Department of Health: Community Pharmacy in 2016/17 & beyond proposals

Consultation questions to be answered

Devon Local Pharmaceutical Committee is a community pharmacy representative body that represents 240 pharmacies in Devon. The response below has been created with comments and thoughts from local contractors, the LPC committee and executive.

BRINGING PHARMACY INTO THE HEART OF THE NHS

What are your views on the introduction of a Pharmacy Integration Fund?

In the Department of Health's vision for community pharmacy, it states that it wants community pharmacy to be integrated with the wider health and social care system, so it can relieve pressure on GPs and Accident and Emergency Departments, and to ensuring optimal use of medicines. We believe this vision of providing better quality interventions for the NHS and enhanced patient outcomes is the right direction for community pharmacy. However, to truely deliver this change to a service based high quality clinical pharmacy; pharmacy will need significant investment which is fair to patients, tax payers, the NHS, and to pharmacy contractors.

The current proposal made by Department of Health (DH) on an integration fund states that in year one the funding is going to be £20million pounds, this fund on a per patient basis is circa 30p per patient. Keith Ridge and the DH have set out their grand vision for community pharmacy and in Keith's speech at Salford University (2nd February 2016) he said, "we want community pharmacy to shift to more high quality clinical services", realistically these high quality clinical services need to be supported a significant investment. We believe that the delivery of high quality clinical services from community pharmacy is the right future, however to effect any signifincant change to the current community pharmacy business model, and to fairly remunerate outcome focussed patient services the fund needs to be in the region of £3-10 per patient.

The integration fund if well structured and fairly resourced can be used to enhance integration and innovation of pharmacy patient outcome focussed clinical services into the NHS care provision.

What areas should the Pharmacy Integration Fund be focussed on?

Listed below are the areas in which we believe the NHS could benefit the most from integration of community pharmacy and pharmacists expertise. These services can if well integrated into the NHS or new models of care create fantastic opportunities for patients and the NHS.

The examples below are not exhaustive, however they do detail the opportunities for the NHS to invest in community pharmacy services with efficiency savings being made on supply.

1) **Urgent and acute care.**
   a. **Community pharmacy integration of acute minor illness provision.** Studies have suggested that 15-18% of the GP managed consultations for minor ailments could be managed in community pharmacy[1]. One study indicated that 8% of consultations undertaken in an A&E department could be handled by a community pharmacist[2]. Evidence from the Scottish Minor Ailment Service (MAS) pilot evaluation demonstrated a 35% reduction in activity in GP minor ailment consultations following the introduction of a community pharmacy MAS[3]. The MINA study undertaken by Pharmacy Research showed that £1.1 billion pounds could be saved by the NHS if a national community pharmacy minor illness service was comissioned[4], the service would save an estimated 5.5% of GP and 3% of A & E consultations. With the current huge pressures on GP and the urgent and acute care system as described by Sir Bruce Keogh's urgent and emergency care review, this pharmacy service would be well received by patients, and both primary care and secondary care providers.

2) **Community pharmacy access and use of the summary care record (SCR).**
   a. **A 'high quality' clinical appropriateness check at point of dispensing.** Community pharmacy enabled access to the SCR and promotion through incentives will facilitate a more robust community pharmacist 'high quality' clinical check. This robust clinical check will reduce the risks of allergic reactions, contraindications and medicinal interactions. The 'PRACtICe' study[5] indicated that 5% of prescriptions written in primary care have an error, and studies have indicated that 7%[6]of unscheduled admissions to hospital are caused by medicines costing around £466 Million[3]. Studies have also shown that around 59% of these unscheduled admissions are preventable[7]. A more robust clinical check with shared responsibility for appropriateness with the prescriber would reduce this wasted NHS resources and enhance patient care.
   b. **Urgent and acute access to regular repeat medicines.** The SCR access will allow pharmacists to respond to patients who need urgent access to their repeat medicines. The joint Devon LPC/NEW Devon CCG evaluation of an urgent repeat medicine service showed that 53.3% of patients would access 'out of hours GP', 5.4% would have visited 'A&E urgent care centre' if the service was not available[8], and the service, if offered from all pharmacies, would reduce the

[1] N.Pillay et al. The Economic Burden of Minor Ailments on the NHS in the UK. Selfcare. 2010;1(3):105-116. http://www.selfcarejournal.com/uploads/products/10024/pdf/IMS%203%3B105-16.pdf (accessed 5/5/2015)
[2] Community Pharmacy Management of Minor Ailments. Pharmacy Research UK, 2015. http://www.pharmacyresearchuk.org/waterway/wp-content/uploads/2014/01/MINA-Study-Final-Report.pdf (accessed 27/3/2015)
[3] Research findings No.29/2003. Scottish Executive Social Research 2003. Direct supply of medicines in Scotland: evaluation of a pilot scheme. Ellen Schafheutle et al. Schafheutle E, Noyce P, Sheehy C, et al. Available from: http://www.scotland.gov.uk/cru/resfinds/
[4] Pharmacy Research UK. Community Pharmacy Management of Minor Illness. January 2014. www.pharmacyresearchuk.org (accessed 2/2/2016)
[5] Tony Avery et al. Investigating the prevalence and causes of prescribing errors in general practice: The PRACtICe Study (2012). The GMC.
[6] Munir Pirmohamed. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. BMJ. 2004 July 3; 329(7456): 15–19
[7] Winterstein AG et al, Preventable drug-related hospital admissions. Ann Pharmacother. 2002 Jul-Aug;36(7-8):1238-48.
[8] Devon LPC and NEW Devon CCG. Pharmacy First: Community Pharmacy Helping Urgent and Emergency Care. June 2015 http://devonlpc.org/our-news/pharmacy-first-evaluation/ (accessed 29/1/2016)

demand on pressurised acute and emergency services. The net saving to the local health community in Devon from this service was £17,214 over the pilot (4 months) with a net intervention cost saving of £6.89[8].

3) **Medicines Optimisation**

a. **Concordance and long term disease management support service.**

The number of patients who are aged 65 years or over will increase to 13.5 million by 2032[9], and those living with three long term conditions is expected to reach 3 million by 2018[10]. This will increase the demand for long term disease condition management services, currently the GP practice consultation rate per patient per year is 7.6 - 8.3 (up from 3.9 in 1995), this growth is likely to continue at a faster rate as the population ages. This ageing pressure in addition will increase the number and cost of medicines prescribed, therefore increase the risk of prescribing errors, adverse events caused by medicines, and medicines waste (both of adherence outcome opportunity costs and actual destroyed medicines). The York Economics medicines waste report stated that wasted medicines cost in 2010 £300 million and missed positive patient outcomes cost £500 million (for 6 disease areas)[11]. Community pharmacy has the ability to support patients with their long term disease management, encourage better self-care and enhance positive behavioural changes. It could offer medicines optimisation services that focus on the outcomes achieved by patients, to deliver higher quality care and efficiency saving for the NHS. The pharmacy futures project has shown the ability of pharmacist to identify and support COPD management, support for patients on four or more medicines[12].The Australian Meds check for diabetes is an example of a Medicines Optimisation service that is well evidences, and could enhance patient care in diabetes[13]. The service delivers education and coaching, monitoring and promotion of patient adherence, and ensures evidence based medicines are used[14].

b. **Support for patient transition of care.**

Studies suggest that almost half of all patients may experience an error with their medication after they have been discharged from hospital[15,16]. The Wales discharge medicine use review aims to reduce the risk of medication errors and adverse events, increase patient involvement in their own care, and reduce medicines wastage. The evaluation completed on the service showed medicine waste savings of £3.3 million and helped reduce demand on hospital wards and A&E, the authors

[9] Future population trends The Kings Fund 2010. http://www.kingsfund.org.uk/time-to-think-differently/trends/demography/ageing-population (accessed 5/2/2016)
[10] Department of Health, Jeremy Hunt GP New Deal Speech July 2015
[11] York Health Economics (Department of Health sponsored). Evaluation of the scale causes and costs of waste medicines. 2010
[12] http://www.communitypharmacyfuture.org.uk/ (accessed 5/2/2016)
[13] I. Krass et al. The Pharmacy Diabetes Care Program: assessment of a community pharmacy diabetes service model in Australia. Diabetic Medicine 2007, 24, 677–683
[14] https://www.psa.org.au/guidelines/medscheck (accessed 5/2/2016)
[15] Kripalani, Sunil, Care Transitions Perspective, as featured in the AHRQ WebM&M magazine (December 2007)
[16] Kripalani S et al, Promoting effective transitions of care at hospital discharge: a review of key issues for hospitalists, Journal of Hospital Medicine, 2007, Vol 2, No. 5, 314–323

stated the investment in the discharge MUR service did represent a "good investment"[17]. Community pharmacies in England could have a similar service commissioned to help support patients at the care transition stage.

c. **Care Home**
The Pharmacy and Care Homes report written by the regulatory body for pharmacy, the General Pharmaceutical Council identifies and evidences the medicine related issues seen in residential and nursing homes. The report outlines the massive need of residents who reside in these care establishments. It proposes a number of ways pharmacy and pharmacists can help support and advice the patients and homes to enhance good medicines use. Studies cited by the report indicate a reduction in prescribing errors, avoidable admissions to hospital, reduced poly-pharmacy and medicines waste[18]. We believe there is a place for a nationally commissioned service to facilitate a community pharmacist to provide clinical medication reviews, transition of care reconciliation, support and advice on medicines use best practice, and ad-hoc medicines information for patients.

4) **Driving the prevention agenda and self-care**

a. **Healthy Living Pharmacy Concept.** The Five Year Forward View emphasises the importance of the prevention agenda, it talks of 'radical upgrade in prevention and public health' to reduce the burden of 'avoidable disease'. Community pharmacy has a large footfall each day with around 1.8 million visits each day[19]. The Health Living Pharmacy Pathfinder Pilot has shown that pharmacies that have achieved the HLP status have improved smoking quits, improved patient experience, and engaged patients with health advice that would not have gone anywhere else[20]. A nationally commissioned HLP concept would help drive the prevention agenda into the community using local pharmacies as community public health advice centres. If the service is to continue to be locally commissioned as it is now, funding for HLP is unlikely to be sustainable because of the austerity and efficiency targets being placed on local government.

b. **Self-care.** The self-care agenda has been identified by the Keogh Urgent and Emergency Care Review[21] as a key area to enhance as it will directly reduce the demand for unnecessary urgent and emergency services. The review states that community pharmacy is best placed in the drive to increase patient's self-management of acute limiting illnesses. We fear the reduction in pharmacy funding will reduce the time to focus on this system important healthcare issue.

5) **New Models of care, partnered working with community pharmacy**

a. **The Primary Care Home (Vanguard Model)**
The evidence base of successful integration of community pharmacy is lacking, and the DH and NHS England must invest into research on the best ways of

[17] K. Hodson et al. Evaluation of the discharge medicines review service. March 2014. http://www.cpwales.org.uk/Contractors-Area/Pharmacy-Contact---Services/DMR/DMR-Evaluation_Final-Report_13082014.aspx. (accessed 5/2/2016)

[18] Jo Webber. Pharmacy and Care Homes. General Pharmaceutical Council. December 2015 . http://www.pharmacyregulation.org/sites/default/files/pharmacy_and_care_homes_report_by_jo_webber_december_2015.pdf (accessed 12-2-16)

[19] The Bow Group Health Policy Committee. Delivering Enhanced Pharmacy Services in a Modern NHS: Improving Outcomes in Public Health and Long-Term Conditions. August 2010

[20] The Evaluation of the Healthy Living Pharmacy Pathfinder Work Programme 2011-12.

[21] NHS England. The Keogh Urgent and Emergency Care Review. https://www.england.nhs.uk/wp-content/uploads/2014/11/comm-pharm-better-quality-resilient-urgent-care.pdf (accessed 12/2/2016)

working. In Devon, community pharmacy has partnered with a successful Primary Care Home (NAPC) bidder, Beacon Medical Group. The project is still in the early stages but the aims are to deliver:

- Building trust and relationships between pharmacy and primary care
- Ensuring patients see the right clinician at the right time in the right place
- Enhancing referrals to Pharmacy First (minor illness service), flu vaccinations. Maximising the effectiveness of the New Medicine Service and Medicines Use Reviews
- Joint delivery of Health checks
- Future aim to test aligning incentives

6) **Training for a more clinical pharmacy**
The undergraduate programme does not fully prepare pharmacists for an extended role[22]. Pharmacists will need to be fully supported with accredited training to develop the necessary skill sets for a more clinical and integrated service provision. There should also be a model career path for a pharmacist that recognises experience and post graduate training.

How else could we facilitate further integration of pharmacists and community pharmacy with other parts of the NHS?

Pharmacy needs to be able to integrate with other primary care provides to provide high quality clinical care. The summary care record and read/write access to the patient's notes would enable the pharmacy service provision to be integrated fully into the NHS. The SCR could notify GPs of the provision of pharmacy services, and act as an evidence base of the value that community pharmacy adds to the patient care.

We would suggest that pharmacy and general practice could be facilitated to work more closely through a partnered quality framework, and more aligned incentives where certain goals or priorities were translated into shared working projects and would be rewarded for providing patient focussed outcomes. Torbay and South Devon CCG has been having discussions with community pharmacy on a population incentive to reach higher vaccination uptake amongst high risk patients; they are proposing a graduated payment scheme which would support more partnered working in this area to reduce A&E flu admission costs.

The urgent and acute services demand issues would be reduced with better referral or signposting from NHS 111. It would enhance patient care with providing a seamless transfer of patients to pharmacy. IT solutions such as Webstar or PharmOutcomes could be utilised, to increase the very low referral rate of 1% we see today[23].

[22] CFWI. A strategic review of the future pharmacist workforce. September 2013.
[23] The Pharmaceutical Journal 23/4/2015 article
http://www.pharmaceuticaljournal.com/yourrps/whydoesntnhs111referpatientstopharmacists/20068378.article

Devon Local Pharmaceutical Committee

MODERNISING THE SYSTEM TO MAXIMISE CHOICE AND CONVENIENCE FOR PATIENTS AND THE PUBLIC

To what extent do you believe the current system facilitates online, delivery to door and click and collect pharmacy and prescription services?

There is already a good option for choice available for patients; they can access distance selling pharmacies that have entered the market for provision of dispensed medicines by delivery. Some patients will use mail order pharmacies services, but most choose the convenience of their local brick and mortar pharmacy, where they have good supportive relationships. The trend reflects the low uptake of mail order pharmacies in many other developed nations e.g. US and Germany (no country has activity over 15-20%).

Community pharmacy is a local community asset with positive patients' relationships; this creates better social cohesion, and could act as referral point to the third sector and mental health. Pharmacies in Devon and Cornwall are being trained with mental tool-kit health skills and knowledge to help identify and support patients in mental health crisis. If pharmacy moved to a commoditised dispensing service this asset would be lost.

The potential risk to system failure of the medicines supply system through moving more supply online delivery through a single or small number of suppliers will reduce the resilience of the medicines supply chain, one can consider the Pharmacy2U issues in December 2015 and January 2016 which posed a potential risk to patient's health. The warehouse delivery model of medicines should be researched by the Department of health to understand the potential negative impact on local communities, through reduction in health care contacts, and ambulatory events facilitated by sedentary lifestyles.

The pharmacy repeat management schemes reduce the need for patients to chase their prescriptions. This service could be enabled by embedding better prescribing activity on the NHS repeat prescription service ('batch prescribing'); this would improve patient convenience and save the GP significant amount of prescription management time.

If the NHS wants to see a delivery of medicines service it should commission this nationally as part of the current terms of service, currently many pharmacies offer this as a free service. However, because of the DH reduction in pharmacy funding proposed the number of free delivery services could decrease.

What do you think are the barriers to greater take-up?

Although online is increasing, people still choose to shop in bricks and mortar retail businesses and this choice should still be available to them. Internationally very few countries have high use of internet pharmacies; this probably indicates that patients prefer accessing their medicines by their local pharmacy.

Patients who access community pharmacy tend to be of an older generation and have limited skills and knowledge, they also have low motivation for using IT to solve health issues, they trust and prefer a face to face consultation with a health professional.

How can we ensure patients are offered the choice of home delivery or collection of their prescriptions?
Delivery of medicines could be supported by a NHS commissioned delivery service, similar to the delivery or urostomy and colostomy appliances.
MAKING EFFICIENCES
What are your views of the extent to which the current system promotes efficiency and innovation?
The current community pharmacy remuneration contract started in 2005 has effectively exerted pressure on pharmacies to identify effeciencies. Community pharmacy has provided savings to the NHS year on year since 2005 at circa 3%, and from 2010 of 4-5% of the cost of service. These savings have been independently verified by the National Audit report which stated it has delivered £1.8 billion savings over the period 2006-2008[24]. The proposed efficiencies in the DH briefing needs to be analysed formally by an official Impact assessment, this could include the targeted savings, any effects on patients health outcomes, social effects of closing key community asset and reduction of health professional contacts. The hub and spoke model is still in its infancy, and it is unrealistic to believe these models can be enacted to elicit efficiencies savings by October 2016 when the significant pharmacy funding reduction is going to be made. The DH and NHS England need to research this structural model change to understand its impact, not only on the cost of medicines supply but also on factors like risk of the increased lag time for to supply to patient and effect on system resilience. The York medicines waste reported on the amount of waste caused by the prescribing of medicines in England, although there was a significant amount of waste caused by medicines that were thrown away £300 million per annum, the larger waste comes from the lack of adherence to medicines and missed therapeutic outcomes, some £500 for six disease areas. Currently there is limited focus of medicines waste and optimisation services funds allocated for community pharmacy Medicines Use Review and New Medicine Service totals £138 million, this should be enhanced to reduce the £800 million in wasted medicines.
Do you have any ideas or suggestions for efficiency and innovation in community pharmacy?
The current contract could be enhanced to encourage an environment for effective innovation in community pharmacy delivery. The contract could incentivise pharmacies to innovate in areas such as efficiency and quality improvement by contractual gain share levers. We suggest these gain share incentives are focussed on areas which are aligned to the local NHS health care and social care priorities, in addition they could be partnered incentives as these would support effective integration of pharmacy into the health care delivery. The Department of Health and the NHS needs to be aware of risks of closing 3,000

[24] National Audit Office. The Community Pharmacy Contractual Framework and the retained medicine margin. March 2010

pharmacies. A significant amount of work will move to other providers in the health care system who are already very stretched (general practice, walk in centres, and A&E), this is why statements have been made in Pulse magazine, "GP practices to face greater demand as community pharmacy budget is cut", and NHS Alliance expressed concerns about the plans – they have called them 'astonishing' and 'extremely short sighted'.

What are your views of encouraging longer prescription durations and what thoughts do you have of the means by which this could be done safely and well?

The risks of incentives to increase prescription duration could cause stock hoarding, increased waste, inappropriate prescribing, increased risk of admissions to hospital, and an increase in year prescribing costs to CCGs. The corresponding reduction in health professional contact for example on high risk medicines, where checks are made by the pharmacy at point of dispensing, will increase the risk of unscheduled admissions to hospital caused by avoidable adverse events.

The Department of Health sponsored York Economics medicines waste report stated "positive opportunities for the further reduction of medicines waste includes: encouraging the flexible and informed use of 28 day (prescribing) and – where benefits patients – either longer or shorter periods'.

The move to longer prescribing periods will reduce the significant amounts of funds the NHS receives from prescription charges, this has been estimated to be around £700 million[25], so although it seems there may be a saving for the NHS this would be diminished by a reduction in receipts.

The patient should have the availability for individualised care as per GPC prescribing guidelines. Patients that are adherent to their medicines, on stable medication, where the medicines are unlikley to cause hospital admissions, and where there is a low risk of stock hording and waste should be offered longer duration prescribing periods within 28-84 days.

MAINTAINING PUBLIC AND PATIENT ACCESS TO PHARMACIES

What are your views on the principle of having a Pharmacy Access Scheme?

Community pharmacy as a public asset, where professional advice can be sought without appointment. We believe this strength of pharmacy needs to be maintained, pharmacy's community links and social capital can be built upon to provide great preventative public health services and high quality clinical care. The risk of reducing the ease of access of local communities to their pharmacies will reduce the positive impact that pharmacies can make on patient outcomes.

[25] John Appleby. Prescription charges: are they worth it? BMJ 2014;348:g3944 doi: 10.1136/bmj.g3944 (Published 17 June 2014)

What particular factors do you think we should take into account when designing the Pharmacy Access Scheme?
We believe that DH identified factors are insufficient and there should be a weighting for elderly patients, those with long term conditions, and the household access to cars where there is poor public transportation available (e.g. in rural areas). Current pharmacy population base, ie. the patients who use the pharmacy. There should be choice aspect for patients to ensure that patients can exercise a level of reasonable choice to where they access to services and medicines. The isolated rural communities will require a whole system approach to the need for a community pharmacy presence, this needs to take into account distance from acute and emergency services and general medical practice services.