Response to Improving General Practice – a Call to Action

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Introduction

In this submission we respond to a number of the questions posed in NHS England's Improving General Practice – A Call to Action document, with a particular focus on collaborative working across primary care, freeing up time and resources in general practice and providing greater choice and convenience for patients.

PSNC, as the representative body for community pharmacies that provide NHS services in England, has developed a Vision for how it believes community pharmacy services should develop over the next few years in order to enhance the care that people receive. It describes a range of developments in the services that community pharmacies offer across four domains:

1. Supporting people to optimise the use of their medicines;
2. Supporting people to self-care;
3. Supporting people to live healthier lives; and
4. Supporting people to live independently.

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

We believe that these developments will be of particular importance to general practice because they will help GPs to improve access to primary care services while also allowing pharmacies to directly take on some of GPs' workload. They will also enable patients to look after themselves more effectively, meaning they can avoid visits to their GP or urgent care providers; this should reduce the burden on those services, which, particularly in the case of costly secondary care services, could significantly reduce costs for the health service.

The Vision and a narrative document describing what implementation of the Vision might look like for patients, commissioners and community pharmacy teams is available to download at psnc.org.uk/vision.

Community pharmacy's relationship with general practice

Community pharmacy and general practice have always worked closely together, linked by the flow of patients and prescriptions between the two professions, but relationships at a local level are not always as strong or productive as they might be.

In PSNC's narrative on its Vision we highlight a number of ways that community pharmacy could work more closely with general practice in the future, in order to support the work of GPs and their teams in improving the care of patients, in particular the management of long term conditions. This could involve pharmacies taking on a greater role in caring for patients and coordinating that care, via shared information and IT systems, more closely with that provided to the patient by their GP practice. We believe that NHS England has a role to play in enabling this by ensuring that GP and pharmacy incentives are more closely aligned and by working to improve interoperability between IT systems.

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

Building primary care capacity – management of long term conditions

In order to release capacity in general practices to allow the provision of new services previously provided by

secondary care, we believe there is a need to shift some of the existing workload within general practice to community pharmacy.

We have already suggested to NHS England that the existing national community pharmacy medicines optimisation services (Medicines Use Review and the New Medicine Service) could be developed to provide support for specific patient cohorts. For example, medicines optimisation support could be provided to all patients with asthma in order to augment the care patients receive from general practice. We have seen the impact this can have as projects in which patients prescribed inhalers receive pharmacy medicines optimisation services focused on teaching them to use those inhalers properly have reduced deaths and hospital admissions caused by asthma.

The routine provision of these sorts of pharmacy services would allow the community pharmacy support for patients to be embedded within local or national disease management pathways and NICE quality standards. In this way, patients and other healthcare professionals involved in the care of the patient would have certainty about what support community pharmacies would provide to patients, thus supporting team working across primary care.

The development of the medicines optimisation services described above could take place alongside a move to provide more active management of long term conditions, allowing the shift of some existing workload from general practice to community pharmacy. For example, the NICE quality standard for asthma requires patients to be offered an annual review of their condition. Traditionally this type of review has been undertaken in general practices by practice nurses; we believe this could instead be undertaken in community pharmacy.

Other disease areas which may be similarly amenable to community pharmacy management include COPD, Parkinson's disease, hypothyroidism, hypertension, type 2 diabetes and poorly managed pain. Any approach to shared care between community pharmacy and general practice would of course require there to be absolute clarity on what the community pharmacy is responsible for providing and its accountability for patient outcomes.

We recognise that this approach does not fit with the generally held desire within healthcare to treat people with multiple morbidities in a holistic manner; however we believe this approach is necessary to start with in order that pharmacists and their teams can develop experience of managing one condition before they go on to provide support to people with multiple morbidities.

A key barrier to the extension of pharmacy's role in managing long term conditions has been resistance from other healthcare professionals. We believe that the Local Professional Network for pharmacy within each NHS England Area Team could play an important role in overcoming this resistance, by supporting effective liaison between community pharmacies, CCGs and GP practices.

We believe that focusing initially on one disease area, such as asthma or hypertension (in patients with no co-morbidities), could also help to break down resistance by demonstrating competence and building confidence in the minds of patients and other professions in pharmacy's ability to manage patients working in collaboration with general practice.

Implementing such an approach to the management of long term conditions would also require alignment of the GP and community pharmacy contracts with the inclusion of clear incentives to drive collaborative working.

Allowing patients to experience an effective and truly integrated service provided by community pharmacy and general practice will bring benefits, but will involve some changes to the ways in which patients have traditionally received their care. There will therefore be a need to develop patients' understanding of the choice of services they have to support the management of their long term conditions. We believe there will also be a need to implement a communications campaign on this issue, particularly in the early days of implementing a model of integrated care.

Another barrier to collaborative working across primary care is the inability of community pharmacy to access GP patient records, where there is a legitimate need for this access and the patient gives their consent. Access to patients' records and the ability to communicate electronically with GPs in a secure manner would increase safety and productivity in primacy care.

The Secretary of State for Health has recently provided in principle support for appropriate access to records, but it is unclear how this can be implemented. NHS policy on IT developments is increasingly to focus development at a local level, but we strongly believe that achieving pharmacy access to GP patient records requires national leadership by NHS England. At the very least, there is a need for national leadership to drive the development of interoperability standards, so that pharmacy and GP IT systems at a local level can all communicate with each other.

Building primary care capacity – supporting self-care

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

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

PSNC has promoted the national commissioning of a minor ailments service for many years and in the 2008 Pharmacy White Paper the then Government proposed that a national service should be discussed by DH and NHS Employers with PSNC. During those discussions the principal block presented to progress was the inability of DH to reallocate funding in the GP contract to community pharmacy, in order that DH did not 'pay twice' for the management of patients with minor illness. The role of NHS England as the commissioner of all primary care contracts, including community pharmacy and general practice, now presents an opportunity to re-visit this issue.

Building primary care capacity - supporting independent living

England's changing demography and the increase in the number of people with life changing conditions such as dementia require that all healthcare providers examine how they can respond to the changing needs of their local population. Community pharmacies already provide a range of services to support people to live independently in their own homes, including the NHS repeat dispensing service; home delivery of medicines to the housebound; appropriate provision of multi-compartment compliance aids and other interventions such as reminder charts to help people adhere to their medicines regimen. These services augment the medicines optimisation services described previously and can help to reduce patient demand for the use of general practice services as well as social care support.

Some pharmacies have also provided reablement services following discharge from hospital and falls assessment / reduction services. Both these services could help to reduce future demand on secondary care and could augment the focussed care that GPs are likely to be providing for vulnerable older people.

Building primary care capacity - supporting people to live healthier lives

It is important that all members of the primary care team ensure that they make every contact count when talking to patients. All community pharmacies provide healthy living advice to patients as part of the public health element

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

Community pharmacy is able to reach a significant cohort of people who do not regularly access their general practice, which presents an opportunity for more preventative interventions to be made to reduce their risk of developing long term conditions. By helping patients to look after themselves more effectively and stay healthy the burdens on general practice and all other health services could be reduced.

PSNC is keen to continue our dialogue with NHS England on how community pharmacy can develop its services to help better support the care provided by general practice and to benefit both patients and the NHS.

About PSNC

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

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