The Pharmacy Practice Research Trust

National evaluation of the new community pharmacy contract

Executive Summary

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Executive Summary

Background

The community pharmacy contractual framework (CPCF) for England and Wales was introduced in April 2005. In mid-2005 the Pharmacy Practice Research Trust (PPRT) invited applications through a competitive process and subsequently commissioned a national evaluation study to begin in January 2006. The CPCF comprises 'Essential', 'Advanced' and 'Enhanced' service tiers, the last of which is locally commissioned by Primary Care Organisations (PCOs).

Scope of the evaluation

The key areas for the evaluation specified by PPRT were: i) Advanced/Enhanced services (extent of implementation, barriers and facilitators, addressing local health needs); ii) Outcomes for staff (role satisfaction, skill mix, inter-professional working); and iii) Quality issues: monitoring and clinical governance. To these specified areas we added progress in implementing Essential services and feedback from patients. The study thus addressed the following research questions:

- What progress has been made in implementing the community pharmacy contractual framework in England and Wales?
- To what extent has the infrastructure and workload of community pharmacy changed?
- What are the views of patients and service users on community pharmacy services?
- What quality assurance measures have been introduced?
- What factors have facilitated and acted as barriers to implementation?
- To what extent are the strategic objectives for the new community pharmacy contract being met?
- How can the implementation process of the new contract be improved?
- Have local working relationships with and within PCOs changed?

Methods

The evaluation used a multi-method approach to yield data at macro and micro levels using quantitative and qualitative methods. Its design elicited data from all of the key stakeholders: community pharmacists, patients, GPs, and the NHS (at PCO and SHA levels). The study focused on a stratified random 10% sample of PCOs in England and Wales at May 2006. It comprised of:

- surveys (the 31 PCOs; all 1,080 community pharmacies in these PCOs, SHAs and the Welsh Assembly Government);
- analysis of routine NHS data on Medicines Use Reviews (MURs) for 2005-6 and 2006-7 and on repeat dispensing;
- focus groups and interviews in five case study PCO sites with community pharmacists, GPs, patients and PCO staff;
- documentary analysis of key public documents in the case study sites; and
- a multi-stakeholder workshop at the end of the study.

The evaluation was also able to draw on specific data from the 3rd annual Keele University/Webstar Health national survey (2007) of community pharmacy development in Primary Care Organisations, and on previous Webstar Health patient surveys.

Overview

Substantial changes have occurred since the introduction of CPCF. Implementation of essential services is well advanced or complete in most pharmacies. The majority (three quarters) of pharmacies now have a private consultation area. Sixty per cent of pharmacies are providing the Medicines Use Review service and over 80% of those who are not, plan to do so in the future. Enhanced services are being provided by 87% of pharmacies, with over 40% providing three or more services.

Almost one third of pharmacists report that they are less satisfied with their job and a quarter say they are less likely to stay in community pharmacy than they were prior to CPCF. Perceived positive aspects of the contract for community pharmacists included increased patient contact and improved relationships with patients. Negative aspects included additional workload arising from the contract, particularly the new requirements for recording data. Facilitators and barriers to implementation have been identified.

Workforce and Workload

One third of the community pharmacists in the sample were self-employed and two thirds were employees. One in five responding ‘pharmacists in charge’ were locums. Only 4% of community pharmacists reported doing sessional work in local medical practices. Two thirds of pharmacists reported having delegated more work to non pharmacist staff since the CPCF was introduced and one quarter to other pharmacist staff. One in three said they planned to make more staff changes in the next year as a result of CPCF

Community pharmacists report increased workload since the introduction of CPCF, some of which is attributable to new services, particularly MUR. Pharmacists also report that the essential services component of CPCF has contributed substantial increased workload, especially from the increased requirements of recording and paperwork.

For around half of pharmacists CPCF appears to have had little effect on job satisfaction but only 17% said they were more satisfied compared with 30% reporting decreased satisfaction. Highest satisfaction was related to colleagues and fellow workers. Lowest satisfaction was related to their role since the introduction of CPCF, remuneration and with respect received from GPs. Many community pharmacists report feeling stressed in relation to their daily work. The three most commonly cited training needs were “clinical”, “research and audit” and “clinical governance”.

Essential Services

Most community pharmacies are delivering most of the Essential services. Provision of repeat dispensing (60%) and prescription linked healthy lifestyle interventions (67%) are the least widely provided. For repeat dispensing, 84% of providing pharmacies were dispensing fewer than 50 items a week. Over three quarters of pharmacists reported recording “clinically significant referrals” and 60% said they recorded “clinically significant OTC purchases”.

The majority (85%) of pharmacies have a clinical governance lead. Standard Operating Procedures are in place in 92% of pharmacies and the same percentage keep a log of safety incidents. Only half of pharmacies send error reports to the National Patient Safety Agency. An in-pharmacy audit was completed by 67% and a PCT-determined multi-disciplinary audit by 55% of pharmacies. Around half of PCOs reported having specified a topic for multi-disciplinary audit. Almost 45% of pharmacists reported having access to the NHS Net and staff in 60% of pharmacies have access to the internet during the working day. One in three pharmacists reported using the internet to obtain information to advise patients and the public.

Most (83%) pharmacists reported that they now record their CPD activities. While 83% reported having an induction programme for pharmacy staff only 51% did so for their locum pharmacists.

Advanced Services

The uptake of the Medicines Use Review/Prescription Intervention (MUR) service is steadily increasing and was 25% of capacity at April 2007. The percentage of pharmacies providing MUR in our sample PCOs rose from 38% in 2005-6 to 64% in 2006-7. Almost three quarters of those not yet providing MURs are independents. The mean number of MURs conducted per pharmacy increased three-fold from 36 in 2005-6 to 115 in 2006-7. Most MURs are currently incorporated into the daily work of the pharmacy without additional pharmacist cover, with only one in four of these pharmacists reporting employing locum cover. There is some emerging evidence of more effective use of skill mix with pharmacy staff assisting with planning and preparatory paperwork for MUR. As the numbers of MURs increase, pressures on pharmacist time are likely to increase, and effective use of skill mix will become more important. Issues in relation to integration with general practice continue to be a key barrier to achieving the potential of MUR and need to be addressed. GPs perceive MUR would be more valuable with a stronger focus on compliance and the reduction of waste. Information flow is almost exclusively from pharmacist to GP and in hard copy, with only one in four pharmacists reporting receiving feedback from GPs. Over 80% of pharmacists providing MUR say it has had no effect on their relationship with local GPs.

Almost all PCOs identified target patient groups for MUR, the most frequently reported being patients with respiratory disease (asthma and/or Chronic Obstructive Pulmonary Disease), followed by patients on multiple medication. Just over half of the PCOs reported having a strategy for medicines review and just under half of these had a strategy that included both community pharmacy and MUR. Monitoring of the MUR service currently focuses on process rather than content or outcomes and PCOs want the service to be subject to audit to provide evidence of value for money. The Prescription Intervention element of MUR is currently an invisible service with no data on its incidence or outcomes.

Enhanced services

More than 40% of pharmacies are providing three or more enhanced services and only 13% are not providing any. Despite a high workload community pharmacists remain keen for more enhanced services to be commissioned. The majority of enhanced services were being commissioned prior to the new contract with around 20% being commissioned after it. Newly commissioned enhanced services were mainly concentrated in minor ailment schemes, emergency hormonal contraception supply and smoking cessation. The introduction of the new contract is associated so far with the spread of previously developed enhanced services for which specifications were available, with very little innovation. The main barrier to commissioning enhanced services was reported by PCOs to be financial constraints. The need for PCTs in England to negotiate payment for enhanced services individually with Local Pharmaceutical Committees (LPCs) was also reported as a potential barrier to commissioning.

All of the PCOs in our sample commissioned enhanced services with a median of seven (range 3-11) services compared with five (range 1-10) prior to the new contract. Almost half of the PCOs reported that the new contract had prompted the commissioning of one or more new enhanced services. Just under half of the PCOs reported that the commissioning of existing enhanced services had been extended since the new contract. Around a quarter reported that they had reduced the commissioning of enhanced services since the new contract. PCOs' Pharmaceutical Needs Assessment had identified an unmet need for

services to support long term conditions, access to primary care services and access to out of hours services. However, service commissioning in response to these identified needs was low. In the case study sites the methods used for the PNAs varied considerably, as did integration with the wider PCO health needs and work programmes. A key issue is whether and how the PNA relates to the PCO wider strategy. In part this is linked to how integrated the pharmacy workstream is across the PCT. However if the findings of the PNA do not chime with the wider PCO strategy they may be seen as less relevant. Since MUR was introduced after the original PNAs were conducted it was difficult to determine how PCO priority patient groups for the service had been identified.

Quality

Almost all PCOs established a group to manage the monitoring of CPCF and all intended to visit their pharmacies as part of the monitoring process. Towards the end of the second year of the contract three quarters of pharmacies reported having had a monitoring visit. Some PCOs reported using the monitoring framework developed by Primary Care Contracting although there seems to be considerable local variation. Benchmarking may be difficult across PCOs without greater consistency in monitoring frameworks. There was little involvement of patients and the public in PCO monitoring processes.

For PCOs with larger numbers of pharmacies, monitoring visits represent investment of a large amount of resource in people and time. Some are visiting all and some a sub-sample of their pharmacies. Almost all PCOs asked pharmacists to complete a self-assessment form and just under half of the PCOs asked pharmacists to complete a workbook or file of supporting evidence. The value which visits added to the paperwork completed by pharmacists was not always clearly articulated by PCOs. Involvement of PCO primary care and clinical governance staff in the visit team offers the opportunity to build mutual understanding and relationships. Patients and the public were rarely involved in PCO visit teams.

Individual pharmacists accepted that visits were necessary. They were generally perceived to be non-confrontational but some pharmacists reported feeling under pressure to complete necessary paperwork. PCO staff felt that there is little meaningful data for them to review in relation to advanced and enhanced services within CPCF. They contrasted this with GMS where extensive data is available electronically and is perceived to be both more robust and meaningful.

By the end of the first year of the new contract two thirds of SHAs had done some assessment of progress with CPCF implementation at PCO level. SHAs used different monitoring frameworks with around three quarters using the CPCF strategic tests. Most SHAs (three quarters) had established some type of forum for PCTs to meet and share experience of implementation of CPCF. The extent of SHA monitoring was related to the amount of time the pharmacy lead had available for pharmacy work. Variation in the monitoring frameworks used by PCOs made it more difficult for SHAs to benchmark across their area.

Integration and collaboration

Most participants in the evaluation thought that CPCF had the potential to increase the integration of community pharmacy into primary care. However in practice CPCF has had little effect on inter-professional working between community pharmacists and GPs so far. Over 80% of pharmacists said that there had been no change in their contact with GPs since the new contract and this was the case for a similar percentage of pharmacists providing MURs. Only one in three PCOs were aware of any regular contact occurring between the local pharmaceutical and medical committees.

GPs identified some areas where they saw opportunities for closer working with community pharmacists, particularly in pharmacists enquiring about compliance and making changes to make repeat prescription supplies more efficient and less wasteful. GPs also expressed concern about the potential for increased workload if pharmacists did not assume greater responsibility for completing episodes of care. However it was unclear how this could be translated into practice.

In the majority of cases the pharmacist communicates with the GP about MUR recommendations through the documentation rather than personal contact. While this is perhaps inevitable it provides no opportunity for inter-professional discussion about patient needs. Pharmacists' lack of access to patient records diminishes the potential value of some interventions and means there is no shared understanding with the GP of the relevant patient history.

Forty per cent of community pharmacists now feel more a part of their PCO. In at least some PCOs the CPCF and PNA have led to closer working between members of the pharmacy team and those in other parts of the PCO, particularly in public health. Pharmacy's visibility in PCO documents for internal and external audiences is variable between PCOs and may be an indicator of integration

Relationships with patients

Prior to the CPCF there was strong support among pharmacy customers for community pharmacists helping to order their medicines (69%) and helping them to understand what their medicines were for (66%). When asked how likely they would be to use a service involving an appointment with the pharmacist to discuss their medicines, support was less strong, at 41%. More people said they would be likely to use the pharmacy for treatment of minor illnesses (85%) than for advice on healthy lifestyle (62%) or advice about diet and/or exercise (55%).

Patients, in our relatively small sample recruited in the case study sites, were generally fairly positive about their experience of having a MUR. Many had been invited to have the MUR by their pharmacist, with few requesting one and none referred by other clinicians. Our data indicate that some pharmacists might unintentionally undervalue the MUR by the language they use to introduce it to patients. Prior to the MUR few patients had heard of it and thus awareness of the purpose of the service was low. There was some concern among patients that in conducting MURs pharmacists were straying into the doctor's territory. Use of the term "review" in MUR creates confusion for some patients because it is also used on patients' repeat prescriptions to denote the periodic review of repeat medicines. Patients want different clinicians to communicate with each other and work together for the patient's benefit. Our data suggest that the concept of an annual MUR might not fit with patients' perceived needs.

Progress against CPCF objectives

In order to set our findings in context the table below shows the original Department of Health (DH) objectives for CPCF with a brief summary of our findings and traffic light colours of green where our data suggest the objective has been achieved, amber where there has been some progress and red little or no progress.

Table 1: Progress against DH objectives for CPCF

	Essential	Advanced	Enhanced
Improved patient choice and convenience in accessing medicines, for example, through repeat dispensing (RD) and electronic prescription service.	Around 1% of prescription items dispensed under RD.		Minor ailments service widely commissioned prior to CPCF and more commissioned since CPCF.
Sustained achievement of 24/48 hour access in primary care, for example, through support for self-care and minor ailment schemes.	Not possible to determine how any changes in provision of support for self care might have impacted. A minority of pharmacies have changed their opening hours since CPCF.		Minor ailment services contribute to achieving primary care access targets.
Reducing demand on GPs and other primary care staff, for example, through repeat dispensing, supplementary prescribing and pharmacist led clinics, for example, for people with diabetes.	Around 1% of prescription items dispensed under RD.		Supplementary prescribing and Disease specific medicines management services rarely commissioned.
Care for people with long-term conditions, for example, through pharmacists undertaking medicine use reviews, supplementary prescribing, monitoring treatment through near patient testing, supporting self-care and signposting to other sources of help.		MUR provided by 60% of pharmacies; value and acceptability to patients and GPs yet to be established.	Little innovation in these areas and no enhanced service templates for care of people with long term conditions.
Supporting the delivery of new General Medical Services contract (nGMS), for example, by helping GPs meet their quality targets for prescribing and medicines management, supporting access to medicines out of hours and as alternative providers of local, enhanced services (e.g., anticoagulation monitoring).			No evidence of pharmacies as alternative providers of local, enhanced services. Anticoagulation monitoring commissioned from 3% of pharmacies.
Reducing health inequalities and improving health for example, through services for drug misusers, stop smoking advice and generally promoting healthy lifestyles.	Prescription linked healthy lifestyle advice provided by two thirds of pharmacies. Participation in public health campaigns almost universal.		Commissioning of Emergency Hormonal Contraception on Patient Group Direction, and smoking cessation services have increased since CPCF.

	Essential	Advanced	Enhanced
Improved patient safety for example through advice to patients and other health professionals, safe systems for handling medicines, including disposal of unwanted medicines, and learning from patient incidents.	Disposal of unwanted medicines and Standard Operating Procedures for dispensing almost universally provided.		
Better value for money by reducing the wastage of medicines, ensuring patients still need their medicines before they are dispensed, know what they are for and how to take them for best effect.		MUR is an opportunity to improve patients' knowledge and reduce wastage but effectiveness unknown.	Prescription intervention as enhanced service commissioned by some PCOs as transitional service until spread of MUR wider.

Key Recommendations

Participants in the multi-stakeholder workshop prioritised the following recommendations:

- Robust Pharmaceutical Needs Assessment (PNA) by PCOs in the wider context of local health and social care needs
- Integration of CPCF and GMS
- Improving working relationships between community pharmacists and general practice
- More information for patients about what CPCF means for them

Stakeholders also identified that additional recommendations were needed in relation to:

- Increasing patient and public involvement
- Developing and disseminating the evidence base on effectiveness and cost-effectiveness of pharmaceutical interventions
- Developing local pharmacy leadership in the context of primary care

The table below brings together the key recommendations and actions needed. Implementing the recommendations will require the involvement of several stakeholders and a lead stakeholder has been identified for each action.

To make the contents legible we have divided the table over two parts, Part A describes actions that are relevant to the Department of Health / CPCF negotiating team, SHAs and Welsh Assembly Group, PCOs and GPs and Practice Based Commissioners (PBCs). Part B describes actions that are relevant to Local Pharmaceutical Committees (LPCs) and Community Pharmacy Wales (CPW) regional committees, individual community pharmacists, community pharmacy organisations and the RPSGB.

Table 2: Part A - Key recommendations and actions for lead stakeholders

	DH / CPCF team	SHA and Welsh Assembly Group	PCO	GPs and PBCs
Robust Pharmaceutical Needs Assessment		Make active use of the new strategic tests for community pharmacy development in monitoring PCO progress.	Ensure the Pharmaceutical Needs Assessment is updated by including in the Joint Strategic Needs Assessment.	
Integration of CPCF and GMS	Identify and implement mutual incentivisation within CPCF and GMS. Introduce participation in multi-disciplinary audit into the Quality and Outcomes Framework (QOF).		Create better integration of CPCF and GMS through use of Medicines Management (MM) QOF points. Use available levers including QOF Medicines Management actions and prescribing incentive schemes to promote local meetings of practices and pharmacists.	
Improving working relationships between community pharmacists and general practice.	Invest in evidence based local support mechanisms for change management, based on peer influence and role models, e.g., MUR champions.	Set local targets for repeat dispensing once Release 2 is rolled out.	Highlight reduction of waste medicines as a key part of MUR and encourage pharmacists to build on this in discussions on compliance with GPs. Use Multi-Disciplinary Audit as a tool to engage community pharmacy with other primary care clinicians. Facilitate regular meetings of LPC and Local Medical Committee (LMC).	Share priorities, plans and data with local pharmacy stakeholders. Discuss local progress with essential and advanced pharmacy services with pharmacy leaders. GP practices to participate in periodic meetings with local community pharmacists.

	DH / CPCF team	SHA and Welsh Assembly Group	PCO	GPs and PBCs
Improving working relationships between community pharmacists and general practice. (cont.)			Include pharmacy in local PBC discussions and development. Ensure that locally the representatives of general practice and practice based commissioning share priorities, plans and data with local pharmacy stakeholders.	
More information for patients about CPCF	Commission national publicity campaigns on key services in CPCF, with strong patient and service user involvement in their design. Provide resources for PCOs to use in local awareness campaigns for community pharmacy services, with strong patient and service user involvement in their design.		Set up local campaigns to raise public and clinician awareness of CPCF.	
Increasing patient and public involvement	Involve patients more at national and local level in the future development of CPCF and its implementation.		Involve patients and the public in PNA.	

	DH / CPCF team	SHA and Welsh Assembly Group	PCO	GPs and PBCs
Develop and disseminate evidence base for pharmacy services	Gather and disseminate evidence of effectiveness and value for money of pharmacy services.			
Develop local pharmacy leadership	Support development work for “market shaping” in primary care to improve market capacity and response in community pharmacy.			

Table 2: Part B - Key recommendations and actions for lead stakeholders

	LPCs and CPW regional committees	Individual community pharmacists	Community pharmacy organisations	RPSGB
Robust Pharmaceutical Needs Assessment	Develop proposals for enhanced services based on local health / social needs data.		Provide tools and resources to increase community pharmacists' understanding of, and involvement in, the commissioning process.	
Integration of CPCF and GMS			Work with other organisations to identify specific areas where CPCF and GMS integration could lead to more effective working and improved patient care.	
Improving working relationships between community pharmacists and general practice.	At PCO level participate in meetings with the LMC. At individual pharmacy level, facilitate and support meetings with local practices.	Engage more proactively with local GPs, thinking collectively and working in groups where that best reflects how a practice's patients are served. These discussions should initially be used to find out from local GPs which patients they wish to be prioritised for MUR and to make arrangements for GPs to refer patients into the service. Subsequent periodic meetings could be used to discuss trends in MUR data and other issues of shared interest. Agree key messages and actions with local GPs.		Commission audit templates for MUR and road test them with pharmacists, GPs and PCOs.

	LPCs and CPW regional committees	Individual community pharmacists	Community pharmacy organisations	RPSGB
More information for patients about CPCF				
Increasing patient and public involvement	Involve patients and the public in service development work.		Involve patients and the public in service development work.	Involve patients and the public in policy work relating to community pharmacy practice.
Develop and disseminate evidence base for pharmacy services		Participate in data collection in studies of effectiveness and value for money of pharmacy services.		Work with other organisations to gather and disseminate evidence of effectiveness and value for money of pharmacy services.
Develop local pharmacy leadership	Increase LPC capacity for community pharmacy development in the light of changing role of PCTs.	Develop abilities to present and discuss new services and roles: features, benefits, anticipate and deal with objections.	Invest, with other organisations, in local leadership development for community pharmacy.	Invest in leadership programme expansion to develop a local community pharmacy leader for each PCO area. Secure, with other pharmacy stakeholders, a practice development programme for community pharmacy.