

Pharmacy Flyer

Focusing on pharmacy in the new NHS



It's official: Community Pharmacy delivers great value for money

The National Audit Office (NAO) recently concluded that England's community pharmacists have saved the NHS £1.8 billion in four years. NAO also noted that pharmacies have made indirect savings over this period by increasing their dispensing productivity by 8 per cent, as well as delivering new services.¹

This *Pharmacy Flyer* looks at how community pharmacy can deliver better care *and* better value, in the face of growing financial pressures in the NHS.

We include a pull out on the Operating Framework for 2010/11, highlighting where pharmacy can contribute to the NHS 'must do's' this year.

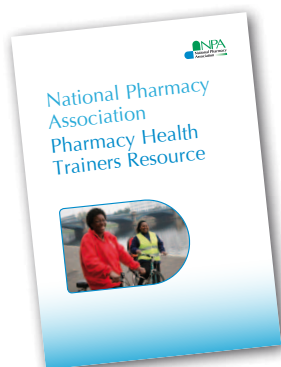
We also list some 'must *not* do's' for commissioners – short sighted behaviours driven by financial pressures that undermine both continuity of care and confidence. The Operating Framework insists that quality and productivity gains cannot be achieved by hasty cuts. Instead, money can be released through more care closer to home, standardisation of care pathways, upstream interventions and greater 'co-production' with people taking more ownership of their health.

The insert with this flyer looks at some of the targets which are set out in The Operating Framework and identifies services which community pharmacy could provide to support PCTs in meeting these targets.

Reference

- 1 The Community Pharmacy Contractual Framework and the retained medicine margin, National Audit Office, March 2010.

Stop Press ... Stop Press ... Stop Press ... Stop Press ...



NPA Pharmacy Health Trainer resource <http://www.npa.co.uk/Resources/PCOLPCs/Health-Trainers/?parentpageid=612&cat=70>

The NPA has prepared the *Pharmacy Health Trainers Resource* in conjunction with the Department of Health and other pharmacy bodies.

The Health Trainer programme is a national scheme aimed at reducing health inequalities. Pharmacy staff trained as Health Trainers or Health Trainer Champions will help to make an important contribution to improving well-being and reducing health inequalities by informing, empowering and supporting people to take responsibility for their own health.

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Pharmacy value for money – the QIPP framework

Tight NHS finances should act as a spur to investment in those services that have the potential for accruing significant cost savings elsewhere in the system as well as delivering improved patient care. The Department of Health's Quality, Innovation, Productivity and Prevention framework provides one way to sketch some of the opportunities in relation to community pharmacy:

Quality

The net ingredient cost of NHS medicines dispensed in primary care in England was £8,539.4 million in 2009. The least cost effective medicine is one that is used improperly or not used at all. It is estimated that between 30 and 50% of these prescriptions are not taken as the prescriber intended or are wasted – the value of the waste is estimated to be £100 million annually. Medicines (including adverse drug reactions, prescribing errors and poor compliance) account for approximately 4-6.5% of emergency hospital admissions. Pharmacist expertise should be more effectively harnessed to improve concordance.

Medicines Use Review (MUR)

Properly targeted MURs could improve medicines usage and achieve a reduction in admissions and readmissions. In 2008, the Isle of Wight piloted an MUR project targeting patients with Asthma. Data² released early shows a 50% fall in emergency hospital admissions, a 25% fall in associated deaths, a 25.2% reduction in the number of prescriptions for short-acting selective beta agonists, a 22.7% reduction in costs associated with short-acting selective beta agonists, and a reduction in use of inhaled corticosteroids.

An evaluation of within PCT support for MURs showed an increase in the number of MURs provided, that pharmacists benefit from peer support and patients valued the MURs³.

Hospital discharge

The Care Quality Commission report, '*Managing patients' medicines after discharge from hospital*', highlights failings in admission and discharge procedures with regard to patients' medication. The report highlights how community pharmacy involvement can improve patients' understanding of discharge medicines and any changes which have been made and ensure that changes have been implemented, leading to a reduction in readmissions. Discharge summaries are not regularly shared with community pharmacists. Research has demonstrated that providing information to a community pharmacist prevents potential adverse events⁴. In one study, for every 19 patients discharged a community pharmacist identified at least one discrepancy.

Vitalising repeat dispensing

With repeat dispensing (RD), the issue of the repeat medication is under the control of the pharmacist who will ensure that each supply is required and seek to ascertain that there is no reason why the patient should be referred back to their GP. The resultant supply of only that medication which is required should lead to a reduction in waste and improved disease management. The use of this service is still very patchy. A report published by NHSBSA states, '24 PCTs account for 50% of items issued via repeat dispensing for the year to December 2009. Richmond & Twickenham has the highest percentage rate of repeat dispensing (repeat dispensing as percentage of all items dispensed within a PCT), at 29%, followed by Bristol and Newham. There are 31 PCTs who still prescribe less than 0.5% of their items using repeat dispensing'⁵. By working with GPs and community pharmacists, uptake can be increased very substantially. GPs don't need to wait for EPS to rollout RD; they may however need some support in understanding that the time spent in setting up the paper based system is worthwhile in terms of time saved later on.



Innovation & Productivity

Service redesign

There are many billions of pounds of investment currently locked into hospital contracts that could appropriately be moved to primary care. Some services, for example anti-coagulation monitoring, could be moved directly to pharmacy. Others could be moved to GPs, with services currently provided by GPs such as immunisation or weight management moved to community pharmacy, thereby freeing up GPs time to take on the new services. This movement of services achieves both improved patient access and better value for money.

Anti-coagulation monitoring of patients on warfarin

The move of anticoagulation services from secondary to primary care reduces costs both for the PCT and the patient. There are secondary cost savings / benefits such as a reduction in travelling

Reference

- 2 A community pharmacy asthma MUR project in Hampshire and the Isle of Wight PJ 31.01.2009 <http://www.pjonline.com/content/a-community-pharmacy-asthma-mur-project-in-hampshire-and-the-isle-of-wight>
- 3 Medicines use Review support and evaluation programme report NPA & PCPA 2010 <http://www.npa.co.uk/Resources/PCOLPCs/MUR-evaluation-report/>
- 4 Moving patients, moving medicines, moving safely- guidance on discharge and transfer planning RPSGB 2006 www.rpsgb.org.uk
- 5 Update on growth in prescription volume and cost in the year to December 2009 NHSBSA http://www.nhsbsa.nhs.uk/PrescriptionServices/Documents/Volume_and_Cost_year_to_Dec_2009.pdf

and waiting time for the patients, continuity of care as the patient is usually seen by the same pharmacist, and for the PCT, a reduction in ambulance costs. The vast majority of patients whose warfarin care is transferred from secondary care to the pharmacist prefer the pharmacy based service. *An evaluation of the safety and acceptability of an anti-coagulation clinic in a community pharmacy setting – pilot study* concluded that; 'A safe and effective anticoagulation monitoring service can be delivered in a community pharmacy by community pharmacists'. (PJ 2004 273 822-824) www.pharmj.com/pdf/papers/pj_20041204_anticoagulation.pdf

Minor ailments Service

Minor ailments services allow certain patients to conveniently access advice and treatment for minor conditions at the cost of the NHS. Rather than needing to make an appointment to see a GP, patients are able to present at a local pharmacy to receive the services from a pharmacist. This frees up GP time, as well as providing greater convenience for patients. To maximise savings the GP time released needs to be identified and used, for example to relocate a service from secondary to primary care. In addition it has been reported that community pharmacy could manage an estimated 8% of adult attendances to A&E departments⁶.

Integrated care pathways

Care pathways should provide the backbone of patient care, integrating all aspects of primary and secondary care. Once developed PCTs should look at each step along the care pathway and identify who will provide each element of the service – this needs to be done in a structured way, identifying the professional with the necessary skills. In addition consideration should be given to ease of access for the patient. For example pharmacists should undertake the medicines management aspects of the pathway and could free up GP time by undertaking routine monitoring of, for example, HbA1c for those with diabetes. *Integrating community pharmacy into the care of people with diabetes*⁷ written in conjunction with the DH diabetes team this resource provides practical examples of the types of services pharmacists and their teams could provide.

A Cochrane systematic review of 5 trials showed that HbA1c levels were reduced with pharmacist support. *Evidence grows for pharmacist input in diabetes care* PJ News 30 April 2005 274 511

Maximising use of the existing pharmacy estate: new builds not always necessary

PCTs considering new builds, including for example polyclinics, should first ask whether this would be more cost-effective than using enhanced services to invest in existing infrastructures, including the community pharmacy network. The development of virtual 'poly-systems' can improve care without disruption to the existing pharmacy infrastructure – existing pharmacies are used to provide pharmaceutical services for the poly-system hub. The principles set out in the NHS London document *Commissioning pharmacy services for polyclinics in London*⁸ are valid wherever

new builds and co-locating GPs are being considered. A number of useful support documents are also included on the Healthcare for London website.

Prevention

Through a range of initiatives, including the NHS Health Check, pharmacies can spearhead preventive health efforts that can contain the financial burden further downstream. There are more pharmacies per head of population in spearhead PCTs than in the average PCT, and services can be targeted to these areas.

NHS Health Check

Community pharmacies are well placed to target those who wouldn't respond to an invitation from a GP surgery for a health check. Pharmacies can offer these tests opportunistically, as well as more formally, to the hard to reach groups including those not registered with a GP. Pharmacies frequently offer services such as stop smoking. PCTs could commission services to support those who have had health checks to make recommended lifestyle changes. Training pharmacy staff to be Health Trainers will increase the capacity to deliver the services identified by NHS health checks. Providing this support at the same location will reduce the likelihood of patients being lost to follow up and maximise the potential of the Health Checks to improve health. When pharmacy staff become Health Trainers they improve their capabilities in managing sensitive conversations and in the delivery of other public health services such as chlamydia testing.



Sexual Health

Provision of emergency hormonal contraception (EHC) from community pharmacy is well accepted. In Liverpool, the start of the pharmacy based EHC service was associated with a decrease in the number of requests for EHC at A&E departments. In addition, community pharmacies have been commissioned to provide chlamydia 'test and treat' services and the provision of oral contraception is being piloted in two London PCTs. The use of community pharmacy has enabled some PCTs to meet their

Reference

- 6 *Identification of patients attending A&E who may be suitable for treatment by a pharmacist* Bednall Fam Prac 2003 20 54-57
- 7 *Integrating community pharmacy into the care of people with diabetes* RPSG, NPA supported by DH April 2009 <http://www.npa.co.uk/Resources/PCOLPCs/Integrating-community-pharmacy-into-the-care-of-people-with-Diabetes/?parentpageid=612&cat=243>
- 8 *Commissioning pharmacy services for polyclinics in London* www.healthcareforlondon.nhs.uk/polyclinics-documentation-2/

chlamydia testing targets, for example Barking and Dagenham PCT have reached their 2009/10 chlamydia screening target using community pharmacies as one source of test kits. In addition community pharmacies can also supply treatment via a patient group direction. The national screening target for chlamydia for 2010/11 has increased to 35% of the target population – community pharmacy can help meet this challenge.

Other health maintenance services

Other community pharmacy services which support the health prevention agenda include stop smoking, weight management and pharmacy based health trainers.

Stop Smoking

Stop smoking is a well established community pharmacy based service and DH guidance recommends the inclusion of community pharmacy in stop smoking services. Community pharmacy stop smoking services have been shown to be as effective and as cost effective as nurse led stop smoking services, with a 43% quit rate⁹.

To support PCTs NHS Employers published *Pharmacy-based stop smoking services; optimising commissioning* in 2009.

Weight management

Improving diet and exercise levels and reducing the weight of the local population are key objectives for all PCTs. This can be achieved by offering motivation and support to those who could change their lifestyles. From signposting and brief interventions through to weight management services (with or without the supply of pharmacotherapy) community pharmacists and their staff are ideally placed to assist members of the public who may or may not be considering lifestyle changes and who may not visit a GP or other providers of health care. Pharmacy based weight management have been shown to be successful.

Health trainers

Whilst training pharmacy staff to become Health Trainers or Health Trainer Champions is in its infancy, the Health Trainer Service is well established and has a proven record of success in improving health outcomes. The *Pharmacy Health Trainers Resource*¹⁰ developed in conjunction with the DH Health Trainer team shows why community pharmacy and the Health Trainer service fit well together and the benefits of commissioning the service from community pharmacy.

Things NOT to do in the face of financial pressures

Health Ministers and officials have been explicit that the NHS should not rush to cut valuable and proven services. This would have the effect of fracturing continuity of care and, as far as independent contractors to the NHS are concerned, undermining confidence of contractors to invest for the future. On the contrary, straightened NHS finances should act as a spur to investment in those services that have the potential for accruing significant cost savings elsewhere in the system as well as delivering improved patient care.

The pharmacy 'global sum' has been devolved to PCTs since 1 April 2010. This funding will be allocated separately in 2010/11 and from then on will be included within PCT baselines. This accords with Department of Health (DH) policy and brings pharmacy into line with other primary care contractors such as doctors and dentists. Some Finance Directors who do not understand the funding for community pharmacy, may be tempted to make crude changes which appear to make savings for the PCT but are in fact a false economy.

In this article, we highlight a number of 'must nots' for PCTs – shortsighted behaviours that surrender quality for a quick but unsustainable financial gain.

Changes to the length of prescriptions

In March Bob Alexander, Director NHS Finance, wrote to PCT Chief Executives, SHA Chief Executives and SHA Directors of Finance explaining the funding system and asking them not to make changes (such as increasing prescribing intervals) which could destabilise pharmacy funding, this letter is available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113792. In addition, DH has introduced a set of measures designed to safeguard this funding, applying from April 2010. They include a revised advanced payment arrangement and the ability for pharmacists to claim for lost fees and allowances arising from changes in the duration of prescriptions, these will be recharged to PCTs. Details can be found in Part XIVC of the April Drug Tariff and on NHSBSA website www.nhsbsa.nhs.uk/3082.aspx

Branded Generics

Another change, which only on the face of it makes savings for the PCT, is the shift from prescribing generically to the prescribing of branded generics. Some branded generic manufacturers promote their products as being cheaper than the drug tariff price for the equivalent generic. Branded generics reduce the earnings for pharmacy, and the national funding mechanism then increases the prices that pharmacies are paid for other medicines thus negating any short term financial benefits to the NHS. Whilst overall the costs to the NHS rise individual contractors are not compensated for the losses made on branded generics which they have dispensed. Consequently a PCT which promotes branded generics causes its own pharmacy contractors to be underfunded, potentially destabilising the financial viability of contractors. In addition, patient care can suffer. Branded generic products are frequently not available through wholesalers meaning that community pharmacies must order directly from the manufacturer, the effect of which is often to increase the time before patients receive their medication. Some of these products are also subject to stock shortages. If you would like more information on the 'Category M' mechanism and the impact of branded generics please contact Gareth Jones at g.jones@npa.co.uk

Decommissioning of Enhanced Pharmacy Services

When considered in the light of other PCT expenditure the money spent on pharmacy services is 'small change'. The local NHS should not hastily cut back on valuable and proven front-line services. This has the effect of fracturing continuity of care and, as far as independent contractors to the NHS are concerned, undermines their confidence to invest for the future. Instead, tight NHS finances should be a spur to investment in pharmacy services that offer value for money and can lever cost savings, for example by tackling medicines waste, preventing ill-health, or freeing up capacity elsewhere in the health system.

Reference

⁹ *Statistics on NHS Stop Smoking Services: England, April 2009 to September 2009* (Q2 - Quarterly report www.ic.nhs/statistics)

¹⁰ *Pharmacy Health Trainers Resource* NPA March 2010
<http://www.npa.co.uk/Resources/PCOLPCs/Health-Trainers/?parentpageid=612&cat=70>