NHS
South West
Clinical Senate

Clinical Senate Council Meeting

Tuesday 29th January 2019
South West Clinical Senate Council: Community Pharmacy

Question

What are the opportunities and limitations for community pharmacy to contribute to prevention, help identify people at risk and manage long term conditions?

Overview

This topic was initially proposed by Public Health England in relation to the management of long term conditions by community pharmacists. It was subsequently agreed to broaden out the question to consider the community pharmacy offer to the wider healthcare system.

In the context of the recent publication of the NHS Long Term Plan, which identifies pharmacists as having an important role to play within the framework of primary care networks, these recommendations are particularly timely. They seek to clearly set out for NHS England, local commissioners, STPs, ICS' and pharmacists where relatively small changes in relationships and practice could reap significant benefits for patient care and service efficiency.

In developing these recommendations, the Clinical Senate brought together national pharmacy leaders, Local Pharmaceutical Committee leads and regional primary care and medicines optimisation commissioners as well as hospital pharmacists and public health leaders to present evidence and consider the opportunities for pharmacists to support community integration and deliver the aspirations of the Long Term Plan going forward.

Evidence

The NHS spends £17bn a year on medicines and provision of medication is the most common intervention that takes place in our healthcare service.

However, one of the most common errors in healthcare is in relation to medication with an estimated 237 million errors occuring in England every year. At the same time only 50% of patients are compliant with their medication instructions with 30% of patients non-adherent 10 days after being given medication. This suggests there is significant opportunity for improvement in these areas. The number of contacts each day through community pharmacists exceeds those elsewhere in primary care, presenting real opportunities to maximise the benefits of both regular and opportunistic contacts.

The Clinical Senate heard that pharmacists are a highly skilled and significantly trained clinical workforce that has the capacity to deliver the aspirations of the Long Term Plan for pharmacy but which is currently an under-utilised professional resource. Whilst a national over-supply of pharmacists is predicted by 2020, it was noted that this masks shortages in some areas, including the South West, in both recruitment and training numbers. It was suggested that there should be a focus on using current pharmacists more effectively, whilst developing roles to attract pharmacists from other areas.

File path:

The Citizens' Assembly shared a powerful patient perspective which welcomed the expanding role of community pharmacists to offer more services, in particular for long term conditions where relationships can be built, but noted that there was a lack of communication to patients around these additional services. It was highlighted that there is anxiety around whether private consultation areas are available and offered, how access to records is set up and interpersonal skills training for pharmacists was recommended.

To release the potential of the pharmacist workforce it is felt that a culture shift is required to ensure there is a shared vision for pharmacy services as part of wider community integration that brings with it stronger multi-disciplinary relationships and builds public confidence and acceptance of the pivotal role pharmacists can play in health promotion, disease prevention and the management of urgent and long-term conditions.

Emergent Primary Care Networks (PCNs), which cover a GP practice population area of 30-50 000 patients, were clearly identified as a useful framework to facilitate primary and community care integration and pharmacists need to be fully integrated into these multi-disciplinary networks to raise the profile of the community pharmacy offer and in turn realise the potential to support the wider system.

There are lots of pharmacy pilots and initiatives underway around the country and in the South West to test and evidence new models and best practice. These include;

- NHS Urgent Medicine Supply Advanced Service (NUMSAS) - the provision of urgent repeat medication without prescription via NHS 111 or GP referral
- Digital Minor Illness Referral Service (DMIRS) – diversion of patients from NHS 111 or GP before appointment for consultation
- New Medicines Service (NMS) – to support compliance
- Medicines Use reviews (MURS) – to support compliance and review medication
- Pharmacy led health checks for high risk conditions
- Pharmacy First Schemes – to encourage patients to consider consulting a pharmacist before presenting elsewhere
- Healthy Living Pharmacy schemes
- Care home resident medication reviews led by pharmacists
- Patient Activation Measures - to improve the overall health of patients with long term conditions
- Social Prescribing – supporting the focus on personalised care and connecting patients to link workers prior to GP attendances
- Public Health Campaigns (eg. Flu jabs)
- Making Every Contact Count (MECC)
- Transfer of Care Around Medicines (TCAMS)

Some of the possible opportunity savings linked to the above are as follows*;

- The estimated NHS costs of definitely avoidable adverse reactions are £98.5m per year, consuming 181,162 bed-days, causing 712 deaths, and contributing to 1,708 deaths.
- Up to £500m of extra value could be generated if medicines were used in an optimal manner in just five therapeutic areas.
- Medicines wastage in England costs £300m each year, £150m of which is recoverable.
- An estimated £135m a year could be saved through pharmacist led interventions and medicine reviews in care homes across the UK.

Source: RPS

There are clear opportunities and existing models to follow for community pharmacy to support urgent care pathways in the community, long term conditions, prevention, lessening the load on the GP workforce, preventing readmission and supporting care home residents. There are also a number of '100 hour' pharmacies across every STP/ICS footprint which offer cost effective patient access.

There was strong evidence presented of the impact some of this work has already had;

- Pharmacist led asthma reviews have been shown to reduce hospital appointments by 30% in one area with the work being co-ordinated by pharmacy technicians.
- Evidence from Scotland demonstrated a 35% reduction in activity as a result of a minor ailment scheme. If all minor ailment consultations were provided by pharmacies it could free up around 1 hour each day per GP.

It was also noted that there is a NHSE led pharmacy integration fund which could be accessed by Primary Care Networks to support the implementation of pharmacy pilots that have been demonstrated to deliver positive health outcomes and are linked to national strategic priorities, in particular urgent care and minor illnesses.

The clearest evidence for change demonstrated to the Clinical Senate was around transfers of care;

- Hospital discharge to a community pharmacist was associated with a significantly reduced risk of re-admission. Royal Cornwall Hospital Trust demonstrated the 30 day readmission rate going down to 8.5% from 23%. There are now a number of published studies which show a similar high level of impact to the work in Cornwall and utilise aligned methodology to the transfers of care between acute hospital trust and community pharmacy. A 50-65% reduction in readmission rates offers huge opportunity in cost savings and bed days as well as a better patient experience.

  It was noted that at University Hospitals Bristol up to 10 minutes was required for hospital pharmacists to discharge the patients and detail any changes to medication for community review via pharmoutcomes and this time constraint can be seen as a barrier for referring hospitals to deliver TCAMs schemes. The scheme currently supports around 30 referrals a month but it is estimated that this could be increased potentially 10 fold given appropriate resources in both hospitals and the community.

One of the key limiters described consistently for community pharmacies was lack of access to a single and complete care record beyond the Summary Care Record, with read and write access to primary care clinical information systems such as EMIS. This currently prevents valuable information regarding medications and patient history being shared with GPs and vice versa.

In many areas there is also scope to improve the interface between Community Pharmacy, General Practice and the wider health system thereby enhancing real time communications and preventing any duplication in services and improving communication to the public and health professionals around the additional services being offered by community pharmacies. The PCN model offers a system solution to integrate community pharmacists with the potential for a significant release of time for the GP workforce and improved access for patients.

Recommendations: Primary Care Networks Harnessing the Assets of Community Pharmacies

The combination of the accessibility of and high footfall through community pharmacies with the skills and competencies of the community pharmacy workforce means that the potential benefits of further integration of these services with the wider community and primary care services, to both patients and the system, could be profound.

The pharmacist workforce is a substantial asset to primary care that isn't always recognised or best used. Whilst there are some organisational interface issues that need to be addressed, the policy drive for Primary Care Networks, set out in the Long Term Plan, provides a real opportunity to overcome some of these existing barriers and upskill the community pharmacy workforce to support self-management in healthcare.

There is strong evidence from a number of community pharmacy initiatives that support urgent care pathways, the management of long term conditions, medicines optimisation and prevention, that there is significant opportunity for the community pharmacy workforce to improve patient outcomes and reduce demand on other parts of the health system.

The roll out of these schemes at scale is currently being limited by a fragmented approach both within and between health care systems, the lack of a common digital platform to support information sharing, inconsistent public messaging on the contribution and role of community pharmacies and a reluctance to utilise existing flexibilities in contractual frameworks to create integrated multidisciplinary teams.

The development of Primary Care Networks offers a framework to address these issues in the context of developing Integrated Care Systems (ICSs) across all the current 44 STP footprints.

Key Recommendations for implementation as soon as possible by commissioners are as follows:

1. Primary Care Networks should be used as an overarching framework to integrate the potential of community pharmacies into wider community services, optimising effective triage and signposting along with joined up continuity of care across care settings.

   All groups involved in determining the future of community and primary care services should have access to advice from individuals who are knowledgeable about the scope and limitations of community pharmacy. Community pharmacists should be core members of the multidisciplinary teams determining care pathways for urgent care and long-term conditions in the community. These should be delivered within a common governance framework which embraces community pharmacy and avoids duplication of provision with other providers.

   All STPs, ICS' and PCNs should make clear their strategy for harnessing the benefits of community pharmacies. They should explicitly consider the range of pharmacy pilots detailed above and how they will be implemented locally and regionally or the rationale for not progressing them.
   The pharmacy integration fund could be approached for support as appropriate, along with localised service development investment and PCN integration monies. NHS England should facilitate building the Quality Improvement evidence base as a result of rapid-test cycles and promulgating best practice as a key way of bringing benefit at scale so each PCN doesn't have to self-discover innovation.

2. Intra-operability between providers is essential. Community pharmacists should have read and write permissions to primary care clinical information systems to facilitate cross messaging between clinical professionals and add value to patient records. This is key to support medicines safety and will reduce duplication across providers. NHS Digital's developing clinical standards for sharing information and phase 1 and 2 work to support pharmacy information flows should take into account these recommendations and facilitate intra-operability.

3. A focus on communication and the patient experience to build public awareness and uptake of the services that pharmacies offer will be crucial to the success of new initiatives. This should include information in pharmacies themselves and reassurance around privacy and the availability of consultation space as well as a wider message to pharmacists and the public around mutual expectations and what good looks like. This should also reinforce the message around using pharmacies as a first point of call.

4. Given the impact demonstrated through studies to date, all providers should be encouraged to implement and automate the Transfer of Care Around Medicine (TCAMs) scheme.

   NHS England should specifically remove the quota cap on community pharmacies which contractually limits them to 400 medicine usage reviews a year in order to facilitate the TCAMs scheme and the provision of post discharge reviews in the community, which will in turn reduce hospital bed days.

   Currently there is AHSN support available to Trusts and LPCs to establish this pathway through funding for the PharmOutcomes license fee (Yr1 in first instance) as well as project support and planning.

5. NHS England should look specifically for progress in the integration of community pharmacy initiatives when reviewing and providing assurance on the developing ICSs.

6. The PHE Healthy Living Pharmacy platform should be used as a vehicle for alignment of Public health campaigns and optimisation of public health prevention initiatives delivered through community pharmacies with wider community services whilst at the same time ensuring that 'Make every Contact Count' initiatives are provided from all pharmacies.

7. New pharmacy contract frameworks being developed by NHSE should take into account and facilitate implementation of the above recommendations, noting the opportunity for the patient and wider health system and considering a move to outcome payments rather than just against medication dispensed.

Next steps

Two of the six STPs across the South West footprint are already developing community pharmacy commissioning strategies and these recommendations should be incorporated within those and used to encourage the development of similar and consistent strategies for other STPs and ICSs, also supporting both community and urgent care transformation programmes. These in turn may then be able to influence

the governance of Primary Care Networks. This should be supported by the NHSE pharmacy commissioning team, NHS Digital and PHE.

As such these recommendations will be shared with the NHSE pharmacy team at a regional and national level, with PHE in the South West, with LPCs and also CCGs and STPs/ICS' in the South West. In addition to this these recommendations will be fed into the current RPS consultation and shared to support the RPS' integrated pharmacy and medicines optimisation framework for STPs that is due for publication.

Pre-reading

- The Murray Review 2016 https://www.england.nhs.uk/commissioning/primary-care-comm/pharmacy/ind-review-cpcs/
- Five Year Forward View for Pharmacists https://psnc.org.uk/wp-content/uploads/2016/08/CPFV-Aug-2016.pdf
- NHS Long Term Plan 2019 https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
- NAPC guide: Community Pharmacy and Integration https://napc.co.uk/wp-content/uploads/2018/05/Community-pharmacy.pdf

The Council Agenda, Speaker slides and meeting notes are available at www.swsenate.nhs.uk