

# Evaluation of the community pharmacy contractual framework

## Multi-Stakeholder Workshop

10<sup>th</sup> May 2007

### Morning session

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#### Enhanced and advanced services – Action needed

##### a. Needs assessment

- Align pharmaceutical services to local health needs as identified and prioritised by PCOs.
- Better understanding of commissioning process – local needs assessment – mapping mutual benefits – developing shared vision of primary care provision.
- Commissioning based on Pharmaceutical Needs Assessment as part of wider health and social care needs assessment (Joint Strategic Needs Assessment).
- Pharmaceutical Needs Assessment needs to be revisited – more integrated.
- Increase patient and public involvement – engage PPI in needs assessment and evaluation of services.
- Ask GPs and patients for their views.

##### b. Evidence base

- Develop evidence base re. effectiveness and cost-effectiveness of pharmaceutical intervention (incentives).
- Evidence base – show improved patient outcomes – cost/benefit.
- Building evidence base – evaluation.
- Need to build up evidence – needs to be collected and collated.
- More “evidence” of different types including good practice and anecdotes.
- More monitoring, audit, outcomes data – impact between acute care, primary care and pharmacy.

- Review what works / does not work to learn lessons (e.g. MUR for patients who have repeat hospitalisation – does it lead to reductions?).

### **c. Other**

- PCOs need to re-engage after reorganisation.
- PCOs need to redefine priorities following a stocktake – linking to PBC – finance, health inequalities (enhanced services floor still seen as “GPs”).
- PCOs should be monitored against framework.
- Engage wider healthcare community – not just GPs – improve “patient capture” – referral from other health care professionals.
- Developing the simpler as well as complex care pathways (protocols, guidelines, referral pathways).
- How will pharmacy contract under any commissioning structure? LPCs cannot contract. Formation of consortia? (?Anti-competitive/illegal?).

### **Integration – Action needed**

- Stimulate effective integration through: joint training; sharing clinical information; common protocols (prescribing, public health); synergistic contacts (as opposed to unrelated/competing ones); multi-disciplinary QOF.
- Shared opportunity on developing the health promotion agenda. Build trust between professionals – local PCO led education; care pathway redesign; co-working / problem solving on projects. Patient-led commissioning; move secondary care services and consider all of the options for reprovision (money saved would fund). Joint development agenda on professional leadership and understanding of potential roles and expertise.
- Better integration of GP and CP contracts, e.g. repeat dispensing not essential in GMS. Technical connectivity – don’t wait for national IT.
- Pharmacists to participate in multi-professional and clinical networks. Use research networks to identify simple and innovative solutions for multi-disciplinary audit.
- Combine LMC, LPC and others to form a LCC (Local Contractors Committee) with PCO represented. Forum at PCO level bringing together all stakeholders to discuss service needs and outline targets. Government needs to promote pharmacy inclusion in primary care and recognise pharmacy contribution in PBC.

- More face to face contact. Protected time to discuss development of services. Selling the concept that the pharmacist can offer something of added value compared to the GP.

#### **a. Relationships with general practice**

- Better alignment of MURs and QOF.
- Linking existing incentive systems together (GP and pharmacy contracts).
- Use QOF to incentivise GPs.
- Enable GPs to nominate patients for service by indicating on prescription (MUR).
- Use LMCs as a lever – “a potent force”.
- Approach GPs before starting service to improve awareness and target priorities.
- What are mutual interests for CP/GP? (repeat prescriptions, MUR, compliance, minor ailments, long term conditions enhanced services, public health). Mutual aims – safety and effectiveness.
- Include an obligation in CP and GP contracts for local liaison meetings between GPs and pharmacists serving their practice.

#### **b. Relationship with patients**

- Raising patient/carer awareness of services on offer – need to reduce “over prescribing”- wrong drug usage, “misunderstandings”.
- Change name of MUR to “medicines check”.
- Pharmacists marketing nationally to patient groups.
- Nationally increase patient awareness to reduce suspicion etc.
- Patient groups are a valuable lever.
- More or compulsory NHS branding, a less ‘commercial’ pharmacy environment – this is a community health service “not just a chemist”.
- Need to know more about how patients view pharmacy services – more surveys and groups etc.

#### **c. Integration of Advanced and enhanced services**

- MUR short term simplify form; long term electronic.

- A “relaunch” of the MUR service.
- Improve ‘electronic’ vs ‘paper’ part of MUR systems.
- Integrating MUR with appointment with GP much more closely, i.e. in terms of timing to make it more meaningful.
- Searchable national database of pharmaceutical care services, existing and planned, with funding levels.
- Monitoring of PCO performance with specific regard to enhanced services.
- Funding at PCO level is a major issue.
- National Pricing Tariff for enhanced services – negotiated centrally.

**d. Other**

- Share good practice through networks – why is it working where it works?
- Identify leadership champions; make better use of those who are innovating.
- Local leader development – pharmacists having the right skills to be effective at group/board level
- How do we guarantee delivery of services?
- Technical connectivity – move away from paper-based systems.
- Sharing of patient records – full access for pharmacists.
- Can “full implementation” be clearly defined?
- Size of pharmacy and availability of cash to invest.
- Links to QOF, reduced admissions, reduced need to see GPs, savings made to impact on PBC, link all into patient care pathway redesign.
- Build together, not “do it to”.
- Pharmacists would be happy to work together to work on MURs (not competing).
- Credibility – pharmacy has public support.
- Resources – improve funding – especially fund training for pharmacists and support staff.

- Communication between and to all parties – differentiate for different audiences.