# Community Pharmacy Clinical Services Review

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The independent review was commissioned by the Chief Pharmaceutical Officer Dr Keith Ridge in April 2016 following the opportunity presented by NHS England's publication of the *Five Year Forward View* in October 2014 and the *General Practice Forward View* in April 2016, both of which set out proposals for the future of the NHS based around the new models of care.

The need for an in-depth pharmacy review was determined by the present context in which pharmacy operates:

- The changing patient and population needs for healthcare, in particular the demands of an ageing population with multiple long term conditions.
- Emerging models of pharmaceutical care provision from the UK and internationally.
- The evidence of sub-optimal outcomes from medicines in primary care settings.
- The need to improve value through integration of pharmacy and clinical pharmaceutical skills into patient pathways and the emerging new care models.
- The need for service redesign in all aspects of care for a financially sustainable NHS.

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# 1. Introduction

It is widely recognised that the NHS needs to change in order to best meet the needs of an ageing population not least as the number of people living with long-term health conditions continues to increase. The Five Year Forward View set out a reform programme to help bring about that change and at its core aims to ensure that the services of the 21st century are built around the emerging needs of patients and citizens and in particular, that the service offers the joined up and integrated care that many want and need whilst also providing a new focus on prevention in order to keep us well.

At the same time, some existing services are already under unprecedented pressure. The General Practice Forward View highlighted the challenges facing GPs and their patients and the need to provide better primary care is essential both now and in the future. More widely there is a well-recognised financial challenge across all of the NHS.

Community pharmacy has the potential to help meet both the short term and long term challenge to provide better outcomes as part of wider integrated services that are efficient and that work for patients. It is widely recognised that community pharmacists and their teams are an underutilised resource. Pharmacists undergo a four year full-time university degree plus a year's work-placed pre-registration training culminating in a further academic examination before being admitted to the pharmaceutical register. In addition to this many also undertake post-graduate academic qualifications and training. Pharmacy technicians are also highly trained and are a registered profession working in all heath sectors.

There have been other reports over the years that have described a vision of how that clinical expertise can be put to better use and what the future roles of pharmacists and pharmacy technicians should be. Whilst some progress has been made towards implementing these visions, there is still great untapped potential to improve care for patients and reduce pressure on other parts of the NHS and provide better services to patients through the better use of the skills of the community pharmacy team. It is essential that this potential is realised as the NHS responds to immediate financial and operational pressures, whilst also developing the new care models that will provide the services of the future.

This report was commissioned by Keith Ridge, Chief Pharmaceutical Officer for England with terms of reference (Annex 1) that in summary included:

- examining the evidence base for clinical services currently provided by community pharmacy;
- identifying the barriers that prevent best use of community pharmacy and the community pharmacy workforce;
- making recommendations for what clinical services should be provided by community pharmacy in the future; and
- making recommendations as to how clinical services provided by community pharmacy in the future should be commissioned.

The review was led by Richard Murray, acting in a personal capacity.

## 2. Approach

A rapid review of the peer-reviewed literature was commissioned from Professor David Wright from the University of East Anglia, to examine the evidence base, value and operationalisation of the clinical elements of the current community pharmacy contractual framework and other clinical services provided by community pharmacy. This excluded consideration of the wider `grey' literature.

An advisory group was established to help consider the evidence provided by this rapid review of the evidence and to act as an expert panel to explore and discuss the issues raised as part of the overall review. The advisory group met 5 times in total with a remit to help inform Richard Murray as he considered the evidence and made his recommendations to the Chief Pharmaceutical Officer for England.

International examples were also considered, in particular from Scotland and New Zealand, where different commissioning models had been tested as well as discussions with some leaders of innovation in England.

Secretarial and professional support to the overall review was provided by NHS England.

The rest of this report looks in turn at:

- the vision for community pharmacy and its development since the 2008 White Paper and the state of the pharmacy workforce;
- the evidence base for current clinical services provided by community pharmacy;
- the barriers that have prevented community pharmacy realising its potential;
- current commissioning models for community pharmacy;
- the wider context in the NHS and the opportunities this creates;
- examples of alternative ways of working from Scotland and New Zealand; and
- conclusions and recommendations.

## 3. The development of community pharmacy

Community pharmacy is one of the four primary care contractor groups and there are over 11,500 community pharmacies in England. Whilst the core role remains dispensing medicines, community pharmacy also provides other services such as medicines use review, support for self-care and promoting healthy lifestyles as well as other services that may be commissioned at local level (such as supporting people to stop smoking or treating minor ailments etc.) Some of these services are commissioned by local authorities, in line with community pharmacy's growing role in improving public health. Over 2,000 pharmacies are accredited as "healthy living pharmacies".

This report builds upon a strong legacy. A landmark in the development of new roles for pharmacy came in the 2008 White Paperi. This stated an ambition for pharmacies not simply to dispense and supply medicines, but to offer an expanded range of clinical services. The white paper set out a vision where further improvements in the pharmacy service would include, amongst other things:

- Pharmacies treating more people for common minor ailments (such as coughs, colds, minor stomach and skin problems) on the NHS;

- taking on a much more visible and active role in improving the public's health through provision of stop smoking services, sexual health services such as chlamydia screening and access to contraception, including emergency hormonal contraception (EHC), involvement in immunisation services, including administration of vaccines, and playing a crucial role in influenza pandemic preparation and crisis;
- supporting people with long term conditions (LTCs) such as diabetes or asthma to improve their quality of life, health and wellbeing and to lead as independent a life as possible by supporting self-care;
- supporting better use of medicines – particularly for those newly starting a medicine for a LTC;
- better choice of services, with pharmacists recognised for their clinical skills and contribution, e.g. blood testing and interpretation of results for cholesterol levels, and helping to deliver screening programmes within national and local guidelines following UK National Screening Committee (UK NSC) recommendations; and
- close involvement in developing clinical pathways that support integrated care.

Whilst progress has been made on some of these issues, others remain underdeveloped, and patients and the public still do not benefit from the full range of skills that community pharmacists possess and that the white Paper envisaged.

This has been recognised by the profession, and in 2013 the Royal Pharmaceutical Society (RPS) established a Commission on Future Models of Care Delivered through Pharmacy. Its first report [ii] "Now or Never", made the following key points:

- Pharmacists must provide direct patient care in the location that is most convenient for the patient;
- 58% of those over 60 suffer from at least one long-term condition. LTCs risk being unmanageable without a significant change to the way care is provided - pharmacists can be integral to this change;
- the NHS needs to make the most of the third largest health profession. Numbers of pharmacists continue to increase; and
- urgent care is under significant pressure. Community pharmacists could provide an alternative triage point for many of the common ailments currently dealt with by out-of-hours services and Accident and Emergency departments.

That report[ii] also painted a vision where:

*"An increase in pharmacists capacity to provide other services focused on patient care would include care of people with long-term conditions, the management of medicines for people taking multiple drugs, the provision of advice for minor ailments, and the delivery of public health services."*

A year later, the RPS commissioned the Nuffield Trust to undertake an independent assessment[iii] of progress made in implementing the recommendations of 'Now or Never'. A key point from this follow up report was that:

*"As described in Now or Never, pharmacists at a local level continue to persuade some local commissioners to fund innovative services to support health and social care, but such progress remains patchy and lacks scale. At a national level, there has been disappointingly little progress over the last year in shifting the balance of funding and commissioning away from the dispensing and*

*supply of medicines toward the delivery of direct patient services; perhaps reflecting the complex and often fractured nature of pharmacy leadership in England."*

A vision for the future of community pharmacy has also been produced by the sector in the form of the Community Pharmacy Forward View[iv], published by Pharmacy Voice, The Pharmaceutical Services Negotiating Committee and supported by the Royal Pharmaceutical Society. This document sets out an ambition for the future of community pharmacy as:

- the facilitator of personalised care for people with long-term conditions;
- the trusted, convenient first port of call for episodic healthcare advice and treatment; and
- the neighbourhood health and wellbeing hub.

We of course need to note that `community pharmacy' does not consist only of pharmacists. Community pharmacy teams also include Pharmacy Technicians, who are a regulated profession in their own right. The advisory group supporting this review included representation from the Pharmacy Technician profession and our recommendations cover this group as well as pharmacists, recognising the essential role they already play as well as their scope to take on new roles.

## 3.1 Pharmacy workforce

The pharmacy workforce has a significant influence on how medicines are used, and is the third largest workforce group in the NHS, with some 150,000 staff working in hospitals, community pharmacy or primary care more broadly. There are two regulated and registered professions which make up around half of the workforce:

- Pharmacists, who train for 4 years at Masters Degree level plus a 1 year pre-registration year, many of whom go on to take further formal post graduate clinical qualifications, and
- Pharmacy Technicians, who train for 2 years for a NVQ Level 3 Diploma.

Pharmacists are able to prescribe medicines if they undertake suitable postgraduate training, at a minimum of 2 years post qualification.

About 20% of pharmacists are employed by the NHS in hospitals, and a further 10% in primary care organisations such as CCGs. The remainder work in community pharmacy, either as owners of pharmacies, or more typically as employees of private sector organisations. It is the pharmacy owners who are commissioned to provide NHS services.

The numbers of schools of pharmacy in England have doubled over the last decade, alongside the number of pharmacy students. Workforce modelling carried out by the Centre for Workforce Intelligence[v] indicated a significant future oversupply of pharmacy graduates. The report concluded that:

*"Supply is forecast to exceed demand…, regardless of the pharmacist's future role, so oversupply is likely no matter how the pharmacist's role develops if the current number of students entering MPharm degree courses continues."*

It also concluded that:

*"The future pharmacist workforce is particularly (and in many cases uniquely) affected by changes in technology, lifestyle behaviours and changes in the wider commercial environment. The essential broader role pharmacists may play in contributing to the delivery of community-based healthcare and public health, combined with the many complex factors shaping the profession, signify the importance of adopting a flexible approach, combined with careful monitoring and review."*

HEE are completing new data collections on trusts and community pharmacy to enable a comprehensive review of workforce demand and supply modelling. The review will inform future planning of pre-registration posts across all trusts, general practice and primary care and community pharmacy.

## 4. Evidence base for current clinical services

A literature review[vi] was commissioned from Professor David Wright, Professor of Pharmacy Practice at the School of Pharmacy University of East Anglia, to consider the evidence for both effectiveness and cost-effectiveness which underpins current 'Advanced' and 'Enhanced' services both from within the UK and internationally.

In relation to research evidence linked to Essential, Advanced and Enhanced community pharmacy services the aim of the review was to:

- Describe the breadth and quality of evidence currently available in the UK and internationally;
- quantify the evidence for service effectiveness and cost-effectiveness;
- identify how the effectiveness and cost-effectiveness of services may be enhanced;
- review the effectiveness of different funding models; and
- identify gaps in research which would enhance the evidence base.

This evidence review draws upon the published peer reviewed literature. As new care models spread in the NHS, there is also a need to ensure that we do not only draw on the best existing evidence of effectiveness and cost effectiveness. Going beyond this, we need to ensure that community pharmacy is fully integrated into these emerging new care models, including, of course, the evaluation of these innovations and the creation of a new, wider evidence base that shows what works to the whole of the NHS.

### 4.1 Findings

The full review can be found on the NHS England website (see reference [vi]) but we draw out here:

- There has been poor take-up of repeat dispensing in England, despite the evidence that supports it;
- Looking beyond the evidence around Medicines Utilisation Reviews and New Medicines Service, there is evidence supporting the wider role for pharmacy in supporting patients with long-term conditions;
- The provision of minor ailments services by community pharmacy is supported, which is important given the current pressures on other parts of the urgent and emergency care system and particularly on GPs;

- There is support for a wide range of public health services provided by community pharmacy. Given the importance of stopping smoking to the health of the population, there is an argument for making smoking cessation a national service offer; and
- However, as a general point, we should note that the evidence for (or against) specific clinical services within the peer-reviewed literature is often relatively sparse.

## 5. Barriers that prevent best utilisation of the current workforce

With the case apparently well-made at least amongst policy-makers, it is fair to ask why progress has been relatively slow and sometimes patchy in better utilising the pharmacy workforce. A sub-group of the expert advisory group developed a paper on the barriers to community pharmacy working when developing new clinical roles and this also provided a set of potential solutions to those barriers. The full paper is available at Annex 2. Along with the barriers to providing more clinical services, this extended to considering the ways to fully integrate community pharmacy into the primary care team and maximising their input to clinical and health outcomes through the new models of care outlined in the Five Year Forward View for the NHS. The paper identified three key thematic barriers to community pharmacies providing clinical services:

1. Poor **integration** with other parts of the NHS – hindered by the lack of interoperability of digital clinical systems

2. Issues around **behaviours** and cultures – including sometimes weak relationships between GPs and pharmacy, which in turn inhibit better integration

3. **System** design issues – including the existing contractual mechanisms for pharmacy, mechanisms that are complex and poorly understood.

While it is not within the scope of this report to address each of these separate issues, some do need to be confronted now.

Firstly, as set out in Annex 2, to unlock the full potential of community pharmacy requires a step change in the availability of information to inform clinical decision making. To overcome it will require greater digital maturity and interconnectivity to allow pharmacy staff to see, document and share clinical information about patient care with the clinical records held by other healthcare professionals.

Secondly, poorly developed local relationships between professionals continues to inhibit both integration and wider engagement between pharmacists and others, particularly GPs. This can be reinforced by a lack of clinical and professional confidence amongst community pharmacists and perhaps until more recently) a relative lack of support for a move away from a primarily dispensing function. To become a fully integrated part of local primary care will require action to overcome these barriers.

Thirdly, specific issues around commissioning and regulation continue to inhibit community pharmacy and we consider commissioning next. On regulation, to make the most of the skills of pharmacists, pharmacy technicians and their teams, there needs to be a shift in the balance of work such that pharmacy technicians can take over more of the day to day management of the dispensary and this should include adding them to the Patient Group Direction list.

# 6. Current commissioning models

The commissioning landscape for community pharmacy is complex and involves NHS England (at different levels), CCGs and Local Authorities.

NHS England commissions community pharmacy owners to provide NHS pharmaceutical services through a Community Pharmacy Contractual Framework (CPCF). The CPCF consists of nationally commissioned essential services (services that all pharmacies must provide) and advanced services (national services that can be provided by all pharmacies once accreditation requirements are met) and locally commissioned Local Enhanced Services (commissioned by local NHS England teams to meet certain needs identified in a Pharmaceutical Needs Assessment). A list of these services can be found in Annex 3.

All pharmacies on NHS England's pharmaceutical list must provide all essential services, but can choose whether or not to provide advanced services or enhanced services – the latter are commissioned by local NHS England teams and may be restricted to a small number of pharmacies in an area, depending on the need for the service.

The Department of Health and NHS England are jointly responsible for negotiating the national CPCF; NHS England for remuneration elements and DH for the medicines reimbursement elements. NHS England local teams are responsible for the enhanced services.

## 6.1 Local Pharmaceutical Services (LPS) Contracts

LPS contracts allow NHS England to commission pharmaceutical services tailored to meet specific local requirements. LPS complements the national contractual framework for community pharmacy but is an important local commissioning tool in its own right. LPS provides flexibility to include within a single local contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements.

Within LPS, dispensing is treated as a 'core' service and all contracts must include an element of dispensing. Going beyond this:

- LPS contracts may include any of these other elements of essential services but they are not mandatory; and
- LPS contracts may include services or parts of services that are similar to "advanced" and/or "enhanced" services.

In this way, services may be designed with particular focus on patient need while at the same time reducing the contracting burden through commissioning all appropriate services within one contract.

One might expect LPS contracts to be a natural commissioning route for wider services and yet they are not common with many being legacy from essential small pharmacy schemes and many of the others were put in place by PCTs. There are a number of reasons why this is the case: as all LPS contracts must include dispensing, some see them as paying twice for this service and LPS contracts require resources to be set up and run – i.e. they need scarce commissioning capacity.

## 6.2 Commissioning from CCGs

CCGs also commission services from community pharmacy but no database is maintained in NHS England of the services currently commissioned. However, according to the PSNC database as of 29th November 2016,

- 182 services are currently commissioned by CCGs
    - 61 of which are listed as minor ailments (+ 19 commissioned by NHS England and 1 by Local Authorities)
    - 45 provide palliative care drugs (+ 1 commissioned by NHS England, 1 from a Hospital trust and 8 from unknown commissioners)
    - 19 are listed as emergency supply (+ 7 commissioned by NHS)
    - 5 have a domiciliary aspect
    - 52 'other' types of service commissioned by CCGs

However, we should note that the PSNC database is believed to be an undercount.

CCGs mainly either commission the services directly or through a CSU using a shorter form of the NHS Standard Contract, although some continue to use Service Level Agreements developed by former PCTs and some may have been commissioned by NHS England for CCGs.

## 6.3 Commissioning from Local Authorities (LAs)

LAs have responsibility for commissioning a wide range of services, including most public health services and social care services. The following public health services provided by community pharmacies would be commissioned by local authorities:

- Supervised consumption
- Needle and syringe programme
- NHS Health Check;
- EHC and contraceptive services
- Sexual health screening services
- Stop smoking
- Chlamydia testing and treatment
- Weight management
- Alcohol screening and brief interventions

Local authorities will use their own contracts or the standard public health contract to commission services from community pharmacies. Most local authorities commission services directly, although there are examples of them using outsourcing the administration of the contracting to other bodies, including Commissioning Support Units (CSU's), third sector organisations and Local Pharmaceutical Committees (LPCs.)

## 6.4 The evolution of commissioning

The complexity of current commissioning routes risks being a barrier to integrating community pharmacy alongside general practice. It also risks leaving community pharmacy on the outside as new care models develop, thereby leaving it a relatively standalone service. Over time STPs may provide the vehicle to ensure community pharmacy (alongside other professions) is `at the table' as a matter of routine. However, STPs are at a fairly early stage of development and already have an

already daunting to-do list. Interim measures to make better use of community pharmacy are likely to work through existing commissioning routes whilst at the same time need to adjust to the new opportunities offered by STPs.

# 7. The wider context within the NHS: opportunities for community pharmacy

## 7.1 The Five Year Forward View and the Vanguards

The Five Year Forward View set out a compelling vision for the health and care in England, looking to ensure that services are designed around the changing needs of the population. The Forward View has spurred a process of change across the NHS and it is important that community pharmacy is integrated into this process of change and not isolated from them and critically this includes both the Vanguard programme and the new Sustainability and Transformation Plans (STPs) which we discuss later.

The Five Year Forward View set out three key gaps that new services needed to bridge and community pharmacy can help to meet all three challenges:

- Helping to close *the Health and Wellbeing Gap*, by extending its role in improving public health and building on the solid evidence of both clinical and cost effectiveness for a range of existing public health services provided by community pharmacy;
- Helping to close *the Care and Quality Gap*, in particular by providing additional services to support patients and the public better manage their own long-term conditions; and
- Helping to close *the Funding and Efficiency Gap*, not just through better management of medications but also, for example, by meeting the demand for urgent care services from patients that would otherwise need to be met by other, more expensive services such as A&E or general practice. Public Health England has already identified 6 interventions involving pharmacy that would save money over the next 5 years, contributing both to efficiency and health.

However, to unlock all the benefits community pharmacy can bring means working in partnership with other parts of the health and care system whether this means other professions or, critically, patients themselves. The need to ensure more integrated services as more of us learn to live with ongoing long-term conditions is central to much of the new care models of the Five Year Forward View. Pharmacy needs to play its part in this new vision and be a core part of the integrated, convenient services the people need but all too often it has proved difficult to make this happen and to some extent, community pharmacy has been left as an outsider. The new Vanguard programme launched by the Five Year Forward View looks to develop practical exemplars for these new models of care and community pharmacy needs to be fully integrated into these new care models.

There are five new care models being developed in the Vanguard programme of which four are particularly relevant for community pharmacy:

- Integrated primary and acute care systems (PACs) that are joining up GP, hospital, community and mental health services;

- Multispecialty community providers (MCPs) that are moving specialist care out of hospitals into the community and establishing better out-of-hospital integration;
- Enhanced health in care home Vanguards that are offering older people better, joined up health, care and rehabilitation services; and
- Urgent and emergency care Vanguards that are supporting new approaches to improve the coordination of urgent and emergency care services and reduce the pressure on A&E departments.

The fifth Vanguard group – acute care collaboration – looks to better join up providers of acute services and will be more relevant to hospital pharmacy.

There are examples of community pharmacy or pharmacists in all of the four community-facing new care model Vanguards and in urgent and emergency care these can build on a long-standing role in minor ailments. However, while a number of MCPs in particular have community pharmacists as part of the team, across the Vanguards as a whole community pharmacy is more noticeable by its absence or by the relatively minor role it plays. This risks being a great lost opportunity, not least as there are exciting examples of the expanded roles pharmacists are taking on in England outside of the Vanguard programme.

## 7.2 Sustainability and Transformation Plans (STPs)

Alongside the Vanguard programme, the need to develop a more integrated, population-based approach to health and care planning led to the announcement in December 2015 of new Sustainability and Transformation Plans (STPs) to be developed across 44 `footprints' in England. These have involved bringing together health and care stakeholders to develop 'place-based plans' showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

These STPs could hold great opportunity for community pharmacy. At their best, they offer the opportunity to provide a coherent strategy toward the commissioning of pharmacy services, currently split across multiple commissioners. Along with other services, they also offer the chance to develop coherent, system-wide services and pathways to deliver better care. However, they also represent a challenge. Community pharmacy has sometimes struggled to be seen as part of the NHS `family' and STPs carry the risk that they may be inadvertently missed out of plans. Public Health England, working alongside the Pharmacy and Public Health Forum, already have plans to help overcome this problem. They intend to publish a suite of quality-assured case studies that will support the mobilisation of pharmacy in respect to public health delivery, in particular for areas where pharmacy has been identified as contributing to the STP's on prevention. However, notwithstanding this welcome start, renewed efforts will be needed to ensure the potential for community pharmacy to help improve the sustainability and transformation of services at local level is not lost from STPs as they develop.

It is within this context of New Care Models, STPs, the Five Year Forward View and the current operational and financial challenges facing the NHS that the commissioning of clinical services from community pharmacy must take place. Only by engaging with these strategies and the general direction of travel from national to local commissioning, will the visions outlined in the 2008 White

Paper and a variety of reports produced by the profession themselves eventually become a reality and pharmacy take its proper place within an integrated NHS.

### 7.3 Current service pressures

However alongside the medium and long- term need to transform services, many parts of the NHS are facing more immediate operational and financial pressures. In particular, the challenges facing general practice are both severe and well recognised. As essential members of the wider primary care team, the ability of community pharmacy to provide a wider range of services, at scale, that reduces pressures on general practice make it an urgent necessity to make progress at greater pace. Of course, helping patients and the public – whether in helping patients manage their long-term conditions, provide easy access to help for those with minor ailments – to improve their own health will also reduce the pressures on all parts of the health and care system. This is not just about diverting demand away from other services that are under pressure. Community pharmacy can provide a wider range of services that provide value for money at the same time as providing a new way to meet patient demand and indeed contribute to reducing demand through better public health.

## 8. Scotland and New Zealand

One of the alternatives to the current volume-based contracting approach to the commissioning of community pharmacy is the development of new systems based on patient registration with pharmacies alongside a greater role for pharmacy in supporting people with long term conditions and in establishing a clear national `offer' on minor ailments. Scotland and New Zealand have both introduced elements of such services on a national scale and some details of their approaches are set out here. Neither are necessarily appropriate for England: however, they do show that other countries have introduced large-scale changes to the services on offer from community pharmacy.

### 8.1 Scotland

**Minor Ailment Service (MAS)** – Scotland has offered a national MAS for nearly a decade, and are in the process of testing an extension of the service. Their particular system relies on patient registration for the MAS and is supported by the ePharmacy programme. All community pharmacies are required to possess the necessary software functionality. This functionality has been embedded in the existing community pharmacy software system used for dispensing. The system supports the patient registration process and also records the outcome of a MAS consultation which can be details of the treatment provided or whether the person has been given advice only or referred. The software also supports the remuneration and reimbursement arrangements.

**Chronic Medication Service (CMS)** - The chronic medication service focuses on patients with long term conditions. It aims to encourage shared decision making between community pharmacists and patients as well as joint working between GPs and community pharmacists to improve patient care by:

- Identifying and Prioritising risk from medicines;
- minimising adverse drug reactions;
- addressing existing and preventing potential preventable problems with medicines; and
- providing structured follow-up and interventions where necessary.

The service is offered to patients with any long term condition(s), and is designed to promote shared decision making between the patient and the pharmacist that leads, where appropriate, to the development of a pharmaceutical care plan for patients with identified pharmaceutical care needs. It also allows a GP the option to provide a patient with a serial prescription of 24, 48 or 56 weeks which can be dispensed in the pharmacy at set intervals determined by the GP (for example every 8 weeks). The CMS is not intended to 'manage the patient's condition'; the intention is to address any medication related problems.

Like MAS, the CMS is based on patient registration with both linking payment partly to capitation. The three stages of the CMS process are underpinned by e-Pharmacy.

* Stage 1 - Registration of patients
* Stage 2 - prioritising patients and pharmaceutical care planning
* Stage 3 - Shared care with the patient's GP establishing a serial prescription for either 24, 48 or 56 weeks

Stage 2 is supported by a web based pharmaceutical care planning tool which is not integrated with the existing community pharmacy software and this lack of integration as well as other IT problems has been problematic to its successful implementation.

The Chief Pharmaceutical Officer for Scotland is reviewing the CMS with a view to making improvements to the service. One such development is an electronic referral tool between community pharmacists and GPs which will be implemented in Spring 2017. The CPO advised that implementation support was essential.

Both the MAS and the CMS are paid for on a capitation basis linked to patient registration.

## 8.2 New Zealand

**New Contract -** A new community pharmacy contract (CPSA) was intended to shift the sector towards a greater focus on person centred services by changing the contract incentives from a simple payment for dispensing. Pharmacists would be paid a reduced dispensing fee for repeat items dispensed to reduce the incentive for unnecessary repeats. It was expected that this reduction in repeat items dispensed would reduce calls on pharmacist time. Pharmacists would be encouraged to use that time for person centred services being, primarily, the Long Term Conditions (LTC) service. The LTC service is essentially a medicine adherence service by which eligible patients are identified, registered and managed to encourage better medicines adherence. Some pharmacists would also be able to participate in some specific clinical services the most important being Community Pharmacy Anti-Coagulation Management Service (CPAMS) (a warfarin management programme).

**Long term Conditions Service** - The Community Pharmacy Long Term Conditions (LTC) Service is designed to provide medicines adherence support services required by those patients who not only have significant long term conditions but also require a high level of pharmacy service to support them to self-manage their medicines regimen and improve their adherence. Pharmacists are paid a monthly fee, per registered Service User, for providing the LTC service.

The expiration of the previous agreement (pre-2012) allowed for significant and far reaching changes to the community pharmacy funding model to:

- Ensure a better focus on pharmacists meeting patient need rather than a focus on dispensing activity;
- appropriately align financial incentives;
- better utilise the skills and expertise of pharmacists and reinforce their role as an integral part of the primary care services team; and
- manage cost growth in a financial sustainable manner.

The intention of the LTC service was to give pharmacists the ability to manage patient adherence and compliance more actively through variable dispensing periods, if registered with LTC. The dispensing fee was removed and other fees were introduced to align funding more closely to patient care rather than volumes dispensed.

The new service is considered to have had the benefit of 'nudging' pharmacists to providing a more patient-centric clinically focused service. Further evaluation has suggested:

- a sense that something has been achieved, particularly with pharmacies getting to know their patients better and attending to clinical note taking;
- strong recognition some pharmacists seized the opportunity and in each District Health Board (DHB) there are "beacon" pharmacies undertaking very good work, some of it beyond the scope of the CPSA; and
- acknowledgement that some medicines management services could be delivered by pharmacists outside of the community pharmacy setting.

# 9. Conclusions

**New models of care**

Many accept and support the vision for community pharmacy to become more overtly clinical in nature and embrace technology to allow that to happen. Reliance on operating primarily as a supply function will not serve patients, the taxpayer or the NHS well in future years and it is in everybody's interests to ensure that the skills of community pharmacists and their staff are better deployed and utilised. The way patients interact with the NHS, and in particular with primary care, is changing and pharmacists are well placed to meet those challenges if the conditions are set to allow them to do so. Patients are encouraged to live independently or in care homes rather than spend extended periods of time in hospital, patients of working age with busy lives often want to interact with the NHS in ways that fits better with their lifestyles, at the same time as pressures on the NHS as a whole all mean that life as a practitioner in the NHS is changing. Roles, systems, skills and services all need to evolve to meet those needs and community pharmacists cannot afford to be left behind in the quest for safer more convenient, efficient and effective care.

As barriers are broken down across the NHS and boundaries become blurred, patient pathways become all the more important and this needs to begin with better support for people to manage their own health. This is reflected in new models of care that are emerging as different health

sectors begin to work together to manage acute episodes of care, long term conditions and improve public health. Integration is key and it is easy to see the potential for pharmacists and their staff to have a significant impact both on the health of the population and patient care. This however needs to be done not as a 'standalone' or 'bolt-on' set of services, but as a fundamental and integrated element of patient pathways that includes the implementation of medicines optimisation as part of something much larger and more comprehensive and which supports the patient. Much greater pharmacist support to people with long-term conditions should be the ultimate aim, but only as one element of a patient's care and alongside measures to improve public health. It needs to be delivered in a way that is integrated both in terms of NHS and public health systems and structures and also in terms of multi-professional accountability and responsibility that leads to improved care, outcomes and convenience for the patient. To achieve this is likely to require action to overcome long-standing professional boundaries in primary care as well as provide more support to pharmacists to make the changes necessary.

**Access to information**

However, during the course of this review a number of key issues and barriers have presented themselves that need to be addressed if community pharmacists are to provide clinical and cost effective services in the future especially as part of new models of care. The poor availability of the information needed to inform clinical decision making is a critical barrier. To overcome it will require greater digital maturity and interconnectivity to allow pharmacy staff to see, document and share clinical information about patient care with the clinical records held by other healthcare professionals. This is a fundamental requirement if new services are to be safe and effective so that the whole multidisciplinary team, with responsibility for direct care of an individual patient, can see and understand the rationale for actions taken and recommendations made by pharmacy staff. This in turn makes the clinical activity of pharmacy staff visible to the system and offers an opportunity for genuine integration of community pharmacists and their teams into primary care and the wider NHS. Whilst some 'summary information' may be nationally available, there is no centralised 'clinical record'; GPs write in the GP record, hospital staff write in the hospital record, mental health records are held in the mental health trust, and homecare staff write in their internal record. Relevant information therefore needs to be shared through transfer of care messages and referrals and pharmacy records need to be incorporated into this 'data sharing pool'.

**Independent prescribing and workforce skills**

Independent prescribing by pharmacists has been available for a number of years and yet its potential has not been realised or exploited, particularly in the community sector. Independent prescribing by pharmacists can make a great contribution to a convenient and integrated pathway approach to patient care that makes full use of the clinical skills and expertise of the pharmacist in implementing the principles of medicines optimisation.

The relative lack of take-up of independent prescribing may partly reflect the apparent tension between the current volume-driven community pharmacy contract and enhanced prescribing roles. There will be alternative ways to overcome this apparent conflict while at the same time enhancing the incentives for more rapid uptake and these should be explored as part of the future work programme.

Some of the wider barriers to the integration between general practice and community pharmacy and the use of pharmacist clinical skills may be reduced as more pharmacists begin to work in general practice settings. As well as providing services within the practice setting, these staff may help engagement and understanding with wider community pharmacy.

Other registered pharmacy professionals are also poised to take on new roles and this is critical to making the best possible use of a skilled workforce (a process that with pharmacy technicians has made faster progress in hospital settings). They will however need to be supported and given the tools to make this a reality.

**Commissioning**

Existing commissioning models are complex, often leading to uncertainty over what services can be commissioned, by whom and under what circumstances. Community pharmacists often find it difficult to 'get a seat at the table' when commissioning strategy and decisions are developed, notwithstanding some examples from across the country that have been more successful. Current NHS and public health policy indicates a move away from national commissioning and towards local commissioning of services that better meets the needs of individual communities yet patients will not be well served unless community pharmacists are involved and influential in those discussions. While the direction of travel is toward local commissioning, cultural barriers often prevent effective working between professions and national levers can sometimes help overcome these by setting a clear direction of travel. This includes work with the public and patients to ensure they are well aware and ready to use new services. In the future evolving STPs may be able to provide the broader, whole-health economy oversight that would enable the system to unlock the potential of community pharmacy. However, STPs are still relatively new and already have much to do and so ensuring that the existing commissioning system works better is still important and this includes looking again at Local Pharmaceutical Services contracts and potential ways to make these easier to use.

There is little point in developing recommendations unless there is a reasonable expectation that they can be implemented in a pragmatic way within the context of current policy. Implementation itself is dependent on co-operation and collective experience from both within and external to the sector and to this end it is imperative that the sector involved is able to bring its membership with it on that journey to effect change. Only by policy makers and practitioners working together will that change be made in a sustainable and robust way that achieves the overall objectives. The advisory group that was established to assist in the development of this report has shown that such joint working can be productive in bringing about a full and frank examination of the evidence while also drawing on collective experience.

# 10. Recommendations

With other parts of the NHS facing severe financial and operational challenges, there needs to be renewed efforts to make the most of the existing clinical services that community pharmacy can provide and to do so at pace. This may require national action through the national contractual framework, as well action at local level. Looking into the medium-term, there is a need to ensure that community pharmacy is integrated into the evolving new models of care alongside other primary care professionals. This will include enhancing the support they provide to people with long-term conditions and public health, but should not be limited to these. Progress here will necessarily be more local in nature, built around the needs of patients and localities, however, NHS England and Public Health England can support and encourage this progress, not least to overcome some of the barriers that have to date prevented full use of community pharmacy.

To make progress on these broader priorities, there are a number of specific steps national bodies can make. Action should include, but not be limited to, these steps.

**Services**

1. Full use should be made of the electronic repeat dispensing service. Except for patients not yet stabilised on their medication, electronic repeat dispensing should become the default for repeat prescribing and its use should be incentivised both for community pharmacies and for GPs.

2. The existing Medicine Use Reviews (MURs) element of the pharmacy contract should be re-designed to include on-going monitoring and regular follow-up with patients as an element of care pathways. This redesign should ensure that they are an integrated part of a multifaceted approach to helping people with long-term conditions that includes medicines optimisation, providing advice and helping people stay well. Such a service should be able to utilise transfer of care and referral schemes and electronic repeat dispensing (ERD), and have a focus on patients at high risk and those with multiple co-morbidities as well as those with single conditions that are clinical priorities such as diabetes, hypertension and COPD where evidence is already strongest. It should also include consideration of appropriate prescription duration to optimise outcomes and convenience for patients. Ultimately MURs should evolve into full clinical medication reviews utilising independent prescribing as part of the care pathway. For these to be safe and effective they would require access to a patient's full medical record which may not be possible immediately in all situations.

3. There is now a commitment that a minor ailments scheme should be locally commissioned across England by April 2018. There is a debate over whether this needs to be a national service, or a service commissioned locally by CCGs. Either way, NHS England should set out how it intends to deliver on this commitment and this should include testing models that use patient registration to enhance take-up, building on the experience in Scotland. While this could take place within the Vanguard programme as new care models develop, progress toward the April 2018 commitment clearly needs to happen sooner.

4. Consideration should be given to smoking cessation services becoming an element of a national contract.

**New models of care**

5. Existing Vanguard programs and resources should be used, in conjunction with the Pharmacy Integration Fund, to develop the evidence base for community pharmacists within new models of care. This applies to all the Vanguard types that work in community settings but should also specifically include:

    - Integrating community pharmacists and their teams into long term condition management pathways which implement the principles of medicines optimisation for residents of care homes. This should include pharmacist domiciliary visits to care home patients and full clinical medication review utilising independent pharmacist prescribing.

    - Community pharmacists being involved in case finding programmes for conditions which have significant consequences if not identified such as hypertension and for which the pharmacist is able to provide interventions (including referral) to prevent disease progression.

    - Utilising existing contractual levers and developing new ways of contracting, with individual or groups of pharmacists, in order to provide clinical services that utilise their clinical skills in ways that mitigate any perceived conflict of interest whilst providing the incentives for more rapid uptake of independent prescribing.

    In all cases, new models of care that integrate pharmacy should involve appropriate patient engagement to ensure that both the service offer is built around patient need and that any necessary marketing with potential new users is effective.

    As best practice in commissioning and delivering these additional services from community pharmacy becomes clear, NHS England, Public Health England and other national partners should look to roll these out at pace, given the opportunities to use community pharmacy better and the deep challenges facing other parts of the NHS. This should include consideration of any workforce training implications for community pharmacists, pharmacy technicians and their teams.

**Overcoming barriers**

6. Public Health England already plans to provide advice to local government and to STPs presenting the evidence base for action. More widely, NHS England and its national partners should consider how best to support STPs in integrating community pharmacy into plans and overcome the current complexities in the commissioning landscape alongside further support for local commissioners in contracting for services now. Specifically this should look

at the changes necessary to make Local Pharmaceutical Services (LPS) Contracts easier to use.

7. Digital maturity and connectivity should be improved to facilitate effective and confidential communication between registered pharmacy professionals and other members of the healthcare team. This should include the ability for registered pharmacy professionals to see, document and share information with clinical records held by other healthcare professionals and allow the actions, recommendations and rationale for clinical interventions made by registered pharmacy professionals to be visible to the relevant wider healthcare team.

8. Regulations should be amended to allow registered pharmacy technicians to work under Patient Group Directions to allow better use of skill-mix in delivering clinical pharmacy services.

9. Community pharmacists should be actively engaged to help explore and develop pathway approaches that integrate community pharmacists and their teams into primary care, and make best use of their skills in the identification and management of patients who will benefit most from their expertise. The leaders of the profession both at national and local level should consider what support is needed to pharmacists to build their professional confidence and break down barriers to new ways of working.

10. The Royal Pharmaceutical Society, Royal College of General Practitioners, the British Medical Association and the Pharmaceutical Services Negotiating Committee should come together to explore the practical steps that could be taken to unravel professional boundary issues and promote closer working between the professions. This would include consideration of professional responsibility and accountability, as well as how to conceptually put the patient at the centre of both professional worlds in a way that allows common objectives to be focused on patient outcomes. Initiatives involving pharmacists working in General Practice, and in some case becoming partners in those practices, should be encouraged and expanded as a way of contributing towards achieving this objective.

11. New evidence becomes available, circumstances change and new barriers can appear. Community pharmacy leaders and trade bodies across the sector, such as Pharmacy Voice, should come together with NHS England and Public Health England as a formal group to keep oversight of progress and recommend further action where necessary.

# 11. Annexes

## 11.1 Annex 1 – Review of clinical services in community pharmacy - Terms of Reference

In the context of:

- the changing patient and population needs for healthcare as set out in the Five Year Forward View, in particular the demands of an ageing population with multiple long term conditions,
- the changing demands and roles in primary care as set out in the GP Forward View
- emerging models of pharmaceutical care provision from the UK and internationally
- the evidence of sub optimal outcomes from medicines in primary care settings
- the objective to improve value through integration of pharmacy and clinical pharmaceutical skills into patient pathways and the emerging new care models
- a complex commissioning environment

The review will:

- examine the evidence base, value and operationalisation of the clinical elements of the current community pharmacy contractual framework and other clinical services provided by community pharmacy that are commissioned by NHS England

- identify the barriers that prevent best use of community pharmacy and the community pharmacy workforce in integrated, safe, clinical and cost effective, high quality care of patients with acute and long term conditions and examine how those barriers might be addressed

- taking into account the barriers identified, make recommendations for commissioning models and clinical pharmacy services that both integrate and transform the clinical contribution of community pharmacy and the pharmacy workforce to the delivery of good outcomes and patient care, whilst considering the relevant evidence generated from local commissioning of community pharmacy clinical services and aligning with the emerging new care models

- make recommendations for commissioning models for community pharmacy and the pharmacy workforce that deliver good patient outcomes and optimal value for money for the taxpayer, when compared to services delivered elsewhere in primary care, taking into account both published national clinical priorities and the need to be able to respond flexibly to local clinical priorities

## 11.2 Annex 2 - Barriers to community pharmacy working in different ways to develop clinical roles

**Purpose** - This paper has been produced for consideration and debate by the Clinical Services Review advisory group which was set up in June 2016 to inform the independent review of community pharmacy clinical services commissioned by NHS England and being led by Richard Murray Director of Policy, Kings Fund.

**Background -** This is one of the papers that have been commissioned to support the review. It considers the barriers to community pharmacy providing more clinical services, fully integrating into the primary care team and maximising their input to clinical and health outcomes through the new models of care outlined in the Five Year Forward View for the NHS.

**Sources of information called upon in production of this paper**

- Royal Pharmaceutical Society. Now or Never: Shaping Pharmacy for the Future (Nov 2013), Survey of pharmacists working in commissioning organisations (Jun 2016)
- Nuffield Trust. Now more than ever: why pharmacy needs to act (Dec 2014)
- Building Capacity: realising the potential of community pharmacy assets for improving the public's health (pre-release PHE, RPH and PPHF document)
- Evaluation of the "Feeling under the weather?" social marketing campaign (2014)
- Stay Well This Winter Campaign 2015/16, Winter Services Evaluation (Mar 2016)
- Personal communication with LPCs, groups of contractors, NHS England Pharmacy Contracts Managers and members of the Company Chemist Association


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## Integration

**Clinical services are often commissioned as a bolt on rather than a truly integrated NHS service, community pharmacy is sometimes considered to be outside of the NHS and are therefore not included as a member of the NHS clinical team**

| Barriers | Potential solutions for discussion |
|---|---|
| **Professional isolation**<br>Professionally community pharmacists are often seen as isolated and poorly integrated into local clinical teams.<br>They are, however, seen as part of the clinical team by patients/carers more than by other health professionals. | **Build local relationships**<br>Foster local relationships, especially with GPs, based on trust and not competition - led by NHS England in collaboration with the pharmacy and GP representative bodies - driven centrally but must be enabled locally.<br>Build a pharmacy network integrating the work of the Pharmacists in GP surgeries with the wider community pharmacy network |
| **Relationships**<br>Key professional relationships between GPs and community pharmacists are often under-developed locally.<br>Community pharmacists can lack confidence in their clinical skills and knowledge and can be reluctant to engage in clinical discussions with their medical peers on an equal footing.<br>No time and space for community pharmacists to develop the relationships that could lead to the commissioning and funding of clinical services. | **Multi-professional training**<br>Build routes of multi-professional training to get confidence earlier in career and also as part of career development, e.g. shared sessions at GP surgeries |
| **Lack of awareness of the contribution community pharmacy can make**<br>Lack of awareness amongst other professionals about the potential impact that community pharmacists can have on medicines optimisation, care and health improvement. Pharmacists and their teams are frequently overlooked or only considered in relation to supply and can be mistrusted by other professionals. | **Ensure community pharmacy is part of local plans**<br>Embed community pharmacy services into the STPs; NHS England and the community pharmacy sector need to work together<br>Engage other parts of the system, patients and carers in remodelling the system to allow community pharmacy to develop clinical roles as an integral part of the multidisciplinary team |
| **Multidisciplinary teams**<br>Community pharmacy professionals don't have a track record of working in integrated multidisciplinary teams, or in networked ways that are necessary when delivering clinical services and that will be necessary to deliver on the care models in the 5YFV. | **Integrated records**<br>Enable shared clinical records and ability to effectively communicate with rest of clinical team<br>Read access to Summary Care Record (SCR) is underway and development of write access, is under consideration currently. This should lead to development of an broader integrated shared care record and the development of shared care plan template with national specification and metrics, shared between all professionals involved in the care of the patient |
| **Competing payment structures**<br>Competing payment structures between general practice and community pharmacy can cause tensions e.g. flu vaccine.<br>NHS vs private perception potentially perpetuating this with "profits" seen to be leaving the NHS. | **Contractual arrangements**<br>Focus upon patient care and develop incentives to facilitate pharmacist and GP engagement<br>Develop formal referral pathways between GPs and pharmacy to ensure patients are managed well<br>Develop NHS 111 pathways enabling all appropriate patients to be referred to community pharmacy relieving pressure on urgent care services |
| **Rapidly changing NHS**<br>Pharmacy not always familiar with quickly evolving NHS structures and language. | |

# Digital Integration

**Interoperability of clinical systems and read and write access to a shared clinical record is key to enable integration**

| Barriers | Potential Solution |
|---|---|
| **Pharmacy and Patient Medication Record IT systems**<br>No centralised specification for required functionality. Functionality is currently based around needs defined by a volume based contract and doesn't support recording of clinical information and monitoring of patient outcomes. Not all current systems allow recording of the existing advanced services and do not have clinical read coding. Connectivity with other systems is limited to EPS (electronic prescription service).<br><br>**Secondary Pharmacy IT Systems**<br>A range of complementary clinical systems are used locally to meet the needs of local commissioners. All are web-based and capable of storing patient identifiable data securely. There is currently no connection to the PMR system in the pharmacy but these systems do have wider interoperability capabilities for example receiving referrals from hospitals and NHS111 but do not providing activity reporting to GPs other than via secure NHS mail.<br><br>**NHS Choices (www.nhs.uk) and the NHS 111 Directory of Services**<br>Currently there are a number of databases holding information on pharmacy opening and closing times and services offered. These are contradictory and often out-of-date. NHS 111 services find it very difficult to map dispositions to pharmacy endpoints because of variability of local commissioning between CCGs and Local Authorities mean there is poor understanding of the service and when it is available.<br><br>**Summary Care Record (SCR)**<br>Increasing, but currently small, numbers of pharmacies access the SCR. There is no write access to this or way of transmitting information back to the GP or other clinicians through this route. The standard SCR does not contain any diagnosis information and, in some cases, no information on discontinued medication. This is not integrated into the pharmacy systems and a privacy officer is required to manually review certain types of record access.<br><br>**Prescription ordering by patients**<br>Currently, except for Repeat Dispensing (12% of electronic prescription items, 9% of total), each prescription needs personally authorising by a GP upon request by a patient through either the surgery web portal or manually leading to system burden that is managed by pharmacy to the detriment of clinical services. Managed repeats services have led to distrust of pharmacy providers driven by a volume based contract.<br><br>**NHS Mail and the Companies Act**<br>The legal requirement to have registered office and number on each email means that companies have been unable to enable nhs.net emails to be used in their pharmacies. Whether NHSMail2 will solve this is by no means certain.<br><br>**Falsified Medicines Directive (FMD)**<br>Implications for change in system and processes in community pharmacy, many unknowns, will add to workload and needs integrated IT solutions to "decommission" each unit of medicine supplied. | **Accelerate IT interoperability**<br>Interoperable messaging systems with hospitals, GPs and integrated urgent care services will enable formal referral pathways to and from community pharmacy enabling the development of robust clinical services and freeing up capacity in the wider system<br>Electronic activity reporting to enable direct reporting of interventions to other health professionals involved in direct care of the patient<br><br>**Accelerate central system development**<br>Shared clinical records with read and write access to enable community pharmacy to take on a meaningful clinical role<br>Development of electronic shared care plans to enable community pharmacy to support implementation and prevent decline requiring admission<br>Electronic repeat dispensing needs to be better understood, trusted and mainstreamed to free up GP, patient and carer capacity and allow pharmacy to individualise care, reduce waste and better manage workflow releasing capacity for more clinically focused work<br><br>**Standards for core pharmacy systems**<br>Agreement with pharmacy system suppliers of functionality availability within all systems to record and report on activity and outcomes |

## Behavioural Constraints
### Public awareness and expectation of the clinical care that pharmacy can and could deliver

| Barriers | Potential Solution |
|---|---|
| **Variation in what services a pharmacy offers**<br>Lack of consistency in the range of services that each pharmacy provides can cause problems with the public knowing what to expect, which can vary on different days according to qualifications of pharmacists / locums etc. This can also be compounded by the postcode lottery issue with regards to the local commissioning of services. Community pharmacy is only consistently known for dispensing medicines.<br><br>**Public perception and experience**<br>Public experience is crucial to changing behaviours. There is a poor understanding of services offered from pharmacy by patients, the public and other health care professionals. Local variation in commissioning accentuates this.<br><br>**Patient Groups**<br>Perceptions of the role of the pharmacist vary with different cultures, age groups and those with different long term conditions.<br>Patients are unaware of the pharmacy team members and their training. | **Raise awareness**<br>Raise awareness of the full range of services community pharmacies provide. Provide easier access to information about the services available from pharmacies via NHS Choices entries and the NHS 111 Directory of Services<br>Drive more consistency and clarity in service offering with clear awareness of the availability of consultation rooms, etc.<br><br>**Specific campaigns**<br>Increase use of specific campaigns e.g. Winter Campaign, in order to change population behaviour. (The Winter campaigns have had an impact on those who would seek advice from a pharmacist on staying well or talk to their pharmacist earlier in an illness to prevent it from getting serious)<br>Use campaigns to inform public of the role community pharmacy can play in managing ill health and keeping people well<br><br>**Patient groups**<br>Work with patient groups and establish patient forums to ensure that community pharmacy services meet the needs of service users |

## Behavioural Constraints
### Pharmacy teams and other health care professionals

| Barriers | Potential solutions |
|---|---|
| **Dispensing is the default position and the comfort zone for pharmacy team**<br>Currently, the measure of a "hard day" is in the number of items dispensed; similarly, the reward is volume-based. This is reflected in staff training and development for both the pre-registration training, with a focus on accuracy, and wider pharmacy team development.<br><br>**Clinical and professional confidence can be lacking**<br>Partially a reflection of underdeveloped consultation and counselling skills and partially a stagnation of previously learned skills given the historic roles undertaken.<br><br>**Pharmacist and pharmacy team inertia**<br>Resistance to change, possibly because future roles have developed on top of current item-focused roles rather than as an alternative leading to workload issues.<br><br>**Support staff not used effectively**<br>The medico-legal responsibilities around accurate dispensing leave some pharmacists feeling unable to use skill mix to effectively manage the risks through the pharmacy team.<br><br>**Lack of trust in the wider system by contractors and practitioners**<br>Lack of action to support - previous positive words at a strategic level have eroded the confidence of both contractors and practitioners that the wider NHS system is willing to develop the clinical role of community pharmacy.<br><br>**Lack of confidence in community pharmacy to consistently deliver**<br>Community pharmacy has not always delivered as expected locally when services have been commissioned. This can be due to fast set up, lack of outcomes measures, multiple small services and complex commissioning arrangements which deter engagement.<br><br>**Poor understanding of community pharmacy**<br>NHS 111 call handlers and others do not understand the training and role of community pharmacy or the complexity of services offered and therefore fail to refer when it is an option.<br><br>**Local peer relationships (see integration/relationships)**<br>Whilst also a barrier to integration, the relationships between GP practices and pharmacy can also be lacking or competitive. In some cases CCG medicines optimisation teams become the trusted pharmacy expert and local relationships with community pharmacy have broken down. | **Define the future role**<br>Articulate a clear vision for the clinical role of community pharmacy with steps towards achieving this outlined in a way that all key stakeholders can clearly see how it will be delivered<br><br>**Manage change**<br>Support community pharmacy and the wider out of hospital team to facilitate and manage change to introduce radically different ways of working and move towards an enhanced clinical role – HEE and the professional leadership bodies have a role to play in helping to support this move<br>Develop and implement a programme of activity to ensure all contractors engage in a new way of working and all commissioners understand the value community pharmacy adds<br>Workforce skill mix review within each pharmacy and support achieve change through this<br><br>**Financial incentives**<br>Use financial incentives to support the vision of moving towards a clinical rather than supply based role for community pharmacy<br>Agree funding arrangements that facilitate long term planning so businesses have the confidence to invest and to remove the existing short-term thinking |

## System Contractual Constraints

### Contractual mechanisms for pharmacy are complex and poorly understood

| Barriers | Potential Solution |
|---|---|
| **Incentives and funding are not aligned to best effect**<br>The nationally negotiated community pharmacy contract is often cited as a barrier to the development of community pharmacy because the bulk of the contract is activity-based. Attempts to introduce patient-focused services through the funding of medicines use reviews and the new medicines service have attracted criticisms of being quantity rather than quality driven and having little focus on patient outcomes. Contractual mechanisms do not promote integration with other elements of the health service. There is an ongoing expectation of backfill requirements in order to deliver new roles.<br><br>**Dichotomy of retained margin**<br>The current CPCF has increased the proportion of income to be provided through profits on procurement from 20% to 35%; this delivers a message of importance of purchasing rather than clinical services, creates a culture of "trading" rather than professional supply. Delivery of funding through margin creates inequities of income, does not reward quality or outcomes but does generate significant savings for the NHS.<br><br>**Definitions of pharmaceutical services and what can and cannot be directly commissioned**<br>Only NHS England can commission pharmaceutical services but others such as local authorities and CCGs can commission services from pharmacy. This leads to confusion about what should be covered by the CPCF and what is the responsibility of others to commission.<br><br>**Governance, assurance and payments**<br>Multiple commissioners of services have different and complex payment, governance and assurance mechanisms, for example, a local contract for smoking cessation requires manual submission of quit records to one body, automatic submission of NRT supplies to another and a quarterly retainer claim to a third.<br><br>**Currently available alternative contracting models**<br>Local Pharmaceutical Services (LPS) contracts are poorly understood by NHS England commissioners who are the only body who can utilise them. Local teams struggle with capacity to develop and the funding needed is outside of the CPCF. Further, they are not trusted by contractors partially because of their fixed-length nature but also the historical events around Essential Small Pharmacies. | **National standards and services models**<br>Nationally contracted services where this model is most appropriate<br>National recommendations, standards and tariffs to enable local commissioning, ensure local integration and ensure consistency in delivery<br><br>**New commissioning models**<br>Develop a new system of funding to enable new ways of working which is patient and outcome focused as opposed to volume driven alone<br><br>**Contractual arrangements**<br>Ensure new contracts for the new models of care include community pharmacy services<br><br>**Different contract models**<br>Use LPS contracts to support innovative practice and as a commissioning tool to develop clinical services |

## System Contractor Constraints

### Multiple perceptions and barriers that lead to lack of contractor engagement in developing clinical services

| Barriers | Potential Solution |
|---|---|
| **Security of funding**<br>Providers are dependent upon external funding to instantiate and invest; they have warranties and guarantees in place which make them averse of the unknown and unable to mitigate risk from a financial perspective without assurance and clear plans to the long-term from commissioners. Similarly, to maintain the gearing of external funding, the pharmacy as a business is expected to grow by such lenders; the growth mechanisms in the current CPCF are clear and well understood; the lack of clarity of this in future plans is a significant barrier to moving to a more clinically focused contract.<br><br>**Longevity of premises and infrastructure**<br>NHS, pharmacies fund their own premises costs. Leases on premises are, typically, tens of years and the need for different premises to deliver clinical services may be a barrier for some contractors to change; this is especially true in High Street and GP surgery sites where moving away from current sites would have other detrimental effects, such as destabilising a neighbourhood where they act as an anchor site for other premises.<br><br>**Vested interests and competition**<br>Whilst contractors compete for their patient list, through service levels and adding health value, there is a good base for peer support locally in their collaboration with stock loans and relationship management. There is a perception that there may be competing interests from wholesale operations which could be a barrier to a more clinically focused future if the incentives are not aligned. Proposed solutions are set aside for fear of ulterior motives.<br><br>**Local strategic negotiation**<br>The requirement for a personally negotiated contract for every pharmacy is prohibitive to any rapid progress. Similarly to commissioners, the capacity of some LPCs could be stretched by trying to adopt new models.<br><br>**Rebalancing, Supervision and the Responsible Pharmacist**<br>Currently, an inadvertent dispensing error is a criminal offence for which the contractor can be vicariously liable (see Behaviours). The introduction of a Responsible Pharmacist for each pharmacy has increased responsibility for safe running and allowed the individual absences of up to two hours from the premises but supervision under NHS Regulation means that single-handed pharmacies are unable to take advantage of this to provide care off the premises. However, changing the supervision role is perceived by some as leading to care without professional input and commoditisation of medicine supply; resistance thereby becoming a barrier to a more clinical role if the full roles and responsibilities of those involved are not clearly mapped out.<br><br>**Risk Management**<br>Pharmacists are trained to be risk averse through the risk of criminal prosecution; a lack of developed systems to mitigate risk whilst taking professional responsibility has led to a lack of confidence in moving to new roles. Similarly, with increased risk comes increased professional indemnity costs; pharmacy practitioners currently rely upon employer's insurance.<br><br>**Accreditation versus Competency**<br>Movement of skills between different commissioning areas is problematic leading to more training requirements along with costs, delays in service delivery and incomplete coverage. | **New ways of working**<br>Support pharmacists in adopting new ways of working to allow them to free up time in order to take on new roles. Areas for consideration include:<br>Clinical check of regular repeats prescriptions – every time it is dispensed or a more efficient system put in place<br>Retrospective clinical checks allowed for acute prescriptions (Dutch model) will allow pharmacists to spend more time with LTC patients without the need for interruptions<br>To achieve this pharmacists will also need to delegate and use skill mix effectively<br><br>**Rebalancing**<br>Engage contractors with the rebalancing programme and introduce through the change programme<br>Implement quality systems building upon existing layers of governance<br><br>**Contracting models**<br>Support the use of different contracting models that bring together a number of contractors as opposed to individual contracts with each provider. This includes enabling local community pharmacy providers to consider federations, led by the LPCs and the use of lead provider models.<br>Enable commissioners to work together on assurance, governance and payment mechanisms.<br>Contractors have demonstrated through large-scale, self-funded pilots and services that they are committed to a clinically focused future.<br>Standard national Declaration of Competence through CPPE rather than accreditation to provide services has worked well.<br><br>**Local leadership**<br>Support local pharmacy leaders to ensure community pharmacy attendance at key decision-making meetings, training events, etc. |

# System Commissioner Constraints
## Multiple commissioners in a highly complex commissioning environment

| Barriers | Potential Solution |
|---|---|
| **Budgets**<br>Budgets are separated across numerous commissioners e.g. a COPD patient could have support for their medicines from one budget, and smoking cessation support from another, with no guarantee that this system would be joined up. Local budgets are perceived to be held in silos by professions with each protecting their own domain.<br><br>**Evidence base**<br>Lack of evidence base against which to commission community pharmacy. Difficult to isolate the impact of the role of pharmacy within the multidisciplinary team. Lack of access to commissioning data for pharmacy, this includes lack of evidence base for the difference pharmacies make to clinical outcomes.<br><br>**Business cases**<br>Services are not always supported by robust business cases that clearly set out the economic benefit of commissioning.<br><br>**Commissioner understanding and knowledge**<br>Lack of understanding of complexity of commissioning pharmaceutical services versus services from pharmacy and legal issues around this. Assumption that NHS England commissions all services from pharmacy by some in the system. This can be exacerbated by the periodic reorganisation of commissioning arrangements in England. Conflict of interests from GP commissioners and unfamiliarity with commissioning services from pharmacy all too difficult.<br><br>**Commissioner capacity**<br>Commissioners with little expertise in pharmacy across NHS England, CCGs and Local Authorities. There is also lack of capacity within commissioning organisations to develop, manage, assure and evaluate services effectively.<br><br>**Pharmacy representation**<br>Pharmacy can struggle to make its voice heard at health policy tables. There can also be a failure to spread local learning and there can be a lack of effective system leadership that recognises and supports the clinical role of community pharmacy.<br><br>**Burden on contractors**<br>Huge burden on contractors with contracts disproportionate to services being provided e.g. palliative care medicines and mandated NHS Standard Contract. Complex for small business to understand, not efficient in terms of contracts, payment mechanisms, assurance processes – procurement process tends to be lengthy and complicated. Commissioning at small scale for short time periods means pharmacy cannot plan and invest in training, equipment, premises etc.<br><br>**Contractor delivery and expectations**<br>Community pharmacy contractors don't appear to performance manage their branches to deliver commissioned services. Managed repeats created much distrust with a perception of putting profits before patients.<br><br>**Perceptions of value**<br>Commissioners believe pharmacy has an unrealistic expectation of the value of the service – pharmacy contractors feel they are undervalued. | **Evidence base**<br>Build on the existing evidence base and cost benefit analysis to promote the impact that community pharmacy can have on patient care, outcomes and efficiencies:<br>• Long term condition support<br>• Public health services and prevention<br>• UEC – e.g. Emergency supply<br>• Care homes support<br>Enable commissioners to pool data on services commissioned from community pharmacy<br><br>**National standards for services**<br>Put in place a national standard framework of services to ensure consistency in how the service is both commissioned and delivered.<br>Ensure all services have clear, measurable outcomes<br>Develop a national framework for evaluation of services<br><br>**Leadership skills**<br>Support local pharmacy leaders to develop the skills to build effective local relationships e.g. Adaptive Leadership<br>Longer term commissioning involving the sector in planning<br><br>**National standards for competencies**<br>Build on the existing Declaration of Competence system to streamline commissioning of services.<br><br>**Align activity to national and local priorities**<br>Align local initiatives to national strategy<br><br>**Improving commissioning uptake**<br>Improve sharing of information and intelligence by NHSE to inform and streamline the process of commissioning services<br>Target commissioning organisations to demonstrate how they are using all of their partners, especially pharmacy<br>Ring-fence funding to commissioners to use for community pharmacy clinical services |

## Skill Mix and Workforce

**Varied funding routes, with focus on range of post registration solutions to equip the workforce to be flexible to patient need, so outcomes are varied**

| Barriers | Potential Solution |
|---|---|
| **Pharmacists skills**<br>Increasing prescription volume and pharmacists feeling they cannot let go of dispensing due to the threat of something going wrong has led to community pharmacists continuing with roles that pharmacy technicians undertake in hospitals.<br>To date training has primarily been focused on knowledge rather than skills.<br>More clinically focused services require a higher level of clinical skill and whilst some are keen to develop these skills others struggle for a variety of reasons including time, capacity and confidence (see behaviours). Pharmacists rarely released with pay to attend training. | **Training and mentoring framework**<br>HEE and community pharmacy representative bodies to work together to support community pharmacy to adopt a new range of skills<br>Develop a training and mentoring framework to support development of enhanced clinical skills<br>Support pharmacy professionals to make best focused use of CPD/CFtP |
| **Independent prescribing**<br>Independent Prescribing training and accreditation has not been widely taken up by community pharmacy as to date the commissioning models are not set up to support this model, although there are examples of this working in Scotland.<br>Some employers are reluctant to continue funding the development of IPs as many of those trained have moved into other areas of work due to lack of commissioning IP models from community pharmacy. | **Independent Prescribers**<br>Incorporate plans into the training framework to enable a move towards more IPs over the next 5 years |
| **Workforce capacity – model of practice**<br>Pharmacy teams have a variety of skills, and some teams use these skills extremely effectively however this is not the case universally and so the full capacity of the workforce is not utilised. Staff capacity, beyond the capacity of the pharmacist, including workload and competencies to take on new roles can be challenging. | **Patient engagement**<br>Support pharmacy professionals to develop improved consultation skills to provide them with the confidence to take on more patient facing roles and allow them to support lifestyle and behaviour change<br>Support community pharmacist to develop their knowledge of longitudinal care of a patient i.e. towards a care plan approach |
| **Training CPPE**<br>Training needs are very different from one pharmacy provider to another. | **Use of clinical tools**<br>Support community pharmacists on the use of clinical tools and therapeutic drug monitoring to allow the management of patient's care more effectively, including patient activation |
| **Role of the Pharmacy Technician**<br>Pharmacy Technicians do not have the opportunity to fully exercise their defined professional role and. there is not a clear career pathway in community pharmacy. | **Pharmacy Technicians**<br>Develop clear role description for Pharmacy Technician and Accuracy Checking Pharmacy Technicians (ACPTs) to include technical, clinical and leadership aspects<br>Increase Pharmacy Technician/ACPT training towards significant workforce shift to free up pharmacist capacity by taking over day to day management of the dispensary.<br>Potential to be included on the PGD list as registered pharmacy professionals. |
| **Locum workforce**<br>Locums are not always engaged in new services and the wide use of locums can result in less stability and a transient workforce in some pharmacies (see integration). This also impacts consistency of service offering and therefore can confuse patients and decreases the confidence of commissioners | **Rebalancing**<br>As a result of the rebalancing work on supervision, support pharmacy contractors to map out their workforce requirements in the future. |

## 11.3 Annex 3 - Nationally commissioned Essential and Advanced services and locally commissioned Local Enhanced Services

| Essential services | Advanced Services | Locally Enhanced Services | |
|---|---|---|---|
| Dispensing | Medicines Use Reviews (MURs) | Anticoagulant Monitoring Service | Minor Ailment Scheme Service |
| Repeat dispensing | New Medicines Service (NMS) | Care Home Service | Needle and Syringe Exchange Service |
| Disposal of unwanted medicines | Flu Vaccination (introduced as a new advanced service in 2015/16) | Disease Specific Medicines | On Demand Availability of Specialist Drugs Service |
| Promotion of Healthy Lifestyles (Public health) | Stoma Appliance Customisation (SAC) | Management Service | Out of Hours Service |
| Signposting patients to other healthcare providers | Appliance Use Reviews (AURs) | Gluten Free Food Supply Service | Patient Group Direction Service |
| Support for self-care | | Home Delivery Service | Prescriber Support Service |
| Clinical governance | | Independent Prescribing Service | Schools Service |
| | | Language Access Service | Stop Smoking Service |
| | | Medication Review Service | Supervised Administration Service |
| | | Screening Service | Supplementary Prescribing Service |
| | | Meds Assessment | An Emergency Supply Service (introduced in December 2013) |
| | | Compliance Support Service | |

# 12. References


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