



The Pharmacists' Defence Association's Response to the NHS England Consultation on the Primary Care Networks Service Specifications

January 2020

About the Pharmacists' Defence Association

The Pharmacists' Defence Association (PDA) is a not-for-profit organisation which aims to act upon and support the needs of individual pharmacists and, when necessary, defend their reputation. It currently has more than 30,000 members. The PDA Union was inaugurated in May 2008 and achieved independent certification in 2011.

The PDA is the largest pharmacist membership organisation and the PDA Union is the only independent Trade Union exclusively for Pharmacists, in the UK.

The primary aims of the PDA are to:

- Support pharmacists in their legal, practice and employment needs
- Represent the individual or collective concerns of pharmacists in the most appropriate manner
- Proactively seek to influence the professional, practice and employment agenda to support members
- Lead and support initiatives designed to improve the knowledge and skills of pharmacists in managing risk and safe practices, so improving patient care
- Work with like-minded organisations to further improve the membership benefits to individual pharmacists
- Arrange insurance cover for individual pharmacists to safeguard and defend their reputation.

Reason for the Pharmacists' Defence Association responding to this consultation

We are responding to this consultation because part of the new Network Contract Direct Enhanced Service (DES) involves the recruitment, training and embedding into General Practice of 7,500 Clinical Pharmacists by 2023-2024 and assumes that an average PCN will have recruited 3 clinical pharmacists (in total around 3,500) for 2020-2021.

We have a significant number of members who may have their workload, training requirements and practice risk profile affected by the proposals contained within this consultation. Our response to the consultation is informed by the emerging evidence from clinical pharmacists already working within GP practices and focuses on key areas of concern.

We focus the body of our reply on the proposal to implement the requirements for two of the five specifications of the DES (Structured Medication Reviews and Optimisation, Enhanced Health in Care Homes) in full from 2020/2021.

Introduction

Phasing-in and full implementation:

The consultation document seems to inhabit a dual reality that is encapsulated within the following

1.4. We recognise that PCNs are at the early stages of development and capacity-building, and that there are concerns about limiting their chances of success by overburdening them at an early stage with **unrealistic expectations for new service delivery.**

*We therefore propose to **phase-in service requirements in a way that is commensurate with the capacity available** to PCNs through the contract and the support available through wider system.*

Though a combination of the additional workforce capacity within primary care, and the redesign of community services provision to link with and support PCNs, we expect the Network Contract DES both to reduce workload pressures on GPs and support improved primary care services to patients

1.17 *NHSE/I is proposing to phase in the requirements over time in order to ensure that they are deliverable as PCN workforce capacity grows, and as the wider system infrastructure develops to support them. This means:*

- ***implementing the requirements of two of the five specifications*** (*Structured Medication Reviews and Optimisation, Enhanced Health in Care Homes*) ***in full from 2020/21***, as agreed in the GP contract framework; and

We specifically expect **1.4** in the consultation document to be given due weight and the dual reality demonstrated by **1.4** and **1.17** to be resolved so that patient care is not compromised.

Is it credible that NHS England genuinely believes that true phasing-in is deliverable within the short time frame described? We have feedback from colleagues that implementing SMR and review for the patient cohorts listed is likely to take more than 5 years, yet the DES requires 100% implementation between July 2019 and March 2020.

We hope the ameliorating words “phasing-in” are not merely there to placate the serious concerns of clinicians who will have to implement the specifications.

PCNs are newly created NHS structures and as such they need time to establish themselves and the priorities that will deliver locally relevant healthcare.

It is not realistic to expect a full delivery of 2 major services within such a short time frame nor to describe such a full delivery by 2020-2021 as “phasing-in”.

Funding, Capacity Building and Additional roles:

There seems to be an assumption throughout the consultation that providing additional funding in 2020/2021 will deliver suitably qualified staff that can meet the full requirements of the proposed DES.

It is not credible that NHS England was unaware that merely providing money will not deliver the roles that are anticipated by the DES.

There are repeated references in the consultation to capacity increase as in item **1.11** “This represents a major uplift in the workforce capacity within primary care.” Or as in item **1.12** “... there will be significant additional capacity within primary care in 2020/21 to deliver the specifications.”

This is clearly not correct. Capacity increase has to be taken in the round. The extra staff may well be recruited from other areas of primary and secondary care. This redistribution does not mean extra capacity as the reduction in staffing elsewhere will have its own consequences with a possible net result of extra demand on the NHS.

2.10 is particularly concerning: “PCNs must ensure that only appropriately trained clinicians working within their sphere of competence should undertake SMRs. These professionals will need to have a prescribing qualification and advanced assessment and history taking skills – **or be enrolled in a current training pathway to develop these skills ...**”

There seems to be an understanding that additional staff may still be undergoing training or require supervision. However, the consultation then fails to acknowledge or recognise that newly recruited clinical staff still require an intense period of structured support, development and monitoring. Capacity building takes time and effort and new staff members cannot be expected to provide SMR including prescribing to complex patients for at least two years from the point they enter the General Prescribing Pharmacist Pathway.

The Primary Care Pharmacists Association (PCPA) booklet created with the Royal College of General Practitioners (RCGP) clearly describes the limited services that Entry Level qualified clinical pharmacists should undertake. The independent

working of newly recruited clinical pharmacists assumed throughout the DES is neither feasible nor appropriate.

This extract from the booklet clearly demonstrates the junior level of initial work that could be carried out by a newly recruited clinical pharmacist

Initial training Those who have not worked in general practice would, as part of an induction programme, require training in:

- Use of surgery computer systems
- Quality and Outcomes Framework and the QIPP agenda
- Clinical coding
- Clinical and information governance
- Safeguarding adults and children
- Management of the practice's repeat prescribing system

The guide also clarifies the qualifications and the overarching competencies for both the Junior and Senior level roles. GPs or senior pharmacists within each PCN will need to allocate time to supervise and train the entry level junior level pharmacists to transition to senior level pharmacists to ensure the safe delivery of the DES.

JOB PURPOSE:

The job description should be amended depending on whether this is an "entry level" or "advanced level" practice pharmacist post.

The employer must decide which of the following job roles are applicable to the post.

Qualifications and experience for junior level practice pharmacist

- Minimum of 2 years post qualification experience in pharmacy (hospital, primary care or community).
- Having the relevant skills, knowledge and experience for the role
- Working towards being an independent prescriber (if required).

Qualifications and experience for a senior level practice pharmacist

- Extensive post qualification experience working with patients and the multidisciplinary healthcare team in general practice.
- In-depth knowledge of medicines and applied therapeutics
- Having the relevant skills, knowledge and experience for the role
- Independent prescribing qualification.

NHS England originally committed to 2000 clinical pharmacists in GP surgeries by 2020/2021 and then relaxed their criteria for pharmacists in GP surgeries to build up numbers. This was based on the evidence that the initial results showed that clinical pharmacists had reduced workload for GPs.

However, in the dual reality the DES for 2020-2021 assumes that 3,600 clinical pharmacists (3 per PCN) who would need to be working at a senior level and capable of working independently to provide the Structured Medication Reviews (SMRs) service or support as part of the Enhanced Health in Care Homes service will all be recruited and in place.

Most of these newly recruited clinical pharmacy staff could only be described as junior level, since many pharmacists with higher level skills are already in the general practice system. There is a real risk to patients were junior staff to be pressurised to deliver services that they are not yet ready to deliver.

A recent article in the Pharmaceutical Journal highlighted the positive impact that clinical pharmacists have on reducing pressures on GP time and the very real positive impact on patient wellbeing and thus outcomes.

However, the research identified a disparity in expectations in some cases with some GPs expecting pharmacists to carry out administrative, medicines management duties and other prescribing tasks and that band 7 pharmacists would be ready to go straight into patient-facing consultations.

“Unrealistic expectations on behalf of the practices had been demotivating for some of the pharmacists,” said the report.

The experts said that clear guidelines should be drawn up to reduce misunderstandings.

Recommendation

- NHS E should halt the current consultation and perform a full impact assessment on the workload and staffing associated with the DES requirements before proceeding any further.

Consultation Questions

We focus the body of our reply on the proposal to implement the requirements in full from 2020/2021 for two of the five specifications of the DES (**Structured Medication Reviews and Optimisation, Enhanced Health in Care Homes**).

1. Is there anything else that we should consider for inclusion as a requirement in this service? For example, are there approaches that have delivered benefits in your area that you think we should consider for inclusion?

N/A

2. Are there any aspects of the service requirements that are confusing or could be better clarified?

Yes see below

Evidence base and best practice

We welcome the acknowledgement in the consultation of evidence that the use of SMRs in targeted cohorts helps to deliver better outcomes. We welcome the consultation focus on pharmacists delivering SMRs and other services.

The evidence base in healthcare is continually evolving. As part of this submission we can share that the early and inappropriate (against best practice) introduction of clinics led by newly qualified independent prescribing pharmacists with inadequate supervision has led to patient harm. Whilst this is not evidence in the classically understood sense it is emerging evidence of a sort and evidence that could have significant impact on public health.

The PDA has felt it necessary to issue a number of recent statements for our members reminding those moving to new roles with increased clinical content that competency and working within safe boundaries is essential. We have reminded

them that using documentation such as our “Boundaries of my Clinical Practice Statement (BCPS) and competency development plan” to reflect on their practice and plan for development is important to ensure that patients receive a safe service.

The PDA questions how wide-ranging and appropriate the engagement undertaken for this specification was, since the suggested metrics and expectations are so far in excess of what would seem reasonable for organisations which in some cases are not yet fully formed. We would be interested to see the evidence upon which the decision that all of the cohorts listed can be offered both initial and subsequent follow-up SMRs between July 2020 and the end of March 2021 was made. It is important that all evidence that is used to inform these DES specifications is subject to open and frank discussion. NHS England is relying on the assertion that it has used wide ranging evidence - it would have been helpful to provide a list of references to that evidence to enable those responding to the consultation to understand the thinking within it.

1.6 NHS England and NHS Improvement (NHSE/I) has undertaken a wide-ranging process of evidence-gathering and engagement in order to inform these outline service specifications.

Recommendations

- NHS E should share the references for the evidence upon which the outline service specifications for **Structured Medication Reviews and Optimisation, Enhanced Health in Care Homes** was based.
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- NHS E should consider best practice for the introduction of new clinical staff into PCNs and should consider producing metrics for that process e.g. All new clinical pharmacists to have regular appraisals with a GP mentor.

3. What other practical implementation support could CCGs and Integrated Care Systems provide to help support delivery of the service requirements?

We do not believe that the help which might be available from CCGs or Integrated Care Systems is sufficient to make full service delivery a viable option at this stage.

4. To what extent do you think that the proposed approach to phasing the service requirements is manageable in your area?

We do not believe the suggested phasing of the service requirements is manageable. Please see introduction and below.

Workload and Capacity

We agree with the emphasis on SMRs being used as a clinical intervention to improve patient outcomes. We agree with this service being primarily delivered by suitably qualified pharmacists whether it is in the GP surgery or the care home.

The DES proposes:

2.7 We propose that PCNs identify people who would benefit most from receiving an SMR. The following groups have been identified as being most likely to benefit from an SMR:

- all patients in care homes as per the Enhanced Health in Care Home specification;
- patients with complex and problematic polypharmacy, specifically those on 10 or more medications;
- patients who are being prescribed medicines that are commonly and consistently associated with medication errors;
- patients with multiple long-term conditions and/or multiple comorbidities – in particular respiratory disease and cardiovascular disease;
- housebound, isolated patients and those with frailty – particularly patients who have had recent admissions to hospital and/or falls;
- patients who have received a comprehensive geriatric assessment as per the anticipatory care requirements;
- patients with severe frailty; and
- patients prescribed high numbers of addictive pain management medication.

These are cohorts that will be most likely to benefit from this service but some are also the cohorts that are the most complex patients and who therefore pose the biggest risk in terms of patient management.

Thus, for this service to be safe and effective for the more complex patients it will need to be delivered by senior suitably qualified clinical pharmacists who are fully trained and fully experienced. Clinics for the complex patients that form part of the proposed service model can only be safely operated by these senior clinical pharmacists. The potential impact this may have on capacity and feasibility of the service has not been addressed in the document.

The patients that would benefit most from a SMR are also those that are the most complex to manage. There is thus an inherent built in risk when clinicians attempt a SMR for persons on 10 or more medications or those with multiple comorbidities etc. There is a real risk that pressures on GP time will lead to inexperienced pharmacists being coerced into running clinics for these complex to manage patients.

There are simply not enough GPs or senior level clinical pharmacists to deliver a “metrics” driven service model as proposed.

3.1 states 1 in 7 people aged 85 live in a care home. But we are not informed of the number of patients that would be captured by this service. The UK wide resident population in care homes is approximately 400,000.

The consultation document acknowledges in **2.11** “We expect that undertaking a SMR would take considerably longer than an average GP appointment” and advises of the need for regular reviews. There is a notable absence throughout the paper of any meaningful data upon which the calculations for the metrics were based.

In the dual reality world of the NHS the associated key metric is that 100% of the identified target cohorts must be offered a SMR. There is little cognisance of workload when complex patients with complex needs have their SMR or have changes in their medications (and the follow-up which would be necessary)

There is a further impact on GP workload (which then potentially spills over to the pharmacist workload) of the requirement to:

From no later than 30 September 2020, deliver a weekly, in person, ‘home round’ for their registered patients in the care home(s). The home round must:

- be led by a suitable clinician.

On at least a fortnightly basis this must be a GP.

NHS England must have working models and a huge set of data which would show the viability or otherwise of these proposals. The proposals are rendered meaningless unless there is a real desire to engage with the professions by sharing the underlying data to make such a proposal.

Recommendations

- NHS E should review the timescales attached to these specifications and review the proposed phasing.
- Actual workforce rather than potential workforce should be used to determine what work can reasonably be expected from PCNs during 2020-21
- Clauses 1.4 and 1.17 in the consultation document are currently incompatible. The implementation plan needs an overarching review to ensure patient care is not compromised.
- Consideration should be given to delaying requirements for delivery of the first service specifications until a period of PCN team building and local integration preparatory work has been completed.

5. Do you have any examples of good practice that you can share with other sites to assist with delivering the suggested service requirements?

N/A

6. Referring to the 'proposed metrics' section of each of the services described in this document, which measures do you feel are most important in monitoring the delivery of the specification?

Clearly metrics in context mean targets, see below.

Metrics and Targets

We agree that in theory metrics help us to better manage the delivery of our services. However, there is a very real risk that if the DES is implemented in its current form metrics will potentially become mere tick-box targets. There is significant time pressure being created by imposing a 100% cohort requirement for delivering SMRs and these being the most complex and time-consuming patients to manage.

We cannot comment in more detail on the metrics as more specific details are not in the document. For example, what would be the outcome measurement to monitor

the impact of a SMR? How would this allow for local needs rather than national priorities? Will the metrics be the same for the most deprived areas compared to the wealthiest areas? The consultation cannot be considered in full unless clinicians know how the metrics will be devised and assessed.

The requirement to design systems for delivering this service, have in place key personnel, to have fully trained non-GP clinicians and then to start delivering home rounds by 30 September 2020 and to deliver assessments as determined by MDT teams will stretch already overburdened GP practices. This will have consequential impacts on other non-GP clinicians such as clinical pharmacists. This is time intensive work.

One of the proposed metrics is the rate of emergency admissions for people living in care homes. This could impact some homes that provide care for residents with greater needs.

The requirement that every resident of these homes has a SMR and the follow up that would be required will create an extra workload for clinical pharmacists. Many of the residents will have complex needs and comorbidities and thus would require experienced senior clinical pharmacists to undertake the SMR.

The inclusion of a metric that merely measures the number of residents that receive an appointment as part of a weekly round seems like box ticking. There is no link to the time spent per resident nor a quality measure.

We also note that the document notes "Potential metrics to monitor the success of the service include, but are not limited to.." What additional metrics would be introduced and on what basis?

Many localities have clusters of care homes. Coastal towns in England may have a significantly higher density of care homes. How will the national DES metrics allow for this extra burden on PCNs that are located in such regions?

Recommendations

- NHS E should review the metrics for the service specifications we are considering (**Structured Medication Reviews and Optimisation, Enhanced Health in Care Homes**) in recognition of the workforce and timescale factors which currently make them unworkable.
- NHS E should consider introducing metrics for 2010-21 which support PCNs to develop optimally through excellent organisational and workforce development

Final Thoughts

These outline service specifications will create a huge extra workload on stretched GP practices. Whilst we accept that SMRs and greater oversight and monitoring of residents in care homes result in better outcomes the workload implications need to be impact assessed.

The plan to include 7,500 extra pharmacists (by 2023-2024) within PCNs to reduce GP workload is achievable and has the potential to be transformative. However, there are not enough clinical pharmacists with suitable expertise at this early stage of PCN development. Training, supervision and guidance will be needed to maximise their impact. Much of the evidence that pharmacists can reduce pressure for GPs is based on senior clinical pharmacists working independently having built up competencies over many years of supervised practice.

We have already seen time pressed GPs asking junior clinical pharmacists to assume responsibilities far beyond their competency. These workplace pressures will only increase if these new specifications were to go ahead in the proposed timescale.

Our recommendation is that a full impact assessment needs to be carried out on workload and staffing and this should form the basis of the rollout of the service specification.

The PDA does not reject the premise of introducing more pharmacists into general practice, indeed we believe this is an important and necessary development. We do however have serious concerns about how this is being done and feel far more time needs to be devoted to building the new practice teams and inducting, training, mentoring and providing clinical supervision for these pharmacists, so that patients are not put at risk and pharmacists can develop into skilled and confident practitioners.