Cheshire Local Pharmaceutical Committee - Call to Action

Cheshire Local Pharmaceutical Committee covers 204 contracts in the Cheshire, Wirral and Warrington Area Team footprint operated by 61 contractors. This document has been prepared by the LPC in response to NHS England's "Call to Action" campaign. It contains the collective views of the Committee members and Officers within the LPC. The basis of the recommendations has resulted from views and opinions expressed by committee members and from attendance at local meetings held to discuss "Call to Action".

The LPC recognises that a shift change in the provision of services will be necessary in order to fully utilise the un-tapped resources and skills that Community pharmacies possess. The LPC recognises the need to fundamentally change the way health services are currently provided and that Community Pharmacy needs to be fully integrated into newly created health and social care pathways.

A brief Summary of the key themes from the consultation includes:

- Integration of community pharmacy into primary care patient pathways via significant pharmacy representation throughout the redesign process and effective partnership working with other health and social care professionals.
- Better access to information to improve decision making and improve patient care via the Summary Care record.
- Redistribution of workload from other healthcare sectors to Pharmacy:- new roles for pharmacy in the management of long-term conditions, a greater role in the management of minor ailments.
- More services to be commissioned nationally to ensure a consistent approach across all communities, with the opportunity for locally commissioned services to develop new innovative services.
- Greater use of technology to improve patient safety and communication with patients and professionals.
- Improved marketing of the role of community pharmacy to the public and healthcare professionals to ensure a full understanding of the services provided and drive more patients into pharmacy as a first port of call.

1) How can we create a culture where the public in England are aware of and utilise fully the range of services available from their local community pharmacy now and in the future?

The Local Pharmaceutical Committee believes that the public have a lack of understanding regarding the range of services that are provided by a community pharmacy. This understanding varies depending on the age group of the individuals, whether they themselves take medication for a long-term condition or are a primary carer. This is in part due to the variation in services that are currently offered by pharmacies. We believe that the following key changes would produce the required shift change in culture and behaviours.

There are currently services that have been widely commissioned across the country at a local level each with variations to the service and specification. These services should shift to being commissioned at a National level to a nationally accredited specification.
For example Minor Ailments services, Emergency Hormonal Contraceptive services (EHC), and the provision of flu vaccinations. This would provide consistency in the healthcare delivered and would allow patient and healthcare providers to better understand what services they could expect. In the case of a minor ailments service a GP, receptionist or practice nurse could readily access national information regarding the conditions included in the service and range of medication supplied. Services developed at a National level would reduce variation and unnecessary duplication of resources required to set up each individual service.

The "Healthy Living Pharmacy" (HLP) concept should be implemented across England as a nationally accredited service.

The Healthy living pharmacy concept, which was piloted in Portsmouth, delivers a range of health and wellbeing services consistently to a high quality, with measured outcomes. It promotes health and wellbeing and proactively offers brief advice on a range of healthcare issues such as smoking, physical activity, sexual health, healthy eating and alcohol consumption. The programme should be rolled out nationally with a clear marketing campaign explaining the services and benefits they offer. Every Pharmacy as a Healthy living pharmacy would help to put pharmacy at the forefront of the patients mind when it came to dealing with health related issues or when they required health related advice. The national accreditation process could be expanded to include some level of self-accreditation and company accredited in house training, where available. This would facilitate the more rapid introduction of Healthy Living Pharmacies; reduce costs to the NHS, whilst maintaining professional standards and providing greater patient care.

Existing healthcare pathways should be reviewed to identify missed opportunities to redirect patients into the pharmacy so as to develop a cultural change in the way patients and other healthcare providers view pharmacy.

There needs to be a consistent message across all healthcare pathways that the pharmacy is the primary starting point for self-management of minor ailments, health education and advice about medications for long-term conditions. It could also be the starting point for the management and monitoring of long-term conditions.

Experience from our branches indicates that NHS 111 referral is uncommon. It appears that not enough NHS 111 end points utilise the opportunity of referral to community pharmacy and these pathways need revisiting.

A triage system could be set up in GP practices and A & E to identify and refer those patients whose condition could be more appropriately managed by the pharmacy team.

Pathways need to be redesigned with a view to changing roles and clarifying the roles healthcare providers have. This would involve some professionals ceasing to carry out some existing roles and passing them to other healthcare providers like community pharmacies e.g. GPs would no longer carry out consultations for Minor ailments which pharmacy would take on. In addition, this would provide the added benefit of reducing the GPs workload and reducing overall costs to the NHS.

A system of rapid pharmacy to GP referrals could be introduced as part of a minor ailments scheme. The patient would be required to attend their community pharmacy, where the pharmacist could then recommend appropriate medication or refer on to the GP. GPs would only see patients that needed to be seen and the patient would gain quicker access to their GP. GP workload would be reduced as the majority of patients in this category would be dealt with by the pharmacist.

A greater number of NHS services which are free at the point of contact would increase patient involvement with pharmacy.

The Community Pharmacy sector and Government need to improve the existing promotion of the services offered by pharmacies and deliver a sustained approach to marketing of services.

We need more national promotion which utilises all forms of media. This could include pharmacists providing advice on TV or radio, pharmacists providing healthcare advice in men's and women's magazines, magazine articles which direct the public to the pharmacy for self- management of minor ailments, greater use of web sites and social media, e.g. twitter.

NHS websites e.g. NHS Choices and patient information websites need to direct patients to pharmacies as a source of information and assistance in managing their long-term conditions.

We need to use media more selectively to target specific hard to reach groups of the population who visit pharmacies less frequently and so are less aware of the services offered. For example the 16 – 25 age group and men aged 40+ without long-term conditions. Many of these individuals are making choices that will adversely affect their long term health and would benefit from healthcare services or advice. The range of services, delivered by pharmacies, which are more relevant to the 16 – 25 age group e.g. sexual health services, should be increased.

In addition, work should be carried out with representatives of these groups to identify the best way to engage with them.

It is felt that one area that could help to change the public's perception of the community pharmacist would be to promote more fully the level of training a pharmacist has. Campaigns should utilise the fact that a pharmacist has studied for 4 years at university to gain a degree and then completed a further years training prior to becoming qualified. This could be included in campaigns covering advice regarding minor ailments, OTC medicines, and life-style changes. As a result of this lack of understanding many people will automatically visit their GP or A&E without considering other healthcare providers like community pharmacy which has significant costs to the NHS.

Pharmacy need to be visible to the public and other healthcare providers and needs effective representation in patient forums and community groups.

GP practices and A & E waiting areas need up to date information regarding the services local pharmacies offer and should signpost patients as appropriate. Services should be promoted via displays on screens in GP surgeries and walk in centres.

If we are to see the full benefits of pharmaceutical care there needs to be a shift in the perception of community pharmacy from within the NHS itself by other healthcare providers. Community pharmacists need to be seen by fellow professionals as full members of the wider primary care team and a core part of the NHS.

Healthcare professionals are reluctant to refer patients into local pharmacies for services which are currently provided. It would be helpful if they were more active in directing patients to pharmacy. For example GPs and hospitals rarely refer eligible patients to their community pharmacy for the New Medicines Service. National data from the service will provide evidence that these referrals into the service are very low in comparison to pharmacy recruitments. GPs should identify patients who would benefit from a Medicines Use Review (MUR) and refer into the pharmacy. These referrals should be monitored to establish how well the process is embedded in the patient pathway.

Promoting the role of pharmacy to other healthcare providers and educating them on the services provided would lead to more effective referrals and improved distribution of healthcare provision.
It is felt that GPs, practice nurses and hospital staff lack a full understanding of the services provided by their local pharmacies and are reluctant to advocate the role that the pharmacist can play in managing the health of their patients. There needs to be a shift in the mind set of these professionals to recognition of the benefits that the community pharmacy can offer and towards regular referral for services. For example a well-informed GP, practice nurse or receptionist would be able to redirect suitable patients to their community pharmacy. Referral from the local surgery reinforces the role of the community pharmacy as a first point of call which will reduce the number of GP appointments lost to patients with conditions that could have been treated effectively via a community pharmacy.

2) How can the way we commission services from community pharmacy maximise the potential for community pharmacy to support patients to get more from their medicines?

In order to ensure that all patients benefit from their medication, pharmaceutical care needs to be provided in the community pharmacy, patient's home and care-homes. There are numerous ways which community pharmacy can deliver or develop such services.

The development of a **national Medicines Optimisation Service for patients with long-term conditions** would ensure the patient obtains the **best outcomes from the medication** they have been prescribed. Medicines optimisation looks at how patients use medicines over time. It may involve stopping some medicines as well as starting others, and considers opportunities for lifestyle changes and nonmedical therapies to reduce the need for medicines.

This service could be provided within a community pharmacy or by the relevant pharmacy contractor in the patient's home or care home. This service would ensure that:- the patient has been prescribed the most suitable medication, is able to take the medication in its prescribed format, understands when and how the medication should be taken in order to provide the best results. It could utilise the Screening Tool of Older People's Potentially inappropriate prescriptions and Screening Tool to Alert doctors to Right Treatments (STOPP/START) medication review process which specifically targets high risk medicines.
Benefits of the service would include reduced medication waste, improved self-management of long-term conditions and better adherence to medication, reduced exacerbations resulting in fewer GP appointments, fewer hospital admissions and a more empowered patient.

Greater use of MURs in the patient's home would support patients with their medication, enable them to better manage their conditions and prevent unnecessary hospital admissions. This would target the most vulnerable group of patients who currently slip through gaps in existing service delivery mechanisms with benefits similar to those above.

All patients with long-term conditions should have to be referred to a community pharmacy to receive an MUR on discharge as part of the hospital discharge pathway. This could include a new medicine review if applicable. Any questions that have arisen since discharge, non- adherence due to side effects or difficulty in taking the medication could be addressed. Issues would be tackled more quickly resulting in less harm to the patient, less likelihood of re-admission to hospital and reduced medicine waste. Current evidence from MUR data collection provides evidence that this model of referral is rarely utilised.

The existing New Medicines Service (NMS) should be developed to expand the list of medicines included. GPs should be **required** to refer the patient for an NMS if an appropriate medicine has been prescribed. Referrals from the GP would help to increase uptake of this service with the benefits of improved patient adherence, increased patient outcomes and reduced wastage. In addition, the GP would gain greater information regarding the patient's issues via the GP feedback / referral form. A positive element of the NMS service is that it provides patient choice, in allowing them to choose a telephone consultation if preferred, which helps with access to patients.

Pharmacists should be commissioned to manage patients with specific long- term conditions to clearly defined protocols. This would reduce the workload for GPs who are currently unable to offer the required number of appointments to meet patient demand. It would enable patients to better understand their medication and how they can make positive lifestyle interventions to improve their health. It would ensure that they are receiving the appropriate monitoring, some of which would be completed during the consultations. Additional services such as smoking cessation programmes and weight management programmes would be provided for relevant patients. The pharmacy is well placed to meet the needs of these patients who often present in the pharmacy on a monthly basis as opposed to infrequent visits to their GP.

The amount of patient support and monitoring done in community pharmacy could be increased to ensure that currently dispensed medication is appropriate. For example a patient who takes medication for high blood pressure could have a requirement to have their blood pressure (BP) checked bi-monthly. This would be recorded in the pharmacy and then paid accordingly. The pharmacist could receive additional payments for the identification of patients who appear to have uncontrolled blood pressure. This may require further tests at closer intervals to confirm that the patients BP is outside of NHS target values.

A national structured emergency supply system should be set up to allow pharmacies to make emergency supplies of medication to eligible patients free of charge, with an associated mechanism to reimburse the pharmacy. At present patients often choose to consult an out-of-hours service or accident and emergency department to obtain an emergency supply of medication. For those patients who don't usually pay for their medication this is due to the cost of obtaining the emergency supply. Community pharmacy could be commissioned to provide a free, NHS funded service, to eligible patients, thus relieving pressure on out of hours and Emergency services and reducing the associated costs.

Pharmacy has a significant role in the promotion of public health. However public health campaigns can be launched with short notice preventing optimum training and engagement of pharmacy staff. Notification of a public health campaign schedule should be provided at least 12 months in advance to enable appropriate planning and effective delivery. Larger community pharmacies could link national public health campaigns to company specific health promotion which would enable better impact of the public health campaign and avoid conflicting priorities. This would enhance the public's awareness of the role of community pharmacy in improving the health of the nation and reduce cost for the NHS. Cost and waste reduction, due to increased uptake and use of NHS engagement materials and as a result of larger community pharmacies providing company specific promotions, boosting the overall campaign effect

Further develop the role of the independent prescribing pharmacist and commission services via the community pharmacy contractor model.
The role of the Independent pharmacist prescriber has shown a slow uptake within the primary care setting. This in many instances is due to the difficulties the independent prescribers have had in accessing a prescribing budget that they can issue prescriptions against. The development of the role of the independent pharmacist prescriber would link to the plans outlined in the Scottish Governments proposal "Prescription for Excellence" and that of the Royal Pharmaceutical Societies "Now or Never".

However, we do not believe that separating the supply function from pharmaceutical care can be cost effective. Furthermore we believe it creates new risk, through communication breakdown, in what is an established safe process. There are also questions about liability, registration and amount of patient contact time that would be available to a peripatetic pharmacist. The local community pharmacy provides easy access to patients who would benefit from the service. The model provides a clear link between the supply of pharmacy services and the prescribing service itself. It provides an excellent opportunity to meet the needs of vulnerable house bound elderly patients. Such patients regularly receive deliveries of medication and would benefit from a home visit from a pharmacy prescriber from their local community pharmacy who understands their history and background.

Pharmacy is well placed to identify patients who would be suitable for the Repeat Dispensing Service and management of this process could be shifted to community pharmacy where ordering of patients medication is routine. The repeat dispensing process allows a GP to issue a number of repeat prescriptions for a patient which are then dispensed in sequence across a number of months, usually as defined by the GP. The patient doesn't need to reorder medication each month, they can simply collect from their pharmacy and the GP practice saves time due to reduced processing of monthly prescription. Since its introduction this service has received an inconsistent uptake and is under-utilised in many areas across England. The current mechanism for selection of suitable patients lies with GP practices, many of which have not fully engaged in the process resulting in poor uptake of the service. The new processes within EPS2 make the management of Repeat Dispensing much easier for both the Pharmacy and GP. A particular benefit is the GP's ability to cancel and reissue a repeat prescription to the spine should a clinical reason become apparent during a patient consultation. This provides the GP with rapid control of the repeat prescription unlike the previous paper based system.
When the patients collect their medication the pharmacy would ensure that the medication was being taken as prescribed, relevant advice was provided or if clinically appropriate the patient was referred to the GP. This has the benefit of reducing ad hoc GP appointments and medication waste in the form of unused medication. Hidden benefits that often go unseen.

As previously outlined, it is recommended that the majority of services provided in a community pharmacy should be commissioned at a National level as Advanced services. These services should be to nationally defined standards and specifications. For example a tiered national minor ailments service should be commissioned across England which at level 1 treats the same basic minor ailments and ensures that each condition is treated with the same medication/s to provide consistency. It could allow for a group of nationally commissioned prescription only medicines (POM) at level 2, with a small number of local POM medicines at level 3 as required. Commissioning services at a national level will ensure consistency in the provision of services and avoid confusion amongst patients and healthcare providers. It will also reduce costs associated with the commissioning of numerous local services.

The commissioning of a greater number of advanced or enhanced services to national specifications should include the adoption of Community Pharmacy Competence Group as a national structure and self-competence declarations by pharmacists as competent to deliver the advanced service.

The need would still exist to develop and commission new and innovative local services to meet specific social and demographic needs of individual communities. A database of local services could be registered centrally so that organisations that wished to develop specific local services could pool resources and work together to develop more consistent new services. At a critical mass this service would then be developed into a national service with a national specification.

The existing contractual mechanism needs to allow for greater collaborative partnerships between healthcare providers. There is a need to align the General Medical Service contract to the Pharmacy contract so that both providers benefit from greater multi-disciplinary working. The existing contractual arrangements provide no incentive for collaborative working between GPs and Community Pharmacy. The General Medical Service contract could provide the GP and practice nurse with an incentive e.g. Quality Outcomes Framework (QOF) points for referring a patient into a community pharmacy for health related services such as a minor ailments consultation, MUR or NMS.

The national NHS standard contract is too complex for the Community Pharmacy services. The contract needs be revised so as to allow for greater flexibility to incorporate newly commissioned services easily and to simplify the process for commissioners and pharmacy providers. For example Local Authorities (LA) and Clinical Commissioning Groups (CCGs) could instruct the local Area Teams to commission pharmacy services to a standard National specification which the Area Team could then manage and the costs associated with the service could be re-billed to the LA and CCG.
With the creation of new patient pathways and the possibility of shared health and social care budgets it is envisaged that the extension to the range of services provided by community pharmacy will be funded by the release and reallocation of existing NHS and social care funding streams. Any recycling of existing funding from dispensing services to newer services would devalue the dispensing service while adding costs into the pharmacy operation. For example a national EHC service in pharmacy is likely to cost less than subsequent payments, both health-related maternity and social care, which arise through unwanted pregnancies. There needs to be recognition that Community Pharmacy can offer more and that innovative ways of looking at budgets will release the funding needed to pay for these services.

A nationally recognised framework could be set up to allow contractors to work together to create a commissioning framework. This could include a change in regulations to allow Local Pharmaceutical Committees (LPCs) to hold contracts.

Community pharmacy needs to utilise systems which are able to capture the range of services provided, the interventions made and the positive outcomes to patients resulting from such interventions. The use of PharmOutcomes was significant in providing sufficient data to enable the commissioning of the NMS service beyond April 2013. Greater use of electronic data capture systems such as PharmOutcomes or Webstar would provide an evidence base for commissioners looking to develop additional services. This data could be used to provide evidence for the further development of services e.g. Anticoagulant services or EHC with follow on contraceptive provision.

There will be a need for effective workforce planning and the development of the appropriate skill mix within community pharmacies. Delivering more innovative care from the community pharmacy setting, with a shift from the pharmacist being predominantly involved in the dispensing process will require a change to roles within the pharmacy. This includes the development of new roles for the accredited checking technician (ACT), dispenser and healthcare assistant. A greater number of ACTs will be required which should be encouraged at a national level. The decriminalisation of dispensing errors would go a long way to encouraging more existing dispensers to take the step to accreditation.

3) How can we better integrate community pharmacy services into the patient care pathway?

The introduction of the Health and Social Care Act 2012 offers significant opportunities for community pharmacy to be integrated into new patient care pathways to improve patient health and wellbeing. This is further enhanced by the move towards combined budgets amongst health and social care with joint accountability and shared objectives.

Optimal delivery of pharmaceutical care requires a step change in establishing collaborative partnerships. The pharmacist working in partnership with the patient, GP, nurse, social care worker and any other professional involved to ensure the best outcomes for the patient.

The local Area Teams (AT) should create Healthcare Engagement networks responsible for developing new patient pathways that include representation from community pharmacy. They should include patients and representatives from the local CCG, LPC, Local Professional Networks (LPN), Social Care, Public health and Secondary Care. The networks would identify opportunities to deliver care differently with the reallocation of funding from existing budgets to provide care in the most cost effective way. This should include the creation of more pathways that redirect patients into the pharmacy and away from overstretched or more expensive NHS resources.
Data from these Networks would feed directly to NHS England for dissemination of ideas to other Area Teams and ultimately the redesign of patient pathways.

Services need to be redesigned to eliminate duplication and free up existing resources to allow the delivery of care more effectively to all patient groups. The current Community Pharmacy Contractual Framework and General Medical Services contract fails to dovetail services effectively. They support duplication of effort and gaps in service provision. For example, a relatively mobile patient may receive a medicine review in their surgery and then shortly afterwards an MUR within their pharmacy. The standard pharmacy contract only allows for the provision of an MUR in the pharmacy, therefore an elderly or house bound patient who is unable to visit the GP surgery or pharmacy receives no service.

Services should be redesigned with an emphasis on maintaining the health and wellbeing of patients and allowing greater self-management of conditions. They should prevent deterioration in the patient's condition resulting in reduced input from hospital services or social care services.

A referral to pharmacy by social services would integrate the role of community pharmacy in relation to social care. For example a vulnerable patient may be identified that needs help and advice in relation to the management of their medication. A home based pharmacy visit to provide an MUR or Medicines Optimisation service has the potential to reduce hospital admissions, improving patient outcomes and prevent the patient from requiring greater access to the health and social care system.

The role of community pharmacy would be better integrated into the wider healthcare system if patient pathways started with the pharmacist managing long-term conditions and referring into the GP as required. The role of the community pharmacist is currently seen as providing isolated "add on" services, for example in the case of MURs and NMS consultations. In addition, many community pharmacies provide EHC and Chlamydia testing and the role of the pharmacy could be further developed and integrated into existing sexual health service pathways.

Hospital discharge pathways need reviewing with a view to ensuring that the patient's community pharmacy is provided with discharge information. This would allow for timely interventions and further embed community pharmacy in the patient pathway.

NHS structures e.g. Local Education and Training Boards (LETB) which provide national leadership on planning and developing the healthcare and public health workforce need to have community pharmacy representation for example in the form of contractors, the LPC or LPN so as to ensure that the appropriate workforce planning is completed in relation to future pharmacy service provision.

Access to the Summary Care record in read and write format would make a huge impact to how a community pharmacy can improve the level of care provided to a patient and been seen more fully as a key healthcare partner with patients GPs and hospital staff. At the moment community pharmacists are responsible for clinically checking prescriptions with limited access to the patient's history yet they will often have greater patient contact than the GP.

Access to the Summary Care record would allow greater ability to identify patients who are potentially at risk, but not apparent due to lack of information. It would enable issues with their medication to be resolved more quickly using information directly from the patients record. It would reduce significantly the amount of time that GPs and practice staff spend resolving queries and would reinforce the message that the community pharmacy is working in partnership with other NHS services. It would clearly identify those patients who have recently been discharge from hospital enabling any new issues to be dealt with in a timely manner, and where necessary could allow for a pharmacy based referral to social care for assistance thus minimising the risk of re-admission to hospital.

An further option would be to develop a system which allowed for information such as:- medication allergies, the patients most recent INR reading or Lithium levels to be sent to the pharmacy when an electronic prescription is drawn.

It is necessary to improve the links between pharmacy and the GP surgery. This would develop a partnership approach which currently exists with some, but not all, GP practices.
It should be possible to allow access to the GPs patient records for patients who are nominated as pharmacy of preference on the Electronic Prescription Service 2 (EPS2) system. This would enable a greater understanding of the patient's health condition and remove the need for many timely queries to the surgery. In addition, there should be a simple electronic mechanism by which the pharmacy can feed information directly into the patient's record in the GP practice. For example to record a patient's blood pressure reading, alcohol consumption or smoking profile. Direct access for the pharmacy would be the most straightforward option.

In order to develop and integrate the role of the pharmacy it will be necessary to change the way in which the community pharmacy is perceived and operates.
The role of the pharmacy technician, dispenser and healthcare assistant needs to be developed and opportunities for the expansion of this role reviewed. Other members of the team could take on the role of healthcare champions as seen in the HLP model.
Pharmacy technicians could be allowed to supervise the transfer of bagged up prescription medication to the patient in the absence of a pharmacist. This would free up the pharmacist to spend more time linking to the GP surgery and developing working relationships. In conjunction with this the Responsible Pharmacist absence rules should be aligned to the NHS Pharmaceutical Regulations to allow absence to occur without breach of contract.

Pharmacy workforce development needs to link into existing structures such as Health Education England (HEE) and their Local Education and training boards that providing national leadership for planning and developing the whole healthcare and public health workforce. This would ensure that the pharmacy workforce plans are integrated and linked to future developments in healthcare services.

Many CCGs have pharmacist employees to provide pharmacy advice to GPs. However this advice could be provided by the local community pharmacy contractor with the benefit of integrating the pharmacist more fully into the practice team, building relationships and developing a greater understanding of roles. Alternatively, opportunities exist for other healthcare professionals for example INR nurses to lease consultation room space and provide their services from a local community pharmacy.

There needs to be greater consideration of how to level the playing field between GPs and pharmacies as independent contractors. Pharmacies are too often seen as commercial organisations; however, GPs are also independent. This similarity is not often understood in the NHS and we need to get around this perception of pharmacy being a more commercial entity.

The current pharmacy payment structure is volume led based predominantly on the number of prescriptions dispensed. The General Medical Service Contract has a greater element of practice based payments to cover populations with payments based on specific outcomes. If transformational change in the delivery of services is to occur there needs to be a full review of the payment structure for community pharmacy to allow for changes in direction.

4) How can the use of a range of technologies increase the safety of dispensing?

We need to improve the use of IT and operational systems to make it easier for medication safety incidents to be reported and shared. The current system of informing pharmacies of recurrent or major errors appears to be ad hoc in nature. Improvement is required in the sharing of dispensing incidents across all pharmacies, multiples and independents.

The incident reporting process needs to be improved to make it simpler. It needs to ensure that the National Reporting and Learning Services (NRLS) regularly reviews data submitted by pharmacies and reports issues of concern to all pharmacies in an easily accessible format. Cascaded information should include the nature of the incident, key lessons to be learnt and how they may be prevented in future. The information should include new errors which are occurring, possibly due to a formulation change, common errors and common near misses. In addition the NRLS system could be incorporated into the GP patient medication record system for those practices that want to use it.

It is necessary to developing a culture which allows staff to feel comfortable reporting a dispensing incident and near misses so that all staff involved in the dispensing process can learn from reported errors. Decriminalisation of dispensing errors would reduce the barriers to reporting.

Technological changes to the dispensing process could be used to reduce human error from the process. Increased use of automated dispensing in the pharmacy could reduce the number of errors made as a result of human error. This would still require the appropriate clinical checks to be made on the prescription to ensure suitability of the medications and dose etc. This could then free up the pharmacist for more face to face consultations and management of long-term conditions. It is envisaged that robotic dispensing may be easier to implement in a multiple pharmacy setting with centralised dispensaries rather than the independent sector. High cost and lack of space being possible barriers to introduction. This development could be facilitated by the introduction of a payment system to support its use.

However, it is felt that the sole use of centralised robotics and the use of mechanised dispensing hubs, with postal delivery of prescriptions would reduce footfall into pharmacies and therefore reduce the opportunities for interventions with patients. Patients would no-longer receive face-to-face advice about their medicines. There is a danger that this would result in poorer compliance and missed opportunities for referral into other services e.g. smoking cessation.

Existing bar code technology could be developed and utilised as part of the dispensing process. This would require scanning the bar code during the dispensing process to confirm that the items that have been selected for dispensing match the items on the prescription and the label. A process such as this would require the consistent use of original pack dispensing and full role out of EPS2 in order to truly be effective.

Patient safety from counterfeit medications could be improved if the recommendations of the Falsified Medicines Directive were implemented. This requires tamper evident packaging and a unique identifier so that the medicine's identity can be verified.

The Electronic Prescription Service 2 needs to be fully implemented and developed so that it works effectively all of the time. The electronic prescription should be the default option without the offer of a paper prescription. The system should be further developed to allow the dispensing of controlled drugs a particularly high risk area for dispensing errors. The electronic prescription would eliminate the opportunity for transcription errors produced during the labelling process and subsequent errors which result due to the ordering of an incorrect medication.

Greater consistency in the dispensing process would be achieved if 28 day Original Pack dispensing was always used.

Access to the summary care record would assist in clarifying medication queries that result during the clinical checking of the prescription.

If there was a mechanism by which medication prescribing and supply could be managed or captured on the same system it would enable all involved in patient care can see what was prescribed and what was actually dispensed.

The introduction of technologies outside of community pharmacy to improve patient safety from dispensing errors include:-

Develop Hospital systems to issue computer printed prescriptions in out-patient settings. This would avoid errors in reading poor handwriting and improve the speed at which a patient receives their medication as fewer delays would occur querying missing or ambiguous information on prescriptions.

Develop computer printed discharge medication sheets that are passed to both the GP and pharmacy. This would make it easier for the GP and pharmacist to identify changes to the medication due to improved clarity and fewer issues relating to poor handwriting. Experience suggests that errors are spotted when a patient passes a copy of the discharge medication summary to the pharmacy and this is cross checked against the prescription. Alternatively, current NHS systems e.g. EPS 2 could be further developed to allow them to be printed in the dispensary with the prescription.

Wider use of phone applications should be made to improve patient care. These could be used instead of the paper based recording systems. They could be used for the patient to log INR readings. Direct reporting of INR readings to the patients registered GP rather than via paper based recording would ensure the most accurate information was available for the GP.

We hope that the suggestions above demonstrate the willingness of Community Pharmacy Cheshire contractors to work with NHS England in tackling some of the challenges that face it by using community pharmacists, often referred to as an unused resource, to deliver innovative and cost-effective solutions.