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.