All PSNC members can attend this meeting and may speak with the permission of the Chairman.

# PSNC Service Development Subcommittee Agenda

# for the meeting to be held on Wednesday 8th October 2014

# At RCGP, 30 Euston Square, London, NW1 2FB

# starting at 9am

**Members:** Stephen Banks, Ian Hunter, Clive Joliffe, Clare Kerr, Indrajit Patel, Gary Warner (Chairman)

## 1. Apologies for absence

No apologies for absence have been received at the time of setting the agenda.

## 2. Minutes

The minutes of the meeting held on 8th July 2014 were shared with the subcommittee.

## 3. Matters arising

## 4. Work Plan

The 2014 work plan, including progress updates, is set out at **Appendix SDS 02/10/14 (pages 8-13)** for consideration by the subcommittee.

## ACTION / RATIFICATION

## 5. Supporting carers in community pharmacies

Support for carers is a high priority for DH and NHS England and it has recently been the focus of political attention, including commitments for greater support of carers being made by Andy Burnham at the Labour Party conference. PSNC has been working with Carers Trust over the last year to develop a project to test carer identification within community pharmacies and Clare Kerr is a member of an NHS England group examining how that organisation can provide more support to carers.

An update on carer support in community pharmacies is set out at **Appendix SDS 03/10/14 (pages 14-16)** for consideration by the subcommittee. This comprises an update on progress with the Carers Trust project and extracts from a paper prepared by Clare Kerr on services community pharmacies can provide to support carers, which was presented to the NHS England group referred to above. Clare will provide a verbal update on the work of this group at the meeting.

The subcommittee is asked to review the elements of support that community pharmacies can provide to carers detailed in the paper and to suggest any additions that may be appropriate. The subcommittee will also be asked to discuss how this work should be taken forward in the short and medium term.

## 6. Criteria to assess and prioritise services for national development

Following the discussions at the last meeting of the subcommittee, further work has been undertaken by the Chair and Vice Chair of the subcommittee to refine the criteria that were proposed for assessing and prioritising services for national development. A suggested approach is set out at **Appendix SDS 04/10/14 (pages 17-18)** for consideration by the subcommittee.

In particular the subcommittee is asked to consider:

a) Whether there are additional criteria we could use to priorities service opportunities?
b) Whether they would suggest amendment or deletion of any of the existing criteria?
c) The scoring mechanic which has been proposed for each criteria. Are they appropriate? Should the final criteria on distance selling pharmacies be scored?

A long list of services that could be provided by community pharmacies was collated following the discussions at the July 2014 meeting of SDS; this is set out at **Appendix SDS 05/10/14 (pages 19-20)** for information. Once the subcommittee has agreed criteria for assessment and prioritisation of service opportunities, these can be applied to the long list of services in order to inform our development plans for the year ahead.

## REPORT

### 7. Providing more service development support

Rosie Taylor joins PSNC as Pharmacy and NHS Policy Officer on 6th October 2014. Her initial focus will be on populating the new services database in order to provide an up to date resource for LPCs and contractors which provides examples of services that can be utilised elsewhere in the country. Once this initial phase of work is complete the focus will turn to keeping the information in the database current and mining the information in order to provide resources for LPCs that can fast track service development and implementation at a local level.

Following discussions at the May meeting of RDF on staffing for service development, PSNC and the Sunderland School of Pharmacy have agreed to collaborate in the appointment of a Senior Lecturer post within the university, also supported by Health Education North East (HENE). The job description is included at **Appendix RDF 06/10/14**. The focus of the role is to support the development of the evidence base for community pharmacy services, including working with LPCs across the North East and in other areas of the country.

### 8. Update on negotiations with NHS Employers

Final agreement on the service changes within the CPCF was reached with NHS Employers, NHS England and DH in September and an announcement on the funding package and contract changes was made on 22nd September. Information on the service changes has been published in PSNC Briefings 015/14 and 016/14. Discussions are continuing with NHS Employers on the outstanding detail on the emergency supply audit. The existing PSNC/NHS Employers guidance documents on MUR, NMS and clinical governance are all being updated.

### 9. Urgent Care

In late August Monitor and NHS England published a discussion document containing proposals on reimbursement of urgent and emergency care. The organisations sought views from interested parties, so a PSNC submission was sent to them setting out how community pharmacy services could be commissioned in order to support other urgent and emergency care providers. The submission is set out at **SDS 07/10/14 (pages 24-27)** for information.

In order to support shared learning by LPCs within the Prime Minister's Challenge Fund areas, a teleconference has been arranged to allow those LPCs that wish to participate to discuss progress on the project at a local level. Key points on current activity in the sites will be fed back to SDS at a future meeting.

### 10. Any other business

**Appendix SDS 02/10/14**

## 2014 Work Plan for the Service Development Subcommittee

The 2014 work plan for the Service Development subcommittee covers all items agreed at the November 2013 planning meeting.

Key for RAG coding
Red – needs attention / not started / high risk
Amber – underway / in progress
Green – completed / no further attention

| Target Plans | Target date | Comment / Update on progress | R/A/G |
|---|---|---|---|
| In 2014 PSNC will seek to:<br>• implement its Vision for community pharmacy by:<br>  ○ influencing the development of NHS England's plans for primary care, ensuring that they include a substantial and central role for community pharmacy (with LIS);<br>  ○ negotiating a framework for the development of the services within the CPCF with NHS England (with FunCon);<br>  ○ collaborating with LPCs and others to build the evidence base for existing and prospective community pharmacy services, including the value of the services to patients and commissioners (with LIS);<br>  ○ ensuring developments in technology support the effective provision of pharmacy services;<br>  ○ working to ensure that regulations and their administration support the effective provision of pharmacy services.<br>• develop stronger and productive relationships with NHS England and Public Health England (with FunCon and LIS)<br>• promote adoption of standardised service commissioning (with LIS);<br>• support LPCs to increase local commissioning of community pharmacy services (led by LIS). | | | |
| 2) Use speaking or other opportunities at healthcare conferences, seminars and other events to promote the use of community pharmacy services. | Ongoing | Speaking opportunities are regularly sought in order to promote community pharmacy services to external audiences. | Amber |
| 3) Following the completion of NHS England's primary care framework development work, negotiate with NHS England a framework for the development of the services within the CPCF, in line with PSNC's Vision. | Commence in June | NHS England is aiming to publish its 5 Year Forward View in October. It is not clear whether this will encompass its strategy for primary care. | Amber |
| 4) Work in partnership with Carers Trust to support the | Commence | Carers Trust has been funded by DH to undertake a range of actions to improve | Amber |

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| testing of carer identification and support in community pharmacies, in order to develop the evidence for community pharmacy services. | in January | the ability of primary care professionals to provide support for unpaid carers. This part of that work is intended to be a one year project to explore the development of a 'Carer Friendly Pharmacy' concept, involving LPCs and Carers' Centres working together, with an evaluation undertaken by the University of Leeds. A draft description of the project was set out in the January 2014 SDS papers for information. Expressions of interest in participating in the project have been received from ten LPCs. Carers Trust has appointed a project manager for the project. An additional smaller project is also underway to examine the needs of young carers; this is being undertaken in Salford. A meeting to report on progress with the project was held with DH in June. An update on the project is set out in the October 2014 SDS agenda. | |
| 5) Develop and submit to NHS England the case for the national commissioning of a seasonal flu vaccination service from community pharmacies. | February | Preliminary work that will support a proposal to NHS England was undertaken (development of a new service specification, SLA and supporting paperwork) as part of work to support urgent and emergency care services during winter. PSNC organised an event for LPCs on flu vaccination in March to share learning from the previous season and to highlight the benefits of taking a standard approach to commissioning the service to NHS England and PHE (who both had officials in attendance).<br>Due to capacity constraints in the office it has not yet been possible to develop the proposal. Information on progress with local commissioning for 2014/15 was collated by the Regional Reps in time for the July meeting.<br>A meeting of the APPG has been called in October to examine the future approach to commissioning of flu vaccination services. | Red |
| 6) Develop and submit to NHS England the case for the national commissioning of a minor ailment service from community pharmacies. | June | Preliminary work that would support a proposal to NHS England was undertaken (development of a new service specification for a winter ailments service, SLA and supporting paperwork) as part of work to support urgent and emergency care services during winter.<br>From informal discussions with NHS England it is anticipated that they may, as a follow on from the Call to Action, seek to develop a business case for MAS that will be promoted to CCGs. As a result of this information, at its July 2014 meeting, the SDS subcommittee decided to de-prioritise this work. A recent presentation given by Keith Willett (NHS England Director for acute episodes of care) has suggested the organisation may be considering national | Amber |

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| | | commissioning of MAS. | |
| 9) Seek opportunities to work in partnership with other organisations to test community pharmacy provision of asthma management, in order to develop the evidence for community pharmacy services. Initiate work on a pilot service with partners if a suitable site can be identified. | October | Two areas have already expressed interest in working with PSNC on this and the likelihood of support from pharma industry companies has also been indicated in exploratory conversations. At the May 2014 SDS meeting it was agreed that the recent RCP report on asthma deaths presented an opportunity to re-prioritise this element of the work plan. A response to the RCP report has been developed and sent to the RCP lead. A meeting has also been held with an LPC and consultant pharmacist to discuss the results of their joint work on asthma management and the potential for this to be built on in another CCG area.<br>A PSNC seminar and dinner in October, focussed on asthma management has been organised.<br>A meeting with Dr Mark Levy (RCP lead on the NRAD) was held in August at which he provided useful advice on how PSNC could progress its proposals. | Amber |
| 10) Seek opportunities to work in partnership with other organisations to test community pharmacy provision of hypertension management, in order to develop the evidence for community pharmacy services. Initiate work on a pilot service with partners if a suitable site can be identified. | December | Support to develop this concept has come from the DDA and they have already indicated an interest in collaborating on testing the concept. An article written by the DDA CEO and Chairman has been published in the British Journal of General Practice promoting the concept of pharmacist management of hypertension. A follow up meeting with the DDA is being arranged to discuss joint work that may be undertaken on this issue.<br>LPCs have been asked to identify CCGs that may be willing to trial pharmacist management of hypertension. | Amber |
| 11) Seek opportunities to work in partnership with other organisations to test community pharmacy provision of diabetes management, in order to develop the evidence for community pharmacy services. | December | Initial discussions have been undertaken with Devon LPC and a pharmaceutical company, as they may both be interested in collaborating with PSNC on this matter. The concept has also been explored in discussions with Diabetes UK. | Amber |
| 15) Work with the RPS and other partners to develop or locate a suitable assessment tool which can be used by pharmacy teams to assess the adherence support needs of patients. | December | The outline plan for this project has been discussed with the RPS and other stakeholders that need to be involved have been identified. The Scottish RPS are exploring whether an existing assessment tool developed in Scotland may be suitable for wider use. | Amber |
| 22) Review the nationally agreed substance misuse template service specifications and seek agreement of Public Health England to endorse and promote the revised | June | Due to capacity constraints in the office it has not yet been possible to undertake this work. It was agreed at the July 2014 subcommittee meeting that | Amber |

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| documents. | | this work would be de-prioritised. | |
| 23) Work with Public Health England to review the service requirements for pharmacy provided stop smoking services. | June | PSNC is a member of the working group on the issue formed by PHE. Barbara Parsons has attended the PHE Pharmacy Commissioning Workshop and work from the group will inform future action by the PHE Tobacco Policy Team. Barbara has developed referral pathways in and out of pharmacy for inclusion in proposed PHE guidance. | Amber |
| 24) Develop a business case and supporting documents on Blood-borne virus testing and Hepatitis B vaccination for LPC use. | March | This work will be carried out in collaboration with HIE/Pinnacle Health Partnership (PHP). A draft business case has been developed by PSNC for blood-borne virus testing and is being finalised with data provided by PHP. | Amber |
| 25) Develop a business case and supporting documents on the NHS Health Check service for LPC use. | April | This work will be carried out in collaboration with HIE/Pinnacle Health Partnership. The draft business case has been developed by Barbara Parsons and is being reviewed by the office and Pinnacle Health. | Amber |
| 26) Develop a business case and supporting documents on EHC and other sexual health services for LPC use. | May | This work will be carried out in collaboration with HIE/Pinnacle Health Partnership. It was agreed at the July 2014 subcommittee meeting that this work would be de-prioritised. | Amber |
| 27) Develop a business case and supporting documents on stop smoking services for LPC use. | June | This ongoing work will be carried out in collaboration with HIE/Pinnacle Health Partnership and is linked to the work being undertaken with PHE (see 23). Due to capacity constraints in the office it has not yet been possible to progress this work. | Red |
| 28) Review all LPC websites and other sources of information on locally commissioned community pharmacy services to find content to populate the new PSNC services database. | March | The LPC website review has been completed, and information is filed and available. Population of the services database will be undertaken by the Rosie Taylor when she commences as Pharmacy and NHS Policy Officer in early October. | Red |
| 29) Once the initial population of the PSNC services database is complete, create a report that details the services commissioned in each LPC area to support a regular review of the services data within the database and national level monitoring of local service commissioning. | May | The reporting fields have been agreed and preliminary discussions have taken place with JellyHaus. This work will be taken forward once the new services database has been populated. | Amber |
| 1) Submit a robust response to NHS England's Call to Action on community pharmacy and any other elements of their work to define future plans for primary care. | March | PSNC's response to the CTA was submitted in March. The key messages in the response have been summarised into a document which is being used to lobby parliamentarians and has been made available to LPCs for use at a local level. | Green |

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| 7) Develop and submit to NHS England and Public Health England the case for the national commissioning of an EHC service from community pharmacies. | November | This activity was intended to allow PSNC to assess the willingness and ability of the two bodies to collaborate on national commissioning of public health services in the current commissioning environment, where local government is the lead commissioner. The concept of national commissioning of this service was recently discussed with the Director of Health and Wellbeing at PHE, who said it would not be a realistic proposition in the current commissioning landscape. It was agreed at the May 2014 meeting of SDS that no further progress on this item could sensibly be made this year. | Green |
| 8) Identify external barriers to community pharmacy service commissioning and seek to develop strategies to address these blocks. | May | This issue was discussed at the May meeting of the subcommittee and it was concluded that the development of more business cases and supporting documents, as per the SDS work plan was the most effective way that PSNC could support LPCs and contractors in securing more locally commissioned services. | Green |
| 12) Consider the option of piloting the national use of a small number of STOPP or similar indicators within the dispensing service, as a way to build the evidence base for future commissioning by NHS England. Implement if the concept is agreed. | August | The CPF project provides some evidence of the benefit of the application of STOPP or similar indicators. The matter was discussed at the July 2014 meeting of SDS and it was agreed that this proposal would not be taken forward. | Green |
| 20) Develop and consider proposals on how the sector can gather evidence to support service development. Implement any subsequently agreed plan. | May | This was discussed at the May 2014 SDS meeting, as part of the agenda item on external blocks to commissioning services. The approach to gathering evidence set out in the agenda papers, which described the new role of the Pharmacy and NHS Policy Officer, was accepted as the best way in which PSNC could support this area of work. | Green |
| 21) Review the support community pharmacy can provide to support people to live independently, and agree actions that PSNC can take to develop this area of service provision. This work will include a review of options for the provision of adherence support by community pharmacies, including appropriate use of MDS. | July | The matter was discussed at the special SDS meeting on 7th June 2014. The ideas developed at that meeting will feed into the November planning meeting. | Green |
| 13) Work with NHS England and other partners to support the wider adoption of the NHS repeat dispensing service. | May | An agreement on changes to repeat dispensing was reached and announced in September 2014. A summary of the agreed changes is set out in PSNC Briefings 015/14 and 016/14. LIS will lead on support for implementation of the change. | Green |

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| 18) Work with NHS England and NHS Employers to finalise the details of the agreement to increase patient safety incident reporting by contractors and support contractors to implement these requirements. | February | An agreement on changes to PSI reporting was reached and announced in September 2014. A summary of the agreed changes is set out in PSNC Briefings 015/14 and 016/14. LIS will lead on support for implementation of the change. | Green |
| 19) Work with NHS England and NHS Employers to finalise the details of the agreement to increase the targeted percentage of MURs and national collation of data, then support contractors to implement these requirements. | February | An agreement on changes to MUR targeting was reached and announced in September 2014. A summary of the agreed changes is set out in PSNC Briefings 015/14 and 016/14. LIS will lead on support for implementation of the change. | Green |

**Appendix SDS 03/10/14**

# Providing support for carers

Carers are people who, without payment, provide help and support to a partner, child, relative, friend or neighbour who could not manage without their help. Support for carers is a high priority for DH and NHS England and it has recently been the focus of political attention, including commitments for greater support of carers being made by Andy Burnham at the Labour Party conference.

PSNC has been working with Carers Trust over the last year to develop a project to test carer identification within community pharmacies. Another Carers Trust project is examining the specific support needs of young carers, working with a number of pharmacies in Salford and the local Carer Service; PSNC and CPPE are participating in the advisory group for this project.

Alastair Buxton is a member of an RCGP group which coordinates the work of a wide range of patient groups and professional organisations in order to provide support to primary care professionals and commissioners on carer support.

NHS England recently published its Commitment to carers, which includes 37 commitments the organisation has decided to implement. Clare Kerr is a member of the NHS England group considering how the commitments can be implemented.

## The Carers Trust project

Carers Trust approached PSNC about a year ago seeking to work with us on a project to test the concept of carer identification and support in community pharmacies. This followed similar work that had been undertaken by the RCGP with GP practices. This work and the Carers Trust project are funded by DH monies that originated in the carers strategy.

Carers Trust identified 9 local carers services that wished to take part in the project and PSNC sought the involvement of the relevant LPCs (Humber, Lancashire, East Sussex, Northamptonshire, Gateshead and South Tyneside, Kent, Devon, West Yorkshire and Bury, Heywood, Middleton & Rochdale).

CPPE have developed a 90 minute training workshop which will be used in each site to train pharmacy staff on carer identification and support. In each area, around 5 pharmacies will work with the local Carer service to identify carers and refer them to the local carer service and / or their GP practice. Promotional materials and documentation have been developed for use by the pharmacies and data collection on identified carers and referrals will be undertaken using PharmOutcomes. The University of Leeds will evaluate the project as part of a wider evaluation of a range of DH funded carer support projects. Pharmacies will commence the active phase of the project in November 2014.

From PSNC's perspective, it is hoped that the project demonstrates that community pharmacies can identify carers and refer them on to other sources of support and that this can provide the evidence base for commissioned services.

## Other community pharmacy support for carers

There is a wide range of existing community pharmacy services which could be 'marketed' to carers in order to support them in their work. There are also services such as MUR which may be of benefit to carers, but which would need to be modified to suit their specific needs.

Clare Kerr recently presented a paper to the NHS England group charged with implementing the Commitment to carers and the following table is extracted from that paper. It details a range of

options that community pharmacies can or could provide to support carers. These could be developed into a variety of support tools both for carers and community pharmacy teams

| Topic | Rationale |
|---|---|
| Managing medicines | |
| Ordering and collecting repeat prescriptions | To ensure carers understand the help and support community pharmacy can provide when managing medication. Repeat prescription collection services can help to ensure they never run out of medication. |
| Electronic prescription service | EPS can help to make life even simpler as the carer doesn't have to go to the GP practice to pick up a paper prescription. |
| Prescription delivery services | Carers may have difficulty in getting out to the pharmacy due to their care and work responsibilities. Many pharmacies offer delivery services that can take the hassle and worry away. |
| Giving medicines to patients<br>• Label instructions<br>• When to give<br>• How to give<br>• What to do if a patient has difficulty taking medicines<br>• Dealing with devices – inhalers, eye drops etc. | Carers find themselves in a position of having to support patients with their medicine taking and this could also include administering medicines.<br><br>Community pharmacy can support carers to ensure they know how to do this safely and accurately ensuring the patient gets maximum benefit and that the carer feels confident in handling the medicines.<br><br>Topics covered would include:<br>• Importance of reading label instructions<br>• Time of day to give medication<br>• Ensuring important instructions are followed e.g. after food<br>• Advice on what to do if patient can't swallow the medicine, e.g. is there a liquid alternative?<br>• Advice on how to administer medicines in devices – how to administer eye drops, correct inhaler technique, how to apply creams and lotions<br>• Support tools to aid adherence to medicines |
| Medicines Use Reviews | Opportunity for the patient to find out more about their medicines.<br><br>Currently MURs cannot be delivered to carers, unless the patient is also present. A version of a MUR could be developed to support carers. |
| New Medicine Service | Ensures the patient understands why they have been given a new medicine and is clear on how to take it. |
| Recognising red flags | Advice on how to identify potential side effects from medicine and actions to take.<br><br>How to recognise deterioration of symptoms e.g. COPD exacerbation and actions to take.<br><br>Both of these actions could help prevents emergency admissions. |
| How to store medicines safely | To ensure carers know how to store medicines safely and |

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| | advice on what to do if medicines need to be stored in certain environments, e.g. fridge. |
| Using OTC medicines safely | How to deal with common ailments. Advice on ensuring the medicine you buy OTC is safe to take with the patient's existing medicine regimen. |
| Out of date medicines and disposing of medicines safely | Advice on keeping track of expiry dates on medicines, including medicines that have a short expiry date once opened. Advice on how to dispose of medicines safely in the pharmacy.<br><br>Could also include a review of why the medicine is being disposed? |
| Young carers and medicine supply | Considerations to take into account should a young carer have to collect medicines from a pharmacy. |
| **Other services/advice** | |
| Flu vaccinations | Many pharmacies offer flu vaccination services – when caring for someone important to protect yourself against illnesses such as flu. |
| Stop smoking services | Stopping smoking will improve health and hopefully help to make a person have more energy. |
| NHS Health Checks | Available in a number of pharmacies – helps to provide an overview of current health and how to improve. |
| Access to general health advice | All pharmacies provide a range of leaflets that can support carers in making healthy choices. A number of pharmacies also provide support with regards to diet and exercise, weight management and alcohol intake. |
| Recognising when a patient is in pain | In some situations patients can have trouble communicating with their carer, so cannot tell them they are in pain. Recognising when someone may be in pain is important in order to help them relieve that pain and be more comfortable. |
| Falls prevention | A number of medicines can contribute to the risk of a patient falling – pharmacists can provide advice on how to reduce this risk and potentially suggest alternatives if they are available. |

**Appendix SDS 04/10/14**

## Criteria to assess and prioritise services for national development

These criteria have been developed by PSNC's Service Development Subcommittee in order to support the systematic assessment of community pharmacy service development opportunities. The focus of the assessment is identifying services that may be candidates for inclusion in the national CPCF, but it may also highlight prospective services that could usefully be commissioned at a local level.

| **Strategic fit with…** | **Scoring mechanic** |
|---|---|
| NHS policy | 1 = low, 5 = medium, 10 = high |
| Government policy | 1 = low, 5 = high |
| Existing services in the CPCF | 1 = low, 5 = medium, 10 = high |
| PSNC vision | 1 = low, 5 = high |
| | |
| **Funding** | |
| Likely funding opportunities can be identified | 1 = low, 5 = medium, 10 = high |
| Provides sufficient value and impact to the NHS | 1 = low, 5 = medium, 10 = high |
| | |
| **Evidence base** | |
| Evidence already exists showing the service will add value to patients / the NHS | 1 = no evidence, 5 = some evidence, 10 = significant evidence |
| Assessment/toolkits used in service are evidence based | 1 = no evidence, 10 = significant evidence/not applicable as no assessments/toolkits used in service |
| Development of further evidence required | 1 = further evidence required, 5 = some further evidence required, 10 = no further evidence required |
| | |
| **Service development and design** | |
| Does the service already exist? | 1 = new, 5 = exists |
| Duplication with other service providers | 1 = duplicates, 5 = complements |
| Capacity within PSNC to develop the service / proposal | 1 = resource intense, 5 = minimal resource required |
| Requires input from other organisations | 1 = requires partners, 5 = standalone |
| Requires specific equipment for provision of the service | 1 = expensive equipment, 10 = inexpensive equipment or none required |
| | |
| **Engagement** | |
| Are there risks concerning pharmacy security or vulnerability | 1 = high risk, 5 = low risk |
| Insurance or liability issues | 1 = insurance implications, 10 = covered by existing |
| Perceived contractor willingness to deliver | 1 = Unwilling, 5 = Willing |
| Perceived pharmacist/team willingness to deliver | 1 = Unwilling, 5 = Willing |
| Likelihood of other healthcare professionals engaging | 1 = Unwilling, 5 = Willing |
| Does it build pharmacy's reputation or is there reputational risk | 1 = reputational risk, 5 = builds reputation |
| | |
| **Operational issues** | |
| Is patient recruitment by referral or by pharmacy identification? | 1 = relies on referral, 3 = willing referral from other HCP, 5 = pharmacy recruitment/ identification |
| Operational ease of delivery | 1 = operationally intense, 5 = operationally easy |

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| Requires service provision off the pharmacy premises | 1 = yes, 5 = no |
| Service can be provided by the wider pharmacy team | 1 = no, pharmacist only, 5 = yes, wider team can provide |
| | |
| **Training and development** | |
| Suitable for self-assessment | 1 = unsuitable, 5 = suitable |
| Requires formal accreditation | 1 = requires accreditation, 5 = does not require accreditation |
| Requires formal training | 1 = requires training, 5 = does not require training |
| Significant skill gap identified in workforce | 1 = significant gap, 5 = knowledge gap minimal |
| | |
| **National versus local** | |
| Does the service provide a solution for a national issue | 1 = no, 10 = yes |
| Is the service more suitable for local commissioning | 1 = local only, 5 = scalable |
| | |
| **Technology** | |
| Is there a dependency upon pharmacy IT system developments | 1 = yes, 5 = no |
| Is there technology available that could support provision of the service, e.g. app for patients? | 1 = no, 5 = yes |
| | |
| **Dependency on Current or Future External Factors** | |
| Is the development dependent upon access to SCR or GP record? | 1 = Yes, 5 = No |
| Are any regulatory changes required | 1 = Yes, 10 = No |
| | |
| **Are distance-selling contractors able to provide the service?** | |

**Appendix SDS 05/10/14**

# Long list of possible services developed at the July meeting of SDS

## Current and future community pharmacy service portfolio

Some services could appear in more than one domain, but for simplicity they have been allocated to one domain only.

| Medicines optimisation | Self-care | Public health/Wellbeing | Independent living |
|---|---|---|---|
| EPS R2 Repeat dispensing<br><br>MUR<br><br>NMS<br><br>MUR / NMS from 'all' pharmacies for specific patient groups<br><br>MO support for carers/parents<br><br>Full clinical medication review<br><br>Adherence assessment (Morisky and PMR data)<br><br>Longitudinal support via MUR/NMS combi-service for registered patients<br><br>Specific disease support or 'full' management:<br>• Asthma<br>• COPD (incl. Rescue packs)<br>• Hypertension<br>• Hypothyroidism<br>• Parkinson's<br>• Diabetes<br>• Pain management<br>[potentially using independent prescribing]<br><br>MO support for 'complex' patients being managed by | Minor Ailments service<br><br>Winter Ailment service<br><br>Management of hayfever<br><br>Urgent care triage using a pharmacist prescriber<br><br>First aid / minor injuries (+ AED)<br><br>Sharps disposal<br><br>Wound management<br><br>Extended opening hours to support medical OOH services<br><br>Mental health counselling<br><br>'Health Translator' for patients | Public health campaigns – linked to PHE and patient group campaigns, e.g. Cancer awareness/early identification<br><br>Flu vaccination<br><br>Other vaccinations<br>• Childhood<br>• Travel (some may not be NHS funded)<br>• Hepatitis<br>EHC<br><br>Supervised consumption<br><br>Needle and Syringe Programmes<br><br>Stop smoking<br><br>'Screening' services (with associated advice and referral where required):<br>• Chlamydia<br>• Dementia<br>• Diabetes<br>• Hepatitis<br>• HIV<br>• Hypertension<br>• Syphilis<br>• Alcohol use | Collection and Delivery<br><br>Adherence support – assessment of need and then provision of support:<br>• Compliance charts<br>• MAR charts<br>• MDS (with pre-assessment)<br>• Electronic reminder devices<br>• Reminder Apps<br>Provision of telehealth 'devices'<br><br>Reablement services<br><br>Domiciliary MUR / other medication review<br><br>Falls risk assessment and reduction – Frailty assessment<br><br>Provision of home assessment checklists and referral to further support<br><br>Carer identification, needs assessment and support services<br><br>Carer Health Checks<br><br>Provision of living aids |

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| GP or 2° care<br><br>STOPP/START and other safety / prescribing quality indicators<br><br>Care home support (possibly using phc ind prescribers)<br><br>Emergency supply<br><br>Anticoagulant monitoring<br><br>Gluten free food supply<br><br>Phlebotomy service<br><br>End of life care (including support for carers)<br><br>Medicines support for schools<br><br>Supervised consumption (non-substance misuse) e.g. severe and enduring mental health conditions<br><br>Not dispensed service<br><br>Provision and setup of Adherence Apps<br><br>MO services fitting in to a wider care plan for the patient<br><br>Assessment of clinically optimum treatment<br><br>Support with use of devices, e.g. inhalers<br><br>Review of meds returned for disposal<br><br>Repeat medicines synchronisation<br><br>Identify generic medicines optimisation services that could form modular parts of care plan for the majority of patients | | • Vitamin D deficiency<br>• Osteoporosis<br>• NHS Health Checks<br>Dementia case finding<br><br>Case finding services:<br><br>• COPD<br>• Hypertension<br>• Type 2 diabetes<br>Weight management (could be targeted at high risk groups, e.g. diabetes)<br><br>Exercise referrals and coordination of community exercise, e.g. walking groups | Nutrition support for older people<br><br>Hearing checks/care |

**Appendix SDS 07/10/14**

# Response to Monitor/NHS England consultation - Reimbursement of urgent and emergency care discussion document on options for reform

**How could community pharmacies help meet urgent and emergency care needs?**
Community pharmacies can deal speedily and efficiently with the needs of many patients presenting at Emergency Departments or seeking urgent GP appointments, releasing and expanding capacity to deal with more serious and urgent cases.

Patients can be referred to participating local pharmacies under agreements to provide a range of services, including:

- Emergency supply of prescription only medicines at NHS expense to avoid patients requesting supplies via GP out-of-hours (OOH) services and Emergency Departments where the patient has run out of their regular medicines.
- Supply of Emergency Hormonal Contraception in order to allow NHS 111, GP OOH services and Emergency Departments to refer all patients requesting this to local community pharmacies.

Additionally, patients reporting symptoms that can be managed by advice and non-prescribed medicines can also be referred to pharmacies to access a Minor Ailments Service, which involves providing advice on the management of minor conditions and the supply of appropriate over-the-counter or prescription only medicines in line with locally agreed treatment guidelines.

In addition community pharmacies could be commissioned to provide First Aid/minor injury services to support management of minor injuries and avoid unnecessary use of Emergency Departments. This service could include the location of Automatic External Defibrillators at or near to community pharmacies, where staff trained in their use would be present during opening hours.

Further details on these services, examples of where they have already been commissioned and evaluations of the impact of the services can be provided on request.

**How could this be commissioned?**
These services could be commissioned separately, but for maximum impact they would be commissioned as a bundle of services from a range of pharmacies, ensuring good geographical spread and extended opening hours.

Template service specifications and associated supporting documentation have already been developed for the individual services and these could be combined into a suite of documents to support efficient commissioning of these services.

Community pharmacies already make extensive use of web-based patient and service records which can facilitate electronic referrals to and from community pharmacies and support the provision of real time activity and quality data for commissioners.

**How could a funding system be structured?**
We believe the payment model proposed in the discussion document, made up of an element of fixed core funding and a proportion of volume-based funding would be an effective means of funding a bundle of community pharmacy services as described above.

A specified volume of service delivery would be covered by the fixed core funding, with service provision above that level being funded via the volume-based element. Reimbursement for the cost of medicines

supplied in any of the service elements could be funded over and above the fixed and volume-related funding, or it may be possible to include this as an integral element of that funding

The service bundle should be commissioned for a duration that provides sufficient ongoing certainty of funding to allow pharmacy contractors to invest in building staff capacity and skills sufficient to deliver the services. We suggest that this should be a minimum three year term.

We believe that this approach to funding the service bundle would be attractive to community pharmacy contractors and would therefore provide commissioners with a wide range of locations at which services can be provided.

The payment system should drive care delivery to the most appropriate setting and encourage collaborative working and as such we believe it would be important that the payment approach used for other urgent and emergency care service providers incentivises them to refer appropriate patients to community pharmacy. This would make best use of the skills and capacity of staff in all urgent and emergency care providers and would drive best value for commissioners.

**How else might community pharmacies help manage demand on urgent and emergency care services?**
Better use of the following services within the national NHS Community Pharmacy Contractual Framework (CPCF) could also release capacity in other urgent and emergency care settings:

- Provision of the NHS Medicines Use Review (MUR) service for patients presenting to NHS 111 and other urgent care services with medicines related queries; and
- NHS Repeat Dispensing service - the wider use of this service by GP practices would help reduce the number of out-of-hours patient requests for prescriptions where the patient has run out of their regular medicines.

Community pharmacy can also help patients to avoid use of urgent and emergency care services, as a result of improved management of long term conditions. This includes wider use of the following community pharmacy services:

1. Medicines optimisation services such as the NHS New Medicine Service (NMS) and the MUR service which support people, particularly those taking high risk medicines and with respiratory disease, to get the most benefit from their therapy;
2. Provision of rescue packs for COPD and other at risk patients, allowing them to quickly commence treatment in their own homes when they suffer from an acute exacerbation of their condition;
3. Falls reduction services focussed on reducing the risk that a patient's medicines can predispose them to falls and provision of more general advice to reduce the risk of falls;
4. Re-ablement services, post-discharge MURs and post-discharge medicines reconciliation services to support people to use their medicines safely and effectively following discharge from hospital, thereby reducing the likelihood of re-admission to hospital.

**Response to the questions posed in the consultation document**

**Questions for engagement on the inclusion of the different payment elements and establishing system-wide accountability**

**1. Taken together, would the elements of the potential new payment approach improve patient outcomes, promote efficient use of resources and allocate risk in a way that supports delivery of the UEC vision?**

A mixed payment system, comprising a fixed element and some recognition of marginal cost through a variable payment applying after an initial activity threshold, is appropriate to match payment to underlying costs (minimising risk to both parties) and to incentivise availability of provider capacity. This could be front loaded as an incentive to encourage new provision. The stated objectives can be achieved if the system of incentives can be designed to ensure patients are treated in the most appropriate setting and that system wide gains are reinvested.

**2. a) How can we best use the payment system to establish system-wide accountability for risks and rewards for activity, costs and outcomes?**

The payment system needs to be designed to encourage care delivery in the most cost-effective setting. The implication is that when this occurs a surplus may be earned by the provider and when it doesn't a loss may be the result. This differential or 'shared ownership' across providers may be sufficient to ensure effective referrals but an explicit benefit sharing arrangement may be needed as part of the package depending on how payment levels are set.

**b) What are the main risks/complications for this type of system-wide accountability?**

There are risks around providing system wide incentives but these can be mitigated to some extent by implementing effective information systems and monitoring behaviours and outcomes carefully. It needs to be recognised that the desired change may be disruptive and affect multiple accounting periods.

**Questions for engagement on combining the payment elements and determining the fixed core funding requirement**

**4. What are the pros and cons of combining the payment elements through a Type A, Type B or any other approach that we should consider?**

The introduction of appropriate incentives is vital to ensuring the system operates effectively to drive the desired change over time. Option B may pose some risks to commissioner budgets in the short term but will result in a better long term outcome if the funding and benefit sharing arrangements are sufficient to cover provider risk, drive care delivery to the most appropriate setting and encourage collaborative working.

**5. What are the pros and cons of determining the fixed core funding element through using capitation, expected activity, planned capacity or any other approach we should consider?**

The difficulty of demand forecasting in this context may frustrate the development of accurate 'capitation' payments and 'planned capacity' requires effective understanding of inputs, which may be difficult to develop in the short term. Current providers are used to an 'expected activity' basis. The key is to supplement these with effective incentives to signpost patients to the most appropriate setting.

**Questions for engagement on level of disaggregation of the payment elements and extent of national versus local determination of payment**

**6. Should the payment elements be uniform or specific across the following elements, what are the key factors we should take into account to inform this decision?:**

**a) different UEC components**

Funding needs to reflect the full economic costs of making the relevant type of capacity available and actual treatment cost (in the most appropriate setting – see 6b).

**b) different providers of the same UEC components**

Different providers should be paid the same rate for delivering the same treatment, with levels and benefit sharing arrangements set to ensure work migrates to the most appropriate provider.

**c) different UEC systems in different regions?**

Nationally specified rates offer simplicity and consistency and would avoid protracted local negotiation costs, providing like for like cost variation over the country within a reasonable tolerance.

**7. What aspects of the payment approach should be centrally determined or locally specified? What are the key factors we should take into account to inform this decision?**

As per 6c, central determination is preferable for all aspects. Some local variation on fixed costs may be feasible if data is available. All quality aspects should be centrally determined.