NHS

Primary Care Contracting

Pharmacists with Special Interests: Learning from National Events for Early Adopters (Leeds and London)

October 2007

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Key messages from participants

It is felt that PhwSI accreditation is essential as the qualification gives credibility amongst clinical colleagues (particularly GPs); Proof of skills and knowledge is also a necessity when competing in the expanding healthcare market in order to win tendered healthcare contracts or develop service pathways.

Boundaries between core services, enhanced service delivery and the role of pharmacists with special interests need to be clarified by commissioners. PhwSI should have a combination of clinical service provision, leadership and training responsibility – that combination setting them apart from enhanced service providers.

It is essential to have patients and carers involved in service redesign. PhwSIs should consider this when developing service specifications.

Commissioners want to see services delivering financial health, quality, equity and access for all patients, sustainability and patient satisfaction. If these targets are identified and processes for meeting them outlined in business cases then these PhwSI services are more likely to be commissioned.

There was general concern that there is an under utilization of skills (eg supplementary prescribers not prescribing in practice since qualification. In some areas, community pharmacy enhanced services have been decommissioned post PCT reconfiguration. These need to be reintroduced.

When PhwSI services are planned they need to be based on a sustainable clinical network . The service needs to be based on a robust needs assessment to define the service gaps and support the overall business case development.

In terms of who leads the services (GP vs Pharmacist) it was felt that GPs can learn from the medicines management expertise of pharmacy – and likewise pharmacists can develop clinical and consultation skills from GPs.

Introduction

On 2nd and 11th October 2007, NHS Primary Care Contracting held two workshops in Leeds and London, which were aimed at supporting PCTs and individual pharmacists in the development of Pharmacists with Special Interests (PhwSIs). These events built on earlier workshops where PhwSI accreditation and roles were introduced and looked at applying the contribution of PhwSIs to local service developments.

The main aims of the workshops were to:-

- learn how care pathways are being redesigned to support moving care closer to home (including an emphasis on 18 week
- Update on national implementation and accreditation of PhwSIs
- learn how speciality-specific guidance is being developed
- consider how to progress to PhwSI accreditation, where pharmacists are already working on a service model similar to PhwSI.

There was additional time spent on supporting early adopters in how to develop action plans as part of local strategic planning. This included addressing such issues as:-

- Working with commissioners
- Developing portfolios of evidence to support individuals going forward for accreditation
- Identifying service models and care pathways for specific clinical specialties (and linking this to priority targets such as 18 weeks)
- Consideration of the practicalities

Background

Key questions raised and discussed at both workshops included:-

What is your experience of PhwSI implementation to date?

Following the high level national launch of national framework and accreditation guidance, service development proposals utilising PhwSIs are slowly evolving. Referral pathways are a challenge for commissioners, but it may work well where PhwSIs are working as part of a multidisciplinary team with access to good data.

What can we learn from each others' experiences?

PhwSI skills need to be developed in parallel with the development of commissioning frameworks and robust needs assessments. Those that are succeeding have adopted a robust business approach and are working with as opposed to against GP colleagues.

What are the key benefits of commissioning PhwSIs?

PhwSI development supports the demand management agenda and service pathway development, especially in the area of medicines management where adverse drug reactions, and compliance can be supervised. The role supports the reduction in unscheduled admissions and enables care closer to home and integrated care management with social service and healthcare colleagues.

What support is needed (locally and nationally)?

Business development skills (ie preparation of effective business cases) are required to compete with other service providers and meet the needs of commissioners.
Community pharmacy must be identified as part of the overall primary care team with barriers being parked to allow for service improvements for patients.

How can you collaborate to influence commissioners (PBC and PCTs)

It is essential that PhwSIs understand the policy drivers for the locality, championing pharmacy as a profession. In addition there is a need to highlight the areas of expertise as medicines experts, and medicines managers. It is important to promote the business acumen and be confident in sharing previous provider and commissioning successes locally.

What PCT opportunities are there?

Community pharmacists need to demonstrate their ability to engage in partnership working, building on previous collaborative successes. There was a key message from both events not to compete but to use a partnership working approach, supporting the primary care shift culture (ie as care moves to general practice from secondary care, traditional GP services can be moved out to pharmacy to support access and capacity).

Early Adopter Work streams – Developing the Clinical Model

Anticoagulation Group

Some services are already in place and have been for some time, commissioned as enhanced services.

Pharmacists working in anticoagulation service development are keen to become accredited under the framework to formalise their skills and status. Independent prescribing could also support this.

Pharmacists are unclear as to how and who to approach in PCTs to become accredited. There has been a commitment by some aspiring PhwSIs to work with their LPCs to drive forward accreditation process. Establishment of virtual networks of commissioners and providers of anticoagulation services will be very helpful.

There are some concerns about equity of opportunity for potential providers and acknowledged need to work with LPC and PCT to enable this.

Commissioners are looking at commissioning strategically based on clear needs assessments and evidence based business proposals. Attention needs to be given to portfolio development to highlight expertise and skills that can support the business plans.

Monitoring the service is an issue for both commissioners and providers of anticoagulation services. Suggestions were made that there should be an anticoagulation service patient satisfaction monitoring process and an adverse incident audit.

It is hoped that demand for commissioning anticoagulation services from alternative providers will support the development of PhwSI in this area.

Further support from CPPE, PCC and other organisations on how to establish clinics, identify funding models and share emergent practice would also be welcomed.

Universities hope that demand will drive supply of provision relevant for this clinical role.

Substance Misuse Groups

Interesting mix of practising pharmacists and service development leads at both events, delivering various forms of substance misuse services. All participants specialising in substance misuse stated that they aim to go forward for accreditation as PhwSIs

Specialist interest has been developed from personal interest/career development and identification of service gaps due to lack of GPwSI provision.

It was agreed that pharmacy should not compete against GPs for services as there is enough work to go around for all in this specific speciality area.

Local needs assessment should be undertaken before commissioning substance misuse services.

Service development may be restricted due to lack of referral rights. This should be tackled by PhwSI taking responsibility for managing interface issues and signposting to appropriate services and support. A shared care co-ordinator was suggested who could link all clinicians and service providers to ensure integrated outcomes.

Support is needed from other healthcare professionals working with substance misuse patients to ensure a robust service specification and clear patient pathway. Skill mix can help in redesigning service pathways.

It was agreed that substance misuse services can work well when commissioned with a hub and spoke model. In Sheffield their substance misuse service is managed this way with one central potential PhwSI acting as clinical champion and satellite community pharmacists providing enhanced services using community pharmacy contractual levers. This enables sustainability, access and patient choice.

Examples of Emergent Practice

Birmingham DAT have looked for the “deserts” in service provision (specifically for patients with complex and problematic needs) and identified ways that the service could be improved for this client group. A DAT pharmacist now delivers every day service provision, and as such has freed up GP time to be redirected to more complex cases.

Long Term Conditions Groups

Participants are working within a number of LTC clinical areas – such as diabetes, dermatology, COPD, asthma, but in some regional areas there has been very slow progress in developing specialist pharmacy roles.

One of the main areas to progress is the lack of clarity determining which is core, enhanced or PhwSI service provision. Equally employment status for the pharmacist leading the service needs to be established (eg PCT employed/practice (PBC consortia) employed/independent provider).

Communication had also proved a challenge with PCTs failing to take the initiative in developing pharmacy roles. Reconfiguration at PCT level had caused problems with focus and led to breakdown of relationships in some areas. The commissioner/provider tension, especially in relation to governance, had also proved to be a barrier in some areas.

Some participants have linked in to public health models to support long term conditions management and admissions avoidance. There is a strong belief that more focus is needed on public health priorities to support the development of LTC pathways. Integration and multidisciplinary working for holistic care and the focus on designing services to fit with the local joint commissioning needs assessment had been recognised.

Those participants who had experienced more success saw long term conditions is the umbrella for specialist development with the opportunity for career progression being realised with the emergence of speciality working.

The generic features experienced by participants involved in supporting LTC pathways were discussed. These included the support of prevention and establishment of robust triage and self help/education, the effective management of long term condition patients in respect of medicines management, compliance and access focusing on clinical assessment and an improvement in clinical assessment.

There was some confusion about the detail required for the business case. It was agreed by commissioners that the contract size should be dependent on the contract value with a more detailed case required for larger service specifications. Above all the specification needs to be robust.

Examples of Emergent Practice

Leeds PCT Medicines Management Team are supporting the LTC agenda by providing domiciliary visits for long term conditions patients

In Calderdale PCT pharmacy is supporting heart failure clinics where primary care links in to secondary care cardiovascular disease commissioned pathways. They piloted the service first to demonstrate value and wider benefits before commissioning more widely

In Hull PCT there is a PCT employed pharmacist who is also a supplementary prescriber working under the mentorship of a Consultant Dermatologist and alongside GPswSIs. The pharmacist receives direct GP referrals. Post PCT reconfiguration he is now being used more for triage in place of GPswSI. In addition he also supports Prison Health services again working as a prescriber within dermatology. See DH Care Closer to Home Demonstration site report for further details.

Leeds Acute Service Commissioners are working along whole systems pathways to support secondary and primary care interface. They are currently working with Lloyds community pharmacists in the area to support domiciliary care and care closer to home with palliative care patients.

Yorks and Humber are currently working on a pilot heart failure care pathways with one of their acute service providers. This includes medicines management support and supplementary prescribing for heart failure patients within primary care. Once VFM and sustainability has been demonstrated via the pilot the aim is to roll it out to the secondary acute trust working with the PCT.

Practice Pharmacists Group

This group identified the main issues as being:

What is the core role of the practice based pharmacist, especially those who are already "portfolio" working.

There is a need to demonstrate competence as prescribers within the practices – due mainly to the scrutiny of others.

What kind of expertise is needed to demonstrate clinical skills?
There are significant differences between the specialist competencies required for nurse prescribers and those required for pharmacists, which need to be clarified..

There are issues around clinical governance for pharmacist prescribers – there is the need to have a commitment to undertaking and receiving supervision once practice is established within the community.

It is unclear what commissioners actually want to commission and how services can be evaluated. More attention needs to be given to this.

Solutions to these issues were identified as follows:

Outcomes of practice need to be audited to challenge existing models with best practice examples being circulated to wider networks.

PhwSIs, though more expensive than nurse prescribers on the whole, will be significantly cheaper than GPwSIs and GP partners, thereby supporting financial health aims of PCTs and practice based commissioning groups.

Areas for potential development for practice based pharmacists working as PhwSIs within the community were identified as diabetes, gastrointestinal services, respiratory disease management and substance misuse.

Public health roles

Sexual Health Services

The National Sexual Health strategy identifies level 1, 2 and 3 tiered services. Pharmacy can mirror this structure, with level 1 services from some locally accredited pharmacists using enhanced services, and other more advanced roles commissioned via PhwSIs.
Services provided include the level 1 services ie undertaking repeat dispensing for contraception, undertaking interventions (e.g. STI scripts) NHS provision of emergency contraception, giving advice re condom provision, supplying pregnancy tests and undertaking Chlamydia screening. Level 2 includes undertaking Chlamydia treatment, overseeing the condom card scheme, supporting NHS funded pregnancy testing, undertaking rapid HIV testing and managing long term oral contraception. Hepatitis B screening is also being managed. To continue to develop the services they are assessing competency of the workforce (including technicians and dispensing assistants.

PhwSIs in sexual health will also be in a position to mentor and support pharmacy colleagues especially those who are less experienced.

The need to work closely with public health clinicians was emphasised as part of the ongoing development of services. Some PCTs are much more willing than others to consider commissioning of sexual health services through pharmacies, even when service needs are similar – is this cultural?

Stop smoking services

Croydon PCT is working towards a service model where PhwSIs might join existing GPwSIs in a networked stop smoking service. They could support more complex patients and those who are finding it more difficult to stop.

GP practices may lack capacity to address all local needs and may support this model.

Examples from practice

Lambeth and Southwark PCTs are implementing a tiered ‘sexual health in the high street’ model as described above. See
http://www.mysexualhealth.org.uk/what_we_do/increasing_access

Croydon PCT is developing the following service model for stop smoking:

- Level 1 advisers: libraries, receptionists, social care assessors
- Level 2 advisers: GPs, nurses, community pharmacists (major provider) stop smoking advisers. If try 3 times and fail, then referral to
- Level 3 practitioners (one per locality): GPwSI, and in future PhwSI

SHA and Regional Priorities

Collectively the regional groups highlighted the main priority as being to establish a robust accreditation process within PCTs from 2008 onwards, and certainly by March 2009 when existing GPwSIs must be reaccredited. This process needs to be clearly communicated and referred to the clinical governance leads to ensure it forms part of the internal risk register.

Delegates suggested using established accreditation process models already in existence (ie Bradford and Airedale PCT) to save on duplication of effort. Delegates were also advised to consider a central hosting agent for the accreditation process (eg local deanery/SHA), again to support capacity and avoid duplication of effort.

Health needs assessments are being developed across regional areas with the strategic support of some SHAs. This needs to be linked to other regional strategic priorities.

There was general agreement that PCTs are at varying stages of developing pharmacists with special interests and PwSI accreditation processes. Some PCTs, such as Bradford, are willing to share accreditation models. Some PCTs are building on the process introduced for GPswSIs and nurse specialists.

Sharing the responsibility across regional areas to support capacity and economies of scale was widely accepted as being a positive way forward. Again SHA involvement is required to promote this across the whole health economy.

There is a need to identify what training resources are available in the region to support PhwSI development (eg NMPT and Deanery funding in the SHA region). Advanced practitioner programmes are under development at Leeds University and Huddersfield. Leeds Acute trust also offers generic course leading to specialist certificates and diplomas.

Service niches can be identified via a robust strategic needs assessment, by identifying gaps in the current workforce, by analysing data sets and converting this into meaningful information (such as waiting list volume and pressures, 18 week pathway breaches in acute trusts) . These steps should lead to innovation in service redesign. Analysis of primary care access pressures and the establishment of PhwSI networks can also support service development.

If PhwSIs are to support the patient pathway in its entirety there must be a regional and national focus on how records can be integrated with existing pharmacy systems – the individual patient record needs to include access for the pharmacy profession if care management is to be fully effective.

Next Steps

It was generally agreed that a way forward is to develop skills and competencies of pharmacists across all areas (Community Pharmacy/Medicines Management Teams/Practice based pharmacists/hospital pharmacy etc) in terms of developing specialist interest areas and obtaining accreditation, and to also link this with advanced practice and consultant pharmacists.

The focus needs to be on identifying service gaps in partnership with PCTs and PBC commissioners where pharmacy can enhance a patient care pathway, supporting access, service redesign and encourage care closer to home – all the priorities coming out of the current Darzi review.

A full needs assessment needs to be undertaken to define service gaps and support pathway development.

Commissioners are looking for sustainable, quality services which deliver financial health for their constituent patients and their carers, and meet Darzi interim report goals of safe, effective, fair and personalised care. PhwSI need to ensure that their specialist skills link in to the overall strategic service development aims of the PCT, help support the achievement of national targets (such as 18 weeks and enhanced patient access) and can demonstrate equity and accessibility for all patients. Above all the service needs to be based on a sustainable clinical network.

When developing services, PhwSIs need to ensure that their service specifications and subsequent business cases have clear links to a portfolio of evidence, competence and service aims.

CPPE are keen to shape additional courses/developmental pathways to support the ongoing development of PhwSI – if pharmacists are aware of courses already supporting specialist development, they are asked to send further information to CPPE so that these can be signposted via the CPPE website at

- http://www.cppe.manchester.ac.uk.

Messages to the public re PhwSI value to patients need to be prioritised. Research shows that pharmacists are the second most trusted profession (first being firemen) and access to pharmacy advice is excellent. These public perceptions need to be expanded to increase confidence in service advice and supporting their care pathways.

Finally, clinical champions within pharmacy need to be identified so that their experiences, competencies and business approaches can be replicated throughout the profession. At both events the clear message coming from many community pharmacists to commissioners was that they are willing to provide whatever pharmacy-based services are required by the PCT to support primary care in their areas.

Frequently Asked Questions

(These were developed from plenary Q&A and direct delegate feedback)

How do you manage the time lag between PCT commissioning and becoming accredited?

PCT managers will need to support the proposal during the lead time. There are two options – potential service providers can either wait for commissioners to express an interest or advertise procurement for service need or preferably pharmacists will look at a service pathway, identify services that they can provide, and proactively approach the PCT with a clear and worked through proposal.

There is a fine line between what is just above core service in terms of service definition and what a service requiring specialist interest is. Can there be consideration of this and allowances made to reward the former role and the specialist service?

The level of cost associated with accreditation will make it unlikely that commissioners will chose to commission PhwSI services that are only marginally beyond core roles. On looking at pathways, there may indeed be areas that don't fit into a PhwSI service definition but this should be commissioned, instead, as an enhanced service under the terms of the pharmacy contract. Access to information is a problem and needs to be addressed to get a balance right between what are core services and what is an area of specialist interest. Can the development of supervision of services clarify this?

How are practice based commissioners being encouraged to take account of other professionals?

Primary Care Contracting has done a great deal of work in relation to engaging other clinicians in PBC. There is general agreement that whilst indicative budgets for PBC rest currently with GP practices, innovative practice based commissioning groups should be considering widening care pathways to include other clinical professionals.

More information can be sourced from the PBC section of the Primary Care Contracting website, in particular the "Developing PBC Capacity through Pharmacy" briefing (Bulletin 7) supports this. This document is available on the following link:-

http://www.primarycarecontracting.nhs.uk/uploads/Pharmacy/sept_07/pbc_bulletin_building_pbc_capacity_through_pharmacy.pdf

What is important is that when approaching commissioners PhwSIs should ensure that their service plans link to the overall strategic plans commissioning plans for the PCT, demonstrate value for money, sustainability and quality.

How does PhwSI development fit within PBC?

Community Pharmacists need to be clear about separating out the roles of commissioning and provision. Community pharmacists and PhwSIs need to become engaged with local PBC groups to demonstrate the areas of expertise that they can bring to patient care pathway

development. To do this they need the support of their PCT and local pharmaceutical committees (LPCs).

PBC groups will be commissioning where they see the see the best opportunities for savings and delivering care closer to home.

Access is crucial on the back of the Darzi review – this is a way of engaging with practices – especially where pharmacy sees itself having a clear role in the pathway – ie supporting LTC management, supporting compliance and overall medicines management.. PBC should be under quite robust governance framework within the PCT.

Engaging with the PCT to ensure PBC is open to alternative providers is crucial.

How can a care pathway be developed, using PhwSIs, specifically for older people, incorporating medicines management?

Older people do fit into some of the 18 week formalised pathways (eg shortness of breath, heart failure, osteoarthritis, carpal tunnel, female incontinence etc). Whilst older people are on multiple pathways, they may help with individual management. Pathways have been more developed for elective care pathway.

There is a need for this clearly, but as part of an established pathway probably, rather than an individual one.

There is an expectation that PhwSIs will provide a role in education and training and leadership. What proportion of time should be spent with this and how is this managed currently with GPwSIs?

Competency clusters are about expert clinical practice, building working relationships, management and leadership. PhwSIs are not expected to have all of the last two, but should have some- it all depends on what is being commissioned. Competency clusters covering research and education and training are optional. .

The competency frameworks underpinning both PhwSI and consultant pharmacists are related, but guidance on consultant pharmacists places emphasis on all 6 clusters, including education and research, and a higher level of expectation for expert clinical practice, building working relationship and leadership. For specialist interests, the emphasis is on clinical role and management, mentoring and leadership but not necessarily research and education.

What is going to ignite the blue touch paper is linking QOF points within general practice. Needs to have a link in to this. Is this a shared view?

Both QOF area of practice and effective medicines/prescribing costs – commissioning area and PBC – various consortia need to look at where they are going to commission their services from (historically provided from hospital and secondary care). The best model there seems to be is developing robust interface service looking at referrals and using a multidisciplinary team to manage the referral process.

Anticoagulation monitoring. Why would you go through a comprehensive accreditation process and not do this as an enhanced service?

Special interest model is about the level of competency you need for delivering the service (ie a quality framework) vs enhanced service process which is a contracting methodology. Certainly it is going to be a choice for commissioners whether they use enhanced services or not. You can use a simple methodology if the competency required is a small extension

beyond core, and ask the pharmacist to undergo training and put in place a contract through enhanced services. . However, there are many potential services where there is a need for competency substantially beyond the core. It is about minimising risk to patients.

Anticoagulation remains a challenge as to what category this falls into. It can be determined by asking "how complex are the patients you are seeing". You could have a tiered model – hub and spoke with PhwSIs co-ordinating and supporting less complex services delivered by a network of pharmacists. .

There is a strong case for it falling into the criteria – challenge is service delivery. Accreditation process can take time. If you have an existing service running now you have the opportunity to move towards a more advanced model.

One of the barriers for accreditation would be supervised practice – and how to find a mentor. Is there a best approach model for this?

Community Pharmacists who are already moving in this direction see this as a huge opportunity. There is an example of this in Lambeth PCT where experts in advanced level consultations are buddying providing mentoring to sexual health services. The Joint Programme Board (www.postgraduatepharmacy.org) in East and South East England has developed a range of performance assessment methods that are deployed in the postgraduate education. These include tools to support supervised practice that have been adapted from the Foundation Programme in Medicine, such as case-based discussion (CbD), mini-peer assessment tool (mini-PAT) and mini-clinical evaluation exercise (mini-CEX). Examples of these will be featured on the PCC website.

In relation to the Specialist guidance framework for diabetes – could you clarify why the summary on page 9 differs from the formal competencies at the back of the document?

Competencies cover the whole range of specialist diabetic care. An accreditation panel wouldn't necessarily be looking for evidence in everything there for PhwSIs – commissioner would need to identify the competences applicable to the service being commissioned. . (Page 9 Guidance and competencies booklet outlines this in more detail)

In terms of clinical responsibility – where does this lie in terms of anticoagulation services? We have this issue with our service – at the end of the day the GP retains clinical responsibility for the patient being seen by the PhwSI – they accept clinical responsibility and write the Warfarin scripts.

It was suggested that PCTs who have these services in place could share information on clinical responsibility.

Dr Steve Laitner: What the commissioners (GPs) would want to ensure is that when they are commissioning alternative service, they would want to see some move in terms of the clinical responsibility. If you are commissioning an element of the care pathway, it makes sense to bring the phlebotomy, prescribing, dosing and management to be in one place.

Clinical responsibility is an interesting area and when you can show you are taking on appropriate clinical responsibility you are demonstrating working as a PhwSI – practitioners are willing to take it on whereas GPs are less keen to allow for this. How can the argument be presented – on a general level that is why I agree with ensuring you have pharmacy representation on the PEC, places of influence, to influence decisions made within the local health community. You need to look at the care pathway and show you can take on that concise area of care and that is it sustainable. Also need to engage with patient groups and

the PCT. If patients advocate why they want to get the care from one centre, this can drive forward the service model. Promote yourself as practitioners who can give holistic care.

If it was part of the local accreditation that clinical responsibility is taken as part of the accreditation, would that not overcome the above potential conflict?

An advantage of using the special interest framework is making it easier to convince other practitioners that people can take on that responsibility and it is much more transparent – this could reassure others that the service is right.

Can an accreditation panel work across geographical areas?

Some PCTs are already going down the route of sharing the process across PCT boundaries. The Department of Health guidance says there has to be a panel that has a specific representation and constitutional make up but it doesn't say it has to be for one PCT, four PCTs or 10 PCTs. This is for local agreement, and PCTs can mandate others to do this on their behalf.

Further Information

NHS Primary Care Contracting

All information in respect of PhwSI is available from the PCC website on the following link:

- http://www.primarycarecontracting.nhs.uk/119.php

A new linked page now focuses on Supporting PhwSI accreditation and includes a template for a PhwSI portfolio of evidence, and also assessment tools for supervised practice.

A suite of guidance on commissioning and accreditation of services using PwSIs is available at:

- http://www.primarycarecontracting.nhs.uk/173.php, and Part 3 describes the PhwSI accreditation process.

As updated PwSI guidance for individual clinical specialties becomes available, it will be included on the PwSI pages at:

- http://www.primarycarecontracting.nhs.uk/245.php

Specific information from primary care contracting on how to build PBC capacity through pharmacy can be found in Bulletin 7 of the PCC PBC briefings "Building capacity through Community Pharmacy"

- http://www.primarycarecontracting.nhs.uk/uploads/Pharmacy/sept_07/pbc_bulletin_building_pbc_capacity_through_pharmacy.pdf

Department of Health

http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Primarycare/Practitionerswithspecialinterests/index.htm

Centre for Postgraduate Pharmacy Education (CPPE)

http://www.cppe.manchester.ac.uk

An extensive range of learning programmes and assessments to support the development of advanced or enhanced community pharmacy services. There is now a section on PhwSI and signposting to specialist courses at:

- http://www.cppe.manchester.ac.uk/specialistPharm/phwsi.asp

National Pharmacy Association:

http://www.npa.co.uk

Pharmaceutical Services Negotiating Committee

http://www.psnc.org.uk

Royal Pharmaceutical Society of Great Britain

A list of all Universities offering courses leading to qualification as an independent and supplementary prescriber is available at:

- http://www.rpsgb.org

National Prescribing Centre

The NPC provides support, advice and resources to promote cost effective, evidence based prescribing and medicines management for PCTs, practice based commissioners and community pharmacists.

- http://www.npc.nhs.uk