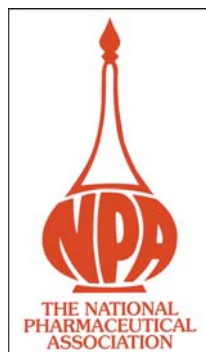


**Briefing paper
on
Out of Hours Services,
Medicines Supply
and the Role
of Community Pharmacy**

April 2005

Prepared by the

**National Pharmaceutical Association
and the
Pharmaceutical Services Negotiating Committee**



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Introduction

From April 2004 the new General Medical Services (GMS) contract saw statutory responsibility for out of hours (OOH) care transfer from GPs to Primary Care Trusts (PCTs). By the end of December 2004, GPs were able to opt out of providing OOH care for patients on their list and PCTs took over responsibility for providing and/or commissioning OOH care from 1st January 2005.

Community pharmacies already play their part in the current provision of OOH pharmaceutical services through extended opening hours, rota services and on-call services. However, the new GMS OOH service developments and the new pharmacy contract provide opportunities for community pharmacists to set up new or novel OOH pharmaceutical services including services designed to support OOH providers, such as minor ailment schemes.

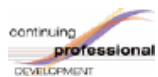
Local community pharmacy leaders should get involved and drive forward discussions on OOH pharmaceutical services.

This briefing paper has been written to develop community pharmacy's understanding of the new OOH arrangements for medicines supply and to promote the involvement of pharmacy contractors in this arena. It provides a brief history of these developments, and details the policy context, the work of the Department of Health (DH) OOH Implementation Team, and current OOH service provision models. It also discusses how community pharmacy could get involved and gives examples of current OOH pharmaceutical services.

We hope you find it useful. If you want to discuss the development of OOH pharmaceutical services further, then please contact:

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The contents of this document apply to England; however the broader principles outlined may be of relevance to pharmacy contractors and local leaders in the other home countries of the United Kingdom.



Pharmacists: Don't forget that by reading this document you are probably performing CPD. Why not make a record in your RPSGB CPD Plan & Record file or on-line at www.uptodate.org.uk.

Section 1 – Historical & Policy Context

This section gives readers an overview of the policy context for changes in OOH services, the key recommendations of the *Carson Review* on medicines supply, and an overview of the planning process for the implementation of the *Carson Review's* findings at PCT level.

Radical changes are being made to the provision of OOH services in primary and secondary healthcare. In primary care, these changes are underpinned by two key policy documents: the DH commissioned independent review of GP OOH services - *Raising Standards for Patients: New partnerships in out-of-hours care*¹ (the Carson Review) and the subsequent DH response².

In secondary care, *Reforming Emergency Care*³ underpins the changes being implemented in the provision of OOH care. Clearly the changes in both sectors have significant interdependencies.

It is necessary to fully understand these changes in order to see how they are impacting on the provision of existing pharmaceutical services in the OOH period and the development of future OOH pharmaceutical services.

To fully appreciate this policy context it is essential that readers familiarise themselves with the following policy documents:

- *Raising Standards for Patients: New partnerships in out-of-hours care*. DH, 2000. www.out-of-hours.info/downloads/oohreview.pdf
- *Department of Health response to the independent review of GP out-of-hours services in England report: Raising Standards for Patients. New partnerships in out-of-hours care*. DH, 2000. www.dh.gov.uk/assetRoot/04/06/68/29/04066829.pdf
- *The NHS Plan: a plan for investment, a plan for reform*. DH, 2000. www.dh.gov.uk/assetRoot/04/05/57/83/04055783.pdf
- *Pharmacy in the Future: implementing the NHS Plan. A programme for pharmacy in the NHS*. DH, 2000 (specifically para 2.12). www.dh.gov.uk/assetRoot/04/06/82/04/04068204.pdf
- *Delivering the Out-of-hours Review: Securing Proper Access to Medicines in the OOH Period. Guidance for PCTs and Providers*. DH, Oct 2004. www.out-of-hours.info
- *Safe Practice Guidance. Medicine Supply in the OOH Period*. NPA, PSNC, RPSGB, CCA Available at www.npa.co.uk from April 2005.

The Carson Review

In March 2000, Health Minister John Denham commissioned an independent review of GP OOH services in England led by Dr David Carson. In October 2000, the review *Raising Standards for Patients: New Partnerships in Out-of-Hours Care*¹, commonly known as the *Carson Review* was published. The *Carson Review* recommended changes to the arrangements for OOH medical services, provided by both GPs and secondary care. It defined the purpose of OOH care as:

'Addressing urgent patient needs that cannot safely be deferred until the GP practice is next open'.

¹ *Raising standards for patients: new partnerships in out-of-hours care*. DH, 2000. www.out-of-hours.info/downloads/oohreview.pdf

² *Department of Health response to the independent review of GP out-of-hours services in England report: Raising Standards for Patients. New partnerships in out-of-hours care*. DH, 2000. www.dh.gov.uk/assetRoot/04/06/68/29/04066829.pdf

³ *Reforming Emergency Care*. DH, October 2001. www.dh.gov.uk/assetRoot/04/05/88/36/04058836.pdf

Two basic principles are central to the document:

1. Patient access to OOH care should be as simple and straightforward as possible – one telephone call (probably in the first instance to NHS Direct), providing effective and timely advice and, where necessary, a face-to-face consultation at a time and place agreed with the patient. No need for multiple telephone calls, no double triage; just prompt, professional and appropriate responses to the many different needs of patients outside surgery hours.
2. All professionals involved in the delivery of OOH care, regardless of the sector of the service in which they work, should work together co-operatively and collaboratively to deliver the best possible service to patients and to make the most effective use of resources.

The *Carson Review* looked at current services from the patient's perspective and sought to improve them working from this perspective. It placed emphasis on the service being accessible to excluded groups, including those whose first language is not English, the hearing impaired, older people and ethnic minorities who tend not to use telephone based services for cultural reasons.

The document proposed an integrated model of OOH care where NHS Direct triages calls on behalf of OOH care providers and refers people requiring a GP consultation to the relevant OOH care provider. It also recommended the introduction of better OOH mental health, community nursing and social care services and the development of OOH primary care centres (OOH PCCs). PCTs would take a lead in developing integrated OOH services, including innovative partnerships between Accident and Emergency departments (A&E) and primary care OOH services. This is especially important in urban areas where it is estimated that as many as 40% of people presenting at A&E could be dealt with by primary care OOH services. Existing *Winter Planning Groups* (WPGs) were seen as a vehicle for developing such integrated services; most of these groups have representation from key stakeholders including Local Pharmaceutical Committees (LPCs). The *Carson Review* also stated that new funding mechanisms needed be found for OOH services.

Chapter 5 of the *Carson Review* details a whole host of quality standards that OOH providers will need to meet. This will need to be borne in mind when designing OOH pharmaceutical service models. The Quality Standards produced by the OOH Implementation Team are discussed in section 2 of this resource. In addition, OOH pharmaceutical services need to meet the standards set out in the OOH Medicines Supply guidance (see section 4 of this resource). A key standard is a requirement to feedback to the patient's GP at the beginning of the next working day. All GPs providing OOH services will need to work to these standards, whether they are part of a GP co-operative or covering their own OOH commitments. The *Carson Review* envisaged all providers working with NHS Direct to triage calls.

All OOH providers have to be accredited by the PCT and will have service level agreements with NHS Direct and the GPs for whom they are providing services.

Chapter 10 of the *Carson Review* highlights the relative inaccessibility of pharmaceutical services OOH. It stated that the 'current situation is far from satisfactory'. It identifies a number of problems with the current system:

- There are variations in the medicines GPs carry for emergency supply purposes.
- Often GPs use starter packs supplied by pharmaceutical companies. This may lead to incomplete treatment of the patient if the remainder of the prescribed medicine is not obtained and also, dependent on the pack, potentially the prescribing of more expensive medicines.
- Where a medicine is not available from GP stocks, the system to enable a GP to access a pharmacist is complex and often involves the police. This makes access to medicines OOHs costly and difficult.

Key Carson Review recommendations for the supply of medicines

As well as the process and service structure focussed recommendations already described, there are two key *Carson Review* recommendations that impact directly on pharmaceutical services:

Recommendation 19:

'Other than in exceptional circumstances, patients should be able to receive the medication they need at the same time and in the same place as the out-of-hours consultation'.

Recommendation 20:

'The existing remuneration and contractual arrangements for out-of-hours providers and pharmaceutical services should be reviewed and, where appropriate, modified to allow for the provision of all appropriate medicines in the manner set out in Recommendation Nineteen'.

It is important to recognise that these two recommendations sit within the overall definition of OOH care, i.e. that OOH care addresses urgent patient needs that cannot safely be deferred until the GP practice is next open.

In the context of medicines supply, this means that medicines will only be supplied during the OOH period if delaying the onset of treatment until the next time a pharmacy is open would compromise the clinical outcome for the patient. **Only in these very specific circumstances does recommendation 19 hold true.** In all other circumstances, patients should be given an FP10 to be dispensed at a pharmacy. Refer to section 4 of this resource for guidance on the supply of medicines OOH.

Recognising that most people requiring medication urgently OOH are seen at an OOH PCC, the *Carson Review* team felt that:

'...it would be better for the patient if the full course of the medicine required was dispensed at the PCC, thus obviating the need for the patient to go to a pharmacy the next day...'

Providing a full treatment course is seen as being more convenient for patients.

New partnerships in out-of-hours care

In response to the Review, the DH published a short policy document - *Response to the independent review of GP out-of-hours services in England report: raising standards for patients. New partnerships in out-of-hours care*².

This paper welcomed the recommendations of the *Carson Review*, the vision it described and the quality standards it proposed. It set the scene for the delivery of the *Carson Review* recommendations and has acted as the catalyst for the development of initiatives such as the OOH service provision changes in the new GMS contract, the development of the OOH Implementation Team, and Exemplar sites. For further details refer to section 2.

OOH Planning Guidance

In addition to *The Carson Review*, an important piece of planning guidance was sent to primary care organisations in 2001:

*New partnerships in out-of-hours care: three year planning guidance*⁴ outlined planning guidance and summarised the actions that PCTs should take to implement the

⁴ *Raising standards for patients: new partnerships in out-of-hours care. Three year planning guidance.* DH, 2001. www.dh.gov.uk/assetRoot/04/06/68/28/04066828.pdf

recommendations of the *Carson Review*. It stated that PCTs had to examine each of the Review's twenty-two recommendations in terms of the following questions:

1. Where are we now?
2. What needs to happen to achieve the recommendation?
3. How will we get there?
4. What resources will it take?

The document also contained an aide-memoir for the initial stock-take which would provide baseline data and support the development of local three year implementation plans.

New General Medical Services contract (nGMS)

The nGMS contract, enables GPs to opt out of care and thus clinical responsibility for their patients during the OOH period.

From December 2004, with the support and approval of their PCT, GPs could opt out of their OOH commitment and from 1 January 2005 they had an automatic right to opt out, in all but exceptional circumstances (e.g. very remote rural areas). PCTs are then responsible for providing or commissioning OOH care to the population of patients whose GPs have opted out of providing OOH care. GPs can continue to provide OOH care for their patients, but they will be expected to work to the same quality standards as other OOH providers.

Once they have responsibility for OOH medical care, PCTs will commission OOH providers (or provide services themselves). It is envisaged that in the future OOH care will in the main be provided by professionals other than GPs and there will be significant integration of OOH primary care services and other emergency care services like accident and emergency.

For further information see: *Out of hours services under the new GMS contract*, NHS Confederation/NatPaCT www.nhsconfed.org/docs/4outofhouse.pdf.

Reforming Emergency Care

The NHS is working towards a 10 year strategy called *Reforming Emergency Care*³, which aims to ensure shorter waiting times for patients and greater choice. This agenda is part of wider policy work to improve access, redesign services and professionals' roles and provide more services in primary care.

The targets set in relation to emergency care include:

- Shorter waits; by end 2004, no more than 4 hours from arrival at A&E to admission, transfer or discharge.
- Simpler, more streamlined access to emergency services, including more primary care based services for minor complaints (in and out of hours).

Minor injury and illness in A&E

Around half the patients visiting A&E have relatively minor illness and these patients often wait the longest. Part of the reform programme aims to facilitate rapid treatment and discharge of this group of patients. This will be achieved through the development of:

◆ 'See and treat' schemes

'See and treat' schemes specifically target people with less serious conditions. A nurse or doctor assesses the person as soon as they arrive, and, where possible, treats them right away.

◆ **Primary care based alternatives**

These promote primary care based alternatives to A&E for patients with minor conditions. Examples include: NHS walk-in centres and NHS Direct. A pharmacy based minor ailments scheme, especially one that operates OOH could provide an alternative to A&E, since research has shown that 8% of all people attending A&E could be treated by a pharmacist⁵.

Out of Hours Primary Care Centres

The Carson Review recommended that when people were referred to an OOH provider, the majority should be seen at an OOH PCC. A definition is given in the box below.

What are OOH PCCs?

It is important not to confuse OOH PCCs with the planned 750 'one-stop primary care centres' announced in the NHS Plan. One stop PCCs are large health complexes that house GPs and other practitioners who provide daytime services. OOH PCCs are normally different, separate centres (although they may be co-located within one stop centres in some locations). OOH PCCs operate solely out of hours. They are centres that patients come to for an OOH consultation with a GP or other health care professional. In most cases, it is the patient's responsibility to travel to the OOH PCC. A premises centred approach is more cost effective as it minimises the need for home visits.

The NHS Plan, Pharmacy in the Future and A Vision for pharmacy in the new NHS

The *NHS Plan* announced that by 2002 there would be 'better OOH pharmacy services'. *Pharmacy in the Future* (PITF) further defined this, stating that PCTs would be required to work with NHS Direct, local pharmacies and patient representatives to ensure that:

- *'There is more easily available and more reliable information for patients on the opening hours of pharmacies;*
- *wherever possible, patients who need to start taking common medicines OOH are able to obtain them at the same time as the consultation;*
- *arrangements for dispensing other drugs required urgently OOH are well co-ordinated and reliable, and readily accessible by those who need them.'*

*A Vision for pharmacy in the new NHS*⁶ published in July 2003, reports on progress towards this goal, stating:

'... By 2004, most patients will be able to receive their medicines at the time and place of their (OOH) consultation...'

and promised further guidance which was published in December 2004⁷.

Control of Entry

The DH announced changes to the Control of Entry criteria for pharmacy applications in September 2004; these came into force on April 1st 2005⁸. The two new criteria that will be exempt from Control of Entry regulations of relevance to OOH services are:

- ◆ Pharmacies which will open for more than 100 hours per week.
- ◆ Applications from members of a consortia establishing a new one-stop PCC, subject to certain conditions.

⁵ Bednall. Identification of patients attending Accident and Emergency who may be suitable for treatment by a pharmacist. *Fam Pract* 2003;20:54-57. www.fampra.oupjournals.org/

⁶ A Vision for pharmacy in the new NHS. DH 2003. www.dh.gov.uk/pharmacyvision/index.htm

⁷ *Delivering the Out-of-hours Review: Securing Proper Access to Medicines in the OOH Period. Guidance for PCTs and Providers.* DH, Oct 2004. www.out-of-hours.info

⁸ The NHS (Pharmaceutical Services) Regulations 2005, SI 641. www.hmsa.gov.uk

More details of the control of entry changes are available from:
www.psn.org.uk/index.php?type=page&pid=50&k=5.

Section 2: Implementation of OOH Service Changes

This section explains how the OOH changes are being implemented through the work of the DH OOH Implementation Team. It provides information on the standards of service expected to be provided in the OOH environment.

In October 2000, ministers accepted all the recommendations in the *Carson Review* and appointed a small team (DH OOH Implementation Team) to implement the recommendations. In the summer of 2002, 13 regional coordinators were seconded to support the work of the project. Five work areas have been focused on:

1. The accreditation of organised providers of OOH services.
2. The Exemplar Programme, in which 34 organised providers of OOH services integrated with NHS Direct to provide learning for the rest of the NHS.
3. The development of appropriate information technology to enable future integration of organised providers with NHS Direct.
4. An OOH providers' development project.
5. Work to achieve the review recommendations in respect of the supply of medicines (see Section 4).

DH OOH Implementation Team website: www.out-of-hours.info.

Accreditation of organised providers of OOH services

Quality Standards

One of the key recommendations of the *Carson Review* was that OOH providers should be accredited by meeting certain quality standards.
(www.out-of-hours.info/downloads/quality_standards.doc)

Quality standard 24 relates to medicines supply and states:

'Medicines should be purchased, stored, supplied, administered and disposed of in a safe and secure manner in accordance with current legislation, licensing requirements and best practice'.

The OOH provider accreditation process and its requirements are the only mandatory quality standards that OOH providers have to comply with. These are contained within the Regulations, *New Regulations Supporting the Modernisation of Out-of-Hours Services*. (www.out-of-hours.info/downloads/new_regulations.doc)

Guidance notes accompany the regulations: *Modernising Primary Care Out-of-Hours Services, Notes for PCTs, GPs and Organised Providers in Respect of Accreditation and Reporting*. (www.out-of-hours.info/downloads/regulation_changes3.doc)

Model contract

At the beginning of June 2004, the OOH Implementation Team issued a model contract for providers of OOH primary medical services to assist PCTs in drawing up their own contracts with providers.
(www.out-of-hours.info/downloads/oooh_model_contract.doc)

Associated guidance notes were also produced.
(www.out-of-hours.info/downloads/oooh_model_contract_guidance_notes.doc)

The Secretary of State Directions for OOH medicines supply⁹ (see section 4) were issued after the model contract was published; consequently PCTs need to include the OOH medicine supply guidance into their contracts with OOH providers.

National Integration between OOH services and NHS Direct and the Exemplar Programme

The Carson Review recommended that NHS Direct act as the single point of contact for all requests for OOH care and that they should triage the calls appropriately.

The Exemplar Programme involved 34 OOH providers that were integrated with NHS Direct. The learning from this led to the publication of *Out of hours clinical integration programme 2004-05, PCT, out of hours provider, NHS Direct*, which provides guidance on making NHS Direct the first point of contact for all patients' enquiries outside of GP surgery hours by the end of 2006. PCTs can use other options to NHS Direct as a first point of call, provided they can make a persuasive argument for this.

The explanatory letter can be found at:

www.out-of-hours.info/downloads/nhs_d_ci_letter.doc

The criteria and application process can be downloaded at:

www.out-of-hours.info/downloads/criteria_document.doc

The application form can be found at:

www.out-of-hours.info/downloads/cl_application_form.doc

Implementing this guidance will be a major priority for most PCTs, who have now taken responsibility for the budgets which commission NHS Direct services for their population.

⁹ National Health Service Act 1977. The Primary Care Trusts Supply of Medicines etc. Out of Hours Directions 2005. www.hmsa.gov.uk

Section 3 – Models of OOH Service Provision

This section explains the models of OOH care that are emerging.

GPs Opting out

GPs who do not want to have responsibility for OOH care, have full rights to opt out of providing the service. Opting out will not be possible on an individual doctor basis. The new GMS contract is a practice-based contract and so the opt-out will be on a practice basis only. In instances where a practice opts out, the PCT will assume responsibility for the practice's patients during the OOH period. The practice must give the PCT 3 months notice and the PCT can defer its responsibility for up to 6 months until it finds a suitable alternative provider. Clearly practices that opt out will no longer receive funding for OOH work; GPs who opt out will lose an average of £6,000 per year per GP. Instead, the PCT will use this funding to set up alternative OOH services. The OOH Development Fund will continue to be available to PCTs to fund the delivery of OOH care.

Any practice that opts out of OOH care loses its automatic right to provide the service if it wants to change its mind at a later date.

GPs Opting in

GP practices are able to continue to provide OOH services on a practice wide basis if they wish to, providing they meet mandatory accreditation standards. They are also able to continue using GP OOH co-operatives and deputising services to provide the service on their behalf.

Those who can't opt out

Practices in particularly remote and isolated areas may not be able to opt out of the provision of OOH care. This should only happen in exceptional circumstances and it is anticipated that very few practices will be unable to opt out. Practices that fall into this group can only be determined locally and they should be identified through agreement between the LMC and the PCT.

When is the OOH period?

From April 2004, the OOH period was defined as:

- The period beginning at 6.30pm on any day from Monday to Thursday and ending at 8am on the following day,
- The period between 6.30pm on Friday and 8am on the following Monday, and
- Good Friday, Christmas Day and bank holidays.

What types of OOH providers have emerged?

An OOH provider is defined as '*an organisation that provides medical care during a defined OOH period on behalf of local GPs within a defined geographical area*'. In many areas, GPs have set up GP OOH co-operatives to fulfil this role. In some areas, GPs still provide their own cover - either individually or working as part of an informal group. In other areas, private providers operate. All of the above models of care are covered by this definition.

○ GP co-operatives

These are the means by which the majority of GPs have covered their OOH commitments to their patients when surgeries are closed. The National Association of GP Co-operatives (NAGPC) represents and supports the majority of these organisations. A GP co-op is defined as a 'not for profit organisation, entirely owned by, and mostly medically staffed by, the GP principals

- (contractors) in the area in which it operates'. Either the GPs work a regular rota or they pay other GPs a fee per shift.
- **Deputising services or commercial sector companies**
Deputising services are commercial organisations that employ GPs as deputies. They typically offer telephone triage, PCC consultations and home visits and employ nurses and other clinicians in addition to GPs. One has recently employed pharmacists to support their triage service.

As GPs have opted out of responsibility for OOH care, PCTs have started to develop new approaches to OOH care provision, including providing care through directly managed services. Many of these services are starting to use significant skill mix to deliver the services required by patients.

Section 4 - Supply of Medicines OOH

This section provides information on the supply of medicines OOH. It also gives an overview of the DH OOH medicine supply guidance, actions for PCTs and the National OOH Formulary.

The *Carson Review* stated that PCTs had to ensure that:

- Where the onset of treatment cannot be delayed until a pharmacy is next open, a full course of treatment can be supplied to patients by an OOH provider at the same time as their OOH consultation (with the majority of OOH consultations taking place in PCCs);
- OOH providers adopt and comply with the National OOH Formulary, which is designed to meet the majority of patients' medication needs; and
- There is a robust strategy in place to facilitate access to urgently required non-formulary medicines.

The *Carson Review* identified a particular problem in respect of patients' access to medicines in the OOH period. Many patients' needs can be met without the need for any immediate treatment; however a small number of patients will need to start their treatment immediately. Where treatment needs to be started immediately, the *Carson Review* recommended that, other than in exceptional circumstances, patients should be able to receive the medication they need at the same time and in the same place as the OOH consultation, and that those medicines should be full courses and not 'starter packs'.

Possible scenarios for the supply of medicines from the agreed OOH formulary include:

- PCTs negotiate with community pharmacies and OOH Providers to agree and co-ordinate best opening times at weekends and bank holidays to meet expected demand;
- Patient seen by NHS walk-in centre (WiC) nurse. The nurse makes a supply (via PGD) from the NHS WiC stock of formulary drugs;
- Patient is seen at an OOH PCC by a health care professional with prescribing rights. Treatment without delay is appropriate. If there is either an attached pharmacy or pharmacy in the very near vicinity, then supply can be via prescription;
- Patient seen at OOH PCC by health care professional. Treatment without delay is appropriate, but pharmacy services are not available. Medication is issued from pre-packed stock;
- Health care professional sees patient at home. Treatment without delay is appropriate. Health care professional supplies medication from pre-packed stock carried in car;
- Patient seen at home by health care professional. Delivery of medication from pre-packed stock or from pharmacy can be arranged;
- Patient who does not need to see a health care professional, but is medically unfit to travel. Delivery of medication arranged or advised to seek advice the next working day.

PCTs must consider the impact on existing pharmaceutical services of any new OOH services contracted and must keep these arrangements under review.

A guide, *Providing Medicines out-of Hours: Achieving Safe Practice* has been designed to help PCTs and providers of OOH services to understand the relevant medicines legislation and thus enable them to achieve safe and legal practice. It is available at www.npa.co.uk (from May 2005).

DH have issued guidance for PCTs and organised providers of OOH services on how to implement the medicines related recommendations of the *Carson Review*. The guidance consists of three interrelated documents:

1. **Delivering the Out of Hours Review: Securing Proper Access to Medicines in the out-of-hours Period. A Practical Guide for PCTs and Organised Providers.** - A detailed guidance document, available at:
www.out-of-hours.info/downloads/medicines_supply_guidance_a_practical_guide.pdf
2. **Delivering the Out of Hours Review: Securing Proper Access to Medicines in the OOH Period: Guidance for PCTs and Providers**⁸ - A summary document with 13 action points, available at:
www.out-of-hours.info/downloads/short_medicines_guidance.pdf
3. **The Primary Care Trusts Supply of Medicines, etc. Out Of Hours Directions 2005**⁹. - From April 2005, these Directions apply to England (only) and require PCTs to use their powers to arrange, in certain circumstances, for medicines and appliances to be supplied to patients as part of primary medical services.

A summary of the guidance, action points and the implications for community pharmacy follows:

Action point 1

Where patients' clinical needs are such that treatment should start without delay, they will need to be able to access the medicines they need at the same time and the same place as the consultation. PCTs will therefore need to develop systems that will allow this to happen; ensuring that responsibility for locating a pharmacist or source of medicines supply will no longer lie with the patient or their representative.

It is estimated that only 10% of the registered population requires OOH services and only a small proportion of these patients will need immediate access to medicines.

'Supply of medicines via a pharmacy (or dispensing doctor*) remains the preferred approach even during the out-of-hours period'.

The guidance emphasises that supply of medicines via a pharmacy remains the preferred approach even during the OOH period and in implementing the guidance, PCTs will be able to use their existing powers to support community pharmacies to stay open longer, or to provide other services (e.g. on-call arrangements).

Only where this is not practical are PCTs advised to make alternative arrangements using new powers to make local Alternative Provider Medical Services (APMS) contracts with organised OOH providers and/or to supply medicines or appliances themselves as part of PCT Medical Services (PCTMS).

Medicines need only be supplied during the OOH period if delaying the onset of treatment would compromise clinical outcomes for the patient. Where a course of treatment does need to be started without delay, PCTs will have to develop systems that allow full treatment courses to be supplied to patients at the same time as their consultation either by:

- Having a prescription dispensed by a nearby pharmacy; or
- An alternative mechanism of direct supply by another health professional if (because of the time of day) prompt access to pharmaceutical services is not possible.

'Starter packs' are no longer acceptable where patients need to commence their medication out of hours. Whatever arrangements are in place to deal with patients who

* Dispensing doctors are able to supply medicines to their own patients. If they have chosen to transfer responsibility for providing out-of-hours services, they will need to make provision to be able to supply out-of-hours formulary medicines to their own patients in the same way as they supply medicines to their own patients in-hours. They can only supply medicines to their own dispensing patients.

need to start their medication without delay, the responsibility for locating a pharmacy or other source of supply should not lie with the patient or their representative.

PCTs are given the responsibility to secure new OOH medicines supply arrangements, taking full account both of the particular needs of their locality and of the range of existing services.

Action point 2

Only by working collaboratively with all appropriate service providers, will PCTs be able to secure services that deliver the *Carson Review's* medicines supply recommendations.

PCTs will need to draw on a full range of service providers across their whole health economy including: local community pharmacies, NHS Walk-in Centres, Minor Injuries Units, NHS Direct and pharmacy services in secondary care, local GPs, GP co-operatives, commercial and other OOH providers. They will need to work with LPCs, Hospital Trusts and Patient Forums to make their arrangements.

Sunday mornings are highlighted as times where demand for OOH services is particularly high and access to mainstream pharmacy provision is most difficult to access. PCTs are asked to consider the level of demand on services when developing their OOH services.

Action point 3

Modernising access to medicines OOH starts with a PCT stock-take of the existing local situation, paying particular attention to the realities of provision.

PCTs are asked to look at the realities of provision of pharmaceutical services rather than core contracted hours.

Action Point 4

PCTs should develop a local formulary, endorsed by the appropriate local prescribing committee(s) which includes all the medicines listed in the new national OOH formulary. A 'whole system' approach should be adopted, in which neighbouring PCTs collaborate to develop out-of-hours formularies which are consistent across the population covered by each OOH provider.

A National OOH Formulary has been developed by the OOH Implementation Team, which identifies the minimum list of drugs and other items that patients should be able to access. Whilst all the drugs identified in the formulary should be available in every locality, this does not necessarily mean that every organised provider of out-of-hours services needs to carry the full range of drugs - local agreement may determine that certain drugs are only held by a particular provider within that local health community. Where this is the case, however, the PCT will need to ensure that this does not compromise patients' prompt and easy access to these drugs.

This formulary is intended to be used for the duration of all designated out-of-hours periods, i.e. evenings, weekends and Bank Holidays. There are only a limited number of situations where treatment needs to be started without delay and it is therefore appropriate that a limited formulary of drugs can be used in an out-of-hours situation, without detrimental effect on the health of the patient. There is well-established evidence to indicate that, for all conditions (and their associated medicines) included on the National Formulary early treatment is either beneficial, or the drug will relieve symptoms of pain or discomfort.

All medicines should be supplied in appropriate quantities for the condition being treated and comply with all relevant legislation regarding packaging, labelling and the use of patient information leaflets (PILs)

There is some flexibility and discretion in the choice and quantities of drugs to be made available in the local formulary. Consequently PCTs need to ensure that their local formulary, incorporating all the items in the national formulary, is agreed and periodically reviewed by the local multidisciplinary prescribing committee.

A copy of the National Out-of-hours Formulary can be found in the Drug Tariff Part XVIIC available at www.ppa.nhs.uk/ppa/edt_intro.htm.

Action Point 5

It is essential that every organised provider has robust, auditable systems in place to cover responsibility, reconciliation, record keeping, and disposal requirements for the drugs for which it is responsible.

Manufacturers' original packs should be used wherever possible. Any pre-packed items should only be obtained from a fully licensed provider who complies with the relevant legislation. Each organisation should have a full audit trail to track movements of drugs, identifying the prescriber (or supplier) at the point of issue.

Action Point 6

PCTs should ensure that, where necessary and appropriate, patients are able to receive the benefit of the advice of a pharmacist or dispensing doctor, although this need not necessarily be face to face.

The guidance states that access to a pharmacy on-call service will still be needed to provide access to non-formulary medicines required for immediate treatment. PCTs are asked to explore a wide range of measures to ensure access to medicines OOH. They should make best use of resources and recognise that additional funding may be needed.

Some suggestions of OOH medicines supply arrangements are provided:

- Use of local resources, such as existing extended hours pharmacies and NHS walk-in centres, either at or in the near vicinity of the OOH primary care centre.
- Specifically funded OOH opening by existing local pharmacies, either at or in the near vicinity of the OOH primary care centre.
- A new pharmacy within the OOH PCC, either to provide a general service or one restricted to OOH.
- A new pharmacy within the OOH primary care centre operating under a LPS pilot scheme. [Further information on LPS schemes can be found in the NPA resource *A Simple Guide to LPS Pilots* e-mail nhs.dev@npa.co.uk for a copy.]
- A stock of pre-packed items held in the OOH primary care centre. Supplies must comply with all relevant legislation and should be supported by a comprehensive service level agreement to provide a pharmaceutical 'top up' service. Pre-packed items should provide a full course of treatment.
- The delivery of medication, if appropriate, to the patient's home from an approved pharmacy.
- The use of local hospital pharmacy departments, for supply or access to on-call rotas.

Action Point 7

PCTs will need to ensure that all health professionals are able to access appropriate levels of pharmaceutical advice OOH.

Specific advice from Macmillan nurses and palliative care specialists has been shown to be particularly valuable. This could be either directly on site, via the telephone or via NHS Direct.

Action Point 8

PCTs will want to consider and adopt, after full consultation with local stakeholders, a clear service plan for improving access to palliative care drugs that best meets the needs of their community.

PCTs are charged with carrying out a 'stock-take' of their current situation in respect of access to palliative care drugs and developing a clear plan to achieve the recommendations of the OOH review.

Action Point 9

As part of their stock-take, PCTs should seek to improve the quality of service delivery for palliative care patients and their carers by setting up systems that will ensure that they have prompt and easy access to medicines in the OOH period.

Possible approaches include:

- GPs or health care professionals being proactively encouraged to prescribe sufficient drugs to be kept at the patient's home to take account of possible changes in the patient's condition during the out-of-hours period, allowing on-call health care professionals to administer these drugs as and when they are required. Such an approach would need to be carefully balanced with the risk to safety of increased quantities of drugs (particularly controlled drugs) left in the patient's home;
- Use of sealed palliative care treatment packs that contain a locally determined range of symptom control drugs (but not controlled drugs). These packs can be left in the patient's home, provided *each item* in the pack is prescribed for that patient on an 'as required' basis.
- Use of new or existing specific palliative care or OOH pharmacy schemes.

Action Point 10

For controlled drugs a complete, documented and coherent audit trail should exist from stock room to patient. This should include drugs administered in the patients' home and drugs returned for destruction.

Some of the key principles that must be addressed, when considering the provision and use of any controlled drugs in an OOH situation, include;

- Doctors and pharmacists are legally permitted to possess and supply controlled drugs when acting in their professional capacity. As long as the ordering and handling of such drugs in an organised provider (e.g. GP co-op, PCT led OOH service) is undertaken by a doctor or a pharmacist, no licence is necessary. However, if these duties are to be undertaken by anyone else (e.g. an office manager), an organised provider, including a PCT, requires a Home Office licence; (for information on how to apply for a Home Office licence see www.homeoffice.gov.uk/tacklingdrugs/licensing/index.html)
- Each provider should keep a 'central' register for all controlled drugs;
- A complete documented and coherent audit trail should also exist;

- There should be a formal system to deal with patients' controlled drugs, which are no longer required;
- Full and robust clinical records should be kept. They should make clear the date, time of administration, strength, presentation, form, batch number and expiry date of any medicines involved;
- Controlled drugs should be stored within a locked cabinet in the OOH PCC, complying with the relevant legislation. Procedures allowing access to the controlled drugs stock should always ensure it is carried out in the presence of two of the following types of individual:
 - a doctor or pharmacist and
 - a designated out-of-hours supervisor,each with appropriate identification;
- A lead clinician, ideally a pharmacist, should be nominated to monitor, audit and reconcile the use of any controlled drugs and the relevant register;
- All clinical practitioners involved should have access to national/local guidance, plus local training on statutory requirements and good practice in the use of controlled drugs.

DH have commissioned a support document, 'A guide to good practice in the management of controlled drugs in primary care (England)', which is available at www.npc.co.uk.

Action Point 11

PCTs should implement new arrangements for the recording and reporting of medicines prescribed and supplied OOHs.

Regardless of the way in which the medicines are supplied, they will all be charged against the prescribing section of the relevant PCT's unified budget. FP10 prescribing in the OOH period will continue as it does now, but each form will have a unique OOH identification code that identifies the organised provider for whom the prescriber is working.

New supply forms (FP10PREC) will also be used by OOH providers to record items supplied directly to patients (i.e. not through a community pharmacy). OOH providers will submit all FP10PRECs, on a monthly basis, to the PPA for information gathering purposes but not for reimbursement.

The PPA will report to PCTs, upon request, prescribing data from OOH providers, data on medicines and appliances supplied directly to patients from OOH providers, and provide monthly OOH expenditure and activity data.

PCTs will be expected to make arrangements for OOH costs to be attributed to the appropriate primary care prescribing budget. The new arrangements for funding OOH access should not have a significant impact on medicines expenditure.

The source of funding for any other related developments will depend on the nature of the development in question. Funding for additional pharmacy opening might be a call on the PCT's unified budgets, whereas other costs might be a legitimate call on the OOH development fund.

PCTs are asked to link in OOH medicine supply plans with the overall PCT planning and local delivery plan (LDP) process. PCTs should ensure continued funding is available to support the delivery of recommendation nineteen of the OOH review.

Action Point 12

PCTs need to ensure that mechanisms are in place for the collection of prescription charges and declaration of exemption status.

Action Point 13

By making appropriate local arrangements, PCTs will be able to improve the quality of their local data on actual community pharmacy opening hours and special OOH schemes. This should include mechanisms for ensuring the information is kept up to date and available to NHS Direct.

The Primary Care Trusts Supply of Medicines, etc Out of Hours Directions 2005¹⁰

These are the Directions which require PCTs to make arrangements for the supply of medicines OOH. They require PCTs to ensure their agreement with the OOH provider shall:

- Provide that only necessary drugs, medicines and appliances are supplied by OOH providers.
- Provide for the complete course of the necessary medicine required to treat the patient to be supplied unless the OOH provider considers that a lesser amount should be supplied
- Prevent the supply, by an OOH provider, of medicines and appliances which that OOH performer (provider) could not lawfully supply.

These Directions apply in England only. They list three examples where it would not be **reasonable** for the patient to wait until normal hours to receive a supply of medicine:

1. His condition would become more serious, or there would be an increased risk of his developing complications of his condition;
2. He is suffering significant pain or distress which the supply without delay of a medicine, drug or appliance would help alleviate; or
3. The medicine, drug or appliance would be less effective or not at all effective if the prescriber were not to supply it without delay.

These Directions prevent OOH providers providing medicines that can reasonably wait until a pharmacy is next open. In addition, the Regulations ask PCTs to consider what pharmaceutical services and LPS are available to recipients of OOH services in its area, and the effect any new OOH arrangements would have on these services.

Section 5 – Models of OOH medicines supply

This section describes the models of OOH medicines supply that are emerging and models that could be adapted in your locality. It also describes the impact of the new community pharmacy contract opening hours requirements.

An identical, national model of medicines supply could never meet the individual needs or demands of every locality, be it urban, rural or a mixture of both. PCTs therefore have the responsibility to secure OOH medicines supply arrangements, taking full account both of the particular needs of their locality and of the range of existing services. They should work with LPCs, Hospital Trusts and Patient & Public Involvement Forums to make their arrangements.

PCTs will have a range of OOH medicine supply providers to choose from including:

- Local community pharmacies
- OOH Primary Care Centres
- NHS Walk-in Centres
- Minor Injuries Units
- NHS Direct and pharmacy services in secondary care
- Local GPs e.g. dispensing GPs in rural areas providing medicines for their own patients
- GP co-operatives
- Commercial and other OOH providers

The first step for most PCTs will be to take stock of the existing arrangements for OOH access to medicines in the area. *PCTs must consider the impact on existing pharmaceutical services on any new OOH services contracted and must keep these arrangements under review.*

Principles for service design

OOH services which supply medicines should be designed with regard to a number of principles:

- (i) OOH PCCs will provide the main focus for OOH care.
- (ii) OOH providers and PCCs are subject to similar quality standards as those for pharmacy contractors and other NHS bodies and will therefore have to put in place systems to ensure high quality medicines management procedures.
- (iii) A high quality pharmaceutical service should be provided OOH, including:
 - the provision of packs of medication, which meet current legal requirements in relation to the labelling of medicinal products and patient information leaflets;
 - the maintenance of up to date patient medication records;
 - checks for drug interactions and adverse effects;
 - provision of advice on medicines taking;
 - supply of medicines, which have been stored correctly to ensure maintenance of product integrity;
 - clinical assessment of medicines supplied to patients and;
 - audit of medicines supplied and quality of prescribing.
- (iv) Wherever full courses of treatment are given, NHS prescription charges are levied and exemption claims are documented to allow checks for patient fraud.
- (v) OOH providers (including NHS Direct call centres) should have access to pharmaceutical advice.
- (vi) OOH pharmaceutical services only address patients' urgent medication needs, that cannot safely be deferred until the patient's usual pharmacy is next open, thus preventing any compromise of the daytime service provided by local pharmacies and reducing the potential for abuse of the system by patients.

- (vii) The OOH pharmaceutical service meets the need of special groups, e.g. the terminally ill, the mentally ill, children and older people.
- (viii) There is continuity of care with daytime services, including provision of feedback to the patient's own GP the next morning.
- (ix) The service is cost effective for the NHS.
- (x) In providing the service, OOH providers discourage people from using the OOH service as just a 'convenient' way to access medicines, since it is not funded for this purpose.

Current community pharmacy OOH models

There are a variety of community pharmacy led OOH medicine supply services currently in place, which dovetail with local provision of OOH medical care. The services fall within the following categories:

1. Co-location
2. Pharmacy On-Call Schemes
3. Extended Opening Hours & Rota Schemes
4. Schemes to deal with Saturday morning GP closures
5. Palliative Care Schemes

These schemes are provided under a number of different contractual and funding arrangements, including:

- Standard Pharmaceutical Services contract
- LPS
- Contract with OOH provider
- Contract with PCT (via LPC or directly)
- Directly employed pharmacists

There are numerous examples of these arrangements held on the PSNC services database, which can be found at www.psnc.org.uk/database. Examples of innovative schemes and existing good practice can also be found on the DH out-of-hours website at <http://www.out-of-hours.info>.

A more detailed explanation of the schemes and local examples follow. Please contact PSNC or the NPA for further details of the examples quoted and contact details for the scheme organisers.

Appendix 1 of this pack also provides a suggested model community pharmacy scheme for OOH medicines provision.

1. Co-location

This type of service involves the pharmaceutical services being located within the same premises as the OOH provider, normally an OOH PCC. The following are examples of co-location OOH medicine supply models.

Fylde Coast Medical Services

This is an award winning, integrated, OOH service based in Blackpool, involving a large GP co-operative and OOH service, emergency dental services, a crisis intervention team for mental health, community nursing including palliative care provision, social services and pharmaceutical services.

Most patients access the service by a single telephone number, and calls are initially managed by non healthcare staff that prioritise urgency and signpost to the most appropriate professional. A purpose built dispensary is on site with twenty five pharmacists and eleven nurse practitioners working on a regular basis within LPS arrangements. The pharmacists and nurses are involved in giving telephone advice to patients and provide a minor ailments service to patients who visit the centre.

Within six weeks of the service commencing, pharmacists and nurse practitioners were managing 20% of the total OOH workload, and prescribing was considerably reduced – for example, antibiotic prescribing was halved. Patient satisfaction with the service is high.

Wirral

The Arrowe Park Walk-in Centre, which provides OOH services, has a LloydsPharmacy co-located with it. The pharmacy is open every day of the year from 8.00am until 10 or 11pm. The pharmacy has piloted NHS pharmacy supply of certain medicines including emergency hormonal contraception, in conjunction with the Walk-in Centre.

2. Community Pharmacy On-Call Schemes

In this model, the OOH provider makes a single call to an on-call pharmacist who is providing the OOH medicine supply service from their own community pharmacy premises. A wide variety of on-call arrangements exist for what seems to be a fairly commonly used model.

Bolton

The service operates from one site, which is adjacent to the Bolton District Medical Services (GP co-operative) base, between the hours of 11pm and 8am every day. Pharmacists who run the service are recruited from the area and an on-call rota is set up. The on-call pharmacist carries a dedicated mobile phone for seven days running from Thursday pm to Thursday am and arranges for transfer to the next on-call pharmacist. The number is only accessed through the police service, on-call GPs and specified Macmillan nurses.

Newcastle and North Tyneside

Community pharmacists provide an on-call service for the dispensing of urgent prescriptions via a rota and are on-call approximately one session every eight weeks. The on-call period is Monday to Thursday inclusive or Friday, Saturday and Sunday. However, the pharmacists are only on-call when all of the community pharmacies in the area are closed. This schemes allows for the dispensing of urgent prescriptions between the hours of:

- Monday to Friday 10pm to 9am
- Saturday from 10pm to 10am
- Sunday from 8pm to 9am

There is a dedicated mobile phone, which is held by the pharmacist who is on-call, so the prescribers only have one telephone number they need to contact. When an urgent prescription is written, the prescriber contacts the pharmacist to give details of the patient and the prescription and contact details for themselves and the patient's representative collecting the prescription. The pharmacist then contacts the police and the patient's representative to arrange a time to meet at the pharmacy. The PCTs current OOH provider (Primecare) will send one of their drivers if the patient has no one who can attend the pharmacy. The scheme is being reviewed and the new OOH provider will send a driver with the prescription to the pharmacy and then take the medicine to the patient or to the closest Primary Care Centre (PCC).

In addition, the on-call pharmacist mans the mobile phone from 5.30pm Friday to 9am Monday or 5.30pm Monday to 9am Friday to signpost OOH providers to available community pharmacy services.

The on-call pharmacists are expected to stock an agreed list of essential medicines in their pharmacies, which include palliative care medicines. The palliative care medicines were agreed with the local palliative care teams. Controlled drugs are stocked by each pharmacy, and the non-CD lines are kept in a drugs box and

transferred with the mobile phone to whichever pharmacist is next on-call.

Eastleigh and Test Valley South PCT

This scheme provides guaranteed access to an on-call community pharmacist OOH (8pm to 8am weekdays and Saturdays and 5pm to 8am Sundays and Public Holidays) via a mobile phone. The scheme covers three PCTs (Eastleigh and Test Valley South, New Forest and Southampton City) and there are currently 10 community pharmacist co-ordinators participating in the weekly on-call rota. The co-ordinator is accessed through NHS Direct or a healthcare professional (patients do not receive the mobile phone number directly).

This scheme began in November 2001 and is funded through the PCTs local pharmacy budgets. Further information can be found in the *Pharmaceutical Journal* article *Providing access to community pharmacy services out of hours* available at http://www.pharmj.com/pdf/articles/pj_20020803_outofhours.pdf.

3. Extended Opening Hours & Rota Schemes

This model involves community pharmacies being paid to open for longer hours than usual in order to cater for demand in the OOH period. Pharmacy 'rota schemes' have for many years been used by the NHS to provide additional pharmacy access and could continue to be used as part of OOH service delivery. These schemes require local determination of the need for additional pharmaceutical services at certain times of the week. Once this information is available, local negotiations, normally between the PCT and LPC can then commence to determine appropriate payment levels for the pharmacies involved.

Sheffield PCTs

In Sheffield, a community pharmacy additional hours dispensing service is provided under a Service Level Agreement with two community pharmacies, one in the north east of the city centre, the other in the south west of the city centre. The scheme has been in operation for about 10 years.

The additional opening hours agreed are:

- 5.30pm to 10pm weekdays and Saturdays
- 10am – 8pm on Sundays and Public Holidays
- 3pm – 5pm on Christmas Day

The community pharmacies are required to provide the following information:

- Monthly returns identifying the number of prescriptions dispensed by the pharmacy during the contracted additional hours.
- For the first 2 weeks in May and October, to identify the number of prescriptions received, advice sought, phone call taken, etc. on an hourly basis throughout the additional hours period.

Further information can be found in the *Pharmaceutical Journal* article *Number of patient contacts undertaken during extended hours at a community pharmacy* available at www.pharmj.com/pdf/papers/pj_20020824_openinghours.pdf.

4. Schemes to deal with Saturday morning GP closures

The introduction of the nGMS contract has resulted in a large majority of GP surgeries ceasing to provide any services to their patients on Saturday mornings. The care for the patients is delegated to the local PCT/OOH provider in these circumstances. This has resulted in many community pharmacies seeing a significant reduction in prescription numbers presented for dispensing on Saturdays, with a consequential impact on the financial viability of Saturday opening. A number of schemes have been developed to cope with the impact of these changes and to support ongoing opening of pharmacies on Saturdays. Many PCTs have commissioned minor ailment schemes from community

pharmacies open on Saturdays to help manage OOH patient demand and provide some financial incentive for the pharmacy to continue to provide Saturday opening hours.

Isle of Wight (IOW)

On the Isle of Wight, GP surgeries are now closed on Saturday. The LPC and Pharmacy Development Group have developed a fax-back system with IOW GPs on-call (IDOC) to allow people who have run out of medication to get one week's supply.

Patients who do not have access to their medication or their repeat prescription that is potentially ready at their GP's surgery can telephone NHS Direct where they are directed in the first instance to the pharmacy that they use regularly to obtain their repeat prescriptions. The emergency repeat service is then triggered. By using a pro-forma, to which the patients address label and supplied medication labels are attached, patients can receive seven days supply promptly without having to pay an emergency supply dispensing fee and the cost of the drugs. Normal prescription charges apply. The form is faxed to IDOC where a prescription is generated and sent to the pharmacy.

A dedicated telephone line has also been set up for pharmacists to contact IDOC urgently for any OOH emergencies.

Fareham and Gosport

The PCT has produced a poster that has been sent to all GP surgeries and community pharmacies to display. The same poster went to both venues to present a united front. The poster relays information about the closure of GP surgeries on Saturday mornings and that most pharmacies would provide a prescription collection and delivery service and directed patients to their local pharmacy.

5. Palliative Care Services

The condition of terminally ill patients can change very quickly, necessitating a rapid response in the provision of medicines for relief of their symptoms. High quality anticipatory care, i.e. planning for likely deterioration in the patient's condition, should be the goal of all clinicians working with this group of patients. This anticipatory care may involve prescribing and supplying medicines for certain circumstances prior to the need arising; this approach obviously requires careful thought and good communication across the team caring for the patient, including the provision of written instructions on when and how the prescribed medicines should be used.

On occasions when changes in the patient's condition have not been predicted and planned for, district nurses and others have had difficulties accessing the medicines they needed for their patients during the OOH period. Hence, a number of schemes have been developed specifically to address this issue.

Newport

This OOH specialist service was established to address the needs of terminally ill patients in the community requiring access to emergency medication. It provides access to pharmaceutical palliative care services, advice and support for patients, carers, colleagues, and other healthcare professionals in Gwent, through a network of trained community pharmacists. Contracted pharmacies are equipped with an agreed formulary of palliative care medication and must also supply oxygen. The service has been used primarily at weekends and during bank holidays.

Stockport

A number of pharmacies carry a designated range of palliative care drugs in stock. Some are also on call 24 hours a day, should one of these drugs be required. All other pharmacies have a contact list for referrals.

A leaflet has been designed to inform participating professionals of which pharmacies are involved and which medicines are stocked.

The New Pharmacy Contract and OOH services

The new contract requires pharmacies to open (subject to certain exemptions) for a minimum of 40 hours per week. From the commencement of the contract, pharmacies were able to choose their 'core' contractual 40 hours, which they would not subsequently be able to amend without seeking PCT consent.

Most pharmacies open in excess of 40 hours a week; these excess hours are termed 'supplementary' hours within the contract. A pharmacy can change these hours without seeking permission from the PCT; however they must give the PCT 90 days notice of any changes they plan to make to their supplementary hours.

Pharmacy contractors are responsible for notifying PCTs of any changes to their opening hours and giving them the appropriate notice period prior to actually making the changes in opening hours (they can use Form HN1 for this purpose, available at [http://www.psn.org.uk/uploaded_txt/Form%20HN1%20\(PSNC\).pdf](http://www.psn.org.uk/uploaded_txt/Form%20HN1%20(PSNC).pdf)). Likewise PCTs have a responsibility to ensure that NHS Direct/www.nhs.uk have access to accurate details of pharmacy opening hours within their area.

PCTs will need to be encouraged to review provision of pharmacy services outside the core contracted hours. Pharmacies, which operate over extended hours, will be a great asset for PCTs, particularly during the early OOH period. If there is a need for additional pharmacy opening during the OOH period, the PCT should first discuss this with the LPC and local contractors in order to come to a voluntary agreement on extended opening hours. PCTs are able to direct pharmacies to open for additional hours, to meet local needs, but must make a reasonable payment to reflect the additional costs to the pharmacy of opening for additional hours.

Further details of the opening hours requirements within the new pharmacy contract can be found at http://www.psn.org.uk/uploaded_txt/DH%20PSNC%20position%20on%20hours.pdf.

The implementation of the new contract has seen the removal of certain Drug Tariff Part IIIA professional fees, including the 'Urgent prescription' fee. Consequently it is important that PCTs consider what arrangements they will need to put in place to allow access to medicines in the OOH period which may be urgently needed, but do not form part of the national OOH formulary.

Section 6 - Why would a PCT be interested in commissioning a community pharmacy-led OOH medicines supply service?

This section will help you make the case for a community pharmacy led OOH pharmaceutical service to your PCT. It outlines the evidence base for a high quality OOH pharmaceutical service, and makes reference to the wider NHS policy agenda that such a service would contribute to.

It is vital that community pharmacists make a good case for PCTs to invest in OOH pharmaceutical services. If a PCT is keen to develop an OOH pharmaceutical service, it has to fund it from its unified budget. To develop the service, it could use the flexibilities offered by an LPS contract, for example. In this case, some funding would be devolved to the PCT from the global sum. However, given that the volume of dispensing would be small, most of the cost would need to be met from the PCT's unified budget. PCT budgets are already under considerable pressure; for many PCTs, the decision will be whether to invest in an OOH pharmaceutical service instead of other primary care services. This means that local pharmacists must make a robust business case for the investment.

This section outlines five good reasons why PCTs should fund such a service; you may also have locality specific reasons which can be included in your business case.

1. Risk Management and Patient Safety

The unique aspect of a high quality OOH community pharmacy service will be the guarantee of safe systems for medicines management and the high quality pharmaceutical care it would provide for patients and professionals.

*An organisation with a memory*¹⁰ and the commitment to implement its recommendations in the *NHS Plan* places patient safety at the centre of the Government's NHS quality programme. It proposes ways of enhancing existing mechanisms to improve the quality of patient care and safety. One of the national targets for reducing serious recurring errors, which will impact directly on primary care, is to reduce the number of serious errors in the use of prescribed medicines. It is estimated that 25% of litigation in general practice is related to medication errors. *Building a safer NHS for patients*¹¹ sets out the Government's plans for promoting patient safety. It highlights the role of the pharmacist in reducing medication errors.

Just as there is very little data on medicines supplied OOH, there is little data about the percentage of medication errors that occur following OOH consultations. However, the clinical audit of Dr Harold Shipman's practice¹² highlighted a number of governance issues, especially in relation to systems for physician-led administration of controlled drugs, which are of relevance to the proposed development of OOH medicines supply.

Whilst the overdoses given to these patients by Dr Shipman were clearly intentional, the investigation highlighted areas of risk, which apply equally to OOH care. The need for stringent audit of the use of medicines where any health professional is both prescribing and supplying medication is clear, especially where professionals have access to controlled

¹⁰ An Organisation with a Memory, DH, 2000. www.dh.gov.uk/assetRoot/04/06/50/86/04065086.pdf

¹¹ Building a Safer NHS for Patients, DH, 2000. www.dh.gov.uk/assetRoot/04/05/80/94/04058094.pdf

¹² Harold Shipman's clinical practice 1974-1998. A clinical audit commissioned by the Chief Medical Officer. DH, 2001. www.doh.gov.uk/hshipmanpractice/shipman.pdf

drugs (as will be the case with OOH providers). It is thus incumbent on PCTs to ensure that there are adequate checks in the system to ensure patient safety.

The Shipman audit¹³ calls for effective systems for the inspection of GPs' controlled drug registers, and the recording of batch numbers administered by doctors. Under the model of pharmaceutical services detailed in this resource pack (Appendix 1), independent audit of the medicines administered by doctors to patients at home by the pharmacy co-operative would provide these safeguards for patients.

The involvement of a pharmacist in the OOH process could ensure access to pharmaceutical expertise during the OOH period so that doctors or nurses with queries regarding medication or possible adverse drug reactions could seek a second opinion from a pharmacist colleague.

2. Quality of Existing Services

Review of OOH pharmaceutical services in Lambeth, Southwark and Lewisham

In 2001, a review of OOH services was conducted in Lambeth Southwark and Lewisham Health Authority (LSL) following the publication of the *Carson Review* to establish a baseline for planning purposes. This is one of few and, certainly the most comprehensive, audits of OOH pharmaceutical services and stakeholders' perceptions of the service conducted to date. It provides an insight into the quality and access issues in an urban setting. The main findings are summarised below.

'On the whole, OOH pharmaceutical provision in LSL appears to be working well. LSL is relatively well served with late opening pharmacies compared with other London health authorities. Out-of-hours pharmacy workload is derived from only 0.3% of all GP consultations.'

Opening hours

Pharmacies in LSL have a range of opening hours. Based on average pharmacy opening hours, the OOH period for pharmaceutical services in LSL runs from 7pm to 9am and all day Sunday. Access could be improved by facilitating later opening hours of pharmacies close to GP practices with extended opening hours and PCCs.

Pharmacies open in accordance with a rota on bank holidays. Total activity per bank holiday is approximately 99-110 patient contacts. 75% of bank holiday activity is dispensing prescriptions (8 per hour). One third of all contacts on bank holidays are with regular patients of the rota pharmacies.

Provision of OOH pharmacy could be tailored in a variety of ways to meet needs at different times of the OOH period. Midnight to 8am is a very low volume period for all OOH services. An on-call rota is the favoured model for this period. Following a successful scheme in Cardiff, the use of 24-hour facilities such as supermarkets and hospitals, could be explored as secure environments for on-call dispensing.

Prescribing and dispensing at Seldoc (GP co-operative)

25% of OOH consultations resulted in an FP10 being issued. Most prescriptions were issued during the daytime periods of the weekend. OOH providers in LSL received on average 10 calls between midnight and 08.00 about prescribed medicines. The majority of these contacts only required access to common medicines.

The majority of consultations are conducted over the telephone. This constitutes a significant consideration for service planners aiming to achieve the *Carson Review* requirements for public access to medicines at the time of consultation.

OTC medicines are more frequently recommended for children. The age of the patient affects whether or not they receive advice, starter medicines or a prescription, but the sex of the patient does not.

Patients' views of OOH pharmacy services

Patients have poor information about the availability, location and opening times of OOH pharmacy services. Patients do not know where information on OOH pharmacy services can be found. NHS Direct offers the most scope for centralising up-to-date and accessible information on access to over-the counter and prescribed medicines.

Doctor-patient communication needs to be improved so that patients feel that their personal circumstances are taken into account when the GP supplies medicines and issues prescriptions. Patients have a different perception of the information and advice that they have received from the GPs' in relation to medicines.

Pharmacists' views of OOH service provision

Pharmacists were willing to extend their opening hours, and a third of the sample was willing to join the bank holiday rota, if invited. Less than half of pharmacies displayed information about other local late-opening pharmacies at the front of their premises when they were closed.

There was widespread support for the desirability of the NHS Plan's aims for OOH pharmacy, but some ambivalence about how realistic they were. There was strong support for hospital pharmacists playing a role in OOH provision. Safety and security concerns were an important consideration in relation to the provision of OOH services for pharmacists in LSL. Pharmacists agreed that on the whole, existing OOH pharmacy services provided the people of LSL with adequate urgent cover, access and could meet clinical need. However, a significant number of pharmacists felt unable to commit an opinion on these issues. An on-call rota system from home was the most popular model for the provision of OOH services.

Stakeholders' views of OOH pharmacy services

Local health professional's considered the current provision of OOH pharmacy services to be adequate. No serious short falls emerged from interviews with stakeholders.

It is important to recognise that different times in the OOH period (day, evening, night) have different requirement in terms of service provision and most stakeholders agree that there is insufficient OOH demand to warrant pharmacies opening beyond midnight.

Hospital pharmacies were considered to be a potential mechanism for improving access OOH. However, hospital pharmacies themselves see substantial barriers to such involvement, e.g. without a Pharmaceutical Services contract they cannot dispense FP10s. They are also already very busy dealing with their own patients during the OOH period.

Police involvement in OOH pharmacy provision is minimal and undefined. Police receive very few enquiries from the public. They are unsure how or when their information on OOH pharmacies is updated. NHS Direct has an important role to play in providing a single point of contact for access to information about OOH pharmacy services.

The audit highlights:

- the low demand for OOH medicines supply
- the need to improve access for the public to information about existing services (through NHS Direct and posters in pharmacy windows once shops are closed)
- the need to design services that will enable access to medicines following telephone consultations with a GP
- the need to design services around PCCs and GP surgeries with extended opening hours
- the support for an on-call pharmacy service.

3. Feedback from the National Association of GP Co-Operatives (NAGPC)

Discussions with the NAGPC¹³, the organisation which represents the majority of GP Co-operative OOH providers, has highlighted that GP co-operatives experience a number of issues related to the provision of medicines during the OOHs period:

- On bank holidays and Sundays, access to pharmaceutical services is particularly poor.

¹³ Correspondence on file. (2000) National Pharmaceutical Association, St Albans.

- There is poor availability of pre-packs for generic medicines.
- GPs require access to a range of medicines OOH including, for example, analgesics, antibiotics, respiratory and occasionally cardiac medicines and controlled drugs.
- The legislation relating to the control, storage and supply of medicines is complex. GP co-ops recognise the need to ensure good management of medicines. The NAGPC recognises that the introduction of the supply of full treatment doses will require a review of current systems e.g. storage of CDs, audit of medicines given out, provision of fully labelled medicines, with patient information leaflets.
- Addressing the requirements of special needs patients e.g. provision of syringe drivers for the terminally ill is a particular challenge OOH. The NAGPC has supported work in this area to raise awareness of the issues.

The NAGPC supports innovative solutions to the supply of medicines OOH, including an enhanced role for pharmacists. There is a need for a nominated pharmacist to represent local contractors in the various capacity planning, winter planning and OOH working groups at local level.

Find out about OOH working groups in your area, do they have a pharmacist involved?

4. Skill Mix and Cost Containment

In 2001, Fylde Coast Medical Services (FCMS), a GP OOH co-operative in Lancashire, conducted an audit of 1073 of their patient consultations. The audit showed that 45% (n = 483) of the GP consultations were for minor ailments. The remaining 590 consultations were for all other conditions. Of the 483 minor ailment consultations, the range and prevalence of individual minor ailments were as follows:

cough	32%
temperature	19%
sore throat	19%
ear ache	12%
diarrhoea	8%
head lice	5%
dyspepsia	2%
vaginal thrush	1%
constipation	1%
nasal symptoms	1%

In total, 528 medicines were prescribed or supplied as a result of the 1073 consultations. 46% of these items (n = 242) were medicines that are available either as a pharmacy only (P) or general sales list (GSL) medicine, although in all 242 cases, starter medication and a prescription were supplied to patients. The remaining 286 medicines supplied were prescription only medicines (POMs).

This audit illustrates that currently, a large proportion of the people presenting for a GP OOH consultation have conditions that could be successfully treated by a pharmacist with a P medicine. This has both budgetary and skill mix implications.

NHS Direct have been referring people to community pharmacy directly since the end of 2002. When the recommendations of the *Carson Review* are fully implemented, many of the people currently treated by OOH providers could be referred directly to community pharmacy by NHS Direct, and would not access the OOH providers service directly. However, if local pharmacies close earlier because OOH providers are now supplying medicines, patients may need to wait longer to access P medicines.

In the meantime, it is likely that many OOH providers will need to treat patients who turn up with minor ailments. By developing an OOH pharmaceutical service that can deal with these minor ailments, through a NHS funded minor ailments service, it will reduce the number of people that need to be seen by a GP, thus ensuring appropriate use of valuable GP time. In this way the model may also reduce or contain the costs of providing OOH medical services, and it will also ensure access to a full pharmaceutical service, conveniently located for patients.

5. Educating the Public about Appropriate use of Services

PCTs have a central role to play in ensuring appropriate use of NHS resources. The involvement of pharmacists in the OOH service would help to educate the public that consulting a GP for minor ailments is an inappropriate use of NHS resources. This could be backed up by local public education campaigns, similar to those run as part of winter planning initiatives, encouraging people to go to their pharmacy for advice, and to keep their home medicines cupboard well stocked. Those people who could afford to pay for their medication could purchase it from the pharmacist, thus reducing pressure on PCT prescribing budgets. In addition, it would demonstrate to the public that there is a high quality alternative to using their GP for minor ailments.

Section 7 - Getting involved

This section outlines the networks that need to be developed at a local level to ensure that community pharmacy is included in the planning process for OOH service development. It suggests what indicators can be used to establish base line data on the current availability and nature of services, and the extent of the demand for OOH medicines supply. Establishing this base line will assist the planning process and enable PCTs and OOH providers to identify their needs for OOH medicine supplies and pharmaceutical advice.

Who to influence

In order to influence the development of OOH medicines supply, there are a number of things that need to be done, such as building local networks, establishing a baseline and participation in audit. This section of the document goes through these in detail and outlines suggested next steps.

Build local networks

Identify and form links with the key players at PCT level:

- Make links with the individual who is leading work related to OOH services within the PCT and the PCT OOH planning group and GMS lead.
- Identify and make contact with the main OOH providers in the area.
- Make links with the local NHS Direct site and find out who is leading on joint working with OOH providers.
- Make contact with the local capacity planning group and winter planning groups (often these two are considered to be the same).

Establish a baseline

Map current OOH service provision in the area and identify gaps in provision of OOH services.

- Identify where current and planned OOH PCCs are and the times they are open.
- Identify any walk-in centres and their opening times.
- Establish the geographical areas different OOH providers cover.
- Establish the hours different OOH providers operate.
- Establish current levels of provision of pharmaceutical services (actual opening hours) and other means of medicines supply within OOH providers' geographical boundaries during the hours OOH providers operate. This audit should also include opening times of walk-in centres or other providers where medicines are available to patients e.g. PCCs, accident and emergency departments and minor injuries units. It will identify areas where there is existing medicines supply out of hours.

Work with PCT and OOH providers to audit demand and use of medicines out of hours.

In order to understand the scope of any pharmaceutical or medicines supply services the PCT might want to commission, it is important to look at current levels of usage and demand. Appendix 2 is a template for an audit report, which highlights the information that would be needed to fully assess the current service. Many PCTs will already have conducted an audit such as this.

Next Steps

If pharmacists are interested in developing a local OOH pharmaceutical service and there appears to be an unmet need which a new service could fill, they should consider the following action points. LPCs should take the lead on moving this initiative forward.

1. Contact PCTs to let them know you plan to submit a proposal for OOH pharmaceutical services.
2. Undertake a consultation of pharmacy contractors on the options for developing the OOH pharmaceutical service and the degree of interest in each. A paper outlining proposals should be circulated and contractors asked to sign up provisionally.
3. Seek a place for a pharmacy contractor on the PCT's OOH planning group.
4. Formalise links with local OOH providers.
5. Develop and submit a proposal to the PCT, including full costings. Ensure that any plans developed take into account the DH guidance on medicines supply (in relation to recommendations 19 and 20) and that services proposed comply with guidance on medicines supply and advice, highlighted in section 3.
6. Persuade PCTs to allocate resources to the development of an OOH pharmaceutical service in their financial planning processes. OOH quality and implementation funds should ideally be used to fund these developments.

Further reading and advice

The following websites provide useful information on OOH service provision.

Website	Key resources on site
www.out-of-hours.info/	<ul style="list-style-type: none"> • DH OOH website – point of access for up to date resources supporting the modernisation of out of hours services in England. • All key DH OOH documents are available via this site. • News updates on OOH services • Subscribe to e-mail alerts on latest developments • OOH Medicine Supply guidance documentation
www.npa.co.uk	<ul style="list-style-type: none"> • <i>Providing Medicines OOH: Achieving Safe Practice</i>

Appendix 1 – model OOH pharmacy service

This model service is provided to stimulate discussions at a local level about the approach that could be taken in that locality; it is not provided as an 'endorsed' approach that would be appropriate in all situations. It has been produced by amalgamating the approaches taken by a number of existing OOH pharmaceutical service providers.

Service design

An OOH pharmacy located within or very close to the PCC, would provide the following services:

- ◆ Dispensing of full courses of treatment against an FP10
- ◆ Provision of medicines information and advice to prescribers and patients
- ◆ Minor illness triage and treatment
- ◆ Audit of quality of prescribing and medicines supply.

The pharmacy would be operated by a pharmacy co-op. The co-op would apply for an NHS or LPS contract. The contract would be limited to a designated OOH period, depending on the opening hours of nearby pharmacies, e.g.

18.30 - 00.00 weekdays
17.30 - 00.00 Saturdays
08.00 - 11.00 and 20.00 - 00.00 Sundays

or any other time combinations identified by a baseline audit of demand and current service provision.

Arrangements for public holidays could be made to cover hours outside normal pharmacy opening – or the OOH pharmacy could provide OOH cover on behalf of local pharmacies, depending on contractors' preferences. Depending on demand, a duty pharmacist may need to remain accessible throughout the night for emergencies, but he or she would not need to be on the premises during this time.

The pharmacist would supply full treatment against an NHS prescription. This would be labelled using the OOH dispensary computer and supplied as an original pack with a patient information leaflet. The pharmacist would conduct a pharmaceutical assessment of the prescription and give advice on the use of the medicines. The pharmacist would collect a prescription charge or obtain an exemption declaration as appropriate.

Patient medication records would be held on the OOH dispensary computer. Information from this record could be made available to the patient's registered GP and usual pharmacist the next day. This could be a very time consuming service and so would need to be appropriately resourced.

The OOH dispensary would hold a limited formulary of drugs, based on the National OOH Formulary and local additions. It would include palliative care medicines, including controlled drugs (CDs). The pharmacist would be responsible for auditing the use of the formulary by GPs, and would be expected to query prescribing where it was not in line with the formulary.

GPs conducting home visits would go to the dispensary to collect a fully stocked medicine bag. The doctor would be expected to keep a record of medicines given to the patient at the home consultation. There would need to be a robust mechanism in place for the collection of prescription charges during or following home visits. On return to the OOH PCC, the medicine bag would be passed back to the pharmacy for stock reconciliation

against the GP records and details of medicines supplied would be added to the PMR, thus ensuring a full audit trail. A similar system could be used for the night time period (00.00 to 08.00) when no pharmacist is on the premises, but some medicines need to be supplied.

GPs and nurses on home visits would be able to contact the duty pharmacist for advice about a range of prescribing issues including administration, drug interactions, adverse drug reactions and problems with patients on multiple therapies.

In addition, the pharmacist may have responsibility for the following:

- reviewing and maintaining the local OOH formulary and assessing the quality of prescribing (using PACT data or local audit data);
- auditing the use of medicines by the OOH provider, including CDs;
- checking safe systems are in place for medicines storage inside and outside the dispensary;
- disposing of out of date medicines, including controlled drugs;
- keeping bags stocked and recording the use of medicines during home visits;
- providing pharmaceutical input into the continuing professional development of OOH providers (e.g. GPs and nurses) and;
- triaging patients with minor ailments and counter prescribing or supplying medicines in line with patient group directions (PGDs) as appropriate.

Patients presenting with minor illnesses could be directed in the first instance to the OOH pharmacist when he or she was present. He or she could triage the patient in line with agreed protocols. The protocols could enable the pharmacist to supply certain formulary medicines to patients directly, e.g. via PGDs. Where a P or GSL medicine was needed, pharmacists could encourage people to purchase the medicine. If they were unable to purchase the medicine, it could be supplied via PGD (for prescription only medicines) or a minor ailments scheme.

Service provider

This service could be provided by a locally run OOH pharmacy co-operative. The co-op could be a 'not for profit' organisation, entirely owned by and mostly staffed by pharmacy contractors in the area in which it operates. This mirrors the OOH co-op model in general practice. A co-op manager would organise rotas for the staffing of the pharmacy.

Funding and remuneration

Premises, management of the co-op and pharmacists' professional fees would have to be funded from the PCT unified budget. It may be possible in areas where a GP co-op is well developed for the GP co-op to be sub-contracted to manage the pharmacy co-op.

The bulk of the costs associated with the OOH pharmacy will need to be met by the PCT. However, pharmaceutical stocks would remain the property of the pharmacy co-op members who would pay a small subscription to cover the cost of maintaining stock in the OOH pharmacy. The co-op would aim to 'break even' in terms of the cost of the supply of medicines, which would be via FP10 only. Prescriptions would be submitted to the PPA for reimbursement in the normal way.

Contractual arrangements

The pharmacy co-op would contract with the PCT or GP OOH co-op to provide OOH pharmaceutical advice and medicines supply in line with a service level agreement. Alternatively, an LPS contract could be set up.

Costing the service

The costs involved in developing this new pharmaceutical service could include:

- A project manager to set up pharmaceutical OOH service and facilitate the development of the pharmacy co-operative.
- A Superintendent Pharmacist for the pharmacy.
- Management and administration costs – staff and premises.
- Professional fees for pharmacists who work at the pharmacy.
- Set up costs for the pharmacy – dispensary/shop fitting, IT equipment.
- Premises registration fees.
- Insurance.
- Rental of pharmacy space.
- Cost of stock.

Appendix 2 – Report template for a baseline audit of OOH pharmaceutical services

Demand for OOH services

Number of patients using OOH provider annually	
Year on year growth	
% patient who make first contact by phone	
% phone contacts triaged by doctor/nurse	
% told to make an appointment to see GP next working day	
% who attend OOH PCC	
% who receive a home visit	
% referred to A&E/999	
% who arrive at OOH PCC without initial phone contact with service	

Number of patients attending OOH PCC annually	
% dealt with by GP	
% dealt with by nurse	
% prescribed a medicine	
% supplied a medicine	

Number of patients visited at home annually	
% prescribed a medicine	
% supplied a medicine	

Number of patients supplied with a medicine at OOH PCC annually	
Number of patients supplied with a medicine at home annually	
Total number of patients supplied medicines annually	

OOH PCC/home visits:	
% of consultations with under 16s	
% of consultations with proxy patients	
% of consultations with adults, consulting about themselves	
% of patients exempt from prescription charges	

Peak period for consultations	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	
Public holidays	

Note for pharmacists

The figures quoted here should all be available from OOH providers (except possibly exemption status and number of proxy patients – if such consultations are allowed). They should be quoted here as annual figures. They will give you the basis for estimating the demand for OOH pharmaceutical services. It is important to have a baseline of all this information so that you can compare once any new service is introduced.

Case mix

Note for pharmacists

This section is based on an audit conducted by an OOH provider. The GP co-operative used the definition of a minor ailment applied in the Bootle Care at the Chemist Scheme as the basis for its definition of a minor ailment. The Bootle scheme transferred the care of these minor ailments to pharmacy - a similar care model could be developed within an OOH pharmacy to reduce the workload on other OOH clinicians.

An audit of xxx patient consultations completed between [start date] and [end date] (total of x weeks) found that xx% (n =?) of all OOH GP consultations were for minor ailments, using a definition of minor ailments taken from recently published research¹⁴. Of these xxx consultations, the range and prevalence of individual minor ailments were as follows:

- cough x%
- temperature x%
- sore throat x%
- ear ache x%
- diarrhoea x%
- head lice x%
- dyspepsia x%
- vaginal thrush x%
- constipation x%
- nasal symptoms x%

The remaining xxx consultations were categorised as follows:

[local pharmacists and OOH provider to decide categories]

(in addition, see section on special needs patients below for specific groups of patients who should be identified through this audit).

xxx medicines were prescribed or supplied as a result of these xxx consultations for minor ailments. xx% of these items (n = xxx) were medicines that are available either as a P or GSL medicine, although in xxx cases, starter medication and a prescription were supplied to patients. The remaining xxx medicines supplied were available as POMs only.

This audit highlights some important issues in terms of service planning:

- Currently xx% of the OOH providers caseload consist of people with minor ailments who could self medicate with medicines available from community pharmacy. With some foresight and advance stocking of their medicines cupboard, many could have avoided the need to visit the OOH PCC at all. A pharmacist, nurse or GP (or in the future, NHS Direct) could have given them telephone advice and helped them to select an appropriate treatment from their medicine cupboard.
- Those clients who insisted on visiting the PCC could have been treated by a pharmacist on site, thus freeing up GP time to focus on more seriously ill people.
- Those people who could afford to pay for their medication could have purchased it from a pharmacy, thus reducing pressure on GPs' prescribing budgets and helping to re-educate the patient to consult their pharmacist first and to keep their medicine cupboard stocked with key treatments.
- Exempt patients who refused to purchase their medication could have been supplied medication by a pharmacist through a voucher scheme, similar to those piloted in Bootle¹⁵ and in other areas.

Special needs patients

¹⁴ Whittington, Z., Hassell, K., Cantrill, J., Noyce, P. (2001) *Care at the Chemist: a question of access. A feasibility study comparing community pharmacy and general practice management of minor ailments.* Royal Pharmaceutical Society of Great Britain.
http://www.pharmi.com/pdf/papers/pj_20010331_chemist.pdf

The Carson Review highlighted the need for OOH services to cater for patients with special needs and to set up robust communication pathways with clinicians involved in the care of these individuals.

The groups highlighted are those:

- With terminal illness
- With complex acute clinical needs
- With mental health problems
- With any other special care needs
- Who access their care through arrangements made under HSC 2000/001: *Tackling violence towards GPs and their staff*

For *each* of these specific groups, audit should be used to establish:

- ♦ The frequency with which these patients use the OOH service.
- ♦ The number of medicines prescribed or supplied as a result of these consultations.
- ♦ The specific drugs supplied.
- ♦ Any special arrangements that had to be made in order to enable supply, e.g. emergency call out of pharmacist, access to syringe drivers.
- ♦ Current links to existing specialist services, e.g. palliative care services, mental health services and any planned developments – especially related to medicines supply.