Community Pharmacy in 2016/17 and beyond proposals

Royal Pharmaceutical Society final response

General comments

We are the professional leadership body for pharmacists and this response reflects this role, as well as the potential impact of these proposals on patients and the public.

We recognise the need to consider efficiencies across the NHS in order to ensure the best use of NHS resources at this time of growing demand. We also realise that other sectors of the pharmacy profession are being asked to make efficiency savings[i]. The best contribution that pharmacists can make to NHS efficiencies is their role in medicines optimisation and prevention of ill health.

We would like assurance from Government that the overarching objective of these reforms centres on improving patient access to high quality care, advice and medicines from pharmacists including those working in community pharmacies.

If there is a mutual understanding between the profession and Government regarding this underpinning aim we believe there is much we can do to work together.

We refer you to our initial response to the proposal submitted on 12 Feb 2016:
http://www.rpharms.com/news-story-downloads/rps-comm-phy-proposal-response-public-final.pdf
and also our further response on the Pharmacy Integration Fund:
http://www.rpharms.com/promoting-pharmacy-pdfs/rps-phif-additional-comments-final.pdf

This final response will only focus on the further information that has been made available since the initial proposal in January 2016.

We are encouraged that the Department of Health and NHS England have engaged with the RPS as the professional leadership body for pharmacists in shaping the future for the pharmacy profession. We hope that this engagement with key stakeholders will continue in future years.

We have concerns that there has been little evidence of patient and public engagement with the proposed reforms. Much of what has been suggested is what pharmacy would like to deliver but we would question whether the proposals have been tested with patients and the public. We would be happy to assist and facilitate engagement with patient groups as pharmacy reforms progress, both now and in the future.

As the consultation on the reforms was being undertaken in parallel with negotiations on changes to the contractual framework for community pharmacy, it has at times appeared disconnected. There has been confusion with regard to what the negotiating body could share with other stakeholders, meaning our initial expectations of being closely involved were not met. We suggest that in the future the discussions are held prior to the actual negotiations to enable negotiations to be based on an agreed future vision for the profession and sector. It would also be useful to have had much greater clarity, at the outset, about the mechanism of the consultation process.

Pharmacy Integration Fund

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We are aware that the consultation on this element of the reforms finished on 24 March 2016. However, since that time more information has been shared with stakeholders as to the purpose of this fund so we think it is relevant to include additional comments on this in our final response.

The purpose of the fund should be to ensure better access to high quality pharmacist expertise and knowledge across all care settings, and in particular primary care. Where a pharmaceutical service can be commissioned nationally then this should become part of the contract negotiations and the PhIF should not be used to develop the service. The PhIF should not be used where existing funds are available through existing sources, e.g. IT funding via the Health and Social Care Information Centre (HSCIC).

The PhIF should only be available for supporting change in pharmacy and its integration into health systems to benefit patients. We would expect bids for this fund to be led by pharmacists.

It is important to acknowledge that successful implementation of the reforms will require an engaged, motivated and inspired pharmacist workforce and this needs to be effectively supported.

Further key points:

- The PhIF could be compared to the funding provided to support GPs and their Forward View. The allocation of this funding via the 10 point plan was a collaborative agreement between NHS England, Health Education England, the professional leadership body for GPs (RCGP) and the trade union (BMA). We would like to see a similar governance arrangement be put in place for the PhIF.

- We recognise that digital solutions could support the integration of pharmacists into primary care and we would support the use of the PhIF to accelerate these, for example mobile technology to enable information to be available at the point of contact with the patient such as in their home or a care home.

- The funding should not be used to do more of the same but instead should test out new and different models of care, for example community pharmacists working with GP practices

- Whilst we agree that the PhIF should be used to develop the clinical skill and expertise of pharmacists in order to deliver new models of care we believe that this should be enabled to be developed at a more local level to fit local needs and requirements. In order to do this training could be developed and provided at a local, rather than a national, level.

- We strongly support the development of pharmacists as non-medical prescribers and we are concerned to hear that prescribing courses in some areas are reducing the number of available spaces on their courses. This needs to change, alongside clear roles for prescribing pharmacists within the NHS.

- We believe there is much that community pharmacists can do to support patients with long term conditions and that this should be recognised, supported and tested via the PhIF, such as community pharmacists delivering packages of care

- The unique skills of pharmacists lie with their knowledge and expertise on medicines and their use and this needs to be recognised and supported in new models of care. We would like to

see a proportion of the PhIF used to support the integration of pharmacists in to the new models of care being developed via the vanguard models.

- The recognition of the skills and expertise of pharmacists should also be recognised by the sustainability and transformation plan (STP) leads so that pharmacists working in community and other sectors are included in the delivery of these plans across the 44 footprints. This will ensure that high quality pharmaceutical care provision is part of future models of care.
- In relation to pharmacists in care homes we believe very strongly that the PhIF should be used to test a range of different models of pharmacist input into care homes, including community pharmacists delivering enhanced care. A rigorous assessment of outcome data should be put in place to ascertain which models work best for patients and care home providers.
- Pharmacists should be provided with the opportunity to use their clinical skills with enhanced softer skills to deliver real person-centred care to patients i.e. undertaking a person-centred clinical medicines reviews based on shared decision making with the patient.
- It would be very useful to have early knowledge with regard to how NHS England intend to allocate the funding over the five year timeframe.
- We welcome the invitation of NHS England to co-chair the workstream looking at the development of the pharmacists in care homes. We are committed to this project and feel this could be a collaborative model for other service development initiatives
- The NHS England 2016/17 document can provide an immediate focus for where community pharmacists can be further integrated into the NHS to deliver value including, for example, their role in identifying people at risk of diabetes, supporting mental health and dementia and people with learning disabilities.
- Some of the barriers to commissioning services from community pharmacy need to be explored and solutions developed, for example co-commissioning.
- A map of the future of community pharmacy is required. Pharmacists need a vision, a model or models, of the future of community pharmacy. Our thoughts on this are laid out in appendix 1 (8 principles).

Funding and the Pharmacy Access Scheme

Pharmacy Access Scheme:

Good access to pharmaceutical care will be achieved when every patient can easily access a pharmacist's knowledge, expertise and support on medicines and their use as well as prevention of ill health in a timely and convenient way. We believe that community pharmacists are part of the pharmaceutical care network to deliver this.

Further key points:

- It is essential that quality criteria are developed and used to allocate funding to pharmacies as part of the pharmacy access scheme. Payment should not be based solely on location and dispensing volume.

- We welcome the fact that the pharmacy access fund will look at how close the pharmacy is in relation to people and a population rather than just the distance between the pharmacy and the next nearest pharmacy.
- We are concerned that the access scheme funding will be reviewed only on an annual basis as this does not encourage long term investment in the business by the pharmacy owner. We would suggest a less frequent review
- We agree that no pharmacy should receive more funding via the pharmacy access scheme than they currently receive.
- We would be concerned if pharmacies had to apply for funding via the pharmacy access scheme and the administration of such a process could be significant. There should be clear and simple eligibility criteria for allocation of this funding.

Funding considerations:

It is important that funding for community pharmacy is maintained at a sufficient level to ensure the quality of service provision to both reward and retain pharmacies in the right location and to ensure high quality services that meet local healthcare needs.

Further key points:

- We are very concerned that the cut in contractual funding will have a negative impact on patients and the public as described in our original response.
- We are also very concerned that pharmacists will be forced to reduce the number of people in the workforce to focus only on safe supply, therefore reducing the potential to deliver additional value in the community, this is already happening as pharmacies prepare for the cuts.
- Quality criteria should also be used as part of the national allocation of payment to pharmacies, with those delivering high quality services receiving more reward. We are aware it may take some time for such criteria to be developed and agreed.
- The proposed single activity fee, whilst making the payment system simpler, is still related to number of prescription items dispensed which continues the current volume based payment system and the potential to concentrate on volume and activity rather than quality of clinical service delivery.
- It is proposed that the establishment payment is phased out. However, a new model should be established which supports delivery of services. The proposed activity payments do not appear to fulfil the government's stated aim of reducing volume based activity. The government should consider how payments can move to rewarding clinical services and patient outcomes. Decisions should be linked to the outcome of the community pharmacy clinical services review.
- The RPS would support the development of a national non-dispensing scheme to increase the efficiency of the prescribing and dispensing system and to support the medicines optimisation agenda. Currently GPs do not realise how many of their patients do not actually need or want to get their prescription items dispensed. The patient should only receive the medicines that

they need and a national scheme should ensure information is fed back to the patient's GP, there should be no disincentive to achieving this aim.

- We agree with the need to ensure actions are put in place to facilitate the consolidation of pharmacies in areas of clustering.

Modernising services, and quality of services

The RPS believes that pharmacists should be wherever medicines touch patients, whether this be in a community pharmacy, a hospital, a GP practice, a care home or an urgent care clinical hub. Pharmacists need to be included in all care pathways where medicines are involved. We also believe that these roles must deliver a cohesive service enabling improved use of medicines that integrates community pharmacists into the delivery of primary care. Pharmacists are the only profession with the pharmacological knowledge and available workforce to deliver on key outcomes in reducing the harms and increasing the benefits of medicines.

We have responded to the current consultation on 'Amendments to the Human Medicines Regulations 2012: 'Hub and spoke' dispensing, prices of medicines on dispensing labels, labelling requirements and pharmacists' exemption' and our response can be found at http://www.rpharms.com/consultation-responses-pdfs/consdoc160520.pdf . In this response we have outlined a number of concerns about a hub and spoke model of medicines supply so we will not reiterate those here.

Further key points:

- Currently pharmacists choose which patients they provide a delivery service for and this is mainly to frail, elderly housebound patients. If pharmacies were required to offer a delivery service to all patients, which market forces would require them to do, then there would be a significant additional cost to the pharmacy. Each delivery costs an average of £2.50 so this would be unsustainable for the pharmacy if the majority of patients requested delivery. However, if pharmacies could add a surcharge for such a service then this could counteract this additional cost burden. If the Department of Health wants patients to receive home deliveries then this service should be funded by them but we do not believe this is the best use of scarce NHS resources.

- Reducing the supply of medicines to a delivery service would minimise the 'touch-point' that a pharmacist can have with a patient to add value and provide pharmaceutical care.

- If patient were to request delivery of their medicines direct to their home then this should not be authorised until they have undertaken a clinical medicines review with their community pharmacist. There should be a regular medicines review at time intervals agreed between the patient and pharmacist and when there are any changes to the patient's medicine(s). This would need to be built into any system developed to enable delivery to a patient's home.

- There are currently GPhC standards for delivery and we also have guidance in this area. These standards should not be relaxed as medicines are not normal items of commerce and carry significant potential risks to unintended recipients, so a signature for receipt of medicines must be obtained (this can be recorded delivery for distance selling / internet pharmacies).

- Whilst we support the service development proposals suggested by PSNC we do not feel they are ambitious enough and the implementation timescales are significantly longer than we would like to see.
- We believe that distance selling / internet pharmacies should have a different contract to a 'bricks and mortar' pharmacy as they are unable to provide the full range of services required under the current contractual framework.
- We support the development of quality indicators and hope that considered though is given to these and we would be happy to contribute to the development of these.
- The emergency supply of repeat medication service should be commissioned at a national level.

Essential enablers

If these enablers are implemented then the resultant action will underpin and support the delivery of clinical services by pharmacists.

- Health Education England (HEE) must be mandated to provide additional resources for pharmacists to ensure the right support and enablers are in place to ensure the workforce can deliver this vision
- Student and pre-registration pharmacists should be given the opportunity to undertake practice within the care settings outlined in the consultation (GP practices, care homes and urgent care clinical hubs)
- The current funding for the education and training of pharmacists needs to be re-prioritised to ensure it provides the skills and knowledge set required to deliver the vision we have outlined in this submission and as part of the RPS vision for the transforming the pharmacy workforce[ii]
- All pharmacists need to be enabled to be prescribers alongside the opportunities, support and enablers to train and practice as an independent prescriber
- Mandate commissioners to commission pharmacists to deliver services that involve medicines and patients. This will mean that local commissioners (CCGs and local NHS England) will be given the explicit responsibility for the 'integration' agenda to involve pharmacists in the strategic planning currently underway to deliver the five year forward view. We are aware there are currently perceived barriers in relation to co-commissioning and these would need to be removed
- Develop drivers and levers that ensure where innovation is successful in one area it is supported and adopted universally to enable equity of access and reduction of variability
- Ensure the new models of care consider the local involvement of pharmacists in delivery of patient care as most aspects of patient care will involve a medicine. Investment in medicines is the largest intervention in the NHS with £15.5 billion being spent on medicines in 2014/15[iii]
- Integration across the pharmacy profession needs to be supported by Government and all stakeholders and should also be a key element of the implementation of the Carter Review

- Any initiatives supported by the PhIF need to be viable, sustainable, scaleable and reproducible.

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Royal Pharmaceutical Society

For further information or any queries you may have on our submission please contact Heidi Wright at heidi.wright@rpharms.com or 0207 572 2344

About us

The Royal Pharmaceutical Society (RPS) is the professional body for every pharmacist in Great Britain. We are the only body that represents all sectors and specialisms of pharmacy in Great Britain.

The RPS leads and supports the development of the pharmacy profession to deliver excellence of care and service to patients and the public. This includes the advancement of science, practice, education and knowledge in pharmacy and the provision of professional standards and guidance to promote and deliver excellence. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

Its functions and services include:

Leadership, representation and advocacy: Ensuring the expertise of the pharmacist is heard by governments, the media and the public.

Professional development, education and support: helping pharmacists deliver excellent care and also to advance their careers through professional advancement, career advice and guidance on good practice.

Professional networking and publications: hosting and facilitating a series of communication channels to enable pharmacists to discuss areas of common interest, develop and learn.

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Appendix 1:

Principles of high quality care from community pharmacists

Below we set out eight principles, and outline descriptions, to drive high quality care from community pharmacists.

1. Part of a multidisciplinary team.

Multi - pharmacist pharmacies would become the norm. In some pharmacies, community pharmacists may work alongside many more practitioners as part of a highly networked wider virtual team. This wider team would include primary care professionals such as GPs, community nurses and, when appropriate, specialist input from hospital pharmacists and social care professionals. Many pharmacies will operate as local federations, sharing caseloads and referring patients. These arrangements would reflect the multi-specialty community provider outlined in the NHS Five Year Forward View (FYFV).

2. Intensive support for those with long term conditions and the frail elderly

Community pharmacist prescribers would routinely adjust, start, stop and change medicines as part of a holistic patient care plan and alongside other non-pharmaceutical interventions to improve care. Many community pharmacists may choose to specialise in supporting people with specific long term conditions (LTCs) or in supporting frail elderly patients with multi-morbidities. Patients could register with a pharmacy if they wished or have their care delivered through many pharmacies through shared care arrangements.

3. Focused on wellbeing and promoting good health

The pharmacy team, led by the pharmacist, would become a community resource for wellbeing and public health services including contraception, vaccinations for adults and children, the provision of stop smoking services and weight and alcohol reduction programmes.

4. Providing better access to effective treatments

Pharmacists will diagnose and treat minor illness, through the provision of NHS and individually funded treatments. Access to NHS prescription medicines and other clinically effective medicines through pharmacists would remain a defining feature of community pharmacy.

5. Open seven days

Pharmacies would be open to reflect a seven day NHS as a minimum, with many open evenings and some open 24 hours a day. The pattern of opening hours for each individual community pharmacy would be defined by the needs of the locality.

6. First contact urgent care

Every local health system (as referenced in the NHS planning guidance 2016/17-2022-21[1]) would have access to a designated urgent care pharmacy that would offer early intervention for those with LTCs and treat minor illness and minor injuries. Community pharmacists with advanced urgent care skills would work alongside other urgent care practitioners to provide a first contact service that can refer to Accident and Emergency (A&E) E and out of hours (OOH) GPs as well as receive referrals from these services.

7. Digitally enabled

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All community pharmacists would be able to read and write to integrated care records, and would be routinely aware of hospital discharge information to allow smooth transfer of patient care. Patients would be able to check medicines availability in real time online and contact pharmacists through Skype, phone as well as face to face.

8. Accessible

Community pharmacists would be more accessible in areas of high social deprivation or in "under doctored" areas.

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[i] https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

[ii] http://www.rpharms.com/workforce-and-education/transforming-the-pharmacy-workforce-in-gb.asp