



NHS Scotland  
Directors of  
Pharmacy



## The Pharmacy Contribution to the National Primary Care Out of Hours Review

### Introduction

The pharmacy profession welcomes the opportunity to contribute to the National Primary Care Out of Hours Review and to offer solutions to address the challenges of providing care both out of hours and in hours. There is much to build on as pharmacy already contributes to primary care through the community pharmacy service, particularly the Minor Ailment and the Chronic Medication Services. In addition pharmacists providing services to GP practices are delivering direct patient care in this setting. Pharmacists are also working strategically in and across primary and secondary care to ensure effective pharmaceutical services.

The challenges in primary care are already well rehearsed and we do not propose to repeat them but rather to present short to medium-term solutions to deliver improved care for patients. In the long term it is acknowledged that the intention is that more will be achieved through the implementation of the Scottish Government's Prescription for Excellence strategy. We also recognise that many existing systems, such as the NHS Chronic Medication Service, if fully implemented would support effective prescribing and supply, reducing medication related enquiries in and out of hours.

We consider that a collective response from Community Pharmacy Scotland (contractor body), the Royal Pharmaceutical Society Scotland (professional body) and Directors of Pharmacy (senior pharmacy leaders for NHS Boards) provides reassurance to the National Primary Care Out of Hours Review that the profession is very much committed to playing a full and active part in improving health outcomes for the people of Scotland.

### Key priorities

The principal enabler to delivering many of this submission's recommendations is to ensure available information is utilised effectively. This requires as a minimum, that community pharmacies are given access to the Emergency Care Summary. This will enable them to play their full part in patient care during the out of hours (OOH) period. In areas where the Key Information Summaries are widely used, these too should be shared with pharmacy.

There should be greater use of the Minor Ailment Service by the whole population, making pharmacy the first port of call for these conditions. This would ease pressure on healthcare services both in and out of hours.

To resource the increased contribution of pharmacists and pharmacies, consideration should be given to reviewing existing funding arrangements for Scottish Government Primary Care programmes. An increased allocation could be provided reflecting added value to out of hours services by the pharmacy network.

### Recommendations

It is our view that with the appropriate resources, a commitment to full integration of pharmacy services and removal of existing barriers that these solutions are deliverable. If supported in principle by the National Primary Care Out of Hours Review then detailed implementation plans, including potential resource requirements will be developed. This detailed planning will require additional leadership capacity and the integration of accepted recommendations to the Prescription for Excellence delivery programme.

## Short Term Solutions

### 1. Enable all community pharmacies electronic access to the emergency care summary (ECS) and/or Key information Summary (KIS) and integrating IT systems.

a. ECS/KIS is already available to community pharmacists in some Health Boards via the Clinical Portal with positive results and is being rolled out in England. Without adequate information it is more difficult for community pharmacists to make informed timely clinical decisions, often resulting in onward referral to other in and OOH Services which could be avoided.

b. Extending community pharmacy access to GP systems e.g. Vision 360, would enable improvements in care, safety and efficiency and allow information about patient care to be pushed and pulled between GPs and community pharmacies. This could be managed in a staged process with access initially through a professional to professional gateway mechanism.

### 2. Extend the use of national community pharmacy patient group directions (PGD) and operating frameworks.

Based on available data, feedback from practitioners and pilots, we propose that national community pharmacy PGDs should be developed for a range of acute common clinical conditions. This should be based on the principles that the treatment of the condition can be undertaken by community pharmacists; that the PGDs will comply with relevant national prescribing guidance; that they will be adopted through usually local formulary processes and that where antimicrobials are to be used that an appropriate framework around antimicrobial stewardship is in place. Based on experience to date it is proposed that the first of these be:

- The treatment of suspected uncomplicated urinary tract infection in females. This has already been piloted in NHS Greater Glasgow and Clyde and NHS Grampian. .

In the medium-term, an additional three to five common minor illnesses should be identified to be managed by the pharmacy network initially via PGDs and by utilising current pharmacy prescribers as part of a staged roll out.

### 3. Maximise the use and promotion of the Minor Ailment Service (MAS).

The Minor Ailment Service (MAS) allows eligible individuals to register with and use a community pharmacy as the first port of call for the treatment of common minor illnesses on the NHS. Currently this service is delivered to 917,000 registered patients and during the April 2014 to March 2015 year over 2.1 million items were supplied.

Many of the top 25 common diagnoses presenting to out of hours services in 25 to 44 year olds could be dealt with by a community pharmacist using the MAS to prescribe to eligible patients. However at present, only about half the eligible population utilise this facility. The MINA Study, conducted in North East Scotland and East Anglia, showed that "Minor Ailment Schemes (MAS)" achieved high rates of symptom resolution, low rates of re-consultation and high patient satisfaction (1). A retrospective review demonstrated that 1 in 10 GP consultations and 1 in 20 A&E attendances could have been managed by community pharmacists (2). Limited evidence from economic evaluations suggests that MAS are less expensive than GP consultations (3). Proposed solutions include:

a. Review and extend access to the MAS by making it a universal service open to all to reduce the financial and resource burden on OOH and in hour GP services. This would require additional funding to be made available and appropriate modelling of the banded capitation system would derive the figure necessary.

b. To offset an element of this cost a national formulary that limits the medicines available for supply should be introduced at the same time as service provision expansion.

- c. Increasing public awareness of the MAS through a national publicity campaign supported by the inclusion of information about MAS in all relevant information leaflets about NHS Services.
- d. Increasing awareness of MAS and appropriate referral to and from GP practice, A&E and out of hours service staff to community pharmacy is required. This could be achieved through a specific communication theme in the winter pressures messaging for 2015.
- e. The inclusion of pharmacy staff in supporting self-care through raising awareness and utilisation of services such as NHS Inform or NHS MSK app

**4. Clarify and strengthen guidance around the use of the national unscheduled care PGD for Repeat Medicines/Appliances to reduce unnecessary workload on the out of hours service and GP services in hours.**

It should be noted at this stage that the statistics published by the Information and Statistics Division of National Services Scotland on the 4th August 2015 show that 997,112 OOH consultations were delivered during the calendar year April 2014 to March 2015. Over the same time period community pharmacies supplied 266,614 items using the unscheduled care PGD.

It can therefore be argued that without this facility the OOH workload would be in the region of 27% higher. (5) This highlights the already significant contribution that community pharmacists are making to the OOH provision using this supply facility.

The current PGD should be consistently applied by community pharmacists and accepted by GPs as a joint service to allow the full benefits of this service to be realised for patients, GPs and OOH services. Strengthened guidance and implementation would support more frequent and consistent use of this service until the Chronic Medication Service Serial Prescribing has been implemented nationally.

As a priority, we would also welcome more information about the medicine related issues that present to OOH/NHS 24 to allow for further discussion and resolution where appropriate within pharmacy services.

**5. Pharmacists with additional clinical skills in the assessment and management of minor illnesses could provide enhanced services in community pharmacies and specified locations in NHS Boards both in and OOH.**

This recommendation is based on the learning from the Scottish Government Pharmore+ Projects (4) which focused on specified common minor illnesses and co-location of OOH services.

In addition the skills of pharmacists could be utilised further in the management of long term conditions to reduce in hours pressures on GPs, with a focus on the recognition and management of exacerbations of chronic conditions that have an impact on unscheduled care.

**6. Extension of Emergency Hormonal Contraception** provision as part of the national community pharmacy Public Health Service to include Ullipristal (Ellaone®) is a welcome addition. This will widen the choice of treatment available and reduce the need for onward referral in and out of hours.

## Medium Term Solutions

The following proposals represent developments that have the potential to further enhance patient care by pharmacists and should be considered for introduction over the medium term.

They could be supported by a data gathering exercise carried out in conjunction with ISD and NHS 24 to identify further areas where pharmacy can alleviate the burden on the out of hours service.

### **7. Inclusion of community pharmacists within anticipatory care plans for chronic conditions**

This would enable community pharmacists to respond effectively as part of the multi-disciplinary approach and support reductions in unscheduled care. By way of an example NHS Forth Valley has operated a COPD PGD through community pharmacies since 2009. This service allows patients to access emergency antibiotics and steroids from community pharmacies to avoid exacerbations of their condition and prevent hospital admissions. Consideration should be given to implementing this service nationally.

### **8. A more formal alignment and partnership approach between community pharmacy providing extended hours, including evenings, Saturdays and Sundays and the OOH service would improve overall service provision and provide a building block for change.**

These extended hours are not currently recognised as part of NHS Services and improved joint working could be enabled by formal recognition and financial recompense where the services are provided based on local need.

- a. Improve the community pharmacy direct referral process. Strengthen the community pharmacy direct referral process between out of hours services and community pharmacists by creating a structured pathway between community pharmacy and NHS 24 supported by a clinical support role through NHS 24.
- b. Explore the need, in all Health Boards, for an extension of community pharmacy opening hours to support OOH services in the evenings and weekends.

The need for enhanced and additional services should also be assessed. The planning for this could become part of the Health Board Pharmaceutical Care Services Plan and be an integral part of the local NHS Board unscheduled care and winter planning process. Additional funding and resources should reflect this service.

### **9. Develop a national direct referral and clinical handover framework**

Building on pilot work in progress, agree a national direct referral and clinical handover framework between community pharmacy and other health care professionals. Pilots are underway in NHS Fife (SPSP) and NHS Highland (CP2GP) utilising the SBAR tool. Clinical handover to and from pharmacy settings should be enabled electronically.

### **10. Further explore pharmacist prescriber input into GP practices to build capacity in the primary care team in hours and to reduce out of hours service pressures.**

- a. Pharmacists can provide direct patient care including chronic disease management, anticipatory care planning and address medication related issues in the GP practice during the day to prevent the issues becoming a concern for out of hours. This would include referring patients to community pharmacies whenever appropriate
- b. A significant barrier to efficient working in any pharmacy setting is that pharmacist prescribers unlike nurse prescribers cannot electronically print prescriptions from GP systems. This functionality should be enabled urgently.

## Medium Term Solutions (continued)

### **11. Examine potential roles for pharmacist prescribers based in OOH service or local A&E Departments**

This role would potentially alleviate pressure on other members of the OOH team and would also include referring suitable patients to community pharmacies. There may also be an opportunity for joint planning with local hospital's A&E departments.

### **12. Expand pharmacist input into NHS 24**

The medicines expertise of pharmacists is an important part of the team within NHS 24. More pharmacist input to address medicines concerns and to enable pharmacist teleprescribing is underway and should reduce pressure on other services out of hours. Moving forward feedback from NHS 24 on common medicine issues that could have been dealt with in hours by pharmacists, GP, nurses and other health and social care staff would enable practice change to reduce this demand.

### **13. Reduce the negative impact of medicines shortages on patients, pharmacists and GPs**

The reasons for medicines shortages are complex and have a significant impact directly on patient care and time resource. A national response is required to identify innovative ways to tackle this.

### **14. Further enhance pharmacist assessment and management skills for common clinical conditions.**

Further develop pharmacists' clinical skills in the management of common clinical conditions. We understand work is underway within NES Pharmacy in this area.

## Long Term Solutions

### **15. Workforce planning for the entire pharmacy work force is required to ensure that current and future population pharmaceutical care needs are met.**

There is an urgent requirement to ensure appropriate funding for the training of pharmacy technicians and support staff across Scotland.

## Conclusions

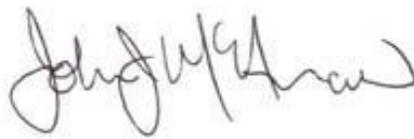
This response to the National Primary Care Out of Hours Review represents the collective views of the key stakeholder groups of the pharmacy profession in Scotland. The proposed solutions would address problems that are reported by pharmacists as multiple daily frustrations and inefficiencies for them, GPs, out of hours services and most importantly, for patients. It is therefore our view that if the solutions described in this paper are combined, scaled up across 1250 community pharmacies and NHS Boards and resourced appropriately they will deliver a sustainable reduction in demand on out of hours services.

Finally, we recognise the challenges in out of hours care and this will require changes to practice for doctors, nurses, pharmacists and other health and social care professionals to underpin the multidisciplinary team approach required. The Integrated Joint Boards and Health Boards must work together to address the current challenges and to plan for effective health and social care provision enabling patients to remain at home for as long as possible.

If you would wish to meet with representatives of our organisations to explore these solutions further or to propose additional options we would be pleased to do so. Meanwhile we look forward to continuing to work with the National Primary Care Out of Hours Review to support the necessary changes.



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## References

1. MINA Watson M.C., Ferguson J., Barton G.R., et al.

A cohort study of influences, health outcomes and costs of patients' health-seeking behaviour for minor ailments from primary and emergency care settings. *BMJ Open* 2015; 5:e006261

2. Fielding S, Porteous T, Ferguson J, et al, Estimating the burden of minor ailment consultations in general practices and emergency departments through retrospective review of routine data in North East Scotland .*Family Practice* (2015) 32 (2): 165-172. doi: 10.1093/fampra/cmz003 First published online: March 5, 2015

3. Paudyal V., et al.

Are pharmacy based minor ailment schemes a substitute for other service providers? *Br. J. Gen Pract* 2013; 63 (621) July 2013: 472-481

4. Pharmore+ Project Report.

## Statistics

5. ePharmacy Team July 2015

Month	Community Pharmacy Urgent Supply Items
April 2014	23,116
May 2014	22,936
June 2014	20,874
July 2014	22,577
August 2014	21,378
September 2014	23,273
October 2014	22,890
November 2014	21,922
December 2014	23,655
January 2015	22,082
February 2015	19,373
March 2015	22,538
<b>Total</b>	<b>266,614</b>

The number of Out of Hours consultations delivered in Primary Care over the same period 997,112.

Taking the number of items provided and comparing to the number of consultations

$$266614 / 997,112 \times 100 = 26.74\%$$

This gives a figure that, if the pharmacies were not providing urgent repeat medication supplies, would require a prescription to be written in an out of hour setting.