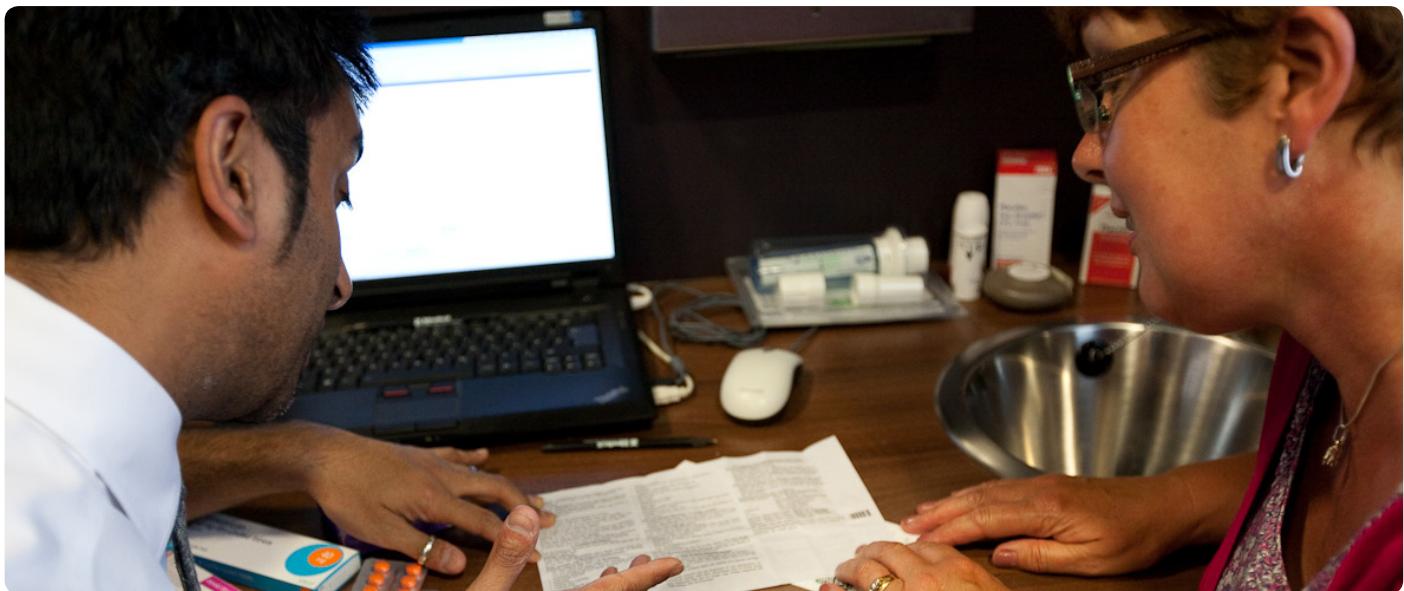




The vision for NHS Community Pharmacies

The path to improved patient care



About PSNC

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

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

This document sets out PSNC's vision for the future of the NHS community pharmacy service and highlights examples of how the service could develop in order to achieve our vision.

About this document

In this document we describe PSNC's vision for community pharmacy services in 2016 and provide a narrative that describes services which could be commissioned to implement the vision. The narrative doesn't describe the only way the vision could be achieved, but in setting out an example, we hope it will help local and national service commissioners envisage what the future community pharmacy service could look like and how the community pharmacy network can help improve patient care and outcomes.

If you have comments on the document or would like to discuss the contents further, please contact alastair.buxton@psnc.org.uk

PSNC's vision for community pharmacy

In 2012 PSNC agreed a four-year strategy which is built around a clear vision for the community pharmacy service in 2016:

The community pharmacy service in 2016 will offer support to our communities, helping people to optimise the use of medicines to support their health and care for acute and long term conditions, and providing individualised information, advice and assistance to support the public's health and healthy living.

To achieve this:

- **All pharmacies will provide a cost-effective and high quality range of services to their patients, encouraged by funding arrangements that motivate service provision, reward positive patient outcomes and offer sustainability to contractors. The value of pharmacy services to patients and the NHS and the wider savings which can be created by the effective use of pharmacy will be evidenced.**
- **Pharmacies will be fully integrated into provision of primary care and public health services, and will have a substantial and acknowledged role in the delivery of accessible care at the heart of their community.**
- **Pharmacies will be able to deliver a wide range of NHS services to support their customers and patients, and be able to offer services on equal terms to other primary care providers.**
- **Patients will be confident that when they access services from a pharmacy, the pharmacist and other members of the pharmacy team will have the skills and resources necessary to deliver high quality services. Effective communication will ensure seamless integration with other NHS care providers.**

In some cases arrangements for the provision of pharmacy services may include patient registration. All patients will have a free and unfettered choice of pharmacy.

In 2012 PSNC confirmed via a survey of all community pharmacy contractors that this aspiration for community pharmacy is supported by the majority of the sector (98% of survey respondents agreed - 37% agreed strongly and 61% agreed).

What will this mean to patients and the public?

In this model the patient sees their community pharmacist and the pharmacy team as health friend, ally and advocate: supporting them to manage their own health needs, and ensuring that they get support when they need it, either by providing services, being able to refer the patient to other sources of support or advocating on the patient's behalf with other members of the healthcare team.

Achieving the Vision

PSNC is working towards its vision by developing the community pharmacy service across four key domains:

1. Optimising the use of medicines

2. Supporting people to live healthier lives/public health

3. Supporting people to self-care

4. Supporting people to live independently

The core Essential and Advanced services within the NHS Community Pharmacy Contractual Framework (CPCF) all fall within one or more of these domains.

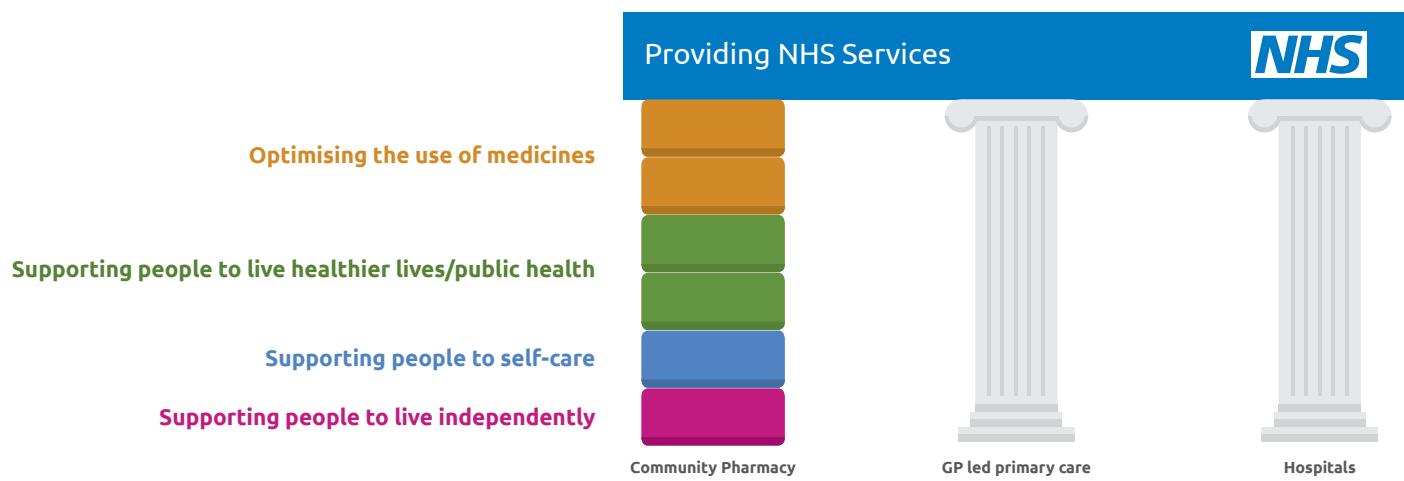
In developing community pharmacy services across these four domains, we believe the NHS community pharmacy service can help the NHS to manage the financial constraints and increasing demands it faces, by becoming the basis of a third pillar, supporting NHS service provision alongside the traditionally dominant pillars of GP-led care and secondary care.

In addition to the national services, locally commissioned services provide a wide range of ways in which community pharmacies can improve healthcare for individuals and the wider population.

There are many examples of innovative community pharmacy services that have been developed at a local level over recent years and these could augment community pharmacy's third pillar.

They include:

- **seasonal flu vaccinations;**
- **medicines optimisation work for respiratory diseases in South Central;**
- **sexual health screening including hepatitis, syphilis and HIV on the Isle of Wight;**
- **alcohol screening and brief intervention on the Wirral;**
- **anticoagulation monitoring in Knowsley;**
- **COPD/healthy lung screening in Essex;**
- **pneumococcal immunisation in Sheffield;**
- **tuberculosis therapy support in NE London;**
- **oral contraceptive supply in Manchester and LARC provision in Newcastle;**
- **MRSA decolonisation in Wakefield;**
- **reablement service on the Isle of Wight;**
- **aseptic dispensing of prefilled syringes for palliative care in Derbyshire; and**
- **phlebotomy services in Coventry and Manchester.**



How can this be commissioned?

Most innovative community pharmacy services are first developed and commissioned at a local level; however the New Medicine Service (NMS) does provide an example of a new service commissioned within the national contractual framework, following initial proof of concept research.

The preference of PSNC is that once proof of concept and initial evaluation of a service has been undertaken, often at a local level, where there is a clear need for a new community pharmacy service in all areas, it should be commissioned at a national level within the CPCF, in order to ensure rapid spread of innovation and widespread population coverage. Such an approach, as demonstrated by the introduction of the NMS, allows the coordination of national and local support for service implementation and the efficient provision of education and development resources to community pharmacy teams.

PSNC does however recognise that this approach cannot be used for all service developments and the local approach to service development has frequently acted as an incubator of innovation, which can then be spread further afield, for example, the Healthy Living Pharmacy concept which was initially developed in Portsmouth, but which has subsequently been used in many areas across England.

Obtaining funding for new community pharmacy services or pilots has always been a challenge and the new tightened financial situation within the NHS only makes this challenge greater. Health economic data demonstrating the value of

a new service is increasingly a pre-requisite to getting the service commissioned. However, even that cannot create a commissioning budget where one does not exist.

The recent reforms of healthcare should provide an opportunity for some money currently spent in secondary care trusts to be re-deployed to the commissioning of similar services closer to peoples' homes. This 'trickle-down effect' should support an increase in the number of services that can be commissioned from primary care providers such as community pharmacy. However, PSNC anticipates that where this shift of funding is achieved by Clinical Commissioning Groups (CCGs), it will often see services developed which will be provided by GPs.

On the face of it, greater general practice provision of services may not be welcomed by community pharmacy contractors eager to provide more services to the local population; however it may in fact present an opportunity for community pharmacy. This development could prompt the shift of existing workload within the general practice to community pharmacy, where there is a need to create capacity in general practices to allow the provision of new services previously provided by secondary care. GP recruitment challenges that are anticipated in many areas due to the retirement of a significant number of GPs over the next few years and the predicted shortage of nurses may also provide impetus for the shifting of specific tasks to community pharmacy.

In this scenario there would be no barrier for community pharmacy related to the need to evidence the health economic benefit of a service, as this will have been demonstrated previously when the service was first commissioned from GPs. It would however be necessary to demonstrate that community pharmacists and their teams could provide the service as competently as general practice teams and for an appropriate price.

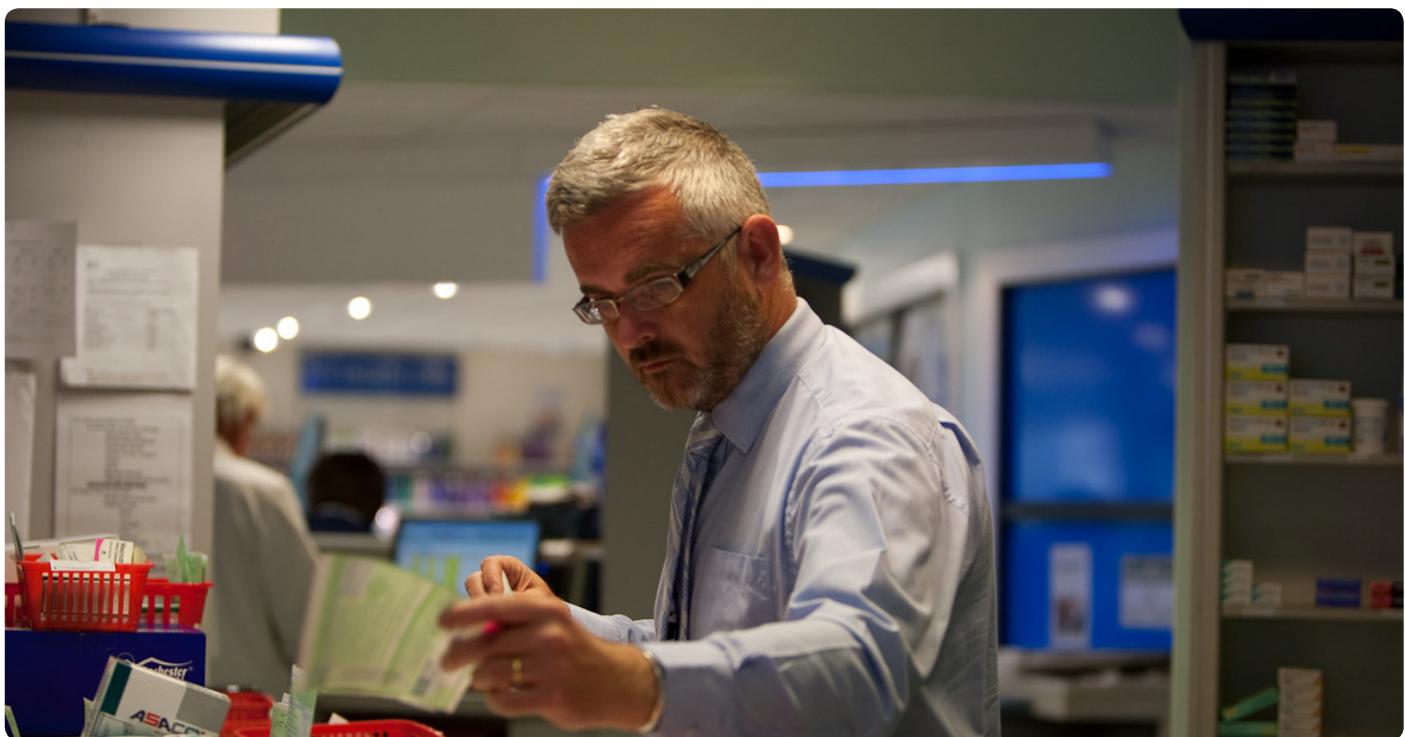
Embedding more medicines optimisation support within the Dispensing service

All pharmacies provide the dispensing service and adding additional elements to this service to provide further support for medicines optimisation, particularly patient safety, could be a way to rapidly increase the contribution of community pharmacy to this agenda.

A range of enhancements could be developed, but one example which is currently being tested within the Community Pharmacy Future project, is the application of STOPP (Screening Tool of Older Person's Prescriptions) and START (Screening Tool to Alert doctors to Right Treatment) indicators during the dispensing process in order to identify potentially inappropriate prescribing or circumstances where additional prescribing may be warranted, based on NICE and other guidelines.

Evidence based indicators, such as STOPP/START, could be applied to all prescriptions dispensed in order to highlight medicines optimisation interventions which may require a discussion with the patient and / or prescriber. A standardised dataset could be used to record interventions undertaken and to record outcomes. A standardised approach to communicating with GP practices could also be utilised, similar to the approach used for the Medicines Use Review (MUR) and NMS services.

The use of evidence based, nationally agreed indicators could support a focus on specific disease areas, or high risk medicines which are currently driving cost and / or patient harm. The set of indicators could evolve over time to focus on new therapeutic areas and to respond to emerging issues.



Community pharmacy supporting medicines optimisation

The nationally commissioned NMS and the MUR service both support patients to optimise the use of their medicines. But notwithstanding the recent targeting of the MUR service towards priority groups of patients identified by the NHS, the two services do not currently fit firmly within locally or nationally agreed care pathways for patients with specific long term conditions.

PSNC therefore believes that the development of the medicines optimisation services within the CPCF could start by focussing the provision of MUR and NMS on one or more patient cohorts. For example, people with asthma and COPD could all be offered annual support via an MUR and additional support when a new medicine is added to their regimen, via the NMS. This would necessitate the provision of the two services by all pharmacies and registration of patients to an individual pharmacy may also be required to allow the management of the service by commissioners and appropriate funding flows to contractors. Patients would have a free and unfettered choice of pharmacy where there was a need for registration.

This approach to medicines optimisation would see community pharmacies taking responsibility for provision of specific support to a cohort of patients, which would allow, where appropriate, the community pharmacy support to be embedded within local or national disease management pathways and NICE quality standards. In this way, patients and other healthcare professionals involved in the care of the patient would have certainty about what support community pharmacies would provide to patients, thus supporting team working across primary care.

The choice of the initial patient cohorts would be a matter for agreement with commissioners and other stakeholders, in light of the clinical and economic priorities at the time.

With a registered patient cohort, it would be possible to implement patient outcome measures for the pharmacy services against which community pharmacies would be held to account and also rewarded where appropriate outcomes are achieved.

One of the failings of the current MUR service is that it generally can only be provided once a year to each patient. This episodic approach prevents the provision of longitudinal care to the patient over the course of the year, which is probably needed in order to have the maximum positive impact on optimising the patient's use of their medicines. A second stage of development of medicines optimisation services may therefore be to encompass the support provided by MUR and NMS within a new service focussed on a specific patient cohort, which allows more frequent interventions with the patient over the course of their year of care.

The use of innovative smartphone apps could be incorporated into this service offering, for those patients with a smartphone. This could include provision of reminders to take medicines and support messages about other aspects of the patient's condition.

Over time and assuming that this approach delivered positive patient outcomes, the range of conditions covered could be extended.



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The next level – long term condition management

The development of the medicines optimisation services described above could take place alongside a move to support more active management of long term conditions. Currently many long term conditions are managed in general practice by practice nurses. Diseases such as asthma, hypertension and diabetes are managed in line with the structured guidelines provided by NICE and other institutions. As described above, there may be a need to release capacity in general practice to take on the management of more complex diseases, currently managed in secondary care, or to allow more active case management of high risk patients. This may therefore create the opportunity for community pharmacies, in collaboration with general practices, to manage specific patient cohorts, or at least to undertake specific elements of disease management detailed in care pathways and quality standards.

For example, the recently published NICE quality standard for asthma requires patients to be offered an annual review of their condition. Traditionally this type of review has been undertaken in general practices by practice nurses. The review includes an assessment of the patient's medicines and their use. With a small amount of extra training and with the availability of appropriate monitoring equipment, it is likely that the annual review described by NICE could be undertaken in community pharmacy. PSNC is currently exploring opportunities to test this concept within a discrete geographical area.

Other disease areas which may be similarly amenable to community pharmacy management include COPD, Parkinson's disease, hypothyroidism, hypertension, type 2 diabetes and poorly managed pain.

Selection of a disease area would need to be informed by the priorities of the service commissioner and the views of other

stakeholders, in particular GPs. A key barrier to the extension of pharmacy's role in managing long term conditions has been resistance from other healthcare professionals. We believe focusing on one disease area, such as asthma or hypertension (in patients with no co-morbidities), could serve a dual purpose in boosting community pharmacists' confidence in dealing with patients on a regular and long-term basis, but also in giving other professions confidence in pharmacy's ability to manage patients on this basis working in collaboration with other healthcare professionals.

We recognise that this approach does not fit with the generally held desire within healthcare to treat people with multiple morbidities in a holistic manner; however we believe this approach is necessary to start with in order that pharmacists and their teams can develop experience of managing one condition before they go on to provide support to people with multiple morbidities. This approach would not of course prevent provision of advice on healthy living, e.g. stopping smoking and health protection, e.g. accessing 'flu vaccination, which would help with the provision of patient-centred care from the pharmacy.

The above options for iterative service development are summarised in the graphic opposite.

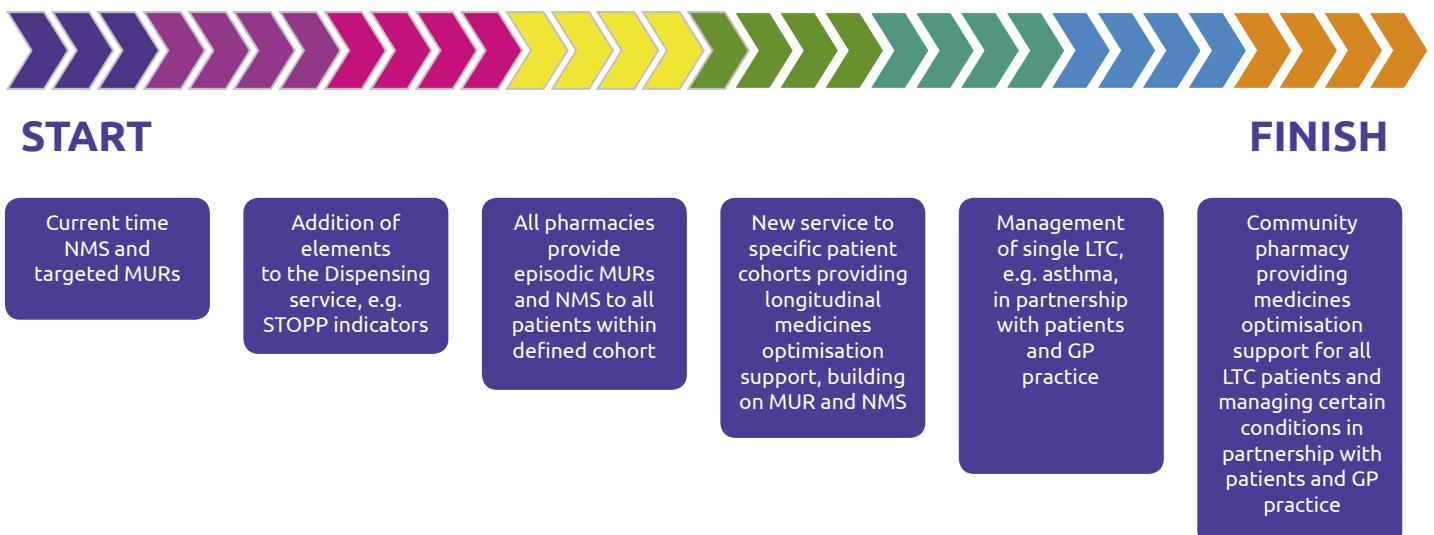
Some stages of the development may co-exist, e.g. additional elements in the Dispensing service could continue to be undertaken when the more developed long term condition management services are implemented.

The services could all be commissioned within the national CPCF, but it is likely that the services focussed on management of specific long term conditions may have to be commissioned at a local level, at least to start.



Iterative approach to medicines optimisation service developments

The different stages of service development may co-exist



Supporting people to live healthier lives

All community pharmacies provide healthy living advice to patients as part of the public health element of the CPCF and provision of relevant healthy living advice is also a component of the MUR and NMS services. The majority of community pharmacies will also provide at least one locally commissioned public health service, such as provision of EHC, stop smoking or supervision of methadone and buprenorphine.

We envisage that locally commissioned public health services will continue to spread across the country in line with local needs identified by local authorities. The Healthy Living Pharmacy (HLP) framework provides a positive approach to focussing the pharmacy team on promotion of healthy lifestyles and associated service delivery. The development of support staff skills and increased motivation to provide services has been a positive achievement of the HLP concept.

Innovative services such as the Isle of Wight sexual health screening for hepatitis, syphilis and HIV are likely to continue to be developed by community pharmacy contractors, Local Pharmaceutical Committees (LPCs) and innovative public health commissioners in response to specific local challenges. Many public health services are not suitable for commissioning at a national level within the CPCF, however, some services, such as supervised consumption of medicines for the treatment of substance misuse or provision of emergency hormonal contraception, there is sufficiently widespread need across all areas that it could be considered for commissioning from all community pharmacies.



Likewise some public health services, such as seasonal influenza vaccination, could be commissioned from community pharmacies on an any qualified provider basis. A great many pharmacies already provide this service on a fee paying basis, but NHS commissioning of the service from community pharmacies has been relatively limited. There is evidence of community pharmacies being able to increase vaccination rates in at-risk groups, where the service is offered over and above the incumbent NHS provision by GP practices.

Local experience suggests that the service has not been widely commissioned from community pharmacies, despite the positive evidence of increased vaccination rates achieved, due to negativity from GP practices about the increased competition which would result from pharmacy provision. It would also be possible to use the community pharmacy vaccinator workforce to support other immunisation programmes, such as childhood vaccinations and the recently introduced MMR catch-up programme.

Supporting people to self-care

Community pharmacy's traditional role in supporting people to self-care for minor illnesses is an important way in which to manage demand for other NHS services, in particular general practices. One of the most important strengths of the sector is the network of over 11,000 pharmacies across England, which effectively act as healthcare walk-in centres where people, live, work and shop.

However, the wider promotion of pharmacies as a location to treat minor illness and the national commissioning of a minor ailment service to provide care at NHS expense to those who would otherwise visit the GP practice could bring a number of advantages. It could increase choice and improve access to services for patients; free up more capacity in general practice; avoid unnecessary visits to A&E departments; and also support the appropriate management of people using the NHS 111 service.

Research commissioned by PAGB and PSNC and conducted by IMS in 2007, revealed that the treatment of minor ailments accounts for 18-20% of GP workload, incurring a significant cost of around £2 billion a year to the NHS. It was estimated that annually 57 million consultations are for minor ailments (51.4 million of which are for minor ailments alone), resulting in over an hour a day of consultation time for every GP and the writing of 52 million prescriptions.

PSNC and LPCs have promoted the national commissioning of a minor ailments service for many years and in the 2008 Pharmacy White Paper the then Government proposed that a national service should be discussed by DH and NHS Employers with PSNC. During those discussions the principal block

presented to progress was the inability of DH to reallocate funding in the GP contract to community pharmacy, in order that DH did not 'pay twice' for the management of patients with minor illness. The role of NHS England as the commissioner of all primary care contracts, including community pharmacy and general practice, now presents an opportunity to re-visit this issue.

The commissioning of a national community pharmacy minor ailments service alongside a sustained information campaign aimed at the public on appropriate use of NHS resources could 're-train' the proportion of the population that default to use of A&E or GP practices when they could safely access treatment at a community pharmacy. This wholesale change in public behaviour requires concerted effort by the NHS over a lengthy period and the uniform availability of services, so a consistent message can be directed at the public across all areas. The subsequent benefits of reducing pressure on A&E services and creating time in general practice which can be re-deployed to coordination of care for patients with complex needs could have much wider benefits for the healthcare system and patient outcomes.

Supporting people to live independently

England's changing demography and the increase in the number of people with life changing conditions such as dementia require that all healthcare providers examine how they can respond to the changing needs of their local population. Community pharmacies already provide a range of services to support people to live independently in their own homes, including:

- **support with re-ordering repeat medicines / the NHS repeat dispensing service;**
- **home delivery of medicines to the housebound;**
- **appropriate provision of multi-compartment compliance aids and other interventions such as reminder charts to help people adhere to their medicines regimen;**
- **reablement services following discharge from hospital;**
- **Falls assessment / reduction services; and**
- **signposting patients or their carers to additional support and resources related to their condition or situation.**

Some of these services will also support formal and informal carers to continue to support their clients or friends / relatives to live independently.

The medicines optimisation services described previously can assist people to adhere to their medicines regimen which ultimately may prevent or delay the development of complications from long term conditions which eventually necessitate care in a hospital or care home.

Supporting adherence to medicines via 'compliance aids' has often not been effectively targeted at patients who would benefit most from such support. The development of a validated assessment that could be used in community pharmacies and elsewhere to determine the most appropriate and safe support to be provided would be of great benefit to patients and healthcare professionals. National agreement on the use of an appropriate assessment tool would assist pharmacies in providing appropriate support to their patients and this is something that the Royal Pharmaceutical Society, as pharmacy's professional leadership body, could lead work on, in collaboration with other interested bodies.

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The application of assistive technologies to support people to live independently in their own homes will increase over the next few years. Pharmacy has already started to provide some such support, including the use of automated medicine dispensers. Providing guidance to patients on the selection and use of such technologies could increasingly be a role that community pharmacy teams play in order to support independent living.

Conclusion

England's community pharmacy teams already play a vital role in supporting the nation to remain healthy or manage disease when it develops. There are many opportunities to enhance their already significant contribution to healthcare, maximising the benefits of the network of pharmacy locations across the country, near where people live, work and shop. NHS England can facilitate this greater contribution by enhancing the range of national services commissioned via the CPCF, alongside greater local commissioning.

Pharmacy's contribution to healthcare can also be enhanced by greater team working across primary care; closer working relationships with general practice are particularly important. NHS England's area teams and CCGs have an important role to play in facilitating such relationships at a local level. Community pharmacy itself also needs to demonstrate the ability to provide services to a consistently high quality in order to enhance its relationships with GPs.



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