1.The Committee would welcome further detail from you on what is preventing pharmacists from feeding back to nursing and GP colleagues now and what role the Royal Pharmaceutical Society can plan in bringing about the changes to information sharing and IT systems you are describing.

Currently the IT systems for different health professionals are not interoperable and do not "talk" to each other. Any important information a community pharmacist wants to make a GP or other health professional aware of must be communicated by telephone (not always directly possible during surgery hours), by e mail or by a written note. There is no direct method of ensuring this information is added to a patient health record to ensure safe interventions from the wider health and social care teams. Feedback can often depend on local relationships and verbal communication with local colleagues.

There are some areas across Scotland where solutions have been found between particular pharmacies and surgeries, using electronic messaging between the parties and a partnership working approach, but this is not the norm This is very useful for routine communication but even this will not ensure urgent attention is obtained.

Some areas have access to a clinical portal which helps with accessing some information but there is no method of adding to this. It also requires patient consent on every occasion, even to clarify essential details for safe prescribing. For routine repeat prescriptions this is clunky, not helpful operationally and we would like to see the issue of consent explored to find a solution which protects patient information but also allows health professionals to carry out routine tasks efficiently with no unnecessary red tape.

At the moment community pharmacists have to use the public phone number to contact NHS 24 for access to the Emergency Care Summary (ECS).This is wholly inappropriate on a professional level and can be very time consuming, resulting in delays to patient treatment and even unnecessary visits to A&E or out of hours centres. Access to ECS was promised by Scottish Government in 2014 but is not yet nationally available. Access to ECS would in any case only be the first step towards being able to input to the patient record.

RPS has lobbied extensively to have a uniform approach across Scotland to support community pharmacist access to ECS, KIS, the clinical portal and both read and write access to records to enable sharing of our interventions.

If NHS systems are to be integrated properly pharmacists should not have more difficulty in accessing essential information than their medical or nursing colleagues.

Our report on Access to Patient Health Records outlines some of the issues the profession encounters on a daily basis and the need for sharing of information.

RPS led the way with the Primary Care Clinical Professions Group to highlight that this issue is not just one for pharmacy alone. The submission to the Scottish Government Digital Strategy and the accompanying principles has also outlined the issues faced by the other frontline practitioners who also cannot send information back to the patient record by any proper means.

2.**You also spoke extensively throughout the sessions with the Committee on the good work community pharmacy does at the heart of the community in discussing medicines and prescriptions with patients. However, it is not clear to the Committee whether these conversations are simply good customer service in a retail environment, or whether they are being recorded and the information provided to prescribers to assist with the ongoing medical care of patients. The Committee is particularly interested in this in the context of patients choosing not to take a medicine following a discussion with a pharmacist and then returning to discuss this further.**

These conversations constitute good pharmaceutical care which is a key role for all pharmacists. However currently community pharmacists are not remunerated for this aspect of their professional expertise and there is therefore no formal way of recording these interventions as no metrics are required.

It's important to note that whether an 'intervention' with a patient or carer is recorded or not does not necessarily define it as patient care (recorded) or good customer service (unrecorded). Any meaningful conversation/ intervention is good pharmaceutical care, but not all such events are fully

recorded. Again, as above, any communication is hampered by poor IT links between community pharmacists and GPs, particularly because pharmacists have no read or write access to patient records. This lack of connectivity creates bureaucratic burden which makes it difficult to share the detail & outcomes of brief interventions in a standardised & constructive way. Safety critical information and incidents are routinely shared by community pharmacy teams with GPs and nursing colleagues e.g. by phone, email or written/ photocopied note, but without access to electronic patient records this will always be more difficult, time consuming (for pharmacists and GP practices) and arguably less effective. In summary most patient care is unrecorded.

RPS has advocated for many years that there must be a change in the system drivers to positively resource pharmaceutical care which is linked to a clinical check of prescriptions. Time is required to have meaningful conversations with patients on how they are managing with their medicines and to have the necessary follow up conversations to find out if a medicine is being taken as prescribed or has been discarded without any healthcare professional's knowledge . We know that somewhere between one third and one half of all medicines are not taken as prescribed and therefore treatment is not optimised with the subsequent negative effects on patient outcomes.

At the moment patients would only ever choose not to take a medicine following a conversation with a pharmacist if it was surplus to requirements and they already had more than enough supply, e.g. medicine which is only taken "as required". In this case it would not be dispensed or charged to the NHS. Sometimes a patient will decide not to take a medicine when they have read the information leaflet listing all possible side effects . This is where an initial conversation with the patient can be extremely helpful to aid adherence and alleviate any anxieties, and so both avoid waste and support better treatment outcomes.

We are not clear what further information the committee is looking for in this respect and would be happy to discuss this further to ensure a clear understanding of the current processes.

3. On 4 February, you suggested discussions with prescribers are necessary because you do not have access to patient notes. The Committee is sympathetic to the view notes and information could be shared more widely to achieve better outcomes for patients but is interested to know more about patient confidential data being shared in the context of the current arrangement. Are prescribers able to share more information with you over the phone and what protections are in place for the personal data of patients?

The usual NHS rules on information governance and patient consent are standard practice in a community pharmacy. In addition, pharmacists and pharmacy technicians, as registered professionals, are governed by their code of ethics. Other support staff are governed in exactly the same way as staff in GP practices where patient confidentiality is a priority. Having access to patient notes would mean not having to disturb a GP by phone for information which could be accessed electronically, but the same stringent rules on confidentiality always apply. Patient consent would always be requested when required and all conversations or access to notes are in the context of obtaining necessary patient safety information, usually to clarify the prescriber's intentions, or remedy prescribing errors, rather than to obtain sensitive patient information.

Our requests to have more shared information when advocating and lobbying have always been for registered professionals so that these safeguards are always in place. Unregistered support staff would not be requesting information verbally or in any other form from a GP .

By way of example some excerpts from professional and regulatory standards are below and comprehensive guidance is available in our *Medicines, Ethics and Practice, Edition 43, July 2019* and from the pharmacy regulator, The General Pharmaceutical Council *In practice: Guidance on confidentiality*, available at:

https://www.pharmacyregulation.org/sites/default/files/document/in_practice_guidance_on_confidentiality_june_2018.pdf

- Respect patient privacy and ensure that confidentiality is protected
- Information is managed to protect the privacy, dignity and confidentiality of patients and the public who receive pharmacy services
- Pharmacy professionals have a professional and legal duty to keep confidential the information they obtain during the course of their professional practice. The duty of confidentiality applies to information about any person, whatever their age and continues to

apply after a person's death.

4. On managed repeats, you said pharmacies tended to "micromanage" the preparation of medicines trays. Could you please provide further detail for the Committee as to what is involved in this?

Dispensing of monitored dosage systems (MDS) is a very time-consuming process which has to be managed very carefully to ensure patient safety.

Unfortunately, patients are not always assessed for suitability or requirement for these systems as an aid to adherence. The use of these in care homes where there are staff to administer medicines is a particular anomaly which has not been proven to improve patient safety and can increase waste of "only when necessary" medicines. We have produced guidance on best practice in the use of MDS which states:

"It's important that the assessment and selection of intervention options to help maintain healthy independent living are patient-centred, therefore the use of MDS must not be regarded as a universal solution"

Available on our website : https://www.rpharms.com/resources/toolkits/improving-patient-outcomes-through-mca

Preparation involves a very time consuming process of removing tablets/capsules from their packaging (sometimes specially designed for optimum storage and shelf life by the manufacturer) and placing them in the individual compartments for different times of the day to aid people who have trouble remembering to take all their medicines. The finished tray then has to have every tablet rechecked before dispensing is complete. If original packs were used as much as possible and MDS only when patient assessment has shown a genuine need, then a considerable amount of time would be freed up for more clinical care . This process also rescinds the product licence and so removes any manufacturer liability. Not every medicine is able to be included which can actually mean there is more risk of some medicines being forgotten.

We are very happy to take Committee members to see this procedure in a real situation by arranging a pharmacy visit for them.

5.The Committee would also welcome elaboration on how prescribers and pharmacists can "tightly control" some prescriptions for delivery and how patients can have more autonomy in other circumstances.

The guidance that Jonathan referred to can be accessed here:
https://www.rpharms.com/resources/pharmacy-guides/supporting-people-to-manage-their-repeat-medicines

6. On waste, you made an interesting point about the prescription of nutritional drinks and how where these are prescribed for individual patients in care homes, they cannot then be reused within the care home should that patient no longer require them. The Committee welcomes your comment this could be changed and asks why this has not already happened, what would be required to allow this to happen and who is responsible for such a change in policy?

Prescriptions are written for individual patients and require a label to identify the patient. This is written into medicines legislation. e.g. If that patient does not like strawberry flavour these would be returned to the pharmacy as waste and could not be used for another patient as labelled and belonging to the original patient.

A change in legislation at Westminster and/or NHS regulations in Scotland would be required to allow bulk prescriptions to be issued for certain items i.e. a supply given to a care home and the stock of nutritional drinks could be used by any patient prescribed them, allowing more flexibility in flavours and empowering staff to order these when required for general use . Our Care Home policy published in 2019 cited bulk prescribing as an enabler for waste reduction and efficiency.

"*Legislative changes/health board policy to allow bulk prescribing (currently possible in England but not Scotland) and supply of commonly used "P" or "GSL" items such as laxatives, calcium, vitamin D supplements and thickening agents.*

Various NHS clinical commissioning groups in England have issued guidance on bulk prescribing e.g. Mid Essex CCG

7. **The Committee was concerned to hear systems in place in pharmacies cannot comprehensively and accurately account for medicines, particularly when this results in the NHS paying for medicines which have not been issued and which can then be reissued by the community pharmacy. Could you please provide further detail on what would be required to improve the audit processes within pharmacies and why this is not being undertaken.**

The discussion which took place was very detailed about the instances where patients might not collect the balance of their prescription which has already been processed. We do not have accurate figures for this but it will be very small as the majority of patients will return to collect any substantial amounts they are still due and any small amounts such as the 5 tablets quoted will be a very insignificant cost overall. The more usual case is for the item not to be collected at all and then endorsed as not dispensed, no payment made and the medicines returned to normal stock as they have not left the pharmacy.

Our colleagues in Community Pharmacy Scotland would be better placed to elaborate on the technicalities and practicalities of the payment and endorsing processes**.** The use of original packs and calendar packs removes the need for splitting packs i.e. if 30 are prescribed but the pack is 28 that is what will be endorsed, paid and dispensed and vice versa. Given the complex nature of the prescribing and dispensing process and human factors involved, we are unclear how a better audit system could be in place which would be economically viable for the small amount of waste involved in the element of dispensing you are referring to.

8. The Committee would appreciate detail on the percentage of medicines which are wasted within a pharmacy through going out of date.

This information is not readily available and will vary between pharmacies depending on the efficiency their stock control processes. Pharmacies try very hard to minimise this while balancing having medicines readily available for their patients**.** Out of date stock is the responsibility of the contractor and is not charged to the NHS.

9. The Committee was interested in your comments about scanning technology which can be used to detect counterfeit medicine and would welcome detail on whether this could be used on returned medicines to ascertain their status and condition. If the technology is not currently able to do this, is it the view of the Royal Pharmaceutical Society this may be possible in future?

The Falsified Medicines Directive (FMD) is recent legislation which uses scanning technology. This does not facilitate using returned medicines because when a medicine is dispensed it has left the system and there are strict criteria for re-entering. These criteria align with the accepted guidance on not re-using any medicines which have left the pharmacy as patency and quality cannot then be guaranteed and counterfeits could re-enter at that point using the original packs.

We cannot envisage this changing in the future in any way which would be cost effective. We believe the World Health Organisation guidelines on not accepting returned medicines are fair and practical and that focus should be on not over prescribing, checking with the patient that all items are still required, and ensuring prescribing is appropriate in the first instance. This preventative approach, with regular medication review, combined with resourcing pharmacist's time for consultations and conversations with patients and deprescribing initiatives could achieve more efficiencies. A service similar to the New Medicines Service in England would provide feedback and follow up to ascertain any pharmaceutical care issues which result in people not taking their medicines but continuing to order.

10. You mentioned a lot of work is required on the career pathways of pharmacy staff. The Committee would welcome detail on what the Royal Pharmaceutical Society is doing in this regard.

We have advocated extensively for improvements in the career pathways of pharmacy staff and there are now changes in place which will support this to some extent but there is still much to be done . Much of this relies on continually enhancing the clinical role of pharmacists in community so that they are more fully integrated into the primary health care teams, using their extensive and unique education in all aspects of medicines more fully**.** Community pharmacists have not traditionally had the opportunities to access training and post graduate education in a similar way to their managed service colleagues, but this is changing. This direction of travel must continue both for pharmacists and pharmacy technicians if we are to avoid a crisis in recruiting enough staff to ensure our network of community pharmacies' remains viable and that the public can still have access to a pharmacy in their locality.

11. You also stated: "It is not an understatement to say that where we are at with our systems does not do justice to the hard work that they put into keeping our population safe". The Committee would welcome further detail on what you mean by this.

The current recording systems do not provide an audit trail of all the work done by pharmacists providing advice, support, expertise to patients and other health professionals. These traditional parts of the role including preventing prescribing errors, ensuring safe use of medicines both over the counter and prescribed, and reducing the need for GP and out of hours appointments, have never been properly resourced. Scotland has led the way in changing the model to some extent but it is still largely focused on supply.

The new Pharmacy First service which is about to be implemented has been structured to shift this balance and the system will start to provide essential data to illustrate the breadth and scope of pharmacy practice and how it contributes to the overall NHS.

12. It was suggested to the Committee that it can take 3 hours for a pharmacist in hospital to fulfil a prescription. The Committee requests your view on why this is the case and what can be done to improve this. Why are pharmacists in hospitals having to put in so much effort to achieve in 3 hours what their community pharmacy counterparts achieve in minutes? What are the barriers for them and how can these be resolved?

Most dispensing in hospitals is carried out by pharmacy technicians and support staff with pharmacists working primarily on the wards carrying out clinical checks on prescriptions and being involved in the initial prescribing decisions. This is a model which we would like community pharmacists to be able to adopt.

The actual dispensing process in the pharmacy is the same as for community. It does not take hospital pharmacists or technicians any longer to dispense a prescription than their community colleagues.

Hospital pharmacies will have similar busy periods to community but it is the very different operational systems in hospital which cause real delays. It could take 3 hours for a prescription to make its way through the hospital system and back to the patient. There can be many reasons for this. The fact that there is current debate regarding the speed of discharge prescription production & dispensing should not detract from the hard work & expertise of hospital pharmacy teams, especially as many of the issues surrounding timescales are at ward level and involve multidisciplinary healthcare teams. When a patient is discharged by a consultant on a ward round it can take some time for a discharge prescription to be written and then to arrive at the pharmacy. This is very much dependent on individual ward systems. Electronic prescribing is not yet the norm in all hospitals. This is being rolled out nationally and should improve many aspects of prescribing as well as speed up communications between wards and dispensaries.

There have been suggestions that with the easy accessibility of community pharmacies discharge prescriptions could be dispensed at the community pharmacy of the patient's choice. This would involve contractual changes and an integrated approach.

13. You expressed frustrations regarding the nature of the supply chain and the time required by pharmacists in procuring medicine. The Committee would welcome your view on why it is a pharmacist and not another member of staff such as a technician or admin colleague who is undertaking this role. As the customer, what can community pharmacies do to encourage better models from wholesalers?

You are correct that technicians will routinely be undertaking this role as part of the pharmacy team. In hospitals both technicians and admin staff will be involved rather than pharmacists. In community unfortunately is it not usual to have any admin support but again this will often involve a technician if available. We have advocated in the past that there is a role for a "pharmacy manager" similar to a GP practice manager who could release pharmacists and pharmacy technicians from many administrative duties. A survey of our members showed that pharmacists are spending up to one day a week dealing with the bureaucratic burden in general. Time which could be used for patient care.

The procuring of medicines became increasingly problematic when some pharmaceutical manufacturers implemented a quota scheme and will not release stock without seeing a prescription to verify that quantity was needed. This is a highly inappropriate and unprofessional practice. Industry effectively have the power to decide their own supply chain options and this 'direct to pharmacy' model, bypassing wholesalers, has become more common in recent years and has made ordering of medicines more complex and time consuming for community pharmacy teams.

14 During discussion of non-medical prescribers, you said pharmacist prescribing has "gathered pace". The Committee would welcome the detail of this, including the relevant figures you mentioned.

National Health Education for Scotland (NES) hold the current figures for prescribing pharmacists. Recently community pharmacists have been funded to undergo prescribing training. This is very welcome but the systems to allow the best use of this prescribing in community practice have yet to be developed. Pharmacist prescribing from community pharmacies has great potential to support improved patient access to the NHS and reduce the pressure on GP appointments in future.

15 You raised concerns about the reuse of medicines which had left the control of a hospital or prescriber due to a lack of knowledge of the storage conditions. The Committee would welcome further detail of which medicines have stringent storage requirements which compromise their efficacy if not handled correctly. The Committee is seeking to ascertain whether this represents a significant proportion of medicines.

This would usually be medicines which require refrigeration and need to be keep in a patent cold chain right through the supply system. Manufacturers will normally provide information on request if there is a query on storage conditions. We have no figures on the proportion of medicines which are affected by this but would estimate this is still very small when compared to the number of items dispensed nationally. It is important that everyone handling medicines is well informed of the requirement. We have produced guidance for other health professionals on this. Available on our website here.

16. The Committee would welcome detail of your estimate that 5% of prescriptions contain an error, including the studies you mentioned on rates of error in prescribing.

In his response, Jonathan referred to a study but wasn't sure he was quoting the correct statistic. The study he referred to can be found here: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/investigating-the-prevalence-and-causes-of-prescribing-errors-in-general-practice

The research found that 1 in 20 prescription items contained either a prescribing or monitoring error, so Jonathan's 5% figure was accurate.

17. During discussion on incentives for prescribing, you promoted the value pharmacists add "through conversations with patients, oversight activities and so on." It is not clear to the Committee whether this does represent added value if community pharmacists are not recording this information or sharing it routinely and consistently with prescribers. You have asserted this is due to the lack of IT infrastructure, and the Committee would welcome your view on why the lack of suitable technology is a barrier to this taking place altogether as opposed to a tool which would make the processes which should exist easier. Furthermore, it is not clear to the Committee why the Royal Pharmaceutical Society cannot take a leading role in development of the tools required.

We have advocated for a long time that the system needs to change to remove targets and incentives which focus mainly on sales and supply. Focus should be on rewarding the pharmaceutical care

which is provided. Traditionally because of the business model it has been difficult to collect evidence on the positive outcome's pharmacists are responsible for. Pharmacists have always provided invaluable advice to patients to improve adherence and health outcomes, but without an audit trail or any resource attached. The new Pharmacy First service is a welcome development which will for the first time provide that evidence. There will no longer be an incentive to prescribe or sell products but more focus on using the expertise pharmacists have in responding to symptoms and treating common clinical conditions. We fully support this new development which aligns well with our manifesto asks from the last Scottish elections. It is not our role to develop the specific tools required but to continue to advocate for improvements in the NHS systems to reflect the clinical skills pharmacist have.

Are you looking to the Scottish Government for action in this area and if so, the Committee would welcome details of the discussions you have had on this issue? You mentioned communicating via Post-Its and sending medicines back to prescribers. The Committee would welcome further detail on why this is deemed the most efficient way to communicate an issue with a prescription, what could be done to improve this, who is responsible for leading on such improvement, what role can the Royal Pharmaceutical Society play in that and what level of delay is the current system causing for patients.

This is answered in question 1 above.

18. The Committee was interested in your view community pharmacies are an "integral" part of communities, particularly in those where other local services such as banks and post offices are no longer physically present. As private businesses, what incentivises community pharmacies to operate in areas where other businesses have deemed it no longer viable? What is to stop a community pharmacy in a remote area from closing? What additional functions can a pharmacist perform which would improve viability?

Community pharmacists are the health professional most people see most often and in some areas are the only health professional nearby. Community pharmacies are contracted to the NHS in the same way as GP practices are and over 90% of their business is NHS related. Realistically with the current business model, they need to be situated close by a doctor's surgery in order to be able to process enough prescriptions to keep the business viable. Online dispensing has not yet affected contractors to the same extent as it has the banking industry and as health professionals, pharmacists prefer to be face to face with their patients whenever possible.

Viability will be sustained if the direction of travel now being implemented by Pharmacy First is continued and the profession is resourced for clinical services.

Hospital at home could be more closely linked with community pharmcy ensuring that patients had pharmaceutical care and access to a health professional linked to their supply. It would also ensure control of the supply chain for the specialist storage requirements for some of these complex medicines, previously supplied from secondary care but much more convenient for the patient at their community pharmacy.

There is great potential to expand the public health role which would support a national prevention agenda. It would also be possible to use remote video consultations for housebound, working people and others who find it difficult to reach services within working hours. Care home and care at home provision could be improved.

All of these suggestions would reduce pressure on other parts of the NHS and make much better use of the clinical skills already available and we would be happy to meet and discuss these in more detail.