Community Pharmacy Scotland Additional Evidence

1) *"…supply data on what the patient comes into the pharmacy to pick up, on how they use it, on whether they use it appropriately and on adverse events are probably captured quite haphazardly throughout the system, and not in a routine way. That is definitely one area in which we can improve."*

The Committee seeks further information on why this information is not collected in a routine way, what are the barriers to doing so and what role Community Pharmacy Scotland can play in ensuring pharmacies are collecting this information.

Medicine Care and Review (MCR) could be the vehicle to improve this. The service is meant to have a feedback loop to GP practices (the treatment summary record (TCR)) on supply made from the pharmacy in relation to the serial MCR prescription. The TCR has not been routinely used due to technical difficulties and the serial prescriptions have also been patchy in use mainly due to GP practices being the ones who have to authorise the initiation of the prescriptions. CPS are now advocating that a mechanism be built in that could allow the pharmacist to request MCR prescriptions for regular repeat medications. This has the benefit of reducing GP workload of repeat requests/signatures and increasing the input of the pharmacy team with long term condition medications. The GP would ultimately still have oversight and cary out annual reviews for patients however the regular repeat, low risk supply can be overseen by the pharmacist and team. This would then allow monitoring of concordance and appropriate use of long term medication by community pharmacy.
On adverse events we have been promoted the use of the 'yellow care scheme' which allows patients and healthcare professionals to feedback adverse events via a mechanism set up by the MHRA. Usage is low but all healthcare professionals across the patient pathway have a duty to capture this appropriately to feed into the larger pool of information around established but particularly newer medicines.

1) *"..from Community Pharmacy Scotland's perspective, there is a need to look at the medicines care review and, potentially, to contractualise that slightly better in order that we focus on a proper medicines review so that we have conversations with patients and record the outcomes. At present, we have the conversations, but we do not record the outcomes. Our doing so would allow us to cement our place."*

   The Committee would like to understand whether this information requires to be contracted to be gathered and used, and what leadership role Community Pharmacy Scotland can take in initiating such action.

MCR has been rolled out over the last number of years however it is realised that the aspirations of the service have yet to be realised. The NHS Pharmacy First service is the focus of major contractual change this year for patient services however CPS have agreed that over the course of the coming year (thanks in part to a 3 year funding settlement being agreed) that we will focus on other areas of service. MCR is top of this list. The serial prescribing element and the capturing of outcomes is patchy at present and alongside officials we have committed to looking at the MCR framework to see what works and what can be learned and built on to do what the service is intended to deliver. The funding framework (not necessarily more money) is one element but the enablers around IT, partnership working with GPs and the clinical development of the service will all be scoped as part of this work.

2) *The Committee is interested in the evidence it has received from both Community Pharmacy Scotland and the Royal Pharmaceutical Society on the discussions which are taking place with patients in community pharmacy settings on their medicines. You suggested "As long as information is shared, the system as a whole benefits". However, it is not clear to the Committee if this information is always shared, whether there is a formal feedback process from the community*

pharmacy to the prescriber following these discussions or which body has primacy in terms of the advice provided to a patient.

The use of SBAR tools (Situation, Background, Action, Recommendation) forms are becoming more commonplace in primary care where a pharmacist will document and inform a GP of a significant intervention or action that they believe needs to take place after discussion with a patient. This is not routine however and at the moment is largely conducted via paper (occasionally through secure generic NHSmail). Most discussions between practitioners takes place informally where the relationship would be instigated by either party. A good example is medicine shortages where a GP may contact the pharmacy to ascertain availability of medicine and ask about alternatives and a pharmacist may contact the GP on receiving a prescription if there is an issue with dose, form or availability with a solution. Positive local relationships help in this instance where information sharing helps the patients and smooth transactions support seamless care . It is the role of all healthcare professionals at each point in the patient journey to advise, discuss and reinforce important messages around a patients medicines and to listen to any concerns they may have. Depending on the outcome of these will depend on whether any discussion is required within the primary care team.

3) *During a discussion on waste you suggested information on why medicines are being returned could be captured in community pharmacies and the Committee would benefit from further information as to why this is not already happening.*

This is not happening (in terms of being captured) as there is no means and obligation to do this. Patient return of medicines happen and patients are normally happy to tell you why they are returning them (e.g. deceased relative, side effects, change of treatment). I am sure an electronic solution to capture this could be developed.

4) *On 4th February, your colleague Campbell Shimmins told the Committee pharmacists attend people's homes to "double-check that the medicines are getting to the patient, that the patient is doing all right, and that the medicines are being used appropriately". The Committee would welcome further information on this scenario, including how a pharmacist would check the patient had the medicine, the professional guidelines to follow regarding home visits, the required safety checks for both patient and pharmacist and regularity (although Mr Shimmins mentioned this was not usual practice). What is preventing the development of a formal home visit service and why is this thought to be a "long way off"?*

This is indeed not usual practice but does occasionally happen. For instance when I was in full time practice I would occasionally visit housebound patients who required support and assessment of their medicine needs. This was not something the pharmacy was remunerated directly for. The main barrier to this is the 'Responsible pharmacist' and 'supervision' regulations for community pharmacy. These regulations mean it is difficult for a pharmacist to leave the premises and for the pharmacy to continue to operate for example without a pharmacist no prescription medicines should be supplied in their absence. There is a long running debate within the profession with regards to these regulations. Should they be relaxed to allow more innovative practice? Would this compromise patient safety? How can the wider pharmacy support team and technicians be used to support patients? These regualtiosna dn the underpinning legislation is reserved.

Use of pharmacy medication records, the patient themselves and if a delivery service is used then medicine supply should be logged and auditable. Some Health Boards are starting to look at models to support patients at home who need it alongside community pharmacy colleagues e.g. the care at home service in Ayrshire and Arran.

5) *You spoke about the need to reach "consensus" and the Committee would welcome further detail about how this is achieved between the prescriber and the pharmacist.*

I believe this is achieved in a number of ways. Best practice would be that referral pathways are shared and the lines of accountability drawn between prescriber and pharmacist. For instance in terms of compliance aids allowing the pharmacist to conduct the assessment with patients and then working in partnership to deliver the right medicine in the right form e.g. patient may have difficulty swallowing large capsules and may require liquid avoids waste and allows patients to get the best form medicines. Again good relationships between GP and pharmacist help demonstrating the value of each partner in the patient journey.

6) *The Committee would also appreciate detail of how reviews and checks are carried out on the medicines of patients to whom they are always delivered.*

Best practice for pharmacies will be captured in robust standard operating procedures. There should be a built in review point for the pharmacy team to check in with housebound patients. Delivery drivers are increasingly being trained to identify issues around medicines and signs of failing vulnerable patients as they are often the only touchpoint for these people. Reviews can be carried out, if appropriate, over the phone but some patients may require a home visit and this may happen where there is additional pharmacist support or elsewhere in the working week.

7) *On compliance aids, Campbell Shimmins suggested patients reviews would be more efficient and cost effective. If this is the case, what is preventing these from happening? What role can Community Pharmacy Scotland play in ensuring these happen.*

These patients will have long term conditions and this type of intervention/review would fall part of the MCR service. Point 1 illustrates how we are taking this forward using evidence based interventions, polypharmacy principles and what is right for the patient would be part of this.

8) *The Committee was interested to hear there are no Key Performance Indicators (KPIs) for waste of medicines in community pharmacy settings. The Committee is curious as to why this is the case and what benefits Community Pharmacy Scotland believe such a system could have.*

CPS would be interested in exploring what this would look like however there are many reasons for waste and it is a complex issue. Avoidable waste has to be understood and tackled however there will always be an element of waste with medicines which is unavoidable. This may be an issue that could constitute part of the MCR review. This service, and the principles behind it, if applied properly should see a reduction in avoidable waste.

9) *Finally, the Committee would welcome detail of the evidence based formulary being developed by Community Pharmacy Scotland, including when this will be ready for use, how the evidence has been developed, gathered and reviewed and whether this can be used in other parts of the NHS.*

The evidenced based formulary is being developed by the Area Drugs and Therapeutics Committee Collaborative (ADTCC). CPS has had input but the governance arrangements and expertise of the ADTCC is rightly being used to facilitate the production of the formulary alongside Health Board colleagues. While this will cover areas principally around common ailments this formulary should be able to be used elsewhere. We believe it will be ready by the end of March 2020 ahead of the launch of the NHS Pharmacy First service and will be reviewed at regular intervals.