Consultation response

UK Influenza Pandemic Preparedness Strategy
2011

17 June 2011
UK influenza pandemic preparedness strategy 2011: strategy for consultation

This document describes proposals for an updated, UK-wide strategic approach to planning for and responding to the demands of an influenza pandemic. It builds on, but supersedes, the approach set out in the 2007 National framework for responding to an influenza pandemic, taking account of the experience and lessons learned in the H1N1 (2009) influenza pandemic.

Overview

The pharmacy bodies of Community Pharmacy Wales (CPW), Pharmaceutical Contractors Committee (NI) Ltd (PCC), Pharmaceutical Services Negotiating Committee (PSNC), Pharmacy Voice (PV), and Royal Pharmaceutical Society (RPS) have come together to produce a joint response. The views represent pharmacy in England, Scotland, Wales and Northern Ireland.

The pharmacy bodies welcome the opportunity to respond to UK influenza pandemic preparedness strategy 2011: strategy for consultation.

Key Messages

Role of pharmacy

- Community pharmacy always rises to the challenge of emergencies and will do its utmost to assist in times of need. The flu pandemic 2009/10 was no exception and at national, regional and local levels, the pharmacy profession, pharmacy member organisations, pharmacy owners, local pharmaceutical committees and individual pharmacy teams responded rapidly to support primary care organisations across the UK.

- Community pharmacists and their teams played a key role in the provision and distribution of information to the public, the supply of antivirals and in many areas the pandemic vaccination programme.

- Pharmacists and pharmacy teams working in primary care played a significant role in the operational activity supporting the sourcing and distribution of treatment, messaging to the public, advice to fellow professionals and vaccination processes during and after the pandemic flu.

- Pharmacists working in secondary care provided antiviral suspension to supplement the commercial supplies, provided walk in services for members of the public to access antivirals and co-ordinated the distribution of prescriptions and vouchers to such areas. Hospital pharmacies also acted as distribution centres for unlicensed intravenous infusions (IV) products and held vaccines that ensured hospital staffs were appropriately vaccinated. A number of hospital pharmacies acted as emergency distributors supplementing the primary care supply system.

- Pharmacists also play a role in supplying antibiotics for secondary infections associated with the flu. The increase in co-morbidities must be accounted for, e.g. pneumonia tends to increase when there is a high level of flu as does chest infections in children.

- The increased demand for the medicines required dealing with these conditions, and pharmacists role in supply, must be considered and included in the preparedness strategy.

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1 Organisational profiles are available at the end of the response
Community pharmacy is a highly accessible resource for the provision of treatment during a pandemic.

- Pharmacists are the experts in medicines use and play several significant roles which support patients in the management of their long term conditions and self care during a pandemic. Pharmacists ensure that supply of medicines to patients with long term conditions is maintained wherever possible.

- Community pharmacy also provides advice on self-management and self-care, often advising members of the public on a course of action which avoids the unnecessary use of other NHS services.

- Over 90% of the services provided by community pharmacies are NHS services. Community pharmacy therefore needs to be included at all stages of planning for pandemic flu. This will include the planning for managing staff and fuel shortages.

For more information on the role that pharmacists played in 2009 influenza pandemic, please refer to Appendix A

Operational

- In the review by Dame Deirdre Hine, *The 2009 Influenza Pandemic an independent review of the UK response to the 2009 influenza pandemic*, key learnings and recommendations were made but the operational side of the response was not reviewed. Effective implementation of a plan is a key measure of success and all sectors of pharmacy played a central role in that success.

- Much work was done in preparation for and in the response to the pandemic and the national pharmacy organisations agree that the lessons learned from pharmacy across the UK should be used as a basis to develop an effective framework for the best delivery and resilience of services in the future; and also to feed into the wider preparedness planning.

- We are also aware that because of the changes in NHS structures in England, potentially much of the expertise gained during the pandemic within Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) could be lost over the next few years. With the new NHS Commissioning Board, Public Health England, Health and Wellbeing Boards, GP-led commissioners and other local commissioning bodies, there will also initially be a lack of knowledge about commissioning of pharmacy services and oversight of sourcing and distribution of vital medicines. The need to build on the lessons learnt is therefore critical to develop more effective continuity plans for any future pandemic.

- To ensure that in all future planning serious consideration is given to the input of pharmacy at the very outset. This means pharmacy organisations should be incorporated into discussions and agreements with Departments of Health in England, Scotland, Wales and Northern Ireland because there is and will be significant differences in implementation plans.

- Pharmacists also need to be involved in planning at a local level as they have much to offer. This point is expanded in Appendix A

- Pharmacists and, where appropriate, their staff must be regarded as frontline health care professionals. Annex D of the seasonal flu plan for 2011/12 states:

Importance of vaccinating frontline health care workers
Examples of staff who may be directly involved in delivering care include:

- clinicians, midwives and nurses, paramedics and ambulance drivers
- occupational therapists, physiotherapists and radiographer
- primary care providers such as GPs, practice nurses, district nurses and health visitor
- social care staff working in care settings, and
- pharmacists, both those working in the community and in clinical settings.

Students and trainees in these disciplines and volunteers who are working with patients should also be included. This is not an exhaustive list and decisions to provide immunisation should be based on local assessment of likely risk and exposure to flu.

- We support many recommendations of The 2009 Influenza Pandemic - an independent review of the UK response to the 2009 influenza pandemic. In particular we would want to take forward Recommendation 23: The four health ministers should commission officials to put in place arrangements to ensure the rapid implementation of a vaccination programme during a pandemic. For example, a sleeping contract with GPs and/or other willing providers could be negotiated. In 7.49 of the review community pharmacy is recognised as an alternative provider.

- We would expand Recommendation 23 to include for community pharmacy; sleeping contracts for Direct Enhanced Services, national specifications for vaccinations and anti-viral distribution and national payment agreements.

- Wholesalers must continue to be fully involved as they also provide a pivotal role when dealing with supply of vaccines and antivirals, as well as other medicines which have increased demands during pandemics

**Vaccinations**

- The demand for vaccination of service providers cannot be met by GPs alone and this should not be the sole option in the future. Appropriate regulations should be put in place (or sleeping regulations applied) to allow wider vaccination programmes. Consideration should be made now to training and maintaining knowledge and skills of staff to vaccinate rather than leave it until plans are actioned. Where private flu vaccination services are being provided, accreditation should be accepted for emergency NHS services as the same standards are required.

Some Health Boards in Scotland asked for vaccination trained pharmacists to work with other Primary Care providers to assist in mass vaccinations.

Although the Health Boards remunerated pharmacists for this work and in some cases services were provided at weekends, community pharmacy owners were mindful that in some cases releasing a pharmacist to vaccinate might disrupt the normal running of the pharmacy especially where there were heightened risk factors which meant additional pressure or additional demand for regular pharmacy services. The key to this is Health Boards and pharmacies working together to identify plans to instigate in this case where appropriate personnel can be released with minimal risk to the normal/increased provision of services in a pandemic
• Wider use of community pharmacists to provide seasonal flu vaccinations will improve the likelihood of reaching the new vaccination targets and ensure that a larger cohort of pharmacists are able to provide vaccinations in a pandemic.

• Pharmacy must be involved at a local level with the ongoing supply of vaccines. Community pharmacy already has significant capability and capacity to provide vaccination services for people who choose to be protected from or are at risk from the effects from seasonal flu. Pharmacists working in all sectors should be involved in the development of local arrangements for the provision of pharmaceutical advice in relation to all aspects of the sourcing, supply, distribution and return of unused vaccinations. This expertise should be built into the capacity plans for pandemic vaccination services.

NHS Isle of Wight commissioned a community pharmacy-led vaccination service which has led to more immunisation services being developed locally to improve patient choice, uptake, and outcomes. The PCT has developed the breadth of vaccination to include seasonal flu, which considerably increased capacity. Top line results for the 2010/11 season include:-

• Total vaccinated: 2903 (approx. 10% of total vaccinated through all services)
• Under-65s with co-morbidities: 36.3% of cohort vaccinated (Other providers: 17.1%)
• Percentage Rating Service OK or Excellent: 99.6% (90.9% Excellent)
• Percentage receiving flu vaccination for first time: 8.2%
• Percentage for whom vaccination unlikely without pharmacy access: 6.2%
• Percentage indicating they would use community pharmacy again: 98.4%
• Percentage indicating they found the service more accessible: 92.8%

The patient survey of reported outcomes (PROMs) at the end of the flu season indicated transport issues, mobility issues either due to age or handicap that make either uphill or long journeys on foot impractical, work commitments, previous experience or non-registration at GP practices when recently moved to the Island.

Antivirals

• The pharmacy bodies wish to strongly emphasise the role that pharmacy played in the distribution of antivirals in 2009 and the need for this to be developed in future plans. This was also seen at the start of the 2010-11 seasonal flu period – pharmacy (community, primary care and secondary care) worked closely with DH, wholesalers and manufacturers to ensure that supplies were available to meet demand with the least possible delay.
Response to specific questions

This consultation seeks views specifically on:

(i) the proposed characterisation of mild, moderate and high impact influenza pandemics in order to understand how best to coordinate a response in the health sector and across wider society and;

(ii) the revised five phase structure of the UK response to the threat of an influenza pandemic.

Question 1

We intend the strategy for responding to low, moderate and high impact influenza pandemics to reflect a pragmatic yet effective approach, taking clinical and operational realities into account. Do you think this is the right approach? Please describe why (or why not). See Chapter 3 page 25.

Yes, the pharmacy bodies believe the strategic approach to pandemic preparedness is correct. We believe, in particular, that community pharmacy is a significant front line service provider that can support the implementation of the government’s strategic objectives. We believe that pharmacy input at a strategic level will ensure efficient and safe systems are put in place for the safe and effective use of medicines during a pandemic.

Every day over 1.6 million people choose to visit community pharmacies for their medicines and advice and can buy over the counter and other healthcare products. We would recommend that all community pharmacies are invited to take part in the distribution of ant-virals. At the heart of communities, community pharmacies are perfectly placed to reach out to people everywhere so that they can maintain good health. It should be noted that community pharmacy is accessed by the unregistered populations which in times of emergency will frequently attend emergency services.

When local organisations and emergency planners develop their plans for a pandemic, it is important that they are aware of local business continuity plans. Many of the large pharmacy companies will have their own business continuity plans and it is crucial that all parties work together to ensure effective implementation at a local level.

We have highlighted below the particular elements of the strategic objectives that pharmacy makes a significant contribution to:

i. Minimise the potential health impact of a future influenza pandemic by:

- Promoting individual responsibility and action to reduce the spread of infection through good hygiene practices and uptake of seasonal influenza vaccination in high-risk groups.
- Supporting the rapid dissemination of government produced patient educational material.
- Ensuring the health and social care systems are ready to provide treatment and support for the large numbers likely to suffer from influenza or its complications whilst maintaining other essential care.

ii. Minimise the potential impact of a pandemic on society and the economy by:

- Supporting the continuity of essential services, including the supply of medicines, undertaking appropriate signposting and protecting critical national infrastructure as far as possible.
- Supporting the continuation of everyday activities as far as practicable.
• Supporting the treatment of those discharged from hospital earlier than usual as a result of the pandemic.

• Promoting a return to normality and the restoration at the earliest opportunity of services which have been disrupted.

iii. Instil and maintain trust and confidence by:

• Ensuring those health professionals, the public and the media are engaged and well informed in advance of, and throughout the pandemic period and that health professionals and the public receive information and guidance in a timely way so they can respond to the public appropriately.

We support the three key principles of Precautionary, Proportionality and Flexibility to underpin all pandemic preparedness and response activity. However in Table 1: Proportionate response to pandemic influenza,

Initial phase:

1. We believe pharmacy should be identified in the ‘key healthcare delivery’ section. This is because from our experience of the influenza pandemic, patients and the public were asking community pharmacists for advice, information, guidance and reassurance as the news of the pandemic emerged.

2. We strongly support that Local Organisations and Emergency Planners (LO&EPs) should start the process of identifying Antiviral Collection Points (ACPs) now and put plans in place to activate them. This information should be a key element of the transition plans and documentation as the NHS reforms take place over the next couple of years.

3. We recommend that a nationally agreed service specification is developed, alongside a nationally agreed fee, for the supply of antivirals via community pharmacies, with a capacity opt out option. This will ensure that a consistent service is provided across the four countries meaning patients can access an equitable, efficient service that is adequately funded and implemented.

4. We recommend that early discussions and agreements are made with pharmacy owners and their national negotiating organisations, the Pharmaceutical Services Negotiating Committee, Community Pharmacy Scotland (CPS), Community Pharmacy Wales (CPW) and the Pharmaceutical Contractors Committee (PCC) in Northern Ireland, together with the British Association of Pharmaceutical Wholesalers (BAPW) in the preparations to implement the National Pandemic Flu Service (NPFS) and the identification of ACPs.

5. One element in planning and identification of ACPs that would assist community pharmacy in their future planning would be an ‘in principle’ funding mechanism in place prior to any plans being activated, and which aligns with the workload impact in the pharmacy.

Low impact stage:

1. We believe contingency plans for the supply of medicines for repeat prescriptions and acute medications should be developed and agreed because it is essential that community pharmacies as front line service providers make sure patients get continuity of care in their supply of medicines. One way of assisting the continuation of medicines supply and management of patients with long term conditions is to promote and increase the number of patients currently using the repeat dispensing service. This is a core, essential service in
the pharmacy contract in England and Wales and every community pharmacy can provide it for appropriate patients.

2. Under the repeat dispensing arrangements, prescribers may authorise pharmacists to dispense a repeatable prescription on a number of occasions for up to a year. This system alleviates workload for prescribers, whilst maintaining a safe and convenient system of supply for patients. The benefits of repeat dispensing have not been fully realised, because many prescribers appear to be waiting for the introduction of the electronic prescription service, in which repeat dispensing is easier to authorise. But, repeat dispensing if in widespread use, would allow pharmacists to continue to make supplies to patients using familiar arrangements, with suitable safeguards. The need for emergency supplies would be reduced significantly if repeat dispensing could be increased to its maximum potential now. This could be achieved by the Departments of Health making this a Directed Enhanced Service for GPs.

3. It is essential that planners of local health services have an effective communications and contact database. In regards to larger community pharmacy organisations, head office and regional contacts should supplement local pharmacy communications routes in order to understand the business continuity plans that are built on their local branches working together in clusters. As the impact of the pandemic increases, decisions will be made at regional and area levels by these community pharmacy organisations. The Company Chemists’ Association maintains a list of national flu leads for its member companies.

4. During the previous pandemic, whereas some primary care organisations made deliveries of antivirals to where they were needed, others did not and insisted that the antivirals were collected. This put an unreasonable burden on the provider to collect the antivirals, and this was not always possible because of the resource issues caused by the pandemic. Systems should be established to prevent this happening in the future by clearly establishing the primary care organisations’ responsibility in the safe delivery of antivirals to the providers.

5. The universal and well established medicine supply routes via a national health prescription should remain the preferred mechanism for the supply of antivirals to patients. Scotland and Wales chose this mechanism in the 2009 influenza pandemic.

**Question 2**

*We have described the response phases and indicators from transition between them. How helpful do you find this? How can we improve upon what we have described?*

- We support a flexible approach of how pandemic services are implemented locally but would recommend a UK framework concerning the response phases and indicators. This will allow pharmacy businesses to develop more consistent continuity plans and respond more effectively to local needs.

- We support the UK’s ‘defence in depth’ strategy to minimise the spread and to treat individual clinical cases of pandemic influenza. This approach will protect the public by:
  1. Detecting and evaluating the impact of the virus and identifying the groups most at risk of severe illness, hospitalisation and death
  2. Reducing the spread of the virus as far as possible, supported by good hygiene advice, appropriate behavioural interventions, and provision of personal protective equipment for front-line health and social care
iii. Minimising serious illness and deaths, supported by rapid access to antiviral medicines, antibiotics and healthcare

iv. Preventing the spread of the disease when possible and appropriate, through vaccination

- Pharmacy is a key partner to help minimise the spread of pandemic influenza and we seek early discussions with all the departments of health strategy teams responsible for pandemic preparedness so that pharmacy can be engaged at the start of planning developments and share our learnings from the last pandemic.

- Disseminating timely and meaningful information to the public and front line staff is essential. The responsibility lies with the departments of health for the four countries and integrated working of various agencies and healthcare professionals and organisations. Scotland has a very effective response mechanism with NHS 24 screening calls, giving telephone diagnosis and then ACPs in Scotland providing the antivirals.

- Local planning must take pharmacy into account. Although community pharmacy provides NHS services it is often seen to sit outside the NHS. It needs to be incorporated into local preparedness planning and continuity planning at an early stage as it offers much to the local community.

**Question 3**

*The language used to describe these response phases is important. How well do the names describe the phases and focus of activity?*

We have no comments on this question.
Appendix A

Pandemic Response – Lessons learnt from Community Pharmacy, 2009 (England only)

Jointly prepared by pharmacy organisations for Department of Health

Community pharmacy traditionally rises to the challenge of emergencies and will do its utmost to help out in times of need. The pandemic was no exception and pharmacies responded rapidly to support PCTs and implement the changes needed to respond to the pandemic, especially during the initial stages in the setting up of Antiviral Collection Points (ACPs). The hard work and continued support of community pharmacy was crucial in the effective national response to the swine flu pandemic, and has been recognised at local and national level.

Much work was done in preparation for and in the response to the pandemic and the national pharmacy organisations agree that the lessons learned from community pharmacy across the country should be used as a basis to develop an effective framework for the best delivery and resilience of services in the future; and also feed into the wider preparedness planning.

We are also aware that, due to the changes in NHS structures, potentially much of the expertise gained during the pandemic within PCTs could be lost over the next few years. With the new GP consortia evolving there will also initially be a lack of knowledge about commissioning of pharmacy services and the need to develop services with LPCs. The need to build on the lessons learnt is therefore critical to develop more effective continuity plans for any future pandemic.

During the pandemic the pharmacy organisations and the Department of Health MPI kept in close contact and community pharmacy issues reported through Local Pharmaceutical Committees and from community pharmacy contractors and staff were fed back so they could be clarified or action could be taken where possible to resolve the issues as they arose.

The lessons learned over the course of the pandemic are reported below and consideration has also been given as to what could be done differently in the future. Recommendations include:

**Antiviral distribution**

- Set a national specification and tariff for the supply of antivirals with agreed fair funding, realistic level of achievable demand and an exit strategy if this is exceeded;
- Examine whether stockpiled antivirals through ACPs is the best option for supply;
- Review antiviral allocation;
- Ensure a consistent approach to antiviral supply authorisation across the country;
- Ensure clear communications and endpoints;
- Allow realistic timescales for the introduction of new systems e.g. the introduction of NPFS, SMS.

**Vaccination**

- Negotiate a sleeping contract for the provision of vaccination by community pharmacies as per the Hine report;
- Recognise that pharmacists and pharmacy staff are frontline healthcare workers and those directly involved in patient care, as part of their pharmacy practice should be entitled as a matter of routine to receive any necessary vaccinations/treatment as set out in relevant prevention programmes;
- Ensure the acceptance by commissioners of equivalent (but non NHS) external training for vaccinators.
Emergency regulatory changes and liability

- Implement emergency regulations along with the accompanying guidance so that pharmacy is ready to adopt the measures immediately if another pandemic situation occurs;
- Approve the Enhanced service specification for an NHS funded emergency supply;
- Ensure liability issues that accompany changes are dealt with in a timely manner.

Negotiations for payment of Community Pharmacy during extreme pandemic conditions

- Build on the agreed framework and finalise the arrangements in a timely manner;
- Inform contractors and avoid speculation, confusion and concern.

Other supporting issues

- Accelerate the take up of repeat dispensing as this would free up GP time, and pharmacy staff and patients would be familiar with the process;
- Negotiate and implement a community pharmacy based Minor Ailments Service as an Essential or Directed Enhanced service.

Public Health messages

- Do more to provide the public with messages about symptom relief and planning ahead in advance of illness. The accessibility of community pharmacies enabled public health messages to be reinforced such as the importance of hand washing etc. These messages would also be helpful for seasonal flu, and encourage behavioural change in the public in preparation for the next pandemic;
- Consider the development of national community pharmacy public health campaigns to cover topics such as flu messages, by amending the existing community pharmacy contractual framework requirement for pharmacies to deliver up to six PCT organised campaigns a year.

Stockpile of essential medicines

- Put clear plans in place to ensure decisions can be make quickly on whether to release the stock and practical arrangements are in place for release of this stock to pharmacies at appropriate times;
- Ensure wholesalers are fully engaged. Logistics should be agreed in advance with wholesalers (whatever their role) because they may have limited flexibility in changing distribution schedules and capacity.

General

- Ensure that in all future planning serious consideration is given to the input of pharmacy at the very outset;
- Restart regular communication with DH MPI, at the beginning of any future pandemic as this enabled community pharmacy issues to be raised with the DH Flu Team where necessary and was instrumental in resolving many pharmacy issues quickly;
- If a major pandemic occurs with serious fuel shortages then pharmacies should be included in fuel planning so that deliveries can be made and consideration made for travel for essential workers.
Looking at feedback, the following lessons are further highlighted:

**Antiviral Collection Points (ACPs)**

In England, Local Pharmaceutical Committees (LPCs) and community pharmacy contractors worked with primary care organisations to set up pharmacies as ACPs to cope with the initial demand during the first wave and to match services to demand as the pandemic progressed. Pharmacies were prepared to assist but expect fair funding, and agreed arrangements to prevent excessive work pressures which impact on the continuity of normal supply of medicines, especially for long term condition patients.

**Antiviral allocations**

Distribution and allocation of stockpiled antivirals to community pharmacies should be reviewed. Large quantities supplied to pharmacies by primary care organisations in infrequent deliveries required large storage requirements in physically small pharmacies and this created problems. The use of wholesalers as the distributors of antivirals should be considered, as happened over the winter last year.

**Increasing use of pharmacies as ACPs over time**

Community pharmacy provided the first ACPs in most areas and these were set up quickly to meet demand.

Pharmacists continued to provide these services so that the needs of their patients were met, possibly at a cost to themselves. There was wide variation in the agreed fees and in general, early agreements had fees set at a realistic level. In some cases, pharmacy had been willing to begin provision before agreement on fees in the interest of rolling out the service quickly, but was then taken advantage of by the PCO which set wholly unreasonable fees. As the pandemic developed, there was some evidence of PCO collusion in setting, and in some cases driving down fees. Pharmacists were in a difficult moral and professional position as they felt unable to withdraw the service as that would have been detrimental to patients.

As the number of cases increased, most primary care organisations extended the number of pharmacy ACPs. Concerns were raised by LPCs about the lack of negotiation, with some PCTs imposing very low levels of funding even though non pharmacy ACPs cost considerably more. PSNC raised the issue of fair funding with DH and although DH confirmed that SHAs had been asked to review their pricing policies for this provision, very few fees were amended.

Many PCTs were not prepared to renegotiate new fees for the increased workload involved with the NPFS and FLUCON/SMS reporting or provide updated SLAs. As a consequence some contractors were not working to an agreed contract and there was been confusion/conflict in some areas over claims and payment.

There were many areas where arrangements worked well with agreement between all parties concerned and some primary care organisations were very supportive, but a growing undercurrent of resentment developed in those areas where pharmacy was involved at a later stage and ACP services were set up very quickly with little or no negotiation or engagement with community pharmacy and with unrealistic targets.

Effective future arrangements must ensure pharmacy support, which has been shown to be cost-effective, is retained by adequate funding. If this is not provided, pharmacies may not be willing to risk exposure to being taken advantage of again.
Lack of exit strategy

As demand decreased after the first wave, LPCs reported that many primary care organisations were closing large non-pharmacy ACPs and going over either partially or often entirely to antiviral distribution through pharmacies. This was even in areas where it was originally agreed that pharmacies would not be used. Few primary care organisations appeared to have a defined exit strategy even though the decline in demand was predictable. There should be acceptable interim standing down policies, and agreed terms and conditions for engagement, not an imposition on pharmacy.

At the height of the pandemic there was growing concern over the sustainability of pharmaceutical services where pharmacies were also acting as ACPs. Planning must allow for pharmacy withdrawal from the ACP service as demand increases beyond an acceptable threshold to ensure continuity of pharmaceutical services.

Impact on community pharmacy workload

The pandemic had significant impact on pharmacy workload. In some community pharmacies at the peak of demand, there were more than 50 requests per day for antiviral medicines. This on top of an increased day to day workload due to increased requests for self care and dispensing to meet the demands of long term condition medication requests meant some pharmacies had to increase staffing levels. Goalposts also moved frequently and planning had to be changed, causing confusion and additional work. The workload of FLUCON reporting and antiviral stock counts were also additional elements introduced during the pandemic which impacted on workload.

The initial lack of clarity initially regarding the responsibilities of the ACPs also created more work than expected for pharmacy contractors; as time went by it became apparent that pharmacy staff not only had to supply the antivirals and the advice that went with them, but also undertake daily stock counts and carry out audit functions. Clear guidelines should be formulated and published in the original guidance so that pharmacies agreeing to act as ACPs are aware of their responsibilities and negotiation of fee payments can accurately reflect the work entailed.

The introduction of the Stock Management System (SMS) and the National Pandemic Flu Service (NPFS) had teething problems but most issues were resolved within the first few weeks - however they did create an increased workload. The speed of the launch and lack of detail of NPFS did not allow time for renegotiation; updating of the SLA; give contractors time to assess the impact on their business and decide whether they want to be involved; or for multiple pharmacy groups to test the system and ‘white list’ it on their intranet.

There were also problems with the authorisation for supply mechanism. Initially there was misuse of FP10s and even when the right hand side (RHS) of the FP10 was used to authorise supply, an intervention of some kind was required with a significant proportion of all prescriptions - e.g. dose, etc. Authorisation vouchers were useful and much clearer than FP10s. There should be a clear direction issued that FP10s cannot be used as antiviral vouchers.

As non pharmacy ACPs closed, few primary care organisations provided the trained staff from ACPs to pharmacies as a resource to reduce impact on pharmacy workload.

What could be done differently?

- Rather than using a stockpile where large quantities were sent to a few ACPs, given the wider use of pharmacies, a system where stock is maintained in each pharmacy would
enable a patient to present in any pharmacy using an FP10 which would give a consistent approach to authorisation across the country and avoid the misuse of the form FP10 as a voucher.

- There is wide support amongst community pharmacy that whatever supply method is determined as most suitable, a nationally agreed service specification and fee should be negotiated, reducing duplication of effort, time consuming local negotiations and ensuring fair funding for all pharmacies involved in the service. This would allow easy commissioning of the service following the transfer of public health commissioning responsibilities away from PCTs.

- Clear lines of communication need to be developed through an agreed system and recognition that some pharmacy IT systems have firewalls which prevent access to certain websites and can prevent swift setup of e.g. reporting systems. Awareness is also needed that when decisions are made and implemented locally, communications need to be robust so that multi agencies/organisations have sight, e.g. corporate pharmacy will have contingency plans with criteria to exit service provision which will need to be taken into account by local public health planners;

Vaccination Programme

Vaccination of the public

The Any Willing Provider model for the provision of vaccination services, in England, allowed the use of community pharmacies as vaccination points where the service was locally commissioned. However, despite the previous development of private vaccination services with accredited pharmacists, some primary care organisations would not accept external training for vaccinations carried out by other agencies even when training was mapped to the national standards for vaccination, infection control, cold chain management etc. These primary care organisations insisted that all the pharmacists undertake the PCO training programme. Duplication of training should be avoided where there is equivalence, especially in a prolonged emergency situation.

As with antiviral supply, a nationally agreed specification and fee for vaccination should be agreed – a sleeping contract is one of the recommendations in the Hine report and PSNC looks forward to discussing this with DH.

Vaccination of pharmacy staff as frontline healthcare workers

Many primary care organisations were excellent in including pharmacy in their planning and implementation of the vaccination programme with easy access drop in centres and using proof of employment or named list as identifiers.

However, some primary care organisations initially refused to acknowledge pharmacists and their staff as priority healthcare workers and in other cases they were accepted but a charge was made for vaccination whereas it was free of charge for other healthcare professionals and ‘at risk’ members of the public.

Concerns were raised about the priority programme, its implementation and the need for a national approach to vaccination of pharmacy staff and a joint letter from Ian Dalton and Sue Sharpe clarified the issue. We welcome the inclusion of community pharmacists in the 2010 Green Book.
Stockpile of essential medicines

Necessary to ensure continuity of medicines supply, mechanisms for stockpiles of essential medicines are now in place for the future. However, there needs to be clear plans in place to ensure decisions can be made quickly on whether to release the stock and practical arrangements are in place for release of this stock to pharmacies at appropriate times e.g. recent supply problem with Gabapentin where there did not appear to be clarity on the process for release in scenarios other than in a pandemic.

This paper (Appendix A) was prepared by the Pharmaceutical Services Negotiating Committee in collaboration with:

The Royal Pharmaceutical Society of Great Britain
The National Pharmacy Association
The Company Chemists Association
The Association of Independent Multiple Pharmacies
Organisational profiles:

**Pharmacy Voice (PV)** represents community pharmacy owners in the UK. Its founder members are the Association of Independent Multiple pharmacies (AIMp), the Company Chemists’ Association (CCA) and the National Pharmacy Association (NPA). The principal aim of Pharmacy Voice is to enable community pharmacy to fulfil its potential and play an expanded role as a healthcare provider of choice in the new NHS, offering unrivalled accessibility, value and quality for patients and driving forward the medicines optimisation, public health and long term conditions agendas.

**The Pharmaceutical Services Negotiating Committee (PSNC)** promotes and supports the interests of all NHS community pharmacies in England. PSNC are recognised by the Secretary of State for Health as the body that represents NHS pharmacy contractors and work closely with Local Pharmaceutical Committees to support their role as the local NHS representative organisations.

PSNC’s goal is to develop the NHS community pharmacy service, and to enable community pharmacies to offer an increased range of high quality and fully funded services; services that meet the needs of local communities, provide good value for the NHS and deliver excellent health outcomes for patients.

**The Royal Pharmaceutical Society (RPS)** is the professional body for pharmacists in Great Britain. We represent all sectors of pharmacy in Great Britain and we lead and support the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession’s policies and views to a range of external stakeholders in a number of different forums.

**The Pharmaceutical Contractors Committee (PCC)** is the body representing Northern Ireland’s community pharmacy contractors in negotiations on remuneration and terms of service with the Health and Social Care Board (HSCB) and the Department of Health Social Services and Public Safety (DHSSPS).

**Community Pharmacy Wales (CPW)** is the body that represents community pharmacy on NHS matters and seeks to secure the best possible NHS services provided by pharmacy contractors in Wales. It is the body recognised by the Welsh Assembly Government in accordance with ss 83 and 85 National Health Service (Wales) Act 2006 as representative of persons providing pharmaceutical services.

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