Community Pharmacy Essex Newsletter

April 2024

Leap in to our Spring 2024 newsletter

Content

https://cpesx.org.uk/

Farewell to Frank and Mo

We are sorry to report that our two field officers, Frank McLaughlan and Mo Raje left Community Pharmacy Essex at the end of March.

Frank started working with us on specific projects in 2017 before accepting the substantive Field Officer role in 2020. His ability to engage with and relate to contractors and the wider team will be greatly missed.

Mo joined us as GP CPCS implementation lead in 2020 and had led on the implementation of several projects in addition to covering the Mid and South Essex ICB area as Field Officer. Mo remains on the Committee and is the current vice-chair.

The committee senior team and office are meeting on 22nd April to discuss the LPC strategy and will include workforce planning in this. Meanwhile any contractor queries should be directed to office@cpesx.org.uk or 01245 460079.

We wish both Frank and Mo well in their new endeavours.

Pharmacy First

Pharmacy First: Urgent Repeat Medicines Supply element

We now have access to more data regarding the Urgent Repeat Medicines Supply element of Pharmacy First, at an ICB and individual pharmacy level.

This has shown that the service seems to be used appropriately on the whole, although there are a couple of little blips: Please remember that the Human Medicines Regulations 2012 (regulation 225) about emergency supplies haven't changed (link below) as a result of Pharmacy First/CPCS, it is just how the medicines are funded that have changed.

Legislation.gov.uk

We have had reports from the Controlled Drug Accountable Officer (CDAO) that pharmacists have broken the law to supply Schedule 4/5 controlled drugs for more than 5 days' supply. Reasons given (paraphrased):

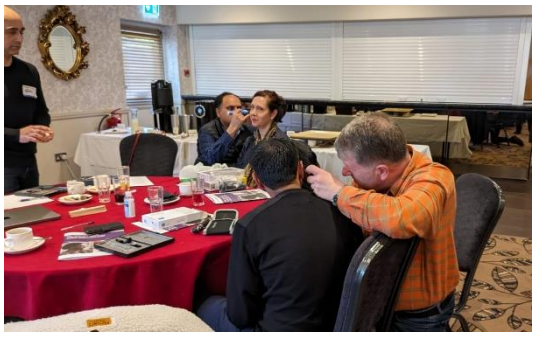
- I had taken the clinical decision in the best interests of the patient.
- The repeat prescription for (the larger quantity that was supplied) had been delayed and the patient was going on holiday.
- The patient takes this regularly so the larger quantity was OK
- A schedule 2 supplied as an emergency 'for immediate clinical need'.

The law is as it states and if the patient needs more than 5 days supply or a drug that cannot be supplied as an emergency supply then an alternative option must be found.

Regarding any other medicines, NHS111 refers patients for an assessment and possible supply, but the test of whether there is "***an immediate need***" is for you to decide.

Finally it is the Pharmacy First Urgent ***Repeat*** Medicines Supply, it is not suitable for repeat issues of acute prescriptions such as short courses of antibiotics.

Clinical Pathways compliance



We were delighted to see so many of you at our two Pharmacy First training days and have every confidence that those who attended are competent to deliver ENT consultations.

If there are any of you out there who still do ***not*** meet the requirement (since 1st April) to have an otoscope available for use on the premises we do still have some available to purchase, please contact office@cpesx.org.uk

Pharmacy First: Consultation records

This is from Community Pharmacy England, we don't normally reproduce what is available on their website, but this seems appropriate.

The simple question we would ask you to consider/reconsider is "**Are you taking and recording sufficient contemporaneous notes during a Pharmacy First consultation to adequately allow you to evidence how and why you reached the clinical decision to treat (or not) a patient under the service as you have, given that legal cases may be brought some years after an incident**?

Even if everything was done correctly at the time of an incident, if it has not been documented, it has not been done from a litigation perspective. Write down what you said, what you did, what you were told, and what you observed. Be succinct and mindful that the quality of the case record is assumed to reflect the quality of care delivered.

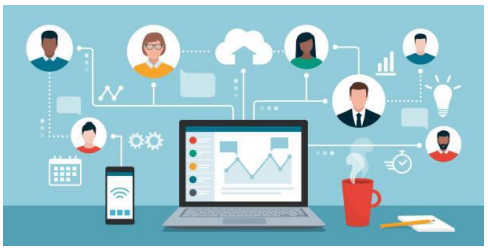
We are all aware that the full IT functionality we were promised to support the service is yet to be made available, but nevertheless it is vital that Pharmacists make sufficient notes in the "Advice and Support" and "Clinical Notes" recording sections to inspire confidence that you have followed the clinical pathways fully. This will ensure that, when the IT eventually "writes" the consultation directly into the GP record, the standard of recording is beyond reproach.

If you feel in any way unsure about the requirements for clinical record keeping we would draw your attention to the service specification:

Pharmacy First service - Community Pharmacy England (cpe.org.uk)

Pharmacists wanting to update their knowledge of best practice record keeping can access the CPPE Documenting in patient clinical records e-learning programme.

Data Security and Protection Toolkit



Just to remind all contractors that the Data Security Protection (DSP) toolkit for the current year must be completed and published by 30th June: This is good as it doesn't clash with lots of other deadlines, but equally that can make it easy to miss. As ever we suggest that you start this as soon as you can to avoid last minute panic and/or IT failures.

Because the toolkit is published it is easy for commissioners to identify pharmacies that have not complied with the requirement, and we now have experience of pharmacies being excluded from lists of service providers on the basis of non-compliance.

Another one to watch out for is the Toolkit training requirements: Community Pharmacy Essex has been in attendance at contract monitoring visits when staff have been asked what Information Governance training they have had in the last year, unfortunately this is often

reported as none: The requirement is for 95% of staff (including drivers, volunteers etc) to have completed induction or refreshment training.

Please see links below for training resources and a recording of this year's Community Pharmacy England webinar

Data security training - Community Pharmacy England (cpe.org.uk)

Data Security and Protection Toolkit Workshop - Community Pharmacy England (cpe.org.uk)

Workforce Efficiency

Efficiency Suggestions

We are aware of the additional workload/reduced workforce that many of you are experiencing, especially those that have been impacted by neighbouring pharmacy closures, growth in patient population and the rise in minimum wage forcing reductions in staffing hours.

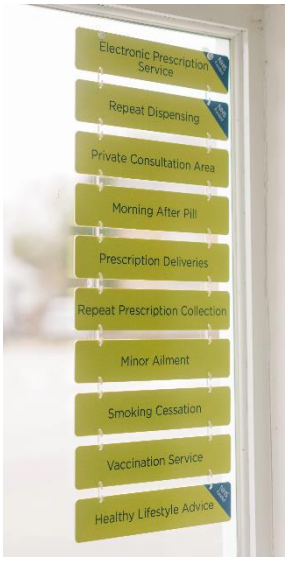
At the same time you want to develop your service offer, because this offers real potential.

Unfortunately we don't have a magic wand to fix this, much of which is national and outside our remit, however the following are a few ideas, suggestions and initiatives that we have seen, heard about or invented that you may want to consider for your own business.

Think like an economist

Instead of looking at service fees on their own, benchmark them against the Single Activity (dispensing) fees. If you complete just **one** of each of the following it is the same in fees as dispensing 100 prescription items:

- 1 Pharmacy First consultation is nearly 12 prescription Single Activity Fees
- 1 Hypertension clinic reading is nearly 12 prescription Single Activity Fees
- 1 Oral Contraception consultation is over 14 prescription Single Activity Fees
- 1 complete Discharge Medicine Service is 27.5 Single Activity Fees
- 1 ABPM recording is over 35 Single Activity Fees.



Stop providing services for nothing

Starting with Dosette boxes/blister packs for the convenience of paid carers or because nurses/GPs/family members demand them. We are happy to support you with this!

Details at https://cpesx.org.uk/wp-content/uploads/sites/124/2020/01/The-Essex-LPC-ultimate-guide-to-Monitored-Dosage-Systems.pdf

Review opening hours

Consider closing for an hour during the day, using the flexibilities agreed in May 2023. If you already close for lunch, consider an extended break, if you don't close for lunch then consider it and have half an hour of "closed door working" to clear the backlog without the pressure of queuing patients.

Review/reduce retail lines

Think about your non-pharmaceutical lines (this will vary on location) and how much time you or your staff spend with reps, receiving and checking orders, merchandising stock etc. If you get a good return on particular lines then go for it, but what sort of return are you really getting on hair ties, gift cards, tights and scented candles? How do they present the pharmacy as a healthcare service?

Consider appointment systems for advanced services

Your time is valuable and patients need to realise that: They cannot demand immediate appointments at any other healthcare provider. You can always suggest something along the lines of "you can wait if you want to although it might be a while, or I can book you an appointment for 2.30pm and see you straight away then?"

Pharmacy First does NOT state that patients have to be seen immediately.

Go paperless

Ok maybe paper light. But really, do you have time to hand-write in controlled drug registers? Fridge temperatures? Responsible pharmacist records? Cheque books?

Prescription ordering lead-in times

We are making some progress with this, as practice systems/timelines reflect what happens at the practice and do not factor in time needed for the pharmacy to process prescriptions.

We sent the following to all three ICBs in Essex and have agreement to work towards this from all of them

"As I am sure you are aware community pharmacies are currently working under extreme pressure due to a number of factors including workforce challenges, contractual flat-funding, closures/ reduced opening hours across the network and additional services to support the wider primary care access recovery plan.

Much of this is outside of local control, requiring contractual and financial changes which we must entrust to our national negotiators, however we would appreciate support for changes that can be made locally with minimal disruption to other colleagues in primary care. We may not be able to increase pharmacy workforce or capacity, but we can take steps to allow the existing capacity to be used more efficiently and to improve the patient experience by reducing unnecessary, premature or duplicate patient visits for repeat prescriptions.

In Essex most GP practices will not allow patients to request repeat prescriptions more than one week in advance of the "due" date, however this lead time is no longer adequate: Practices regularly take 72 hours/3 **working** days or more from request to issue of prescriptions, which leaves 2 **working** days for pharmacies to check prescriptions, clarify any queries, source stock and safely dispense the prescription. As "managed repeat" systems are more or less obsolete and patients are encouraged to make requests through practice websites or the NHS app there does not seem to be any reason not to extend the permitted lead-in time to 10 days or even 2 weeks. Patients can then track their prescription on the app and avoid wasted journeys to the pharmacy with subsequent impact on queues and workload. Of course a greater implementation of eRD could mitigate against this even further.

To support this we would also like communications to patients from practices to change. There is a tendency, no doubt inadvertent, for practice staff to advise patients that the prescription has been sent to the pharmacy thus creating the patient expectation that it has been dispensed and is ready for collection. If this communication could be amended to advise patients that their prescription may have been issued but that the pharmacy needs time to process the

prescription as outlined above this could reduce patient frustration and unnecessary additional work at the pharmacy if patients present too early.

Finally we would like to work with Patient Participation groups and similar to ensure a wide and consistent communication about managing repeat medication requests and the prescription journey."

Direction of Prescriptions (and other services)

We seem to be having a bit of an outbreak of prescription direction across the county, or at least an outbreak of reports of prescription direction.

Direction by GP practice staff

GP staff cannot send prescriptions to a pharmacy without the consent of the patient; this would constitute a breach of confidentiality as patient information would be shared with an organisation that was not entitled to see it. The GP practice should be advised of the breach of confidentiality, and if more than one patient is involved or if the direction is repeated then the Information Commissioner's Office should be contacted.

We are aware that this can happen when a pharmacy closes, or when a new ODS code has not been activated on the spine. In these circumstances practices should be sending prescriptions to the spine rather than to another pharmacy, unless there is clear patient consent: Although consent for nomination does not have to be written any more, it can provide useful reassurance that the patient has chosen a particular pharmacy.

Changing patient nominations at a pharmacy.

This is a bit more of a minefield. Often this will be because a patient goes to a different pharmacy for some reason, such as convenience or extended opening hours. Occasionally the prescription will have been issued by a service or a prescriber who is not familiar enough with prescribing systems to issue a prescription to the spine and so they will change the nomination to a pharmacy known to be open: This does not happen as much as it did, but it does still happen.

More often the prescriber will issue a prescription to the spine and this will be accessed when the patient presents at the pharmacy.

In either of these occasions it is perfectly acceptable for the "receiving" pharmacy to ask the patients if they would like to change their nomination for future prescriptions: However the patient has to give informed consent, ie they need to understand that they are changing their nomination from their previous pharmacy and that their repeat prescriptions will no longer go to their previous pharmacy.

It is possible that this information is not being made clear to patients, or that patients don't really understand what they are agreeing to, in particular if they have an acute prescription because they are feeling unwell and are in a different pharmacy to what they are used to. This certainly seems to be what we are hearing back from contractors.

If you do access a prescription from the spine for a "new" patient who has nominated a different pharmacy please make sure they fully understand what they are consenting to if they elect to change their nominations.

Changing nominations back from another pharmacy

We are hearing a few reports (often from both of the two pharmacies involved) that pharmacy A has looked on the tracker for patients that have changed to pharmacy B and changed their nominations back again and vice versa. Unfortunately this does not reflect professional conduct, raises concerns and complaints from GP practices and commissioners and is not in the patients' best interests.

If a patient has chosen a different pharmacy please be really careful before changing their nomination back again, and make sure you have clear consent (again we would recommend written consent even though it is not required by regulations).

Direction of patients for other services

We have been working with ICB colleagues and communications teams to ensure that lists of Advanced Service providers are accurate, so referrals can be made confidently. Please make

sure that you invoke the Business Continuity Plan if you are temporarily unable to provide any advanced service for a period of time.

Practice teams should refer patients to their usual pharmacy if the required service is available, if not they may use look-up services to find the nearest pharmacy/ies that provide the service. Patient direction on the basis of a specific service is allowed. However, if you have evidence of practices directing patients on any other grounds please let us know.

Antimicrobial Stewardship

United Kingdom Health Security Agency (UKHSA) East of England: Teaming up to tackle Healthcare Associated Infections and Antimicrobial Resistance – Committee Member Babatunde Sokoya attended

I attended the above meeting on "Teaming up to Tackle Healthcare Associated infections and Antimicrobial Resistance" on Wednesday 27th March 2024. The day was focused a great deal on how well systems are prepared for handling outbreaks of infections in secondary care. We were given some insight in to the roles of the Health Protection teams (HPT) and the need for wider healthcare practitioners to be aware of what needs to be reported and the guidance on how this should be escalated.

We had two presentations from microbiologist and their perspective around sampling and again being in a position to provide results promptly. This depended a lot on information provided and following the necessary guidance, This was key in the measles scenario the break out groups were tasked to review. The measles scenario involved a black 7 year old who had been seen by 3 GPs who failed to recognise the measles diagnosis due to the dark skin and how this presented. Implications were delayed treatment in a patient with history of eczema and the increased risk of spreading the condition. It was stated although it was very rare to see someone with measles despite having had two MMR jabs the illness would have been milder and less likely to be spread. Also given the majority would have been vaccinated the dangers or risk of this patient was reduced.

Data was reviewed on the Group A strep epidemic in 2022 where in Essex we lost 19 people.In late 2022, an ongoing disease outbreak caused by the bacterium Streptococcus pyogenes, It is often referred to as the Strep A outbreak. These bacteria cause group A streptococcal infections (Strep A or iGAS) and scarlet fever. In the UK 516 deaths from iGAS have been recorded, of which 61 were children, 52 in England, five in Wales,three in Scotland, and one in Northern Ireland. There were 3,729 notifications of iGAS recorded in England between 12 September 2022 and 18 June 2023. Notifications of scarlet fever have also seen a large increase, with 58,972 infections reported in England during the same period.

The UKHSA said that rate of iGAS cases were fluctuating at the upper end of the range expected for the time of year after the high levels seen during December 2022. Some of the learnings were around how quickly were cases identified and reported and the need for contact follow-ups.

Contact tracing was of great importance when we considered one of the scenarios where a patient who was positive for Hepatitis A had attended A &E and having to wait over 4 hours before being seen. The patient had used at least three of the toilets at the hospital which was one of the ways hepatitis is spread. The patient had left the hospital to go home and still no clear diagnosis of the Hepatitis infection. Issues arose around how we fast track patients with suspected infections.

During discussions in the afternoon I highlighted the need for increased awareness to community pharmacies of what needs to be reported and when in light of the new pharmacy first services. I stressed in particular in relation to GAS infections pharmacist will now often be the first to see and examine such patients as these are likely to be referrals under the pharmacy first scheme. I feel community pharmacies need to be reminded of the statutory obligation to report notifiable diseases to enable the proper action and follow-up to be made.

Notifiable diseases and causative organisms: how to report - GOV.UK (www.gov.uk)

Ride London – Friday 24th May to Sunday 26th May 2024

This is a cycling race with 120 athletes competing on across 160kms of road (which will involve rolling road closures) with stage one of the event starting in Saffron Walden which subsequently enters into parts of Essex. Potential impacts may include staff/patients travelling for appointments/work due the rolling road closures.

Details of the planned route can be found on our website.

https://cpesx.org.uk/resources/signposting-resources/contractor-support-material/

Meetings taking place soon

Pharmacy Forum Meetings

Monday 15th April 2024 at The Lion, Chelmsford 7 – 10pm

Tuesday 23rd April 2024 at Masons Restaurant 7 – 10pm

Wednesday 8th May 2024 at Caraways, Gants Hill 7 – 10pm

Community Pharmacy Essex Conference and AGM

Sunday 29th September 2024

Details of all our events are widely circulated to Essex Community Pharmacies and appear on our website.

Office Contact points

Office contact phone number: 01245 460079

General queries can be e-mailed to office@cpesx.org.uk or essex.lpc@nhs.net

Karen Samuel-Smith (Chief Officer)
karen@cpesx.org.uk mobile number 07900 218444

Angela Culleton (Office Manager)
angela@cpesx.org.uk mobile number 07566 798980
(Monday to Thursday 9am to 4pm)

Lisa Lovell
lisa@cpesx.org.uk