THE NEW CONTRACTUAL FRAMEWORK FOR COMMUNITY PHARMACY

Section 1 – New contractual framework

Introduction

1.1 The new contractual framework for community pharmacy agreed for England and Wales between the Department, the Pharmaceutical Services Negotiating Committee (PSNC) and the NHS Confederation, completes a long-held ambition to modernise and shape NHS community pharmacy services for the future. Subject to a ballot of contractors, it will go live from April 2005.

The Vision

1.2 It makes clear the role of community pharmacy and its contribution to the achievement of targets for the health sector on improving access and choice and helping people with long-term conditions. It also brings to fruition the objectives set out in *A Vision for Pharmacy in the New NHS* (July 2003). Drawing on community pharmacy's assets of the skills, expertise and experience of pharmacists and their staff and its presence in the community with a tradition of ready access to all, community pharmacy should

- Be – and be seen to be – an integral part of the NHS family in providing primary care and community services;
- Support patients who wish to care for themselves;
- Respond to the diverse needs of patients and communities;
- Be a source of innovation in the delivery of services;

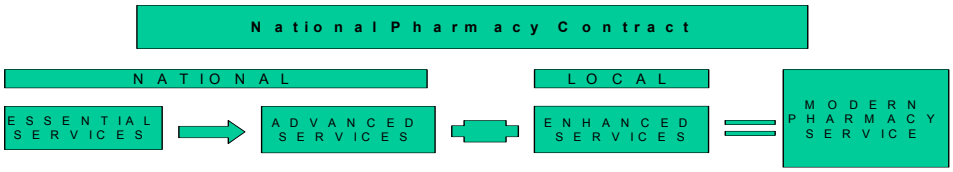
- Help deliver the aspirations within the National Service Frameworks, and
- Help tackle health inequalities.

Community pharmacies will provide a greater range of services and be rewarded for the range and quality of those services.

The service framework

1.3 There are three tiers of services: nationally set essential and advanced services (for which £1.766bn funding is available in 2005/06) and locally enhanced services commissioned by PCTs.

1.4 It is envisaged that there should be a periodic review of services in the contractual framework to allow for updating or revision of service requirement and standards of provision. As part of this, there may be a shift in the categorisation of services, for example, a service might move from being in the enhanced category to the essential category.



Essential Services

1.5 Essential services are defined as those services that must normally be provided by all community pharmacy contractors under the new arrangements. Such services together with advanced services will form the 'nationally agreed' services and will not be open to local negotiation. Activities to be undertaken as part of each essential service and standards of delivery are specified in **Annex A**.

1.6 Essential services include:

- Dispensing,
- Repeat dispensing
- Disposal of medication
- Promotion of healthy lifestyles
- Sign-posting
- Support for self care
- Support for people with disabilities
- Clinical Governance

All pharmacies will be required to put in place clinical governance systems and support continuing professional development, elements of which are specified at national level - specification for Clinical Governance is shown in **Annex A**.

Advanced Services

1.7 Advanced services are those services that require accreditation of the pharmacist providing the service and/or specific requirements to be met in regard to premises. Medicines Use Review and Prescription Intervention Service is the one service under this heading at present but others may follow in due course. Under medicines use review the pharmacist will periodically undertake a structured review with patients receiving medicines for long term conditions, to establish a picture of their use of the medicines – both prescribed and non-prescribed. The review will help patients to understand the therapy, identify side-effects and changes that may be beneficial. A report of the review will be provided to the patient and to their GP.

1.8 Pharmacists and pharmacies will need to be accredited to provide the service. Details of accreditation requirements for pharmacists will be made available in due course.

1.9 The pharmacy premises will need to meet certain standards to ensure the review takes place in a confidential and suitable environment. Consultation areas must meet the following principles:

- the patient and pharmacist can sit down together;
- they can talk at normal speaking volumes without being overheard by staff or customers, and
- the area is clearly signed as a private consultation area.

Pharmacy contractors will certify to the PCT that their consultation area meets these requirements.
Specification for Medicines Use Review and Prescription Intervention Service is shown at Annex B

Enhanced Services

1.10 Enhanced services are those which will be commissioned locally by PCTs. In the case of each additional service identified in the new contract framework, actions and outcomes of the service will be specified. Examples of enhanced services include:

- Minor ailment schemes
- Smoking Cessation Services
- Supervised administration of prescribed medication
- Needle and syringe exchange schemes
- Anticoagulant Monitoring
- Medicines assessment and compliance support

- Care home support
- Patient group direction service
- Full clinical medication review
- Supplementary prescribing

1.11 PCTs will also be able to develop other enhanced services to meet their needs over and above those already identified, and LPS will continue to be an option available to PCTs for delivery of local services.

The benefits

1.12 Through the new contractual framework, community pharmacy will help address a number of health priorities bringing new benefits for patients. These include:

- *Improved patient choice and convenience* in accessing medicines, for example through repeat dispensing
- *Sustained achievement of the 24/48 hour access target*, for example through minor ailment schemes,
- *Reducing demand* on GPs and other primary care staff, through pharmacist lead clinics, for example for people with diabetes.
- *Care for people with long-term conditions*, through pharmacists undertaking medication reviews and monitoring treatment through near patient testing.
- *Supporting the delivery of nGMS*, by helping GPs meet their quality targets for prescribing and medicines management, supporting access to medicines out of hours and as alternative providers of local, enhanced services (eg anticoagulation monitoring).
- *Reducing health inequalities and improving public health* through services for drug misusers, smoking cessation clinics and generally promoting healthy lifestyles.
- *Improved patient safety* through advice to patients and other health professionals and safe systems for handling medicines and learning from patient incidents.
- *Better value for money* by reducing the wastage of medicines, ensuring patients still need their medicines before they are dispensed, know what they are for and how to take them for best effect.

Section 2 - PCTs and the new contract: commissioning, support and monitoring

2.1 Primary Care Trusts (PCTs) will have a key role to play in the implementation of the new contract and in its ongoing monitoring. As commissioners of all local NHS services, PCTs will take the lead in the development of new pharmacy services to meet the needs of people in the area and also in supporting the implementation of the new contract by pharmacy contractors.
The terms of the contractual framework or 'contract' will be, as with current arrangements, national arrangements laid down in secondary legislation (Regulations).

2.2 In order to maximise the benefits of the new contract, PCTs will need to plan for the development of community pharmacy services in their area. Conducting a pharmaceutical needs assessment is the first stage of developing a coherent plan for service development. This planning process will help to determine the Enhanced Services that could be commissioned from pharmacies in order to meet the PCT's service development needs. A pharmaceutical needs assessment will also inform the services PCTs are able to prescribe for applications under three of four of the control entry exemptions. PCTs should make available information on these prescribed services before applications for these exemptions are made.

2.3 PCTs will also have a role in the monitoring of the Essential and Advanced Services provided by pharmacies within their area. This monitoring role will not commence immediately on implementation of the contract: there will first be a transition period until 1 October 2005 to allow pharmacy contractors and PCTs to get to grips with the changes necessary. However, PCTs should initially assess the preparedness of contractors for the new contract and monitor progress in order to identify support that the PCT could provide to contractors. Guidelines on monitoring will be published to inform the implementation process.

Essential Services

2.4 To realise the full benefits of essential services, PCTs have several key functions to perform

- agree with the Local Pharmaceutical Committee the topics to be covered in the campaign element of the Promotion of Healthy Lifestyles (PublicHealth) service.
- work with their GP practices and pharmacies to facilitate the move towards repeat dispensing services being provided across their area.
- make arrangements for the supply of receptacles and collection of waste medicines

Advanced Services

2.5 PCTs will be able to offer guidance to contractors on the groups of patients within their area who may benefit most from receiving a Medicines Use Review (MUR) and Prescription Intervention Service. The PCT will maintain a list of pharmacists who have demonstrated that they have successfully completed an Advanced Service competency assessment. PCTs will also monitor the quality of Advanced services being provided and confirm that the consultation area meets the required standards.

Enhanced Services

2.6 Service specifications for Enhanced Services have been developed using experience from existing locally negotiated services. LPCs and contractors will be able to negotiate to provide services in accordance with these specifications where a local need for the service is determined. National benchmark prices will be agreed for these services which will help to guide local funding discussions. Alternatively LPCs, contractors or the PCT will be free to develop their own local services in response to identified needs. The list of service specifications will grow, but the initial list includes:

- Minor Ailments Services
- Smoking Cessation Services
- Supervised Administration of Prescribed Medication
- Needle and Syringe Exchange Schemes
- Anticoagulant Monitoring
- Medicines Assessment and Compliance Support
- Care Home Support
- Patient Group Direction Service
- Full Clinical Medication Review (Room for Review Level 3)
- Supplementary prescribing

Enhanced Service specifications and benchmark prices will be published later in 2004

Section 3 - Financial summary

Introduction

3.1 All contractors, large and small, depend at present on profits from purchase of medicines dispensed for the NHS to supplement the Global Sum income. This income source is substantial, but was not recognised under the present arrangements.

3.2 In 2001, following the generics shortages in 1999 and the market turbulence that ensued, the Government published a paper, *Options for the Future Reimbursement of Generic Medicines*, which canvassed two options, and which included the express objective of paying pharmacies as closely as possible what they actually pay for medicines they dispense under the NHS. Pharmacies reliance on purchase profits has been recognised by the Department of Health and PSNC. Thus, money released from a reduction in reimbursement prices for generic medicines will be used to contribute to funding the new contract. These changes will be implemented to the same timescale as the contract in a move to greater transparency in the funding of community pharmacy.

3.3 To support the new funding, a cost inquiry was undertaken in July 2003, using a statistically representative sample of pharmacies. In addition, detailed modelling was undertaken of the new services to ensure that they were fully costed. An accepted financial model was adopted for assessing what return on their investments community pharmacies needed in order to gain fair funding for the services. In the course of negotiations, it was agreed that both the costs and fair return would be based on the independent pharmacy sector. Analysis of profits in the supply chain also looked at prices available to the independent pharmacy sector, to ensure consistency of approach in the evaluation of both costs and income.

Funding for ETP

3.4 The costs of existing pharmacy computer systems were captured in the cost inquiry so this has been recognised in the funding for Essential Services. This excludes the costs of new IT which will be required to support the contract.

3.5 To be able to participate in electronic transmission of prescriptions (ETP), communicate electronically with other members of the primary care team and access the NHS Care Records Service (NHS CRS), pharmacies will be required to use a National Programme for Information Technology in the NHS (NPfIT) compliant pharmacy system, which will need to be connected to N3, the NHS' new national network. Pharmacies have various options to choose from as to how they connect to N3. They do not have to purchase a direct connection through N3, however they will need to acquire a service that provides a sufficient quality and speed of connection to enable the pharmacy to operate an efficient ETP service.

3.6 Contractors will be paid a set allowance once the pharmacy has sufficient connectivity, an NPfIT compliant pharmacy system and undertakes to transmit electronically to the PPA. Whilst pharmacies continue to provide an ETP service they will receive an allowance for maintenance and connectivity. At present, pharmacy system suppliers are working directly with the NPfIT on upgrading their systems to achieve NPfIT compliance. The payment level of the allowance will be agreed once the cost of NPfIT compliant systems in the market place is known.

Payment for advanced services

3.7 Pharmacies providing Advanced Services, once accredited, will be paid a fee based on the number of reviews that they agree to undertake during the course of the year. The fee, which amounts to £23 per review, takes account of staff costs and allowances for premises conversion, booking appointments, administration, and fair return.
Pharmacies will need to meet fully the Essential Service requirements before they can provide Advanced Services. In the first year of the new contract, the number of reviews that each pharmacy may undertake will be limited to 200. This limit will be reviewed for future years and it is expected that the funding available for Advanced Services will grow as pharmacies develop this service.

Overall funding

3.8 The table below sets out the funding for England for 2005-6.

Service Elements	**Total Remuneration £million**
Essential Services	£1,669m
IT/ETP	£58m
Advanced Services	£39m
Total	£1,766m

Funding streams

3.9 The overall funding described above is made up of a number of elements described in the table below:

Source	**Sum £million**
Global Sum – new	£866m
Addition for repeat dispensing	£100m
Payments from PCTs*	£300m
Retained generics margin**	£300m
Additional retained purchase margin**	£200m
Total	£1,766m

DH will remove £300m from retained purchase profit by reducing Drug Tariff generics reimbursement prices. This money will be used to fund the new national contract, i.e. not for the locally commissioned Enhanced Services.

***** This therefore assumes that in total £500m will remain in purchase profits, between generics and other purchases.***

Payments for PCTs

3.10 Practice payments, advanced services and the allowances for IT/ETP will be funded from the £300m released from the reduction in the margins on generic medicines. At the start of the new contractual framework, the Drug Tariff will be issued with revised generic medicine prices, which will reduce the margins on generic medicines and lower the cost to PCTs' drugs bills. PCTs will be charged by the PPA for their contribution to the cost of the new community pharmacy contractual framework, which will be met from money released from the drugs bill through lower generic medicine prices. The potential impact on individual PCTs is being modelled, i.e. the cost of the new contractual framework to PCTs versus funds released from PCTs' drugs bills from lower generic medicine prices. Further information will be made available shortly. Please note these reductions in generic medicine prices are quite separate to those already actioned in December 2003 and September 2004 for four recently off patent medicines.

Formula for future years

3.11 Under the new contract arrangements the Global Sum will continue to be adjusted, as now, by sums reflecting general government indices. Staff cost increases and costs associated with dispensing volume rises will be recognised, and adjustments additional to those in the Global Sum will be made to establish fee levels.
The components that will inform annual adjustments will be:

- The GDP deflator, the Government's measure for underlying inflation.
- Increases in dispensing volume, at marginal cost.
- Increases in staff salaries in excess of GDP deflator levels.
- An efficiency assumption, which assumes some ability to make efficiencies and is consistent with efficiency targets in the NHS as a whole.

In addition to the above, adjustments to the sums will need to reflect costs necessitated by significant additional regulatory burdens on contractors.

3.12 Reviews will take place at three yearly intervals as to whether a new cost inquiry is needed.
Agreement has also been reached to ensure that the levels of supply chain profit reflect independent contractors' ability to secure those levels. The arrangements will avoid undue delays in making any adjustments needed.

Section 4 - Payments, fees and allowances

Funding for the new essential services

4.1 Detailed calculations of funding for average pharmacies at different dispensing volumes can be found in Annex 4 of PSNC book entitled 'The New Contract for Community Pharmacy 2004 ' at http://www.psnc.org.uk

4.2 The income pharmacies derive from purchase profits will differ: the arrangements will be based on prices available to independent community pharmacies.
Individual pharmacies' income levels will also vary, as now, according to numbers of fees earned for CD dispensing, dispensing of expensive prescriptions, and also provision of aids for people eligible under the Disability Discrimination Act (a new Essential Service requirement).

Global sum payments

4.3 The item fee under the new contract will be 90p per item dispensed. The balance of the Global Sum will be distributed in special fees and allowances, and as Establishment Payments.

4.4 The special fees and allowances will include, as now, payments for dispensing Controlled Drugs, an Expensive Prescription Allowance, and fees for measuring and fitting appliances.
The Establishment Payments are set at the levels shown in the table below for 2005-6.

Number of items dispensed per month	Annual Establishment Payment £
2,000	£20,000
2,250	£20,911
2,500+	£21,821

These payments will be adjusted annually to reflect the increase in dispensing volumes and the balance of the Global Sum.

Practice Payments

4.5 All pharmacies dispensing 1,100 items or more per month will be eligible to receive a Practice Payment. These are set at the following levels shown in the table below for 2005-6:

Number of items dispensed per month	Payment Level
1,100	£2000pa
1,600	£3000pa
2,000+	24.2p per item

4.6 Pharmacies will be required to have minimum dispensing support levels in order to receive the full Practice Payment. Reduced levels of payment will apply where pharmacies do not regularly employ the prescribed level of support. The requirements shown in the table at the top of the next column will apply.
These levels do not reflect desirable staffing levels. They are the bare minimum below which no pharmacy could meet the new contract service requirements. For most pharmacies higher staffing levels will be required to provide the new contract services.

Number of items dispensed per month	**Dispensing staff in addition to pharmacists FTE***
3,500	0.5
5,000	1.0
6,500	1.5
8,000	2.0
9,500	2.5
11,000**	3.0

* *Dispensing staff include: a second pharmacist, a non-practising pharmacist working as a dispenser; a pre-registration student (50% full time equivalent) or an assistant in the dispensary trained to undertake the functions being performed*
** *Pharmacies will be required to employ an extra0.5 FTE dispensary staff for each additional 1,500 items they dispense per month.*

4.7 Pharmacies that cannot demonstrate that they employ dispensing support staff at these levels will receive the payment levels only for the number of items indicated for their actual level of staffing. So for example a pharmacy dispensing 7,000 items a month employing only one full time equivalent dispensing assistant would receive Practice Payments for only 5,000 items, not the level for 7,000 items.

Pharmacies dispensing low numbers of prescriptions

4.8 Additional measures will be available to support pharmacies that are dispensing fewer than 2,000 items per month.

Protected Payments

4.9 Special arrangements will apply to pharmacies that dispense more than 1,100 items but fewer than 2,000 items each month. These pharmacies presently receive payments from the Global Sum (the Professional Allowance) to a maximum of £18,000 per annum. They will continue to be eligible to receive these payments for three years under the new contract.

Practice Payments

4.10 All pharmacies dispensing 1,100 items per month or more will receive Practice Payments (see Table above). In addition, pharmacies will receive funding for repeat dispensing.

Exit Payments

4.11 For pharmacies with low dispensing volumes that wish to close, there will be a limited opportunity to claim an exit payment. A pharmacy may relinquish its contract and receive the Global Sum Professional Allowance it would have earned had it remained open for a further year. So a pharmacy dispensing 1,600 items receives £1,500 per month at present. If it opts to relinquish its contract, it could claim a £18,000 exit payment. Conditions will apply and this option will be available only for the first full year of the new contract (i.e. until March 2006).

Local Pharmaceutical Services

4.12 Local Pharmaceutical Services (LPS) will continue. Parties to the negotiations are discussing a Standard Form LPS. This will specify services to be provided by a contractor to receive increased payment levels, to raise income for low volume contractors. Contractors would be able to apply to their PCT to provide services under this Standard Form LPS. This would enable a low volume pharmacy providing valuable services to its patients, during the first three years of the new contract, when the protected payments will be available, to make arrangements for the continued provision of services.

ESPS Pharmacies

4.13 The ESPS arrangements will continue to supplement the income of low volume pharmacies located more than 1km from the nearest pharmacy, under which they will receive payments applying to pharmacies dispensing fewer than 2,200 items per month. A Standard Form LPS for ESPS pharmacies is being considered

Section 5 - Transition and implementation

Transition to the new contract.

5.1 The new contract will go live, subject to the contractor ballot, from April 2005. Contractors will be expected to make arrangements to comply fully with the new Essential Services as soon as possible. Some pharmacies will need time to make adjustments to their procedures, in particular to undertake the clinical governance requirements. Compliance with other Essential Services: signposting, waste disposal and health promotion, will be subject to the local PCT making arrangements and communicating those to pharmacies.

5.2 There will be a minimum transitional period for contractors. Monitoring for compliance with the requirements will not begin until 1 October 2005 and PCTs will need to give contractors at the minimum three months written notice to remedy any non-compliance before any formal action for non-compliance can be taken.

Implementation of new essential services

5.3 Repeat Dispensing
Contractors' payments include payment for undertaking repeat dispensing services (see the service specification in **Annex A**). PCTs should work with their GP practices and pharmacies to facilitate the move towards repeat dispensing services being provided across their area. Initially, until the introduction of the electronic transmission of prescriptions, repeat dispensing will be paper-based

5.4 Compliance support for people eligible under the Disability Discrimination Act
Pharmacies have an existing legal obligation to make reasonable adjustments to their service provision to support people with disabilities. They will therefore be required to provide the service on request to eligible patients. The service specification found in **Annex A** explains the service.

5.5 Waste
This will be subject to the PCT making arrangements for supply of receptacles and collection of waste at intervals and contractors will be obliged to provide the service once those arrangements are in place. Again, the service specification is found in **Annex A.**

Implementation support

5.6 The Department is working closely with a number of organisations to support implantation of the new framework. These include the National Primary and Care Trust Development Team (NatPaCT), the National

Primary Care Development Team, the Medicines Management Service of the National Prescribing Centre and the Centre for Pharmacy Postgraduate Education, as well as NHS colleagues from SHAs and PCTs and others.

5.7 A prospectus is being produced to publish this package of support and will be available in early November at http://www.natpact.nhs.uk

Elements of the support package to be available in due course include:

- guidance on the new framework and control of entry reforms
- roadshows for PCTs in December
- a help-line
- information on web-sites, including “frequently asked questions”
- tool-kits, for example to support PCTs in undertaking pharmaceutical needs assessments to inform commissioning and their role in supporting and monitoring
- the development of strategic tests

Section 6 - Pharmacy IT and electronic transmission of prescriptions

Pharmacy IT systems

6.1 Information technology will play a fundamental part in helping pharmacists to provide the new services outlined in the framework for the new pharmacy contract. Electronic Transmission of Prescriptions (ETP) will allow some of the new contract Essential Services, such as Repeat Dispensing, to be carried out more efficiently.
Access to electronic patient records, via the NHS Care Records Service (NHS CRS), will assist with provision of Advanced and some Enhanced Level Services.
In order to be able to operate ETP all pharmacies will need to use a NPfIT compliant pharmacy system connected to N3. This IT functionality will be a requirement of the new contractual framework although there will be a suitable transitional timetable to allow contractors to install and upgrade their systems. This transitional period will be set independent to the general transition period, described above, for providing Essential Services.

6.2 During the initial implementation of the contract, measures will be put in place to allow pharmacists to undertake new services without supporting functionality being available in the pharmacy, for example, repeat dispensing will use a paper-based system until ETP is introduced.

Getting connected

6.3 N3 is the new integrated network for the NHS which pharmacies will need to connect to. It is a combination of broadband connections and network services that will link all NHS sites in England. Unlike NHSnet, N3 is an open network and there are a number of ways to connect to it:

- By direct connection using one of the N3 Catalogue services
- By connection through a corporate network or managed network (such as NPAnet)
- By connection via any broadband internet service provider, using an N3 virtual private network (VPN) product as a security layer

6.4 It will not be mandatory to purchase a direct connection through N3 as secure access to NHS information can be provided via third party links. However, if a provider other than N3 is used, the NHS will not be able to guarantee service levels or performance. The NPfIT N3 team will be able to assess a pharmacy's requirements and recommend the required quality and speed of connection. Minimum connectivity requirements will be specified. An on-going funding allowance will be paid for connectivity and maintenance, in addition to the set-up payment.

ETP

6.5 NPfIT has been working with pharmacy system suppliers on the changes needed to their systems in order to achieve NPfIT compliance. It is anticipated that the first pharmacy systems will undergo compliance testing in December 2004. The aim is to progressively roll out ETP from early 2005.
It is likely that the initial roll out of the ETP service will be via a small number of early adopter sites. The speed of roll out will then be accelerated to cover the whole of England.
ETP will bring about a change in working practice within the pharmacy. There may be additional service requirements when operating ETP. However, some of these may be offset by a reduction in others, such as no longer needing to key in information.

Access to patient information

6.6 Individual electronic NHS Care Records will contain the patient's medication history, details of any allergies and medical conditions and will include a summary of a patient's contact with all care providers.
A care professional providing care to a patient will be able to access the records. However, sharing of patient information is sensitive and the care professional should only have access to the information needed to carry out the care role safely and effectively. He or she should not pass that information on to anyone without the consent of the patient
To ensure that patient information in the electronic Care Records remains confidential and only the information needed is shared, there is provision in all NPfIT compliant systems for robust information governance controls. The information about an individual that will be made available to the care professional will be determined by the role that the care professional is undertaking at that time for the individual.

6.7 This is known as 'role based access control'. Discussions as to what levels of access to patient information a community pharmacist may need when undertaking services within the new contractual framework have been ongoing and it is anticipated that there will be a wider consultation. The NHS Care Records Service will be gradually implemented over the next five years, starting in 2005 as a summary health record.

Simplification of Drug Tariff rules

6.8 Over the past year, discussions have taken place between the PSNC, the Department of Health and the Prescription Pricing Authority (PPA) to simplify the Drug Tariff rules. Simplification will provide increased transparency of the system for contractors and is critical to the introduction of the electronic processing of prescriptions at the PPA. The joint aim of this work is to ensure that the revisions provide a more simple but fair allocation of payments. This programme will not be used to remove any of the current funding provided to contractors.

Section 7 - Control of Entry

7.1 In August 2004 the Government announced that the changes to the current Control of Entry regime will be implemented in tandem with the new community pharmacy contract.

- The changes will include four automatic exemptions to the Control of Entry requirements:
  Pharmacies in shopping centres over 15,000 square metres; only pharmacies which are away from town centres will be included within this exemption. A provisional list of such centres is on the DH website.
- Pharmacies that are set up by consortia establishing new one-stop primary care centres. The primary care centres must offer a wide range of primary care and community based services in addition to the usual GP services, for instance, dentistry, optometry, podiatry, or other social or community-based services to a substantial population of around 18,000 to 20,000 patients and be included in the PCTs Strategic Service Development Plan or written equivalent.
- Pharmacies that commit to opening more than 100 hours per week. There will be a requirement that these pharmacies must adhere to this opening hours commitment.

  (Pharmacies claiming these first 3 exemptions must provide a full and prescribed range of services as agreed by the local PCT)

- Pharmacies that are wholly internet or mail order based. These pharmacies must provide a full professional service in line with the new contractual framework.

7.2 Other changes that will be made to the Control of Entry system include:

- Introducing the criteria of ‘competition and choice’ to the current regulatory test.
  PCTs will be able to invite applications from contractors and the application forms will be revised to reflect the criteria that PCTs use in assessing applications.
- PCTs will be allowed to set a fixed date every month for the receipt of applications. PCTs will be required to reach a decision on an application within four months of the due date for receipt, unless there is good cause.

- PCTs will also be required to consult widely with patient, consumer and local community groups that have a direct interest in local pharmaceutical services provision. An administrative minimum consultation period of 45 days will be set.

- An automatic exemption will be introduced for all minor relocations under 500 metres, but the discretion for PCTs to override this where there is good cause will be retained.

- After a successful minor relocation, there will be a minimum 12-month trading period requirement before a further application for a minor relocation can be accepted, unless the applicant shows there is good cause.

- The current restriction which prevents cross-PCT boundary minor relocations will be removed.

- The concept of preliminary consent for a pharmacy application will be retained, but the maximum period for grant of such consent will be limited to six months.

- Similarly, a maximum period of grant of full consent of nine months will be set. Also PCTs will be enabled to have the discretion to require an applicant to commence pharmaceutical services within a given period not exceeding three months unless there is good cause.

- The long-stop discretion which enables PCTs to decide competing applications of equal merit on the basis of 'the first past the post' will be retained in guidance.

- The appeals system will also be reformed. Appeals for change of ownership will be allowed to be combined with appeals concerning minor relocations.

- There are also plans to introduce, subject to further discussions, measures to reform the rules governing NHS rural dispensing.

7.3 See also information on 'Implementation of the Government response to the Office of Fair Trading report on The Control of Entry Regulations and Retail Pharmacy Services in the UK' at http://www.dh.gov.uk/mpi

Annex A

Contents

Essential Services

1. Dispensing
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NHS Community Pharmacy Contractual Framework

Essential Service 1 – Dispensing

1. Service Description

1.1 The supply of medicines and appliances[1] ordered on NHS prescriptions, together with information and advice, to enable safe and effective use by patients and carers, and maintenance of appropriate records.

2. Aims and intended service outcomes

2.1 To ensure patients receive ordered medicines and appliances safely by

- the pharmacy performing appropriate legal, clinical and accuracy checks;
- the pharmacy having safe systems of operation, in line with clinical governance requirements;
- the pharmacy having systems in place to guarantee the integrity of products supplied;
- the pharmacy maintaining a record of all medicines and appliances supplied which can be used to assist future patient care;
- the pharmacy maintaining a record of advice given, and interventions and referrals made, where the pharmacist judges it to be clinically appropriate.

2.2 To ensure patients are able to use their medicines and appliances effectively by:

- Pharmacy staff providing information and advice to the patient[2] on the safe use of their medicine or appliance;
- Pharmacy staff providing when appropriate broader advice to the patient on the medicine, for example its possible side effects and significant interactions with other substances.

3. Service outline

3.1 Orders for NHS medicines and appliances are dispensed for patients on demand, with reasonable promptness.

3.2 Records of all supplies will be maintained to facilitate continued care of the patient.

3.3 Appropriate advice is given to the patient to enable them to utilise the medication or appliance and to meet their personal need for general information on the item.

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[1] As now, pharmacies will not have to supply any (listed) appliance that is prescribed, rather only such appliances as they supply in the normal course of business.

[2] For patient where appropriate read patient's carer.

3.4 Patients are advised on the safe storage and keeping of medicines and of the recommendation that unwanted medicines should be returned to the pharmacy for safe destruction.
3.5 Where deemed clinically appropriate by the pharmacist records will be made of advice given and interventions and referrals made.
3.6 Patients are provided with a written note for any medicine which is owed, and they are informed when the medicine is expected to be available. A record of items owed is made in the patient's medication record.

Essential Service 2 – Repeat Dispensing

1. Service Description

1.1 The management and dispensing of repeatable NHS prescriptions for medicines and appliances[1], in partnership with the patient and the prescriber.

1.2 This service specification covers the requirements additional to those for dispensing, such that the pharmacist ascertains the patient's need for a repeat supply and communicates any clinically significant issues to the prescriber.

2. Aims and intended service outcomes

2.1 To increase patient choice and convenience, by allowing them to obtain their regular prescribed medicines and appliances directly from a community pharmacy for a period agreed by the prescriber.

2.2 To minimise wastage by reducing the number of medicines and appliances dispensed which are not required by the patient.

2.3 To reduce the workload of General Medical Practices, by lowering the burden of managing repeat prescriptions.

3. Service outline

3.1 Pharmacists should undertake appropriate training. Pharmacy contractors are responsible for ensuring pharmacists they employ are competent to provide the repeat dispensing service. Pharmacy contractors will need to ensure that there are systems in place to make locum pharmacists aware of any local agreements, such as arrangements to communicate with prescribers or storage and audit trails of repeatable prescriptions and batch issues. Local workshops may be provided by CPPE and PCOs to facilitate any local arrangements, but attendance at these will be voluntary.

3.2 Pharmacy staff will educate patients about the repeat dispensing system and its operation, including the importance of only requesting those items which are actually required by the patient.

3.3 Community pharmacies will securely store at the pharmacy a patient's repeatable prescription and, if requested by the patient, the related batch issues.

3.4 Community pharmacies will dispense in accordance with the directions given on the repeatable prescription. If no specific instructions are given by the prescriber, the pharmacist will use his professional judgement to decide when it is appropriate for the items to be dispensed. An NHS repeatable prescription needs to be dispensed for the first time within six months of being written and can then only be dispensed subsequently for up to a year from being written or until any expiry date specified by the prescriber, whichever is less.

3.5 Prior to each dispensing episode the pharmacist will ensure that the patient is taking or using, and is likely to continue to take or use, the

[1] As now, pharmacies will not have to supply any (listed) appliance that is prescribed, rather only such appliances as they supply in the normal course of business

medicines or appliances appropriately, and that the patient is not suffering any side effects from the treatment which may suggest the need for a review of treatment. The pharmacist will also check whether the patient's medication regimen has been altered since the prescriber authorised the repeatable medication and whether there have been any other changes in the patient's health since that time, which may indicate that the treatment needs to be reviewed by the prescriber.

3.6 After each dispensing episode, an appropriate batch issue will be endorsed in accordance with Drug Tariff requirements and forwarded to the PPA as directed by the Drug Tariff.

3.7 If a pharmacist is concerned about the safety of dispensing a batch issue, due to a change in the patient's medical condition or medication regimen, then he may refuse to dispense the item. The pharmacist will advise the patient to seek an appointment with the prescriber and/or may contact the prescriber to alert him to the matter of concern.

3.8 The community pharmacy will maintain records of the dispensing of repeatable prescriptions in order that there is a clear audit trail in place which will allow pharmacy staff to unambiguously determine dates and quantities of medicines or appliances supplied during each dispensing episode. Records of interventions made by the pharmacist, considered by the pharmacist to be clinically significant, will be maintained in the patient's record.

3.9 The community pharmacy will inform the prescriber of any issues which are deemed to be clinically significant by the pharmacist, which occur in relation to the repeatable prescription.

Essential Service 3 – Disposal of unwanted medicines

1. Service Description

1.1 Acceptance, by community pharmacies, of unwanted medicines from households and individuals which require safe disposal. PCOs will need to have in place suitable arrangements for the collection and disposal of waste medicines from pharmacies.

2. Aims and intended service outcomes

2.1 To ensure the public has an easy method of safely disposing of unwanted medicines.

2.2 To reduce the volume of stored unwanted medicines in people's homes, by providing a route for disposal, thus reducing the risk of accidental poisonings in the home and diversion of medicines to other people not authorised to possess them.

2.3 To reduce the risk of exposing the public to unwanted medicines which have been disposed of by non-secure methods.

2.4 To reduce the environmental damage caused by the use of inappropriate disposal methods for unwanted medicines.

3. Service outline

3.1 Community pharmacy responsibilities where the PCO has in place suitable arrangements for the collection and disposal of medicines from pharmacies:

3.1.1 Community pharmacies act as a collection point for the public's unwanted medicines. Returned medicines can be accepted from households and individuals. In this instance the term household is taken to include residential homes[2]. However medicines cannot be accepted from nursing homes[3], who must themselves arrange for their waste medicines to be disposed of appropriately.

3.1.2 Returned medication will be stored in UN type containers provided by the waste disposal contractor.

3.1.3 Returned solid medicines/ampoules, liquids and aerosols must be separated.

3.1.4 Returned liquid medicines should be stored in special containers provided by the waste disposal contractors for that purpose. Aerosol containers should be stored separately from the rest of the returned medicines.

3.1.5 Schedule 2 and 3 Controlled Drugs that are subject to safe custody regulations, which are returned by patients, must be segregated from other returned medicines and stored in compliance with the Safe Custody Regulations until they have been rendered irretrievable. All controlled drugs in Schedule 2 and 3 should be rendered irretrievable before they are

[2] i.e. care homes that were previously registered as residential homes.

[3] i.e. care homes that were previously registered as nursing homes.

disposed of (as the company who collects medicines for disposal is not authorised to possess or transport controlled drugs)[4].

3.1.6 Waste medicines produced in the pharmacy (which were held in stock to fulfil NHS prescriptions) can be disposed of via this route, but they should be stored in separate containers from waste returned from households and individuals. The Special Waste Regulations 1996 (as amended) indicate that an establishment which collects special waste shall not mix different categories of waste nor mix special waste with waste which is not special waste.

3.1.7 Community pharmacies will comply with all relevant waste management legislation, including:

- Registration of their conditional exemption to store waste pharmaceuticals returned from households and by individuals, with the local office of the Environment Agency (in line with the requirements of paragraph 39 (1) of the Waste Management Licensing Regulations 1994 (as amended). Registration of the conditional exemptions does not currently incur a charge.
- Securely storing waste medicines (including those which are special waste) which have been returned to the pharmacy from households or by individuals for no longer than six months and not exceeding 5 cubic metres in volume at any time.
- Retaining Special Waste consignment notes (and any associated lists or schedule) on a register for a period of not less than three years.
- Retaining descriptions and transfer notes for at least two years.
- Registration of the pharmacy/company as a waste carrier with the local Environment Agency office if the pharmacy/company carries waste medicines from peoples' homes/residential homes back to the pharmacy.

3.1.8 Pharmacy contractors should ensure that their staff are made aware of the risk associated with the handling of waste medicines and the correct procedures used to minimise those risks.

3.1.9 Appropriate protective equipment, including gloves, overalls and materials to deal with spillage, should be readily available close to the storage site.

3.2 PCO responsibilities:

3.2.1 Pharmacies will only have to act as a collection point for disposal of unwanted medicines if the PCO has in place suitable arrangements for collection and disposal.

3.2.2 When a PCO arranges the collection and disposal of returned medicines from pharmacies it is acting as a 'broker'. PCOs will have to register themselves as a broker with the local office of the Environment Agency.

3.2.3 To use an appropriately registered specialist contractor to remove waste from pharmacies and convey it to a licensed site for safe disposal.

3.2.4 Collections from pharmacies should be on a regular basis, at a frequency agreed by the PCO and the pharmacy contractor. There should also be the ability for the pharmacy to request extra collections if required.

[4] The Environment Agency (EA) has suggested that the denaturing of CDs is likely to constitute a waste treatment, which would require the pharmacy to hold a waste management license. DH is in discussion with DEFRA and EA to resolve this matter.

3.2.5 The PCO will provide a contact for any queries relating to disposal of returned medicines.

Essential Service 4 – Promotion of healthy lifestyles (Public Health)

1. Service Description

1.1 The provision of opportunistic advice on lifestyle and public health issues to patients receiving prescriptions and pro-active participation in national/local campaigns, to promote public health messages to general pharmacy visitors during specific targeted campaign periods.

2. Aims and intended service outcomes

2.1 To increase patient and public knowledge and understanding of key healthy lifestyle and public health messages so they are empowered to take actions which will improve their health.

2.2 To target the 'hard to reach' sectors of the population who are not frequently exposed to health promotion activities in other parts of the health or social care sector.

3. Service outline

3.1 Prescription linked intervention

3.1.1 Pharmacists and their staff will give opportunistic advice, as appropriate, on specified healthy living/public health topics to people presenting prescriptions with diabetes, those at risk of coronary heart disease, especially patients with high blood pressure, those who smoke and those who are overweight.

3.1.2 The advice will be given verbally, but may be backed up by the provision of written information, e.g. leaflets, and a referral to another source of advice or assistance.

3.1.3 A record of the advice given will be made on the patient's pharmacy record. This record will facilitate service audit and also future follow up with the patient.

3.1.4 Pharmacy contractors should have systems in place to ensure that appropriate advice is given to patients.

3.2 Campaign based service

3.2.1 Pharmacists and their staff will pro-actively take part in and contribute to national/local campaigns for patients and general pharmacy visitors during the campaign period, including giving advice to people on the campaign issues. This advice may be supplemented by provision of written information and in-store displays.

3.2.2 The pharmacy will provide this service to its PCO for up to 6 campaigns per year. The pharmacy will record the number of people who receive advice if requested to do so by the PCO.

3.2.3 The PCO will determine the topics of the campaigns and will provide any appropriate support, e.g. briefing packs and patient literature to support campaign messages.

Essential Service 5 – Signposting

1. Service Description

1.1 The provision of information to people visiting the pharmacy, who require further support, advice or treatment which cannot be provided by the pharmacy, on other health and social care providers or support organisations who may be able to assist the person. Where appropriate, this may take the form of a referral.

2. Aims and intended service outcomes

2.1 To inform or advise people who require assistance, which cannot be provided by the pharmacy, of other appropriate health and social care providers or support organisations.

2.2 To enable people to contact and/or access further care and support appropriate to their needs.

2.3 To minimise inappropriate use of health and social care services.

3. Service outline

3.1 Pharmacy staff will inform or advise people visiting the pharmacy of other health and social care providers and support organisations, such as patient groups, when appropriate.

3.2 A written referral note may be provided when this is felt appropriate by the pharmacy staff.

3.3 When the patient is known to the pharmacy staff, a record of the advice or referral may be made on the patient's pharmacy record, when the pharmacist deems it to be of clinical significance.

3.4 PCOs will need to provide pharmacies in their area with details of health and social care providers to whom patients can be referred. Likewise contact details for local patient and support groups can similarly be provided to pharmacies.

Essential Service 6 – Support for self-care

1. Service Description

1.1 The provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families.

2. Aims and intended service outcomes

2.1 To enhance access and choice for people who wish to care for themselves or their families.

2.2 People, including carers, are provided with appropriate advice to help them self manage a self-limiting or long-term condition, including advice on the selection and use of any appropriate medicines.

2.3 People, including carers, are opportunistically provided with health promotion advice when appropriate, in line with the advice provided in ES4 – Promotion of healthy lifestyles (Public Health) service.

2.4 People, including carers, are better able to care for themselves or manage a condition both immediately and in the future, by being more knowledgeable about the treatment options they have, including non-pharmacological ones.

2.5 To minimise inappropriate use of health and social care services.

3. Service outline

3.1 Pharmacy staff will provide advice to people, including carers, requesting help with the treatment of minor illness and long-term conditions, including general information and advice on how to manage illness.

3.2 Pharmacy staff will advise on the appropriate use of the wide range of non-prescription medicines which can be used in the self-care of minor illness and long-term conditions.

3.3 Pharmacy staff will make healthy lifestyle interventions opportunistically when appropriate, in a similar manner to that provided in ES4 – Promotion of healthy lifestyles service.

3.4 Pharmacy staff will receive self-care referrals from NHS Direct and other health care professionals.

3.5 Pharmacy staff will signpost patients to other health and social care providers, when appropriate (in line with the service provided in ES5 – Signposting).

3.6 For patients known to the pharmacy staff, records of advice given, products purchased or referrals made will be made on a patient's pharmacy record when the pharmacist deems it to be of clinical significance.

Essential Service 7 – Support for people with disabilities

1. Service Description

1.1 Provision of support for people with disabilities who need assistance in managing and taking their prescribed medicines. The needs of other people, not eligible under the Disability Discrimination Act 1995 (DDA) should be met through locally commissioned services, such as an Enhanced Service within the community pharmacy contractual framework, at the discretion of PCO.

2. Aims and intended service outcomes

2.1 To support people with disabilities to manage their prescribed medicines and use them safely and appropriately.

2.2 To meet the requirements of the Disability Discrimination Act 1995, that requires service providers to make reasonable adjustments to their service delivery to allow people with disabilities to be able to use their services.

3. Service outline

3.1 Pharmacies will provide patients who have a disability and who request assistance with managing and taking their medicines, with an assessment form. Pharmacy staff will assist the patient in completing the form if requested to do so by the patient. The assessment form will be produced nationally.

3.2 When the patient has completed the assessment form, the pharmacy staff will be able to make an initial determination, using a scoring method, as to whether the patient is eligible for support through this service.

3.3 Eligible patients will be able to receive a range of support to help them take their medicines effectively. This support will be provided at two different levels, depending on patient need. The two levels of support will attract different fee levels.

Level 1 support	1. labelling of medicines in a legible way for people with impaired vision 2. removing solid dosage forms from blister strips (subject to stability of the product) and re-packaging in a tablet container (maximum of 1 month supply at any one time) 3. reminder charts 4. medicines administration records
Level 2 support	medication supplied in a multi-compartment compliance aid

If the patient needs greater support beyond the provision of these services the pharmacy will refer the patient to the PCO for any further assessment and provision of further assistance.

3.4 Patients eligible to receive their medicines in a multi-compartment compliance aid will be provided with an initial four-week supply in such a

system. Only multi-compartment compliance aids on the nationally approved list should be used in this service.

3.5 The completed assessment form will be forwarded by the pharmacy to the PCO. The PCO may undertake a review of these forms if this is deemed appropriate.

3.6 The PCO may determine subsequent to review of the assessment form that the service is not appropriate for the patient. The PCO should communicate this decision to the patient before instructing the pharmacy to cease provision of the service. In reaching such a decision the PCO may arrange for a full assessment to be undertaken.

3.7 Unless otherwise instructed, the pharmacy will continue to provide the service to the patient, until a review is conducted.

Essential Service 8 - Clinical governance requirements in the new community pharmacy contractual framework

1. Service description

1.1 Pharmacies have an identifiable clinical governance lead and apply clinical governance principles to the delivery of services. This will include use of standard operating procedures; recording, reporting and learning from adverse incidents; participation in continuing professional development and clinical audit; and assessing patient satisfaction.

1.2 Definition of clinical governance:

Clinical governance is a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. There are seven key components:

Resources and processes	Component
(i) processes for quality improvement	(1) Patient and public involvement (2) Clinical audit (3) Risk management (4) Clinical effectiveness programmes
(ii) staff focus	(5) Staffing and staff management (6) Education, training and continuing professional and personal development
Use of information	(7) Use of information to support clinical governance and health care delivery

1.3 Principles:

1.3.1 Clinical Governance (Continuous Quality Improvement) should be built into all professional service[organisations are accountable for continually improving the quality of their services and safeguarding high standards].

1.3.2 Clinical Governance is driven by a genuine desire on the part of the contractor and their employees to improve the service that is delivered to patients [creating an environment in which excellence in clinical care will flourish].

1.3.3 The development of clinical governance of community pharmacy services is supported and encouraged by Primary Care Organisations (PCOs). The providers of community pharmacy services engage in PCO clinical governance programmes [creating an environment in which excellence in clinical care will flourish].

2. Framework

2.1 Patient and public involvement

2.1.1 The pharmacy should produce and display a practice leaflet

2.1.2 The pharmacy should notify its patients of the NHS services which are being provided by the contractor. This information may be included in the practice leaflet, displayed as a notice in the pharmacy or using an alternative method.

2.1.3 The pharmacy should undertake a patient satisfaction survey annually (based on a national template). The minimum sample size of returned surveys varies in line with dispensing volume as described in the table below.

Average monthly script volume	Minimum number of returned surveys
0 – 2000 items	50
2001 – 4000 items	75
4001 – 6000 items	100
6001 – 8000 items	125
8001 items upwards	150

The pharmacy should review survey results and consider changes which could improve service provision. The pharmacy will share with the PCO the area where the survey identified the greatest potential for improvement and the action being taken to improve performance, along with the areas in which the pharmacy is performing strongly.

2.1.4 Medicines owed to patients or out of stock should be monitored. Patients who cannot be supplied the complete prescription when it is first presented should be issued a written note detailing any medicine owed including the quantity outstanding. The patient should be informed when the medicine is expected to be available and a record of the owing should be made in the patient's medication record.

2.1.5 A complaints system should be in place, incorporating national requirements. The pharmacy should review complaints received, and, as well as taking appropriate action on individual complaints, consider more general changes which could improve service provision.

2.1.6 The pharmacy should co-operate with local Patient & Public Involvement Forum visits and give consideration to any report of such visits and identify and take appropriate action.

2.1.7 The pharmacy should co-operate with PCO and other appropriate external bodies, e.g. Healthcare Commission, Local Authority Overview and Scrutiny Committees, on monitoring and auditing of pharmacy services, by authorised persons.

2.1.8 The pharmacy should act on the Disability Discrimination Act 1995 duty to make 'reasonable adjustments' to the physical features of premises.

2.2 Clinical audit

2.2.1 Pharmacists and their staff should participate in clinical audit – at least one practice based audit and, one PCO determined multidisciplinary audit (to aid the development of team working) each year. The PCO must give reasonable notice to allow the pharmacist to leave the premises to participate in any local meetings relating to the multidisciplinary audit. Both audits must have a clear outcome, which will assist with developing patient care. The two audits should be capable of being completed within 5 days of pharmacist time.

2.3 Risk management

2.3.1 Procedures are in place to ensure that all stock is procured and handled in a way that maintains its integrity.

2.3.2 All equipment used in the provision of pharmaceutical services is maintained appropriately.

2.3.3 Incident reporting system – all pharmacies to maintain logs of patient safety incidents, including all stages of the medication process, i.e. not just dispensing errors. The information recorded in the log will populate the mandatory fields in the National Patient Safety Agency's (NPSA) National Reporting and Learning System (NRLS) reporting form. Incidents (with the focus initially on serious ones) will be reported anonymously via NRLS to the NPSA (this may be directly from the pharmacy or via a Head Office system etc.). NPSA are exploring how a copy can automatically be sent anonymously to the pharmacy's host PCO. Where an appropriate environment and relationship between community pharmacy contractors and PCOs exist, such that community pharmacy contractors are already content to report direct to the PCO, this should continue. Key characteristics of the system will be:

- Non-punitive – PCOs should not link financial incentive payment or non-payment to reporting.
- Confidential.
- Seeks to provide information on patient safety incidents, i.e. not just dispensing errors.
- Open disclosure – telling patients when something goes wrong (includes apologising and an explanation of what will be done to prevent re-occurrence)

In the future (with the agreement of the key stakeholders), when a mature and trusting relationship has developed between PCOs and pharmacy contractors and the necessary IT capability is in place, a transition towards full local, identifiable reporting will take place.

2.3.4 Analysis of critical incidents by the whole pharmacy team to inform individual and organisational learning. Proactive consideration and prevention of potential risks.

2.3.5 Pharmacists should be competent in risk management, including the application of Root Cause Analysis.

2.3.6 Pharmacies should be able to demonstrate evidence of recording, reporting, monitoring, analysing and learning from patient safety incidents.
2.3.7 Standard operating procedures (SoPs) – these should cover all the areas specified by RPSGB as a minimum (this covers the handling of a prescription from receipt to handing to a patient/carer). SoPs should also be produced to cover advanced and enhanced services.
2.3.8 Suitable waste disposal systems for any clinical and confidential waste should be in place.
2.3.9 An identifiable clinical governance lead should exist for each pharmacy. This may not need to be a pharmacist; it could be another member of the pharmacy team. PCOs could request the attendance of one member of staff per pharmacy to attend local clinical governance training each year. The PCO would be liable for paying all training costs.
2.3.10 Health and Safety legislation is complied with in order to reduce the risk of harm to pharmacy staff and the public.
2.3.11 Pharmacy contractors and their staff should comply with local and national guidance relating to child protection procedures. (DH to advise what requirements are anticipated).

2.4 Clinical effectiveness programmes

2.4.1 Systems are in place to ensure appropriate self-care advice is given to patients, e.g. use of protocols/standard algorithms, SoPs.
2.4.2 Through the management and dispensing of repeatable NHS prescriptions for medicines or appliances, in partnership with the patient and the prescriber and the medicines use review service, in particular, pharmacies will contribute to improving the clinical effectiveness of prescribing.

2.5 Staffing and staff management

2.5.1 All staff and locums receive appropriate induction on entering employment, e.g. confidentiality procedures, health and safety issues and security.
2.5.2 All staff are trained or undergoing training appropriate to their role.
2.5.3 The qualifications of all staff providing NHS services are checked and references are taken. [For professional staff this requirement will in part be supported by the introduction of PCO main and in particular, supplementary lists; qualifications etc will be checked prior to entry to a PCO list. These lists may also be used to check a health professional's legitimate requirement to have access to the NHS Care Record Service.
2.5.4 Contractors should identify and support the development needs of staff providing NHS services.
2.5.4 The main and supplementary pharmaceutical lists, when introduced, will provide a basis for addressing poor performance. Pharmacy contractors and their staff would be expected to co-operate with local poor performance arrangements.

2.6 Education, training and continuing professional and personal development

2.6.1 Pharmacists are able to demonstrate a commitment to continuing professional development (CPD), via a CPD record. This requirement will be rolled out in line with the national RPSGB scheme.

2.6.2 Any necessary accreditation is achieved prior to provision of advanced or enhanced services.

2.7 Use of information to support clinical governance and health care delivery

2.7.1 Pharmacy staff have access to up to date reference sources, such as the BNF and Drug Tariff, and, with appropriate IT links, electronic reference sources.

2.7.2 Contractors and employees need to comply with legal obligations on data protection and confidentiality. This includes the Data Protection Act 1998, Human Rights Act 1998 and common law of confidentiality.

2.7.3 Contractors and employees must conform to the NHS Code of Practice on Confidentiality and contractors must have systems and policies in place to support this, including ensuring staff are appropriately trained.

2.7.4 Employee contracts must include a duty of confidence as a specific requirement linked to disciplinary procedures.

2.7.5 Appropriate patient records are maintained and utilised to improve patient care. Over and above the basic recording of medication supplied, pharmacists will be encouraged to make records of interventions they have made and advice they have given. The need to make such a record is determined by the pharmacist's professional judgement.

2.7.6 Public access to information on how to obtain medicines urgently – pharmacy contractors should ensure that their PCO and NHS Direct are aware of the pharmacy's actual working hours, in order that they can provide appropriate information to members of the public.

2.7.7 Pharmacy contractors display their opening times prominently. In addition and wherever practicable, when the pharmacy is shut, opening times are legible from outside the pharmacy.

Annex B

Contents

Advanced Services

Medicines Use Review and Prescription Intervention Service

Advanced Service – Medicines Use Review & Prescription Intervention Service

1. Service Description

1.1 This service includes medicines use reviews undertaken periodically, as well as those arising in response to the need to make a significant prescription intervention during the dispensing process. Medicines Use Review (MUR) is about helping patients use their medicines more effectively. Recommendations made to prescribers may also relate to the clinical or cost effectiveness of treatment.

2. Aims of Service

2.1 To improve patient knowledge, concordance and use of medicines by:

• establishing the patient's actual use, understanding and experience of taking their medicines;

• identifying, discussing and resolving poor or ineffective use of their medicines;

•identifying side effects and drug interactions that may affect patient compliance;

• improving the clinical and cost effectiveness of prescribed medicines and reducing medicine wastage.

3. Service Specification

3.1 The pharmacist will perform a MUR to help assess any problems patients have with their medicines and to help develop the patient's knowledge about their medicines.

3.2 The MUR will normally be carried out face to face with the patient in the community pharmacy. If a pharmacy wants to provide MURs in another location, e.g. patients' homes or day care centres, they must seek the prior approval of the PCO for this. Only when it is not practical for the patient to get to the pharmacy should a MUR be conducted by telephone.

3.3 For face to face consultations, the part of the pharmacy used for provision of MURs must meet the following requirements for consultation areas set nationally.

- The consultation area should be a designated area where both the patient and pharmacist can sit down together.
- The patient and pharmacist should be able to talk at normal speaking volumes without being overheard by other visitors to the pharmacy, or by pharmacy staff undertaking their normal duties.
- The consultation area should be clearly designated as an area for confidential consultations, distinct from the general public areas of the pharmacy.

3.4 A MUR can be conducted with patients on multiple medicines and those with long term conditions, every 12 months. These regular MURs, initiated by the pharmacist, must only be provided for patients who have been using the pharmacy for the dispensing of prescriptions for at least the previous three months. The next regular MUR can be conducted 12 months after the last MUR.

3.5 PCOs, working with their community pharmacies, may identify specific patient groups who would be appropriate for targeting, based on the needs of the local health economy. Pharmacists may accept referrals for MUR from other health care professionals and pharmacists can accept requests from patients for a MUR to be conducted as long as the criteria laid out in 3.4 are met.

3.6 The requirement for a MUR to be undertaken may be highlighted by the pharmacist identifying a significant problem during the dispensing of regular prescriptions. This 'Prescription Intervention' would be over and above the basic interventions, relating to safety, which a pharmacist would make as part of the Essential level dispensing service and would highlight the need for a more detailed examination of the patient's medication regimen. The requirements in 3.4 would not apply to this type of intervention. The initiating issue which led to the need for a prescription intervention will be discussed with the patient as part of the MUR and communicated to the patient's GP.

3.7 Recommendations will be made to the patient's GP using the nationally agreed reporting template.

3.8 Pharmacists providing the service will have passed an assessment based on the nationally agreed competencies for the service.

3.9 Interventions made as part of a MUR will include:

- advice on medicines usage (prescribed and OTC), aiming to develop compliance and concordance;
- effective use of 'when required' medication;
- ensuring appropriate use of different medicine dosage forms [e.g. inhaler type, soluble tablets];
- advice on tolerability and side effects;
- dealing with practical problems in ordering, obtaining, taking and using medicines;
- identification of items without adequate dosage instructions;
- identification of unwanted medicines (patient is no longer taking the medicines);
- identification of the need for a change of dosage form to facilitate effective usage;
- proposals on changing branded medicines to generics (exclusions will apply)
- proposals on changing generic to branded where appropriate to ensure consistent supply or when clinically appropriate;
- proposals for dose optimisation (higher strength substitution where multiple doses of lower strength products are prescribed, provided it does not interfere with the patient's clinical management);
- suggestions to improve clinical effectiveness. These interventions could be agreed at a local level between the PCO, pharmacist and prescribers. Example: highlighting patients who are on a treatment dose of a Proton Pump Inhibitor, rather than a maintenance dose.

3.10 A record of the MUR will be made on the patient's pharmacy record. A summary of the MUR and any recommendations will be sent to the patient's GP, using the nationally agreed recording template.

3.11 A copy of the MUR summary and recommendations will be given to the patient.