PSNC Service Development Subcommittee Agenda

For the meeting to be held on Tuesday 9th October 2018

At Swindon Marriott Hotel, Pipers Way, Swindon SN3 1SH

Commencing at 11am

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

1. Welcome from Chair
2. Apologies for absence
3. Conflicts or declaration of interest
4. Minutes of the last meeting **(Appendix SDS 01/10/2018)**
5. Matters Arising

Action

6. Discussion on revision of PSNC's service development proposals and options for quality measures which could be included in a revised CPCF **(Appendix SDS 02/10/2018)**
7. Revision of NMS and MUR consent requirements **(Appendix SDS 03/10/2018)**

Report

8. Update on NHS IT projects **(Appendix SDS 04/10/2018)**
9. Research on GP's views on remote provision of pharmacy services **(Appendix SDS 05/10/2018)**
10. National clinical audit on flu vaccination for people with diabetes **(Appendix SDS 06/10/2018)**
11. Any other business

PSNC Service Development Subcommittee Minutes

for the meeting held on Tuesday 10th July 2018

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

Present: Richard Bradley, Sunil Kochhar, Prakash Patel, Faisal Tuddy, Gary Warner (Chairman)

In attendance: David Broome, Mark Burdon, Alastair Buxton, Peter Cattee, Mike Dent, Marc Donovan, Simon Dukes, Jessica Ferguson, Sam Fisher, Jas Heer, Gordon Hockey, Tricia Kennerley, Mike King, Andrew Lane, Zoe Long, Fin McCaul, Garry Myers, Bharat Patel, Indrajit Patel, Jay Patel, Sir Mike Pitt, Adrian Price, Sian Retallick, Suraj Shah, Stephen Thomas.

Appointment of Vice-Chairman

The Chairman reported that Clare Kerr was happy to be re-appointed as Vice-Chairman of the subcommittee; the subcommittee agreed to that proposal.

Apologies for absence

Apologies for absence were received from Clare Kerr.

Minutes of previous meeting and matters arising

The minutes of the meeting held on 8th May 2018 were approved.

Review of the subcommittee's remit

The subcommittee reviewed its remit and did not suggest any changes.

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

Action: Re-commissioning of NUMSAS

The subcommittee considered potential changes to the service requirements or design to make it a more efficient service, noting the helpful feedback that been received from LPCs on the Gaggle group (see Annex). If PSNC members would like to be part of the Gaggle group they are very welcome to do so and should contact Mike King.

The subcommittee also noted that the service was not one which PSNC had agreed, but the focus of this conversation is operational improvements rather than funding. Funding would however be picked up in any discussions with DHSC and NHS England. The Chairman noted the very positive impact that the service is having for those patients who need it, and the important work that pharmacies are doing to ensure that this happens.

The following points were agreed:

- We should push for an IT solution for pharmacies to be provided, to include the functionality for digital referrals to be made from NHS 111;

- A walk-in approach to the service would be beneficial; and
- We would like to extend the service to include referral from settings other than NHS 111 but recognise the need to ensure that the business case for the service still remains strong.

The need for NHS 111 processes to be as streamlined and effective as possible, and for call handlers to be well trained to refer people to the service, was also noted.

Report: Proposals for a services-led contract

The information in the agenda was noted and the subcommittee agreed the proposed next steps. Following feedback from the GPC, the subcommittee agreed the removal of the element of the CPCF development proposals related to challenging antibiotic prescribing which was not in line with local formularies.

Report: Transitional arrangements for the CPCF in 2018/19

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

Report: Flu Vaccination service

2017/18 Patient Questionnaire results

The information in the agenda was noted. The Chairman noted that it is very positive that NHS England had felt willing to share the results with PSNC and that this was a testament to the strong working relationships that the team had built up. The Subcommittee praised the exceptionally positive results delivered by contractors and their teams.

Competency requirements

The information in the agenda was noted.

Adjuvanted Trivalent Influenza Vaccine (aTIV)

The information in the agenda was noted and an update on the calls with the aTIV working group was given. Guidance for GPs and pharmacies is being written and this will advise on targeting, but also that no patients should be turned away if the appropriate vaccine is available. This will be supported by the national campaign which will advise patients to get vaccinated between September and November, rather than the usual 'as early as possible' message. There will also be a need for good local communications.

Changes to the flu vaccination service

The information in the agenda was noted and the Chairman was positive about the proposed extension of the eligible groups. The issues with the internal review by NHS England's Burden Assessment and Advice Service of the patient questionnaire had not been resolved.

Consent form

The information in the agenda was noted.

Payment claims

Alastair Buxton updated the subcommittee on the latest discussions with the NHS BSA and NHS England. The NHS BSA did not wish to invest money on the development of an electronic claims system if a paper claiming option was still available, as it was likely that many contractors would opt not to use the new digital approach. Running a paper and digital solution side by side would require two teams to be involved in the processing of claims, which would add to costs. It was also likely that the NHS BSA would not have time to develop the system by September 2018. For these reasons it was initially decided that a paper claims process would continue to be used in 2018/19.

The NHS BSA subsequently reviewed their decision not to invest in an electronic claim system, and concluded that they would after all develop an electronic system for 2018/19. It is expected that this is a transitional solution for this year, because next year flu submissions should be added to the wider NHS BSA Manage Your Submission system.

Digital transfer of information to general practices
The information in the agenda was noted. It is uncertain whether the tactical solution will be implemented this year, as this relies on all the GP system suppliers to make changes to their systems. This may be possible by October, but there is a risk that this may not be achieved. A substantive solution is to be developed for implementation in 2019/20, which will allow data on vaccination to be inserted directly into the patient's GP-held record.

Vaccination dataset
The information in the agenda was noted.

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.

Report: Research
The information in the agenda was noted and Alastair Buxton gave a summary of proposed research which would investigate what patients think about seeing pharmacists for clinical consultations rather than GPs and whether there are any tipping points at which seeing pharmacists becomes acceptable for patients. The subcommittee agreed that subject to capacity, this should be taken forward.

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.

Report: EPS Phase 4 (Confidential)
The information in the agenda was noted.

Report: Real Time Exemption Checking (RTEC)
The information in the agenda was noted and an explanation of how the system is intended to work in pharmacies was given by Alastair Buxton.

Concerns were expressed about the impact this would have on top of other matters impacting on pharmacy workflows such as FMD; the timing of implementation within individual pharmacies would therefore be a potential operational challenge. This point will be raised in discussions with NHS England and DHSC.

Any other business – for action

National clinical audit
The information in the agenda was noted and Alastair Buxton was thanked for his excellent work to develop the audit. The subcommittee agreed the proposed next steps.

Pandemic flu planning

The subcommittee and wider Committee were asked for volunteers to work as part of a virtual working group on extreme pandemic flu planning. Please email Alastair Buxton if you are interested in joining this.

Any other business – report

Consultation responses

The information in the agenda was noted.

Annex

Feedback from the LPCs on NUMSAS

- **Should remain as a national service:**
  - If locally commissioned, DoS information won't be shared which presents challenges if patients access the service across different boundaries.
  - Service consistency.

- **Removal of the NHS 111 point of entry** – risk of triage to OOH etc. due to algorithm 'fail'. NUMSAS should allow:
  - **Walk-in access**
  - Walk-in access with community pharmacy contacting NHS 111 via backdoor function.
  - Fast-track disposition to community pharmacy.
  - One LPC said it was important to restrict access to demonstrate channel shift.
  - **NUMSAS needs to expand to accept referrals from other NHS organisations e.g. GPs, A&E and urgent care.**

- **General issues with the service**:
  - **The payment to the contractor does not reflect the value of the service.**
  - **'frequent flyers' - high service users requesting medicines that are addictive in nature.**
  - Local issues due to sick leave: some pharmacies have signed up for NUMSAS but still have not been activated; lack of clear communication; multiple head offices signing up centrally and not making local pharmacies aware. LPCs need a better dataset on a regular basis to monitor and address issues.
  - The current service is **cumbersome** for the system. The contractor signs up on the BSA website, NHS England picks up the message from the BSA. NHS England informs the NHS 111 local DOS lead, who profiles the pharmacy and tests the messaging works with the pharmacy. The DOS lead then informs NHS England who then inform the pharmacy they are ready to go! This process can take months.
  - **Lack of advertising is an issue – people will simply turn up to A&E or OOH as they are unaware of NUMSAS.**
  - Contractor apprehension about service sign-up due to lack of information on NUMSAS long-term future.
  - Some patients are referred to the in-house NHS 111 pharmacist when they could be sent to community pharmacy.

- **Staff training/contractor support:**
  - Locums being unaware of the service.
  - Difficult for our LPC to support pharmacies and work out what's happened when

things go wrong due to lack of information on contractor sign up etc. and it has taken a while to obtain information and contacts/networks with NHS England, DoS leads etc.

- **Stakeholder issues:**
  - CCGs and urgent care boards not being informed about NUMSAS and its outcomes – need to share outcomes with them regularly.
  - **Local commissioners can influence the prioritisation of local CAS offerings, which results in several calls that should have ended with NUMSAS going through CAS and generating faxed prescriptions.**

- **IT:**
  - **PharmOutcomes process could be simplified.**
  - National digital solution for recording, reporting and claiming.
  - With local PURM services, PharmOutcomes identifies frequent flyers, even if it's a different pharmacy.
  - **Pathways to GP/OOH can be unclear and customer / pharmacy are left to sort this out.**
  - Issues with NHSmail address, particularly when pharmacist moves on.
  - Will the NHS app be a portal into NHS 111 for NUMSAS?
  - Community pharmacy has to be integrated within NHS 111 for not just NUMSAS but for as many services as possible – DoS should be more sophisticated and include more services.
  - **The service needs to be integrated in such a way that when a pharmacy cannot supply (e.g. controlled drugs or the requested item is not a repeat medication) a message, preferably electronic can be sent back to NHS 111.**

- **Issues with NHS 111 call handlers:**
  - Don't always refer to CP – often see a spike in referrals post-training.

- **Surveys/questionnaires/research:**
  - Should be utilising the rich data from the service and analyse it to identify common trends.
  - Increasing number of surveys but not much quantitative or qualitative feedback.

Return to agenda item

Subject	Revision of PSNC's service development proposals and options for quality measures which could be included in a revised CPCF
Date of meeting	9th October 2018
Committee/Subcommittee	SDS
Status	Public
Overview	Recent discussions with NHS England have highlighted the priority they currently place on community pharmacy supporting urgent care services. The work on development of the NHS long term plan has highlighted a need for more NHS commissioning of public health/prevention services. Both these developments mean that it is appropriate for PSNC to review its service development proposals and to identify its priorities for early implementation. The forthcoming negotiations will discuss development of further quality indicators for the CPCF, building on the Quality Payments Scheme. PSNC therefore needs to review its previously considered options for quality indicators and identify new options too. This paper provides information to support a discussion on the above topics at the subcommittee meeting.
Proposed action(s)	Consider the contents of the paper and then, where appropriate, agree revised service development proposals and priorities for early implementation which can be discussed with DHSC and NHS England. Consider and agree potential quality indicators for the CPCF which can be discussed with DHSC and NHS England.
Author(s) of the paper	Alastair Buxton

Introduction and context

The Prime Minister's promise of £20bn additional funding for the NHS and the subsequent work to develop a new long term plan for the NHS means that it is a good time to review PSNC's service development proposals, ahead of negotiations with DHSC and NHS England.

The important contextual information to consider when revising our proposals includes NHS England's stated interest in services to relieve pressure on urgent care and their new focus on the need to do more work on prevention/public health. On the latter point, Simon Stevens said in July 2018:

> "It's pretty clear we are going to have push harder on smoking, and smoking cessation is part of that. **That can't all be done through local authority commissioned services.**
>
> "**I think we are going to have to look at whether the NHS can embed smoking cessation in more of the routine contacts we have with vulnerable groups who are smoking.**"

And Duncan Selbie, CEO of Public Health England, recently said in relation to the development of the NHS long term plan:

> "I believe there will be three over-arching priorities where we can make the biggest difference.
>
> "We need to remove **smoking** from England – for good, address our appalling **obesity** levels in both adults and children and tackle the high rates of avoidable deaths from **cardiovascular disease**. Each will require action from every part of civil society and the public to make healthier choices about their lifestyles, but the NHS can and must play a bigger role."

Both these developments mean that it is appropriate for PSNC to review its service development proposals and to identify its priorities for early implementation.

In addition to service developments, the forthcoming negotiations will also discuss development of further quality indicators for the CPCF, building on the Quality Payments Scheme (QPS). PSNC therefore needs to review its previously considered options for quality indicators and identify new options too.

PSNC's current service development proposals

Our current set of service development proposals are set out in documents which can be downloaded from psnc.org.uk/vision. They were restricted to the priorities that were the focus of NHS leadership at the time of development, rather than covering the full range of areas where community pharmacy can make a difference.

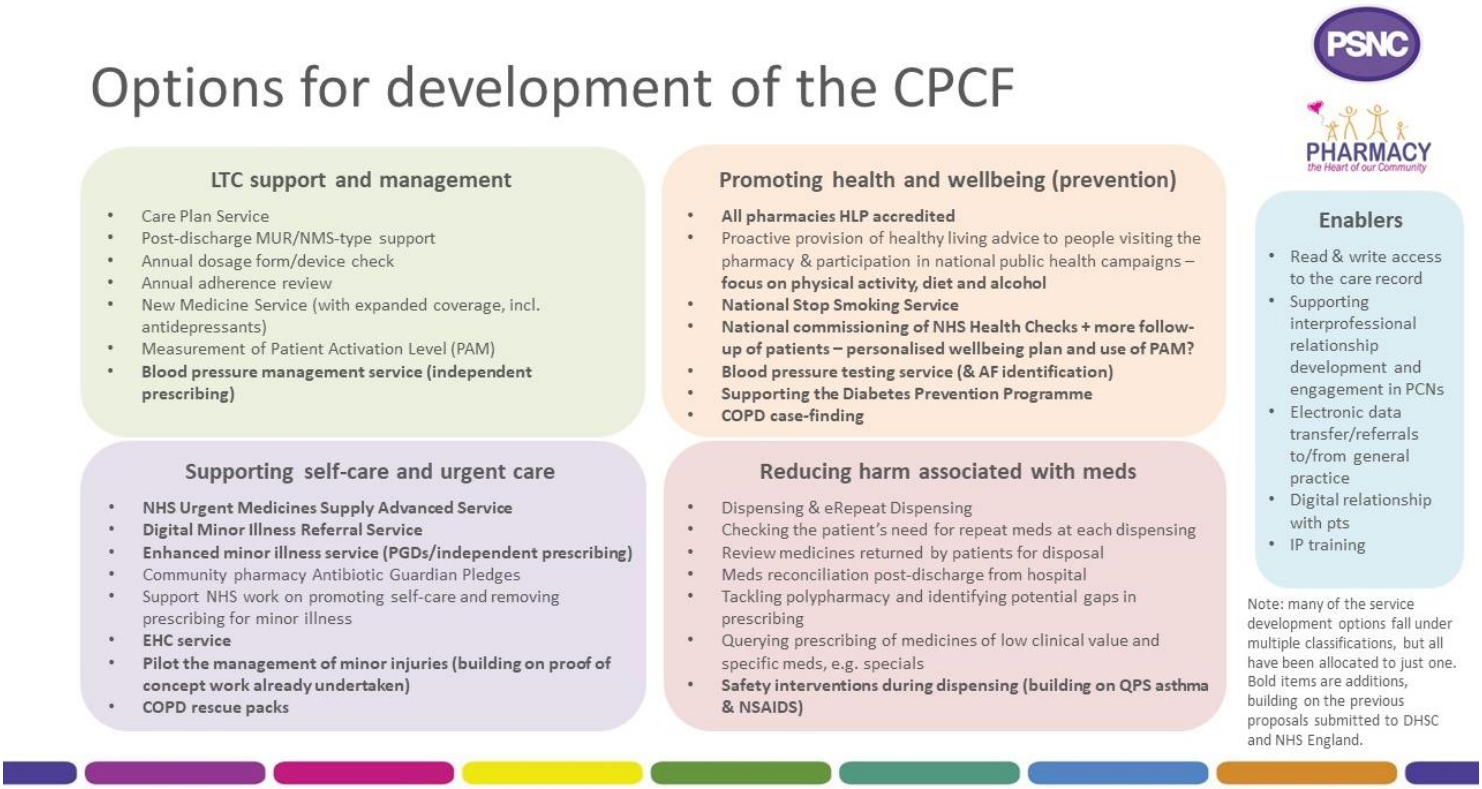
Public health and prevention were de-prioritised as the NHS was not recognising the need for action in this area and the message on urgent care was that this would be a priority for local commissioning not national commissioning. The NHS view on both these issues has now changed.

Revised service development proposals

The Negotiating Team has considered how our current proposals could be revised in the light of the current context described above. At the LPC Conference, a discussion session considered the top three priority services for national commissioning in both the public health and urgent care areas. The overall top three choices were:

Public health/prevention:	Support for urgent care:
1. CVD (BP & AF) detection & management	1. Expansion of DMIRS
2. Smoking cessation	2. PGD-based minor ailments scheme
3. Sexual health services (EHC, BBV screening)	3. Post-hospital discharge/TCAM services (medicine reviews with proper remuneration above MUR rate & electronic summaries sent to pharmacy)

In Scotland, the national contract includes the following public health and urgent care services: EHC, Stop Smoking Service, Urgent Medicines and Appliances Supply, Minor Ailment Service. The following graphic details our current service development proposals, with suggested additions in bold.



Subcommittee action 1

Consider the above revised service development proposals and suggest appropriate amendments or additions. The resultant list of service developments will then be used in future discussions with DHSC and NHS England.

When the original service development proposals were formulated, we recognised that it would not be possible to implement them all in one go. Recognising this and that DHSC and NHS England may only have an appetite for a small number of service developments in the near future, consider the priorities for early implementation which can be discussed with DHSC and NHS England.

Potential quality indicators for inclusion within the CPCF

It is likely that DHSC and NHS England will wish to discuss the further development of the QPS or similar in the forthcoming negotiations. In the recent revision of the QPS, NHS England stated that their priorities for development of the QPS from 2018 include:

- Relieving pressure on urgent care;
- Supporting infrastructure for integration;
- Reducing harm associated with medicines;
- Improving awareness of mental health illnesses;
- Promotion of health and wellbeing.

SDS has previously considered options for new quality criteria, which are included in the following list of potential quality criteria topics:

- Pharmacists or other staff trained in quality improvement methodologies, which could be focussed on, for example, patient safety;
- Digital communications with patients – collect mobile numbers or emails to allow post-service text communication/follow-up/proactive comms on key health issues, e.g. circulation of flu in the community
- Digital communications with patients – invite patients to talk remotely to pharmacists and seek feedback using social media;
- Digital communications with patients – offer of app use to patients which allows communication with the pharmacy on readiness of prescription for collection etc.
- Development of Health Champion training, with the intention of supporting provision of services to people with low health literacy;
- Additional staff trained as Health Champions (over and above 1 FTE per HLP);
- Data capture for public health advice provision, as described in Everyday interactions (RSPH);
- Improved communication with general practices – linked to the development of Primary Care Networks. This could start with adoption of the Walk in my shoes programme. Funding for general practice would also be needed to support their engagement in collaborative projects;
- Consultation skills training for all registered professionals;

- Promote eRD – GP practice visit to promote eRD, similar to the visits within the quality system in the Scottish contract;
- NMS engagement – now that we have the evidence on the value that NMS provides, should we be encouraging wider engagement over and above it being included in the Advanced service Gateway criteria?
- Pharmacovigilance training for all registered professionals.

Subcommittee action 2

Consider the above suggested quality criteria and the priority areas listed by NHS England and suggest appropriate amendments and additions to the list of potential quality criteria topics which can be discussed with DHSC and NHS England in future negotiations.

Note: future quality criteria need not necessarily sit within a QPS, but they could instead be service developments which would support quality service provision to patients and the public.

Return to agenda item

Subject	Revision of NMS and MUR consent requirements
Date of meeting	9th October 2018
Committee/Subcommittee	SDS
Status	The proposed amended requirements and wording are confidential until agreed with NHS England and published.
Overview	The current requirements for obtaining NMS and MUR consent are not GDPR compliant and therefore need to be updated. Proposed amendments have been discussed with NHS England and they are set out in this paper for review by the subcommittee.
Proposed action(s)	Review the proposed new consent requirements, suggest any amendments and agree the wording to be finalised in discussions with NHS England.
Author(s) of the paper	Alastair Buxton

Introduction

The current requirements for obtaining NMS and MUR consent are not GDPR compliant and the strict requirement currently applying does not actually require the pharmacy contractor to include patient identifiers in the form used to capture a patient's consent. As a consequence of both these issues, the requirements need to be updated.

Current requirements

The current requirements for consent are set out below.

NMS service specification:
8. The pharmacy will obtain written consent from the patient to confirm that they agree to information being shared. If the patient does not consent to share information then they are not able to use the service.

MUR service specification:
All patients receiving the MUR service must sign a consent from which allows the pharmacy contractor to share information from the MUR with:

- the patient's GP, as necessary
- the AT as part of a clinical audit
- the AT, NHS Business Services Authority (NHSBSA) and the Secretary of State for Health to verify that the service has been delivered by the pharmacy as part of post-payment verification.

If patients do not consent to share their information then they will not be able to access the service.

Secretary of State Directions:
5 MUR services: ongoing conditions of arrangements
5.—(1) (o) P must obtain from each patient to whom P provides MUR services a signed consent form to receiving those services, which—

(i) includes the approved wording as regards consent ("approved" for these purposes means approved by the NHSCB), and
(ii) amongst other matters, indicates the patient's consent to particular information, specified in the form, relating to MUR services provided to the patient being handled in the manner specified in the form (for example, for the purposes of post payment verification),

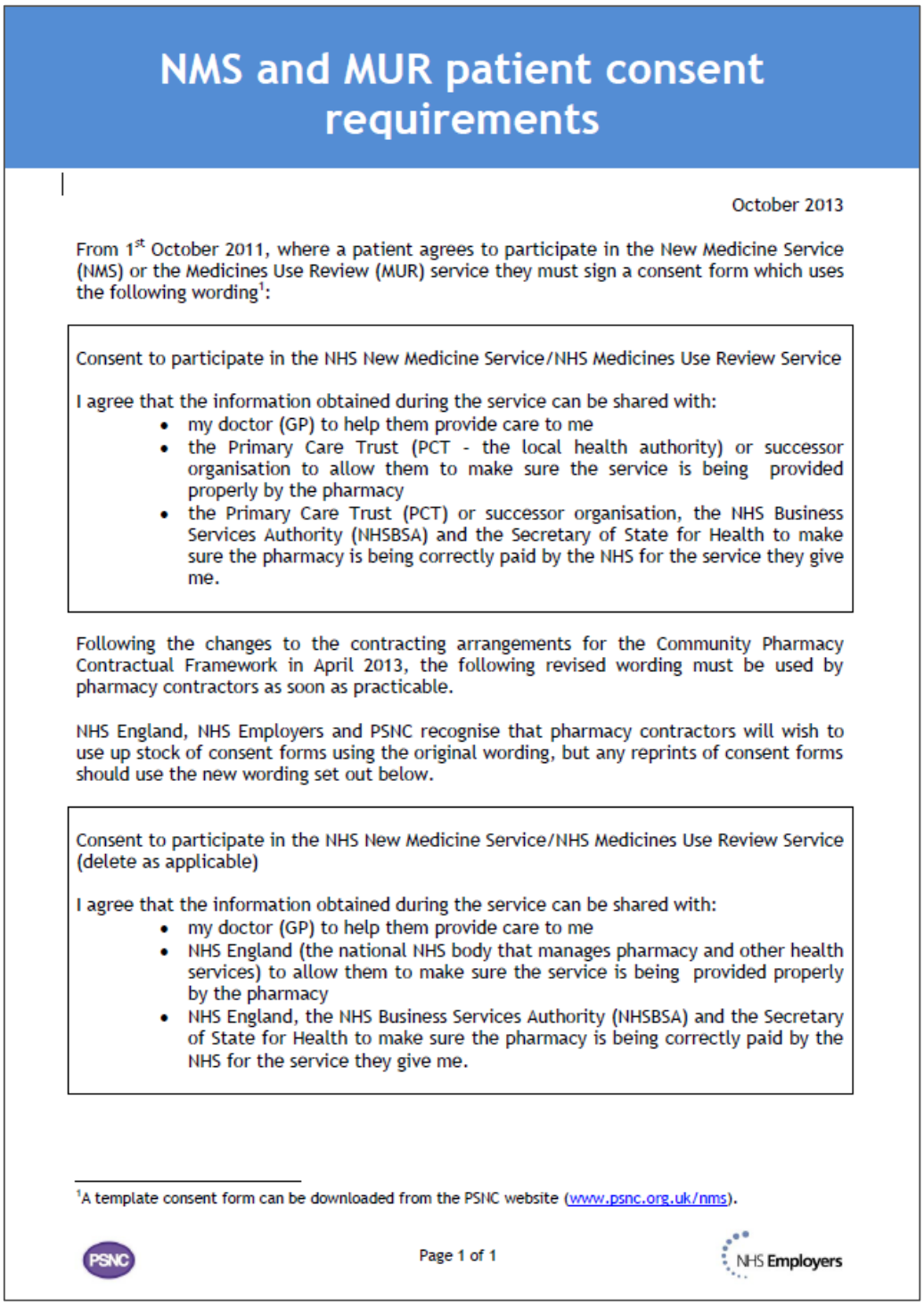
and P must not provide MUR services to a patient unless the patient's consent to that information being handled in the manner specified has been obtained.

7 New Medicine Service: ongoing conditions of arrangements
7.—(1) (f) (ii) providing the patient with sufficient information about the New Medicine Service (for example, in a leaflet) to enable them to give their informed consent to receiving the service, obtaining from the patient a signed consent form to receiving services as part of P's New Medicine Service, which—

(aa) includes the approved wording as regards consent ("approved" for these purposes means approved by the NHSCB), and

(bb) amongst other matters, indicates the patient's consent to particular information, specified in the form, relating to services provided to the patient as part of the New Medicine Service being handled in the manner specified in the form (for example, for the purposes of post payment verification)

NHS England's current "approved wording":



NMS and MUR patient consent requirements

October 2013

From 1st October 2011, where a patient agrees to participate in the New Medicine Service (NMS) or the Medicines Use Review (MUR) service they must sign a consent form which uses the following wording[1]:

Consent to participate in the NHS New Medicine Service/NHS Medicines Use Review Service

I agree that the information obtained during the service can be shared with:

- my doctor (GP) to help them provide care to me
- the Primary Care Trust (PCT - the local health authority) or successor organisation to allow them to make sure the service is being provided properly by the pharmacy
- the Primary Care Trust (PCT) or successor organisation, the NHS Business Services Authority (NHSBSA) and the Secretary of State for Health to make sure the pharmacy is being correctly paid by the NHS for the service they give me.

Following the changes to the contracting arrangements for the Community Pharmacy Contractual Framework in April 2013, the following revised wording must be used by pharmacy contractors as soon as practicable.

NHS England, NHS Employers and PSNC recognise that pharmacy contractors will wish to use up stock of consent forms using the original wording, but any reprints of consent forms should use the new wording set out below.

Consent to participate in the NHS New Medicine Service/NHS Medicines Use Review Service (delete as applicable)

I agree that the information obtained during the service can be shared with:

- my doctor (GP) to help them provide care to me
- NHS England (the national NHS body that manages pharmacy and other health services) to allow them to make sure the service is being provided properly by the pharmacy
- NHS England, the NHS Business Services Authority (NHSBSA) and the Secretary of State for Health to make sure the pharmacy is being correctly paid by the NHS for the service they give me.

[1]A template consent form can be downloaded from the PSNC website (www.psnc.org.uk/nms).

PSNC Page 1 of 1 NHS Employers

Proposed revised wording

The wording of the Directions (and service specifications) allow NHS England to issue new "approved wording" to amend the wording used in consent forms. The following new requirements are proposed to address the two issues referenced above.

Subcommittee action

The subcommittee is asked to review the proposed new consent requirements, suggest any amendments and agree the wording which will then be finalised in discussions with NHS England.

The final revised consent requirements will then be published by NHS England once they have passed through their Gateway process.

Return to agenda item

Subject	Update on NHS IT projects
Date of meeting	9th October 2018
Committee/Subcommittee	SDS
Status	Public
Overview	This report provides a summary of the current position with the following NHS IT projects: Citizen Identity, NHS App, EPS Phase 4, EPS Controlled Drugs and Real-time Exemption Checking.
Proposed action(s)	None
Author(s) of the paper	Daniel Ah-Thion

Citizen Identity

NHS Digital are developing a single system for verifying the identity of those requesting access to digital health records and services, to authenticate people for access to information about themselves and those they care for. Citizen Identity is important in supporting future NHS Digital national programmes, local initiatives and other government organisations.

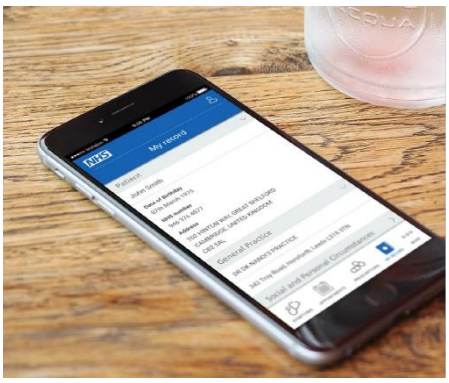
Currently, patients can access health records through a variety of local and national online systems. Because different systems require users to verify their identity in different ways, some patients report gaining access to multiple systems can feel complicated and time-consuming.

A single trusted identity verification system intends to make it simpler for patients to access digital records and services and to support more informed health and care decisions.

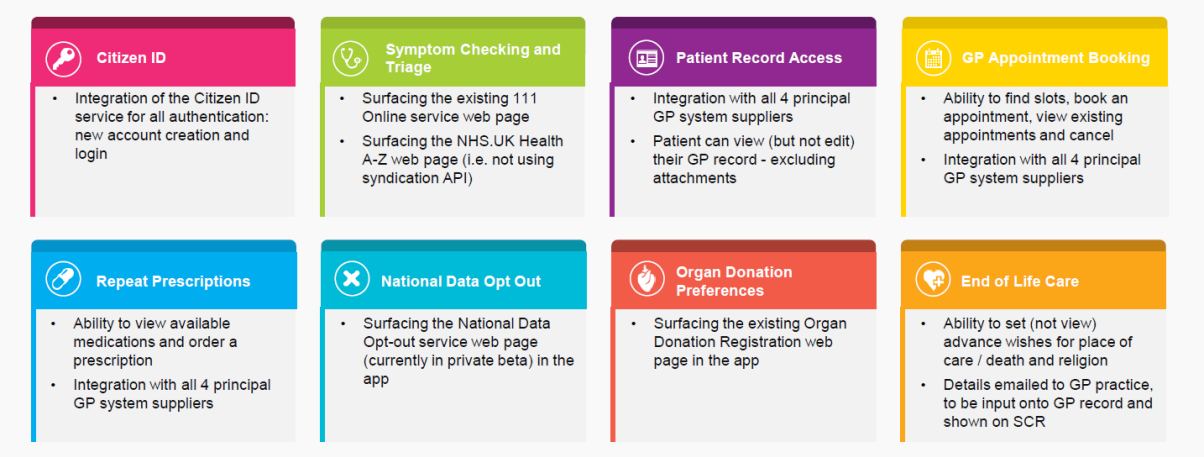
NHS Digital are working with system suppliers, clinicians and the public to develop identity standards, and are carrying out local testing of different services to try to ensure patient and system needs are met. Citizen Identity will be used within the NHS App.

NHS App

The NHS App will enable patients in England to connect to digital health services on their mobile or tablet device. The app is being tested from September 2018 and it will be rolled out gradually across England from December 2018.



The app will co-work with the NHS website (previously called NHS Choices) and will use Citizen Identity to allow citizens to register for personalised access. The following functionality will be available at launch:



The app is expected to provide opportunities and challenges for existing/future third party health app developers. It will be possible for approved apps to interoperate with the NHS app,

using Citizen Identity where appropriate. These apps may function alongside the NHS app or in the case of web-based apps, they would open within the NHS app.

Over time, further services will be added to the NHS App. For example, it is planned the NHS App will:

- suggest health apps that may be of benefit to patients from the NHS Apps library;
- enable commissioners to promote digital, or face-to-face services to patients that are available locally;
- enable input of end-of-life care plan wishes; and
- include a link for GP video consultation options.

Some of the NHS App functionality will be similar to the GP online services that have been available for some time.

A pilot phase for the NHS App began in Liverpool on 30th September 2018. Thousands of patients will be able to test the app during the next few months and before the December 2018 release date.

The Community Pharmacy IT Group (CP ITG) briefly discussed the NHS App at its October 2018 meeting, suggesting that a future development would be to allow patients to use the app to make or amend their EPS nomination; the NHS App team have confirmed that this feature is being considered for inclusion in their product development roadmap. It would require the app to be able to "write" to the Patient Demographic Service, which would be a major change.

PSNC and the CP ITG will continue discussions with the NHS App team and NHS England's 'Empower the Person' team to consider developments of the app which may be beneficial to community pharmacy contractors and their patients.

EPS Phase 4

Amendments to the pharmacy and GP regulations to allow EPS phase 4 have been discussed with the Department of Health and Social Care (DHSC) and after several revisions, the final amendments have been agreed. Phase 4 will be piloted from October 2018 at the earliest.

NHS Digital has been testing some 'dummy' Phase 4 prescriptions with PMR suppliers. They have also been working closely with PSNC to refresh the pilot plans and communications which were developed ahead of the original planned pilots in 2016. PSNC will maintain close involvement as the pilots commence and further reports on progress will be provided to the Committee in due course.

EPS Controlled Drugs

NHS Digital is preparing to pilot the prescribing and dispensing of EPS Schedule 2 and 3 Controlled Drugs (CDs) in England. Initially around ten GP practices will gain the ability to

prescribe CDs with the project aiming to demonstrate that EPS CD prescribing capability is safe and appropriate to be rolled out more widely.

The first pilot GP practices will be some of those using the *Vision* and *EMIS* GP systems in the North and London. However, because patients can get their prescriptions dispensed from any community pharmacy in the country, community pharmacy teams outside of these areas should also take note of these developments. Pharmacies near the pilot GP practices will be notified ahead of time. The pilot timing is to be announced shortly but is expected from October 2018.

EPS instalment dispensing (FP10MDA forms) won't be possible because this requires additional changes to be made to EPS to support this. As not all dispensing systems are able to endorse electronic prescriptions for oral liquid methadone with a packaged dose endorsement (PDn), a paper FP10 prescription will still need to be generated for this medicine. Prescribers are being asked not to prescribe oral liquid methadone using EPS.

Feedback from GP practices, community pharmacies, PSNC and other stakeholders will be used to refine the process prior to further roll-out. If the pilot is successful, EPS will be deployed to all *Vision* and *EMIS* sites. Other GP system suppliers are developing CD prescribing capability and NHS Digital will manage the deployment on a supplier by supplier basis.

Real-time exemption checking (RTEC)

To date, there has not been a 'live' technical solution for a pharmacy team to check a patient's active prescription exemption status. The project to enable that was a Ministerial initiative driven by the former Secretary of State for Health and Social Care to reduce prescription fraud – estimated at £237 million a year.

Soon, real-time exemption checking (RTEC) is expected to enable pharmacy systems to check a patient's exemption status automatically in the background and apply that status to EPS prescriptions.

Exemptions will be onboarded into the system in three phases:

- Phase One will comprise of maternity, medical, pre-payment, low income scheme and HMRC exemptions;
- Phase Two will include all Department for Work and Pensions (DWP) exemptions, including Universal Credits when they become available; and
- Phase Three will investigate the possibility of onboarding the Education and Ministry of Defence exemptions. A prioritisation and costing exercise will be required.

NHS Digital and NHS BSA are working with some of the PMR suppliers to test this functionality – a pilot with at least one supplier is scheduled for November 2018 at the earliest.

It is anticipated that RTEC will:

- reduce the risks of contractor loss caused by pharmacy staff being able to inadvertently submit prescriptions with paid status when the category should have been exempt; and
- enable a reduction of paper tokens required for sending from pharmacies to NHS BSA (where RTEC identifies the patient as being exempt from prescription charges, the patient will not need to complete a declaration on an EPS token).

NHS Digital suggest that some other benefits will emerge:

- The NHS (as a whole) may benefit from the reduced cost of prescription fraud due to a decrease in false prescription claims;
- It will reduce the burden and time taken to manage numerous exemption certificates within the care environment;
- Patients will benefit from fewer Penalty Charge Notices caused by accidental/erroneous exemption claims. Patients will benefit by not paying for prescriptions when they didn't realise they were exempt;
- Patients may no longer need to provide physical proof of exemption saving patient time whilst also reducing administrative and postage costs for the NHS BSA;
- Pharmacy teams will benefit from more efficient exemption status checks due to digitising the process; and
- Less confrontation between patients and pharmacy team members thereby reducing stress to pharmacy staff.

The check of the NHS BSA data will usually occur at the time the prescription is being processed in the PMR system to produce dispensing labels. PMR suppliers have some flexibility about the point that the data will be requested from the NHS BSA.

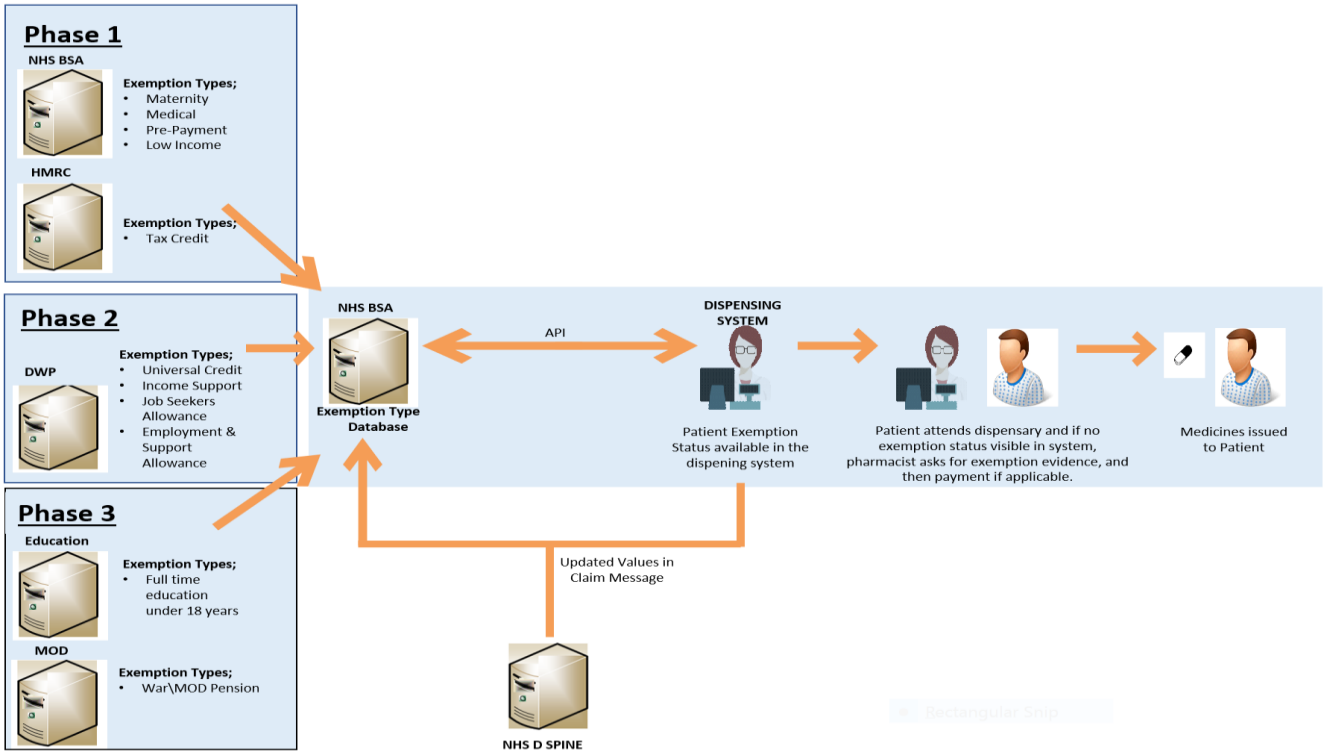
Pharmacy staff will not normally need to check the patient's exemption status more than once, but a second check will be possible, if the patient queries the initial status returned by the NHS BSA. If the patient believes they are exempt from prescription charges, but RTEC returns no exemption information, the patient will complete a declaration on an EPS token in the normal way.

If a prescription is confirmed by RTEC as exempt, it will be treated as such by the NHS BSA and no further prescription exemption checks will be applied.

DHSC's lawyers have advised that due to the General Data Protection Regulation, the exemption type should not be shared with the pharmacy contractor via RTEC. PSNC has challenged this view in relation to the maternity exemption, as this provides clinically relevant information to the pharmacist and the information could potentially be shared under the GDPR health exemption. DHSC are still to make a final decision on this matter, but the

amendments to the regulations have been drafted in a manner which allows this data to be shared with the contractor.

Work will continue with NHS Digital, DHSC and NHS England on the planning for the pilot and subsequent rollout of this functionality.



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Subject	Research on GP's views on remote provision of pharmacy services
Date of meeting	9th October 2018
Committee/Subcommittee	SDS
Status	Public
Overview	This poster, presented at the RCGP Conference, provides a summary of the findings from the research Dr Nicky Hall has been undertaking into the views of GPs and their teams on the remote provision of pharmacy services.
Proposed action(s)	None
Author(s) of the paper	Dr Nicky Hall

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Views of GPs and other general practice staff on the impact of distance-selling pharmacy and remote dispensing

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BACKGROUND

- Recent technological advances, market competition and increasing pressures for efficiencies in both the NHS[1] and community pharmacy[2] have resulted in a range of changes to the processes and policies involved in medicines prescribing and dispensing within the UK.
- Little is known about the views of general practice staff in relation to the perceived impact of changes associated with remote dispensing and the increasing availability of distance-selling pharmacies.

Aims

To explore the experiences and opinions of GPs and general practice staff in relation to the perceived impact of distance-selling pharmacy and remote or centralised dispensing.

METHODS

Focus Groups (n=2)

GPs from North East England

Purposive sampling[3]

Inductive thematic analysis[4]

Online Questionnaire

GPs and practice staff from across England

Recruited via email, newsletters and twitter

Informed by focus group findings

FINDINGS

Thematic analysis

Value of Community Pharmacy "safety net"

- Perceived importance of: continuity of care; local patient knowledge ; and relationships with GPs
- Valued alert system for compliance problems and prescribing errors
- Increased reliance on distance-selling pharmacy and centralised dispensing may result in a loss of valued elements of community pharmacy

Lack of common practice and terminology

- Confusion and inconsistent use of the terminology associated with electronic, distance-selling, online, centralised and remote prescribing and dispensing
- Reflective of rapidly changing processes, technologies and associated role boundaries

Legitimising role boundaries

- Addressing dispensing-related problems in primary care is not often seen to be within the remit of the GP role unless it impacts directly on patient care
- Resolution of dispensing issues is often delegated to other primary care staff
- Potential impact of changes to dispensing models on practice and/or patients is not routinely considered by GPs

Patient-centred and problem-solving discourses

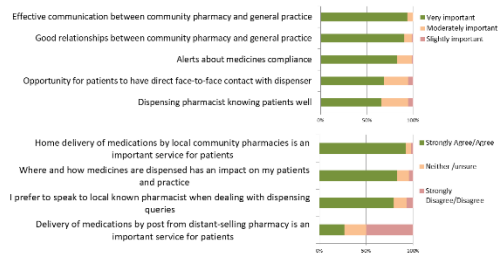
- Changes to electronic repeat prescriptions and remotely dispensed medi-boxes were seen as particularly complex and time-consuming to resolve, but could be facilitated by known community pharmacists
- Problems encountered are not routinely discussed within or between practices, limiting opportunities for reflexive monitoring

GP1: There's a big issue around continuity in care generally... I think if you take out yet another community based resource or you denigrate it as (participant 2) sort of described by challenging their financial viability, ... you could very readily lose that immediate contact with patients" (Focus Group 1)

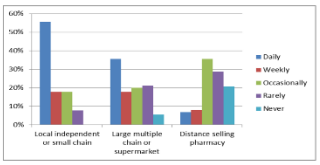
Questionnaire analysis

Respondents	n=96	%
Participants		
GP	19	19.8
Practice Manager	25	26.0
Nurse	5	5.2
Pharmacist/dispenser	12	12.5
Admin/clerical	22	22.9
Other/missing	13	13.5
Practices		
Dispensing practice	16	16.8
Rural	13	13.7
Semi-rural	34	35.8
Urban	37	37.9
1-3 FTE GPs	36	36.9

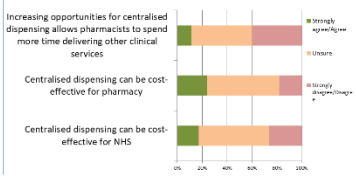
General views – safety and efficiency



Contact with community pharmacy



Centralised and remote dispensing



Distance-selling pharmacy (internet)

- Only very few respondents (15%) dealt with distant selling-pharmacies on a regular basis.
- **Perceived Advantages (27%):** centred around patient choice and convenience for a selected group.
- **Concerns (98.5%):** Thematic analysis of free text comments summarised below.
- Only 13% felt advantages outweighed concerns.

Concerns (free text thematic analysis)	% of respondents
Communication, customer service and resolution of problems	48.5%
Appropriateness and reliability of postal delivery **	42.4%
Potential for abuse, aggressive marketing and lack of trust	39.4%
Lack of direct patient contact**	37.9%
Lack of patient knowledge	36.4%
Ordering processes	27.3%
Potential threat to sustainability of community pharmacy and dispensing practices	21.2%
Potential for errors	13.6%
Suitability for select group of patients only	7.6%

*** most often ranked highest in order of priority***

DISCUSSION/CONCLUSIONS

- Community pharmacy's local knowledge of patients, communication with general practice, and opportunities for direct pharmacist/patient contact are highly valued by general practice staff in relation to the safe and efficient supply of medicines.
- Perceived advantages of distance-selling pharmacy services for a limited group of patients are recognised, however these are most often outweighed by concerns.
- Less than a fifth of respondents deal regularly with distance-selling pharmacies. Knowledge and understanding of the potential impact of changes to regulations and practice relating to centralised dispensing was low.
- Identified issues and concerns are not encountered regularly or discussed within or between practices. This limits opportunities for reflexive monitoring or consideration of how changes in dispensing processes and policies may be affecting general practice and patient care.
- Strengths/Limitations: The response rate to the online questionnaire was low, limiting statistical analyses. Our multi-method approach allowed an in-depth exploration of issues and responses from a diverse sample of primary care staff.

Acknowledgements

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2. SPINKS, J., JACKSON, J., KIRKPATRICK, C. M., & WHEELER, A. J. (2017) Disruptive innovation in community pharmacy - Impact of automation on the pharmacist workforce. Res Social Admin Pharm, 13, 394-397.
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Subject	National clinical audit on flu vaccination for people with diabetes
Date of meeting	9th October 2018
Committee/Subcommittee	SDS
Status	Confidential until publication of audit paperwork by NHS England
Overview	This report contains the draft clinical audit documentation for the forthcoming national audit which NHS England will be asking contractors to complete in October or November. NHS England will also be adding ethnicity to the data which is collected on patients covered by the audit. The documentation is currently working its way through the NHS England approvals process.
Proposed action(s)	None
Author(s) of the paper	Alastair Buxton

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