

Community Pharmacy in 2016/17 and beyond proposals

Royal Pharmaceutical Society additional commentary on the Pharmacy Integration Fund (PhIF)

Introduction

The RPS believes that the purpose of the fund should be to ensure better access to high quality pharmacist expertise and knowledge across all care settings. This is consistent with the letter from Dr Ridge in January 2016 stating that 'A new *Pharmacy Integration Fund (PhIF)* will be established to help transform how pharmacists, their teams and community pharmacy will operate in the NHS and that the proposal for year one of the PhIF will be to focus particularly on the key enablers to achieve integration of community pharmacy'.

What the PhIF should not be used for

The PhIF should only be available to support change in pharmacy and to facilitate its integration into health systems in order to benefit patients. We would expect bids for this fund, enabling multidisciplinary team working, to be led by pharmacists.

Where a pharmaceutical service can be commissioned nationally then this should become part of the contract negotiations outside of the PhIF. Services in current discussion as part of national community pharmacy negotiations should not be considered as part of the PhIF.

We agree that it is critical that there is development of an IT infrastructure to enable interoperability between community pharmacy and the wider NHS. We consider that read and write access for all pharmacists to the patient record is a basic pre-requisite for the delivery of medicines optimisation. However, the PhIF should not be used where funds are available through existing sources such as the development of the IT infrastructure via the Health and Social Care Information Centre.

Integration of pharmacists

We would like to see the PhIF used to integrate community pharmacists more fully into local care models, particularly those models outlined in the Five Year Forward View (FYFV), and supported to fully deliver the medicines optimisation agenda. Embedding community pharmacists into the innovative FYFV models of care will normalise their inclusion into NHS planning.

We agree that the "action research" approach used in the new care models must be used to encourage the spread of good practice. Where innovations are delivered via PhIF and demonstrate value, these should then become part of core contractual negotiations.

Pharmacists should be functionally integrated into the delivery of urgent and emergency (U&E) care. Community pharmacists provide a range of clinical services that reduce the pressure on A&E and GP practices and these include supply and advice around common ailments, supply of urgent repeat medicines and emergency hormonal contraception (EHC). Out of hospital care will be more efficient if NHS111 and GP out of hours services can refer patients directly to community pharmacies. The spread of pharmacists working in out of hours response centres will better enable the uptake of this service as well as providing direct clinical expertise in this role. We are very keen to see community pharmacies

used as a first contact point for urgent care that is functionally integrated into the wider NHS provision. We have also proposed the creation of a number of local 'urgent care pharmacies' in each locality. The current development of NHS Sustainability and Transformation Plans within 44 areas or 'footprints' within England should be used to include community pharmacy urgent care.

Patients should expect to see community pharmacists delivering an integrated service for patients with stable long term conditions (LTCs) and they should be the first point of contact for health and wellbeing advice as well as the supply and advice of medicines. In the future community pharmacists will optimise medicines for individual patients as part of their LTC care. In order for this to be realised community pharmacists need to become an integral part of the primary care team and be a natural part of care pathways. The PhIF should be used to support local initiatives that do this.

We recognise and support the three examples of a new clinical infrastructure for the profession, in general practice, care homes and urgent care clinical hubs, but this needs to operate in collaboration with a robust community pharmacy network. A pilot exploring the potential of pharmacists working in GP practices is already underway and we expect the evaluation to encourage even greater uptake of this role as it becomes more widely acknowledged. The PhIF can now be used to develop other new roles for pharmacists.

The more that pharmacists are integrated within the NHS the more often local commissioners will realise the benefits they can bring. This will mean that pharmacists will have greater opportunity to access other funding sources such as transformation funds, funds for delivery of the FYFV vanguard models and Better Care funding.

It is also important to address the issue of better integration within the pharmacy profession so that we can bring together the clinical skills of pharmacists in the community, pharmacists in GP practices and pharmacists in the hospital to improve transfer of care, outreach and medicines optimisation for all patients.

Evaluation and research

There are already many innovative services being delivered by pharmacists and we want to see the evaluation of these, using action research methodology, so that the adoption and spread will be accelerated through an evidence base. We believe that it is right that the PhIF is used to evaluate new practice as it supports its development. This would demonstrate evidence based innovation that would result in viable, sustainable improvement in care for patients and the public.

What action is needed to make this happen?

We want patients to receive more direct care from community pharmacists providing a wider set of clinical services, therefore it is critical that the available funding is sufficient to make this happen. Having other roles for pharmacists, as highlighted in the consultation letter and working in partnership with community pharmacists will create a mutually supportive pharmacy service. This will greatly accelerate the delivery of medicines optimisation.

Education and training

Health Education England (HEE) should enable the pharmacist workforce to deliver the ambitions of the PhIF. HEE funds, or other workforce development funding such as the NHS

Leadership Academy, could provide practical support around change management and leadership and other relevant enabling skills within the first year.

The current funding for the education and training of pharmacists should be prioritised towards providing the skills and knowledge set required to deliver the ideas outlined in this consultation, those that we have described in our campaigns¹ and the RPS vision² to transform the pharmacy workforce.

All pharmacists providing patient care should be able to train and practice as independent prescribers, however this should be supported through mainstream healthcare workforce funding rather than the PhIF. The RPS will work to remove barriers to the uptake by pharmacists to independent prescribing training, such as the need for a medically trained mentor. In addition, 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).

Drivers and incentives

NHS England needs to develop mechanisms to ensure that where innovation is successful in one area it is supported and adopted universally to enable equity of access and reduction of variability. They also need to encourage the FYFV new models of care to include pharmacists in all situations where medicines are used, during national and local strategic planning. Commissioners should also be required, via the Commissioning Outcomes Framework, to commission pharmacists to deliver any services that involve both 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 pharmacist led services in the strategic planning currently underway to deliver the FYFV, such as the Sustainability and Transformation Plans³. The delivery of this commissioning would then be subject to the monitoring of delivery against these plans. We are aware there are currently perceived barriers in relation to co-commissioning in relation to pharmacy services and these would need to be resolved.

Pharmacy profession

There is also a requirement for a change in culture across community pharmacy to prepare for a greater role in patient care. Community pharmacists and their employing organisations need to embrace this change and the move towards enhanced clinical roles with support to make this happen.

What the RPS can do

We would like to use our wide breadth of expertise to help shape the PhIF and its use. We understand that the PhIF needs to be flexible as the NHS changes and adapts over time, and we are ideally placed

¹ <http://www.rpharms.com/what-we-re-working-on/models-of-care.asp>

² <http://www.rpharms.com/workforce-pdfs/transforming-the-pharmacy-workforce-in-great-britain.pdf>

³ <https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>

to provide clinical leadership in this area due to our ongoing relationships with other Royal Colleges, all sectors of the pharmacy profession and patient representative organisations.

We would also like to lead on the development of new models of integration (both intra and inter-professional) to fully deliver the principles of medicines optimisation, taking a system wide approach. We would aim to do this by developing a collaborative working model, similar to that which we have successfully used in the early adoption of the transfer of care guidance and hospital standards implementation. This would need to be resourced with PhIF funds.

We believe that there should be an oversight group which will come together to determine the allocation of the PhIF funding and this should be made up from key stakeholders such as DH, NHS England, RPS, PSNC, PV, patients and the LGA.

The PhIF needs to be flexible and adaptable to ensure pharmacists and the services they provide are fully integrated into new models of care and that there is continuity of care within the models of integration. Any initiatives supported by the PhIF need to be viable, sustainable, scalable and reproducible. In effect, the PhIF should be regarded as Pharmacy's own Vanguard Scheme.



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