# **Primary Care Pharmacy Expert Advisory Group Agenda**

**Tuesday 29 March 2022 19.00 – 21.00 By Zoom:**

Attendees:

* Anne Thomson
* Jennifer Weston
* Ewan Maule
* Jodie White
* Rosie Furner
* Raj Bajwa
* Shasta Chimhau
* Lucy Higgins
* Graham Stretch
* Helen Kilminster
* Hadeel Mohammed
* Kemi Gibson
* Kam Takher
* Jane Hall
* Jalak Shukla
* Aileen O’Hara – observer (CPhO clinical fellow)
* Wing Tang, Head of Professional Standards, RPS (for fit note item)
* Heidi Wright, Practice and Policy Lead, England, RPS
* Ravi Sharma, Director for England, RPS
* Paul Bennett, CEO, RPS

Apologies

* Emily Bond
* Clair Huckerby
* Brendon Jiang
* Aiysha Raoof

## **1: Welcome, Apologies and introduction - Led by Anne Thomson**

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| **Description** | Introduction and brief update since we last met   * New pharmacy technician members - JW and SC introduced themselves |
| **Purpose** | To raise any matters arising |
| **Outcomes** | * AO’H presented her project – what does good clinical governance look like in a community pharmacy setting.   ***Actions***: Slides will be circulated to the group and group members to contact Aileen directly with any further comments |

**2: The King’s Fund ARRS report – What does this mean for pharmacy? – Led by Ewan Maule**

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| **Description** | The [report](https://www.kingsfund.org.uk/publications/integrating-additional-roles-into-primary-care-networks) explored the ARRS roles in terms of the issues related to the implementation of these roles, experiences of working in these roles and of the people managing them. To support Primary Care Networks, the Additional Roles Reimbursement Scheme (ARRS) provides funding for 26,000 additional roles to create bespoke multi-disciplinary teams. Clinical pharmacists are one of the ARRS roles and others include pharmacy technicians, social prescribing link workers, associate physicians and community paramedics. These roles are currently 100% reimbursable.  The report found a lack of shared understanding about the purpose or potential contribution of the roles, combined with an overall ambiguity about what multidisciplinary working would mean for GPs. Successful implementation of the scheme requires extensive cultural, organisational and leadership development skills that are not easily accessible to PCNs. |
| **Purpose** | To discuss the outcomes of the Kings Fund ARRS report and what implications this might have for primary care pharmacists. |
| **Outcomes** | * Focused on England but likely to be similar in other countries. * Scotland expanding number of pharmacists in practice. MDT survey happening in Scotland to try and determine how the extended MDT members have integrated into the practice team.   Issues identified by report:   * What roles were designed to do is not clear * Needs not always being met * Variety in level of support available to ARRS roles * Lack of adequate estate for MDT in practices * Commitment to fund until 2023/24 only * Professional isolation   Discussion   * Expectation is that pharmacist will work across a PCN rather than in individual practice – but better for continuity if in practice. In Scotland employed by Health Board and also work across practices * KF report highlighted the problems. Need to identify root cause – lack of workforce planning, not considering estates when asked to * Problems associated with all ARRS roles as is professional isolation * Clinical leadership- advocate for roles that are funded at place / neighbourhood level * Learning from initial Nottingham review of first wave of practice pharmacists * Lack of understanding at NHSE/I as to what it is really like at practice level   RPS potential opportunities   * Shared vision for MDT (with others) * Support to develop leadership. How can RPS influence this? * Peer support, supervision and mentoring – already in place but need to be seen as a benefit, and resourced adequately * Credentialing and use of this support so see pathway and aspiration to develop in this way * Advocacy and influence at a national level – need more than one session a month – minimum requirements within DES, period of supervision as requirement of ARRS, not work 100% remotely, ensure delivery of DES is carried out appropriately * Distinction between pharmacist role compared to other ARRS roles * Help PCNs and the CDs and members understand how to digest and understand the problem to then find shared solutions that fit e.g. how to undertake workforce planning for 5 years * Clarity around what is happening in terms of funding of ARRS roles from NHSE/I * What do we want to see around primary care – linked to Fuller Review   ***Action:*** PCPEAG members to think about ‘what are top/key areas they want RPS to focus on in terms of advocacy’ and send to [england@rpharms.com](mailto:england@rpharms.com) by Tuesday 5 April |

## **3: RPS Organisation update and Q&A – Led by Paul Bennett**

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| **Description** | An update on recent RPS matters, followed by Q&As |
| **Purpose** | * An update from RPS * To allow group members to ask questions |
| **Outcomes** | Paul Bennett gave an update on the following Society matters:   * Executive restructure * FIP decision * Royal College   ***Action:*** EAG to email RS with any further views or questions for Paul. Members welcomed to join the AGM on 25th May and put forward motions |

## **4: Fuller Stocktake - RPS submission - Led by Ravi Sharma / Heidi Wright**

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| **Description** | Fuller Stocktake is exploring how primary care is integrated into the wider system as Integrated Care systems develop |
| **Purpose** | * PCPEAG members to share their views on Fuller Stocktake * PCPEAG members to comment on RPS submission |
| **Outcomes** | Discussion on review   * Terminology, as pharmacist might not be in the job title but could still be a role for a pharmacist * Must focus on professional side * Subsequent contracts / incentives to follow to make vision form * Need more about pharmacy technicians in it – Pharmacy technicians are also essential to recovery * Sections on primary care sections to be beefed up and role of practice pharmacist in terms of what the future will be * Primary care team in terms of commissioning, Heads of Medicines Management, going into Integrated Care Systems (ICS), where do they sit, best place to support education agenda etc * One member is a Chair of Long-Term Condition board and Out of Hospital board * Need to align with what ICS / PCN wants such as virtual wards * Understand difference between system and place and how we fit within each tier – understand population at place and how to create efficiencies and how does this then fit in wider system * Opportunity for pharmacists as clinicians / strategic leaders, can have their voice at board level – not specific to one particular profession * CORE20PLUS5 and digital health – make it tangible to ICS agenda * Community Pharmacy as part of primary care estate but logistics around this could be difficult * Place-based collaborative contract – joint initiative contract   ***Action:*** PCPEAG members to send in comments and amends to RPS draft submission by midday on Monday 4 April. If a one-to-one conversation was preferred, members to email Heidi at [heidi.wright@rpharms.com](mailto:heidi.wright@rpharms.com) to arrange this |

**5: AOB and summary** - **Led by Anne Thomson**

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| **Description** | AOB items: |
| **Purpose** | Review feedback to date |
| **Outcomes** | **Fit notes**: part of working group with Department of Work and Pensions and Health Education England and royal colleagues to develop national guidance and implementation support. Expecting legislation to enable digital certification and in summer extension of fit notes to other groups including pharmacist. Will be accompanied by guidance and training package from HEE. Issues around workload and shift of responsibility for task and access to records. Extend date at the point at which a fit note is needed – extend 7 days to longer or evidence review around this. Caseload directed to pharmacists in GP practices a concern. Concerns around charging for fit notes a concern with private providers. In what capacity you know the patient in also important, and appropriate access to records. RPS position statement is available at <https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/fit-note-position-statement>  **PCPEAG as an open meeting:** Initially group had been members only to allow the group to form and be a safe space to allow people to speak up, bearing in mind range of experience on group. Individuals are currently able to come along if they contact a member of the group Agenda and notes / actions will be put on website for all EAGs once signed off by chair. It was suggested that one member could do a post meeting video. Group discussed reasons for making group open to RPS member observers including transparency of advice which may influence RPS board; remote meeting accessibility; development of others etc. Flexible blended approach could still be taken and a decision from the chair taken as to which business is open or not.  Members supported motion of making the meeting open with a blended approach with open and closed business with agreement by chair.  ***Action***: Future meetings to be open to all RPS members with the option for some of the meeting to be closed business |