NHS England

GP Community Pharmacy Transformation

Closure Report April 2017

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GP Community Pharmacy Transformation (GPPT)

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Document control

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Contents:

1 Executive Summary

The business case for General Practice Pharmacy Transformation (GPPT), Appendix 1, set out to explore whether Community Pharmacy Independent Prescribers could support the delivery of Primary Care from within General practice, as a response to growing pressures on GP time, and problems in recruitment and retention.

The project has achieved its aims and demonstrated that transformation in Primary care is achievable:

Improving Access and Releasing GP time and Value for Money	• **Over 13,000** consultations have taken place with Pharmacists. • It is estimated these consultations saved in excess of **2,300** hours of GP time. • The average pharmacist consultation costs a **third less** than that of a GP consultation and is **twice as long** (average 21 minutes).
Improving Patient Experience	• Patient satisfaction is excellent. **100%** of patients surveyed are happy with the consultation and would recommend to family and friends. • **100%** of patients surveyed agreed or strongly agreed that they felt their health would be improved following the consultation.
Improving Health Outcomes	• There is evidence of significant clinical interventions improving safety and quality - Medicines were changed in **56%** of consultations - Blood tests were initiated in **14%** of cases - Medicines review improved safety / reduced side-effects in **15%** of cases • Changes to improve disease management were made in **66%** of cases
Better Use of Healthcare system	• Additional benefits are been delivered from depth medication review, such as improved medicines optimisation, improved monitoring and avoidance of hospital attendance - Improvements in self-care were made in **29%** of interventions - Medicines were stopped in **22%** of cases as they were not being taken or no longer necessary - Pharmacist interventions were estimated to have reduced hospital attendance in **7.8%** of cases (estimated saving £710k) • **100%** of Patients reported that their medicines understanding was improved, leading to better self–care and potential reduction in use of healthcare services.

Pharmacists can play a pivotal role in relieving pressures on GP teams and can be quickly and effectively embedded into Primary Care. This has resulted in GPs feeling supported, and improvements in their work life balance. Pharmacists were also used to support practices with added capacity to help with winter pressures.

The learning from the pilot has enabled critical success factors to be identified, and has demonstrated that the model is a sustainable solution for addressing Primary Care pressures.

The major key learning points and critical success factors from the programme are the need to:

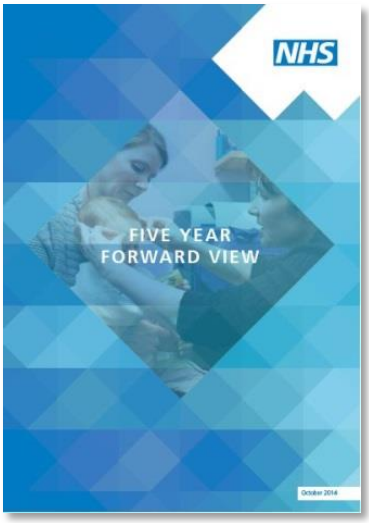
- Develop strong relationships between the Pharmacist and the GP Mentor
- Develop effective communications with the practice team and with patients
- Provide sufficient appointment time for the pharmacist interaction with the patient
- Ensure there are appropriate outcome measures and activity reporting

All participating practices completing the programme wish to continue with Clinical Pharmacist input, either by direct employment of through programmes such as NHS England Clinical Pharmacists in General Practice [6].

2 Background

2.1 Introduction to the programme

NHS England Five Year Forward View [1] and the Royal College of General Practitioners and The Royal Pharmaceutical Society joint statement [4] describe the current challenges facing the NHS and the opportunities to use Pharmacists to help support delivery of Primary Care.



In response to these challenges, NHS England, Derbyshire and Nottinghamshire Area Team (now NHS England, North Midlands) agreed non recurrent funding for a GP Pharmacy Transformation Project designed to maximise patients' health and wellbeing by making efficient use of the skills of both General Practitioners and Community Pharmacists, as outlined in the business case developed by NHS England in 2014 (Appendix 1). This programme of work is separate to the NHS England national pilot for Clinical Pharmacists Employed in General Practice[6], announced in September 2015.

2.2 National Context

Nationally policy makers recognise that there is much potential for Community Pharmacists to play a stronger and more integrated role in the delivery of high quality Primary Care. Pharmacists are highly trained health care professionals who are experts in medicines *(Liberating the NHS 2010).* It is generally recognised that their skills are under-utilised.

To date the implementation of policy has failed to gain widespread momentum for a number of reasons. These include the economic challenge facing small businesses with General Practice under pressure to diversify and maximize income sources; fragmentation of commissioning of community pharmacy services, coupled with the competition of GPs and pharmacists needing to also maximize income.

NHS England, Derbyshire and Nottinghamshire Area Team (now restructured as NHS England, North Midlands), developed a 5 year primary care strategy, in collaboration with key stakeholders, which set out its aspirations and ambitions for the transformation of Primary Care. NHS England and Derbyshire and Nottinghamshire Clinical Commissioning Groups (CCGs) are committed to exploring how different skill sets in Primary Care can be utilised to transform current models of care delivery. In particular the strategy aimed to scope how the skills of pharmacists could be integrated and their role maximized in the management of patient and population care within primary care settings. This also aligned to the 5 year forward view [1,2,3] from Simon Stevens, Chief Executive of NHS England.

Improving health and patient care through community pharmacy – A Call to Action (2014) set the context for releasing the potential of community pharmacists so they can provide a range of clinical and public health services to deliver improved health and consistently high quality; play a stronger role in the management of long term conditions; play a significant role in a new approach to urgent and emergency care and access to general practice; provide services that will contribute more to out of hospital care; and support the delivery of improved efficiencies across a range of services.

Access to Independent Prescribing for Pharmacists has not always been matched by the availability of prescribing roles. The business case set out to test whether there was a pool of pharmacists, trained as independent prescribers, with limited opportunity to utilise their advanced skill that could deliver services in primary care if given the opportunity. Coupled with the extra demand on GP services overall and the workforce issues in recruiting and retaining GPs, it made sense to utilise pharmacists as part of a possible solution to some of the these workforce pressures. In order for pharmacists to realise their aspirations and to support the rise in demand for GP services there was a need to test new models of care which better utilise professional expertise and skills to enable people to get the most from the right clinician so they have the right medicines and the right care plan to stay healthy, well and safe.

The Royal Pharmaceutical Society and The Royal College of General Practitioners issued a joint position statement [4] in March 2015, supporting the development of such new models of care. The Chief Pharmaceutical Officer (CPO) and the local NHS England North Midlands Corporate Management Group approved the business case. The CPO was the National Clinical sponsor. The Head of Primary Care Policy, NHS England Central Team also supported the project.

2.3 Aims of the programme

The programme aimed to develop and evaluate a new model of care and test whether the quality of patient care could be improved by utilising community pharmacy independent prescribers (CPIP) in both a GP practice and a community pharmacy setting.

By improving quality of care it was anticipated that changes in the following areas could be achieved:

- Patient experience
- Freed up GP time
- Improved access to Primary Care
- Increasing value
- Improved Safety
- Reductions in unnecessary prescribed medicines
- Reductions in the likelihood of secondary care referrals

2.4 Programme Overview

CPIPs were contracted into the wider General Practice team in partnership with Community Pharmacy Organisations, and co-managed patients with long term conditions and urgent care needs, working closely with GPs and the practice team. In some pilot sites, care for patients in nursing homes and house bound patients was also tested.

The project was hosted by Newark and Sherwood CCG, and ran from April 2015-March 2017, and was planned, managed and reported on by a project team, reporting to a programme board.

3 Activity and key performance indicators

Activity was captured in each pilot site by Practice managers / Pharmacists and reported in a monthly reporting template (Appendix 8)

3.1 Pilot site activity to end March 2017

The following table summarises the overall activity and information by pilot site (the Pharmacy provider, the number of days that the pharmacist was seconded to the practice, dates and CCG).

CCG	GP Practice & List size	Pharmacy Provider	Dates	Days p week	Patient Activity
North Derbyshire CCG	Chesterfield Medical Partnership (17,000)	PCT Healthcare Ltd (Peak Pharmacy)	July 15 - Mar 17	4	5,148
Newark and Sherwood CCG	Abbey Medical Group (12,000)	HI Weldrick	Sept 15 - Mar 17	3	3,108
Nottingham North and East CCG	Giltbrook Surgery (4,700)	PCT Healthcare (formerly WR Evans / Manor Pharmacy)	Sept 15 - Mar 17	2	1,951
Southern Derbyshire CCG	Swadlincote Surgery (8,000)	PCT Healthcare (formerly KM Brennan)	Nov 15 - May 16	2	510
Nottingham City CCG	Wellspring Surgery (10,500)	Jaysons	Feb 16 - Mar 17	2	1,208
Southern Derbyshire CCG	Lister House Surgery (35,000)	Nottingham University Hospitals	April 16 - Mar 17	3	1,162
				Totals	**13,087**

3.2 Activity by Patient contact type to end March 2017

The majority of contacts were either face to face or telephone, some contacts involved dealing with 3rd parties such as hospitals, community pharmacy, and clinic letters and administration.

Contact type:

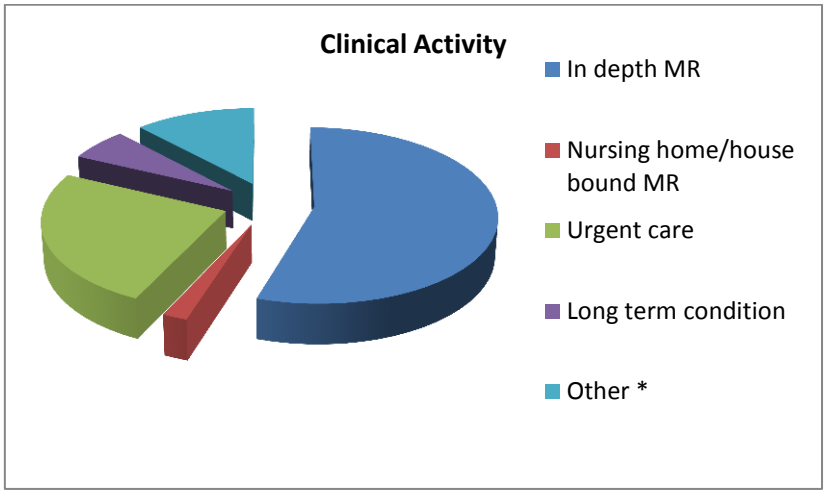
Face to Face	53%
Telephone	33%
Administration	14%

4 Types of clinical activity undertaken and outcomes

The majority of these consultations have involved a in depth clinical medication review (MR), the following summarises the primary reason for the patient having the consultation:

In depth medication reviews	55%
Nursing home or house bound medication reviews	2%
Long term condition reviews	25%
Urgent care	6%
Other	12%

(*Other care includes but is not limited to secondary care discharges to primary care, medication advice and queries, Coronary Heart Disease risk assessment, travel medicine queries, smoking cessation, and prescription switches).



4.1 In depth medication reviews

- Complex disease reviews

  For patients on high risk medicines, such as anticoagulants and disease modifying anti-rheumatic drugs (DMARDS). AF reviews, COPD, Asthma reviews, Chronic kidney disease (CKD) Audits.

  An example of practice the activity can be summarised as:

  - Pharmacist responsible for all DMARD patient monitoring:
  - Patient reviewed on discharge to shared care
  - 104 patients on Practice register with DMARD on repeat
  - Blood monitoring in accordance with Shared care
  - Close liaison with patients and secondary care
  - Improved safety for patients and practice
  - Better patient experience

4.2 Nursing care home reviews

- *Covering 60 medication reviews across 8 care homes,*
  - Remote access to records.
  - Tasks include adherence to medication, de-prescribing, changes and timings of medications,
  - Support to carers, safety
  - GP time released to address more complex patient needs

4.3 Long Term Conditions

- Asthma. *A study of 90 asthma patients showed that patients appeared to be over-ordering inhaler medication. Patient reviews showed that there were issues with over and inappropriate use, poor technique and a lack of understanding of how best to take the medications. Targeted annual saving of £1,000 (in one practice), if medications ordered are reduced to nationally recommended levels. Risk of patient exacerbations and avoidable admissions greatly reduced.*

- AF and hypertension reviews
  Lifestyle indications and reductions in medications as well as patients being able to self-care with confidence.

- CKD registers and reviews
  An audit of over 200 patients on CKD register for tests and medication reviews allowed GP to conduct comprehensive CKD review, increase QoF score and increase income.

4.4 Urgent care

This included minor illnesses such as hay fever, skin conditions, tonsillitis, ear infections, ear wax, and UTIs. Under close supervision Pharmacists can conduct their own urgent care clinics creating more general practice capacity to see patients quickly.

4.5 Other activities

Other care includes secondary care discharges to primary care, medication advice and queries for patients, nurses and GPs, Cardiovascular Heart Disease review clinics, travel queries, smoking cessation, and prescription switches. In addition, the Pharmacists are increasingly becoming involved in lifestyle advice and support to change and promote self-care.

4.6 Outcomes

As this work was innovative, KPIs were developed applicable to the different services being offered. This includes:

- Increased Patient access and increase in primary care capacity.
- Patient experience and satisfaction.
- Medication savings from stopping unnecessary or unwanted medicines.
- Safety improvements by initiating routine blood testing where appropriate
- Reductions in avoidable secondary care admission.

The principle outcomes for the programme and emerging findings are as follows (Appendix 12):

- Release of GP time (estimated to be 2,300 hours equivalent GP time)
- Patient satisfaction is extremely high, with excellent feedback, and 100% satisfaction from surveys reported back so far (See section 8).
- Improved access to Primary Care (released GP capacity, creating up to an additional 800 appointments per month).
- Value for money improvements with consultation rates below £20 per consultation.
- Improved Quality (100% patients confirm that they understand medications better).
- Improved Safety (14% patients had blood tests initiated to improve patient monitoring, and 15% patients had changes to medicines to reduce side-effects).
- Changes to medicines were made in 56% of reviews. 22% of those patients had reductions in prescribed medications, due to the removal of unnecessary items not being taken or no longer required.

Reduction in the likelihood of referrals to secondary care. 7.8% patients were judged to have a significant chance of a hospital admission, the likelihood of which was significantly reduced by the Pharmacist intervention).

Outcomes were captured periodically by the pharmacists using the Data outcomes template (Appendix 9). The results of the completion of these is summarised in Appendix 12.

5 Training and professional development

5.1 Induction

All practices were encouraged to provide the CPIP with a comprehensive practice induction, in line with any permanent member of staff, which was typically a minimum of 8 days.

This covered Introductions to staff, practice meetings, clinical system use, clinical meetings, appointments systems, time shadowing GPs and other clinical staff, practice policies and procedures, mandatory training, confirmation of insurance and indemnity arrangements and authorisation to prescribe through CCG/PPA.

5.2 Consultation skills and history taking

Two courses were undertaken in the first 3 months of the programme.

A 2 day course with CNCS covered basics of consultation skills and history taking, which whilst it was well received, feedback showed that too much was covered in too short a space of time. A 6 day course was developed for a group of 14 pharmacists by the DREEAM team, at Nottingham University Hospital, led by Professor Frank Coffey. Details of the training can be found in Appendix 13.

The 6 days covered the following topics:

- Consultation skills and history taking
- Cardiovascular system
- Respiratory system

The training was a combination of academic and background knowledge building followed by practical hands on experiences using patient actors. The course included an examination and test of the knowledge (Multiple Choice and Objective Structured Clinical Examination, OSCE). (Feedback on this was excellent, with the main recommendation that future courses be tailored more to primary care situations, as opposed to secondary care).

5.3 Clinical System Skills

All CPIPs attended an independently run session on clinical systems (all pilot sites were operating with SYSTMONE) provided by a local Health Informatics Systems provider. (Feedback from all pharmacists was that this training and background into the clinical systems was valuable. In addition time was spent with the whole team in the practical use of the clinical system).

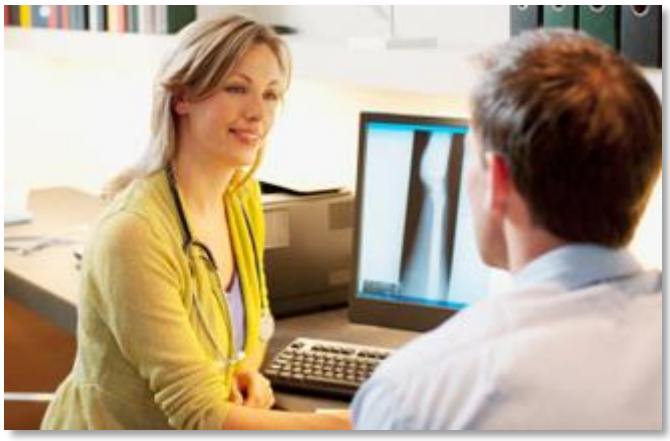
5.4 Personal coaching and mentoring

The project team arranged for personal coaching and mentoring sessions with a trained coach from East Midlands Leadership Academy. This comprised of a minimum of two personal sessions and 360 feedback. Feedback from all delegates (via survey monkey) was 100% positive from all respondents.

The project team witnessed changes and improvements in the confidence of the CPIPs as a consequence of attending these courses, backed up by the survey results.

5.5 Clinical supervision and mentoring

As part of the contract with practices it was agreed that GP Mentors would provide 3 hours supervision/review time per whole time equivalent. In practice, this was split between reflective reviewing and skills development and day to day queries in relation to patient care. The reflective reviews took place with the nominated GP mentor and the patient queries generally from the duty doctor or first available appropriate clinician. Experience showed that this element was critical in development of the clinical pharmacist role and confidence of the pharmacist and the practice in activities undertaken.



5.6 Minor ailments

In three of the pilot sites, a minor ailments course was undertaken. These varied in duration and content, and were found to be helpful, alongside GP supervision and mentoring.

5.7 Ongoing professional skills and development

Each pilot site was encouraged to provide additional professional skills sessions, as well as mentoring and opportunities to attend courses that would benefit the CPIP in their work and development. These included:

- Pain Management
- Venepuncture

At least two of the pilot sites are looking to invest in further training of the CPIPs to develop as Advanced Care Practitioners following closure of the pilot programme.

6 Critical success factors and key learning

6.1 Relationship building

Critical to the success of the programme is the relationship that the CPIP has with the practice, particularly their GP mentor and that they feel truly embedded in the GP team. Where this is effective, the development of the pharmacist is much quicker and what they can give back to the practice in terms of capacity and skills increases. It is important to create a sense of shared purpose.

Where pharmacists were known to practices (e.g. co- located Pharmacy or part time CCG Pharmacist), this enabled the relationship and trust to build more quickly. Where the pharmacist was not known previously to the practice, time needed to be invested in building that relationship, which typically took 3-6 months, and develops best with at least 2 days per week in practice. In one pilot the CPIP started on 1 day per week and progress was very slow, but when increased to 2 days this rapidly improved.

A key element of recruitment and selection is that the Pharmacist and the Practice have confidence in each other. This was supported and emphasised by the Project team, who played a key role in emphasising this as a priority.

6.2 Experience and qualifications of the Pharmacist

All of the Pharmacists were Independent prescribers, although their experience in working as an Independent Prescriber varied. All of the CPIPs were at least 4 years post registration. One of the pharmacists was seconded from an acute hospital trust (as opposed to Community Pharmacy) due to recruitment issues with one site.

6.3 Clinical supervision, reviews and mentoring

The review processes are vital for building skills, trust and confidence. In practices where this was regularly conducted, progress was rapid. In practices where this was more ad hoc, or where the supervisor changed, this impacted on skills development, integration and trust.

Working in general practice and seeing patients one to one can leave clinicians feeling very isolated. Pharmacists are moving from a different environment of the Community Pharmacy into General Practice and the environmental and mental pressures need to be considered and managed. Initially Pharmacists felt vulnerable and GPs were concerned about risk management.

6.4 Numbers of sessions per week

The pilot sites had varied amounts of CPIP time mainly based upon their list size. This varied from 1 day (2 sessions) to 4 days (8 sessions per week). Where pilot sites were allocated 2 sessions per week slower progress was observed. This was thought to be due to the amount of time needed to build relationships and issues with lack of continuity. As a consequence the only site with 1day per week was increased to 2. Whole days of working allow for more continuity than half days. In the pilot sites, the optimum whole time equivalent Pharmacist to patient list size is 1 to 15,000.

6.5 Appointment types and average time for appointments

In the initial 3 months of the pilot, appointment times were set at between 20 and 30 minutes. Initial appointments were centred on conducting medication reviews, particularly in depth reviews for patients with multiple medications. As confidence grew and the CPIP developed, the appointment times were reduced and the range of appointment types expanded. Critical to the development of this is the relationship between the CPIP GP mentor and Practice Manager/Director. Initial shadowing sessions were invaluable in developing the skills and confidence. A mixed appointment schedule with face to face and telephone reviews was appropriate from a scheduling point of view and also met the needs of the patient.

6.6 Training and development

Pharmacists are highly trained clinical professionals, undertaking 4 years of academic training with an additional preregistration year. Their medicines knowledge is vast, but their experience in applying this to patient diagnosis and consultations is limited in most cases. The GP mentor has a key role in developing confidence and application of that medicines knowledge to patient care in General Practice.

The development of skills and confidence is equally important, and competencies need to be mapped and checked regularly. Independent Prescribing Pharmacists will have an area of expertise and interest, which can be exploited e.g. Respiratory disease of cardiovascular, but their skills and as advanced practitioners can also be rapidly developed.

Alongside the need to develop clinical skills, is the need to develop operational skills and knowledge in practice especially around clinical systems, signposting patients to other services, and referral processes. Above all the person needs to be considered in terms of their personal skills attributes and personal traits. The Leadership coaching and mentoring was one of the most important elements of the training provided, because it allowed dedicated one to one time to meet the needs of the individual, by having their personal and emotional needs assessed and supported.

6.7 Communications

Communications in any transformational programme are going to be important and should not be underestimated. Pharmacists need to be clear about what their role is and how they integrate into the General Practice. GPs other clinicians and practice staff need to be clear about what it is that the Pharmacist can do. Practice communications and practice meetings should help to embed the pharmacist, but also patient representative groups also need to be informed of the new skills. Local relationships with community pharmacy can be improved through the CPIP, and this represents an opportunity for improving relationships at a time when there have been pressures from funding cuts in Community Pharmacy, financial pressures on practices and changes in patient pathways such as Flu vaccinations being promoted through Community Pharmacy.

Wider communications need to be considered, particularly if the Pharmacist can prescribe. Appropriate prescribing access should be set up through the practice, CCG and Prescribing Authority so that the Pharmacist is authorised to prescribe through the local clinical system. Communications

to wider networks such as Local Pharmaceutical Committees, Clinical Commissioning Groups, Health Education England, NHS England, Local Professional Networks and other key stakeholders was key on ensuring the system is aware of the contribution and capabilities that the CPIP bring into General Practice.

Regular progress reports and newsletters were of significant benefit to communications and raising the profile of the programme (Appendix Newsletter 14).

Liaison with local Pathology laboratories should also be conducted in instances where the pharmacist can instigate blood tests through clinical systems automatically (e.g. through ICE).

6.8 Induction

Thorough induction will promote the role and benefits of the role of the Pharmacist, and help to build relationships. Where induction was thorough and comprehensive, integration of the pharmacist was quicker and their contribution was more rapid. The project team developed and induction checklist for pilot sites to aid this process.

6.9 Practice typology (AHSN[5])

General Practices can be categorised into types according to cultural, operational and business perspectives. Practices can be categorised as Traditional, Developmental, Entrepreneurial or Overwhelmed.

Generally speaking the practices in the pilot were either in the developmental or entrepreneurial category, and this was excellent for this type of transformational work. Traditional and overwhelmed practices are unlikely to be able to provide the level of support needed to make this a success. All of the participating practices were recognised training practices, so were familiar with the demands of developing and mentoring clinicians.

6.10 Practice list size

Practice list size varied in the pilot sites from 4,700 to 35,000. The impact that the CPIP had on the practice skill mix and care to patients was not dependent on list size, but more dependent on the right relationships and processes. The optimum ratio is 1 WTE pharmacist to 15,000 list size.

6.11 Management and support

The project team provided support, liaison, facilitation and direction in a co-produced, trust based management approach. This meant that the practices and pharmacists were not told what to do but guided to the possibilities, enabled by local priorities for patients and the resources the practices had in place. This meant that a truly co-produced system of working evolved, where all key stakeholders felt that they had a say and a stake in the direction of travel.

The project team helped to facilitate a local network of the pharmacists and held 4 Action learning sets, which provided a safe environment for pharmacists to share ideas, progress, and challenges that they faced. It also helped to develop an informal network of peer support. For example one practice was considering using the CPIP to monitor all DMARD Patients, but was able to link with

another pharmacist who had done that successfully, to get advice on set up and implementation. In another practice, the Practice Manager had concerns about what the pharmacist could do but was able to speak directly with another Practice Manager to get advice and reassurance about what could be achieved.

A key role within the management support was the regular gathering of activity data, financial monitoring, disseminating examples of good practice, developing outcome measures and patient feedback mechanisms, as well as a central point of contact for queries and support.

6.12 Outcome measures and reporting

The project team developed an activity report that was completed each month by each site. This was a co-produced report from the CPIP and the practice. This report was developed and amended over time, so that it provided more comprehensive feedback from each site, and provided a mechanism for regular reviews or highlighting issues (Appendix 8).

In addition the project team recognised that a number of benefits from the pilot were not being appropriately captured and so developed an outcome measures report. This was a comprehensive assessment of the intervention between the pharmacist and patient, to determine the following:

- Assessment of medication review and changes
- Impact on quality of care
- Impact on safety of care
- Potential Impact on secondary care admission
- Impact on patient knowledge and understanding

Due to the high level of time required to complete these assessments these were conducted on a sample basis e.g. all patient for periods of 2weeks, repeated twice in the pilot (Appendix 12).

6.13 Governance

In order for the Project team and pilots to be properly accountable, a programme management board was established and reporting was also conducted into NHS England North Midlands Direct Commissioning Performance Group, which provided objective reviews and assessments of the programme.

6.14 Networks and sharing

The project team invested time and resources into developing a local network of Pharmacists and pilot sites. In the main these were brought together through quarterly stakeholder events, that were used for the pilot sites to showcase their work, share ideas and experiences and to allow an opportunity for others to understand the work that was being carried out.

In addition the project team produced quarterly update reports that were circulated to a named contact list including the following groups:

- NHS England North Midlands
- Nottinghamshire and Derbyshire CCG Primary Care leads and Medicines Management and Commissioners of Pharmacy and Primary Care
- Nottinghamshire and Derbyshire Local Pharmaceutical Committee (LPCs)
- Derbyshire and Nottinghamshire Local Medical Committees (LMC) and Primary Care Development Centre (PCDC)
- Health Education England
- Centre for Postgraduate Pharmacy Education (CPPE)
- Community Pharmacy providers
- Healthwatch
- Care Quality Commission (CQC) local inspectors
- GPs
- National colleagues including NHS England, Pharmacy Voice, RPS, PSNC
- Local Professional Network for Pharmacy

6.15 Workforce planning and development

6.15.1 Pharmacists

The pilot set out to work with Independent prescribing pharmacists and the original business case was based on a recruitment model. Due to the limited timescales and the employment risk , the project team engaged with community pharmacy providers and seconded independent prescribers on a part time basis. Initial expressions of interest were sought from Pharmacists who were Independent Prescribers. Liaison with the General Pharmaceutical Council revealed the following independent prescribers from the registered list of pharmacists (Primary and Secondary Care, CCGs, Community Pharmacy) in Derbyshire and Nottinghamshire (April 2015 National Average 6%):

Derbyshire	43	11.2%
Nottinghamshire	33	5.1%

So the project team revised its plans of recruitment because of a realisation that independent prescribers were a scarce resource, particularly in Nottinghamshire, which helped to frame recruitment thinking.

An issue arising from the pilot was retention of staff in community pharmacy, with staff migrating to the NHS England Clinical Pharmacists programme and/or General practices. It highlighted the need to invest more in independent prescribing resources and qualifications, which is now being addressed through the NHS England National Clinical Pharmacists in GP practices programme and a local programme funded by HEE to encourage Pharmacists to undertake the Independent prescribing course.

6.15.2 GPs and Nurses

Huge pressures exist locally in Nottinghamshire and Derbyshire with the lack of GPs entering vocational training schemes (38% places not filled 2016), retirement of GPs and the pressures resulting in more GPs wanting to work part time. The pilot sites have all demonstrated that workload

pressures and additional capacity can be supported by Community Pharmacist Independent Prescribers. More needs to be done to accredit advanced care practitioners and pharmacists to support delivery of Primary Care.

Five of the six practices have indicated that they will employ the pharmacists directly or through the NHS England Clinical Pharmacist programme [6].

6.15 Additional unintended beneficial consequences

There have been a number of unintended and beneficial consequences of this pilot, that were not originally anticipated, with two key benefits emerging:

1 GP Welfare

GPs in 3 of the pilot sites have expressed their surprise at the rapid mobilisation and development of the Pharmacists into clinical roles. In one case this has helped to facilitate the senior partner in being able to have a day off during the week. This was as a direct result of having the pharmacist role in the practice and the consequential added capacity.

In a second pilot site one of the senior GPs reported that he could now leave the surgery at 7pm instead of the average 9pm due to the additional capacity and expertise from the Pharmacist.

This had a significant impact on their work / home life balance.

In a third pilot a senior partner GP described the beneficial impact the pharmacist had on dealing with urgent medicines queries reducing the workload pressures on the duty doctor of the day.

"I was sceptical, at first I wasn't sure what the pharmacist could do…" (GP Mentor).

Link to GP discussion about programme involvement: https://youtu.be/hJZt09MJk9M

2 Patient experience

Patient experience was excellent; one GP described the feedback as "the sort of feedback that he could only wish for". The trust that the Pharmacist can build with the patient and the additional time that the pharmacist spent with the patients meant that lifestyle issues could be discussed and be addressed to benefit the overall health and well-being of the patient. There are numerous examples of patients feeling positive about their visit to surgery, and the benefits that they get, as opposed to feeling pressurised not to waste GPs time.

6.16 Role of Community pharmacy

One of the areas the project team did not fully explore, was to take the clinical expertise back into Community Pharmacy, partly due to lack of time within the pilot and partly because the Patient feedback from a focus group discussion to suggested that such a change might be premature.

6.17 Professionalism of Pharmacists

There was a concern nationally that Pharmacists may influence prescription direction and put commercial interests above those of the patient and the programme. In none of the pilot sites was this found to be the case.

"The Pharmacist has made my team more complete" (Practice Director)

6.18 Lifestyle advice, self-care and patient risk assessments a proactive approach as part of medication review:

The structure of one of the pharmacists consultations with patients in a practice in a deprived area of Nottingham City is described below

1. Making the most of the current medications for best patient outcomes

- Review Drug - drug interactions
- Review Appropriate doses
- Check out for side effects: overt and hidden on renal, hepatic and haematological or physiological

2. Support with healthy living advice to optimise patient outcomes

3. Risk assessment undertaken: This is often misunderstood, but is key for patients taking control of their health care.

- BP
- Heart rate and it's regularity or irregularity
- Smoking
- Alcohol
- Ethnicity (Any predisposition to LTCs)
- Past work and exposure
- Support systems at home
- Diet
- Exercise
- Family history (Genetic predisposition)
- Weight
- BMI
- Waist
- Q Risk
- Cholesterol (total, HDL, TC:HDL ratio, LDL)
- Inhaler techniques

This identified what are the biggest risk factors towards their current condition and if no current conditions exist yet, then it is possible to anticipate what is likely to occur in the next 5-10 years without lifestyle changes. Action plans were drawn up to address the top 3 risk factors that the patient agreed to make changes on.

If the risk of a LTC is already high, but not yet symptomatic, then further tests like Blood glucose and Hba1c will pick up 'Pre-diabetics' and diabetics early enough in the pathway before much irreversible microvascular damage (Eyes, nerves and kidneys) is done.

Many patients have been picked up with this system of operation. With this approach the NHS, not to mention the patient, will benefit from this over the next 5-10 years and but there is no way of contracting for this type of work at present.

7 Finance

7.1 Financial Model

NHS England committed £653k of non-recurrent funding over 2 years to test the proposition of using Community Independent Prescribers to support healthcare delivery in General Practice.

7.2 Costs of programme

Programme Costs	Description	Total Project costs
Pilot Site Costs	**Total cost of Community Pharmacist, GP Mentor across 6 sites**	**£316,050**
Project Costs	**Includes project management, clinical leadership, administration training and evaluation**	**£336,950**
Total programme Costs		**£653,000**

*Additional funding from HEE of £142k to enable full winter pressures benefits to be reviewed.

7.3 Cost benefits of programme

In terms of added capacity, it is estimated that the programme has released over 1,300 hours of GP time annually. However one Practice considered that the Pharmacist appointments freed up more than 1 appointment, as many patients would present several times for multiple conditions with GPs, given the 10 minute constraint on appointment times. Now many of these are being dealt with in one visit with the pharmacist, thus preventing unnecessary additional appointments.

Benefits	Description	Annual Saving
Release of GP time	**Estimated 1,300 hours of GP time saved through Pharmacist consultations**	**£240,905**
	Estimated 7.8% reduction in hospital attendance – Emergency Department and Outpatients	**£710,000**
Total		**£950,905**

Avoidable secondary care admissions is estimated at 7.8% equates to a saving of £710k pa.(See Appendix 12).

If we consider the direct costs of the Pharmacists and GP time, the above shows that for every £1.00 invested there is a return of at least £3.00. If we consider the return on investment for the full programme costs it is approximately £1.50 benefit for every £1.00 invested.

7.4 Other cost benefits

Medicines waste is reduced by stopping unnecessary prescriptions, and by making more cost effective medicine switches, as appropriate. In addition the instigation of blood tests in the data outcomes sampling has the potential to improve safety and prevent future acute events from happening.

7.5 Average cost per consultation

In terms of average cost per consultation, our results indicate that the average cost per Pharmacist consultation, is approximately £20 (including GP supervision, with a range £16.70 to £30.30, based on activity after 6 months).

This compares to £44 per patient contact for a GP [7].

7.6 Indemnity

The indemnity insurance for the pharmacists work in the programme was covered by corporate policy arrangements through the Community Pharmacy provider organisations. Their policies were generally through the National Pharmacy Association.

Pharmacists were also encouraged to have their own personal indemnity, which was generally through the Pharmacists Defence Association.

Some practices found that additional providers were entering the market offering more attractive rates such as MIAB. This pilot and the NHS England Clinical Pharmacist programme are raising the profile of the indemnity aspects of clinical provision by Pharmacists, although at this early stage the risk is uncertain.

8 Patient feedback and case studies

8.1 Patient feedback

Patients were invited to complete a survey after each consultation (Appendix 10) whether the consultation was face to face or by telephone. The following table shows the overall results:

Patient Experience – short survey Summary findings (596 surveys)

	Strongly Disagree	Disagree	Agree	Strongly Agree
I am happy with the consultation and how I was treated today.	0%	0%	11%	89%
I feel that my knowledge and understanding of my medications is improved and I trust the information provided by the Pharmacist today.	0%	0%	13%	87%
I felt respected and had enough time during my consultation.	0%	0%	11%	89%
I expect my health and how I am feeling to improve	0%	0%	17%	83%
I would be happy to see the Pharmacist again.	0%	0%	12%	88%
I would recommend the Pharmacist to family, friends	0%	0%	11%	89%

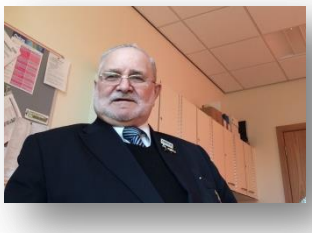
Results of patient feedback to telephone consultations (67 surveys) are consistent with the above:

	Strongly Disagree	Disagree	Agree	Strongly Agree
I am happy with the telephone consultation and how I was treated today.	0%	0%	10%	90%
I feel that my knowledge and understanding of my medications is improved and I trust the information provided by the Pharmacist today.	0%	0%	22%	78%
I felt respected and had enough time during my consultation.	0%	0%	10%	90%
I would recommend the Pharmacist to family, friends	0%	0%	15%	85%

Selected Patient Comments/Quotations

- Excellent service, thank you.
- I felt really at ease. R was very kind respectful helpful in every respect. I am pleased with it all.
- It's a really good idea to have a specialist Methotrexate person for reference. I feel cared for.
- I was treated with respect and was given all the relevant information to allow me to make a decision on further medication.
- RS was fantastic, really polite helpful and gave good advice.
- Good consultancy. Discussed BMI and how to bring it down and what the benefits are. Received leaflet on change point and will follow up.
- I felt very confident that the pharmacist will help me because I have been feeling like I haven't been listened to in the past.

- Lovely manner and covered everything I was worried about or needed to ask.
- J was very nice. She was polite and listened to everything that I said. She was very knowledgeable. I felt better after seeing her, thank you.
- A very thorough consultation, I understand my tablets better now.
- He was very calm and nice to speak with. I would like to meet him again.
- My health issues and advice has never been explained like this before. It was very well done and I would recommend to anyone.
- A very thorough examination compared with those by another surgery.



- Can't fault today at all, why can't it always be like this?
- My visit was extremely informative and in-depth analysis of my medical condition was exceptional. I came away feeling that better informed and my condition was being monitored much better. The changes in my medication were a surprise, but reasoning was correct.
- I learned things in my review about my medication which I did not know before. I felt I was able to discuss my medication with the pharmacist and did not feel rushed at all.
- He was understanding and listened attentively to what I had to say. He also gave suggestions and recommendations on how to effectively take my medication and health options. I felt respected. A very effective consultation.
- Fantastic idea, as I work 8.30am to 7.00pm and have difficulty getting to see a GP (Telephone Consultation)

8.2 Patient Case Studies

The following case studies summarise examples where Pharmacist interventions have shown positive results:

- During a BP review the pharmacist managed the step down of treatment for a patient previously diagnosed with hypertension. He had recently lost a considerable amount of weight so it was possible that he was no longer hypertensive. His BP was at target so his BP medications were stopped and BP reviewed at a later date where his BP was still at target. It was agreed with the patient that he no longer needed medication which he was very pleased about and regular monitoring will continue.
- A patient reported that she was worried about going deaf, and the pharmacist established that there was a substantial build-up of earwax, and provided treatment to relieve it.
- A patient attended ENT hospital and was prescribed medicines for their condition from hospital. The pharmacist conducted a review and found that the dose was not high enough to be effective, and the medicines were also not being taken regularly. The Pharmacist explained how the medicines worked and why they were important. The patient now understands their medicines better and is able to take them as required and is getting the benefit intended from the medication.
- A patient was non-compliant with antihypertensive medication, but by providing an in-depth discussion on the importance of managing BP and consequences, the patient is now much more motivated to take medication and BP is now well controlled.

Video link to patient feedback about their consultation with the Pharmacist.

https://youtu.be/HgGRjCtVWJQ

9 Communications and Stakeholder feedback

9.1 Communications and Stakeholder feedback

A communications strategy was developed in collaboration with NHS England communications team, approved by the Programme Board. Part of the communications strategy was an interactive project update, featuring each pilot to capture good patient stories and develop case studies. This included video interviews with patients accessing the service.

The project team regularly presented at Pharmacy and Primary Care events, the following summarises the key events:

Date	Event	Nature of communication
Jun 15	CPPE / HEE Pharmacy Workforce forum (Derby)	Presentation
Sept 15	RPS Annual Conference (London)	Poster
Oct 15	LMC Workforce Development (Nottingham)	Presentation
Jan 16	RPS Innovators Forum (London)	Presentation
Jan 16	Annual Chemist and Druggist Awards (Wales) GP Pharmacy Partnership, Clinical Service	Award submissions – shortlisted finalist both categories
April 16	Pharmacy Congress (London)	Presentation / Poster
May 16	Public Health and Primary Care (NEC)	Presentation
June 16	CPPE / HEE Pharmacy Workshop Forum (Ruddington)	Presentation
July 16	HEE Workforce Workshop (Loughborough)	Presentation
Sep 16	East Midlands Community Pharmacy Strategy event	Presentation
Sept 16	Pharmacy Show (NEC)	Presentation
Dec 16	Connected Notts Event (NHIS)	Presentation / Workshop
Jan 17	BBC East Midlands today news "Clinical Pharmacists in General Practice"	Live News article on using Clinical Pharmacists in General Practice
Jan-Mar 17	NNE Locality Meetings	Presentation
Mar 17	Future of Role of Pharmacy (Stakeholder Event)	Presentation/Discussion
Mar 17	5Year forward view events Derby and Nottingham	Presentation
Apr 17	HSRPP University of Nottingham	Poster and Presentation
Jul 17	Chemist and Druggist awards	Shortlist for GP Pharmacy Partnership of the Year

There were 4 stakeholder events held throughout the duration of the programme where the role of the CPIP in general practice was presented and discussed. All events were well attended and feedback was positive in all cases. The following comments came from feedback at the March event:

- Interesting to hear GPs views about pharmacists in community and as prescribers
- Useful to make connections with community pharmacists, GPs and hospital pharmacy
- Interesting to see the diverse innovations in pharmacy across the region
- Was not sure what to expect, but found it very interesting and thought provoking
- Interesting to see the range of developments in primary care and how to apply this
- Event was excellent for getting people to openly discuss concerns, issues etc, which produced a rich vein of information and discussion
- Good to see that there is a groundswell of opinion supporting the need to make better use of community pharmacists, pushing at an open door
- Very useful event fantastic to bring together professionals from different backgrounds & allow discussions
- Great to speak to other pharmacists and hearing about their roles
- Very useful valuable and relevant networking opportunity

10 Independent Evaluation

An independent evaluation of the programme is being conducted by the University of Nottingham, School of Pharmacy, led by Dr Matthew Boyd.

10.1 Provider Brief

The proposed formative evaluation addresses a number of key developmental questions that will assist the future roll out of the initiative:

1. What is the underlying theory or model of change on which the initiative is developed, what forms of evidence or experience have been influential and how can a refined model of change be used to inform future measurement and summative evaluation;
2. How does the initiative move from concept to specification to practice, with particular attention to the influence of key decision-makers, patient co-design and local service leaders;
3. How are CPs integrated into local GP practice arrangements, with particular attention to the local contextual factors, e.g. resource profiles, occupation and organisational boundaries; leadership, service cultures, established ways of working, IT and other technological capabilities;
4. How is the service organised and delivered in the different pilot sites as a 'situated' intervention, with particular attention to the local changes in practice and the influence of wider contextual factors, as detailed in question 3
5. How do different stakeholders perceive and experience this new service configuration, including GPs, CP, patient and family members, practice managers, practice support staff and other community based healthcare professionals
6. What evidence can be found, primarily qualitative, but also from routine service data, that the pilot has brought about change in the management and delivery of primary healthcare, with particular attention to the developed model of change including assessments of GP workload and time management, patient access, and health benefits.
7. What type and number of consultations are the pharmacists conducting and what are the routes of consultation initiation and disposal? Are these consultations in addition to GP workload or a replacement for (patient reported)?

Evaluation has included observations of Pharmacist led consultations with patients, and interviews with practice staff, and the programme board team. Focus groups have also taken place between the evaluation team and patients attending services. A final report will be available by June 30th 2017.

The University of Nottingham will also be involved in evaluating the NHS England Clinical Pharmacist programme pilot and second wave implementation.

11 Programme Management and implementation

11.1 Programme Board

A programme board was established, with membership from NHS England, CCGs, LPCs, Pharmacy Voice, Project Team, Citizen representative, Community Pharmacy and GPs. Agreed terms of reference were established (Appendix 7). Meetings were held every 2 months to monitor progress, manage the programme and consider key decisions. Minutes and supporting papers of the Programme board meetings were kept and circulated. The board was chaired by Samantha Travis, (Clinical Leadership Adviser / Controlled Drugs Accountable Officer, NHS England, North Midland)s.

The main areas discussed and updates reported on were:

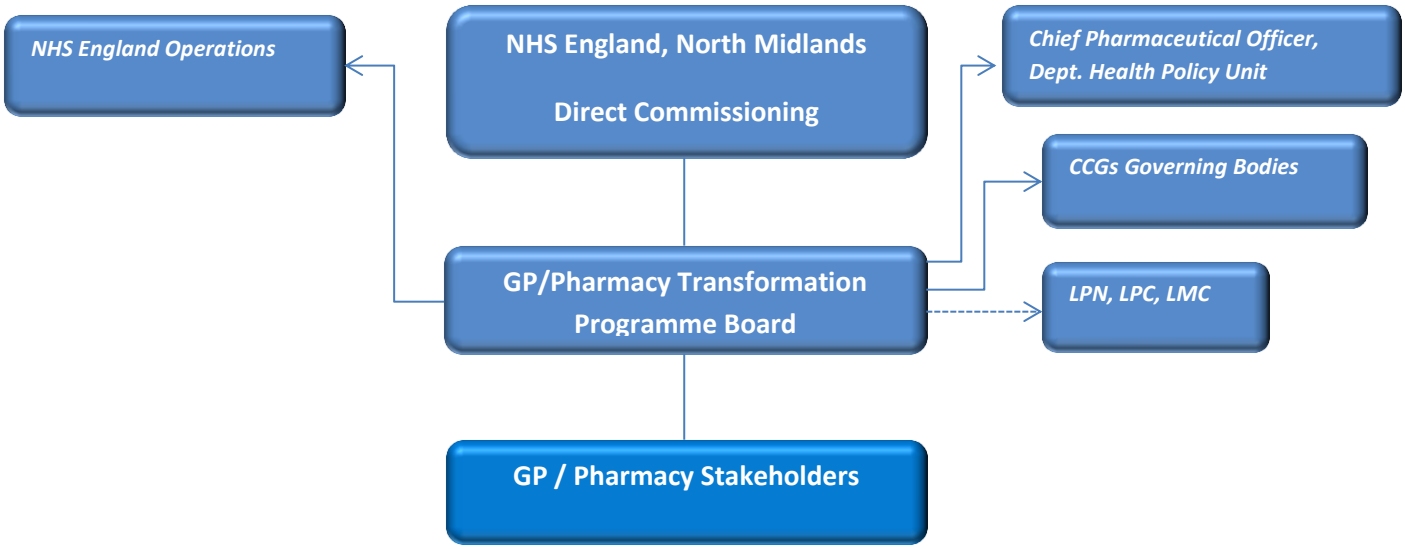
- Project Team progress
- Pilot site progress and issues
- Activity update and progress
- Finance
- Risk and Issues log
- Communications
- Stakeholder engagement events
- Future priorities

11.2 Project Team

Robert Ferris Rogers Director of Service Improvement (Newark and Sherwood CCG) and latterly David Ainsworth, Director of Primary Care, Mid Notts CCGs had overall responsibility for the programme. Amanda Rawlings and latterly Cathy Quinn was the Clinical Pharmacist Lead for the Programme. Gerald Ellis was the Programme Manager. Newark and Sherwood CCG provided programme and administrative support.

11.3 Governance

The project team produced regular 3 month progress reports for key stakeholder communications and for reporting to NHS England North Midlands Direct commissioning Performance Group:



11.4 Implementation

Implementation was conducted in line with Prince 2 Programme management principles. A project initiation document (Appendix 2) was written, with supporting project planning documentation, and milestones mapped out. A service level agreement and specification (Appendix 3) was developed and contracts were drawn up between Newark and Sherwood CCG, practices and local CCGs (Contract variations, Appendix 5) Community Pharmacy Providers (NHS Contracts Appendix 4) and Honorary Contracts (Appendix 6) between Pharmacists and practices.

Regular reports on progress were sent by each pilot site (Appendix 8) to the project team and regular visits took place between the project team and pilot sites, including Pharmacist, Practice Manager and Supervising GP.

Newark and Sherwood CCG contracted with Community Pharmacy organisations for the Pharmacist time on a part time seconded basis, in order to mobilise quickly and mitigate financial risk of employment. General practices were contracted to provide dedicated clinical supervision.

12 Sustainability and Future Commissioning

The CPIPs have demonstrated their value in General Practice. Within 18 months several sites have committed to employ the Pharmacists directly.

The CPIPs have shown that they can apply their vast medications knowledge effectively, but have also been able to develop diagnostic and clinical skills, that can be compared to those of a junior doctor.

In one practice, an experienced Advanced Nurse Practitioner, with the Non-medical prescribing qualification reduced their hours, and the Practice Manager had no hesitation in offering those hours to the Clinical Pharmacist.

"The Clinical Pharmacist can offer more to the practice in terms of medicines knowledge, applied to medication reviews, and has shown the commitment and drive to develop clinical and diagnostic skills so that they can run long term condition clinics, including asthma reviews, hypertension reviews and urgent care clinics. As such this makes them at least comparable to an ANP."

In one practice, there was a difficulty in recruiting GPs. Practice Director and Partners took the strategic decision to employ the Pharmacist.

"The Clinical Pharmacist can be compared to a junior doctor, but provides the practice with additional medications knowledge that is so useful to the practice team and patients. The Clinical Pharmacist has reduced the daily workload on the duty doctor by dealing with urgent medications queries. In the near future we expect to expand the role to cover more urgent care needs"

Considerations for future commissioning of pharmacists from a programme such as this have been influenced by the NHS England Clinical Pharmacist programme and the investment into 2,000 Clinical Pharmacists by 2020, as outlined in the GP Forward view.

In the 6 pilot sites, 4 have indicated that they would / have employed the pharmacists as part of their practice team based upon progress and contribution to date. These practices have also applied for wave 2 Clinical Pharmacist funding and to date two have been successful with two applications being resubmitted

One pilot site had to finish prematurely, due to personal circumstances of participating staff, and so could not be fully implemented and evaluated.

The final site has applied for Wave 2 Clinical Pharmacist funding [6], as part of a collaborative bid and has been successful.

In summary, the pilot has proved its concept, achieved its aims and objectives and consequently practices are prepared to fund this as they see the benefits.

13 Appendices

1 **Unlocking Potential of Community Pharmacy Business Case**

2 **Project Initiation Document**

3 **Service specification**

4 **NHS Contract with Community Pharmacy**

5 **Contract Variation with General practices**

6 **Honorary contracts with Pharmacist and practice**

7 **Programme Board terms of reference**

8 **Monthly reporting template**

9 **Outcome measures template**

10 **Patient Feedback Survey**

11 **Clinical Pharmacist Job description**

12 **Outcomes and Data analysis**

13 **DREEAM Clinical Skills Training**

14 **GPPT Newsletter**

14 References

1 **NHS 5 year forward view, NHS England 2014**
https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

2 **GP 5 year forward view, NHS England April 2016**
https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

3 **Community Pharmacy 5 year forward view PSNC August 2016**
https://psnc.org.uk/our-news/community-pharmacy-shares-its-forward-view-a-vision-for-the-future/

4 **Joint statement RCGP and RPS 2011, Updated 2014**
https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Policy%20statements/rcgp-joint-statement-for-pharmacists-in-gp-surgeries.pdf

5 **Practice Typology, 2017**
Dr Guinery J, Dr Brown Sue, University Of Nottingham Business School
(yet to be published)
Further information available on request Gerald.ellis@nhs.net

6 **NHS England Clinical Pharmacists Programme 2017**
https://www.england.nhs.uk/gp/gpfv/workforce/cp-gp/

7 **Unit costs of Health and Social Care 2015**
Lesley Curtis and Amanda Burns (Personal Social Services Research Unit)
http://www.pssru.ac.uk/project-pages/unit-costs/2015/

15 Acknowledgements

The project team wishes to highlight thanks for the support and contribution from the following:

1 **Samantha Travis and Pharmacy Team at NHS England, and members of the Programme Board**

2 **Newark and Sherwood CCG for hosting the programme**

3 **Nottinghamshire and Derbyshire Local Pharmaceutical Committees and Local Medical Committees**

4 **General practices GPs and Practice managers for their support**

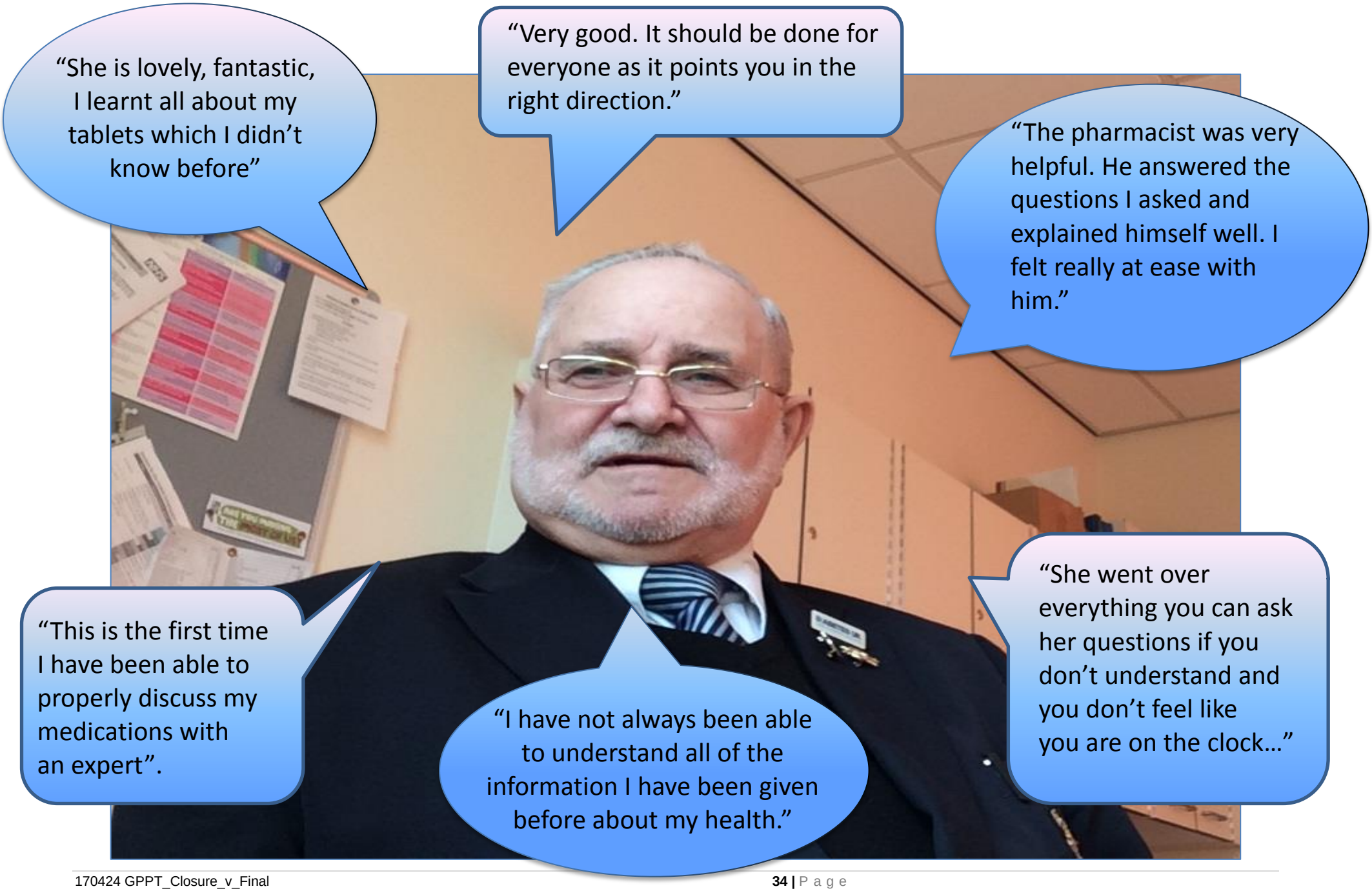
Abbey Medical Group
Chesterfield Medical Practice
Giltbrook Surgery
Lister House Surgery
Swadlincote Surgery
The Wellspring Surgery

5 **Participating Pharmacists for their support and commitment**

6 **Patients for their feedback**

7 **Community Pharmacy providers for their support in seconding staff:**

8 **Health Education England and CPPE**


"She is lovely, fantastic, I learnt all about my tablets which I didn't know before"
"Very good. It should be done for everyone as it points you in the right direction."
"The pharmacist was very helpful. He answered the questions I asked and explained himself well. I felt really at ease with him."
"This is the first time I have been able to properly discuss my medications with an expert".
"I have not always been able to understand all of the information I have been given before about my health."
"She went over everything you can ask her questions if you don't understand and you don't feel like you are on the clock…"