Improving Health & Patient Care through Community Pharmacy - a Call to Action

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Introduction

This response to NHS England's Community Pharmacy Call to Action (CTA) (Improving Health and Patient Care through Community Pharmacy – a Call to Action) sets out PSNC's vision for the development of community pharmacy services and the NHS Community Pharmacy Contractual Framework (CPCF), detailing how that development would improve health outcomes for individuals and help the NHS to surmount the very significant challenges it faces as a result of population growth, an increase in long term conditions (LTC) and fiscal constraints.

Transformational change: Without transformational changes like those we outline, which will better harness the potential of community pharmacies to contribute to patient care and in doing so relieve burdens elsewhere in the NHS, we do not see how the health service will be able to survive the combined pressures of financial restrictions and increasing demand that it now faces.

Contractor engagement: PSNC is recognised by the Secretary of State for Health as being the representative of community pharmacies on NHS matters. The committee includes 31 independent community pharmacy contractors and representatives of multiple community pharmacy businesses, who between them represent all 11,500 community pharmacy contractors in England. As well as drawing on their insights and experience in writing this response, we held three regional events across England through which the committee sought the views of Local Pharmaceutical Committees (LPCs). LPCs have in turn arranged local events across the country for pharmacy contractors and their teams and in some areas for wider stakeholders, and we have attended a number of these. Engagement with pharmacy teams, who directly provide services to patients and the public every day, has allowed the views of a wide range of stakeholders to be considered.

Our response has also been informed by a range of evidence from local and national service evaluations collated over recent years, as well as a survey of pharmacy contractors which we used to assess their views on the development of community pharmacy services.

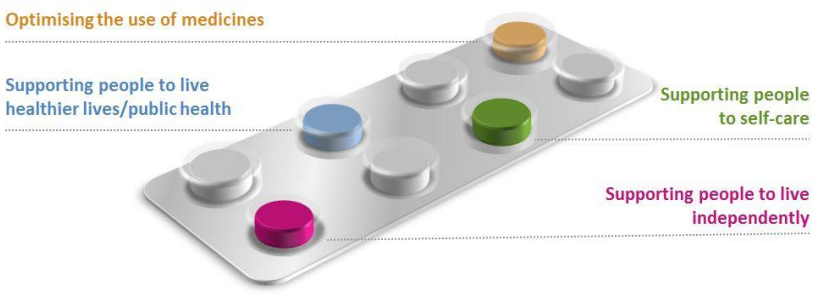
In the CTA document NHS England has posed four questions; we provide our answers to these questions below.

PSNC's vision for community pharmacy

Recognising the challenges the NHS faces and the need to significantly improve patient outcomes, in 2012 PSNC agreed a four-year strategy which is built around a clear vision for the community pharmacy service in 2016; this is detailed in Appendix 1.

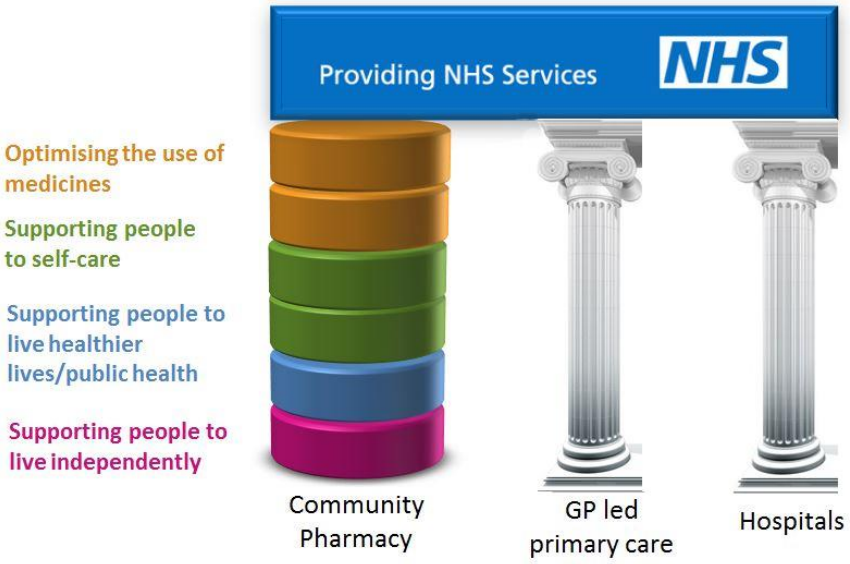
The four service domains: Within PSNC's vision there are four key domains across which there is significant potential for community pharmacy teams to improve the lives of patients and the public:

1. Optimising the use of medicines;
2. Supporting people to live healthier lives / public health;
3. Supporting people to self-care; and
4. Supporting people to live independently.



The core Essential and Advanced services within the CPCF and locally commissioned community pharmacy services all fall within one or more of these domains and they contribute to improving the health of the population, but, as we will describe later in this response, community pharmacy has much more to offer to patients and healthcare commissioners.

A third pillar of care: If the community pharmacy service were to be further developed, building on the central medicine supply function across these four service domains, pharmacy could help the NHS to manage the financial constraints and increasing demands it faces by becoming the basis of a third pillar of care, supporting NHS service provision alongside the traditionally dominant pillars of GP-led care and secondary care.



In 2012 PSNC confirmed via a survey of community pharmacy contractors that this aspiration for community pharmacy service development is supported by the majority of the sector. In total 1,080 pharmacy contractors who between them owned or were responsible for 5,216 pharmacies responded to the survey, and 93% of responding pharmacy owners representing 98% of pharmacies agreed with this aspiration, with 45% representing 37% of pharmacies strongly agreeing.

Question 1 - How can we create a culture where the public in England are aware of and utilise fully the range of services available from their local community pharmacy now and in the future?

Raising the public's awareness of the community pharmacy services available to them

In order for the public and healthcare commissioners to maximise the benefits they can receive from community pharmacy services, it is important that the public has a better understanding of the range of services available to them at their local community pharmacy and that they know it should be used as the first port of call for many healthcare needs.

Enabling consistent service delivery: One of the barriers to patients recognising and using the services provided by community pharmacies is the inconsistency in the range of services commissioned from and available at different pharmacies across the country. This can lead to patient confusion about the availability of services, which can deter them from seeking to use community pharmacy services. We recommend that this is tackled by NHS England commissioning a wider range of services as part of the national CPCF, in order that a consistent core of services is available from all community pharmacies. PSNC's initial suggested priorities for national commissioning would be a minor ailments service and a Flu vaccination service.

This winter NHS England promoted both of these services to local commissioners as a means of helping to manage the increasing demands on hospital and GP services. Both the services can have a significant impact on patient outcomes and they can enable more efficient use of healthcare resources by the NHS, for example by helping to prevent people visiting their general practice or hospital when they have a condition that could easily be treated with support from a community pharmacy, or by preventing hospital admissions caused by flu. Commissioning them nationally within the CPCF, so they are provided in a consistent manner from pharmacies across the country, would be the most effective way to enable community pharmacy to rapidly assist the NHS with tackling the challenges being experienced by urgent and emergency care services and GP practices. In Appendix 2 we describe in more detail how community pharmacy services can support the NHS to meet the challenges it is facing and improve patient outcomes.

Communications to develop patients' understanding: If these and other community pharmacy services are to be widely taken up by patients as part of an effective and truly integrated service provided by community pharmacy and other providers, there will be significant changes to the ways in which patients have traditionally received care. As a consequence of this there will be a need to develop patients' understanding of the choice of services they have to support the management of their long term conditions and other care needs. A communications campaign to develop patients' understanding of these changes would be required, particularly in the early days of implementing a new model of integrated care.

NHS England's recent investment in a promotional campaign to highlight to the public the availability of self-care advice from community pharmacies, alongside similar campaigns undertaken by national community pharmacy organisations, will help to raise the public's awareness of community pharmacy services. Additional promotional campaigns of this type are required on a continuous basis in order to achieve a change in the public's behaviour and their use of healthcare services.

Alongside such campaigns, if NHS leaders and politicians routinely spoke of pharmacists as part of the healthcare network ("pharmacists, doctors and nurses" rather than the oft heard "doctors and nurses") this would help to positively influence the public's perception of community pharmacy and the services it can offer.

Increasing referrals to community pharmacy

Increasing referral of patients to community pharmacies by other primary and secondary care professionals and NHS 111 services would not only assist in managing constrained workload capacity in GP practices and hospitals, but it would also help to re-educate patients about the range of services available at their local community pharmacy.

Referring patients who are being discharged from hospital to their community pharmacy for provision of an MUR provides one example of such a referral which is clearly in the interests of the patient and the NHS, but which currently does not occur routinely.

Referral incentives: Increasing the number of this type of referral requires incentives to be included in the relevant contracts for GP practices, hospitals and NHS 111 providers to encourage this behaviour. NHS England's Local Professional Networks (LPN) for pharmacy should also seek to support increases in the number of referrals to community pharmacies. In part this may be achieved by the agreement of formal referral pathways between the different providers, which can, where relevant, be incorporated into clinical systems such as NHS Pathways. Development of formal referral pathways will frequently require the application of local knowledge, but it should be possible for aspects of this work to be undertaken nationally in order to reduce local duplication of effort and to increase the speed of implementation. As an example, the national pharmacy bodies are currently working together with the team responsible for the development of NHS Pathways to identify opportunities for greater use of the pharmacy disposition within NHS Pathways algorithms.

Sharing of patient information: In order to support appropriate patient referrals being made to and from community pharmacies it is important that healthcare IT systems develop to allow the sharing of patient information between all healthcare providers. The inability of most community pharmacy teams and GP practices to communicate and share patient data electronically is proving to be a major block to developing new innovative services and effective collaborative relationships that would benefit patients.

There are two aspects to this information sharing and transfer. Firstly, direct electronic communication between community pharmacies and other healthcare providers must be facilitated, using standardised messaging systems which allow easy integration of the communications into patients' records. These systems may be used to share the results of patient tests relevant to pharmacy service provision, e.g. the INR of patients being dispensed warfarin. They may also be used to feed information and queries about prescriptions directly from the community pharmacy to the prescriber.

East Lancashire Hospitals NHS Trust has recently collaborated with partners to develop one such system (refertopharmacy system) to allow patients being discharged from hospital to be referred to their community pharmacy for support with their medicines post discharge.

The second aspect to information sharing and transfer is for community pharmacy to be able to access the Summary Care Record (SCR) and GP patient records, where there is a legitimate need for this access and the patient gives their consent. To support the development of a single consolidated record for information that could be used by all professionals actively involved in a patient's care, community pharmacy should be able to add content to the SCR and GP records, as well as being able to read them.

National leadership: The Secretary of State for Health has recently provided in principle support for appropriate community pharmacy access to records, but it is unclear how quickly this can be implemented. NHS policy on IT developments is increasingly to focus development at a local level, but PSNC is very concerned that achieving pharmacy access to GP patient records will not be possible without national leadership by NHS England. At the very least, there is a need for this leadership to drive the development and / or adoption of suitable interoperability standards, so that pharmacy and GP IT systems at a local level can all communicate with each other.

We therefore suggest that NHS England should put in place the infrastructure to let patients give community pharmacists access to their SCR and in due course their GP record, where the patient wishes this to happen. It is also likely to be necessary for contracts for all healthcare providers to include a requirement that they put in place systems to share patient information electronically across the NHS.

Community pharmacy's relationship with general practice

Community pharmacy and general practice have always worked closely together, linked by the flow of patients and prescriptions between the two professions, but relationships at a local level are not always as strong or productive as they might be and this can adversely impact on the ability of the two professions to collaborate to maximise health outcomes for patients.

Incentivising collaboration: Community pharmacy could work more closely with general practice, in order to support the work of GPs and their teams in improving the care of patients, in particular the management of patients with long term conditions. This could involve pharmacies taking on a greater role in caring for these patients and coordinating that care, via shared information and IT systems, more closely with that provided to the patient by their GP practice. NHS England has a role to play in enabling this by ensuring the alignment of the GP and community pharmacy contracts with the inclusion of clear incentives in both to drive collaborative working. In Appendix 2 we provide illustrations of how community pharmacy medicines optimisation services could develop in a collaborative manner with GP practice provided care for patients.

Alignment of the contracts needs to happen at a time at which changes are being made to both the contracts; if, for example, changes are made to the GMS contract without consideration of how the CPCF could be aligned with those, then the opportunity to incentivise collaborative working between general practice and community pharmacies may be missed until the next contract review is undertaken. As an example, the development of a national community pharmacy minor ailments service, building on the widespread commissioning of this service at a local level, has always been blocked due to the inability of the Department of Health to avoid 'paying twice' for such a service (the GMS contract includes funding which would cover GP treatment of minor ailments). This has historically been a problem due to different policy teams within the Department of Health being responsible for the two primary care contracts, but NHS England, as a single commissioner of both contracts, should be able to coordinate its work to avoid missing opportunities to facilitate and incentivise better team working across primary care.

Joint local projects: NHS England's LPNs could play an important role in supporting effective liaison between community pharmacies, clinical commissioning groups (CCGs) and GP practices. This could include LPNs developing joint projects on issues of shared interest to GP and community pharmacy teams, as a means of creating better relationships between them, e.g. improving the flow of information about patients following discharge from hospital.

Supporting people to live healthier lives

It is important that all members of the primary care team ensure that they make every contact count when talking to patients. Community pharmacy is able to reach a significant cohort of people who do not regularly access their general practice, which presents an opportunity for more preventative interventions to be made to reduce people's risk of developing long term conditions. By helping patients to look after themselves more effectively and stay healthy, the burdens on general practice and all other health services could be reduced and significant cash savings, for example through prevented hospital admissions, could be made.

All community pharmacies are already providing healthy living advice to patients as part of the public health element of the CPCF and other services. For example, an evaluation of New Medicine Service (NMS) interventions recorded on the PharmOutcomes IT system in the first year of the service found that a total of 366,702 separate

pieces of healthy living advice were given to the 224,554 patients who received the NMS. The majority of community pharmacies will also provide at least one locally commissioned public health service.

The Healthy Living Pharmacy (HLP) framework has provided a positive approach to focussing the pharmacy team on the promotion of healthy lifestyles and associated service delivery. The development of support staff skills and the increased motivation to provide these services seen has been a positive achievement of the HLP concept. Likewise the quality criteria used by HLPs has helped pharmacy teams to reflect on and improve the quality of the services they are providing. Learning from these and other aspects of the implementation of the HLP concept across the country may be able to inform the future development of the CPCF.

Maximising public health innovation and impact

We hope innovative services such as the Isle of Wight sexual health screening service for hepatitis, syphilis and HIV will continue to be developed by community pharmacy contractors, LPCs and innovative public health commissioners in response to specific local challenges. These local developments then provide inspiration and learning for commissioners to apply in other areas across the country and they can also inform the development of the CPCF.

Not all public health services are suitable for commissioning at a national level within the CPCF. However, for 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, and we believe this approach would make sense. Currently there is unwarranted variability in the way in which many public health services are commissioned and specified. This leads to additional complexity and expense for commissioners and providers alike which in turn reduce the effort which can be focussed on successful provision of the services. We comment further on how this issue can be addressed in our response to question 2.

Question 2 - How can the way we commission services from community pharmacy maximise the potential for community pharmacy to support patients to get more from their medicines?

National versus local commissioning

Most innovative community pharmacy services are first developed and commissioned at a local level as a result of providers and commissioners responding to a specific patient need within their locality. 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, PSNC believes that it should be commissioned at a national level within the CPCF.

Dynamic services framework: The original vision for the CPCF, held by all negotiating parties, was for a 'dynamic framework' which, where appropriate, took local innovation and learning and used this to develop nationally commissioned services. Unfortunately this has not been realised since the implementation of the revised CPCF in 2005, but it is still the approach which PSNC and community pharmacy contractors believe should be used, through an ongoing active review and development process for the national elements of the CPCF. Utilising such an approach would support NHS England to adapt the community pharmacy offering to patients in a more active manner, responding to emerging healthcare priorities and NHS challenges.

National standards and services: PSNC believes that national commissioning of services and the application of a nationally agreed community pharmacy quality framework and, where needed, any additional accreditation requirements for individual services, brings a number of benefits to patients, commissioners and providers. The approach supports the rapid spread of innovation and widespread population coverage, so the maximum number of patients can benefit from provision of the service. As noted in our response to question 1, consistency of service provision across all pharmacies can help support a change in patient behaviour towards greater use of community pharmacy. As demonstrated by the introduction of the NMS, commissioning at a national level also allows the coordination of national and local support for service implementation and the efficient provision of education and development resources to community pharmacy teams. As a consequence, it allows a more cost effective and efficient rollout of services across the community pharmacy network compared to local commissioning of services.

Optimising local commissioning

Despite the benefits of a national approach, PSNC does recognise that it cannot be used for all service developments and that the local approach to service development must act as an incubator of innovation, which can then be spread further afield.

Local authorities and CCGs both have an important role in commissioning local community pharmacy services, but they will benefit from the support of NHS England Area Teams and their pharmacy LPNs, who can provide expert advice on commissioning services from community pharmacy. We believe Area Teams and LPNs should support the strengthening of community pharmacy and local authority / CCG relationships in order that community pharmacy can effectively play its part in providing high quality services and delivering the best possible outcomes for patients and the local population.

Streamlining contracting to improve patient services: Where it is necessary to take a local approach to commissioning services, the current bureaucracy surrounding local contracting is proving to be a major barrier to commissioning of services from pharmacies and it is impeding the provision of services to patients. The current use of complex and unwieldy standard or locally developed contracts and tendering processes by commissioners for locally commissioned services, which may be of limited financial value, is seen on a regular basis. PSNC has already discussed with NHS England some of the challenges community pharmacies face with use of the NHS standard

contract, but we believe further collaborative work on this topic would be beneficial. We are keen to work with NHS England and other interested parties to undertake a further review of the elements of the standard NHS contract which are applied to primary care providers in order to increase the chance of innovative local services being successfully commissioned by this route, to the benefit of patient care.

PSNC would also encourage NHS England to consider how it may facilitate easier local commissioning of services from community pharmacies via more extensive use of the less bureaucratic Enhanced services commissioning route where a CCG / local authority wishes NHS England to commission a service from community pharmacies on its behalf.

Standard service specifications: Another approach to simplifying the local contracting process for all parties is the use, wherever possible, of standard service specifications, service level agreements, service documentation, patient group directions, datasets and outcome measures. In the past, PSNC, the Department of Health and NHS Employers have collaborated to develop standard service specifications for commonly commissioned community pharmacy services. We understand that these documents were used extensively by Primary Care Trusts (PCTs) in order to avoid 'reinvention of the wheel' at a local level.

PSNC is keen to work with NHS England and other relevant stakeholders, such as Public Health England and local commissioners, to review the current suite of nationally agreed service specifications and where necessary to develop new specifications and associated documents, datasets and other tools to support local commissioning. This would build on successful collaboration in 2013 between PSNC, NHS England, LPCs and local commissioners which led to the development of a range of materials, including service specifications, service level agreements and documentation for use by pharmacies and with patients, for three services focussed on managing winter pressures (the documentation is available at psnc.org.uk/winter). Following the publication of these resources they were rapidly used by LPCs and local commissioners to commission and implement at least 14 new services in a very short space of time.

Supporting the quality of locally commissioned services

In the past, PCTs in the North West collaborated with community pharmacy organisations and the Centre for Pharmacy Postgraduate Education to develop and roll out a standardised approach to the assessment of pharmacists' competence to provide locally commissioned services.

Standardising accreditation: This approach has recently been developed, in collaboration with the Local Education and Training Board, to include Declaration of Competence frameworks for a number of locally commissioned services. This approach helps to make commissioning of community pharmacy services easier and brings greater consistency to the knowledge and skills required by pharmacy professionals providing services, which in turn should lead to a more consistent, higher quality service being provided to patients across different areas.

Alongside the suggestion made above to review and augment the current range of national service specifications and associated documents, PSNC is keen to work with NHS England and other relevant stakeholders to consider whether the Declaration of Competence framework approach, or something similar, could be used across England to support easier commissioning of community pharmacy services where an assessment of staff competence is necessary.

Supporting the shift of services into primary care

Over recent years health service commentators and leaders have highlighted the need 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 and general practices.

An increase in provision of patient services in primary care has been an aim of numerous commissioners, including CCGs, however little progress has been made. One of the reasons for this is the lack of capacity in general practices to take on more workload from secondary care. PSNC believes that this challenge can be overcome by the transfer of some existing general practice workload to community pharmacy, freeing up capacity in general practices to allow the provision of new services previously provided by secondary care. We outline in detail some examples of how this might work in Appendix 2.

Extending the provision of clinical services

Community pharmacy's most important role must be helping patients, and consequently the NHS, to get the maximum value from prescribed medicines. This is at the heart of the medicines optimisation agenda and it allows community pharmacists to properly focus their core professional skills and knowledge on improving outcomes for patients.

To achieve this aim, the CPCF needs to support and incentivise community pharmacies to provide a wider range of medicines optimisation services. In Appendix 2 we describe in more detail possible options for the development of the CPCF to provide much more support for people to optimise the use of their medicines. For example, more support could be provided to patients within a specific cohort of diseases, such as people with asthma or COPD. We also illustrate how community pharmacy could take on some current general practice workload in a collaborative manner. For example this could involve the management of patients when they are first diagnosed with hypertension.

Clarifying pharmacy and GP roles: In order to support the implementation of such an approach to the collaborative management of LTCs, we believe that shared care protocols for the most common LTCs should be developed which clearly set out the roles and responsibilities of community pharmacy and general practice teams. Along with developments to ensure that GPs and pharmacies are working under contracts that incentivise them to work together to deliver the best possible patient care, as we have outlined above, this use of shared protocols will be a crucial step in the development of the community pharmacy service. We have seen in some areas GPs deliberately trying to block the commissioning of local pharmacy services, such as the provision of flu vaccinations to patients in the NHS target groups. While this territorialism is not surprising in the current financially squeezed environment, it does not lead to the best outcomes for patients and the NHS and we are keen for NHS England, given its new position commissioning services from both professions to consider how this can be addressed in the two national contracts, as we describe above.

Extending the provision of clinical services would necessitate much greater application of the community pharmacist workforce within community pharmacies towards provision of clinical services than is currently the place. However the supply of medicines should remain an integral part of the care provided by pharmacies to patients as this core function can provide key opportunities for pharmacies to have contact with patients and to couple it with the provision of patient care. This will mean that pharmacy teams' skills must be developed to allow other members of the team to take on additional roles to support pharmacists as they work to expand the care being provided.

Incentivising care: As community pharmacists become more involved in making decisions on the treatment of patients' LTCs, the current community pharmacy funding mechanisms would need to be revised in order to remove the perceived incentives to supply medicines that are not needed by the patient. However, it is important that this only happens as part of the recognition and commissioning of care services provided by community pharmacists and their teams. This could include the development of a care fee based approach to commissioning integrated supply and care services, which would see community pharmacy funding incentivising the provision of high quality care to patients.

The community pharmacy network

The community pharmacy network provides very convenient access to healthcare services to most of the population of England, as highlighted by the Department of Health statistics quoted in the Call to Action Resource Pack. Following changes to the control of entry system, introduced by Government in 2005, there has been a significant growth in the number of community pharmacies with NHS contracts. This has led some to ask whether all community pharmacies are appropriately located to meet the needs of patients and the NHS, or whether there are now too many community pharmacies with NHS contracts.

Identifying service needs: PSNC does not believe that it is possible for NHS England to assess whether the current community pharmacy network is appropriate at present, as it first needs to identify the services that it wishes community pharmacies to provide in the future. It is only once NHS England's future commissioning intentions are determined for community pharmacy that an informed assessment of the appropriateness of the community pharmacy network may be made.

PSNC is also keen to have an open dialogue so that NHS England can understand the barriers its regulatory regime places on mergers and closures of community pharmacies, and how it can depress innovation. PSNC would wish these matters to be addressed in future reform of NHS regulations and policy.

Question 3 - How can we better integrate community pharmacy services into the patient care pathway?

Better integration of community pharmacy services with the wider healthcare system

We have described in the answers to questions 1 and 2 and in Appendix 2 how community pharmacy services could be developed to create better outcomes for patients, and how improved use of referrals and data sharing between all healthcare providers could support this. We have also described in our answer to question 1 the importance of enhancing the community pharmacy / GP practice relationship, potentially by joint working across the two professions on matters of common interest, such as improving the provision of care to patients that have recently been discharged from hospital.

Access to records: We reiterate the importance of improving the flow of data between healthcare providers and the need to provide community pharmacists with access to patients' Summary Care and GP records (with appropriate patient consent) to achieve better integration of services.

Integrating pharmacy into care pathways: Developing community pharmacy services across the four domains of PSNC's vision for community pharmacy (described in Appendix 1 and 2) would enable the NHS to achieve better integration of community pharmacy services into patient care pathways.

In particular, as the national commissioning of services within the CPCF allows the provision of a consistent range of services from all community pharmacies, this would in turn make it easier to include community pharmacy services in nationally or locally produced care pathways, as commissioners and other healthcare professionals could be confident that a specified service is available from all community pharmacies, making it easier for them to refer patients to receive a specific pharmacy service.

Identifying key services: We suggest that NHS England should work with PSNC to identify the disease areas or services where community pharmacy can best deliver outcomes for large numbers of patients in order to guide the agreement of early service development priorities.

Recognising the role of medicines in pathways: In addition to this, when patient care pathways are being developed at a local or national level, there should be a greater recognition of the role that medicines play in almost all care pathways. As a consequence, pharmacy should have a voice in the development of the vast majority of pathways, right from the start of the process.

Improving the use of data by community pharmacies

Community pharmacies were first to adopt the use of IT within primary care and its effective use continues to be integral to the provision of services. However, despite this the full range of functionality available in community pharmacy IT systems is frequently not used to best effect, and pharmacy contractors report that IT systems can be slow to adapt to their evolving requirements. In the past this may in part have been a feature of the restrictive top down approach to the development and rollout of IT specifications for NHS projects such as the Electronic Prescription Service (EPS). This saw the NHS setting out complex and detailed requirements for systems without significant engagement with either system users or developers. Learning from this experience of the National Programme for NHS IT (NPfIT), PSNC believes that although national leadership on IT is vital to drive development in the right direction, stakeholder engagement must be a key feature in any IT projects and the pharmacy and primary care IT market should have more freedom to respond to customer demands and to develop relevant functionality for those customers.

Data and service evaluation focus: The major step change in community pharmacy service provision we have already described in this response will require further development of pharmacy IT, so that systems facilitate

efficient recording of information about patients and services provided to them. At the same time systems need to support the capture and interrogation of data to demonstrate the outcomes and effectiveness of commissioned services. Over the last few years community pharmacy has made significant progress in developing systems to capture and report on service data, but more progress could be made if agreement could be reached on standard datasets and outcome measures for commonly commissioned services. This approach has already been adopted for the nationally commissioned NMS and MUR services.

Making best use of the whole pharmacy team

Community pharmacy teams generally have a wide range of skills which are role based, but adaptable. As a consequence, if commissioners recognise what community pharmacy teams currently do and could do in the future, their value to improving patient outcomes, particularly in relation to promoting public health topics and supporting behaviour change, could be harnessed more effectively.

Certainty needed to support investment: Maximising the value of the community pharmacy team will require investment in developing the skills and capacity of that team. It may be that some of this investment can be provided directly by commissioners or Local Education and Training Boards, but where this is not possible, it is important that community pharmacy contractors have certainty on future commissioning intentions so they can confidently plan for and invest in the development of their teams and facilities. In the past, certainty on commissioning intentions has been sadly lacking and this has negatively impacted on the willingness and ability of community pharmacy contractors to invest in such developments. The current fragmented approach to local commissioning does not support the development of such confidence to invest, which is another key reason why national commissioning of services could provide a better route for all.

Question 4 - How can the use of a range of technologies increase the safety of dispensing?

Enhancing the safety of dispensing

Community pharmacies currently provide a very safe dispensing service for the millions of prescriptions prescribed every year, but the sector must continuously strive to identify ways to further improve the safety of this and all other community pharmacy services.

PSNC recognises that there is a need for greater reporting of and learning from patient safety incidents across primary care, but greater clarity is required by community pharmacy teams on which patient safety incidents should be reported to the National Reporting and Learning System (NRLS) and we also suggest that NHS England needs to have realistic expectations, grounded on real evidence, of how many reportable patient safety incidents, i.e. those that meet the NRLS criteria, occur in community pharmacies.

Improving reporting functionality: NHS England needs to work collaboratively with community pharmacy stakeholders to improve the functionality of reporting via the current NRLS system or using a centralised approach to reporting in the case of larger community pharmacy companies. Feedback from community pharmacy contractors suggests that the current NRLS web-based system is very time consuming to use and this inevitably impacts on the willingness of busy pharmacy teams to take time away from the provision of services to patients to report incidents. An effective system will be one which allows rapid and simple reporting of those patient safety incidents which are most likely to bring valuable learning for the NHS and community pharmacy.

The Department of Health and stakeholders also need to make rapid progress in removing the criminal sanctions for dispensing errors which inevitably depress the willingness of pharmacy professionals to report dispensing errors to NRLS.

Better use of technology

We have already highlighted in the answers to the previous questions the importance of community pharmacy access to patients' SCR and GP records, where the patient consents to this, as a means of enhancing the medicines optimisation support that community pharmacies can provide. Access to these records could also support improved safety in the dispensing process, for example, allowing assessment of recent test results when dispensing high risk medicines, without the need to contact the GP practice. We reiterate our view that NHS England should put in place the infrastructure to let patients give community pharmacists access to their SCR and in due course their GP record, where the patient wishes this to happen. We also believe that it is necessary for contracts for all healthcare providers to include a requirement that they put in place systems to share patient information electronically.

Standardised bar coding approach: Some pharmacies have already adopted integrated robotic and IT systems to partially automate the dispensing process, but this approach is not currently a viable proposition for many community pharmacies. The use of original pack dispensing using barcode scanning technology as a part of the robotic dispensing process can improve the accuracy of dispensing, but the same accuracy checking software could also be implemented at much lower capital cost without the use of robotic technology. Adoption of this type of technology to assist in safe dispensing of medicines may in some circumstances need the support of the NHS or Government intervention, for example, to ensure a standardised approach is taken by medicines manufacturers to labelling and bar coding of products.

PSNC was disappointed by the reduction in the scope of the NPfIT, when it moved from a broad programme aiming to support the expansion of primary care and harness community pharmacy's potential, to a modular approach, where the only element for community pharmacy has been the EPS.

Community pharmacy has however embraced other digital technologies to improve patient convenience and medication safety, for example online management of repeat prescriptions, the use of smartphone apps to alert patients when to take medication, or the use of text messages to communicate with patients. The sector has already demonstrated that it can use these technologies and it is willing to continue to do this in line with the rapid advancement of smartphone and mobile technologies.

IT market freedom needed: Learning from the previous experience of the NPfIT, PSNC believes it is important that the pharmacy and primary care IT market has freedom to develop relevant functionality for its customers. NHS England can support this approach by facilitating collaboration at a national level, for example by securing industry agreement on interoperability standards and the best way to implement them. In doing this, NHS England should again learn from the experience of NPfIT by ensuring there is wide stakeholder involvement throughout the process.

PSNC also suggests that NHS England should avoid imposing systems and solutions that are not yet evidenced, such as the much wider use of robotic dispensing technology.

Conclusion

England's community pharmacy teams already play a vital role in supporting the nation to remain healthy or manage disease when it develops. But there are many opportunities to enhance the already significant contribution to healthcare that community pharmacies make, maximising the benefits of the network of pharmacy locations across the country, near where people live, work and shop. Doing so will not only bring benefits for patients, commissioners and the health service as a whole, but we also believe it will be absolutely vital if the NHS is to have a sustainable future.

The pressures on the NHS are well documented and Ministers continue to make clear that in their view, the health service must make radical changes if it is to survive. A move to develop the community pharmacy service, so that pharmacies are empowered to help patients to get the most from their medicines; allowed to take responsibility for patients with long term conditions; incentivised to work collaboratively with other healthcare professionals towards the same patient outcomes for which everyone will be rewarded; and enabled to offer all patients advice on how best to lead healthy lifestyles and lead independent lives, could represent just such a radical change.

We have shown how these roles are supported by existing evidence for community pharmacy services and pilots, but the extended roles for pharmacy are also supported widely beyond the community pharmacy network. As examples of this, Diabetes UK in a statement prepared for the Call to Action states:

"Community pharmacies are easily accessible and better use can be made of them to support people with diabetes in the future - including pharmacies providing advice, medicine reviews and healthy living guidance to help people to better manage their medicines and their condition. Diabetes UK support such initiatives and would like to see them rolled out more widely to assess how pharmacies can best contribute to the integrated care pathway."

While Asthma UK similarly highlights the need for further community pharmacy involvement, stating:

"Over one fifth of people with asthma have told us they didn't get their inhaler technique checked in the last year, so it is clear that we need more advice and support to help people with asthma. Pharmacists can play a pivotal role here to educate patients, help them to understand how to get the best out of their medicines and to support them in using their self-management plans.

With the new commissioning environment in England, [community pharmacy] should play a greater, more central role in meeting the changing needs of people with asthma and becoming a key player together with other healthcare professionals. One important way is through implementing the NICE Quality Standards and we look forward to working closely with the profession to achieve this."

In this response we have outlined how the development of community pharmacy services across a number of important domains could help to improve patient outcomes and reduce pressures on other health services, and we have sought to find ways in which NHS England could achieve these changes. We have highlighted some of the obstacles to progress, such as resistance from other professionals and the complexity of commissioning arrangements, and we have detailed how NHS England could facilitate the greater contribution of pharmacy, by enhancing the range of national services commissioned via the CPCF, alongside greater local commissioning; by making pharmacies an integral part of all care pathways and granting them access to patient records; and by designing primary care contracts that ensure healthcare professionals are working together rather than competing with each other.

We hope that NHS England will be able to take many of these ideas forward, but we recognise that NHS England alone cannot be responsible for the radical changes we have proposed. Local government, Clinical Commissioning Groups and other local commissioners will have a role at a local level to facilitate the development of innovative

practice and the fostering of better relationships between pharmacists and all other healthcare professionals. But equally community pharmacy itself needs to demonstrate the ability to provide services to a consistently high quality in order to enhance its relationships with GPs and commissioners.

Everyone has a part to play, and as such PSNC is very keen to continue a close dialogue with NHS England on how community pharmacy can develop its services to better support the care provided by general practice and to benefit both patients and the NHS.

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.

Appendix 1 - PSNC's vision for community pharmacy

Recognising the challenges the NHS was facing and the need to significantly improve patient outcomes, 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.

Further information on PSNC's vision is available at psnc.org.uk/vision. In Appendix 2 we illustrate how this vision may be achieved by development of the range of services provided by community pharmacies.

Appendix 2 – The development of community pharmacy services to improve patient outcomes

In this Appendix we illustrate how community pharmacy services could be enhanced in order to improve patient outcomes and the wellbeing of the population.

Optimising the use of medicines and managing long term conditions

Community pharmacies in England safely and efficiently supply nearly one billion prescriptions each year, but as a consequence of the competent and efficient manner in which this service is undertaken its importance to patient outcomes and safety is often missed by those outside the profession.

However we also know that safely supplying a prescribed medicine to a patient does not necessarily provide sufficient support for the patient to use that medicine correctly and to gain the maximum benefit from it. In this Appendix we therefore describe PSNC's proposals for the development of medicines optimisation services within the CPCF and we describe how community pharmacies could collaborate with general practice teams to undertake the management of LTCs.

Enhancing the dispensing service

All pharmacies provide the dispensing service and building additional elements around this service to enable pharmacies 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, to ensure that the NHS spend on medicines is being used effectively, and to help patients to get the best outcomes from their medicines.

A range of enhancements could be developed, but one example which has been successfully 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 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. The use of such 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.

Developing community pharmacy's medicines optimisation services

The nationally commissioned NMS and the MUR service both support patients to optimise the use of their medicines and to get the maximum benefit from them. But although changes in recent years have targeted the MUR service towards priority groups of patients identified by the NHS, the two services still do not currently fit firmly within locally or nationally agreed care pathways for patients with specific LTCs.

The development of the medicines optimisation services within the CPCF could therefore start by focussing the provision of a proportion of MUR and NMS on one or more patient cohorts; we believe this approach could be quickly implemented within the CPCF.

As an illustrative 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. We have already seen the impact this could have as projects in which patients prescribed inhalers receive pharmacy medicines optimisation services focused on teaching them to use those inhalers properly have reduced deaths and hospital admissions caused by

asthma. For example, one study on the Isle of Wight in 2010 examined the effects of educating patients regarding the use of their medicines and the adoption of correct inhaler technique. Through the analysis of hospital data, it was seen that emergency admissions due to asthma fell by more than 50% over a three month period with resultant bed occupation days falling by a similar percentage. Additionally the numbers of asthma related deaths reported over the same time period were seen to have fallen by 75%.

This sort of approach may benefit from the registration of patients with an individual pharmacy to allow the management of the service by commissioners and appropriate funding flows to community pharmacies. 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.

With a registered patient cohort, it would also 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 be provided only 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 needed if pharmacies are 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. PSNC believes that adoption of such community pharmacy service developments can only be effectively implemented by commissioning services nationally from pharmacies working within a quality framework and meeting professional regulatory requirements.

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 by pharmacies. Currently, many long term conditions are managed in general practice by practice nurses. Diseases such as asthma, hypertension and type 2 diabetes are managed in line with the structured guidelines provided by NICE and other institutions. As noted earlier in this response, there is a need to release capacity in general practice to enable surgeries 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, such as the over 75 years age group. To create this capacity there is therefore a need for community pharmacies, in collaboration with GP 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 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; in the future these reviews could be undertaken in community pharmacy, thus freeing up capacity in the GP practice to undertake other LTC management.

Another example is the initial phase of hypertension treatment for people who have been diagnosed with the condition, but who have not yet developed other co-morbidities such as dyslipidaemias or type 2 diabetes. This group of patients could be managed primarily in the pharmacy using a share care agreement with the patient's GP practice. The agreement may include the practice taking back the lead on care of the patient if the patient were to at some point develop co-morbidities.

Other disease areas which may be similarly amenable to community pharmacy management include COPD, Parkinson's disease, hypothyroidism, type 2 diabetes and poorly managed pain. Any such approach to shared care between community pharmacy and general practice would of course require there to be absolute clarity on what the community pharmacy is responsible for providing and its accountability for patient outcomes. The national development of template shared care protocols for the most common LTCs would be a major enabler to implementing this type of care.

Applying this approach to patient care may also require a review of the suitability of the current routes by which pharmacists can amend the dose of prescribed medicines, or supply or prescribe an additional medicine to a patient.

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 historic 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.

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

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.

Supporting people to self-care

Community pharmacy's traditional role in supporting people to self-care for minor illnesses has always been 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 community pharmacies across England, which effectively act as healthcare walk-in centres where people, live, work and shop.

However, the network could be used to much greater effect and the ongoing promotion of pharmacies as a location to treat minor illness coupled with 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, potentially focussed on a restricted range of common ailments which would not require the attention of a GP, 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 could 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 all healthcare providers to examine how they can respond to the changing needs of their local population, including how they support people to live independently in their own homes.

Community pharmacies already provide a range of services to support people to live independently, 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 regimens;
- 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 regimens which may ultimately prevent or delay the development of complications from LTCs which eventually necessitate care in a hospital or care home.

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 in patients' homes. 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.

Supporting people to live healthier lives

As we highlighted earlier in our consultation response, it is important that all members of the primary care team ensure that they make every contact count when talking to patients. Community pharmacy is able to reach a significant cohort of people who do not regularly access their general practice, which presents an opportunity for more preventative interventions to be made to reduce people's risk of developing long-term conditions. By helping patients to look after themselves more effectively and stay healthy, the burdens on general practice and all other health services could be reduced and significant cash savings, for example through prevented hospital admissions, could be made.

All community pharmacies are already providing healthy living advice to patients as part of the public health element of the CPCF and other services commissioned by local authorities, NHS England's area teams and in some cases CCGs. These services may support health improvement or health protection and represent an important part of primary care's focus on wellbeing.

Some public health services are locally commissioned from community pharmacy in the majority of areas, for example emergency hormonal contraception (EHC) and supervised consumption of medicines to manage substance misuse. As we highlighted in our answer to question 1, where there is a widespread need across all areas for a specific service, we recommend that it should be considered for commissioning from all community pharmacies via the national CPCF. This approach can provide consistency of access for patients and the public and also reduce local bureaucratic burdens on commissioners and providers alike.

PSNC also believes that 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 private basis, with extremely positive patient feedback reported for many of these services. There is also evidence of community pharmacies being able to increase vaccination rates in at-risk groups, where the service is commissioned by the NHS over and above the incumbent NHS provision by GP practices.

For example, in 2012/13 community pharmacies in Sheffield were commissioned to provide NHS flu vaccinations, with a particular focus on groups who were missing out on vaccinations, such as hard to reach at-risk 18 to 65 year olds. Of the 573 patients vaccinated in Sheffield pharmacies:

- 290 patients chose to use a pharmacy for the vaccination because of convenience;
- 17% of patients were vaccinated for the first time;
- 93 patients would not have been vaccinated if it had not been offered by pharmacy; and
- 99% of those vaccinated considered the service provision good or excellent.

Expanding the primary care vaccinator workforce, by greater use of community pharmacy, could also support other immunisation programmes, such as childhood vaccinations and programmes introduced during flu pandemics.