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Network Contract Direct Enhanced Service: Draft outline service specifications
Royal Pharmaceutical Society response

The Royal Pharmaceutical Society is the professional body for pharmacists and pharmacy in Great Britain. We lead and support the development of the pharmacy profession to improve the public's health and wellbeing, including through advancements in science, research and education.

We welcome this open approach from NHS England and NHS Improvement (NHSE/I) to consult on the five Primary Care Networks (PCNs) service specifications and the opportunity to provide feedback.

We welcomed the concept and development of PCNs as the right size and the right vehicle to deliver primary care. When PCNs were set up, the expectation was that they were to be flexible and develop at their own pace to deliver the care that is needed within their locality. PCNs were to enable collaboration and partnership working with multiple providers (including non-medical providers) to deliver local population health. The additional medical and pharmacy workforce, as part of the PCN agreement, would help to deliver the current workload, freeing up GP time and improve patient access.

Whilst we support the intention of these draft service specifications, we have concerns around implementation and delivery which we hope will be addressed during this consultation process.

1. Making best use of pharmacists' skills and knowledge

PCN pharmacists will have a significant role within PCNs over the next five years to help deliver these service specifications, particularly structured medication reviews (SMRs). It is important that NHSE/I continues to value the additional role and activities of pharmacists working in PCNs and continue to invest in their development.

Pharmacists should play a leadership role more broadly in medicines optimisations across all PCNs, supporting the health and social care needs for people and helping tackle health inequalities. We strongly support the enhancement and extension of the PCN pharmacist's role to support all service specifications across the five-year period and hope NHSE/I continues to ensure that the roles are patient-facing and integrated as part of a multidisciplinary team.

RPS has long advocated for the increasing use of pharmacist's skills and expertise across the NHS. We are pleased to see that pharmacists will be one of the lead clinicians undertaking the SMRs. Medicines are a vital health intervention and we welcome measures to support quality, safety and helping the NHS and patients maximise the benefit from them. We are aware that 5-8% of avoidable hospital admissions are related to medicines[1], 50% of patients not taking their medicine[2]s

[1] http://www.bmj.com/content/329/7456/15
[2] https://www.who.int/chp/knowledge/publications/adherence_full_report.pdf

as intended and approximate £300 million is wasted every year[3] on unused or partially used medicines. With most prescribing taking place in primary care, SMRs will be pivotal in improving patient care and safety around medicines through shared decision-making. They will help address issues such as problematic polypharmacy, avoidable admissions into hospital caused by medicines, and reduce medicines waste. We are pleased to see that the draft specification also includes commitments to tackling antimicrobial resistance.

We support the inclusion of Enhanced Health in Care Homes (EHCH) in the draft specification. Pharmacists have a proven track record for improving the care of people in care homes in terms of medicines optimisation. Benefits have been seen through the NHS England Pharmacy Integration Fund (PhIF) Medicines Optimisation in Care Home (MOCH) programme. PCN pharmacists and wider pharmacy teams should continue to be able to contribute to the delivery of this service specification, improving patient care and safety whilst also helping optimise GP workload across PCNs.

The anticipatory and personalised care specifications and interconnected with many elements in the SMR and EHCH specifications. PCN pharmacists and the wider pharmacy teams will also value a role in supporting the delivery of these, as many people have complex needs, multimorbidity and/or frailty, and are often taking a greater number of medicines. Optimising medicines for these types of people should help to improve health outcomes and maintain or improve functional ability.

The role of pharmacists and pharmacy teams in the early cancer diagnosis specification has been missed. There are many examples of the contribution pharmacy teams can make in this area and would want NHSE/I to consider exploring how this can be integrated into this service specification during the consultation process.

Within the proposed draft specifications there is little mention of working collaboratively with community pharmacy or working with other pharmacy teams, such as those in secondary care or mental health services. Considering the mandatory requirement for PCNs to work with non-GP providers such as community pharmacy, this seems a missed opportunity to promote integrated services for patients. Primary care is broader than general practice and collaboration is one of the key fundamental principles associated within the NHS LTP around the aims of PCNs. These draft specifications fail to recognise the contributions of pharmacy teams outside of general practice and how they can play a fundamental role in supporting service specification delivery. We would hope NHSE/I reviews the draft specifications to ensure they are more inclusive and enable more collaborative working between GP and non-GP providers to help empower PCNs to consider how they deliver these service specifications using the whole pharmacy workforce according to local population needs.

2. Pace of delivery and impact on workload

RPS supports NHSE/I ambitions for PCNs outlined in the service specifications. Utilising pharmacists and pharmacy teams to support the multidisciplinary team across PCNs will help

[3] https://discovery.ucl.ac.uk/id/eprint/1350234/1/Evaluation_of_NHS_Medicines_Waste__web_publication_version.pdf

improve patient care, safety, access, optimise workload and reduce pressure on the NHS. We want the role of PCN pharmacists to flourish and be really successful.

PCNs must be given time and space to recruit to the new roles, integrate new staff (e.g. PCN pharmacists) into established teams and ensure they are adequately supported. As the draft specification currently stands, we have concerns about the workload that will be required of PCN healthcare professionals to deliver the full extent of them within the proposed time period. We are keen that all healthcare professionals can effective deliver patient care safely. We would recommend a more structured and phased approach across the five years for all the service specifications to enable this to happen. This would also enable PCN pharmacists to develop more experience and confidence to support delivery of these specifications.

3. Workforce and recruitment

These draft specifications provide a great opportunity to enable the pharmacy workforce to support patients, the multidisciplinary team and the wider NHS. PCNs have a unique opportunity to focus the pharmacy workforce to support the delivery of services across the entirety of primary and secondary care, moving away from 'place based' service delivery to one of which is person-centred.

PCNs need to be supported and resourced to utilise their full workforce allocation. PCN pharmacist recruitment and retention will continue to be key to delivering the PCN service specifications. Therefore, there is a need to make sure these jobs are attractive, exciting and focussed on quality. PCN pharmacists should be well supported and able to develop during their careers. RPS would be keen to work with NHSE/I on recruitment initiatives, supporting tools or additional resources to help PCNs.

The specifications should encourage and promote more collaborative workforce models to deliver the PCN services. This would be particularly useful in hard to recruit or rural areas of England and enable more innovative/flexible workforce modelling to be done across a system, e.g. hospital or community pharmacists rotating into PCNs. The specifications should be more flexible to enable PCNs to develop local approaches that meet their local population needs, in line with their current and future workforce.

RPS is committed to working with partners and stakeholders to maximise pharmacy's contribution to patient care and the NHS. We recognise the positive efforts by NHSE/I to engage on these draft proposals and would welcome the opportunity to discuss this further.

We would welcome clarification on specific parts of draft service specifications, listed below.

Structured Medication Reviews:

1. Points 2.5 and 2.7 – the volume of SMRs that will be required to deliver within the first year is very ambitious if all the specified cohort of people are to be addressed, especially if they have yet to recruit PCN pharmacists. We strongly recommended that this is reviewed and staggered over a period or focus on a few specific cohorts of populations within the first year, as the workforce grows and develops.
2. Point 2.10 – we would like clarification on what level of practice is required for different levels of complexity of SMRs, e.g. what should a newly-qualified vs completed foundation vs advanced practice pharmacist do. This would help to assure patient safety, especially if we are using a new workforce or looking to develop pharmacists in a range of settings to take on new roles. RPS can support this through our programme of work on defining levels of practice with associated curricula.
3. Point 2.11 - We are pleased to see that those undertaking an SMR are encouraged to refer people to Healthy Living Pharmacies (HLP) where appropriate. We would strongly suggest the specifications refers to community pharmacy's further contributions to supporting medicines optimisations in delivering the New Medicine Service (NMS) and the development of medicines reconciliation services. Both the NMS and further medicines reconciliation service have further opportunities to compliment PCNs, integrate PCNs with community pharmacy network, improve patient care and optimise GP workload.
4. Point 2.15 clarifications
    a. We would strongly recommend that these audits are developed by NHSE/I nationally to support PCNs to avoid duplication, increased workforce and reduce unnecessary variation.
    b. The RPS will be keen to engage with NHSE/I on any forms of the guidance would like to produce around SMRs.
5. There should be greater recognition of the use of shared decision-making and personalised care as part of SMR service specifications.
6. 2.16 clarification
    a. Metric 2 - Further clarification is needed on how will these be measured or collected.
7. The specification should enable more flexible workforce models of SMR delivery particularly in rural areas or hard to recruit areas. Such models for SMR delivery could include using community or hospital pharmacists to support PCNs through collaborative working between PCNs and non-GP providers. RPS can provide examples if helpful.
8. As community pharmacists develop their clinical skills and become independent prescribers, systems need to be in place that enable them to have read and write access to a clinical record, so they can have access to the data they need to undertake an SMR and record any interventions they make. An approach like this will help to promote innovation, increase capacity for GP practice, reduce workflow, create space within GP premises, address any workforce issues, and support PCNs to deliver local population health.

Enhanced Health in Care Homes:

1. Point 3.5 clarification – Are there any transition plans in place to ensure continuity of care provided to local populations? Will any support be given to PCNs and CCGs to enable this to happen?
2. Point 3.12 clarification/adjustment – would suggest a phased approach as per the SMR specification in line with workforce development and capacity building.
3. Point 3.13 clarification/adjustment – We would want to see a more inclusive approach to this specification around those supporting those in care homes (nursing/residential) alongside those who are housebound and the frail living in the community. The later part could be a development phase in further years of the service specification implementation.
4. Point 3.16 additions and clarifications
    a. We would welcome further clarification from NHSE/I on who is considered to be suitable 'providers of community services'.
    b. *"home round must be led by a suitable clinician that that on at least a fortnightly basis this must be a GP. With local agreement the GP can be substituted by a community geriatrician."* We would like to see more flexibility around this and would question why other senior clinicians could not lead the home round, or could a collaborative multidisciplinary home round, such as a PCN pharmacist and paramedics round, be more effective? This would help optimise GP workload and help PCNs locally work out who is best positioned to support this. As it stands it could increase GP workload if capacity is an issue.
    c. In point 3.11 there is the mention of 'Improve sub-optimal medication regimes in care homes , and we would like to see the role of pharmacy mentioned 3.16 more to showcase the value impact pharmacists and pharmacy teams can help to support this agenda.
    d. Within this part of the specification there is no mention of the role that wider pharmacy teams must play with this service delivery. Community pharmacy works closely with many care homes, supplying residents their medicines and providing ongoing advice and support. Community pharmacists provide advice to care home staff on a range of issues such as safe storage and handling of medicines, administration of medicines, use of medicines (including indication) and homely remedies. All of this improves the safety of medicines in the care homes and should be included as part of the service specification. There is a role for community pharmacy, working with the PCN to support this specification through activities such as education of staff on safe storage. There should be a broader inclusion in the specification to reflect this increasing role of community pharmacies and how they can work together with PCNs on this agenda.
    e. Alongside the note of community pharmacy, hospital pharmacy teams also play a vital role in support care/nursing homes. RPS can share examples of how this takes place.
    f. Role of community pharmacy in palliative care services may be a useful addition to the specification as outlined in the Community Pharmacy Contractual Framework.
5. Point 3.7 clarification
    a. further clarification will be required on metric one - how NHSE/I will want this information to be collected and how they intend to support PCNs to track this?

Anticipatory Care:

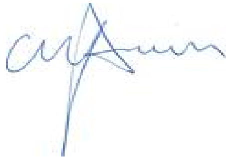
1. Point 4.3 and 4.4 – this a significant gap in joining up health care, social care and voluntary care services. Achieving these aims will require further consideration of how these three parts functions together and are funded appropriately.
2. Point 4.6 – while we acknowledge 2020/21 is a 'preparatory year', are NHSE/I confident that this is an evidence-based approach in its current form? Patient segmentation and risk stratification as part of anticipatory care has a weak body of evidence as there is little agreement as to where best to invest time and effort, e.g. high user's vs the tier below (predictive vs threshold modelling).
3. Would it be more sensible to gather more evidence, knowledge on successful implementation and lessons learned information to support future implementation this PCN specifications?
4. There should be a recognition that community pharmacy can play a vital role in this area as the most accessible points for people in primary care. Primary care is broader than general practice and the specifications need to reflect this 'collaborative' primary care approach. Many of the people in the 'at risk' groups, and their carers, are living in the community and are probably seen most frequently by a community pharmacist. There needs to be mechanisms in place to facilitate referral from community pharmacies into the appropriate multidisciplinary team (which should include a pharmacist).
5. We welcome the commitment to ensure data sharing across the system for all those providing care to the identified people.

Personalised Care:

1. Point 5.6 (2020/21)
    a. Are NHSE/I confidence that 'social care prescribing' pathways are well developed, supported and delivered across the country to enable this proposed phasing model?
    b. We would want to see inclusion of the wider primary care team to support the delivery of this specification. PCN pharmacists will receive education and training on shared decision-making as part of the training for this role. It would be beneficial to the system if other pharmacists across primary care and secondary care also received training in this area, as they have frequent contact with people and would help support PCNs in delivering this service specification and providing more tailored/personalised services to their local populations.
    c. Community pharmacists should be enabled to refer people to link workers for local social prescribing interventions. As all community pharmacies will be level one HLPs by April 2020, they will all have health champions. The health champions could undergo further training to become link workers and support people in the local community. People with long-term conditions spend on average four hours a year with their health team and the rest of the time they manage their conditions themselves. Pharmacists can provide ongoing support to help people self-manage.
2. Metrics should avoid making personalised a "tick box exercise" and instead support a quality interaction between clinicians and people. Personalised care is all about the relationship between clinicians and the people they have conversation with, and this is difficult to measure. Further clarification around the detail of the metrics will be required.

Supporting Early Cancer Diagnosis:

1. Section 6.5 - We would like to see pharmacist's (PCN, community an hospital pharmacy teams) contribution to this service specifications mentioned within this area alongside nurses and GPs.
2. Section 6.10 – the RPS would welcome how this could link the community pharmacy contract leverages to enable alignment and collaborative working potentially via Pharmacy Quality Scheme.



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About us

The Royal Pharmaceutical Society (RPS) is the professional body for every pharmacist in Great Britain. We are the only body that represents all sectors and specialisms of pharmacy in Great Britain.

Our mission is to put pharmacy at the forefront of healthcare.

Our vision is to become the world leader in the safe and effective use of medicines.

Since the Society was founded in 1841 we have championed the profession, and are internationally renowned as publishers of medicines information. Our Royal Charter gives us a unique status in pharmacy.

We promote pharmacy in the media and government, lead the way in medicines information, and support pharmacists in their education and development.