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Commissioning medicines optimisation services from community pharmacy

Guidance for commissioners

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A. Introduction

A1. Foreword

The University of Manchester, along with Primary Care Commissioning (PCC), has launched a toolkit to support commissioners to strategically plan, design and evaluate services provided by community pharmacies for patients requiring medicines.

By integrating a medicines optimisation service into the patient pathway, the patient can access the expertise of a pharmacist and their team in community pharmacy, which can improve their medicines taking, reduce unplanned hospital admissions and reduce pressure on the wider health and social care system [1, 2, 3].

The content of this toolkit is based on evidence drawn from a large National Institute for Health Research (NIHR) funded study investigating organisational factors associated with variation in the quality and quantity of services provided by community pharmacies [4]. Commissioning and pharmacy leaders attended a workshop on 17 July 2015 (see Appendix 1) to sense-check study findings and to use these to inform discussions around how to design a toolkit to assist the commissioning of medicines optimisation services from community pharmacies.

A2. Aim of toolkit

This toolkit is for all commissioners who may wish to commission a medicines optimisation service from community pharmacies.
By working through this toolkit you will find **guidance, resources and tips** to improve the outcomes of services that involve medicines as part of the patient pathway. You will:

- Understand **how to use community pharmacies** to reduce hospital admissions, improve access to medicines, improve patient safety and reduce morbidity
- Understand the **unique features of community pharmacy organisations** and how these influence the quality and quantity of services provided
- Assure yourself and demonstrate to others that you follow **best practice in commissioning** services from community pharmacy
- Consider how to **monitor and improve** the quantity and quality of these services.

A3. Supporting evidence

Throughout the toolkit, you will find **supporting evidence** drawn from our NIHR-funded study of the organisational factors associated with variation in the quality and quantity of community pharmacy services. This evidence is highlighted clearly in the 'supporting evidence' boxes positioned close to the associated guidance.

Supporting evidence – our study

This study investigated variation in both the quality and quantity of community pharmacy services and the organisational factors associated with this variation. Starting in April 2013, it was conducted over two-and-a-half years, across nine socio-demographically diverse areas of England.

Findings were drawn from various sources including:

- A survey of community pharmacies
- Pharmacy activity data provided by the NHS Business Services Authority
- National socio-economic datasets (eg 2011 Census)
- A survey of community pharmacy patients
- Research interviews with pharmacists, pharmacy managers/owners and service commissioners.

B. Background

B1. The case for commissioning medicines optimisation services

- Community pharmacies dispensed 978.3 million NHS prescription items in 2014/15 [5]
- Twenty-five to 50 per cent of medicines are not taken as intended or directed **(non-adherence)** [6,7]
- Fifteen per cent of people receiving new medicines take few, if any, doses [8]
- Non-adherence may lead to further prescriptions, tests and investigations, poor clinical outcomes, increased admissions to hospital, and premature mortality.

Non-adherence to appropriately prescribed medicines is therefore a considerable issue for the NHS. It has been suggested that improving the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments [9].

- A systematic literature review of pharmacist-led, fee-for-service medication reviews [10] has suggested that such reviews are effective at improving adherence and clinical outcomes
- Proof of concept research [11] has shown that pharmacists can successfully intervene when a medicine is newly prescribed to increase effective medicine taking for the treatment of a long-term condition.

The term used for such services is **medicines optimisation**. The Royal Pharmaceutical Society (RPS) has defined four guiding principles of medicines optimisation:

- Understand the patient's experience
- Evidence-based choice of medicines
- Ensure medicines use is as safe as possible
- Make medicines optimisation part of routine practice.

These principles are consistent with existing national guidance and good practice guidance that supports medicines optimisation [1, 2, 12] and have been endorsed by NHS England, The Association of the British Pharmaceutical Industry, The Royal College of Nursing, The Royal College of General Practitioners, and The Academy of Medical Royal Colleges.

So medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time. By focusing on patients and their experiences, the goal is to help patients to:

- Take their medicines correctly
- Avoid taking unnecessary medicines
- Reduce wastage of medicines
- Improve their outcomes
- Improve medicines safety.

B2. Examples of medicines optimisation services

There are currently two medicines optimisation services which are commissioned nationally by NHS England from community pharmacies – **Medicines Use Reviews (MURs) and the New Medicines Service (NMS)**. Further details about these services may be found in Appendix 2.

There are also a **growing number of medicines optimisation services commissioned locally** from community pharmacies that complement and build on existing MUR and NMS provision but aim to meet local need in relation to particular long-term conditions or other patient groups.

The following resources are available which you may find useful when looking for examples of how other commissioners are tackling medicines optimisation:

- The Royal Pharmaceutical Society (RPS) has published a document [13] highlighting some examples of medicines optimisation services. It has also produced a searchable map of evidence [14]
- On its website, The Pharmaceutical Services Negotiating Committee (PSNC) maintains a searchable database of community pharmacy services including a number of examples of medicines optimisation services [15]
- NHS England has published the 'Quick Guide: Extending the role of community pharmacy in urgent care' [16]. While focusing on how community pharmacies can relieve pressure on urgent care, it includes examples of medicines optimisation services.

B3. Commissioners of services from community pharmacies

Since April 2013, the number of potential commissioners of services from community pharmacies has increased.

NHS England is responsible for commissioning **pharmaceutical services**. The term 'pharmaceutical services' is defined in legislation and includes **essential, advanced and enhanced services**, generally referred to as the **community pharmacy contractual framework (CPCF)**. Further information can be found on the PSNC website [17]. MURs and the NMS are examples of advanced services whereas dispensing (ie the supply of medicines, the traditional core function of community pharmacies) is an example of an essential service.

Commissioners other than NHS England, such as clinical commissioning groups (CCGs) and local authorities (LAs), can also commission services from community pharmacies. These are referred to as **locally commissioned services**.

There is a need for clear communication between commissioners to **avoid duplication** of services. CCGs and LAs should therefore familiarise themselves with the services that are commissioned by NHS England and seek to commission services that, while meeting their commissioning intentions, do not duplicate but instead build on nationally commissioned services.

For example, to address an identified need locally, a CCG or LA may wish to commission a service that is similar to either the MUR or NMS service but which, for example, focuses on a particular patient group, medicine or long term condition.

Supporting evidence 1

Since the 2013 NHS reorganisation, the commissioning structures and processes for pharmacy had become fragmented between NHS England, CCGs and local authorities. This has caused confusion for some community pharmacies, a perceived increase in commissioning-related bureaucracy and some decommissioning of services.

Many pharmacists view this **fragmentation** as a threat to both the quality and quantity of services they can provide. **Variation** in commissioning, both between geographical areas and within the same locality, is seen as a barrier to extending the range of services provided.

The **short commissioning cycle** operated by many CCGs is also seen by community pharmacies to hamper longer term planning and the investment required for pharmacies to be able to deliver new services.

C. The commissioning process

This section of the toolkit is organised around the **key stages in the commissioning process**, each encompassing a number of different steps:

1. **Strategic planning:** Assess needs, review existing service provision, gather supporting evidence, engage stakeholders
2. **Procurement:** understanding community pharmacies, design service, assess financial implications, contracting and procurement
3. **Monitoring and evaluation:** define patient outcomes, capture evidence, review service

C1. Strategic planning

Supporting evidence 2

Nationally, the volume of MURs and NMS interventions conducted by community pharmacies is **inversely related** to local area **deprivation** and prevalence of certain **long term conditions** (eg asthma).

Local area **deprivation can be viewed as either an opportunity or a barrier** to service provision. For example, in more affluent areas, customers or patients are sometimes perceived to be less receptive to pharmacy services or advice. More deprived areas, on the other hand, offer opportunities to deliver some services (eg needle exchange or minor ailments) and barrier to others (eg private services).

The **age profile** of the local population is also associated with dispensing volumes, with higher proportions of both older people (≥75 years) and young children (aged 0-4) in the local population associated with higher dispensing volumes. However, an older customer base may limit the number of MURs and other services offered as a result of them either being housebound or receiving services for long term conditions from their GP.

Pharmacies in **different locations** (eg city centre, suburban, GP surgery) are known to cater for different types of customer or patient. This influences the range of services they can provide, eg the volume of NMS provision is significantly lower in city centre pharmacies than in pharmacies in other locations.

Step 1 Assess needs

Depending on what you are seeking to achieve, there are a number of documents you may wish to refer to rather than undertake a fresh needs assessment of your population:

Joint strategic needs assessments (JSNAs)

- Assessments of current and future health and social care needs of the local community
- Assess needs that could be met by services commissioned by the LA, CCG, or NHS England
- Produced by health and wellbeing boards (HWB) and are unique to each HWB area

Joint health and wellbeing strategies (JHWSs)

- Strategies for meeting the needs identified in JSNAs
- Produced by the HWB and unique to each HWB area

Pharmaceutical needs assessments (PNAs)

- Assessments of how the provision of pharmaceutical services can contribute to meeting the identified current and future health needs
- Produced by HWBs
- Focus on NHS England-commissioned pharmaceutical services, but may also include community pharmacy services commissioned by CCGs and LAs.

It is likely that these documents will not specifically identify the need for a medicines optimisation service per se. However, you may wish to identify how such a service could address a health need identified in one or more of these documents. Alternatively you may wish to consider medicines optimisation when redesigning patient pathways and incorporating them from the start.

The medicines optimisation dashboard [18], developed in collaboration with CCGs, hospital trusts and the pharmaceutical industry, brings together a range of medicines-related quality indicators from across sectors, in one place, in a way never done before. CCGs will therefore wish to review their achievements against the indicators in order to identify areas that could be improved by a medicines optimisation service.

Step 2 Review existing service provision

While collating information on the health needs of the population, current service provision should be collected – remembering to **consider all NHS services provided by community pharmacies**, irrespective of the commissioner.

Contact your NHS England local office and request the relevant HWB pharmaceutical list(s) if you are unsure where the community pharmacies are in your area. NHS England is required to prepare, maintain and publish a list of contractors who provide pharmaceutical services in each HWB area, including the address of each set of premises and the opening hours.

As patients will access services at locations that are most convenient for them, you should also **look at services provided outside your area but which your population may access**, for example community pharmacies just over the boundary in another CCG or LA area. CCGs will wish to use ePACT.net to identify these out-of-area providers [19].

It is strongly recommended that you **liaise with the local pharmaceutical committee (LPC)** throughout the process of developing the service.

The NHS Business Services Authority (BSA) publishes monthly activity data for all community pharmacies in England [20]. This data includes the number of MURs and NMS completed by each pharmacy, which will be of use when identifying the level of activity currently taking place within your area. There are two particular issues to note:

1. The activity for the community pharmacies within your area may include patients who live outside it (for reasons mentioned above)
2. The data is identified to NHS England area team level. You will need the contractor codes (also known as the 'F codes') for your pharmacies. NHS England will be able to provide those.

Analysing the MUR data in particular will allow you to identify which of your community pharmacies provides the service, their level of activity and those who complete the maximum annual number (400). This will assist in identifying any particular localities within your area that might benefit from a medicines optimisation service that complements the national MUR service.

Supporting evidence 3

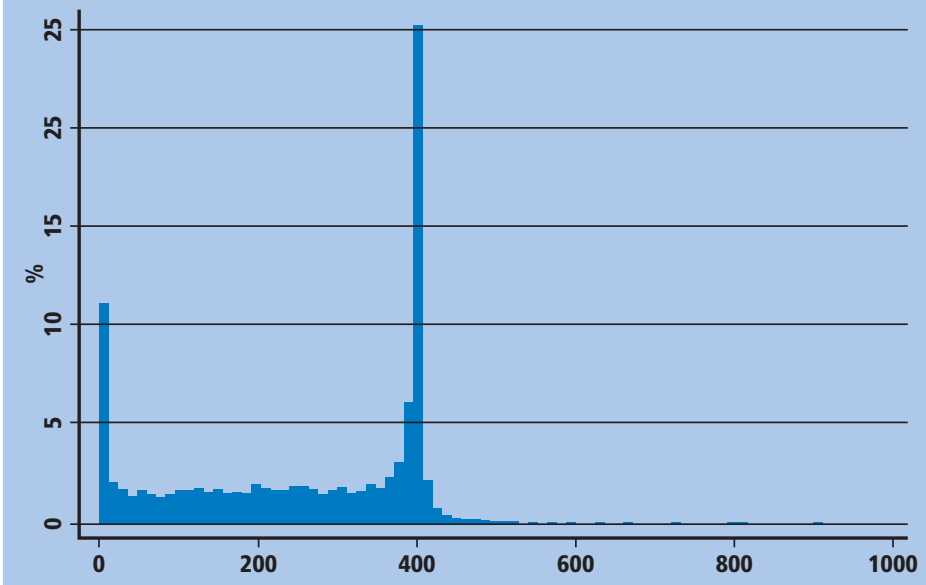

Figure 1 Distribution of annual volume of MURs conducted by community pharmacies in England (N=10,973)

Step 3 Gather supporting evidence

To support the medicines optimisation service, you will need to **obtain the relevant data and statistics** in order to identify pattern, correlation and forecast. The evidence to be explored will depend on the particular service that is to be commissioned, as well as patient need and desired outcomes to be achieved, but common data examples include: **GP data, A&E and mortality statistics**. You may find the **public health profiles** published by Public Health England [21] useful when gathering this information.

Step 4 Engage stakeholders

Follow your usual process when prioritising services to be commissioned but **ensure that the following parties are consulted:**

- Local Healthwatch and other local patient and public groups
- Local pharmaceutical committees (LPCs)
- Local medical committees (LMCs)
- CCG and neighbouring CCGs (dependent on commissioner)
- NHS England local offices and neighbouring local offices (dependent on commissioner)
- Persons on the relevant pharmaceutical lists
- NHS trusts or NHS foundation trusts
- HWBs.

The precise list of relevant stakeholders will depend upon the service being commissioned and who would have an interest in that service.

C2. Procurement

Step 1 Understanding community pharmacy – the nature of the market and community pharmacy organisations

Supporting evidence 4

There are more than 11,000 community pharmacies in England. They represent a **range of ownership types**, from large multiples (>100 branches) and supermarkets to small independents (<6 branches), with the 12 largest chains (eg Boots, Lloyds, Well) owning almost 50% of the market [22].

Pharmacy ownership type is strongly associated with the volume of services provided by pharmacies, particularly the volume of MURs and NMSs, with large multiples and supermarkets providing a significantly greater volume of these services than independent pharmacies (although dispensing volumes in supermarkets are significantly lower than in other types of pharmacy).

Pharmacies with higher dispensing volumes provide more MURs and NMS interventions; however, there is no association between dispensing volume and the quality of these services. Pharmacies conducting the fewest MURs each year (<12) have significantly lower patient satisfaction than those conducting close to the annual maximum of 400.

Organisational culture may be important to the levels of service quantity and quality reached, both in relation to the drive to reach business targets (and the degree to which that is prioritised above service quality) and the relative importance placed on investment in staffing and staff and team development.

Community pharmacies are unique as service providers in terms of the scale and range of business activities undertaken alongside healthcare provision. As well as NHS dispensing, medicines-related healthcare and public health services, they also provide private services and a wide range of consumer goods. They are private sector, for-profit organisations employing a mix of regulated pharmacy professionals (pharmacists and pharmacy technicians) and non-registered pharmacy support staff (eg dispensing assistants and medicines counter assistants). They are **subject to a number of legal, regulatory, contractual, professional and business constraints**, which you need to be aware of.

Community pharmacies tend to operate in a reactive way due to the nature of their work, balancing the need to dispense prescriptions within a reasonable timescale and the provision of other services. If the community pharmacy is to be a more integrated part of the primary care team, it is likely that they will need to move from an opportunistic service provision model, to one that is structured more around scheduled appointments, and/or the need for more than one pharmacist to be present.

Supporting evidence 5

There is a widely held belief that **current workloads and time constraints are a barrier to increasing levels of service provision** in community pharmacy.

Workload pressures are also sometimes thought to **adversely affect service quality**.

Because of its reactive nature, **dispensing is often prioritised over other services**.

A number of **strategies for workload management** are being adopted by community pharmacies to allow them to maximise both the quantity and quality of services they provide. These include:

- Offering appointments for MURs
- Use of off-site dispensing
- Prescription collection services to manage workflow
- Delegation of dispensing tasks
- Managing patient expectations around waiting times.

A pharmacist must be present at the community pharmacy throughout the NHS contracted opening hours to oversee the sale and supply of medicines. You will need to bear this in mind particularly if the medicines optimisation service is to be provided off-premises.

Manchester University study findings suggest that community pharmacies working with **more than one pharmacist or a pharmacy technician** can increase medicines optimisation as there is increased capacity for pharmacists to provide extended services. This is something to consider when commissioning a service focused on medicines optimisation.

However, there will be **important financial implications** to the community pharmacy if two pharmacists are to be employed at the same time, with one overseeing the sale and supply of medicines and the other providing other services, including medicines optimisation. You will therefore need to give consideration to sufficient payment to the pharmacy to support the provision of a reliable and safe service; in particular, if the service activity levels are likely to be low.

Within the service specification you will want to acknowledge that you have **confidence in the competency of the pharmacy staff** providing the service. When drafting the service specification you will need to consider whether:

- You wish to specify the competency requirements for staff providing the service,
- Staff will be required to self-declare, or
- The provider ensures those providing the service or elements of the service are competent to undertake the roles expected of them.

Appendix 3 looks at the advantages and disadvantages of each approach you will need to consider.

Guidance and resources for commissioners are available on the **Centre for Pharmacy Postgraduate Education (CPPE) website** if you choose the self-declaration option [23].

If the onus is to be placed on the provider, ensure that the contract includes details of what action will be taken where concerns are raised or identified regarding staff competence.

Supporting evidence 6

The average number of staff working in a community pharmacy is between five and six:

- **Four-fifths of pharmacies operate with only one pharmacist**
- Only two-fifths of pharmacies employ a pharmacy technician and only one-quarter employ an accuracy checker
- Most community pharmacies employ between one and two dispensing assistants and one to two medicines counter assistants
- Over a half of pharmacies regularly use locum pharmacists.

Overall **staffing levels and the skill-mix deployed are perceived as crucial to the quantity and quality of services provided**. Staffing levels have been squeezed, limiting both the quantity and the quality of services delivered. However, the availability of a trusted and competent team with appropriately trained pharmacy technicians, dispensers and medicines counter assistants is viewed as necessary to support the pharmacist to take on an effective clinical role.

Significant **associations exist between staffing, skill-mix and service quantity and quality:**

- Higher dispensing volume pharmacies are more likely to have longer pharmacist daily working hours or to employ more than one pharmacist, pharmacy technicians and accuracy checkers
- Pharmacies employing more than one pharmacist conduct a greater volume of NMS interventions
- The employment of a pharmacy technician is associated with higher levels of patient satisfaction
- Regular use of locums may be associated with poorer patient self-reported medicines adherence.

Step 2 Understanding community pharmacy – meeting patient needs and expectations

Traditionally, community pharmacies have not been seen by patients and the public as a source of healthcare advice and treatment. Progress has been made with the introduction of enhanced and locally commissioned services as well as campaigns such as 'Ask your pharmacist'. However, **many patients still see their community pharmacy as somewhere to go with a prescription to have it dispensed**, or to buy over-the-counter (OTC) medicines.

Public knowledge, perception and expectations of services in community pharmacy remain limited. Therefore, **integrating medicines optimisation services into the patient pathway** rather than having them as a separate, standalone services is advisable.

Supporting evidence 7

Public perceptions and expectations of the pharmacist's role and the services available from pharmacies influence the quality and quantity of services provided by pharmacies:

- A lack of understanding by patients of the complexity of the dispensing process and that the clinical input of the pharmacist contributes to pharmacists' prioritisation of dispensing over other services provided, and of speed over other aspects of quality
- A lack of awareness of the range of services available from the pharmacy limits public demand and receptiveness to being offered information or advice
- Where patients have more reasons for choosing to visit a particular pharmacy, or where they usually receive advice from the same member of staff, they are likely to experience greater satisfaction with the service provided.

Patients will often fit collecting their dispensed medicines around their daily schedule or may not actually attend a community pharmacy to receive a service. Therefore:

- Be mindful of your duties under the Equality Act 2010 and **consider the need for a domiciliary service** for those patients who are unable to access a community pharmacy whether due to age, disability or another protected characteristic
- **Give consideration to patients who access their medicines from their general practice** rather than a community pharmacy (dispensing practices) and how they will access the service
- **Consider the use of different media for service provision such as telephone, FaceTime and Skype** so that patients have the choice of engaging through these routes rather than with a medicines optimisation service when visiting the community pharmacy. Ensure patient confidentiality is maintained at all times during virtual appointments and build appropriate information governance requirements into the contract, for example by requiring that the pharmacist participating in a virtual appointment can talk at a normal speaking volume without being overheard by any other person including community pharmacy staff.

You will also need to consider whether you commission the service from all the community pharmacies in your area, that are able to meet the service requirements, or whether you wish to commission it from a specified number. Therefore, bear in mind that:

- Many patients who regularly take medication will have **developed a relationship** with one particular community pharmacy and may not wish to access a different one for a medicines optimisation service
- Patients may find it **difficult to access** a community pharmacy that is some distance away. Take into account the level of car ownership and public transport when deciding where the service is to be provided
- Some patients will use a community pharmacy that is **outside of your area**. If so, do you wish to commission the service from out-of-area community pharmacies?
- **Medicines-based delivery of care for people with long term conditions should be integrated**, and medicines should be managed together rather than in therapeutic silos [24]
- **Access to the summary care record (SCR)** may help address the issue of integration by ensuring that the pharmacist providing the service is able to access information on other prescribed medicines that the patient is taking, or should be taking.

Step 3 Designing the service

When commissioning a service it is important to establish the desired patient pathway first and identify patient need. The starting point for designing any service is to **involve users of the service to identify what good looks like for the patient** and based on that understanding then define the required patient outcomes.

Seek the views of patients and the public as to how the medicines optimisation service can be designed **so that it fits in with patients' use of medicines and community pharmacies**.

To maximise the benefits patients can receive from their medication, **identify where within the patient pathway a medicines optimisation service should sit** to help to ensure patient adherence with their medication.

An effective referral pathway allows pharmacists to focus on delivering the service rather than spending time recruiting or assessing whether the patient is eligible to receive the service. Integrating a medicines optimisation service into the patient pathway, so that the pharmacist becomes one of a range of healthcare professionals involved in a patient's care, ensures that both the pharmacist's time and the patient's benefit are maximised. **This avoids the need for the pharmacist, or another member of the community pharmacy team, having to identify appropriate patients and then 'sell' the service to them.**

Support good patient outcomes by **involving multiple specialities in the skill mix as relevant**, for example involving dieticians when looking at a medicines optimisation service for diabetics. A joined-up approach working with other professionals is required to highlight target areas for medicines optimisation.

If the service will involve a multi-speciality team then a**n appropriate shared patient record will need to be considered**. Legal advice will need to be sought where patient identifiable information needs to be shared between health and social care.

Step 4 Assess financial implications

Supporting evidence 8

The existing **community pharmacy contractual framework** and associated levels of **remuneration for services** are seen by many in community pharmacy to have a negative impact on the quality and quantity of services they can provide.

The perceived insufficiency of remuneration and the short-term nature of the commissioning cycle have had the effect of **minimising investment** in the number and skill-mix of staff employed by some pharmacies, limiting the range of services taken up by pharmacies, and/or reducing the volume of those services delivered.

In establishing a financial forecast for the service it will be necessary to explore:

- What is the funding allocation?
- Is the service sustainable within the funding available?
- Is the funding recurrent?
- Will the service result in cost savings or be value for money?
- Will the level of remuneration available be sufficient to cover any required investment from community pharmacy (for example staffing levels, staff training or premises improvements)
- Would a longer contractual period such as three years be more beneficial than annual?
- Will protected educational time for community pharmacy staff have a financial impact and how can this be addressed?

Step 5 Contracting and procurement

There are **various contractual vehicles to commission a service from community pharmacy** and which is used will depend on the type of commissioner:

- The NHS standard contract (for CCGs)
- The public health services non-mandatory contract (for LAs)
- Local authorities' own services contract (for LAs)
- CPCF enhanced services or local pharmaceutical services (LPS) contract (for NHS England).

A medicines optimisation service may also be subcontracted through other providers. For example, if a CCG is looking to tackle hospital admissions for asthma it would be appropriate to commission a medicines optimisation service via the NHS standard contract. If, however, the CCG was seeking to redesign the whole asthma pathway, with a medicines optimisation service forming just one part of it, then it may wish to consider the prime contractor model [25].

There are a number of **considerations** that you will wish to give thought to when drafting the service specification and contract:

- Should there be a requirement that the provider is satisfactorily compliant with the essential services and clinical governance system that form part of those services that NHS England commissions from them?
- Should there be a requirement that the provider is included in the relevant pharmaceutical list held by NHS England?
- Do you wish to include a provision within the contract which obliges the provider to tell you if they are investigated by NHS England, NHS Protect or another commissioner of services that are part of the NHS?
- Do you wish the service to be provided throughout the provider's NHS England contracted opening hours, or is it just at certain times or on certain days ?
- NHS England has commissioned NHS Digital (formerly known as the Health and Social Care Information Centre) to support all community pharmacies in England to implement access to the summary care record (SCR) . It is anticipated that national roll-out will take two years and it is expected to be complete by Autumn 2017 [26]. You may wish to consider making it a requirement that pharmacists providing the medicines optimisation service are able to access the SCR as soon as it is rolled out in your area
- Community pharmacies are able to apply to NHS England to relocate to new premises. Depending on the service that you are commissioning and the local situation you may not wish, or need, to commission the service at their new premises
- Pharmacy premises are required to be registered with the GPhC. You may wish to include a provision within the contract that the premises remain registered with the GPhC and that if they aren't that the contractor is required to advise of this
- Pharmacists and pharmacy technicians are required to be registered with the GPhC. You may wish to include a provision within the contract that requires the provider to tell you if any pharmacist or pharmacy technician who provides the service is subject to an investigation by the GPhC.

For each of the requirements above, you will also need to consider the **implications and actions to be taken should the provider become non-compliant** due to changes in circumstance.

The details can now be populated into your **business case template** for approval.

To secure providers to deliver the service, it is important that you offer the service out to providers in an open, transparent and equitable way. If a full **procurement** is not required, give consideration to how widely the opportunity should be promoted. You will need to adhere to current **procurement regulations**. It is strongly advised that you seek the most up-to-date guidance on procurement before proceeding [27].

[1]Community pharmacies have core opening hours which they may only change after a successful application to NHS England. Generally these are 40 hours a week but may be up to 100 hours per week. They may open for additional hours and these are known as supplementary opening hours.
[2] The SCR is an extract of key patient data (medications, allergies and adverse reactions) from the GP record. It is used by authorised healthcare professionals, with the patient's consent, to support their care and treatment.

C3. Monitoring and evaluation

Service evaluation and monitoring must be designed at the outset to ensure that decisions to modify the service, or whether to continue to commission it, are based on reliable and valid data. Only request information that is required, and be clear on what you will do with the information that is to be provided.

The **National Audit Office** has defined eight questions for **'intelligent monitoring'** [28] that you should use to test and validate your approach to monitoring. They should be asked at regular intervals to ensure that reporting remains proportionate.

1. Can the information be provided less frequently?
2. Can the information be provided in time with the community pharmacy's own reporting systems?
3. Can the information be reported only by exception?
4. Is there an alternative item of information, perhaps more cost-effective that could be used instead?
5. Can information that the community pharmacy already collects for another commissioner be used instead?
6. Can this information be collected on a sample basis?
7. Can this information be collected other than from the community pharmacy – such as a survey?
8. How can you assure the reliability of this information?

Step 1 Define patient outcomes

Develop indicators to ensure the service is delivering the expected outcomes. The outcomes-based approach demands that patients, clinicians and commissioners work together to agree what services are needed. However, whether or not you adopt an outcomes-based approach, developing indicators requires the same level of collaboration and consensus.

Ensure that a range of **both quantity and quality indicators** is adopted. These could include, for example, measures of service volume, patient satisfaction and/or changes in medication adherence.

The indicators provide the detail that enables the service specification to be expressed in the contract, **allowing community pharmacies to be held to account by the commissioner and for the commissioner to be clearly accountable to patients**.

Explore the possibilities of commissioning a service with a degree of flexibility, providing outcomes are met. An example of this would be implementing a service with an indicator that maintains targets of at least 80% face-to-face consultations and an option of 20% virtual consultations. Engagement with the target patient groups would allow you to test whether using such technology will be accepted and used, and what percentage of virtual consultations is realistic.

Ensure that the outcomes are measurable in order that the community pharmacy can demonstrate achievement so that:

- Payment can be made (including any quality payments that may have been achieved)
- Decisions can be made as to the whether the service should continue to be commissioned or whether changes need to be made
- Improvements in patient care can be demonstrated.

Supporting evidence 9

Arrangements for monitoring service provision which already exist in **community pharmacy organisations** focus primarily on the quantity of services but also look at quality in terms of obtaining informal customer feedback, patient survey returns, monitoring and analysing errors and near misses, and monitoring complaints.

Existing arrangements for monitoring service provision by **NHS commissioners** are almost exclusively focused on quantity. Where quality is monitored, it is usually through self-assessment by the pharmacy or following reported incidents or complaints from patients.

A number of **benefits** to monitoring community pharmacy services exist including the ability to benchmark activity, helping to improve quality and safety, and providing an indicator of underlying problems. However there are also **drawbacks**, not least the bureaucracy involved.

The barriers to monitoring community pharmacy services include the inherent difficulty in measuring quality, poor recording by pharmacies, findings not being monitored by pharmacies or commissioners, a lack of resources and manpower, the fragmentation of commissioning and responsibilities for monitoring.

Most stakeholders agree that there should be more **monitoring of clinical productivity in the future** but there is a need for more quality markers to be developed and the additional regulatory burden should be recognised.

Step 2 Capture the evidence

Consider how the data will be captured to evidence achievement and the frequency of that data. This will determine the date on which the service can be reviewed. **Review services at least annually** to ensure you are obtaining the best outcomes for patients.

IT systems used by pharmacies have generally developed from medicines labelling and stock-ordering systems and therefore may not easily lend themselves to the recording of data. **Consider how community pharmacies are to submit activity data**, and whether this is to be in a **paper-based** or **electronic** format. While most community pharmacies will have access to software packages such as Word and Excel, not all will, and not all will be able to access the internet. Consider whether the service specification and payments should reflect particular IT requirements and whether the payment needs to reflect those requirements.

Patients must give their written consent to receive the MUR service and NMS. This then allows NHS England as the commissioner of the service to review patient records for post payment verification and monitoring purposes. Put similar arrangements in place for any medicines optimisation services you commission **if there may be a need to see patient identifiable information**.

Incorporate patient evaluation into the service specification and contract to ensure the service is meeting patient needs. While the 'Friends and Family test' has not been rolled out to community pharmacies, you may wish to use the patient question . Other measures of patient satisfaction are available [29-32] or can be developed.

Step 3 Review the service

The final stage in the cycle is to **review the service to ensure that the anticipated aims and objectives have been met** and, if they have not, to identify why not. The success of this stage will largely depend on how clear the outcomes were and whether achievement of them could be measured.

This stage is crucial in helping you **to identify whether the service should continue to be commissioned as it is, whether it requires amending or modifying, or whether it should be decommissioned**.

If the contract is for more than one year, consider how it can be amended or terminated should the service need to be changed or decommissioned as a result of a service review.

Reviewing the service **should not be done in isolation from the community pharmacies providing it or those using it**; there may be valid reasons as to why the aims and objectives have not been met. For example, there may have been a change in user needs and the current service no longer adequately supports users. Involve the users of the service to allow you to identify if this is the case.

[3]*How likely are you to recommend this service to friends and family if they needed similar care or treatment?*

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Glossary

Accuracy checker – sometimes known as accuracy checking technician or ACT. A pharmacy technician or dispensing assistant trained to carry out a final accuracy check of listed dispensed items clinically approved by a registered pharmacist.

Advanced services – there are five national services (including MURs and the NMS) which community pharmacies may provide if they meet specified conditions. Advanced services are commissioned by NHS England.

Dispensing assistant – sometimes known as pharmacy assistant. A member of the pharmacy team involved in some elements of the dispensing process, including assembly of prescribed items and provision of information to customers.

Enhanced services – these are services which NHS England may commission from community pharmacies in order to meet identified health needs locally.

Essential services – those are services that all community pharmacies included in a pharmaceutical list must provide. There are six essential services, for example dispensing prescriptions and disposal of unwanted medicines.

Healthwatch – Healthwatch England is the national consumer champion in health and care. It has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services. There is a local Healthwatch for each local authority area and contact details can be found at **http://www.healthwatch.co.uk/find-local-healthwatch**

Local pharmaceutical committee – local pharmaceutical committees (LPCs) represent all NHS community pharmacy contractors in a defined locality. They are recognised by NHS England and are consulted on local matters affecting community pharmacy contractors. Contact details can be found at **http://lpc-online.org.uk/**

Local pharmaceutical services – local pharmaceutical services (LPS) contracts allow NHS England to commission pharmaceutical services tailored to specific local requirements. LPS complements the community pharmacy contractual framework for community pharmacy but is an important local commissioning tool in its own right. It provides flexibility to include within a single local contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under the community pharmacy contractual framework.

Locally commissioned services – these are services commissioned by CCGs and LAs from community pharmacies to meet identified health needs locally.

Medicines optimisation – the term used to look at how patients use and take their medicines in order to support patients to get the maximum benefit from them.

Medicines counter assistant – a member of the pharmacy team involved in selling over-the-counter medicines, receiving prescriptions from customers and issuing prescribed items.

Pharmaceutical list – to provide pharmaceutical services, a community pharmacy must be included in the pharmaceutical list for the area of the health and wellbeing board where their premises are located. Pharmaceutical lists are maintained and published by NHS England.

Pharmaceutical services – the term used to describe those services commissioned by NHS England from community pharmacies. It includes essential, advanced and enhanced services.

Pharmacy technician – a pharmacy professional registered with the GPhC. Technicians are able to supply medicines to patients, whether on prescription or over the counter, assemble medicines for prescriptions, and provide information to patients and other healthcare professionals, all under pharmacist supervision.

Polypharmacy – the concurrent use of multiple medications by one individual.

Abbreviations

ACT – accuracy checking technician
CCG – clinical commissioning group
CPCF – community pharmacy contractual framework
CPPE – Centre for Pharmacy Postgraduate Education
GPhC – General Pharmaceutical Council
HWB – health and wellbeing board
JSNA – joint strategic needs assessment
JHWS – joint health and wellbeing strategy
LA – local authority
LMC – local medical committee
LPC – local pharmaceutical committee
LPS – local pharmaceutical services
MUR – medicines use review
NHS BSA – National Health Services Business Services Authority
NICE – National Institute for Health and Care Excellence
NIHR – National Institute for Health Research
NMS – new medicine service
OTC – over the counter
PCC – Primary Care Commissioning
PNA – pharmaceutical needs assessment
PPI – patient and public involvement
PSNC – Pharmaceutical Services Negotiating Committee
RPS – Royal Pharmaceutical Society
SCR – summary care record
WHO – World Health Organization

Appendix 1 – acknowledgements

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Appendix 2 – National medicines optimisation services

There are currently two national medicines optimisation services which are commissioned by NHS England from community pharmacies – MURs and NMS. These may be provided by community pharmacies where they are fully compliant with the essential services requirements and the national clinical governance system as set out in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended. Ultimately it is for a pharmacy to decide whether it wishes to provide one service or both of them and where it does wish to do so then NHS England enters into arrangements for the provision of the service or services. This approach means that service provision may not always reflect patient need.

Details for both services can be found in Part VIC of the Drug Tariff (33).

1. Medicines use review (MUR) service

This service was introduced in April 2005 as part of the community pharmacy contractual framework as an advanced service. The aims of the service are to improve patient knowledge, concordance and use of their medicines by:

- Establishing the patient's actual use, understanding and experience of taking their medicines;
- Identifying, discussing and assisting in resolving poor or ineffective use of their medicines;
- Identifying side effects and drug interactions that may affect patient compliance;
- Improving the clinical and cost effectiveness of prescribed medicines and reducing medicine wastage.

Only pharmacists may provide the service and they must hold a 'MUR certificate' which is defined as a satisfactory performance certificate awarded or endorsed by a higher education institute being evidence that a person has satisfactorily completed an assessment relating to the competency framework for registered pharmacists providing MUR services as approved by NHS England (or, pending the first such approval, by the Secretary of State). In addition the service may only be provided at an 'acceptable location' as defined in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013, as amended, or over the phone.

Each pharmacy may generally complete up to 400 MURs each financial year (April to March), and must ensure that 70% of completed MURs are undertaken on patients who fall within one or more of the national target groups e.g. patients taking a specified 'high risk medicine'. Patients consent to receive the service and the pharmacist must record specified data which is then provided to NHS England on a quarterly basis.

In 2014/15, 93.5% of the community pharmacies in England provided this service and completed 3,183,094 MURs, an average of 292 per pharmacy (5). The number of community pharmacies providing the service and the number of MURs provided have increased year on year since 2006/7 (73% and 469% respectively).

2. New Medicines Service (NMS)

This service was introduced in 2011 and its underlying purpose is to promote the health and wellbeing of patients who are prescribed a new medicine or medicines for certain long-term conditions, in order—

(a) As regards the long-term condition—

(i) To help reduce symptoms and long-term complications, and
(ii) In particular by intervention post dispensing, to help identification of problems with management of the condition and the need for further information or support; and

(b) To help the patients—

(i) Make informed choices about their care,
(ii) Self-manage their long-term conditions,
(iii) Adhere to agreed treatment programmes, and
(iv) Make appropriate lifestyle changes.

As with the MUR service only pharmacists holding a MUR certificate may provide this service at an 'acceptable location', patients consent to receive the service and the pharmacist must record specified data which is then provided to NHS England on a quarterly basis. Only patients who have been prescribed a particular NMS medicine (as listed in the directions) may be offered the service.

In 2014/15 79.7% of community pharmacies in England offered the service, completing 755,998 interventions equating to an average of 83 per pharmacy [5].

Key points to note for both services

- Pharmacists are required to undertake nationally specified training and provide their certificate as evidence of accreditation.
- Patients must consent to receive the services. This allows NHS England to undertake post payment verification to ensure the service has been provided in accordance with the directions.
- There are nationally agreed standards for the location at which the service is provided.
- Specified data must be recorded and provided on a quarterly basis, in addition to submitting monthly details of the number of MURs and NMS interventions provided for payment purposes.
- Community pharmacies must be satisfactorily complying with the essential services and clinical governance requirements.
- The two services may only be provided to certain patient groups. These may not be the same as those patient groups that other commissioners wish to target.
- Community pharmacies may only provide up to 400 MURs each financial year. Some community pharmacies will have completed this level of activity some time before the end of the year.
- Not all community pharmacies provide these services and that may reflect the fact that not all them can meet the national standards for the consultation area within their premises.

Appendix 3 – approaches to staff competency

Approach	Advantage(s)	Disadvantage(s)
Commissioner specifies the required training to be undertaken, runs it locally and assesses competence.	Commissioner can be assured that each person providing the service meets their specified requirements.	Many pharmacists will work in more than one community pharmacy. They will need to hold a number of certificates in order to meet the accreditation requirements of different commissioners. This may delay a community pharmacy being able to provide the service, or may reduce the ability to provide the service throughout their opening hours. The commissioner will need to regularly run the required training course, sometimes for very few staff, and accredit new staff on a potentially regular basis, with the associated costs of doing soa
Staff providing the service self-accredit their competence.	The Centre for Postgraduate Pharmacy Education is developing a 'declaration of competency' system for pharmacists and is increasing the number of services it covers (23). Pharmacists will be able to provide a service across a number of areas and will be 'service ready' more quickly. Community pharmacies will be able to start to provide the service sooner as staff may already be accredited and the community pharmacy will be more likely to be able to provide the service throughout their opening hours when they have to rely on locums. Pharmacists, especially locums, will be able to complete the required training and be confident that they will be able to provide the service in more than one commissioner's area. Reduced time spent by the commissioner in accrediting staff. Reduces the cost of having to arrange and run training courses. The NMS evaluation showed that stakeholders are supportive of this approach.	A declaration of competence may not exist for the specific service that the commissioner wishes to commission, or may not cover a particular nuance of a service. Commissioners may feel uncomfortable in releasing control of the competence and accreditation requirements.
Providers ensure their pharmacists and staff are competent to undertake their required roles.	Places the onus on the provider to ensure their pharmacists and staff are competent, as happens with many other commissioned services. Commissioner time is freed up.	Commissioners may feel uncomfortable in releasing control of the competence and accreditation requirements. However the contract can include the action that will be taken where concerns are raised regarding staff competence. Providers may not robustly ensure that staff are competent. Relevant training may not exist locally or nationally.