Establishing Effective Therapeutic Partnerships

A generic framework to underpin the Chronic Medication Service element of the community pharmacy contract

A Report for the Chief Pharmaceutical Officer

December 2009
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Preface

I am delighted to receive this report from Professor Ritchie and I am grateful to him and to all of the individuals and organisations who have contributed to it.

The report provides a very sound base on which to build the Chronic Medication Service element of the Community Pharmacy Contract within NHS Scotland. The major theme of the report is improved patient care through the establishment of therapeutic partnerships between patients, general medical practitioners and community pharmacists. It builds on the existing strengths of the NHS in Scotland; a collaborative, integrated approach based on traditional values. The report also reflects the vision set out in the Scottish Government’s Action Plan, ‘Better Health, Better Care’, which is patient centred and aims to ensure better, local and faster access to health care.

Implementation of this report will further strengthen joint working between general practitioners and community pharmacists and will assist patients to obtain the best outcomes from their medication. Medicines are one of the most commonly used healthcare interventions in the NHS and play a vital role in improving patient care. However, the incidence of medicine related adverse events, as well as medicine wastage, are well documented and continue to present challenges to NHS Scotland. The generic framework for the Chronic Medication Service outlined in this report focuses on the importance of therapeutic partnerships to help address these challenges.

The real benefits to be gained by patients will require a service which is customised for each patient and provides continuity of the pharmaceutical care provided by their pharmacist from each and every community pharmacy.

I see this report as another important building block in modernising community pharmacy practice and reinforcing the place of community pharmacists within the NHS family.

Professor Bill Scott - Chief Pharmaceutical Officer, Scottish Government
Remit

To advise the Chief Pharmaceutical Officer on a generic framework, which is supported by disease specific protocols, to underpin the contribution of community pharmacists to the management of long term conditions through the Chronic Medication Service (CMS).
Foreword

In primary care, healthcare professionals currently manage over 90% of all patient contacts with the health service, co-ordinating diagnosis, treatment and care to ensure that as many of these services are provided as close to home as possible. The General Medical Services (GMS) contract has built on this by providing a major focus on quality and outcomes through the introduction of an evidence based Quality and Outcomes Framework (QOF) for general medical practices. The QOF rewards practices for delivering high quality care associated with chronic disease management. The introduction of the new Community Pharmacy Contract and, in particular, the Chronic Medication Service (CMS) element, provides an excellent opportunity to build on and consolidate existing good pharmacy practice and to encourage joint working between general medical practitioners (GPs) and community pharmacists, in order to further improve patient care.

At the outset of its work programme, the CMS Advisory Group considered models of existing good practice for the management of long term conditions. It was important to assimilate lessons that could be learned from the implementation of similar programmes elsewhere - in the UK and beyond - in order to ensure that CMS would be introduced in a measured way. For CMS to be established successfully, it will be imperative that the ‘basics’ are put in place; that it is anchored upon the right founding principles, that it supports the patient ‘journey of care’; that there are clearly defined roles for all health professionals involved; that it is underpinned by robust routes of communication and appropriate referral pathways; that there are identified links to existing work programmes; and that adequate incentives are provided to promote joint working. Straightforward design and shared understanding will be key components. It will also be essential to promote the benefits and provide clear explanations of this new way of working - both to healthcare professionals and to patients, alike.

Advisory Group members initially agreed six core founding principles to underpin a generic framework for the Chronic Medication Service covering the following key areas: patient centred; clinical governance; collaborative working; support for implementation; monitoring and review; and service development. These principles were used as the benchmark for testing this generic framework and are listed in Appendix 3.

We went on to consider the patient ‘journey of care’ and associated interdependencies, including the specific roles of GPs, their practice teams and community pharmacists in supporting patients with long term conditions. We agreed that all the health professionals involved had to be comfortable with their specific role(s); there should be no duplication of effort; the framework had to promote a holistic approach to the pharmaceutical and clinical care of patients with the right balance between the condition specific elements and a wider overview across different conditions, taking into account any associated co-morbidity and polypharmacy aspects. The introduction of CMS should play to the professional strengths and skills of all involved, with a particular emphasis, in this new model of care, on the specific contribution of community pharmacists. Medicine related issues would be key: safety, efficacy, side effects, drug related problems, improving compliance, achieving better concordance, identifying markers of poor control, using symptom specific triggers to prompt referrals, and providing high quality patient information/education.
Good communication between healthcare professionals and also with patients was seen as essential. Previous experience has illustrated the need for information exchange to be clear, concise and in the right format (whether written, electronic and/or web-based). Importantly, practitioners and patients alike should not be overwhelmed with extraneous information which could only serve to confuse; it should, instead, be about reinforcing the key points of optimal care. In relation to information sharing, CMS will need to be underpinned by robust information flows in both directions, linking community pharmacies and general practices, supported by explicit and informed patient consent. We agreed that information sharing systems should be based on the principle of exception reporting in order to provide specific, necessary and appropriate information to be shared on a need-to-know basis.

We also agreed that defined referral pathways were important to facilitate the patient journey between healthcare professionals and to ensure that, as and when required, a patient could be referred to the appropriate member of the health care team in a timely manner.

Advisory Group members concluded that the QOF offered a means initially both to link to existing work programmes within the GMS contract and to incentivise future joint working. Linking the disease specific protocols that support serial dispensing to a number of the conditions in the QOF was viewed as providing a helpful mechanism to encourage a multi-professional team approach, as well as supporting evidence based practice.

We also considered essential preparatory activities to underpin CMS. These key activities included: practitioner support, patient information, IT developments and the need for adequate governance arrangements. We reflected on the lessons learnt from the implementation of similar models elsewhere, to try to ensure that we identified and responded to any key themes that would support the development and delivery of CMS.

In summary, in order to harness the significant potential of CMS to secure enhanced patient care and professional collaborative working, it will be crucial that the guiding principles in this report are translated as effective operational plans, sufficiently resourced and adequately piloted/tested, as an essential precursor to national roll-out. Resilient information technology, timely communications and a shared understanding - among both patients and health professionals - will be key factors for successful realisation of CMS.

I would like to convey my personal thanks to the members of the Advisory Group and their respective organisations for their support and constructive, detailed comments on the various papers and draft forms of the report. I would also like to express particular appreciation to Ms Alison Strath, Principal Pharmaceutical Officer, and to the secretariat to the Group, Mary Waugh and Norma Darroch, Pharmacy Division, Scottish Government for all their endeavours in bringing this report to fruition.

Professor Lewis Ritchie - Chairman of the CMS Advisory Group
**Summary**

**Description of the Chronic Medication Service**

The Chronic Medication Service (CMS) is a service requiring voluntary patient opt-in before participation. There are three stages to CMS each of which will be underpinned by the ePharmacy Programme (see Appendix 6):

- **Stage 1**: involves the registration of patients for CMS.

- **Stage 2**: introduces a generic framework for pharmaceutical care planning which is based on a systematic approach to the practice of pharmaceutical care as described in the CRAG Framework document, *Clinical Pharmacy Practice in Primary Care*¹.

- **Stage 3**: establishes the shared care element which allows a patient’s GP to produce a serial prescription for up to 48 weeks and which is dispensed at appropriate time intervals to be determined by the patient’s GP. This stage is supported by disease specific protocols for a number of conditions which outline common potential pharmaceutical care issues, referral criteria and reporting requirements.

**Potential benefits of the Chronic Medication Service**

This way of working formalises the role of community pharmacists in the management of individual patients with long term conditions, assists in improving patients’ understanding of their medicines and optimises the clinical benefit from their therapy. It also facilitates a holistic approach to promoting health, thereby ensuring that disease prevention, health education and health protection are all integral elements of CMS. This model of practice supports self management, and promotes therapeutic partnerships between community pharmacists, patients and the general practice teams. It introduces an approach to practice which helps to minimise adverse drug reactions, address existing problems with medicines and to prevent potential ones. It also provides structured follow-up and referral interventions where necessary.

The establishment and evolution of CMS will support key aspects of healthcare policy and quality improvement through the following mechanisms:

- facilitate shifting the balance of care for the management of long term conditions;
- improve multidisciplinary and collaborative working and minimise duplication of effort between healthcare professionals;
- establish a framework to improve the monitoring and continuity of care for patients with long term conditions; and
- improve the efficiency of information transfer locally and of data capture both locally and nationally.

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Section 1  Introduction

1.1  Policy context

NHS Scotland faces a number of challenges; changing demographics, an increasing prevalence of multiple long term conditions (co-morbidity), a widening gap in health inequalities and increasing pressures and expectations on the health care system itself. Medicines are the most commonly used commodity in the NHS and they form part of the backbone of modern healthcare. However, whilst medicines are used for the purpose of improving a patient’s quality of life, for example by reducing or eliminating symptoms, slowing the progression of a disease or preventing a disease or symptoms, under certain circumstances there is also the potential for outcomes that reduce a patient’s quality of life and place them at increased risk of drug related morbidity and mortality. Additionally, a significant number of hospital admissions are associated with adverse drug reactions, both of which increase in frequency within the elderly population. Research has shown that the majority of drug related morbidities are predictable and as a result should be preventable².

Drug wastage represents a significant lost resource within the NHS. It is estimated that around 50% of medicines are not taken as prescribed by patients with long term medical conditions³. The literature suggests that there are two main areas related to non-compliance⁴. The first is based on patient values i.e. the patient’s motivation, ability and beliefs. The second is related to healthcare professionals; their awareness of and attention paid to patients’ values. As a result, one of the main reasons for non-compliance is a pervasive failure to establish effective therapeutic partnerships between healthcare professionals and patients. This suggests the need for a paradigm shift in the way that healthcare professionals think about how patients take medicines; working together to ensure that the views of both the healthcare professional and the patient are part of the decision making process. In other words, there should be a shared and common understanding on agreed outcomes between healthcare professionals and patients, which encourages patients to make decisions about their health and healthcare as genuine partners in their care.

These challenges, whilst demanding, are not insurmountable. By harnessing the energy and enthusiasm of its employed and contracted workforce, the NHS should be able to provide more effective treatments, improve outcomes from therapy, lessen unnecessary hospital admissions, reduce wastage and, through better concordance, improve adherence to drug therapy. In turn, this will result in services for patients and carers that help people stay healthy, improve health outcomes and provide better patient care.

1.2 A focus on long term conditions

A long term condition can be defined as a condition that requires ongoing medical care, may limit what one can do and is likely to last longer than one year\(^5\). The World Health Organisation defines it as: ‘a health problem that requires ongoing management over a period of years or decades’. The increasing number of people with long term conditions presents a major challenge for health and social care services and for society.\(^6\) As a result, healthcare providers are seeking ways of creating more gateways to support self care and provide better access to services in local communities. Self care involves individuals taking action to stay healthy, preventing illness, accessing and complying with appropriate treatments, managing symptoms and side effects, managing chronic conditions and disabilities, recovery and rehabilitation. It can take many forms, but the greatest potential for self care is most likely to be within the management of long term conditions which needs to be customised, for example, to reflect an individual patient’s ability to self manage allowing for variations which can occur over time as their condition changes through relapse or improvement or their capability to access information and support according to their circumstances.

Healthcare professionals have a key role in empowering and supporting patients in order to help them assume a greater role in the self-management of their own health and health care. In order to be able to deliver sustainable improvements in patient centred services, there is a need to balance professional care with enhanced support for self management. This can be achieved by building effective partnerships between informed and motivated patients and the healthcare professionals engaged in their care. Good communications and a clear understanding of respective roles and expectations are critical success factors.

1.3 Pharmaceutical care

Pharmaceutical care can be defined as: ‘the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve the patient’s quality of life’\(^7\). It represents a holistic approach to patient care, involving the healthcare team in a much wider and ongoing responsibility for a patient’s medicine related needs. It aims to help patients get the most benefit from their medicines and to minimise the associated risks. This is done by identifying, resolving and preventing medicine related problems so the patient understands and gets the desired therapeutic goal for each medical condition being treated. Implicit in this approach are the principles of patient centred care, professional responsibility, partnership working, shared outcome measures, concordance, medication surveillance, robust communications and a quality system of work. Pharmaceutical care is an effective tool in the management of long term conditions as it provides a structured and systematic approach to pharmacy practice, building on the concordance model by maximising the therapeutic partnership between healthcare professionals and patients.

\(^7\) Hepler CD, Strand LM. March 1990. *Opportunities and responsibilities in pharmaceutical care*. American Journal of Hospital Pharmacy, Volume 47, pages 533-543.
1.4 Responding to the therapeutic challenge

The Right Medicine; A Strategy for Pharmaceutical Care\(^8\) outlined the then Scottish Executive’s commitment to make better use of pharmacists’ skills and expertise to improve patient care. It called for the development of quality services based on a patient centred approach to pharmaceutical care. It set out an action plan for the redesign of community pharmacy services based on the introduction of a new pharmacy contract to support community pharmacists in the delivery of pharmaceutical care. This has been taken forward using the results of research evidence and tested through the establishment of pilots and early implementation sites. The Chronic Medication Service (CMS) element of the contract integrates two previous policy initiatives: serial dispensing and Pharmaceutical Care Model Schemes with a view to helping patients manage their long term conditions.

1.5 Summary

Work in progress has demonstrated a willingness on the part of patients to engage in more innovative ways of obtaining their medicines and to take a wider role in self management with help and support from their pharmacist. The outline for the serial dispensing element of CMS has been built on earlier pilots which demonstrated that involving the pharmacist more formally with the patient and their repeat prescription(s) identifies medicines that patients may not need and addresses many issues around non-compliance with treatment, leading to reduced drug wastage. In addition, introducing a focus on pharmaceutical care as an integrated approach to improving the management of long term conditions - with clear responsibilities and shared objectives - has the potential to deliver sustainable improvements in patient centred services.

\(^8\) Scottish Executive. The Right Medicine; A Strategy for Pharmaceutical Care in Scotland. 2002.
Section 2   The Chronic Medication Service

2.1   An overview

The purpose of the Chronic Medication Service (CMS) is to further develop the role of community pharmacists in the management of individual patients with long term conditions. It is underpinned by a systematic approach to practice, in order to improve a patient’s understanding of their medicines and to work with them to maximise the clinical outcomes from their therapy. It facilitates a holistic approach to promoting health, ensuring that disease prevention, health education and health protection are all integral elements of CMS. This model of practice is based on patient need, clinical practice and quality improvement. It is patient centred, supports self management, promotes a partnership approach between the pharmacist, the patient and other healthcare professionals, ensures systems are in place to help minimise adverse drug reactions and address existing and prevent potential problems with medicines. It also provides for structured follow-up and referral interventions as, and when, necessary.

CMS encourages collaborative working between GPs and other healthcare professionals, community pharmacists and patients and puts in place systems to:

- ensure that drug therapy is evidence-based;
- help minimise adverse drug reactions;
- address and prevent potential problems;
- promote health;
- maximise patient safety;
- provide a structured follow-up intervention where necessary;
- reduce wastage; and
- improve outcomes from therapy.

The core objectives of CMS are to:

- underpin the pharmacist’s developing role in improving the management of long term conditions;
- improve patients’ understanding of their medicines and their long term conditions, enhancing self-care;
- use a systematic approach to prioritise pharmaceutical care by implementing the CRAG Clinical Pharmacy Practice Framework;
- document pharmaceutical care;
- facilitate continuity of care;
- ensure that a focus on health improvement is integral to practice; and
- facilitate partnership working.

In order to achieve these aims and objectives it is important that GPs and community pharmacists are comfortable with their respective roles. Figure 1, on the following page, illustrates the patient ‘journey of care’ when CMS is in place and the resulting information and communications flows between the two healthcare professionals.
Figure 1: The information and communications flows during the patient journey of care
## 2.2 CMS service outline - the community pharmacy component

There are three stages to the community pharmacy component of CMS as outlined in **Figure 2** below.

### COMMUNITY PHARMACY

#### STAGE 1: PATIENT REGISTRATION
- A patient with a long term condition/s registers with the community pharmacy of their choice
- A patient must be registered with a GP practice in Scotland
- A patient can only register with one pharmacy
- An electronic message is sent to the GP practice

#### STAGE 2: PHARMACEUTICAL CARE PLANNING
- The pharmacist identifies and prioritises patients with unmet pharmaceutical care needs
- The patient and pharmacist discuss and assess the patient’s condition/s, medicine/s and general health
- The patient and pharmacist identify any issues/ problems and agree any actions to address them
- The agreed actions are documented in a pharmaceutical care plan
- The care plan is periodically monitored and reviewed

#### STAGE 3: SHARED CARE
- The patient’s GP decides on their suitability for a serial prescription for up to 48 weeks
- The pharmacist cares for the patient over the time period according to national, evidence-based clinical protocols supported by the care plan
- Relevant information is shared between the GP and pharmacist with informed patient consent
- The GP carries out the QOF medication review at the end of the duration of the serial prescription

**Figure 2:** A summary of the Community Pharmacy component of CMS
### 2.3 CMS service outline: the General Practice component

There are three stages to the GP component of the CMS as outlined in Figure 3 below.

<table>
<thead>
<tr>
<th>GENERAL PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STAGE 1: PATIENT REGISTRATION NOTIFICATION</strong></td>
</tr>
<tr>
<td>- Patient registers with a community pharmacy for CMS</td>
</tr>
<tr>
<td>- An electronic registration notification message is sent to the GP practice</td>
</tr>
<tr>
<td>- GP IT systems flags a patient CMS registered</td>
</tr>
<tr>
<td>- GP can issue a serial prescription for the patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STAGE 2: SERIAL PRESCRIPTION</th>
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<tbody>
<tr>
<td>- GP generates serial prescription (up to 48 weeks)</td>
</tr>
<tr>
<td>- Pharmacist dispenses serial prescription over the time period supported by national, evidence-based clinical protocols</td>
</tr>
<tr>
<td>- Dispensing information is sent electronically to the GP practice</td>
</tr>
<tr>
<td>- Pharmacist sends an electronic end of care treatment summary, including a request for a new serial prescription/s</td>
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<tr>
<td>- This triggers the annual QOF medication review</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>STAGE 3: QOF MEDICATION REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The dispensing and end of care period treatment information summary is available in the GP IT system</td>
</tr>
<tr>
<td>- The GP undertakes a medication review using information provided in the end of care treatment summary</td>
</tr>
<tr>
<td>- The GP produces the next serial prescription</td>
</tr>
<tr>
<td>- Any relevant information is updated on the GP IT system</td>
</tr>
</tbody>
</table>

**Figure 3:** A summary of the General Practice component of CMS
2.4 CMS service specification

**STAGE 1 PATIENT REGISTRATION**

A patient with a long term condition/s registers for CMS with the community pharmacy of their choice. The patient can only register with one pharmacy at any one time. Registration is voluntary and open ended; a person can withdraw from CMS at any time. Patients not registered with a GP practice in Scotland or who have a temporary resident status⁹ are not eligible to register for CMS.

A patient is registered electronically for CMS by the national **Patient Registration System (PRS)**. A **CMS patient registration request** is generated by the pharmacist’s **Patient Medication Record (PMR) system** and sent to PRS via the **ePharmacy Message Store (ePMS)**. PRS will send back a message informing the pharmacist whether registration has been successful or not.

Registering for CMS means a patient must take their serial prescription to the pharmacy where they are registered. They are free to take non-serial prescriptions elsewhere. However, wherever possible, patients are encouraged to use the same pharmacy to ensure continuity of care.

- **Patient consent**

Registration includes an explicit informed patient consent process to allow the pharmacist and GP to exchange any relevant clinical data, where appropriate, to support the shared care element of CMS. The consent is given to the registering pharmacist. Robust systems for secure data exchange to maintain patient confidentiality are provided through the ePharmacy Programme.

- **GP patient registration notification**

Once a patient with a long term condition/s has registered for CMS with a community pharmacy then the pharmacy PMR system generates an electronic **CMS registration notification message** which is sent to **ePMS**. This message is pulled down from the store by the relevant GP IT system which, in turn, flags the patient as CMS registered in the patient electronic record at the GP practice.

This flag acts as a trigger to the GP when they open the electronic patient record so that they know that they can then enter into a **shared care arrangement** with the patient and their community pharmacist. This arrangement includes the option to generate a **serial prescription/s** for the patient. This is a prescription for medicines, medical sundries or appliances which is dispensed in instalments for up to a 48 week period. Serial prescriptions are supported by **national CMS disease specific protocols which** outline common potential pharmaceutical care issues, referral criteria and reporting requirements.

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⁹ ‘temporary resident’ is a person who is resident in Scotland for more than 24 hours but less than three months.
**CMS withdrawal**

Withdrawal from CMS is also electronically supported in the same way as registration. Again, the GP practice is alerted to a registration withdrawal. If a patient wishes to change their registration to another pharmacy the new pharmacist will be prompted firstly to establish that this is what the patient wants to do. In these circumstances the patient’s registration will be withdrawn from the original pharmacy and they will be **re-registered** with the new pharmacy. A patient registration notification message will be sent to the patient’s GP practice to update their record.

**STAGE 2 PHARMACEUTICAL CARE PLANNING**

Pharmaceutical care planning requires the pharmacist to identify a patient’s **pharmaceutical care needs**, **care issues**, any **desired outcomes** and the **actions** required to deliver the outcomes. These are then recorded in a **pharmaceutical care plan**. This approach essentially forms a dynamic continuous model of care as identified in **Figure 4** below. By undertaking an initial **risk assessment**, the pharmacist identifies and prioritises individuals who have unmet pharmaceutical care needs and, as a consequence, may be at risk from sub optimal therapeutic management, side effects or poor compliance. This assists the pharmacist in introducing CMS in a planned and achievable manner, using the pharmacist’s time effectively to initially target patients most in need of their support.

![Diagram]

**Figure 4:** Pharmaceutical care planning

Pharmaceutical care planning formalises and documents much of what community pharmacists already do in their day to day practice. It promotes a holistic approach by focusing on the whole person, involves the patient in their own care and takes into account co-morbidity as well as disease specific issues. The care planning process also supports the continuity of pharmaceutical care.
• **Prioritising pharmaceutical care planning**

*Prioritising pharmaceutical care planning means: identifying and prioritising individual patients most in need of pharmaceutical care. This is achieved by undertaking an initial risk assessment.*

• **Pharmaceutical assessment**

*The pharmaceutical assessment involves identifying and reviewing the patient’s pharmaceutical care needs and any pharmaceutical care issues which need to be addressed.* The pharmacist undertakes an assessment of the patient and their general health and then builds a medication profile for the patient by assessing all the medicines prescribed for their long term condition/s. They do this by evaluating the therapeutic efficacy of each drug and the progress of the condition/s being treated. The assessment process allows the pharmacist to gauge the patient’s understanding of their condition/s and medication and helps to identify any unresolved issues.

• **Pharmaceutical Care Planning**

*Pharmaceutical Care Planning involves generating a pharmaceutical care plan, based on the pharmaceutical care issues identified during the assessment process, and which is agreed with the patient.* The patient’s pharmaceutical care needs and pharmaceutical care issues are confirmed and prioritised with the patient. This is documented within a pharmaceutical care plan and the pharmacist and patient jointly agree actions to solve any problem/s over a period of time. Some actions may involve other members of the healthcare team and the pharmacist takes responsibility for communicating those actions to the appropriate individual. The plan also states how and by whom this will be monitored. The process of pharmaceutical care planning is described in more detail in Appendix 4.

• **Monitoring and review**

*Monitoring and review describes the implementation of the care plan and includes the ongoing monitoring and reviewing of progress against the plan.* The pharmacist and patient monitor and review progress against the actions in the pharmaceutical care plan. Agreement is reached on whether the desired outcomes are being achieved and, if not, the plan is reviewed. Ideally, to assist in this process the patient should be given a personal copy of their pharmaceutical care plan. Pharmaceutical care plans should be open to a process of peer review as part of the quality element of the pharmacy contract.

• **Counselling and advice**

In order to achieve maximum therapeutic benefit from prescribed medicines and appliances it is important that patients understand their therapy and how to use the products prescribed appropriately. The pharmacist should, therefore, also consider the counselling and advice needs of the patient in relation to their medicines both during the initial assessment and on an ongoing basis. This is underpinned by the CRAG Framework for
STAGE 3 SHARED CARE

Once a GP receives a CMS registration notification message they can choose to enter into a shared care arrangement with the pharmacist and patient which allows them to generate a serial prescription underpinned by national CMS disease specific protocols. Ultimately, it is a matter for the GP to determine an individual patient’s suitability for this component of the service. The pharmaceutical care plan remains as the basis of the ongoing care for the patient and the national CMS disease specific protocols outline any referral criteria and reporting requirements.

- **Ongoing care planning: building on the systematic approach**

Stage 3 is also underpinned by pharmaceutical care planning. Where a pharmaceutical care plan is already in place from Stage 2 then the pharmacist continues to monitor the control of the condition/s and symptoms, side effects and compliance. In addition, serial prescriptions provide the opportunity for a more planned and structured follow up by the pharmacist. Where a patient without a pharmaceutical care plan receives a serial prescription, the pharmacist should, if necessary, formulate a care plan as part of the serial dispensing process.

- **Serial prescription**

A serial prescription is a prescription for medicines, medical sundries or appliances which is dispensed in instalments for up to a 48 week time period. A GP can choose to generate a serial prescription for a patient through a number of routes; during a patient’s annual QOF medication review, during a routine appointment, at a chronic disease management clinic or as a result of a patient or pharmacist request. In doing so the GP takes into consideration the stability of the patient’s condition/s, the medicines they consider to be appropriate for serial dispensing and the duration of the prescription. They also select the serial prescription dispensing intervals. In the future, it may be possible to allow the pharmacist and patient to determine the time intervals supported by national guidance. The GP system generates the paper serial prescription and associated electronic prescription message. The electronic message is automatically sent to ePMS.

Once received in the pharmacy, the serial prescription is scanned and subsequently dispensed at the time intervals determined by the GP. This establishes the medication supply arrangements for the duration of the serial prescription. The electronic prescribe message is used to generate the dispensing instalments and associated electronic claim messages for the serial prescription. These messages form the basis of the ePay element of

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the ePharmacy Programme. In addition, information on items dispensed against a serial prescription, ‘dispensing information’, is automatically sent via ePMS back to the GP practice after each serial dispensing episode. The final dispensing episode triggers the pharmacist to generate and send an end of care treatment summary to the GP practice. This can include an electronic serial prescription renewal request.

A GP can cancel either the serial prescription or an item on the serial prescription electronically at any point. For example, if a patient’s medication has been stopped or altered or if the patient’s circumstances have changed - they may have been admitted to hospital or their condition is no longer stable. Once cancelled, the pharmacist can no longer dispense any outstanding instalments for that item/prescription.

- **Clinical disease specific protocols**

The shared care stage is also supported by national CMS disease specific protocols which outline common potential pharmaceutical care issues, referral criteria and reporting requirements. The protocols complement the pharmaceutical care planning process and help the pharmacist to identify any requirement to refer the patient back to an appropriate healthcare professional over the period of a serial prescription as well as any end of care period reporting requirements. This facilitates partnership working with other members of the primary care team. Evidence from both England\textsuperscript{11} and the USA\textsuperscript{12} has identified that thirteen long term conditions represent the most frequent indications for drug therapy (over 50%). These are detailed in Appendix 5. When considering the disease specific protocols it would seem sensible to start with these conditions initially whilst remembering that they do not occur in isolation; patients have co-morbidities.

- **Referrals**

If necessary, a pharmacist will refer a patient to an appropriate healthcare professional (usually the patient’s GP but may also include other members of the practice team or secondary care colleagues) based on either the referral criteria within the disease specific protocols or their own professional judgement.

- **Reporting**

Once the last instalment from the serial prescription has been dispensed the pharmacist sends a serial prescription renewal request for a new serial prescription/s to the GP practice. This request can form part of the end of care treatment summary. This summary details any information pertinent to the GP, such as the dispensing history for the serial prescription, relevant QOF data and any recommended actions for the GP to consider. This supports the sharing of information between the GP and pharmacist with appropriate informed patient consent and through secure systems of communication.

\textsuperscript{11} Royal Pharmaceutical Society of Great Britain. 2006. \textit{Long Term Conditions: Integrating Community Pharmacy}.

The end of care treatment summary, including the renewal request, is queued in the GP IT system for review along with any other relevant patient correspondence, hospital letters and information that the GP needs to consider when reviewing the patient. This establishes a formalised system for follow up. It can also form the backbone of the annual QOF medication review as well as other long term condition reviews. When the GP reviews the shared care arrangement, prompted by the serial prescription renewal request, they can take into account the information in the end of care period treatment summary to inform the review process. They then update or continue the existing package and issue a new serial prescription/s, taking into account any required actions. Any relevant information is recorded and/or updated in the GP system. The QOF medication review marker and any other relevant QOF domains are also updated and stored.

2.5 Summary

Long term conditions require proactive, continuing care as opposed to reactive, episodic care. CMS outlines the community pharmacist's contribution to the care of patients with long term conditions, based on a holistic approach. It builds on the existing strengths of community pharmacy practice; it focuses on the continuity of pharmaceutical care of patients with the right balance between the condition specific elements and the wider overview reflecting the incidence of co-morbidity and the associated polypharmacy aspects. The focus on therapeutic partnerships facilitates the policy of shifting the balance of care for the management of long term conditions and introduces multidisciplinary and collaborative working between healthcare professionals. It also improves the efficiency of information transfer and data capture both locally and nationally. CMS introduces systems to help prevent and solve adverse drug reactions, with structured follow-up and referral if necessary. This should, in turn, improve health outcomes for patients with long term conditions as well as contribute to the Scottish Patient Safety Programme.
Section 3  Supporting delivery of CMS

3.1 Introduction

Each of the four core elements of the new community pharmacy contract in Scotland have been designed on the basis of the results from research evidence and tested through pilots and early implementation sites. For CMS this means building on previous policy initiatives such as the CRAG framework, *Clinical Pharmacy Practice in Primary Care*, serial (repeat) dispensing studies and trials and the Pharmaceutical Care Model Schemes (PCMS) initiative. In addition, when considering the CMS generic framework, any precedents in terms of implementing similar models of practice across the rest of the UK and elsewhere have been reviewed and lessons learned have been taken into account. This approach consolidates existing good practice and utilises methods that appeared to be successful in other similar programmes of work.

3.2 Supporting implementation

The areas that need to be considered in order to support the successful implementation of CMS can be summarised under the following categories:

- communications
- inter-professional working
- education and continuing professional development (CPD)
- governance
- wider integration.

*Communications*

Good communication is critical to the successful implementation of CMS. In order that patients understand how the service works, they should be provided with a specific CMS information leaflet advising about the service and explaining the implications of sharing relevant clinical data between GPs and community pharmacists, including associated aspects of consent. These leaflets should be available both in GP practices and community pharmacies.

Additional awareness raising and communication materials should be considered in order to target patient group associations (such as the Long Term Condition Alliance and Scottish Patient Association) and other NHS organisations (such as the NHS Help Line). These materials should also cover patient information about their disease condition/s, advice on taking their medication and any other pertinent issues. Experience from NHS 24 has demonstrated success in standardising information and advice given to patients and carers. This also helps ensure that the information given to patients is consistent across the whole healthcare team. NHS 24 has a dedicated, maintained website, [www.NHS24.com](http://www.NHS24.com) containing relevant information that can be used by patients or healthcare professionals.

It is important that GPs and community pharmacists are clear about their own roles throughout the patient journey of care in order to support delivery of the service, prevent
any overlap or duplication of actions and also to clarify appropriate referral pathways and criteria. This includes the role of the secondary care team who may receive referrals from pharmacists.

- **Inter-professional Working**

In order to support GPs and community pharmacists in the successful implementation of CMS, including the IT underpinning the service, it would be beneficial for NHS Education Scotland (NES) Pharmacy to provide a CMS implementation resource pack. This could act as a quick reference to the service, the underpinning software support and housekeeping requirements. This approach has been used for other elements of the new community pharmacy contract – see [www.nes.scot.nhs.uk/pharmacy/newcontract](http://www.nes.scot.nhs.uk/pharmacy/newcontract) - and has received very positive feedback from community pharmacists. To date, these NES packs have only been provided to community pharmacists. However with the introduction of CMS it would now seem logical to extend provision to GP practices.

Previous lessons learnt have identified the importance of GPs and community pharmacists being able to start working simultaneously. If one group is ready ahead of the other it becomes a rate limiting step to progressing new ways of working. A patient must be registered for CMS at a community pharmacy in order for a GP to be able to generate a serial prescription. It is important therefore that there is no time delay in patients being registered which means that an opportunity is lost for a GP to instigate a serial prescription. It may therefore be beneficial for GPs and community pharmacists to consider, in advance of the service starting, a list of suitable candidate patients to be registered for CMS. This means that once systems are enabled community pharmacists will have a list of patients to register and GPs can produce serial prescriptions for eligible patients.

Once CMS is live, community pharmacists are well placed to register suitable patients from existing repeat dispensing episodes. In addition, appropriate patient support materials can be used to raise awareness of the service. Pharmacy Patient Medication Record (PMR) systems may also be able to highlight patients on regular repeat prescriptions and flag them as potential CMS patients. In turn, GPs can use routine patient appointments and chronic disease management clinics to identify, for serial prescriptions, suitable patients who are stable on their medication. Community pharmacy referrals, specialist referrals and individual patient requests may also trigger requests for consideration for serial prescriptions.

- **Education and Continuing Professional Development (CPD)**

To ensure that newly qualified pharmacists are suitably equipped to provide CMS, it is important that relevant competencies are incorporated into both the undergraduate and pre-registration training programmes. From an undergraduate perspective continued close working by both Scottish Schools of Pharmacy should facilitate this. NES Pharmacy oversees the Scottish Pre-Registration Training Programme and should be able to incorporate any necessary requirements. In addition, a range of continuing education options are already available to support community pharmacists providing CMS including NES Pharmacy Core Chronic Disease materials.
• **Governance**

A quality system promotes and assures consistent service provision to an appropriate standard. CMS must be founded on evidence-based practice. It should also have governance arrangements in place that ensure continuous quality improvement, including a system that supports regularly measuring and evaluating practice (audit) and peer review.

The new community pharmacy contract will be underpinned by a quality framework. Whilst it will cover all aspects of practice, CMS will be a key element and there will be a number of process and outcome measures which could contribute to the development of a quality framework. eLearning will also be a useful resource in terms of supporting CPD. As many community pharmacists may work in relative isolation from other professional colleagues, a process of peer review can help test and develop individual competence, support CPD via reflective practice and sustain quality assurance.

• **Wider integration**

CMS will be underpinned by eCMS, which replaces most paper-based reporting systems with electronic reporting. As a result administrative arrangements for CMS will be kept as straightforward as possible and rely principally on IT rather than paper-based systems. eCMS will deliver electronic feedback on both dispensing and other activities undertaken by the pharmacist as well as facilitate regular communication between the GP and the community pharmacist. There may however be other databases and services provided by secondary care practitioners which may benefit from secure information exchange with CMS. Any such exchange will be according to agreed and verifiable protocols - and on the basis of a defined need.

As CMS offers the opportunity to develop a patient version of the pharmaceutical care plan this could in the future be hosted electronically as part of the Scottish eHealth programme developments – [www.ehealth.scot.nhs.uk/](http://www.ehealth.scot.nhs.uk/). These aim to provide individual patient health plans for example through a patient access portal or an extension of the emergency care summary record, and be used collaboratively by patients and their NHS clinicians.

3.3 **Summary**

Some common themes regarding delivery have emerged when considering existing best practice and lessons learnt in implementing similar programmes of work elsewhere. Addressing these in good time, prior to introduction and throughout the implementation programme for CMS, should provide a sound foundation on which to build this new service. Following the launch of CMS, there is a requirement for ongoing review of progress to robustly address any additional issues that may arise over time.
Appendix 1

MEMBERSHIP OF THE CMS ADVISORY GROUP

Chairman
Professor Lewis Ritchie  Mackenzie Professor of General Practice  University of Aberdeen

Group members
Professor John Cromarty  Director of Pharmacy  NHS Highland
Dr George Crooks  Medical Director  NHS 24
Dr Scott Cunningham  School of Pharmacy and Life Sciences  Robert Gordon University
Dr Richard Groden  General Practitioner  NHS Greater Glasgow & Clyde
Ms Annamarie McGregor  Community Pharmacist  Aberfeldy / Glasgow
Professor Ray Newton  Consultant Diabetologist (retired)  Tayside
Mr George Romanes  Community Pharmacist  Duns
Dr Andrew Russell  Medical Director  NHS Tayside
Mr Campbell Shimmins  Community Pharmacist  Doune
Dr Derek Stewart  School of Pharmacy and Life Sciences  Robert Gordon University
Dr Sara Twaddle  Heath Economist  Scottish Government  Formerly Director, Scottish Intercollegiate Guidelines Network (SIGN)
Additional advice was sought from and kindly provided by the Scottish General Practitioners’ Committee (SGPC) of the British Medical Association (Scotland) and Community Pharmacy Scotland (CPS).

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Ms Alison Strath  
Principal Pharmaceutical Officer  
Scottish Government

**Secretariat**

Mrs Norma Darroch  
Pharmacy Division  
Scottish Government

Mrs Mary Waugh  
Pharmacy Division  
Scottish Government
Appendix 2

REMIT AND WORK PROGRAMME

Remit

To advise the Chief Pharmaceutical Officer on a generic framework, which is supported by disease specific protocols, to underpin the contribution of community pharmacists to the management of long term conditions through the Chronic Medication Service (CMS).

Work programme/Group process

The whole group met on three occasions

The first meeting in November 2007.

The second meeting in February 2008.

The third meeting in May 2008.

In addition a sub-group met in March 2008.

A number of draft versions of the report were considered and refined further using electronic (e-mail) communications, prior to finalisation.

The Group issued their report outlining a generic framework to underpin CMS with a separate, supporting set of recommendations to assist the CPO in defining the work programme required to assist with the introduction and implementation of the service.
Appendix 3

PRINCIPLES FOR A GENERIC CMS FRAMEWORK

1. PATIENT CENTRED

- must engage patients (and carers) as active, informed and willing participants
- must assure patients of confidentiality and safe and secure data management
- should ensure equity of access to CMS for all patients
- should involve patients in the development, implementation and review of CMS care plans
- should encourage and support self care

2. CLINICAL GOVERNANCE

- must be evidence-based, linking to and complementing the GMS Quality Outcomes Framework (QOF)
- must have governance arrangements in place that ensure continuous quality improvement including peer review
- should encourage and support patients to take responsibility for their own health through enabled health improvement and self-care measures (a partnership approach) in order to support meeting the clinical objectives

3. COLLABORATIVE WORKING

- should promote and support joint working between general practitioners and community pharmacists with appropriate information sharing and feedback
- should link to the GMS QOF where appropriate
- should facilitate patient referrals to an appropriate member of the healthcare team (and not necessarily always to the patient’s general practitioner)

4. IMPLEMENTATION

- must be achievable by all community pharmacists to ensure all patients can benefit from the service
- should be adequately resourced in terms of manpower (e.g. through induction, training and educational support to providers)
- should be adequately resourced in terms of technology (e.g. through development and provision of appropriate IT software, hardware and support)

5. MONITORING AND REVIEW

- should have appropriate parameters for any monitoring to be undertaken in the community pharmacy supported by education, training and/or guidance
- must have protocols that outline any appropriate action(s) required by the pharmacist if the patient’s results are out with specified criteria/ranges
- should have data management systems and procedures that are not overly bureaucratic
6. SERVICE DEVELOPMENT

- should be simple at the outset with clearly defined outcome measures
- should develop in time subject to evaluation and improvements
- must be evidence based
Appendix 4

PHARMACEUTICAL CARE PLANNING: THE SYSTEMATIC APPROACH

Background

Using a systematic approach to pharmaceutical care allows the pharmacist to identify and record in a pharmaceutical care plan a patient’s pharmaceutical care needs, care issues, the desired outcomes and the actions required to deliver the outcomes (see figure 5).

![Figure 5 Pharmaceutical care planning](image)

1. Assessment: identifying and reviewing pharmaceutical care needs and issues

The first step establishes a patient’s pharmaceutical care needs and identifies both actual and potential pharmaceutical care issues. A patient’s own health beliefs are an important part of the patient assessment. This includes identifying the patient’s perceived needs, their understanding of the indication/s, frequency of use of their medicine/s and any outcomes, such as perceived benefits, side effects and adverse reactions.

Pharmaceutical care needs

Pharmaceutical care needs are identified as part of day to day practice through face to face dialogue with patients, carer/s, and other healthcare professionals and from the pharmacy Patient Medication Record (PMR). They can be product specific needs or service specific needs.

**Product specific needs**

*These might include the requirement for an additional or alternative medicine, addressing sub-optimal therapy, prescribing a different formulation or providing some form of compliance support.*
Pharmaceutical care issues

Pharmaceutical care issues, whether actual or potential, are identified from the patient’s pharmaceutical care needs. This is done taking into account any patient and medication risk factors. It is often the combination of these factors which predisposes a patient to the risk of adverse reactions or treatment failure. Again, identifying these care issues is best achieved by talking to the patient, as well as eliciting and interpreting information from any appropriate records available.

Patient risk factors

These might include age, current relevant medical problems including any relevant indications and past history, functional and cognitive factors such as mobility and comprehension, social and environmental factors and a patient’s own health beliefs.

Medication risk factors

These might include responses to current and previous therapy, drug disposition factors such as reduced renal clearance, potential drug toxicity factors (including special precautions and contraindications), polypharmacy, complexity of drug regimen and the use of other medicines (purchased medicines and complementary therapies). The review of current and past medication highlights important risk factors such as drug interactions, duplication of therapy and possible inappropriate drug regimens.

2. Formulating a pharmaceutical care plan

The second step involves prioritising the pharmaceutical care issues, identifying desired outcomes, proposing any necessary actions and documenting them in a pharmaceutical care plan. The desired outcomes and proposed actions are jointly agreed with the patient, are supported by other practitioners where appropriate, and are subject to ongoing review in order to respond to any changes.

Prioritising pharmaceutical care issues

The pharmacist prioritises a patient’s pharmaceutical care issues within the context of the overall clinical management of the patient. This allows the pharmacist to address each issue based on its importance, where appropriate in a phased approach over a period of time.

Identifying desired outcomes

The pharmacist describes what they want to achieve for a patient in relation to their pharmaceutical care issues as desired outcomes. These are measurable outcomes within a
defined timescale. The pharmacist then considers what pharmaceutical actions are required to achieve these outcomes.

**Desired outcomes**

Examples of desired outcomes include ensuring that patients understand their medicines and know how to take them appropriately, improving health outcomes, improving compliance, reducing side effects or preventing an adverse drug reaction.

**Proposing pharmaceutical actions**

Any proposed actions to address the desired outcomes need to take account of the particular needs of the patient, any previous adverse reactions or sensitivities, the patient’s own beliefs and expectations and evidence based practice and guidelines. Some actions may require the involvement of other members of the health care in which case the pharmacist takes responsibility for communicating with the appropriate practitioner. The end of care treatment summary can be used as a useful tool to communicate with GP practices.

**Pharmaceutical actions**

These include providing advice to a patient on his/her condition(s) or medicine(s), contacting the patient’s GP, discussing a change in medication or requesting some additional patient monitoring.

**Documenting pharmaceutical care planning**

The pharmaceutical care issues, the desired outcomes, the proposed pharmaceutical actions and any monitoring / follow up requirements are documented in a pharmaceutical care plan. This allows the pharmacist to record the actions they require to undertake and provides the basis for the ongoing monitoring and review. It also offers a mechanism to facilitate information transfer in order to ensure continuity of care. In addition the pharmacist provides the patient with their own action plan detailing any actions they themselves require to undertake and providing any additional self management advice and support.

**Pharmaceutical care plan**

The pharmaceutical care plan is jointly agreed with the patient and, where appropriate, is supported by other practitioners. It is subject to ongoing review, in order to respond to any changes in a patient’s needs. The care plan supports continuity of patient care, quality improvement and facilitates audit of practice. It also underpins effective communications between pharmacists, patients and other healthcare professionals.
3. Implementing, monitoring and reviewing the pharmaceutical care plan

Implementation, monitoring and review of the pharmaceutical care plan are carried out on an ongoing basis linked to either the dispensing of repeat prescriptions or serial prescriptions (stage 3). In addition, the pharmacist provides regular counselling and advice on the medication provided and promotes self management in order to support the patient’s active involvement in their care.

Implementing the pharmaceutical care plan
The pharmacist implements the pharmaceutical care plan with the agreement and support of the patient and, where appropriate, other members of the healthcare team who may have specific actions to undertake or review. Any specific monitoring requirements are agreed with either the patient or other members of the healthcare team and are undertaken at specified intervals and for a defined time period prior to further review. In instances where there is a reliable indicator of disease progression, drug efficacy or drug toxicity then the pharmacist should monitor the indicator to assist them in managing and addressing the ongoing needs of the patient.

Implementing the care plan

This can involve a range of activities: such as counselling the patient on their medicines, monitoring the effects of therapy, referral to a GP, confirming the indication for a medicine or arranging for new medication to be commenced.

Monitoring the patient and the pharmaceutical care plan
The pharmacist tracks actual outcomes against desired outcomes in order to determine whether the pharmaceutical care issues previously identified have been resolved. Where desired outcomes are not met then the pharmaceutical care plan is reviewed and other actions considered. In some cases the actual outcome may be the best achievable one; in other cases an alternative approach may be required to achieve the desired outcome. Once an issue has been resolved then no further action may be required resulting in closure of the action.

Reviewing the pharmaceutical care plan
The pharmaceutical care plan requires ongoing review in order to be updated in line with any changes to a patient’s pharmaceutical care needs, resulting in new care issues and new actions. This is an iterative process.
Appendix 5

DISEASE PROTOCOL PRIORITY CLINICAL AREAS

The long term conditions identified as the most frequent indications for drug therapy (over 50%) are:

- Hypertension
- Hyperlipidaemia
- Asthma
- Diabetes
- Angina
- Heart Failure
- COPD
- Epilepsy
- Rheumatoid arthritis
- Parkinson’s disease
- Osteoporosis
- Chronic pain
- Hypothyroidism
Appendix 6

The ePharmacy Programme

Background

In 2001-2002 a pilot project was established within NHS Ayrshire & Arran PCT to develop a system to provide the necessary functionality for the Electronic Transfer of Prescriptions (ETP). Stage I of the pilot was completed in the latter part of 2002-2003 and provided valuable lessons to inform a wider Stage II roll out of the pilot. The Right Medicine; a strategy for pharmaceutical care in Scotland, was published in February 2002 and resulted in a broadening of the pilot’s objectives to include the development of e-applications to support the future delivery of the new community pharmacy contract and improve communications across the healthcare team. To reflect the extended remit, the initiative was re-branded as the ePharmacy Programme. Since then, there have been further policy and service developments that have impacted on the ePharmacy initiative. Figure 6, below, depicts the core infrastructure which provides a robust model for secure data transfer.

Figure 6  The ePharmacy Programme infrastructure

The Generic Architecture and Infrastructure

At the heart of the ePharmacy infrastructure is an ePharmacy Message Store (ePMS), which is used as a gateway and store for encrypted messages sent between GP systems, community pharmacy systems and National Services Scotland (NSS). ePMS supports all current e-service developments. It has been designed on the basis that further system

developments or changes can be accommodated where required. The standards and architecture used for this and all other system developments and interfaces are developed in conjunction with national and European guidelines and within the overall direction of the national IM&T strategy so, for example, the data collected in ePharmacy transactions can be a contributor to the Electronic Health Record (EHR) in the future.

All community pharmacies have been connected to N3 as part of the infrastructure programme and this has also allowed access to NHSmail. Another infrastructure requirement has been the need for drug dictionary mapping functions to enable a common language between GP and pharmacy systems and NSS until such time as all systems use the UK agreed drug dictionary, the Dictionary for Medicines & Devices (dm+d). This allows for a more efficient system for processing ETP transactions, and for the development of automating the payment process for reimbursing pharmacists’ drugs costs.

The current payment process for both remuneration (fees and allowances) and reimbursement (of drug costs) is already automated to a degree whereby dispensed prescriptions are scanned by an optical reader and processed accordingly. The advent of ETP and drug dictionary mapping allows this to be further automated through ePay which will improve the efficiency of the current payment system by removing the reliance on paper processing. This will also provide quicker and richer sources of data for the NHS.

A central Patient Registration System (PRS) has been developed in order to allow community pharmacists to register patients for both the Minor Ailment Service (MAS) and the Chronic Medication Service (CMS). It uses Community Health Index (CHI) as the unique patient identifier during the registration process.

Developments have also impacted on both the community pharmacy and GP IT systems in terms of ePharmacy functionality. This covers the distribution of digital certificates to authenticate valid message sources (i.e. GP practices and community pharmacies) and system application developments in terms of specific software enhancements. A key action in the ePharmacy programme has been the early engagement of the system suppliers to inform them fully of the strategic and operational direction of the programme and to secure their commitment to configuring their systems accordingly. This initiative is going well with all suppliers playing in positively to the ePharmacy development process.

A centrally funded IM&T Facilitation Programme for community pharmacy provides a CP IM&T facilitator network to support the delivery of the ePharmacy Programme.

Minor Ailment Service (MAS)

eMAS allows a pharmacist to register a patient electronically via PRS. A MAS patient registration request is electronically generated by the pharmacist’s IT system and sent to PRS via ePMS. PRS will send back a message informing the pharmacist whether registration has been successful, rejected or is pending further follow up. A pharmacist also uses their PMR system to generate a CP2 form detailing the outputs of a MAS consultation; the treatment provided, a referral or advice only provided. A corresponding electronic claim message is generated and sent to Practitioner Services Division (PSD) via ePMS.
**Acute Medication Service (AMS)**

The functionality of electronic transfer of prescriptions (ETP) is required to enable eAMS. At the same time as printing the form, the GP IT system automatically sends an electronic prescribe message to ePMS. The electronic message contains exactly the same information as printed on the GP10. On receiving a prescription in the pharmacy the pharmacist scans the bar code which pulls down the electronic message from ePMS. The pharmacist then uses the information in the electronic message for dispensing purposes, reducing the need for data entry and transcription. Dispensing a prescription triggers the creation of a corresponding electronic claim message which the pharmacist sends to ePMS from where it is accessed by Practitioner Services for payment processing through ePay.

**Chronic Medication Service (CMS)**

eCMS builds on both the Acute and Minor Ailment Service elements. Like eMAS, a patient is registered electronically for CMS by PRS. A CMS patient registration request is generated by the pharmacist’s PMR system and sent to PRS via ePMS. PRS will send back a message informing the pharmacist whether registration has been successful or not. The patient’s GP practice is also notified electronically once a patient is registered for CMS and the patient’s record is flagged. This acts as a trigger for the GP when they open the patient record so that they know that they can enter in Stage 3 of CMS and generate a serial prescription for that patient. Withdrawal is also electronically supported, in the same way as registration. Again the GP practice is alerted to a registration withdrawal.

eCMS also utilises ETP, enabling a GP to produce a “master” serial prescription which is transmitted by ETP to ePMS. When the paper form is scanned in the pharmacy this retrieves the electronic prescription. The pharmacist retains the serial prescription and scans it at the appropriate dispensing intervals to pull down the electronic data. As with eAMS each dispensing triggers the creation of an electronic claim message which the pharmacist sends to ePMS from where it is accessed by PSD for payment processing through ePay.

The GP practice receives feedback on the dispensing of serial prescriptions and an end of care period treatment summary electronically via the ePMS. The end of care treatment summary also includes a serial prescription renewal request. When the serial prescription has been completely dispensed or is no longer valid the pharmacist sends the paper form to PSD to complete the audit trail.
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AMS</td>
<td>Acute Medication Service</td>
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<tr>
<td>Assessment</td>
<td>The identification and review of an individual patient’s pharmaceutical care issues</td>
</tr>
<tr>
<td>Clinical guideline</td>
<td>Systematically developed statements which assist in decision making about appropriate health care for specific clinical conditions</td>
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<tr>
<td>CMS</td>
<td>Chronic Medication Service</td>
</tr>
<tr>
<td>Compliance</td>
<td>Adherence to a course of instructions for the use of a medicine or appliance</td>
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<tr>
<td>Concordance</td>
<td>A negotiated agreement between a healthcare professional and a patient which aims to optimise the health gain from the best use of medicines and is compatible with what the patient desires and is capable of achieving</td>
</tr>
<tr>
<td>Counselling</td>
<td>The interactive process involving a consultation about medicines or appliances between a pharmacist and a patient</td>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
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<tr>
<td>Desired outcome</td>
<td>A statement of what the pharmacist aims to achieve for a patient in relation to a pharmaceutical care issue</td>
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<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
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<tr>
<td>ePMS</td>
<td>ePharmacy Message Store</td>
</tr>
<tr>
<td>ETP</td>
<td>Electronic Transfer of Prescriptions</td>
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<tr>
<td>End of care treatment summary</td>
<td>A report which details any relevant data such as compliance reporting, pharmaceutical care issues, desired outcomes and recommended action/s for the GP</td>
</tr>
<tr>
<td>GMS</td>
<td>General Medical Services</td>
</tr>
<tr>
<td>GP</td>
<td>General medical practitioner</td>
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</tbody>
</table>
Long term condition  A condition that requires ongoing medical care, may limit what one can do and is likely to last longer than one year

MAS  Minor Ailment Service

NES  NHS Education for Scotland

Peer review  A continuous systematic and critical reflection by a group of health care professionals on their own and colleagues’ performances using structured procedures

Pharmaceutical action  An action by a pharmacist to address a pharmaceutical care issue for a patient

Pharmaceutical care  The responsible provision of drug therapy for the purpose of achieving definite outcomes that improve the patient's quality of life

Pharmaceutical care issue  An element of a pharmaceutical care need which is addressed by the pharmacist

Pharmaceutical care need  A patient’s requirement for a pharmaceutical product or service

Pharmaceutical care plan  One or more pharmaceutical care issues for an individual patient, together with the desired outcome/s and the action/s planned to achieve the outcome

PMR  Patient Medication Record

Protocol  An adaptation of a clinical guideline to meet local conditions and requirements

PRS  Patient Registration System

PSD  Practitioner Services Division

QOF  Quality and Outcomes Framework (of the General Medical Services Contract)

Quality  A level of excellence related to structure, process and / or outcome
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Scottish Patient Safety Programme</td>
<td>A programme to improve the safety of hospital care using evidence based tools and techniques to improve the reliability and safety of every day healthcare systems and processes</td>
</tr>
<tr>
<td>Serial prescription</td>
<td>A prescription for medicines, medical sundries or appliances which is dispensed in instalments for up to a 48 week time period</td>
</tr>
<tr>
<td>Shared care</td>
<td>An agreement between a patient, GP and pharmacist which outlines the arrangements and clearly defines the respective roles and responsibilities of the healthcare professionals when a patient receives a serial prescription</td>
</tr>
<tr>
<td>Standard</td>
<td>A specification of process and/or outcome against which performance can be measured</td>
</tr>
<tr>
<td>Targeting</td>
<td>The process of selecting patients and/or patient groups to receive a service (in relation to CMS in this case)</td>
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Establishing Effective Therapeutic Partnerships

A generic framework to underpin the Chronic Medication Service element of the community pharmacy contract

A Report for the Chief Pharmaceutical Officer

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RR Donnelley B59292 12/09

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December 2009