PSNC Service Development Subcommittee Agenda

for the meeting to be held on Tuesday 10th July 2018

at Crewe Hall, Weston Road, Crewe, CW1 6UZ

commencing at 11am

Members: Clare Kerr, Sunil Kochhar, Prakash Patel, Faisal Tuddy, Gary Warner (Chairman)

Apologies for absence

Apologies for absence have been received from Clare Kerr.

Minutes of previous meeting and matters arising

The minutes of the meeting held on 8th May 2018 are set out in **Appendix SDS 01/07/18** for approval.

Review of the subcommittee's remit

At the May 2018 meeting of the Committee, revisions to the subcommittee remits were agreed, to bring them into line with the current distribution of policy topics across the subcommittees. The subcommittee is asked to review its remit:

1. Keep Community Pharmacy Contractual Framework (CPCF) services under review and identify opportunities for services to change categories (e.g. to become Essential services);
2. Monitor uptake of non-Essential services;
3. Identify and prioritise opportunities for new community pharmacy services commissioned nationally or locally;
4. Develop or oversee the development of service specifications and other materials to facilitate the commissioning of services; and
5. Ensure community pharmacy IT supports service development.

Subcommittee Action:

- Review the remit to ensure it reflects the work of the subcommittee and make recommendations for its amendment, if necessary.

Agenda and Subcommittee Work

Below we set out progress and actions required on the work plan areas for the year. The subcommittee is asked to consider the reports, address any actions required and review the proposed next steps, suggesting additional activities which could be undertaken, if appropriate.

1	Develop proposals for a services-led contract for England and secure its adoption by DH and NHS England. Agree transitional changes to the CPCF with DH and NHS England

Action: Re-commissioning of NUMSAS

The NHS Urgent Medicine Supply Advanced Service (NUMSAS) is currently commissioned until the end of September 2018. The service was originally commissioned until March 2018, but NHS England extended the service by six months to allow more time for an evaluation of the service to be undertaken.

We have no definitive news on the future commissioning of the service beyond the end of September but it is likely that this will be a topic covered in the forthcoming negotiations with NHS England and DHSC.

In anticipation of potential discussions on the future commissioning of NUMSAS, the subcommittee is

asked to consider what could be changed within the service requirements or design to make it a more efficient service. The service requirements and documentation are all available via psnc.org.uk/numsas.

Subcommittee Action:

- Consider what could be changed within the NUMSAS service requirements or design to make it a more efficient service.

Next Steps:

- Collate a list of potential changes to the service which can be discussed with DHSC and NHS England.

Report: Proposals for a services-led contract

Since the May 2018 meeting of the subcommittee, work has been undertaken on the economics of the proposed services within the Universal Community Pharmacy Care Framework. This was discussed at a meeting of the New Funding Models Working Group; an update on this work will be provided in the plenary meeting on Wednesday 11th July 2018.

The proposals have also been discussed in detail with members of the General Practitioners Committee (GPC) of the BMA; they were supportive of the proposals, bar the element of the antibiotic guardian pledges which requires the challenging of antibiotic prescribing outside of local guidelines. This was viewed as being problematic, as GPs may legitimately prescribe outside of local guidelines where there are individual patient reasons for doing so, e.g. drug allergy.

A meeting with representatives of the RPS, NPA, CCA, AIMp, PDA and the Pharmacy Schools Council was held on 15th May 2018 to start the development of a description of pharmacy services across primary care, including PSNC's proposed changes to the CPCF. Further work on this matter with the other bodies is to be organised in the coming weeks.

Next Steps:

- Continue work to further develop the proposals for a service-led contract and seek further discussions with DHSC and NHS England; and
- Continue stakeholder engagement work on the proposals, including working with the other pharmacy bodies on a joint description of pharmacy services across primary care.

Report: Transitional arrangements for the CPCF in 2018/19

Since the last meeting of the subcommittee, work has continued to provide support to contractors on the revised Quality Payments Scheme (QPS) and discussions have continued with NHS England colleagues to address individual issues raised by contractors and wider problems which were affecting multiple contractors.

Work is ongoing to ascertain barriers to use of the NHS Summary Care Record (SCR) within community pharmacies and this will feed into further discussions with NHS England and NHS Digital and the development of further resources to support use of SCR will be considered.

Next Steps:

- Continue to work with DHSC and NHS England to ensure the transitional arrangements are implemented effectively.

Report: Flu Vaccination service

2017/18 Patient Questionnaire results

NHS England has shared the data from the 2017/18 flu vaccination patient questionnaire and the Services team have analysed it so that PSNC and NHS England can issue some joint communications on the ongoing

success of the service. A media release and infographic summarising the results have been drafted and these are being considered by NHS England.

Competency requirements

Following the receipt of queries from several pharmacy contractors and LPCs on the training requirements for the Seasonal Influenza Vaccination Advanced Service and whether the revised National Minimum Standards and Core Curriculum for Immunisation Training for Registered Healthcare Practitioners which were published in February 2018, change the requirements, the Services team published a set of frequently asked questions to address the issues raised. These are set out in **Appendix SDS 02/07/18 (pages 16-17)**.

The Community Pharmacy Competence Group has combined the Declaration of Competence (DoC) documents for the flu vaccination service and other vaccination services, so there is one DoC which covers all vaccination services. This has been agreed with NHS England and it is expected to be published by CPPE shortly.

Adjuvanted Trivalent Influenza Vaccine (aTIV)

Regular meetings to discuss the issues associated with aTIV use in 2018/19 and the development of guidance for community pharmacy and general practice teams are ongoing with DHSC, NHS England, PHE and the GPC (the aTIV working group).

Separate meetings are also now being held on communications to the professions and patients, including the use of the winter Stay Well campaign to communicate appropriate messages. In discussions with NHS England and PHE, PSNC has repeatedly emphasised the importance of the NHS bodies taking a leading approach in communicating to the public the different approach being taken in the vaccination campaign this year.

A joint letter to pharmacy contractors and general practices was drafted and agreed in early June, but at the time of setting the agenda, the letter was still working its way through the NHS England Gateway process.

The group was told that Seqirus has written to all general practices and pharmacies that have placed an order for aTIV to give them details of the weeks during which they will receive their vaccine deliveries. The order split will be approximately 40% of a contractor's order delivered in September, 20% in October and 40% in November.

The group has considered advice from PHE on the targeting of the vaccine to patients as a result of the phased delivery. This prioritisation approach is likely to be easier for general practices to implement than for community pharmacy, where patients do not attend for vaccination in an "organised" manner. Pinnacle Health Partnership have analysed over 31,000 historic flu vaccination records from local services commissioned prior to the national service. The data shows the following split across the priority groups:

Over 75s: 41%
Between 65 and 74 with at-risk co-morbidity: 17%
Between 65 and 74 with no at-risk co-morbidity: 42%

This data suggests that were it possible for patients to present at the pharmacy in a prioritised manner, the availability of aTIV would almost match the flow of patients. It is however not going to be possible for pharmacy contractors to manage the presentation of patients in this manner and in discussions with the group, NHS England and others recognise that it would not be appropriate to turn patients away if they did not meet the prioritisation approach described in the table above, asking them to return to the pharmacy later in the season.

The group is developing guidance for pharmacy contractors and general practices on managing these prioritisation challenges.

The Services team is also drafting a short Flu vaccination collaboration toolkit for general practice and community pharmacy which will be agreed with GPC and will be jointly published by both organisations. The toolkit draws on work previously undertaken by several LPCs and contractors to engage GPs in collaborative work to increase the overall number of patients vaccinated against flu.

The next meeting of the group is to be held on 9th July 2018 and a verbal update will be provided at the subcommittee meeting on any developments.

Changes to the flu vaccination service
Since the last Subcommittee meeting, discussions have continued with NHS England to finalise the agreement changes to the service requirements. The agreed changes to the service requirements are being incorporated into the service specification by NHS England and the revised draft will then be shared with PSNC for review and amendment as necessary.

Consent form
Work has continued with NHS England to agree a revised standalone consent form which complies with GDPR requirements.

Payment claims
The NHS BSA are keen to implement an interim solution in 2018/19 to allow contractors to claim payment for the service via a web-based system. On the basis that a paper claim form submitted with the script bundle can continue to be used by contractors if they wish, the introduction of a digital claims approach has been agreed as an alternative to paper. A verbal update will be provided at the meeting.

Digital transfer of information to general practices
NHS Digital is working with Pinnacle Health Partnership and Sonar Informatics to implement a tactical solution to improve the way flu vaccination data is sent to general practices. This will also require some minor changes to be made to the GP clinical systems and at the time of setting the agenda, it is uncertain whether these changes will be possible in time for the start of the service in September. A verbal update will be provided at the meeting.

Vaccination dataset
The Professional Record Standards Body (PRSB) for health and social care have been commissioned by NHS Digital to develop standards for the records to be maintained of vaccinations administered in community pharmacy and the information which should be sent to the patient's general practice. The Services team have had several discussions with the team undertaking this work to ensure that their final proposals will be practical for pharmacy contractors. PRSB have also started work on developing standards for records for emergency supplies made in community pharmacies. The Services team will continue to input into the work of PRSB.

Next Steps:

- Work with NHS England to finalise the documentation and guidance for contractors on the 2018/19 service and develop additional resources to support contractors, where necessary.

2 Develop template service specifications, business cases and other resources with relevant research, to support local commissioning of services

Report: Service support toolkits
The draft stop smoking toolkit is still awaiting internal review as other work has had to take priority since

the May 2018 meeting; once the internal review is undertaken, the draft toolkit will be emailed to SDS members to allow them to review the toolkit and provide feedback. The feedback will be used to create a second iteration of the toolkit, which will then be issued for review by LPCs and other stakeholders.

Development of a draft toolkit to support commissioning and implementation of post-hospital discharge support services is nearing completion; the next stage for this work will be internal review followed by a review by SDS members.

Collaborative work with volunteer LPCs to develop a CVD Prevention and Case Finding commissioning toolkit commenced in May with the first collaborative meeting held via video/teleconference on 5th June 2018 and the second on 19th June 2018.

A scoping document on the work is to be finalised at the next meeting on 10th July 2018 but the following outline has been agreed:

- hypertension, atrial fibrillation, cholesterol and NHS Health Checks will be covered in the service commissioning toolkit;
- the whole care pathway for these disease areas will be included particularly screening/case finding services, condition management, monitoring, medicines optimisation and treatment;
- Chronic Kidney Disease (CKD) and diabetes are out of scope; and
- diabetes should be considered for its own service development toolkit and that work being undertaken by the Royal Pharmaceutical Society should be engaged with.

At the meeting on 10th July 2018, the focus will be on development of a draft template with headings with specific actions for everyone to take away to work on. The aim is to publish the toolkit in November 2018.

The LPC group leader is Matt Harvey (Liverpool LPC) and the deputy group leader is Sandie Hall (Tees LPC). The LPCs involved in the main steering group are North East London, Dorset, Herefordshire & Worcestershire, Coventry, Warwickshire, Suffolk, Lancashire, Essex, Norfolk, South Central, North Yorkshire, Hertfordshire, Greater Manchester and Camden and Islington.

LPCs involved in the reference group are Cornwall and Isles of Scilly, Halton, St Helen's and Knowsley and Dudley.

Next Steps:

- Undertake an internal review and SDS review of the stop smoking toolkit and then issue it for review by the LPCs and other stakeholders;
- Conclude the initial drafting of a toolkit to support commissioning and implementation of post-hospital discharge support services and then commence the internal and SDS review process; and
- Continue joint work with volunteer LPCs on development of a CVD Prevention and Case Finding toolkit.

Report: Research

Dr Nicky Hall is continuing her research on the views of GPs on remote pharmacy service provision, with the RCGP having circulated to their members a link to the online survey.

Nicky has also worked with Gemma Donovan on a funding application for research into prescribing errors identified in community pharmacies. A proposal for a preliminary piece of research related to the ECCIP proposal has been drafted, which would examine the views of patients on seeking a consultation at a community pharmacy versus a general practice. Further information will be provided on this proposal at the meeting.

Subcommittee Action:

- Provide feedback on the ECCIP preliminary research proposal.

Next Steps:

- Conclude the research on GP views on remote provision of pharmacy services;
- Submit the funding application for the prescribing error research proposal; and
- Secure additional funding to support the ECCIP research proposal.

3 Ensure community pharmacy IT infrastructure meets the needs of contractors

Report: This area of work is generally overseen by the joint Community Pharmacy IT Group. The agenda and draft minutes from the last meeting of the group, held on 5th June 2018, have been circulated with this agenda for information.

Next Steps:

- Work will continue on this policy area, as described in the Community Pharmacy IT Group papers.

Report: EPS Phase 4

NHS Digital are continuing work to prepare for a pilot of EPS Phase 4 in October 2018. DHSC are working on changes to the regulations that will be required ahead of the pilot.

Report: Real Time Exemption Checking (RTEC)

NHS Digital have been working for several months on the development of functionality that will allow real-time data on a patient's entitlement to exemption from prescription charges to be made available to pharmacy teams via their PMR system. This work is funded by DHSC and is a priority for the Secretary of State in order to reduce the level of prescription exemption fraud and mis-claiming by patients.

The NHS BSA have developed an Application Programming Interface (API) which will undergo a proof of concept test by three PMR suppliers in August. Subject to a successful test and the necessary regulatory changes being made, a pilot would then commence later in 2018. The regulatory changes will be to allow the prescription charge exemption data to be shared with pharmacy contractors and to remove the need for a patient to complete the declaration on an EPS token where the data provided by the NHS BSA says they are exempt from charges.

Assuming the pilot is successful, NHS Digital and DHSC are then aiming for rollout to commence in 2019.

The design of the proposed technical solution assumes that:

- Paper FP10 prescriptions and EPS release 1 prescriptions are out of scope, as in these cases, the paper prescription rather than an electronic message is used by the NHS BSA to price the prescription;
- PMR systems will display the exemption type to the pharmacy contractor;
- Prescription exemption checks via the API can only be undertaken where the patient demographics related to the prescription exemption status record are synchronised to the demographic information held on the Personal Demographics Service on the NHS spine.

PSNC has been invited to join the NHS Digital working group which is supporting the ongoing work on this project and separately discussions have commenced with DHSC on the implications of the change for pharmacy processes and the regulatory changes which will be required.

In discussions with DHSC, the need for consideration of wider changes to the regulations has been raised by PSNC, so that the need for a patient declaration/signature for patients receiving free of charge contraceptives or those paying for their prescriptions is removed at the same time that RTEC is

introduced. The need for collectors of Schedule 2 and 3 Controlled Drugs to sign the FP10 or EPS token has also been raised.

Further discussions with NHS Digital on this topic are planned ahead of the subcommittee meeting; any additional information gleaned from these discussions will be provided in a verbal update at the meeting.

Next Steps:

- Discussions will continue with NHS Digital and DHSC, and further information on the proposals will be circulated to the Committee.

Any other business – for action

National clinical audit

Following previous discussions on a national clinical audit, a revised proposal was received from NHS England prior to the May 2018 subcommittee meeting. Feedback on this draft was provided and a revised proposal was sent to PSNC in mid-June and the Services team then edited this to ensure it covered the points necessary for a clinical audit. At the time of setting the agenda, a response from NHS England is awaited. A verbal update will be provided at the meeting.

Subcommittee Action:

- Provide feedback on the latest audit proposal.

Next Steps:

- Conclude discussions with NHS England on the design of the audit and then support its implementation.

Any other business – report

Consultation responses

In mid-May, the Services team responded to the British Lung Foundation's call for evidence on "treatment and medicines, living with a lung disease and end of life". The evidence submitted is available on the PSNC website.

PSNC Service Development Subcommittee Minutes

for the meeting held on Tuesday 8th May 2018

at the Mercure Bristol Holland House Hotel

Present: Marc Donovan, Clare Kerr, Sunil Kochhar, Faisal Tuddy, Gary Warner (Chairman)

In attendance: David Broome, Shiné Brownsell, Mark Burdon, Alastair Buxton, Peter Cattee, Jack Cresswell, Ian Cubbin, Mike Dent, Simon Dukes, Sam Fisher, David Hamilton, Jas Heer, Gordon Hockey, Tricia Kennerley, Mike King, Zoe Long, Margaret MacRury, Fin McCaul, Bharat Patel, Prakash Patel, Umesh Patel, Jay Patel, Janice Perkins, Sir Mike Pitt, Adrian Price, Suraj Shah, Anil Sharma, Sue Sharpe, Stephen Thomas.

Apologies for absence

None.

Minutes of previous meeting and matters arising

The minutes of the meeting held on 13th March 2018 were approved.

Agenda and Subcommittee Work

1	Develop proposals for a services-led contract for England and secure its adoption by DH and NHS England. Agree transitional changes to the CPCF with DH and NHS England

Report: Proposals for a services-led contract

The information in the agenda was noted and the subcommittee agreed the proposed next steps.

The summary of feedback from the national meeting of LPCs on 21st March 2018 was considered, with the initial responses from the subcommittee set out in Annex 1.

The outline proposals for the framework and the Community Pharmacy Care Plan (CPCP) service have been published on the website and a survey will be issued to garner feedback on the proposals from contractors and their teams. The new funding models working group has been considering detailed descriptions of the individual elements of the care framework, which is required to inform the next stage of work on potential financial models. Once the working group is content with the service descriptions, these will be shared with the full Committee for further consideration, including the practicality of the proposals and how they might be implemented by contractors.

Report: Transitional arrangements for the CPCF in 2018/19

The information in the agenda was noted and the subcommittee agreed the proposed next steps.

A verbal update was provided on the meeting with NHS England and NHS Digital to discuss what can be done to support greater use of the NHS Summary Care Record (SCR) in community pharmacies. The office will discuss this issue with the LPCs and a sample of community pharmacists and pharmacy technicians to try to identify any barriers to use of SCR which could be tackled.

Committee members considered potential barriers to use of SCR and the following points were made:

- We need to clearly articulate the relevance of SCR use to people's practice, giving them reasons to use it. This may not all be relevant to clinical practice;
- Collating scenarios would help to show people the different ways they can use SCR;
- Some pharmacists are very worried about accessing the SCR, so this must be presented in a non-threatening way;
- Some pharmacists are worried that accessing SCR will create more work for them, so we must help them to understand the benefits, e.g. reducing workload in checking patient histories; and
- Integrating SCR access into pharmacy IT systems would be helpful but is technically very challenging.

Report: 2018/19 Flu Vaccination service

aTIV
A verbal update was provided on the first of a series of meetings that have been arranged with DHSC, NHS England, PHE and the GP Committee of the BMA to discuss the practical implications of the phased supply of aTIV.

Targeting of the vaccine to the highest risk patients will initially be required in September and this will present logistical challenges for pharmacy teams and general practices alike. The best solution to support this targeting may necessitate coordination of activity by LPCs, LMCs and CCGs; this may also present an opportunity to develop a more collaborative approach to flu vaccination between the two professions. There will be obvious communications challenges which we are seeking to ensure NHS England manages.

Committee members suggested sharing examples of best practice on collaborative working, e.g. the work in Devon with Beacon Medical Group, which has already been featured in PSNC communications in 2017.

The urgent need for communications was noted, as contractors will need to have time to plan their flu vaccination service ahead of the summer break.

Changes to the flu vaccination service
The information in the agenda was noted and the subcommittee agreed the proposed next steps.

The subcommittee considered the NHS England response to PSNC's suggested amendments to the service. On capturing consent or a declaration of vaccination, the subcommittee suggested that a standalone consent form would be the preferable option, with consent given before the vaccination is administered.

2 Develop template service specifications, business cases and other resources with relevant research, to support local commissioning of services

Report: Service support toolkits
The information in the agenda was noted and the subcommittee agreed the proposed next steps. A plan for the first collaborative work with volunteer LPCs had been drafted, but timelines for the work were difficult to predict at this point, as the cooperation of multiple LPCs would be required.

Report: Research
The information in the agenda was noted and the subcommittee agreed the proposed next steps.

3 Ensure community pharmacy IT infrastructure meets the needs of contractors

The information in the agenda was noted and the subcommittee agreed the proposed next steps.

SCR 1-click access was suggested as a topic that the Community Pharmacy IT Group may wish to consider. It was also noted that work which NHS Digital is undertaking with Pinnacle Health Partnership and other IT suppliers to improve the provision of data on flu vaccinations to general practices, would only work optimally where the pharmacy user has an NHS smartcard; this would have implications for pharmacies that may access PharmOutcomes and other systems on, for example, tablet devices, without smartcard readers.

Any other business – for action

GPhC consultation on the education and training standards for pharmacist independent prescribers

The subcommittee considered the points which should be included in PSNC's response to the consultation. The subcommittee was supportive of the consultation broadly. Independent prescribers on the Committee may wish to reflect on this further and can offer feedback to Alastair Buxton by 21st June 2018.

Review of CPPE

Feedback on the current CPPE service can be provided by email to Alastair Buxton.

Any other business – report

Consultation responses

The information in the agenda was noted.

Pandemic Flu planning

The information in the agenda was noted. A verbal update was provided on recent discussions with NHS England about planning for a flu pandemic. There will need to be wide ranging discussions with all professions to ensure that primary care does not grind to a halt in the event of a pandemic, but also detailed discussions, e.g. on what services, such as MURs, might be "switched off" in the event of a pandemic. This is likely to take many months of discussions and wider involvement of other pharmacy bodies.

Prescribing guidance for minor illness

The information in the agenda was noted. It was noted that it would be helpful if PSNC could see feedback on how CCGs are planning to implement the guidance, but this will need to come through local intelligence from LPCs (e.g. looking at CCG Board papers). There does so far seem to be a variation in approach, with some CCGs deciding that this suggested approach is not right for their GPs and patients.

Revised NUMSAS guidance

The information in the agenda was noted.

Hospital to Home Pharmacy Reference Group (formerly the Out of hospital urgent care group)

The information in the agenda was noted.

Summary of feedback from the table discussions on the care framework at the national meeting of LPCs – SDS initial responses

1. Are there any elements you would remove, amend or replace?

- Waste – change what is proposed to focus on not dispensing items that are not needed by the patient, so that patients are not discouraged from returning waste medicines to pharmacies or pushed to disposing of medicines inappropriately. Review at the point of return is too late; [The proposals on eRD should address the concern of the LPC, but the purpose of this proposed service element also needs to be more clearly articulated.]
- Improve integration between community pharmacy and general practice; [That is one of the intentions of the proposals.]
- Ensure there is no duplication of work across community pharmacy and general practice; [Improving integration with GPs is part of what we are trying to achieve more broadly, but we will need to ensure that we do engage with GPs along the journey. Any proposals must avoid giving GPs more work and reducing their funding.]
- Concern over challenging antibiotic prescribing – like idea of advising patient at first contact before they get to the doctor; [We recognise the challenges around checking antibiotic prescribing, and clearly pharmacists would need more access to information on the patient and their condition to assess the appropriateness of the prescribing.]
- Part of support for patients should also include support for family/unpaid carers, e.g. children/grandchildren etc.; [This is intended and will be clearly articulated in the service descriptions.]
- Introduce independent prescribing as an earlier part of this new framework, focussing on urgent care and/or prevention; [In principle this is a good idea, but it is too ambitious for many contractors, for inclusion in a universal framework.]
- Alignment with local services, so the risk of services being decommissioned is minimised; [The Services Team could ask LPCs to highlight areas where they feel the Care Framework/Plan proposals could impact on local commissioning.]
- Move away from unstable cash flow that results from the purchase margin model; [Funding approaches have not yet been developed.] and
- No mention of MECC. [Making Every Contact Count is included within the public health parts of the proposals, and this can be more clearly articulated in the service descriptions. MECC training could be a potential future QPS criterion.]

2. What are the gaps in the proposals? How would you fill in the gaps?

- There must be adequate funding for this agreed pathway; [Adequate resources are a must.]
- Workforce planning; [We recognise the importance of workforce planning; it may be useful to map what we think the requirements will be with the pharmacy workforce to identify any gaps.]
- Integrated IT systems – should capture evidence; [Integrated IT would be useful but may take time to develop.]
- Look at the New Zealand model – to make benefits from the 'bricks and mortar' pharmacies rather than internet pharmacies; [Contractors in New Zealand are currently having many problems with their Government, so we should learn from this.]
- Should be a 'push' service – GPs should pass on 'care plan' to community pharmacies to implement with patients; [In principle, that suggestion is valid, but solely adopting that approach would make GPs the gatekeeper for patients accessing pharmacy services, which would not be appropriate.]
- Add return of sharps to the framework; [NHS England are not likely to pick up the costs of disposing of householders' sharps/clinical waste, as that responsibility sits with local authorities.]

- Patient registration – needs to be formalised; [This applies to the care plan, not the care framework.]
- Would telephone/remote models threaten the network? [The implications of telephone/remote options for the proposals will be considered.]
- Secondary care pharmacists need to be engaged with; [Agreed.]
- Doesn't address GP workload and urgent care capacity; [The expectations of how pharmacy supports urgent care should be articulated in the description of the care framework. The Pharmacy Integration Programme evaluation team has asked for access to the PharmOutcomes data on the CPRS and NUMSAS services to support their evaluation of these services.] and
- Do we want to move away from the Declaration of Competence model? [No, it is an important approach for community pharmacy and it should be maintained and developed, where necessary.]

3. Which elements of the proposals would you prioritise for final implementation and why?

- Clinical safety;
- Transfer of care (using PharmOutcomes) – MUR & NMS type support;
- Healthy living advice;
- Ascertaining the patient's need for a repeated medicine;
- NMS – immediate – already in place; and
- Public health priorities: prevention/screening, falls, AF.

4. What are the barriers to implementation and what could help contractors to overcome them?

- Effective leadership & training;
- Sustainability of leadership & coaching;
- IT infrastructure & PMRs need to be more functional;
- Negotiations between BMA & PSNC to align working between both contracts;
- Regulations around supervision - Second pharmacist in each pharmacy?
- Funding & staffing levels – no costing;
- Read/write access to records;
- Consent requirements – removal of consent eases process; [This would not be possible, but an enduring consent model could be developed.]
- Local flexible approaches to meet local needs;
- Any professionals liability issues?
- What referral mechanisms will be in place?
- Destabilisation of market entry and funding cuts;
- Three-year plan of what funding is going to look like and provide a staffing model; and
- Risk of decommissioning local services due to overlap with the national framework. [While we recognise this concern, this is a universal framework to be implemented at a national level.]

5. What can LPCs do now and in the future to support contractors with these new ways of working?

- Training, mentoring & upskilling;
- CCA contractors versus independents – same needs?
- Walk in my Shoes approach?
- Collaborative working with Health Education England and other stakeholders;
- Support for eRD – GPs to be 'encouraged'; and
- Consultation pack to use with contractors to ascertain needs.

Return to agenda item

FAQs on flu vaccination competency requirements

Q. Do the 2018 National Minimum Standards and Core Curriculum for Immunisation Training for Registered Healthcare Practitioners contain lots of changes compared to the previous 2005 versions?
No. The revised document contains several updates to the 2005 version, but most of the revisions reflect the expansion of the immuniser workforce beyond doctors and nurses, and the approach that has been taken in recent years to the training of pharmacists and other "new" vaccinators. For example:

- e-learning courses may provide an effective mechanism through which immunisers can access training. A blended learning approach can be utilised with an e-learning course used alongside face-to-face sessions;
- foundation training and updates should be tailored to suit the requirements of the immunisers to their specific area of practice and the vaccine(s) that they administer. So, the training of a new immuniser who will only administer one type of vaccine should cover all the topics in the core curriculum, but these should be made context and vaccine specific. With only one vaccine to cover, length of training will be shorter than for those who give a range of different vaccines; and
- annual update training – face to face updates are likely to be of particular value to those who give or advise on a diverse range of immunisations, e.g. practice nurses. However, it is recognised that for some immunisers in some areas of practice, face-to-face updates may not be feasible, and updating may be best undertaken through self-directed learning. Methods for this may include undertaking the assessment modules of an immunisation e-learning programme and doing/re-doing the necessary modules to refresh knowledge. Practitioners could also read through the "Information for healthcare practitioner" documents on the PHE website, listen to any available webcasts and read recently published articles on immunisation relevant to their area of practice.

Q. I have heard that the 2018 National Minimum Standards and Core Curriculum for Immunisation Training for Registered Healthcare Practitioners include a new requirement for supervised clinical practice following training. Is that correct?
A period of supervised clinical practice is recommended, but this is not a new requirement – this was also recommended in the 2005 documents.

Q. Who does the recommendation for a period of supervised clinical practice apply to?
The document states that those new to immunisation should receive comprehensive foundation immunisation training, either through a face to face taught course or a blended approach of both e-learning and a face to face taught course. New immunisers should also have a period of supervised practice and support with a registered healthcare practitioner who is experienced, up to date and competent in immunisation.

Q. Does the recommendation for a period of supervised clinical practice apply to pharmacists who have previously been trained to vaccinate?
If you have vaccinated patients in the past and consider yourself to be an experienced vaccinator, supervised practice would only be required if you feel it would benefit your professional practice, e.g. if a long duration of time has passed since you last vaccinated patients.

Q. I am a pharmacist who is commencing immunisation training for the first time so I can provide the Flu Vaccination Advanced Service. What are the steps I need to take?
If you are a new vaccinator we recommend the following steps:

1. Complete your core training (face to face and any other learning directed by your training provider);
2. Complete the Vaccination Services Declaration of Competence (DoC) on the CPPE website;
3. Undertake a period of supervised practice with a registered healthcare practitioner who is experienced, up to date and competent in immunisation; then
4. Should any additional training need be identified during your supervised practice, undertake the further training and then review your DoC.

Q. What is the idea behind undertaking a period of supervised practice?
In addition to acquiring knowledge through a theoretical taught course, practitioners need to develop clinical skills in immunisation and apply their knowledge in practice. A period of supervised practice will allow acquisition and observation of clinical skills and application of knowledge to practice when the practitioner is new to immunisation.

Q. What happens during a period of supervised practice?
Before starting to give immunisations, it is recommended that all new immunisers should spend time with an experienced registered practitioner, such as an experienced pharmacist immuniser, who has undertaken training that meets the national minimum standards and is experienced in advising about immunisation and giving vaccines. The new immuniser should have the opportunity in these sessions to observe and discuss relevant issues with the experienced practitioner.

Those new to their role in immunisation should also demonstrate an appropriate standard of practice to their supervisor. This supervised practice should be structured and robust and follow a clear, comprehensive checklist so each step of the consultation is considered. A competency checklist such as that written by PHE and the Royal College or Nursing (see Appendix A of the National Minimum Standards and Core Curriculum for Immunisation Training for Registered Healthcare Practitioners) should be used for formal assessment and sign-off of the practitioner's clinical competency in immunisation. A copy of the completed checklist should be retained in the practitioner's personnel file.

Q. How long should a period of supervised clinical practice be?
PHE advise that there is no agreement or evidence as to how many times supervised practice should occur, but both the supervisor and new practitioner need to feel confident that the practitioner has the necessary skills and knowledge to advise on and/or administer vaccines. If the practitioner administers a range of different vaccines to patients of different ages, their supervisor should ensure this is taken into account and they should be given the opportunity to observe and also be assessed on this range.

Q. Are there any qualifications which apply to the experienced healthcare practitioner?
The supervisor does not require a formal teaching and assessing qualification but should be competent in immunisation and have the ability to make an assessment of a new immuniser's knowledge and skills. One of the supervisor's key roles is to go through the assessment document with the new immuniser and assure themselves that the new immuniser has the appropriate level of knowledge and skill to undertake their role in immunisation.

Q. Can another pharmacist act as the experienced healthcare practitioner within a period of supervised clinical practice?
Yes, as long as the pharmacist is competent in immunisation and has the ability to make an assessment of a new immuniser's knowledge and skills.

Q. How can a period of supervised clinical practice be arranged?
There are several ways a supervision session could be arranged, for example:

- At the point of arranging face-to-face immunisation training, trainees could enquire whether the training provider could arrange such a session;
- New immunisers could speak to the pharmacy contractor they work for to enquire whether they could arrange a supervised session with an experienced immuniser, within the same organisation; or
- New immunisers could contact local pharmacist colleagues, who are experienced immunisers, and ask them whether they would be willing to supervise a session within their pharmacy.

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