- The ability for new or existing providers of GP services to develop the scope of the NHS services they offer, including in new locations; and
- New models of primary care that local health communities are planning or considering and the potential barriers to these being implemented.

This is not a formal investigation under Monitor's enforcement powers, nor is it a review of the quality of individual GP practices in England. Under its primary duty to protect and promote the interests of patients, Monitor wants to increase its understanding of this part of the health sector at a time when it is operating under increased pressures. Monitor will publish an update and set out any next steps in the autumn 2013.

A PSNC submission will be made to the review, building on the points related to GPs within our submission to the Fair Playing Field review, which included the challenges related to GP records access and transmission of data back to the GP record by other providers. We will also highlight the role of community pharmacy in provision of 'flu vaccination and the current blocks to provision of that service due to the core contract sitting with general practice. If Committee members have other issues they wold like to be raised, please send suggestions to Alastair Buxton by 15th July.

13. Urgent and Emergency Care Services

Information on the NHS England review on Urgent and Emergency Care services is set out in the Health and Care Landscape update in the main committee agenda paper.

In addition to writing to NHS England to highlight the role that community pharmacy can play in this area, PSNC has encouraged LPCs to discuss the issue with area teams. As part of PSNC's membership of the Health Hotel, we will also be holding roundtable discussion sessions jointly with the Dispensing Doctors' Association on urgent care. A government health minster or shadow minister will participate in each of the sessions.

14. Pharmacy and Public Health Forum

A report of the meeting held on 18th June is set out at **Appendix SDS 09/07/13** for information. The work of the Forum is confidential until communications are approved by the Forum, so the report is to be treated as confidential.

15. New Medicine Service

In June a focus group for pharmacists/contractors on MUR and NMS was jointly organised with NHS Employers and Nottinghamshire LPC. The event was designed to seek feedback on the services, in particular to collate information on problems contractors may be experiencing and potential solutions. A second event is being held after the PSNC meeting in Southampton in collaboration with Hampshire and Isle of Wight LPC. The outputs of the meetings will be shared with the subcommittee at its next meeting.

Pharmacists from Sweden's Medical Products Agency (MPA) - the equivalent of the MHRA - recently visited PSNC to learn more about the MUR and NMS services. The Swedish Government has asked the MPA to develop proposals on how a medicines support service provided by community pharmacists can be introduced in Sweden. The experience of PSNC, LPCs and contractors in introducing MURs and NMS in England has provided valuable learning for the Swedish team, who attended the MUR/NMS event in Nottingham. The delegation also visited a number of pharmacies in Nottingham and Hertfordshire to learn more about the practical aspects of providing services from community pharmacists.

Entries to the Health Service Journal awards have been submitted proposing the NMS for the Primary Care Innovation and Primary Care and Community Service Redesign awards.

The Nottingham/UCL NMS evaluation team held a stakeholder event in late June to share initial findings from the evaluation and to gather the views of stakeholders on the service. The data collection is continuing, but early findings include:

- Pharmacies appear to be pragmatically accommodating the service alongside other competing priorities;
- Many pharmacists have adapted the NMS interview schedule to make it a more natural conversation, but that means some opportunities to probe patients on adherence may be missed;
- Most contact following recruitment is by telephone; and
- Patient feedback on the service is positive

16. Sustainable Development

The NHS has sustainability targets and although good progress has been made so far, more effort is required as current measures will fall short of achieving these targets. Transformational change is proposed and a draft Sustainable Development Strategy for the Health, Public Health and Social Care System 2014-2020 is currently under development after a consultation. A background paper is set out as **Appendix SDS 10/07/13** for information.

17. HEE/HSCIC Primary Care Workforce data collection

The Health and Social Care Act 2012 places a duty on all organisations that deliver care funded by the NHS to provide data on their current workforce and to share their anticipated future workforce needs. Following the publication by DH of information on the workforce minimum dataset, Alastair Buxton has contacted the HSCIC to discuss their plans for the collection of data on the primary care workforce, including the community pharmacy workforce. They are currently piloting data collection from GP practices in the south west, but don't yet have plans to start to pilot data collection from community pharmacies.

A meeting with Health Education England is being arranged to discuss the data collection, the appropriateness of some of the data points for community pharmacy, how the data would be used and to consider the commercial sensitivities that pharmacy contractors would have over its use and in particular its potential disclosure under FOI.

18. Report of a meeting with NHS England on IT

In May, PSNC wrote to NHS England, highlighting a range of issues about EPS. In June, PSNC met with Beverley Bryant, Director of Strategic Systems and Technology, NHS England and Rachel Habergham, EPS Programme Head (HSCIC) to discuss the matters raised in the letter and the future of EPS in general, as well as touching on other NHS IT issues.

A confidential report of the meeting is set out as **Appendix SDS 11/07/13** for information.

19. Any other business

Appendix SDS 02/07/13

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, a narrative document describing the options for development of services in the CPCF has been written for consideration by SDS.	Amber
Develop a business case and supporting documentation / resources to support the commissioning of public health	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	Red

services.		the Chairman of SDS for discussion with PHE.	
Develop a business case and supporting documentation / resources to support the commissioning of services to support independent living.	November	This work will be commenced in due course. A project to support the identification of carers is being investigated with a carers' charity.	Red
Develop a business case and supporting documentation / resources to support the commissioning of self-care/minor ailment services.	August	Current information on this topic is being compiled to create a business case which can be used at a local or national level.	Amber
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.	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 a meeting of the NMS Evaluation Advisory Group in February, where an update on the progress of the research was provided; another meeting of the group will take place in late July. AB has also had a bilateral meeting 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 directorate. Steve Lutener and Alastair Buxton will shortly be meeting with the central team of the operations directorate. 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. Alastair Buxton, Barbara Parsons and Sue Sharpe recently had a meeting with Prof Kevin Fenton (PHE) to open discussions on the role of community pharmacy in public health.	Amber
• 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.			

The vision for NHS Community Pharmacies

- the path to improved patient care

About PSNC

PSNC promotes and supports the interests of all NHS community pharmacies in England. We are recognised by the Secretary of State for Health as the body that represents NHS pharmacy contractors. We work closely with Local Pharmaceutical Committees to support their role as the local NHS representative organisations.

Our goal is to develop the NHS community pharmacy service, and to enable community pharmacies to offer an increased range of high quality and fully funded services; services that meet the needs of local communities, provide good value for the NHS and deliver excellent health outcomes for patients.

This document sets out PSNC's vision for the future of the NHS community pharmacy service and highlights examples of how the service could develop in order to achieve our vision.

About this document

In this document we describe PSNC's vision for community pharmacy services in 2016 and provide a narrative that describes services which could be commissioned to implement the vision. The narrative doesn't describe the only way the vision could be achieved, but in setting out an example, we hope it will help local and national service commissioners envisage what the future community pharmacy service could look like and how the community pharmacy network can help improve patient care and outcomes.

PSNC's vision for community pharmacy

In 2012 PSNC agreed a four-year strategy which is built around a clear vision for the community pharmacy service in 2016:

The community pharmacy service in 2016 will offer support to our communities, helping people to optimise the use of medicines to support their health and care for acute and long term conditions, and providing individualised information, advice and assistance to support the public's health and healthy living.

To achieve this:

- All pharmacies will provide a cost-effective and high quality range of services to their patients, encouraged by funding arrangements that motivate service provision, reward positive patient outcomes and offer sustainability to contractors. The value of pharmacy services to patients and the NHS and the wider savings which can be created by the effective use of pharmacy will be evidenced.
- Pharmacies will be fully integrated into provision of primary care and public health services, and will have a substantial and acknowledged role in the delivery of accessible care at the heart of their community.
- Pharmacies will be able to deliver a wide range of NHS services to support their customers and patients, and be able to offer services on equal terms to other primary care providers.
- Patients will be confident that when they access services from a pharmacy, the pharmacist and other members of the pharmacy team will have the skills and resources necessary to deliver high quality services. Effective communication will ensure seamless integration with other NHS care providers.

In some cases arrangements for the provision of pharmacy services may include patient registration. All patients will have a free and unfettered choice of pharmacy.

In 2012 PSNC confirmed via a survey of all community pharmacy contractors that this aspiration for community pharmacy is supported by the majority of the sector (98% of survey respondents agreed - 37% agreed strongly and 61% agreed).

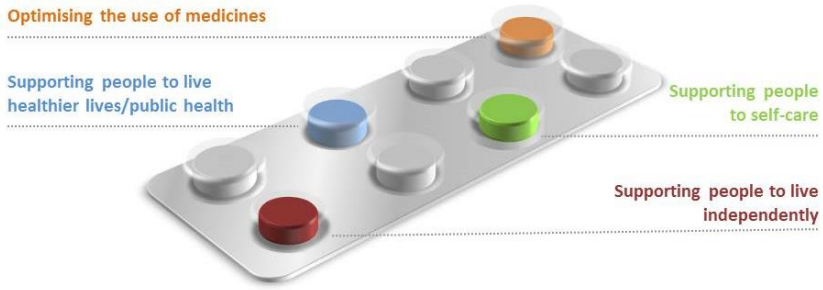
What will this mean to patients and the public?

In this model the patient sees their community pharmacist and the pharmacy team as health friend, ally and advocate: supporting them to manage their own health needs, and ensuring that they get support when they need it, either by providing services, being able to refer the patient to other sources of support or advocating on the patient's behalf with other members of the healthcare team.

Achieving the Vision

PSNC is working towards its vision by developing the community pharmacy service across four key domains:

1. Optimising the use of medicines;
2. Supporting people to live healthier lives/public health;
3. Supporting people to self-care; and
4. Supporting people to live independently.



The core Essential and Advanced services within the NHS Community Pharmacy Contractual Framework (CPCF) all fall within one or more of these domains.

In developing community pharmacy services across these four domains, we believe the NHS community pharmacy service can help the NHS to manage the financial constraints and increasing demands it faces, by becoming the basis of a third pillar, supporting NHS service provision alongside the traditionally dominant pillars of GP-led care and secondary care.

In addition to the national services, locally commissioned services provide a wide range of ways in which community pharmacies can improve healthcare for individuals and the wider population.

There are many examples of innovative community pharmacy services that have been developed at a local level over recent years and these could augment community pharmacy's third pillar.

They include:

- seasonal flu vaccinations;
- medicines optimisation work for respiratory diseases in South Central;
- sexual health screening including hepatitis, syphilis and HIV on the Isle of Wight;
- alcohol screening and brief intervention on the Wirral;
- anticoagulation monitoring in Knowsley;
- COPD/healthy lung screening in Essex;
- pneumococcal immunisation in Sheffield;
- tuberculosis therapy support in NE London;
- oral contraceptive supply in Manchester and LARC provision in Newcastle;

- MRSA decolonisation in Wakefield;
- reablement service on the Isle of Wight;
- aseptic dispensing of prefilled syringes for palliative care in Derbyshire; and
- phlebotomy services in Coventry and Manchester.

How can this be commissioned?

Most innovative community pharmacy services are first developed and commissioned at a local level; however the New Medicine Service (NMS) does provide an example of a new service commissioned within the national contractual framework, following initial proof of concept research.

The preference of PSNC is that once proof of concept and initial evaluation of a service has been undertaken, often at a local level, where there is a clear need for a new community pharmacy service in all areas, it should be commissioned at a national level within the CPCF, in order to ensure rapid spread of innovation and widespread population coverage. Such an approach, as demonstrated by the introduction of the NMS, allows the coordination of national and local support for service implementation and the efficient provision of education and development resources to community pharmacy teams.

PSNC does however recognise that this approach cannot be used for all service developments and the local approach to service development has frequently acted as an incubator of innovation, which can then be spread further afield, for example, the Healthy Living Pharmacy concept which was initially developed in Portsmouth, but which has subsequently been used in many areas across England.

Obtaining funding for new community pharmacy services or pilots has always been a challenge and the new tightened financial situation within the NHS only makes this challenge greater. Health economic data demonstrating the value of a new service is increasingly a pre-requisite to getting the service commissioned. However, even that cannot create a commissioning budget where one does not exist.

The recent reforms of healthcare should provide an opportunity for some money currently spent in secondary care trusts to be re-deployed to the commissioning of similar services closer to peoples' homes. This 'trickle-down effect' should support an increase in the number of services that can be commissioned from primary care providers such as community pharmacy. However, PSNC anticipates that where this shift of funding is achieved by Clinical Commissioning Groups (CCGs), it will often see services developed which will be provided by GPs.

On the face of it, greater general practice provision of services may not be welcomed by community pharmacy contractors eager to provide more services to the local population; however it may in fact present an opportunity for community pharmacy. This development could prompt the shift of existing workload within the general practice to community pharmacy, where there is a need to create capacity in general practices to allow the provision of new services previously provided by secondary care. GP recruitment challenges that are anticipated in many areas due to the retirement of a significant number of GPs over the next few years and the predicted shortage of nurses may also provide impetus for the shifting of specific tasks to community pharmacy.

In this scenario there would be no barrier for community pharmacy related to the need to evidence the health economic benefit of a service, as this will have been demonstrated previously when the service was first commissioned from GPs. It would however be necessary to demonstrate that community pharmacists and their teams could provide the service as competently as general practice teams and for an appropriate price.

Embedding more medicines optimisation support within the Dispensing service

All pharmacies provide the dispensing service and adding additional elements to this service to provide further support for medicines optimisation, particularly patient safety, could be a way to rapidly increase

the contribution of community pharmacy to this agenda.

A range of enhancements could be developed, but one example which is currently being tested within the Community Pharmacy Future project, is the application of STOPP (Screening Tool of Older Person's Prescriptions) and START (Screening Toot to Alert doctors to Right Treatment) indicators during the dispensing process in order to identify potentially inappropriate prescribing or circumstances where additional prescribing may be warranted, based on NICE and other guidelines.

Evidence based indicators, such as STOPP/START, could be applied to all prescriptions dispensed in order to highlight medicines optimisation interventions which may require a discussion with the patient and / or prescriber. A standardised dataset could be used to record interventions undertaken and to record outcomes. A standardised approach to communicating with GP practices could also be utilised, similar to the approach used for the Medicines Use Review (MUR) and NMS services.

The use of evidence based, nationally agreed indicators could support a focus on specific disease areas, or high risk medicines which are currently driving cost and / or patient harm. The set of indicators could evolve over time to focus on new therapeutic areas and to respond to emerging issues.

Community pharmacy supporting medicines optimisation

The nationally commissioned NMS and the MUR service both support patients to optimise the use of their medicines. But notwithstanding the recent targeting of the MUR service towards priority groups of patients identified by the NHS, the two services do not currently fit firmly within locally or nationally agreed care pathways for patients with specific long term conditions.

PSNC therefore believes that the development of the medicines optimisation services within the CPCF could start by focussing the provision of MUR and NMS on one or more patient cohorts. For example, people with asthma and COPD could all be offered annual support via an MUR and additional support when a new medicine is added to their regimen, via the NMS. This would necessitate the provision of the two services by all pharmacies and registration of patients to an individual pharmacy may also be required to allow the management of the service by commissioners and appropriate funding flows to contractors.

This approach to medicines optimisation would see community pharmacies taking responsibility for provision of specific support to a cohort of patients, which would allow, where appropriate, the community pharmacy support to be embedded within local or national disease management pathways and NICE quality standards. In this way, patients and other healthcare professionals involved in the care of the patient would have certainty about what support community pharmacies would provide to patients, thus supporting team working across primary care.

The choice of the initial patient cohorts would be a matter for agreement with commissioners and other stakeholders, in light of the clinical and economic priorities at the time.

With a registered patient cohort, it would be possible to implement patient outcome measures for the pharmacy services against which community pharmacies would be held to account and also rewarded where appropriate outcomes are achieved.

One of the failings of the current MUR service is that it generally can only be provided once a year to each patient. This episodic approach prevents the provision of longitudinal care to the patient over the course of the year, which is probably needed in order to have the maximum positive impact on optimising the patient's use of their medicines. A second stage of development of medicines optimisation services may therefore be to encompass the support provided by MUR and NMS within a new service focussed on a specific patient cohort, which allows more frequent interventions with the patient over the course of their year of care.

Over time and assuming that this approach delivered positive patient outcomes, the range of conditions covered could be extended.

The next level – long term condition management

The development of the medicines optimisation services described above could take place alongside a move to support more active management of long term conditions. Currently many long term conditions are managed in general practice by practice nurses. Diseases such as asthma, hypertension and diabetes are managed in line with the structured guidelines provided by NICE and other institutions. As described above, there may be a need to release capacity in general practice to take on the management of more complex diseases, currently managed in secondary care, or to allow more active case management of high risk patients. This may therefore create the opportunity for community pharmacies, in collaboration with general practices, to manage specific patient cohorts, or at least to undertake specific elements of disease management detailed in care pathways and quality standards.

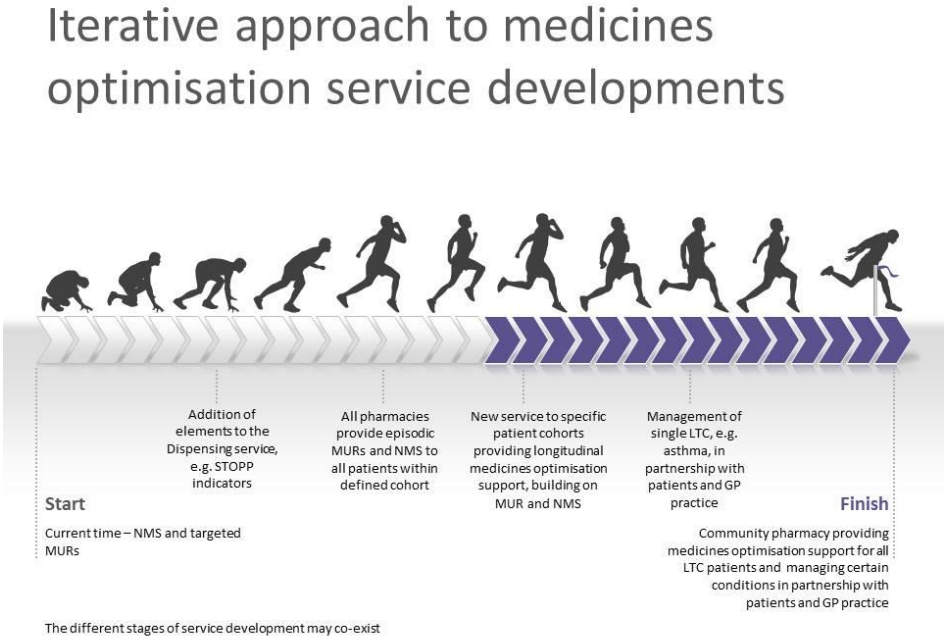
For example, the recently published NICE quality standard for asthma requires patients to be offered an annual review of their condition. Traditionally this type of review has been undertaken in general practices by practice nurses. The review includes an assessment of the patient's medicines and their use. With a small amount of extra training and with the availability of appropriate monitoring equipment, e.g. a spirometer, it is likely that the annual review described by NICE could be undertaken in community pharmacy. PSNC is currently exploring opportunities to test this concept within a discrete geographical area.

Other disease areas which may be similarly amenable to community pharmacy management include COPD, Parkinson's disease, hypothyroidism, hypertension, type 2 diabetes and poorly managed pain.

Selection of a disease area would need to be informed by the priorities of the service commissioner and the views of other stakeholders, in particular GPs. A key barrier to the extension of pharmacy's role in managing long term conditions has been resistance from other healthcare professionals. We believe focusing on one disease area, such as asthma or hypertension (in patients with no co-morbidities), could serve a dual purpose in boosting community pharmacists' confidence in dealing with patients on a regular and long-term basis, but also in giving other professions confidence in pharmacy's ability to manage patients on this basis working in collaboration with other healthcare professionals.

We recognise that this approach does not fit with the generally held desire within healthcare to treat people with multiple morbidities in a holistic manner; however we believe this approach is necessary to start with in order that pharmacists and their teams can develop experience of managing one condition before they go on to provide support to people with multiple morbidities.

The above options for iterative service development are summarised in the graphic below.



Some stages of the development may co-exist, e.g. additional elements in the Dispensing service could continue to be undertaken when the more developed long term condition management services are implemented.

The services could all be commissioned within the national CPCF, but it is likely that the services focussed on management of specific long term conditions may have to be commissioned at a local level, at least to start.

Supporting people to live healthier lives

All community pharmacies provide healthy living advice to patients as part of the public health element of the CPCF and provision of relevant healthy living advice is also a component of the MUR and NMS services. The majority of community pharmacies will also provide at least one locally commissioned public health service, such as provision of EHC, stop smoking or supervision of methadone and buprenorphine.

We envisage that locally commissioned public health services will continue to spread across the country in line with local needs identified by local authorities. The Healthy Living Pharmacy (HLP) framework provides a positive approach to focussing the pharmacy team on promotion of healthy lifestyles and associated service delivery. The development of support staff skills and increased motivation to provide services has been a positive achievement of the HLP concept.

Innovative services such as the Isle of Wight sexual health screening for hepatitis, syphilis and HIV are likely to continue to be developed by community pharmacy contractors, Local Pharmaceutical Committees (LPCs) and innovative public health commissioners in response to specific local challenges. Many public health services are not suitable for commissioning at a national level within the CPCF, however, some services, such as supervised consumption of medicines for the treatment of substance misuse or provision of emergency hormonal contraception, there is sufficiently widespread need across all areas that it could be considered for commissioning from all community pharmacies.

Likewise some public health services, such as seasonal influenza vaccination, could be commissioned from community pharmacies on an any qualified provider basis. A great many pharmacies already provide this service on a fee paying basis, but NHS commissioning of the service from community pharmacies has

been relatively limited. There is evidence of community pharmacies being able to increase vaccination rates in at-risk groups, where the service is offered over and above the incumbent NHS provision by GP practices.

Local experience suggests that the service has not been widely commissioned from community pharmacies, despite the positive evidence of increased vaccination rates achieved, due to negativity from GP practices about the increased competition which would result from pharmacy provision. It would also be possible to use the community pharmacy vaccinator workforce to support other immunisation programmes, such as childhood vaccinations and the recently introduced MMR catch-up programme.

Supporting people to self-care

Community pharmacy's traditional role in supporting people to self-care for minor illnesses is an important way in which to manage demand for other NHS services, in particular general practices. However, the wider promotion of pharmacies as a location to treat minor illness and the national commissioning of a minor ailment service to provide care at NHS expense to those who would otherwise visit the GP practice could bring a number of advantages. It could increase choice and improve access to services for patients; free up more capacity in general practice; avoid unnecessary visits to A&E departments; and also support the appropriate management of people using the NHS 111 service.

Research commissioned by PAGB and PSNC and conducted by IMS in 2007, revealed that the treatment of minor ailments accounts for 18-20% of GP workload, incurring a significant cost of around £2 billion a year to the NHS. It was estimated that annually 57 million consultations are for minor ailments (51.4 million of which are for minor ailments alone), resulting in over an hour a day of consultation time for every GP and the writing of 52 million prescriptions.

PSNC and LPCs have promoted the national commissioning of a minor ailments service for many years and in the 2008 Pharmacy White Paper the then Government proposed that a national service should be discussed by DH and NHS Employers with PSNC. During those discussions the principal block presented to progress was the inability of DH to reallocate funding in the GP contract to community pharmacy, in order that DH did not 'pay twice' for the management of patients with minor illness. The role of NHS England as the commissioner of all primary care contracts, including community pharmacy and general practice, now presents an opportunity to re-visit this issue.

The commissioning of a national community pharmacy minor ailments service alongside a sustained information campaign aimed at the public on appropriate use of NHS resources could 're-train' the proportion of the population that default to use of A&E or GP practices when they could safely access treatment at a community pharmacy. This wholesale change in pubic behaviour requires concerted effort by the NHS over a lengthy period and the uniform availability of services, so a consistent message can be directed at the public across all areas. The subsequent benefits of reducing pressure on A&E services and creating time in general practice which can be re-deployed to coordination of care for patients with complex needs could have much wider benefits for the healthcare system and patient outcomes.

Supporting people to live independently

England's changing demography and the increase in the number of people with life changing conditions such as dementia require that all healthcare providers examine how they can respond to the changing needs of their local population. Community pharmacies already provide a range of services to support people to live independently in their own homes, including:

- support with re-ordering repeat medicines / the NHS repeat dispensing service;
- home delivery of medicines to the housebound;
- appropriate provision of multi-compartment compliance aids and other interventions such as reminder charts to help people adhere to their medicines regimen;
- reablement services following discharge from hospital;

- falls assessment / reduction services; and
- signposting patients or their carers to additional support and resources related to their condition or situation.

Some of these services will also support formal and informal carers to continue to support their clients or friends / relatives to live independently.

The medicines optimisation services described previously can assist people to adhere to their medicines regimen which ultimately may prevent or delay the development of complications from long term conditions which eventually necessitate care in a hospital or care home.

Supporting adherence to medicines via 'compliance aids' has often not been effectively targeted at patients who would benefit most from such support. The development of a validated assessment that could be used in community pharmacies and elsewhere to determine the most appropriate and safe support to be provided would be of great benefit to patients and healthcare professionals. National agreement on the use of an appropriate assessment tool would assist pharmacies in providing appropriate support to their patients and this is something that the Royal Pharmaceutical Society, as pharmacy's professional leadership body, could lead work on, in collaboration with other interested bodies.

The application of assistive technologies to support people to live independently in their own homes will increase over the next few years. Pharmacy has already started to provide some such support, including the use of automated medicine dispensers. Providing guidance to patients on the selection and use of such technologies could increasingly be a role that community pharmacy teams play in order to support independent living.

Conclusion

England's community pharmacy teams already play a vital role in supporting the nation to remain healthy or manage disease when it develops. There are many opportunities to enhance their already significant contribution to healthcare, maximising the benefits of the network of pharmacy locations across the country, near where people live, work and shop. NHS England can facilitate this greater contribution by enhancing the range of national services commissioned via the CPCF, alongside greater local commissioning.

Pharmacy's contribution to healthcare can also be enhanced by greater team working across primary care; closer working relationships with general practice are particularly important. NHS England's area teams and CCGs have an important role to play in facilitating such relationships at a local level. Community pharmacy itself also needs to demonstrate the ability to provide services to a consistently high quality in order to enhance its relationships with GPs.

Appendix SDS 04/07/13

Notes from meeting with Kevin Fenton, Director of Health and Wellbeing, PHE

Present – Sue Sharpe, Barbara Parsons, Alastair Buxton

As Director of Health and Wellbeing, Kevin Fenton is responsible for:

- design and delivery of national health and wellbeing programmes delivered through and by the NHS and local authorities;
- cancer screening programmes, and national screening programmes for genetic diseases and other conditions;
- supporting programmes to combat the effects of drugs and alcohol and promote recovery;
- development and delivery of national health marketing campaigns including Change4Life and Stoptober; and
- coordinating prevention and early intervention programmes delivered across the lifespan, focused on major killers including smoking, obesity, mental health, HIV, and alcohol and drugs.

Following introductory comments from PSNC describing the public health services provided by community pharmacies, Kevin Fenton listed his priority areas:

- NHS Health Checks
- Tobacco control
- HIV & sexual health
- Obesity
- Alcohol and drugs
- Vaccination
- Screening

Kevin Fenton had recently met with DH (Gul Root and Jeannette Howe) and was very enthusiastic about the role community pharmacies can play in tackling public health issues. Considering this potential and the good leadership that pharmacy appeared to have, he posed two questions:

1. Why is community pharmacy not moving forward on public health service provision more quickly? and
2. Is there a problem with relationships with GPs which is impacting on moving forward?

A conversation on the local blocks to commissioning services followed, reflecting on the experience of LPCs and pharmacies working with PCTs. Solutions to some of these issues were discussed and Kevin Fenton stated that community pharmacy needed to emphasise in its messaging to commissioners the ability of the sector to respond flexibly to public health needs. The sector also needed to address GPs concerns about community pharmacy service provision, by demonstrating the quality of the services being provided.

PSNC highlighted the opportunity for PHE to influence the choice of the six public health campaigns run as part of the CPCF. Kevin Fenton was unaware of these campaigns and was very positive about PSNC's proposal for some or all of the campaign topics to be set nationally, in order to make best use of the resources available within PHE's nationally managed campaigns, e.g. Stoptober.

Actions agreed included:

1. PSNC to provide a resource pack for PHE leaders, explaining what community pharmacy can provide that addresses the PHE priorities. This can be used to promote community pharmacy internally within PHE and to external audiences.
2. As part of the resource pack, provide a PowerPoint presentation with key data on community pharmacy which KF and Duncan Selbie can incorporate into presentations they give to LA and other audiences.
3. KF will talk to his counterparts at the LGA to assess their awareness of and views on community pharmacy.
4. KF agreed to do a video interview with SES talking about his passion for community pharmacy services.
5. PSNC to map the LPCs to the 15 PHE centres and provide contact details so KF can ask his staff in the centres to make contact with the LPCs.
6. KF agreed to speak at a PSNC event, subject to diary commitments.

Appendix SDS 06/07/13

Proposal for PSNC Evidence Awards

It is proposed that PSNC launches two awards for LPCs aimed at improving and increasing the evidence base for community pharmacy services.

Award One - PSNC Evidence Awards

Proposal

The importance of evidence for the effectiveness of services has increased with the recent changes in the healthcare system. PSNC receives a great deal of information from LPCs when new local services are set up, but very few reports, either interim or final when services are assessed or evaluated.

PSNC will call on all LPCs to look for existing service evaluation reports for current or previously commissioned local or national services and send them to PSNC. These submissions can be used to enhance the evidence base for pharmacy services, benefiting PSNC, LPCs and community pharmacies in their discussions with commissioners. LPCs may also hold evidence which has otherwise been misplaced in the transition of services from PCTs to CCGs and LAs.

Relevant evidence can also be shared with Public Health England and can be added to the evidence base being collated by the Pharmacy and Public Health Forum.

To encourage LPCs to submit evidence, the reports will be sifted by an Awards Panel (tbd but to include sponsors) to a final 6-8 using a scoring matrix and four Awards of £500 will be made at the LPC Conference. The final voting, based on paper summaries of the final 6-8 entries, will be made by the LPCs themselves on the day using the interactive voting system. The winners will also be given the opportunity to present at the Community Pharmacy Conference (with two free places).

The prizes can be spent by LPCs as they see fit but a suggestion would be to use for training on research/evaluation or attendance at a conference.

As we would like to collect as much evidence as possible, there would be no specific classification, so any service, including public health or medicines optimisation, could be entered and the evaluations, which need not be peer reviewed, can be interim or final. A simple entry pro-forma will be prepared setting out the criteria for submission. This could take the form of a poster pro-forma which could then be printed for display at the LPC Conference.

Additional notes:

- Evidence received can be summarised for use by LPCs;
- PSNC Partners will be approached first to sponsor but if they do not sponsor then non-Partners will be approached.

Award Two – New Evaluation Project

Proposal

The quality of evidence produced by service evaluations is crucial. LPCs will have seen the business case for seasonal flu vaccination services produced by Pinnacle Health which is backed by peer-reviewed evidence and designed to include local data.

This is the kind of evidence based material that LPCs will need to support them in the future. We need to encourage LPCs to undertake more, high quality evaluations of services to ensure that the amount of evidence collected increases and that it is consistent. LPCs should be encouraged to ensure service evaluation is a key part of the service development process. Using a consistent approach to recording data for commonly commissioned services and assessment of outcomes using a standardised approach will help create comparable data from different part of the country.

To support this, Pinnacle Health has agreed to sponsor an award and support a new evaluation project.

LPCs will be asked to submit proposals for evaluation of services which are commissioned or already have agreement for funding and are about to commence.

Master Class proposal

To further support LPCs to better understand and improve the evaluation of their services, it is proposed that a Master Class for LPCs is organised which will provide a basic introduction to service evaluation. This may be organised in partnership with a school of pharmacy with relevant experience, and possibly with a Pharma company where they have relevant experience in health economics.

The Francis Report – implications for community pharmacy

In late March 2013 the Department of Health (DH) published 'Patients First and Foremost' the initial Government response to the report of the Mid Staffordshire NHS Foundation Trust Public Enquiry.

In an accompanying letter to Chairs of NHS Trusts, Jeremy Hunt, Secretary of State for Health said:

'This is a call to action for every individual and organisation within the health and care system, to reflect on our behaviours and priorities. I know that many of you are delivering outstanding care, and this should not be taken as a negative reflection on the hard work that many in your organisations are doing to respond to the many pressures facing the NHS. However there are lessons for all of us to learn from the appalling events at Stafford Hospital, and it is important that we do so.'

The response is divided into five areas, designed to improve the care that people receive from the NHS:

1. Preventing problems;
2. Detecting problems quickly;
3. Taking action promptly;
4. Ensuring robust accountability; and
5. Ensuring staff are trained and motivated.

The recommendations of the Inquiry focussed on acute hospitals and so too does the response to the Inquiry, however, DH states that many of the messages from the Inquiry are equally relevant to other health and care settings. Issues such as the culture of care and the vital importance of listening to and being open with patients, their families and advocates apply across the health and care system.

A summary of the main points in the documents and the actions listed by DH are set out below:

1. Preventing Problems

- A Chief Inspector of Hospitals will be appointed by CQC to lead inspection and highlight where standards are not being met.
- Time to Care – DH will ensure that paperwork, box ticking and duplicatory regulation and information burdens are reduced by at least one third.
- The Health and Social Care Information Centre will act as a single national hub for collecting information, and it will have a duty to seek to reduce the information burden on the service year on year.
- The Berwick Review - Prof Don Berwick, former adviser to President Obama, is working with NHS England to ensure a robust safety culture and a zero tolerance of avoidable harm is embedded in the DNA of the NHS.

2. Detecting Problems Quickly

- The CQC Chief Inspector of Hospitals will make assessments based on judgement as well as data. The Chief Inspector will be supported by expert inspectors (rather than generalists) who have 'walked the wards, spoken to patients and staff, and looked the board in the eye'.
- The Chief Inspector will become the nation's whistle-blower – naming poor care without fear or favour from politicians, institutional vested interests or through loyalty to the system rather than the patients that it serves.
- A 'comply or explain' approach to known good practices will be used in inspections. So, where there are well-established practices that benefit patients, inspectors will expect to see these being used across hospitals or a valid explanation given if this is not the case.

- The CQC will be given the power to conduct ratings at the earliest opportunity and will work with the Nuffield Trust to develop these proposals further. This will ensure that there is a single version of the truth about how hospitals are performing, not just on finance and targets, but on a single assessment that fully reflects what matters to patients.
- A Chief Inspector of Social Care will be appointed who will adopt a similar approach to social care and will be charged with rating care homes and other local care services, promoting excellence and identifying problems.
- Publication of information at a department, specialty, care group and condition-specific level. Initially this will see an extension of the transparency on surgical outcomes from heart surgery, to cardiology, vascular surgery, upper gastro intestinal surgery, colorectal surgery, orthopaedic surgery, bariatric surgery, urological surgery, head and neck surgery and thyroid and endocrine surgery.
- Implementation of penalties and possibly additional legal sanctions at corporate level for organisations that are found to be massaging figures or concealing the truth about their performance.
- Create a statutory duty of candour on providers to inform people if they believe treatment or care has caused death or serious injury, and to provide an explanation.
- A ban on clauses intended to prevent public interest disclosures.
- Complaints Review - a review of best practice on complaints to ensure that when problems are raised, they are heard, addressed and acted upon, and seen as vital information for improvement rather than irritations to be managed defensively.

3. Taking Action Promptly

- CQC, working with NICE, commissioners, professionals, patients and the public, will draw up a new set of simpler fundamental standards which make explicit the basic standards beneath which care should never fall.
- Introduction of a time limited hospital failure regime for quality as well as finance.

4. Ensuring Robust Accountability

- The Health and Safety Executive to be able to apply criminal sanctions where the Chief Inspector identifies criminally negligent practice in hospitals.
- Faster and more proactive professional regulation - as part of the implementation of the Law Commission's review, DH will seek to legislate at the earliest possible opportunity to overhaul 150 years of complex legislation into a single Act that will enable faster and more proactive action on individual professional failings.
- Introduction of a national barring list for unfit NHS managers.

5. Ensuring Staff are Trained and Motivated

- Healthcare Assistant training and practice for up to a year to be undertaken before people undertake NHS funded nursing degrees.
- Introduction of revalidation for nurses.
- Publication of a Code of Conduct and minimum training for Healthcare Assistants.
- Introduction of a barring system for Healthcare Assistants
- The NHS Leadership Academy will initiate a major programme to encourage new talent from clinical professionals and from outside the NHS into top leadership positions.
- Frontline experience for DH staff - within four years, every civil servant in the Department will have sustained and meaningful experience of the frontline with Senior Civil Service and Ministers leading the way.

Implications for community pharmacy

Some of the actions and issues raised in the Government response and the Francis report that could be applied to community pharmacy are detailed below. Some of the points are areas where action has already

been taken by community pharmacy, but where additional effort may be required to meet the vision included in the Francis report.

PSNC undertook an initial review of the Francis Inquiry report and the initial DH response to the inquiry's recommendations at its meeting in May 2013. A further discussion on the topic and in particular its relevance to quality standards in community pharmacy will be undertaken at the July 2013 meeting of the Committee. PSNC plans to work with the other pharmacy bodies over the next few months to consider the actions community pharmacy needs to take in response to the report.

1. Development of (quality) standards for services (fundamental, enhanced and developmental standards).
2. Development of evidence based standard procedures, e.g. for provision of medicines optimisation services.
3. Increased patient safety incident reporting and appropriate feedback following reporting.
4. Development of outcome measures for services.
5. Development of risk management standards.
6. Improving complaints handling processes and learning from complaints.
7. Being alert to concerns raised by patients about other services, and taking necessary action to raise these concerns on behalf of patients.
8. Embedding a culture within community pharmacy that supports the raising of concerns and open discussion about care and system failures in order to improve future patient care.
9. Implementing the duty of candour and ensuring that is part of the culture of community pharmacy practice (but recognising the need to tackle decriminalisation of dispensing errors).
10. Enhancing the caring culture within community pharmacies.
11. Enhancing team working in primary care and between primary care and secondary care, in particular to support transfer of care for individual patients, when they move from one care environment to another, e.g. living in their own home to a care home.
12. Access to shared clinical records to facilitate improved patient care.
13. Building robust follow up of patients into community pharmacy services.
14. Creation of a system to support collation of real-time performance information on community pharmacy services.

As previously stated, many of the recommendations within the Francis report focus on secondary care services, but some of these 'hospital specific issues' may map across to support community pharmacies provide to care homes.

Sustainable Development

The Government is committed to sustainable development, which is about balancing social, economic and environmental considerations, meeting the needs of people now and in the future.

A sustainable development approach to health and social care is effective in:

- Improving the quality of life of people who use services;
- Reducing health inequalities;
- Protecting those in vulnerable circumstances;
- Improving the resilience of individuals, communities and services;
- Engaging citizens in creative discussion, planning and designing the future of care;
- Saving money, increasing efficiency and reducing waste;
- Managing risk;
- Enhancing the reputation of councils and CCGs as local leaders; and
- Meeting regulatory requirements.

The current levels of resources cannot continue to be used at the current rate as this will not leave enough for future generations. Stabilising and reducing carbon emissions is key to living within environmental limits. The NHS has a very large carbon footprint and is the largest public sector contributor to climate change in Europe. Each year it emits 21 million tonnes of carbon dioxide equivalent (CO_2e).

An integrated approach across health, public health and social care is sustainable as a result of reduced duplication, reduced waste of resources, and improved patient experience. Energy efficiency and reduced overall energy consumption can have significant and long term financial benefits.

The Public Services (Social Value) Act 2012 places new obligations on commissioners and requires public authorities 'to have regard to economic, social and environmental wellbeing in connection with public services contracts; and for connected purposes'. Commissioners are being encouraged to promote sustainable development, particularly to reduce carbon emissions and adapt to climate change. Further information can be found in PCL(S) 002/13.

Climate Change

Climate change is one of the biggest public health threats with the potential to increase health inequalities. Therefore the threat posed by climate change to people who use and provide services needs to be considered, including severe weather events such as flooding and heat waves, along with air pollution, vector-, food- and water-borne diseases. The Heat wave plan and the Cold weather plan, both for England, are published annually and highlight the increasing threat of climate change and provide guidance on the protection of vulnerable people.

The Climate Change Act (2008) set a legally binding target to reduce greenhouse gas emissions by at least 34% by 2020 and 80% by 2050 against a 1990 baseline. Carbon reduction targets for the NHS are set in line with the Climate Change Act, and take into account for example, energy use, procurement and food, transport, water, waste and built environment design. Whilst good progress has been made in reducing carbon emissions, more is needed to meet the NHS targets by 2020, and transformational change is required. Reducing carbon emissions must be a core component of any future strategy.

Climate change risk management and adaptation is embedded in many Local Authority's (LAs) service development and delivery, as a sustainable development approach supports the role of LAs in promoting health as a function. HWBs need to promote sustainable health and social care in the way they structure

their business and integrate the design and delivery of services. It is also a pre authorisation requirement for CCGs to commit to promoting environmental sustainability.

Sustainable Development Strategy for the Health, Public Health and Social Care System 2014-2020

A commitment to a new sustainable development strategy is included in the NHS Business Plan for 2013-16. Building on the NHS Carbon Reduction Strategy (2009), this new strategy is not just for the NHS but embraces the whole health, public health and social care system. It will define the path to sustainable health care by 2020 and the measures and targets against which progress will be measured.

The NHS Sustainable Development Unit ran a consultation and engagement programme in order to produce a new Sustainable Development Strategy for the Health, Public health and Social Care System to from 2014 to 2020. The two key aspects were:

- Should we widen the scope beyond the NHS to the wider social care and public health system?
- Should we widen the approach beyond carbon reduction to include other areas of sustainable development?

The consultation on the draft strategy received nearly 1000 responses which are currently being analysed and used to determine the scope and further develop the strategy for launch in January 2014. Sustainable development areas which were suggested for focus included commissioning for sustainable services, models of care, pharmaceuticals and R&D. PSNC made a response to the consultation.

Some immediate themes emerging are:

- The strategy should look beyond the NHS and beyond carbon reduction;
- Keep it as simple as possible with a clear, practical and realistic approach;
- Work should be integrated and aligned across the system, delivering sustainable health, public health and social care;
- Avoid burdensome reporting requirements; and
- Focus on outcomes rather than processes.

Useful websites

www.sdu.nhs.uk

The NHS Sustainable Development Unit provides organisational development and support on sustainable development and carbon reduction and is funded by NHS England and Public Health England to work across the NHS, public health and social care system.

www.hpa.org.uk

The Health Protection Agency is now part of Public Health England, and provides the evidence base of the health effects of climate change and extreme weather events.

www.ukcip.org.uk

UKCIP supports adaptation to the unavoidable impacts of a changing climate through tools such as carbon emission scenarios, and guidance to organisations.