Guidance to support independent prescribing (IP) pathfinders

NHS England (NHSE) have asked each ICS to submit Expressions of Interest for IP services, called ‘IP Pathfinders’. Each ICS will decide how this will be designed, and LPCs may be able to offer practical support. The process closes at the end of February (28th). A second Expression of Interest will be launched shortly for pharmacies.

The IP pathfinder programme presents a unique opportunity for community pharmacy to redesign current pathways and play an increasing role in delivering clinical services in primary care. Pharmacist independent prescribers will be supporting patients from diagnosis to prescribing, providing advice, and delivering clinical services closer to people’s homes. The success of the programme is critical in tackling health inequalities, reducing pressure on other parts of the NHS and ensuring viability of the community pharmacy network.

Providing care to patients through independent prescribing is a hugely positive step for community pharmacy. All CCA members are keen to see this programme succeed, and we hope the information below can support local thinking and decision making.

As part of the process, there are several questions each ICS will need to answer relating to service design, contracting and clinical governance. IP does require a significant cultural and operational shift in how pharmacies provide care. LPCs will play a key role in offering practical support to both design and delivery of pathfinder sites.

Please share this information with LPC chief officers or local NHS colleagues, to support local conversations.

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There are many different considerations to implementing IP services. This contents page will guide you to the most relevant area.

If you have any specific questions or want further information on any of the topics listed, please email office@thecca.org.uk
Identifying costs

1. IP services are new to pharmacies and there are many costs associated with this. They need to be acknowledged in the reimbursement structure. These costs include (but are not limited to):
   a. Physical changes to premises, i.e., consultation room upgrade and changing pharmacy layouts.
   b. Equipment to support clinical diagnosis (and ongoing maintenance and calibration).
   c. Clinical governance and oversight (including production of SOPs).
   d. Central costs to manage the service, meet reporting requirements and monitor training activity.
   e. Design and implementation of new supervision pathways.
   f. Indemnity.
   g. IT software and support. This may include upgrades to hardware, and internet depending on the exact needs.

Contractual model

2. The pilots will initially be commissioned as local enhanced services (LES) contracts. The commissioner will be either the NHS locally or the ICS.

3. In future, it is likely that IP will be rolled out nationally. It is unclear how this will be contracted but there is significant value in a ‘core offer’ to patients. Focussing on urgent care will allow promotion nationally to patients. PSNC will lead these discussions, but the success of IP pathfinders will be important to this.

Service design

4. There are many different models of payment for providing IP care including clinics, activity, and block payments. It is important that commissioners understand the varied costs incurred by contractors when implementing IP services.

5. Learnings from the provision of similar services in Scotland and Wales show that several elements need to be built into the service design including activity payments, a banded availability payment, a ‘golden prescription’ payment, and funds to prepare for the service.
   a. Community pharmacy works well when paid directly for activity. This accounts for immediate costs, the ongoing costs of providing the service, and a reasonable return.
   b. Different volumes of activity have different costs. It is in the interests of the NHS to encourage, support, and incentivise high volumes of care. A banding system can recognise the costs of ensuring IPs are available for longer proportions of the working week.
   c. “The first consultation is the most expensive”. Regardless of whether a pharmacy provides a single consultation or hundreds, the costs to prepare for this remains the same. As IP services are very new to the sector, there is a need to recognise set up costs, beyond pharmacist training. There should be a large payment for the first prescription – the ‘golden prescription’.
   d. Preparing to provide IP care will be different for every pharmacy. Some may need physical work on the premises, specific equipment, or practical support to meet local
needs. The COVID vaccination programme recently saw great success by setting aside a fund to support increasing access to underserved communities. We would recommend a similar approach is taken, allowing contractors to request ‘one-off’ grants to support preparation for IP.

Implementation

6. There is a need for commissioners to assure themselves of key requirements before a service begins. The COVID vaccination programme demonstrated how contractors deliver things differently. Commissioners should be encouraged to adopt a ‘principles approach’ similar to that of the GPhC standards. It is up to contractors to demonstrate how they are meeting key principles, rather than commissioners dictate how these are met.

7. A key objective of the pathfinders is to test new models of care. LPCs and commissioners are encouraged to be ambitious in their plans, commissioning as many sites as possible and allowing for new sites to join. Ideally, every pharmacy with an IP should be invited to join the service.

8. Many pharmacists are currently undergoing training and the number of IPs is growing. To avoid delays in implementation or a much smaller programme, a ‘wave’ approach would be useful. As with COVID, early innovators should be able to start immediately, but later waves should allow pharmacies who need a little more time to prepare to join the programme at a later date. This could, for example, align with IP training schedules.

9. Contractors employ pharmacists directly and have a responsibility to train, supervise, and support their work. Whilst it is expected (and welcomed) that NHS partners will want to support pharmacists, the contractual obligation sits with the pharmacy contractor. This means that contractors will need to assure pharmacists have the necessary skills and competencies to meet the service requirements. The NHS should not be attempting to take an employer role for community pharmacists, nor contacting them directly to gain information.

10. As a rule, commissioners should direct all contractual or operational queries to CCA head offices. Patient specific queries should be directed to individual clinicians via NHSmail, unless it is an incident, which should be escalated following each company’s processes.

11. Implementation will vary depending on local experience and the therapeutic area. It may be appropriate to start the service with a relatively small scope of practice, which develops over time.

12. It is imperative that there is sufficient volume to support competency as using skills regularly is core to maintaining and developing those skills. The NHS should support this by promoting services and helping to update patient pathways. LPCs should play a role in support relationship building between primary and secondary health care providers.

13. The rollout of CPCS resulted in many learnings that can be used here. Similarly, this offers an opportunity to maximise patient access by linking services (e.g., CPCS referrals leading to IP consultations).

Digital

14. The IP pathfinders require the ability to access appropriate records, generate electronic prescriptions, and update GP records. This is not possible within existing PMRs. There are several solutions being proposed, whilst ideally one method would be used across the country.
this is unlikely. ICSs are encouraged to consider pharmacies working at the boundaries of their geography and attempt to align with their neighbours. It is impractical to require pharmacies to use different systems for patients living in different places.

15. The requirement to access records is dependent on the specific therapeutic area being treated. Many elements of urgent care do not need access to full GP records and Summary Care Records may prove sufficient. Local Health and Shared Care Records (LHCRs) are often challenging for CCA companies, due to the variation and data protection requirements and are not currently supported by CCA members. Out of hours settings use stand-alone clinical software (e.g., Adastra) to access GP records through ‘GP Connect’ which offers a pragmatic solution.

16. Communication between clinicians is essential to multi-disciplinary care (MDT) and an important part of IP services. It is important that data protection and confidentiality are carefully considered when sharing information or sending messages. Systems such as WhatsApp are not appropriate for clinical information. NHSmail or built-in messaging function in clinical systems should be used. However, the urgency of the message is also important when considering how to share information.

Practical considerations

17. Many therapeutic interventions need additional tests. Phlebotomy is the most common. It is important that access to these services is carefully considered. IP services in community pharmacy should not place administrative burden on GP practices, nor suffer delays from this admin. Similarly, prescribers will need access to the results available from these tests. There will be costs associated with these tests and ensuring these are appropriately allocated to a budget line is important to avoid future difficulties.

18. There is a need to consider onward referral. Prescribers will need the ability to refer within their competence and this will not always be to the GP. Ideally these referrals should be electronic, with NHSmail as a backup solution. Designing these pathways must be part of the planning and implementation phase.

19. The proposed therapeutic area and model will greatly influence how contractors are able to provide IP services. Urgent care services can be added to CPCS referrals and provided on demand – meeting minimum service expectations. Other areas may require planned clinics. Regardless, the number of qualified IPs is low (about 5% of community pharmacists), therefore, it is essential that there are allowances in the service for holidays and other breaks in service as finding IPs to cover cannot be guaranteed.

Training

20. In addition to developing the initial skills and competencies of an IP, there is a need for pharmacists to maintain (and expand) their competence. The required continued professional development should be built into the service design. NHS partners could support this through facilitating access to local training programmes or observation of other prescribers.

21. Training must not be restricted to the pharmacist. Protected and funded learning time for the whole team is necessary to meet patient demand as public awareness about the services grows. Pathfinders offer an opportunity to support the necessary cultural change in pharmacy by incorporating planned pharmacy closures to enable pharmacy teams to engage in training.
22. Independent prescribers should continuously review, reflect to identify gaps in their knowledge or skills. They should plan, apply and evidence any relevant learning. The portfolio of learning should be available for review by either the Superintendent, NHS England or the ICS should they consider it necessary.

23. Prescribers should log their professional development reflecting on services they have delivered and maintain this portfolio according to the Royal Pharmaceutical Society’s competency framework for prescribers. Under competency 8 of the framework, IPs should:
   a. Improve by reflecting on their own prescribing practice, including by acting on feedback and discussion.
   b. Take responsibility for their own learning and CPD relevant to their prescribing role
   c. Make use of networks for support and learning

24. To support meeting this competency, pharmacists may use tools such as supervision, observation of practice and clinical assessment skills, workplace competency-based assessments, questionnaires, prescribing data analysis, audits, case-based discussions with peers, personal formularies and regularly seeking patient and peer feedback.

Clinical scope of practice

25. Whilst each ICS will consider local needs, implementation will be simplified by reducing variation. Urgent care prescribing provides immediate benefits to local health systems whilst supplementing CPCS.

26. CCA member companies, and many pharmacists have significant experience in minor ailment services (or Pharmacy First/Common Ailments in Scotland and Wales). Our experience shows that new prescribers in community pharmacy are more comfortable providing urgent care services as the types of patients and their needs are very similar to what pharmacists are used to.

27. Independent prescribers should define a scope of practice before prescribing commences and should be reviewed by an appropriate peer/clinician. The prescriber should make a declaration of the scope of practice and a commitment to continual learning to both their employer and the relevant commissioner. Time to carry out CPD should be included as part of the service design and within the funding envelope.

28. The commissioner should prepare an appropriate formulary, including any restrictions on prescribing. This should be reflected in the scope of practice, held and maintained by the IP as assurance of quality.

29. A prescribing practice audit plan should be agreed by the IP and the commissioner. This should be available for review by the commissioner and the superintendent.

Governance

30. NHSE has shared key criteria for a clinical governance framework required for each pathfinder site. Contractors have significant experience in providing safe care and are able to draw from private prescribing services and practice in Wales and Scotland. All contractors work differently and, as with COVID, contractors should be free to meet the requirements in their own way. To avoid barriers, the onus should be upon contractors to demonstrate how they meet governance requirements upon request – rather than as a pre-requisite to commissioning.
Risk management

31. As part of contractors’ submissions to the EOI process, they should agree a service proposition with the prescriber and the relevant commissioner.

32. Service propositions include commitments for the prescriber to carry out the relevant risk assessments and risk management for service design and delivery. This will include risk assessments for:

a. The premises in which the prescriber will be based, to include consultation rooms and space required for consultations and additional equipment, and;

b. The capabilities of the prescriber, and;

c. The support the prescriber will receive from the wider pharmacy team (including technicians and dispensing assistants)

33. Pathfinders should describe how they will minimise risk during service delivery, including through having necessary systems, SOPs, and appropriate skilled staff in place. There should also be mechanisms in place to learn from situations where something has gone wrong (further detail is available at Appendix I).

34. The risk assessment should consider the factors affecting the risk in the pharmacy, including:

a. The services the pharmacy provides.
b. The knowledge and experience of staff.
c. The scale and nature of the activity.
d. The number of people potentially affected by any incident.
e. The likelihood of something going wrong.
f. The likely impact on the patient or service user if something does go wrong, considering their health and vulnerability.

35. The risk assessments should be linked to the General Pharmaceutical Council’s (GPhC) standards for professionals (standard 9.2) and premises (standard 1.1).

36. Risk assessments should be carried out before service provision commences, reviewed at regular intervals (i.e., quarterly), and made available to commissioner upon request. However, we do not expect them to be a pre-requisite of commissioning.

Conflict of interest

37. We recognise that the introduction of IP services alters the traditional split between prescribers and dispensers. There are several checks and balances in place, through clinical governance, SOPs, and professional standards which reduce the risk of influence on clinical decision making.

38. GPhC standards state pharmacy professionals should “consider and manage appropriately any personal or organisational goals, incentives or targets and make sure the care they provide reflects the needs of the person”. A lapse in professional judgement impacting prescribing and/or dispensing decisions, would be referred to the Superintendent Pharmacist or GPhC for action (as appropriate).

39. The GPhC guidance “In practice: guidance for pharmacist prescribers” sets out common examples of conflicting interests. These standards already apply in pharmacy and ensure that
prescribing decisions are based on the needs of the person and not because of commercial interests or pressure from colleagues or employers.

40. Individual pathfinder sites should be able to demonstrate that all prescribing arrangements reflects the needs of the patients. Patients should be made aware, both through printed materials and during consultations, that they may choose the pharmacy they receive their prescription from. This may or may not be the pharmacy in which they have their consultation.

41. Available data will enable commissioners to identify outliers. For example, reviewing changes in nominated pharmacies to ensure prescription direction is not taking place.

42. Pathfinder sites should have SOPs (written by each contractor) detailing how patient safety is maintained through an internal separation of prescribing and dispensing services, which should be made available to NHSE or ICSs on request.

43. Audit is an essential part of clinical practice and will develop in line with IP services. A prescribing practice audit plan should be agreed by the IP and the commissioner. This should be available for review by the commissioner and the superintendent.

44. In addition, automated reports and real-time data flow will allow for commissioners to actively investigate concerns, without waiting for formal reporting.

Incident reporting

45. Incidents which occur during independent prescribing services should be reported and investigated in the same way as other pharmacy incidents (see appendix I).

46. When incidents occur, the pharmacy team will report the incident to their Superintendent’s Office and carry out an on-site internal incident review. The Superintendent’s teams will review, and if necessary, investigate further and carry out a risk & harm assessment. They will provide advice to pharmacy teams, and escalate incidents where appropriate, including to Controlled Drugs Accountable Officers, the Yellow Card Scheme and the LFPSE service. Investigations and learnings are documented and, where necessary, changes to professional practice are made to improve the safety of services.

47. It is important that there isn’t a situation whereby each incident must be reported to differently depending on the ICS. Superintendents should be able to decide how and when they report incidents (for example, some members report incidents in real-time, whilst others may batch-report fortnightly or monthly) in line with current practice.

LPC Governance

48. LPCs were heavily involved in supporting the COVID vaccination programme. It is important that LPCs carefully consider requests from NHSE to ensure they are representing all contractors equally. LPCs should not be asked to select pathfinder sites. There is an important role for LPCs in co-ordinating information, representing all pharmacies, and ensuring contractors are able to equally engage with local processes.

49. Please ensure local NHS teams have up to date contact information for CCA member head offices, who will manage any pathfinder opportunities. If these details are needed, contact your LPC lead.
Appendix I

Community pharmacy patient safety incident reporting
An Overview

Safety incident brought to attention of pharmacy
patient, carer, hospital, police, area team

Pharmacist and team in pharmacy handle incident

Incident reported directly to LFPSE or Yellow Card Scheme

Pharmacy reports incident to local reporting system / MSO
  e.g. company Head Office, NPA online tool, regional managers or team

Incident review / risk & harm assessment
  including contributory factors / root cause analysis;

Internal incident review
  Harm assessment, contributory factors / root cause analysis;

Reassurance of patient / carer and family using incident management SOP

Contact patient’s GP (if applicable)

Discuss with pharmacy team e.g. in safety huddle

Resolution of error e.g. through changes to practice; dispensary re-organisation; contacting manufacturer

Share learning and changes to practice locally e.g. with LPC

Review learning and changes to practice

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Incident details shared with relevant or required bodies to act upon and investigate further
  (including police, coroner etc.)

Collation and analysis of incidents
  Trends and learning opportunities identified;
  changes to standard Operating Procedures

Shared learning resources created
  Reports, newsletters, Superintendent emails, best practice, Top Tips

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Incident details and learning shared with NHS Improvement / MIRA national medication safety network
  e.g. on global MSO webinar

Incident details and learning shared with other community pharmacy Medication Safety Officers at Patient Safety Group meeting

Learning and changes to practice disseminated across wider healthcare

Learning and changes to practice disseminated across pharmacy network

Review learning and changes to practice

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Report to primary care organisation
  (e.g. Controlled Drugs, significant events)

Report to insurance provider (if applicable)

Report to company Board (if applicable)

Corporate review of incidents