ROYAL PHARMACEUTICAL SOCIETY

Royal Pharmaceutical Society and Royal College of General Practitioners

Making the Community Pharmacist Consultation Service a success

RCGP Royal College of General Practitioners

Foreword

The last year has been incredibly challenging, both personally and professionally, wherever we work in healthcare. Teams across the NHS continue to be under pressure and there is a clear focus on how we utilise the full skill set of our workforce to help increase capacity, optimise workload, support the wellbeing of the workforce, and improve access to services across primary care.

The Royal Pharmaceutical Society (RPS) and Royal College of General Practitioners (RCGP) are committed to supporting GPs and community pharmacists to work together to look after patients and the public. The Community Pharmacist Consultation Service (CPCS) is an important example of how we can be more effective at managing demand across the health service and making best use of the primary care workforce.

Making CPCS a success is important for both GPs and the pharmacy profession. Getting this right would mean:

- Making greater use of pharmacists' clinical skills
- Reducing the workload for GPs
- Improving patient access to primary care
- Building the evidence base for an integrated primary care service

This service can provide a means of working differently to meet the needs of our populations.

We have heard about some good examples where CPCS is working well but we also know there are areas where there is still room for improvement. In many places we are not yet seeing the kind of referral rates we would have hoped for.

Our joint workshop explored some of the challenges around CPCS implementation and how the service could be supported to ensure success. There are huge benefits for collaboration between general practice and community pharmacy to achieve the very best outcomes for patients and improve access to primary care. We have a whole host of skilled professionals working together across primary care to help patients and the public stay well. We need to make sure they are utilised in the right way.

How we emerge from COVID-19 and work better together to support the NHS recovery is really important for the future.

We hope that the recommendations from this report are taken on board by stakeholders, both locally and nationally, to support GPs and pharmacists to provide the best care for patients.

Professor Martin Marshall
Chair

Royal College of General Practitioners

Thorrun Govind
Chair, English Pharmacy Board

Royal Pharmaceutical Society

Introduction

BACKGROUND

The purpose of the Community Pharmacist Consultation Service (CPCS) is to allow community pharmacists to support general practice by undertaking minor illness consultations after referral. The benefit is increased capacity in practices, utilisation of the clinical skills of pharmacists, and improved access to care by the public.

The CPCS was launched in October 2019 with initial referrals from NHS 111 providers. This was expanded in November 2020 to include all GP practices in England. Under the NHS 111 service referrals could be made from 17 providers. There are currently 11,700 community pharmacies and over 6,500 GP practices in England, however to date (October 2021) there are only 862 GP practices that are fully operational and referring to community pharmacists under this service. If the service reaches its full potential and is implemented across all GP practices, it could help better manage demand across primary care, and enable patients to see the right clinician at the right time.

There is evidence that advice provided by community pharmacists about minor illness results in the same outcome as if the patient went to see their GP or attended an emergency department.[1] The CPCS pilots have demonstrated that patients valued this service, particularly being able to arrange a same day appointment with a community pharmacist. Some pilots have suggested that 10% of GP appointments could be referred to community pharmacists via the CPCS. Additional feedback demonstrated that community pharmacy is viewed by patients as a vital.[2,3]

Recent developments and incentives as part of the Investment and Impact Fund for Primary Care Networks (PCNs) are to work with community pharmacy in developing and commencing a plan for increasing referrals in 2021/22.[4] In 2022/23, PCNs will be incentivised to increase their referral rates to the CPCS which could lead to over one million referrals annually.[5] Some localities have expanded the current service to include the provision of some Prescription Only Medicines (POMs) via Patient Group Directions (PGDs), like that of the 'NHS Pharmacy First Scotland' service.[6]

Since the workshop was held, a £250 million Winter Access Fund for general practice was announced on 14 October, which included a requirement for practices to sign up to the CPCS by 1 December 2021, alongside a wide range of requirements and actions for practices to meet in order to receive some additional funding.[7] However, in some areas this requirement and timeline is being relaxed, according to local discretion, due to some of the challenges of implementation covered in this paper.

The CPCS is an example of how an integrated service across different elements of primary care can work, but to make it successful there needs to be local collaboration and communication.

The Royal Pharmaceutical Society (RPS) and Royal College of General Practitioners (RCGP) hosted a workshop on 29 September 2021 to discuss the barriers and solutions to implementing the CPCS and achieving higher referral rates. The workshop brought together commissioners, pharmacists and GPs with experience of providing the CPCS, representative bodies and patient representation (participants are listed in Appendix 1).

The main aim of the workshop was to collaboratively explore and develop a set of recommendations that, if implemented, will help support the successful implementation of GP CPCS. Participants received an overview of the current situation and were asked to identify barriers to successful implementation and discuss potential solutions to them.

This report summarises discussions on the day and suggests how the implementation of the CPCS could be improved.

Barriers and Solutions

The workshop explored barriers to the current implementation of the service and potential solutions to how these could be overcome.

1. PROFESSIONAL BARRIERS

There is a need to ensure a consistency of service provision across the country and across the workforce. Some participants felt that there was patchy coverage of the service across England. There is a need to ensure that all pharmacy teams are engaged and are committed to delivering the CPCS service and for all pharmacists to take up the offer of commissioned CPCS continual professional development (CPD) opportunities from the NHS. In addition, it was felt that general practice staff (including receptionists and practice managers) were not fully engaged with the service or its benefits and required resources/support/training in how to triage (remote/face to face consultations) and manage referrals to and from community pharmacists.

The feedback from the workshop highlighted that there are variable local relationships between GPs and community pharmacy colleagues and in some areas these relationships are still non-existent. Even with the best efforts and resources to engage with PCNs to socialise the service benefits, only a small proportion of local stakeholders engage and want to know more about the service and how to implement it.

Some local systems do not completely understand the CPCS and undervalue its potential benefits, therefore there is a lack of local or system level buy in or support to help with implementation.

Discussion on doing things differently

All participants felt that there needed to be a greater focus on clearly explaining, engaging, and communicating the benefits of the service to patients, PCN/general practice teams and system leaders both at national and local level.

General practice staff are a key factor in helping to drive implementation and should be better supported to make appropriate referrals. Practice staff will need additional support with setting up the service, training on how to make a referral and how to manage/explain the service to patients. The narrative around the support and services that community pharmacists can provide is critical to ensure that the practice staff and patients see community pharmacy as part of the primary care multidisciplinary team. The ability to explain what the service involves, the experience and benefits of a CPCS consultation, and being seen on the same day for advice/support in a consultation room from a skilled clinician, needs to be made clearer.

In addition, it was seen that relationships between both Local Medical Committees (LMCs) and Local Pharmaceutical Committees (LPCs) were key to help drive and advocate for the benefits of the service. There have been examples where strong relationships have helped drive local implementation and buy in from system leaders working with PCNs. However, capacity continues to be a limiting factor and additional implementation and project management support focused on the CPCS from the NHS would help drive implementation. It was clear that additional investment is needed to help community pharmacy and PCN/general practices set up and operationalise CPCS and to support the delivery of collaborative/clinical incentives and services across PCNs for now and the future.

The collection of data and feedback is crucial so that the benefits and the value of the service can be highlighted, evaluated, and publicised alongside helping to understand how the service can be improved and developed further. The impact on workload and patient experience were said to be key to helping promote the service and should be made more widely available.

2. PROCESS / PRACTICAL BARRIERS

We heard that the initial setting up of the service can sometimes increase the workload within general practice. If staff do not see the immediate impacts and benefits, then they may be reluctant to refer or triage to the service. This impacts on referral numbers and how much time and effort is invested in establishing the service locally. Low numbers of referrals also have an impact on community pharmacists as they may not check the electronic system for the service as regularly. As a result, unless the patient informs the pharmacist that they have been referred through the CPCS they may not always be logged as a referral.

It was noted that not all GPs and practice management staff have the information or understanding of the service and what can or can't be referred to a community pharmacist. Some participants said there was a general lack of awareness of the referral pathway, evaluation findings from the pilots, how the service is quality assured, and feedback to general practice. These issues were raised as key factors causing a lack of buy in at PCN or general practice level which contributes to a reluctance to implement the CPCS. There is a clear need for better national and local engagement and communication regarding the service, and the process around referral and management of patients.

There was a general view that the referral process and IT systems currently used are not designed to make the process of referring to CPCS easy. General practice teams would like to see how this service could fit into their current triage systems and pathways to ensure their teams didn't have to learn additional/different IT systems or processes. General practice teams are more likely to engage and implement if the referral mechanism was more streamlined and easier to operate daily. The need for improvements to the technology involved is explored further below.

While not all CPCS consultations result in the supply of a medicine, there was frustration amongst GPs, pharmacists and patients' representatives that the pharmacist was sometimes unable to 'close' an episode of care because they could not supply a medicine/product that a patient may need, due to the fact either:

1. patient is unable to afford a product
2. patient is exempt from prescription charges/ entitled to free prescriptions
3. there was a need to supply a licensed Prescription Only Medicine (POM) along with advice.

The community pharmacist would need to refer the patient back to general practice for an appointment with a prescriber for a prescription to be supplied. This was seen to produce extra workload on general practice, taking up additional appointment slots, delaying care for the patients, and potentially widening health inequalities, despite community pharmacists being more than capable of completing the episode of care and supplying a medicine. It was felt that while the CPCS has the offering to be extremely helpful, a more advanced service, which included the supply or prescribing of POMs by community pharmacist for minor ailments, would help general practice and patients even further. Several workshop members pointed out the *'NHS Pharmacy First Plus'* service in Scotland as a good example of how the CPCS should evolve in England.[8]

During the workshop there was a clear call for additional and extra national resources to support local project management and implementation beyond what has already been provided by NHS England and Improvement. This additional local support is needed to help to drive, engage, develop relationships, and provide practical solutions to support service implementation and uptake.

The practical implementation of the CPCS will happen at a neighbourhood and place level rather than at system level as it will be individual practices making the referrals. Some conversations around the CPCS service implementation are happening at ICS level, requiring additional permissions/"sign off" and are not involving those who will be implementing the service in practice. There is a need to ensure ICS leads are behind

nationally commissioned services and do not further delay implementation plans across PCNs.

Clearer messaging and alignment of public facing messages are needed to avoid confusion as to where members of the public should go if they have a minor ailment. Current national messages around 'Pharmacy First', for example usetherightservice.com, encourage people to go directly to their pharmacy for a minor ailment whereas with the CPCS service you need to be referred from your GP or NHS 111.

Discussion on doing things differently

Having an effective process in place in terms of electronic referral and making it easy for referrals to happen is critical to successful implementation. The current referral pathway needs to be streamlined so it is easier for referrals to be made between GP practices and community pharmacy IT systems.

Suggestions from the group were to upgrade IT systems to enable 'one-click' style referrals which have been seen to be feasible and easy and should be encouraged and supported by working collaboratively with system providers. Alongside this, there is a call to explore how the NHS could integrate the CPCS into e-consultation platforms/algorithms to triage a patient and refer them to the CPCS, building on current triage systems and pathways that general practices use regularly.

The group felt there was a need to understand the NHS plans and timelines (a roadmap) around integrating GP and community pharmacy IT systems and enabling read/write access to medical notes for community pharmacy teams. This was felt to have clear benefits to enabling referrals between general practice and community pharmacy alongside helping improve continuity of clinical care for patients.

There is a need for additional project management support and resources at a local level, above what is currently being provided by the NHS. Additional project support would provide local capacity to help engage stakeholders, promote the service, and drive implementation. Participants spoke of having appointed project teams going into PCNs/GP practices to provide training on how to implement the service, triaging to community pharmacists and managing referrals back from community pharmacy teams. Alongside this there would be an opportunity to explain how the service worked, what it involved and the benefits for general practice teams and patients, i.e., what type of consultation patients would have with a community pharmacist and the potential outcomes.

Participants felt that having a clear definition of successful implementation, nationally and locally, would help with delivery of the service. Although the NHS England Improvement Impact and Investment Fund provides a new incentive and resourcing to help drive the CPCS, it was not felt to be enough to drive behavioural changes. Some participants felt there needs to be more substantive national incentives and targets for referral rates, and a clear description of what 'good' looks like in terms of numbers (short, medium, and long term) and changes in where patients are being seen for minor ailments.

Having a named person within the GP practice who acts as a point of enquiry for the CPCS is helpful and this means that both the people who have been referred and pharmacists who may have queries, are not held in a telephone queue. Using PCN and GP practice pharmacy teams to support implementation within GP practices has shown to lead to better uptake and should be encouraged.

Participants would like there to be a greater focus on supporting GP practices with setting up the referrals to the service and embedding it into referral triage processes that may already exist. Alongside this, the group would like to see a more joined-up approach from the national NHS teams to engage and work with ICSs to help system leaders:

1. understand the valuable contribution of primary care teams;
2. ensure they support the implementation of nationally commissioned services;
3. explore how national services could be further enhanced and developed to support local population health approaches; and
4. meaningfully engage with all primary care teams, representatives, and professions on the future development of ICS plans and services.

3. PEOPLE BARRIERS

Participants indicated that more was needed to be done to engage and support patients and the public to understand and engage with the service. It was highlighted that most patients either did not know the service existed or understand what would happen to them once referred or the role that the community pharmacist in providing advice and support for their ailment/s.

Some patients are sometimes reluctant to be referred to a pharmacist as there is a misconception or belief that the 'quality' of service they receive will be 'less' than that from a GP for treatment of a minor ailment. Similar behaviours have been observed and still seen today when GPs refer to PCN/general practice pharmacists. More needs to be done nationally and locally to help public understanding of important services such as the CPCS, working in collaboration with key stakeholder organisations.

There was a clear understanding of the value and impacts of CPCS on patient experience from the pilot's evaluation. The group raised the issues around some patients not being able to afford to purchase a medicine or product advised by a community pharmacist following a CPCS consultation, and the impact this may have on widening health inequalities and adding to GP workload.

When people are referred to the pharmacy, they do not always mention that they have been referred by their GP surgery. This means the pharmacist treats them in the same way they would any other person walking into the pharmacy asking for advice on a condition and does not note them as a CPCS referral. With the current referral numbers, pharmacists may only check the electronic referral system infrequently, which means some patients may be seen before the pharmacist is aware they have been referred. This means the patient does not experience the full service and relevant data is not captured, and the pharmacist does not receive the service payment for the consultation and assessment that was conducted.

Due to current capacity and workload issues across primary care, patients have reported that when they attend a pharmacy, the pharmacists do not always have the time to talk to them. This issue could be because they have not been referred via the CPCS referral pathway. Patients are then more likely to want to see their GP as they know they will have a dedicated amount of time via an appointment slot provided by the GP practice.

Discussion on doing things differently

Greater engagement and clearer communication about the benefits of the service are needed. This can be in done in various ways working in collaboration with patient groups/charities/ representation through posters, adverts or infographics for example. These should include information on helping people understand the service, what the service will offer (e.g., on the day appointment, assessment, private consultation) and the potential outcome without needing to wait for an appointment. Support for general practice teams to explain this to patients and the public will be important.

There needs to be clear communication for patients and the public about what conditions can be seen, treated or managed by a community pharmacist in a community pharmacy and where people should go first for minor ailment management. General practice also plays an important role in helping with the consistency of these messages to the patient they interact with.

Recommendations

1

NHS England and Improvement should provide additional investment in local system support and resources to drive the CPCS implementation and uptake between general practice and community pharmacy.

- Additional investment in project management support on the ground including teams who will work with LMCs, LPCs, PCNs, GP practice, and community pharmacy teams to support engagement, drive service implementation and project delivery.
- Additional investment in software technology to support easy referrals.
- Additional investment in developing and supporting general practice reception teams and practice managers to help implement the service. This should include resources to explain the service to patients, CPD opportunities to support their understanding the role of community pharmacy, the CPCS referral pathway, the benefits of the service, how it will help manage/optimise workload, and how to manage referral cases.

2

National representative bodies should work with NHS England and Improvement to develop national and local engagement and communication plans that champion the role of community pharmacists and the CPCS.

- The plans should examine key drivers to support local uptake of the CPCS, including communication with general practice teams.
- Alignment with, and supported by public-facing communications on accessing primary care, including role of community pharmacists to treat minor ailments and seeing the right healthcare professional at the right time.
- Pharmacy and GP stakeholders should work together to encourage greater adoption of the CPCS.
- RPS and RCGP should continue to promote the uptake and delivery of CPCS CPD for community pharmacists.

3

National pharmacy, GP stakeholders and NHS England and Improvement should explore how the CPCS referral pathway can be streamlined by:

- Developing easier general practice referral/triage functionality and interoperability with community pharmacy IT systems, so that all members of the general practice teams or patients who wish to make an appointment are diverted to an appropriate appointment type, with an appropriate person, at an appropriate time. This must include referrals to community pharmacists for minor illnesses and management of medicine requests but in the future for certain long term condition management.
- Streamline the service referral pathway through use of e-consultation platforms/algorithms to triage a patient and refer them to community pharmacists from general practice.
- NHS England and Improvement should invest in general practice and community pharmacy systems to enable seamless integration and exchange of clinical information for incorporation into the patient medical record as required. A clear roadmap and timeline around complete read/write access to medical notes for community pharmacy is needed. This will ensure further integration of community pharmacy across the NHS and enable better continuity of care for patients.

4

The Government and NHS organisations should work with national pharmacy and GP stakeholders to expand the role of community pharmacists in the management of minor illness to include the supply of certain Prescription Only Medicines (POM) through national PGDs and the use of Pharmacist Independent Prescribers in Community Pharmacies, similar to 'Pharmacy First' and 'Pharmacy First Plus' services in Scotland.

5

NHS England and Improvement should work with stakeholders to develop the ongoing evaluation of the service and its impacts on general practice workload, patients' outcomes, and any impacts on health inequalities. Results should be shared across the healthcare system.

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Appendix 1: Workshop Attendees

Name of Attendee	Role / Organisation
Alistair Buxton	Director of NHS Services, Pharmaceutical Services Negotiating Committee
Andre Yeung	Member, English Pharmacy Board, Royal Pharmaceutical Society
Anne Joshua	Head of Pharmacy Integration, NHS England / Improvement
Aron Berry	Community Pharmacist, Lloyds Pharmacy
Austin Ambrose	Client Services Director, Practice Managers Association
Brendon Jiang	Senior Clinical Pharmacist, North Oxfordshire Rural Alliance PCN and member of RPS Primary Care Pharmacy Expert Advisory Group
Cheryl Fitchew	Community Pharmacist, Day Lewis Pharmacy
Danielle Fisher	Head of Policy, Royal College of General Practitioners
Ella Wright	Senior Policy Lead, National Voices
Heidi Wright	Practice and Policy Lead, England, Royal Pharmaceutical Society (Facilitator)
Janice Perkins	Chair, RPS Community Pharmacy Expert Advisory Group
John Lunny	Public Affairs Manager (England), Royal Pharmaceutical Society (Facilitator)
Luvjit Kandula	Chief Officer, Greater Manchester Local Pharmaceutical Committee
Professor Martin Marshall	Chair, Royal College of General Practitioners
Michelle Caton-Richards	Advanced Nurse Practitioner and GP CPCS facilitator, Royal College of General Practitioners Representative
Mike Maguire	Member, English Pharmacy Board, RPS
Neil Bhayani	Public Affairs Manager, National Pharmacy Association
Nick Thayer	Professional Healthcare and Policy Researcher, Company Chemists Association
Ravi Sharma	Director for England, Royal Pharmaceutical Society
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee
Sarah Crawshaw	CPhO Clinical Fellow, Royal Pharmaceutical Society (Facilitator)
Selva Selvarajah	General Practitioner, St Andrews Health Centre
Shilpa Shah	Chief Executive Officer, Kent Local Pharmaceutical Committee
Thorrun Govind	Chair, English Pharmacy Board, Royal Pharmaceutical Society
Tom Gregory	Practice Pharmacist, 168 Medical Group, Weston Super Mare
Tom Yerburgh	Member, British Medical Association GP Committee
Waqas Ahmed	Community Pharmacist, Prescriptions Pharmacy
Yvonne Dennington	Business Manager (England), Royal Pharmaceutical Society (Facilitator)

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