Response to NHS Chief Executive’s Open Call for Evidence and Ideas

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Introduction

Pharmacy Voice (PV) represents community pharmacy owners. Its founder members are the Association of Independent Multiple pharmacies (AiMp), the Company Chemists’ Association (CCA) and the National Pharmacy Association (NPA). The principal aim of Pharmacy Voice is to enable community pharmacy to fulfil its potential and play an expanded role as a healthcare provider of choice in the new NHS, offering unrivalled accessibility, value and quality for patients and driving forward the medicines optimisation, public health and long term conditions agendas.

Pharmacy Voice creates a stronger, unified voice for community pharmacy. We are pleased to have the opportunity to contribute to the calls for evidence to support the Innovation Review.

Key facts about community pharmacy

- There are over 10,700 community pharmacies across England, employing tens of thousands of people directly in the provision of healthcare services to the public. No other healthcare contractor provides such access.

- 99% of the population, even those living in the most deprived areas, can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport.

- An estimated 1.6 million people choose to visit a pharmacy each day, of which 1.2 million do so for health-related reasons. Community pharmacies are perfectly placed to reach out to people everywhere so that they can maintain good health.

- Over 812 million medicines were supplied on prescription in 2009/10 at a cost to the NHS of £8.8 billion and as medicines experts we are uniquely qualified to ensure that medicines are more effectively managed to benefit patients as well as the taxpayer.

- For the typical independent pharmacy over 90% of their income comes from the NHS.

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1 Department of Health, *Improving quality in primary care*, 7 October 2009

2 NHS Business Services Authority website, *Statistical Data Relating to Prescriptions Dispensed by Pharmacy Contractors*
Summary

1. Patients and the public have most to gain from community pharmacy being fully integrated in the design and delivery of health and social care reforms.
2. A vibrant, sustainable, competitive pharmacy market is important to all our futures and local economies.
3. Community pharmacy is a good model for developing and delivering the ambitions of health and social care reforms because we already demonstrate innovation and spread through choice, competition, price and quality.
4. Pharmacy Voice invites the NHS Chief Executive Innovation Review Team to meet our members so that we can share our commercial expertise and show how we engage customers to continually drive up the quality of service provision.
5. Community pharmacy could make a significant contribution to the successful outcome of the Quality, Innovation, Productivity and Prevention (QIPP) programme. This will happen when commissioned services integrate provision across care pathways so that people get the best use of their medicines.
6. Community pharmacies are increasingly delivering a range of public health services that are producing positive outcomes, notably for people in deprived or vulnerable circumstances. Well established services include harm reduction programmes for substance misusers, stop smoking, sexual health, weight management, NHS Health Checks and flu vaccinations. The Department of Health recently recognised pharmacists as ‘a valuable and trusted public health resource.’ (Healthy lives, healthy people White Paper: Our strategy for public health in England. DH 2010).
7. Central to achieving progress in the community pharmacy IT landscape is sector engagement during the Government IT policy development stage and devolution of systems development to the market.

Pharmacy Voice response for calls for evidence and ideas

Learning from elsewhere about adoption and spread

What can the NHS and NHS Commissioning Board learn from local, national and international best practice to accelerate the pace and scale of adoption of innovations in the NHS? [Please include relevant examples, published papers or other evidence you have found useful.]

There are several comments and reports that highlight key learning and issues for the successful implementation of innovation across healthcare systems and Pharmacy Voice references these sources to support our key “asks”; please see below:

- **Disruptive innovation** Professor Paul Corrigan: “We have seen the way in which those with vested interests in the NHS react to the possibility of reform. They react even more directly to innovations that really disrupt the way in which they work. Therefore if you have a truly disruptive innovation you’re going to need a political and organisational process to overcome the opposition of those not wishing to be disrupted. Without the latter then you won’t achieve the former.
• **The emerging market in health care innovation** McKinsey Quarterly, May 2010. In this article, Tilman Ehrbeck, Nicolaus Henke and Thomas Kibasi consider the common features of almost thirty health care innovations, the majority of which are from so-called ‘emerging markets’.

Ultimately the authors recognise that the ‘real challenge’ for leaders worldwide is “how to implement, not how to invent” innovative solutions in the delivery of health care.

• **The ‘five laws’ of integrated care developed by Walter Leutz** following his observations of the process in the UK and USA. These laws contain enduring truths, for example:

“Law 4: You can’t integrate a square peg into a round hole. All integrated care is local and no one model can be effectively prescribed. Whereas the problem to resolve may look similar (say, reducing re-admission rates to hospitals because step-down care is inadequate) the approach to solve it must be adapted to meet local circumstances. Hence, integrated care is not a solution that can be implemented wholesale or imposed from on high. It must be built from the bottom up, driven by local ownership, within a system that rewards this.”

• **Plan for Growth**, HM Treasury and Department for Business, Innovation and Skills, March 2011

“The Government will build a consensus on using e-health record data to create a unique position for the UK in health research. The NHS could offer unique opportunities for this country’s international competitiveness in health research. Government can create the capacity to draw on the power of large linked data sets on a scale unprecedented here or elsewhere in the world.”

• **Open Public Services White Paper** July 2011, paragraph 1.3

“We believe that a new approach to delivering public services is urgently needed. The principles that inform our approach, and the policies we will enact to give it force, signal a decisive end to the old-fashioned, top-down, take-what-you-are-given model of public services. We are opening public services because we believe that giving people more control over the public services they receive, and opening up the delivery of those services to new providers, will lead to better public services for all. Whatever the circumstances, this Government would be modernising public services in this way. But in this economic climate, when times are tight and budgets are being cut to stabilise the economy and reduce our debts, opening public services is more important than ever – if we want to deliver better services for less money, improve public service productivity and stimulate innovation to drive the wider growth of the UK economy.

But nevertheless, it is still the case that many public services are closed to new and innovative provision, either because of the barriers that have been erected to keep new entrants out, or because the bureaucracy forced onto existing providers stifles innovation before it can flourish.” [our italics]
Actions at national level in the NHS

What specific actions do you think national NHS bodies, such as the NHS National Commissioning Board, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?

There are several actions that are in the power of the National Commissioning Board to bring about the successful and rapid adoption and spread of innovations throughout the NHS:

1. **Produce national frameworks and tariffs** – Pharmacy Voice would like to see more national guidance, in the form of service frameworks; the multiplicity of specifications and accreditation requirements in the current system has stifled delivery, and created unnecessary barriers to patient care. A new system could be designed to avoid the current failing and would lead to the following benefits:

   - Save time – currently all PCTs have to or choose to develop their own specifications and Service Level Agreements (SLAs); these resources are commodities in short supply.
   - Ensures standard quality of care based on evidence.
   - In the future Local Authorities will be responsible for commissioning public health services through Health and Wellbeing Boards (HWBs). Unless it transfers in there is little or no expertise to develop services such as harm reduction programmes for substance misusers, stop smoking, sexual health, weight management, NHS Health Checks and flu vaccinations. National frameworks for these services will solve the potential capability and competency gap (see appendix 1 for pharmacy lead public health services).
   - National frameworks and associated tariffs would help deliver a level playing field for all providers taking into account premises and staff costs, which in turn would encourage more qualified providers to enter the market.

Please see below two examples of how national frameworks for services could work in practice:

- Model template for commissioning health checks from community pharmacy. The Chief Pharmaceutical Officer for England, Dr Keith Ridge, has written\(^3\) to PCT Chief Pharmacists to promote a new model template\(^4\) designed to help

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PCTs who may wish to commission NHS Health Checks from community pharmacy.

- The National Electronic Link to Medicines (NELM)\(^5\) for Patient Group Directions demonstrates the benefits of sharing service specifications. Healthcare professionals can draw down this information and also add audit results so viewers can review evidence.

2. **Link together** QIPP programme and national frameworks for commissioning outputs, outcomes and costs by incorporating a holistic approach to the public’s health and wellbeing. At the same time ensure effective information and communications plans are in place. Enabling IT across organisations is essential and must support data input analysis and outputs which are meaningful, timely and robust.

3. **Incorporate Medicines Optimisation into the Whole System Demonstrator (WSD) for telecare and telehealth.**\(^6\) NICE reports that 30-50% of medicines are not used as intended, and evidence demonstrates that between 5-8% of admissions to hospitals are as a result of adverse effects of medicines, many of which are preventable. Integrating the medicines expertise of community pharmacy into the care pathways of people living with long term conditions would make a significant contribution to the Nicholson Challenge. One way of doing this is to incorporate medicines optimisation into the WSD for telecare and telehealth.

4. **Extract key principles** from a generic framework to underpin the Chronic Medication Service (CMS) element of the Community Pharmacy Contract in Scotland (see appendix 2) and apply to the Community Pharmacy Contract Framework (CPCF) in England.

   Professor Lewis Ritchie, Chairman of the CMS Advisory Group, said “resilient information technology, timely communications and a shared understanding - among both patients and health professionals - will be key factors for successful realisation of CMS.” The NHS CB could take the principles and key learnings from Scotland and apply them to England, for example:

   - The e-connectivity works through the NHS N3 connection in Scotland which is only accessible through secure lines because of the transfer of patient data. All GP systems and all community pharmacy PMR systems in Scotland have a N3 connection.

5. **Accelerate the QIPP work stream** of Systems Enablers, C2 technology and digital vision. This work stream will offer the NHS:

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The help to put in place the underpinning technology required for the other national work streams;

Support in the development of regional and local IT strategies; and

Compatibility and interoperability of IT systems.

In order to help the NHS CB deliver this key QIPP work stream, Pharmacy Voice recommends the following:

Representatives of community pharmacy, including those with specific IT responsibility for multisite systems delivery, have a seat at the table when the Department of Health and Connecting for Health set community pharmacy IT policy and the IT strategy for healthcare. Pharmacy Voice can be a strategic partner and can ensure policies that are developed are implementable by all pharmacy contractors.

Systems suppliers deliver a single central community pharmacy IT framework for England, Scotland and Wales that will include all the operational IT requirements for all community pharmacies across the sector. ‘Add-on’ solutions can then be developed between suppliers and individual contractors and implemented to address local needs or to provide contractor USPs.

The market is freed up to develop systems to implement those policies. Connecting for Health should step back from developing systems, and allow community pharmacy contractors to work with systems suppliers to develop solutions that will achieve the policy objectives, be interoperable with existing IT infrastructure, and add value to the pharmacy service.

The following two examples show the impact of making decisions without including sharp end community pharmacy providers in the process.

1. **The Electronic Prescription Service (EPS) system** has been incorporated into the NPfIT/Connecting for Health (CfH) programme for a number of years. However, during the planning stages, there was minimal input from community pharmacy or our software suppliers. As a consequence, a system is being implemented which:

   a. Will fundamentally change the way in which pharmacies function and, as a consequence, could affect patient safety.

   b. Is overly complex and incredibly bureaucratic, particularly when considering issues relating to smartcards, which provide access to the system and which form part of the confidentiality protocols.

There is a two-phase roll-out of the EPS system. EPS release 1 allows the electronic transfer of prescription information alongside a paper prescription. Release 2 will allow the electronic transfer of information without the need for a paper prescription. Both releases require a pharmacist to have smartcards. With release 2, if the pharmacist does not possess an eligible smartcard then the prescription cannot be accessed and cannot, therefore, be dispensed. The smartcards required
for each release are different and need to be upgraded/re-supplied when changing from release 1 to release 2 with consequent administrative burden.

The possession of a smartcard is key to the system operating. The process is controlled by Primary Care Trusts and no indication of who will control the process after PCTs are abolished has been given. CfH has issued guidance to PCTs; however, each PCT seems to have interpreted this guidance differently and, as a result, there are as many ways of getting access to a smartcard as there are PCTs.

Pharmacy managers’ smartcards only work in the pharmacy they are connected to (and therefore of no use if a manager works elsewhere in an emergency). Locum cards allow multisite activity, but locums have less functionality than managers. Since the pharmacy regulator (the General Pharmaceutical Council) does not make any distinction between managers and locums it seems extremely odd that CfH have decided to take this approach.

We were told that the reason smartcards were required was that pharmacy would be fully integrated with the care records system. We now understand this integration is unlikely – the trials are proceeding at snail’s pace – so now a smartcard-based system seems overly complicated.

By contrast, the models for EPS in Scotland and Wales are much more straightforward and considerably less burdensome. For example, in Scotland pharmacists and staff are not required to possess a smartcard to process prescriptions even though the system is similar to that in England. In Wales prescriptions bearing 2D barcodes are being used which also negate the need for smartcards.

Pharmacy Voice recommends that the NHS CB adopts the simpler, less burdensome EPS systems that are implemented in Wales and Scotland for community pharmacy in England at national, regional and local levels.

2. **New toolkit to improve care after hospital discharge.** A new NHS toolkit launched in July7 will help NHS trusts implement an electronic 24-hour discharge summary allowing GPs, patients and carers to continue care effectively following a stay in hospital. However this new e toolkit does not link to the New Medicines Service (NMS) or targeted MUR service (tMUR) that the Department of Health has negotiated with community pharmacy for implementation in October this year, in part in recognition the errors of transmission that occur as patients move in and out of hospital.

Professor John Williams, director of the RCP’s Health Informatics Unit, said: “This website will help trusts implement the standards we developed, and by doing so improve the quality, accuracy and consistency of information that is passed to GPs,

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7 NHS CfH. *Electronic 24-hour discharge summary implementation*, http://www.connectingforhealth.nhs.uk/systemsandservices/clinrecords/24hour
patients and carers. We believe this will bring great benefits to the quality and safety of patient care."

The NMS will provide support for people with long-term conditions newly prescribed a medicine to help improve medicines adherence. The successful implementation of NMS should:

- improve patient adherence which will generally lead to better health outcomes;
- increase patient engagement with their condition and medicines, supporting patients in making decisions about their treatment and self management;
- reduce medicines wastage;
- reduce hospital admissions due to adverse events from medicines;
- lead to increased Yellow Card reporting of adverse reactions to medicines by pharmacists and patients, thereby supporting improved pharmacovigilance;
- receive positive assessment from patients;
- improve the evidence base on the effectiveness of the service; and
- support the development of outcome and/or quality measures for community pharmacy.

The department has linked the electronic 24-hour discharge summary to GP practices which contains medication details but this is not accessible to community pharmacy. The effectiveness of the new hospital discharge programme and the success of implementing the new medicines services will be constrained by this barrier.

6. **Ensure a communication plan is in place** so users understand of why there is a need for change and the benefits the service will deliver.

**Actions at local level in the NHS**

*What specific actions do you think local NHS bodies, such as providers and Clinical Commissioning Groups, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?*

Pharmacy Voice invites Clinical Commissioning Groups to meet our members so that we can share our commercial expertise and show how we engage customers to continually drive up quality of service provision.
Community pharmacy is a good model for Clinical Commissioning Groups and GP practices because the community pharmacy sector already demonstrates innovation and spread through choice, competition, price and quality.

The success of the community pharmacy sector depends on excellence in customer service because people can choose where, when, and how they want to access pharmaceutical services in the UK.

The competition to gain and secure the loyalty of customers is the mechanism by which community pharmacy drives quality, innovation and service. Community pharmacy is a mixed sector of individual contractors in rural and inner city settings, small and medium regional chains and large national corporate pharmacy businesses.

**Actions by NHS partners**

*What specific actions do you believe others, such as industry, academia, patient groups or local authorities, could take to accelerate adoption and spread, and what might encourage them to do so?*

Pharmacy Voice is keen to share our experience of innovation, integration and cooperation at local, regional and national levels and seeks an early meeting with the NHS Chief Executive Innovation Review Team.

END
Appendix 1

Pharmacy lead public health services in England

Many locally commissioned pharmacy enhanced services are directly aligned with the Government’s policy emphasis on public health and preventative healthcare:

- **Stop Smoking services** have shown very good results in pharmacy: In 2009/10, 140,000 people chose community pharmacy to set a quit date and 62,000 had successfully quit by week four, a 13% increase on the previous year.

- **NHS Health Checks.** Birmingham South PCT commissioned a ‘Heart MOT’ pilot, a cardiovascular risk-based assessment, in 30 community pharmacies in Birmingham. The results of the pilot show that males who would not normally see a GP access the pharmacy led-services in addition those individuals from deprived areas and with a minority ethnic background also accessed this service from community pharmacy. Of those assessed, 60% were male, 65% were from the average, less deprived, and most deprived quintiles, and 7.4% and 24.8% were from Black and Asian communities respectively. Importantly, it highlights that a significant number of individuals can be identified for whom intervention for vascular disease risk or other risk factors is required.

- **Alcohol intervention** in the North West of England pharmacy is playing a key role in the provision of alcohol intervention and brief advice (IBA). Around 125 pharmacies across Wirral, Blackpool, Knowsley, Oldham, Liverpool and Warrington are involved in service provision. The service can be targeted to those who may be at high risk such as those who present for treatment of hangovers, gastric problems and falls. Pharmacy sees a different demographic of people from those who may visit a GP practice, especially in areas of health inequality.

Examples of the benefits are as follows:

1. Members of the general public chose community pharmacies in NHS Knowsley pilot to seek out advice concerning their alcohol use. The outcome was that 1,165 interventions were carried out and 26% of people who participated were identified as having an increased risk and 6% at high risk of alcohol misuse.
2. Based on these results the potential cost savings could be significantly greater than those estimated by the Department of Health, which makes an assumption that only one in four people would be identified at increasing or high risk.
3. Directors of Public Health increased their capability and capacity to access people in the community by integrating community pharmacy into their implementations plans.
4. An application for funding the evaluation of the NW pilots has been successful from which robust evidence of the value community pharmacy can make to public health service delivery will be published.
• **Sexual Health screening and treatment.** Pharmacy has become an increasingly important venue for community sexual health services. Access to emergency contraception is a common enhanced pharmacy service as pharmacies are open in the evenings and at weekends, with no need to book an appointment.

In the first year of the service, it was found that 50% of women accessed the service at the weekend or on Mondays, when it can be difficult to obtain appointments at family planning clinics or GP in some localities; pharmacies are the largest providers of EHC to women.

• **Weight management services** evaluated by the University of Central Lancashire showed statistically significant results for agreed weight maintained for 12 months. The service was more cost effective than prescribing Orlistat over 12 months (£160 per patient versus £419.51). People liked the informal pharmacy environment, the accessibility and the flexibility.

• **Healthy Living Pharmacies** (HLP). Figures from the Portsmouth pilot project showed that 30% of patients seen for a MUR had not seen their GP or practice nurse in the previous 12 months. Research also shows HLP had a 36% increase in the number of people who quit smoking and approximately a quarter women who were provided with EHC were also offered Chlamydia screening and almost half (46.4%) of all those accepted a screening kit. A total of 264 who accepted a kit returned a sample, of whom 24 (9.1%) tested positive, concluding that Chlamydia screening for EHC pharmacy patients was warranted.

• **Isle of Wight community pharmacy seasonal flu vaccination report.** Community pharmacists have an important role to play in the delivery of many services commissioned by public health whether these are health promotion services to raise awareness, services offering health prevention or services offering protection. Top-line results indicate significant success:
  - Total vaccinated: 2,903 (approx. 10% of total vaccinated through all services)
  - Under-65s with co-morbidities: 36.3% of cohort vaccinated (Other providers: 17.1%)
  - Percentage Rating Service OK or Excellent: 99.6% (90.9% Excellent)
  - Percentage receiving flu vaccination for first time: 8.2%
  - Percentage for whom vaccination unlikely without pharmacy access: 6.2%
  - Percentage indicating they would use community pharmacy again: 98.4%
  - Percentage indicating they found the service more accessible: 92.8%

• **Minor Ailment schemes.** It is estimated that some 57 million GP consultations each year involve minor ailments, which could in most case be dealt with at a pharmacy. The average cost of a pharmacy consultation (£17.75) relative to an average GP consultation (£32) is £14.25 less expensive. If all patients with minor ailments were to receive pharmacy consultations, then over £812 million could potentially be saved from the NHS budget, or resource redeployed (or 4% of the Government’s pledged £20 billion target for efficiency savings).
Appendix 2

Establishing Effective Therapeutic Partnerships - a generic framework to underpin the Chronic Medication Service (CMS) element of the Community Pharmacy Contract Scotland

“In summary, in order to harness the significant potential of CMS to secure enhanced patient care and professional collaborative working, it will be crucial that the guiding principles in this report are translated as effective operational plans, sufficiently resourced and adequately piloted/tested, as an essential precursor to national roll-out. Resilient information technology, timely communications and a shared understanding - among both patients and health professionals - will be key factors for successful realisation of CMS”.

Professor Lewis Ritchie, Chairman of the CMS Advisory Group

PRINCIPLES FOR A GENERIC CMS FRAMEWORK

1. PATIENT CENTRED

- must engage patients (and carers) as active, informed and willing participants;
- must assure patients of confidentiality and safe and secure data management;
- should ensure equity of access to CMS for all patients;
- should involve patients in the development, implementation and review of CMS care plans; and
- should encourage and support self care.

2. CLINICAL GOVERNANCE

- must be evidence-based, linking to and complementing the GMS Quality Outcomes Framework (QOF);
- must have governance arrangements in place that ensure continuous quality improvement including peer review; and
- should encourage and support patients to take responsibility for their own health through enabled health improvement and self-care measures (a partnership approach) in order to support meeting the clinical objectives.

3. COLLABORATIVE WORKING

- should promote and support joint working between general practitioners and community pharmacists with appropriate information sharing and feedback;
- should link to the GMSQOF where appropriate; and
- should facilitate patient referrals to an appropriate member of the healthcare team (and not necessarily always to the patient’s general practitioner).
4. IMPLEMENTATION

- must be achievable by all community pharmacists to ensure all patients can benefit from the service;
- should be adequately resourced in terms of manpower (e.g. through induction, training and educational support to providers); and
- should be adequately resourced in terms of technology (e.g. through development and provision of appropriate IT software, hardware and support).

5. MONITORING AND REVIEW

- should have appropriate parameters for any monitoring to be undertaken in the community pharmacy supported by education, training and/or guidance;
- must have protocols that outline any appropriate action(s) required by the pharmacist if the patient's results are out with specified criteria/ranges; and
- should have data management systems and procedures that are not overly bureaucratic.

6. SERVICE DEVELOPMENT

- should be simple at the outset with clearly defined outcome measures;
- should develop in time subject to evaluation and improvements; and
- must be evidence based.