Report to:	**SINGLE COMMISSIONING BOARD**
Date:	6 September 2016
Reporting Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**INTEGRATED NEIGHBOURHOOD PHARMACY PROPOSAL**
Report Summary:	This report outlines a model for pharmacy and medicines management support to our integrated neighbourhood model. As a part of the consultation process for the emergent Integrated Neighbourhood offer the single commission and care together programme have held workshops in all 5 of our neighbourhoods to agree the Integrated Neighbourhood priorities and core offer. One issue which has arisen as a priority from discussions in all 5 neighbourhoods is the need for pharmacy and medicines management support.
Recommendations:	SCB are asked to APPROVE the proposal to develop a Neighbourhood Pharmacy model to support our model for integrated neighbourhood working.
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	The CCG has a £1m QIPP target for medicines management/GP prescribing in 2016/17. This saving is risk rated red and we are currently reporting circa £500k overspend in this area. Due to the financial pressures in prescribing and other areas the CCG has no money available for schemes which cannot guarantee quick wins and savings in excess of investment. As part of the integrated neighbourhood funding request from GM, there is an element of money, which is not currently allocated. Assuming our business case is approved, the intention is that funding will be delegated to each neighbourhood to invest in new ways of working that address the unique needs of each community and which aligns to the neighbourhood development and wider Care Together strategies. Consideration must be given to determining the most appropriate employer for these appointments. It may be beneficial for these to be employed in the ICO as part of the neighbourhood offer, which could potentially improve recruitment and retention and allow rotation from hospital to community and vice versa. It could also broaden skill sets. If SCB support the principle of community pharmacists, the only source of funding available is the GM transformation money. A decision would need to be made about whether we top-slice money from devolved neighbourhood budgets to fund a consistent neighbourhood pharmacy offer, or if we share the business case with neighbourhoods to allow them to determine for themselves whether the pharmacists represent value for money within the unique circumstances of their community. This is a decision which would need to be made in conjunction with Programme Board.
Legal Implications: (Authorised by the Borough Solicitor)	If the principle is agreed a further report will be required setting out the implementation plan, how it will be funded and options and/or recommendations as to the way forward in respect of

	issues for consideration set out in the report such as whether employed or not. It may be the case that these are irrelevant to the delivery of the outcomes.
How do proposals align with Health & Wellbeing Strategy?	Reduce health outcomes variation, help elderly population, deliver lifestyle interventions, reduce premature deaths.
How do proposals align with Locality Plan?	Healthy lives, self-care, neighbourhood based services, planned care services.
How do proposals align with the Commissioning Strategy?	Improved management of long term conditions, lifestyle, mental health, planned care, urgent care, end of life.
Recommendations / views of the Professional Reference Group:	The model is accepted by PRG.
Public and Patient Implications:	Improving patient outcomes, supporting patient care and independence. Developing patient centred care models
Quality Implications:	Ensure correct levels of support are given to patients around their medicines with a particular emphasis on safety and quality. Ensure prescribing is in line with national and local guidance as well as NICE and GMMMG.
How do the proposals help to reduce health inequalities?	Ensuring prescribing is in line with guidance as per NICE and GMMMG. Ensuring reduction of any geographic variation.
What are the Equality and Diversity implications?	Equality and Diversity implications have been addressed in the development of this model, and will continue to be in the implementation and ongoing design and delivery.
What are the safeguarding implications?	All providers included in the Integrated Neighbourhood model are bound by safeguarding standards and policies. We will ensure through the implementation of this model that these are in place and that any new providers / partners understand their responsibilities.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is included as an element of the core offer for Integrated Neighbourhoods, and will be addressed via the Care Together IG and data sharing agreement work. All partners in the neighbourhood work will be bound by the necessary guidelines, including the pharmacy support function.
Risk Management:	Risks related to the Integrated Neighbourhood pharmacy support will be managed and reported through the Care Together and single commission governance as appropriate.
Access to Information :	The background papers relating to this report can be inspected by contacting Clare Watson, Director of Transformation.  Telephone: 0161 304 5300  e-mail: clarewatson2@nhs.net

1. INTRODUCTION

1.1 As a part of the consultation process for the emergent Integrated Neighbourhood (Integrated Neighbourhood) Offer the CCG has held workshops in all 5 of our neighbourhoods to agree the Integrated Neighbourhood priorities and core offer. One issue which has arisen as a priority from discussions in all 4 neighbourhoods is the need for pharmacy and medicines management support. The request for GM Transformation funding for our neighbourhood model is £400k per neighbourhood for the implementation of service developments and redesign initiatives to deliver prevention of growth in elective and non-elective activity across the system. Our proposed approach, which if supported we will take through the appropriate Single Commission and Care Together governance, is that we 'top slice' any GM transformation funding awarded to enable us to commission any initiatives developed to support this workstream, to include a 'Neighbourhood Pharmacy Support Team'.

1.2 Both nationally and locally there is a recruitment/ retention issue with both GPs and practice nurses. According to the GP Taskforce, the number of GPs per 100,000 population in the UK fell from 62 in 2009 to 59.5 in 2012. Incorporation of a practice pharmacist element in the workforce Has generated national interest.[1,2,3].

1.3 In tandem with this crisis in General Practice most areas of the Health care system are under increasing financial pressure. Even the most optimistic predictions on efficiency savings mean £8 billion a year above inflation would have to be found to close the gap. That would require efficiency savings of about 2-3% per year Locally T&G has a £70 million financial gap over the next 5 years.

1.4 Commonly identified issues for patients regards their medicines are: (5)

- Up to 50% of medicines are not taken as intended by the prescriber
- Between 5 to 8% of all unplanned hospital admissions are due to issues related to medicines (this figure rises to 17% in the over 65s).
- Multi-morbidity and inappropriate poly pharmacy in frail elderly people can be problematic. These patients need regular review of their medicines to ensure that all medicines prescribed, or bought over the counter, are safe and appropriate.
- There is often a communication breakdown at the point of discharge from hospital resulting in prescribing errors. These errors can lead to damage to health, much time wasted for administrative and clinical teams in primary care and potential re-admission to hospital.
- From the patient perspective, with increased focus on patient-centred care, there is much more to be done to allay concerns about polypharmacy and address the lack of support with medicines taking.
- Transfer of care issue on medicines has also been highlighted by the CQC when they surveyed 280 GP practises and found that in 17% of GP practices patient notes are updated by managerial or clerical staff, rather than someone with a clinical background. They concluded that there is not always timely, complete sharing of patient information on medication changes.
- T&G has the potential to be innovative in investing in this clinical workforce and linking it to the integration work and to share learning across the GM devolution platform. Such a service may also provide a unique selling point for practices recruiting GPs to come to T&G.

1.5 The key outcome of this new service will be improved care and health outcomes for patients as well as improved access to care in general practice. Pharmacists will work as part of the Integrated Neighbourhood team to help identify patients at risk and intervene to reduce this risk as well as make interventions to help those in frequent contact with health services, this will include those in care homes. They will support patients to self-manage their well-being and long term conditions, through optimising medicines, and enabling improved medicine related communication between general practice, hospital and community pharmacy. It is also expected that this service will release savings in primary care budgets through a

reduction in medicine related non-elective admissions. **The CCG spent £14,230,672 on unplanned admissions last year**. As noted literature suggests that between 5 to 8% of all unplanned hospital admissions are due to issues related to medicines (this figure rises to 17% in the over 65s). The scheme complements the Integrated Neighbourhood offer and the Care Homes policy.

2. CURRENT PRACTICE PHARMACIST POSITION

2.1 The current practice pharmacist situation is confusing as it has evolved over the last 12- 18 months in an ad-hoc manner. Thirty five practices currently have or soon will have some practice pharmacist provision, some of this being practice level some being neighbourhood level. This support is being provided by 7 WTE pharmacists who are working a variety of hours as arranged by the practices or the neighbourhoods. The latest current funding will extend to is 31 March 17.

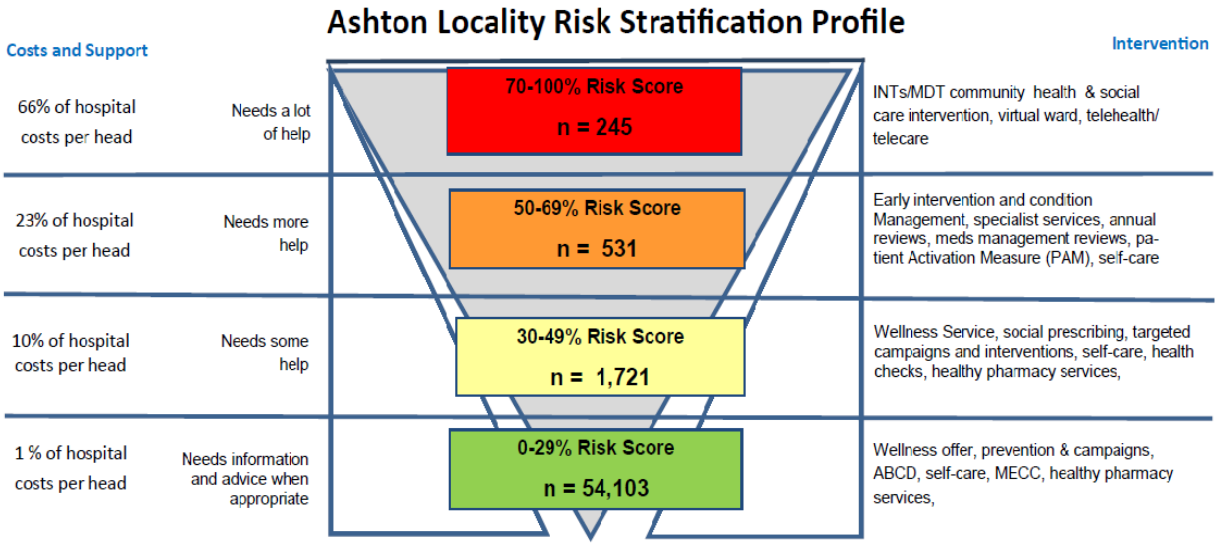
2.2 The model this report is proposing is provision of pharmacist support from the ICO across a neighbourhood as part of the Integrated Neighbourhood Offer. Any existing pharmacists will be able to apply to switch to the proposed Integrated Neighbourhood team should they wish.

3. POTENTIAL BARRIERS

3.1 There are a number of potential barriers to effectiveness of service offerings.

- *Pharmacist availability* - other CCGs and NHSE via its national scheme are recruiting practice based pharmacists. Medium risk/medium impact. A phased implementation would probably be needed.
- The practices would need to provide a GP to liaise with the pharmacists to ensure those areas where they were only able to make recommendations were fully actioned. Low risk/ High Impact.
- *Lack of suitably skilled staff* - If recruits come from community setting they may lack the clinical skills necessary particularly for the Over 75s work. Medium risk/high impact.
- *Lack of familiarity with GP i.t. systems* - It is possible that many will not be conversant with GP i.t. systems and so the CCG MMT and the practices would need to arrange arranged for a quick, on the job, training program to up-skill the pharmacists in operation of EMIS & Vision Medium risk/low impact.
- *Lack of non-medical Rx*. - Wherever the source it is unlikely that many non-medical prescribers would be amongst those recruited. High risk/ Medium impact. Whilst this is a risk and a limiting factor regards initial level of support it is also an opportunity longer term for primary care work force enhancement.
- *Increase in meds queries to CCG MMT* - Depending on level of expertise there may be more queries, Medium risk/ Medium impact.
- *Practices don't engage with service* - Low risk/ Medium impact. T&G practices have always engaged with CCG MMT. Discussions with GPs at neighbourhoods indicates practices would welcome the types of support described in this report.

3.2 Key pharmacist led



4 INTERVENTIONS

4.1 The Ashton neighbourhood risk profile is given as an example. Though the numbers in above schematic change slightly by neighbourhood from the Ashton example they are very similar across all neighbourhoods and the level of resource drawn by the upper two strata is also very similar across the whole economy. The top two categories account for approximately 90% of hospital costs even though they only contain 245 and 531 of individual patients respectively.

4.2 The Integrated Neighbourhood design is intended to better synchronise support to these groups in a more co-ordinated manner. This proposal in this report is in line with that requested via the neighbourhood consultation and would see practice pharmacist support as part of the Integrated Neighbourhood Offer delivered across a neighbourhood.

Pharmacist interventions

4.3 **Discharge facilitation** In-reach to liaise with ward based pharmacist teams to plan ahead of discharge and also with community pharmacy to help streamline transition post discharge. There will be reconciliation of medicines post discharge and any changes managed including performing a clinical medication review where indicated. Production of a post-discharge medicines care plan including dose titration and booking of follow-up tests.

- Undertake clinical medication reviews with patients with LTC and polypharmacy issues in particular those medicines associated with unplanned hospital admissions and including care home and domiciliary bound patients, in the case of an NMP implement own prescribing changes. In the case of care homes work with care home staff, LA commissioners and MMT technicians to improve safety of medicines ordering and administration. Attend and refer patients to multidisciplinary case conferences. Input into case management plans to ensure optimal benefit and reduced harm from medicines.
- Carry a case load of patients including those in the care home setting from the upper two strata of the Risk Profile, intervening pro-actively to reduce likelihood of crisis, in effect conducting a community based ward round.
- Deliver training programmes to other members of the Integrated Neighbourhood team designed to allow them to assess patients need and level of intervention required.

Support Integrated Neighbourhood team in application of assessment. Work with members of the MMT to deliver medicines training to nurses and carers

4.4 **Pharmacist support to GP practices** Working across a neighbourhood the practice pharmacist team would help relieve some of the pressure on General Practice as indicated in the five year forward view and 'The future of primary care ; creating teams for tomorrow'.

4.5 **Repeat Systems** Produce and implement a practice repeat prescribing policy. Manage the repeat prescribing reauthorisation process by reviewing patient requests for repeat prescriptions and reviewing medicines reaching review dates; make necessary changes as an independent prescriber.

4.6 **Acute management** Provide a telephone help line for patients with questions, queries and concerns about their medicines. Hold clinics for patients requiring face-to-face reviews.

4.7 **CQC** Work with the practice manager and GPs to ensure the practice is compliant with CQC standards where medicines are involved.

4.8 **Cost Savings Programmes** Undertake changes to medicines (switches) designed to save on medicine costs where a medicine or product with lower acquisition cost is now available.

4.9 **Medicines Information** Answers all medicine--related enquiries from GPs, other practice staff and patients suggesting and recommending solutions and providing follow up for patients to monitor the effect of any changes.

4.10 **Medicines Quality improvement**
Undertake audits of prescribing in areas directed by the GPs, feedback the results and implement changes in conjunction with the practice team. Implement changes to medicines that result from MHRA alerts, product withdrawal and other local and national guidance.

4.11 **GMMMG** Monitor practice prescribing against the GMMMG formulary/ NT decisions/ DNP and RAG list and ensure shared care is in place before amber prescribing and that red prescribing is repatriated to the relevant Trust.

4.12 **Training** Provide education and training to primary healthcare team on therapeutics and medicines optimisation. Provide training to visiting medical students.

4.13 **Non-Medical Prescribing** It is unlikely that there will be many NMP pharmacists available to hire but although the majority of the practice based pharmacists are not NMPs they do form a pool of potential non- medical prescribers. With the likelihood of no short term reversal of GP shortages development of non-medical prescribers would be an approach to help strategically the local health economy. We already have two of the practice pharmacists working in area who have just completed an NMP course and three more are to sign up to commence a course in September. The practices in which they work have been keen to support this development. It does need to be recognised that 285 hours per pharmacist would be lost over a 6 month period covering time at university and experience/ mentor time.

5. INTER PHARMACY LIAISON

5.1 The Integrated Neighbourhood pharmacist would work with community pharmacy to ensure patient centred care. This could include where there was any necessary adaptation of service to meet patient specific needs under DDA. The patient could also be offered access to appropriate additional and enhanced services as provided by the community pharmacy and currently commissioned by NHSE. Within the constraints of patient choice the practice pharmacist would help arrange the patient to 'register' with the community pharmacy they

used regularly. This would allow the community pharmacy to help in the longer term management of the patient through proactive assessment of issues as they presented.

5.2 The Integrated Neighbourhood pharmacist would work with members of the CCG MMT around case management of specific patients, training of carers, care home audit and high cost medicines reviews. The practice pharmacist would work with ward pharmacist in cases of in-reach and supported discharge. This function would help ensure a seamless transition as patients are prepared for discharge and help ensure effective discharge with reduced possibility of re-admission. The practice pharmacist could facilitate clarity of information post discharge so that an ambiguity was addressed and provide a link to the community pharmacy notifying them of the patient's imminent discharge. If common problems were found to be present the pharmacist could ensure these fed into a system wide review.

5.3 The practice pharmacists may in part be drawn from the hospital team as part of the re-deployment necessitated by the shift of emphasis as more care is provided in the community

6. OVERARCHING BENEFITS

6.1 Quality

- Improved communication between Practice and community pharmacy, hospital pharmacy on admission, discharge and community/ social services.
- A sector wide, co-ordinated, pharmacy approach to patient care such that all pharmacy activity be it in community, hospital or primary care is centred around the needs of the patient.
- Enhanced medicine reconciliation at transfer of care and mores seamless transition.
- Medications reviewed in more patients who have been discharged from hospital/ are house bound/ in nursing homes/ LTC patients.
- Enhanced patient access and experience
- Reduction in preventable harms and admissions from medicines
- Patients better empowered to manage their long term conditions
- Increase in skill mix within general practice and release of GP time by pharmacist managing repeat prescribing and medication/ acute queries
- Improved management of long term conditions for T&G patients
- Movement towards the GM mean in prescribing area where practice is an outlier based on practice prescribing data obtained from GM IMPACT system.

6.2 Financial

- Reduction in practice costs and WHE costs. Depending on pharmacist areas of expertise and activity:

Activity	**GP**	**Pharmacist**
11 minute appointment	£45	£6.50
7 minute telephone consultation	£27	£4.10
23 minute visit	£114	£13.50

6.3 GP costs. 2013 Units Health and Social Care report from the Personal Social Services Research. Pharmacist costs based on current practice pharmacist rates paid. Allowing that most practice pharmacists will not have the range of skills or experience of a GP so long as they concentrated on medicines and related interventions they could substitute for a GP. Even allowing for possible longer appointment times there is still a significant saving. For example current local practice pharmacist experience shows a care home patient review takes between 30 – 60 minutes this is still only £35 cost versus £114 cost. Outcomes from other areas show that with experience the pharmacist can both broaden their range of skills and trim their consultation times allowing a greater realisation of potential savings.

6.4 The CCG spent £14,230,672 on unplanned admissions last year. Literature suggests that between 5 to 8% of all unplanned hospital admissions are due to issues related to medicines (this figure rises to 17% in the over 65s) if the service saved the lower quoted figure of 5% then **£711,533p**.a. savings would be achieved. If this were 8% it would rise to **£1,138,452p**.a.

6.5 Patients will transition through the levels of the risk pyramid over varying periods of time so that future patients at the highest risk are currently in the next level down. If through activity targeted at this second strata 5% of this population (just over 100 patients) were prevented from moving to the highest need strata then based on unplanned activity costs **£302,400** p.a. would be made.

6.6 KPIs:
To determine effectiveness of pharmacist interventions a number of KPIs should be set.

- To conduct at least 20 patient reviews, per neighbourhood, per week (based on 1WTE pharmacist per neighbourhood).
- To receive good patient/carer feedback
- To receive good practice feedback
- For the pharmacists themselves to provide good feedback about the role.

6.7 It is difficult to predict that a quality/safety intervention would have prevented an ADR but if a couple of such had occurred resulting in a hospital admission then this would have paid for the scheme in itself. The CCG will look internally at whether expected reductions on baseline on the re-admissions and unplanned admissions across the Neighbourhood within the patient cohort reviewed is realised.

6.8 The levels of support would be based on affordability and commitment of any transformational monies available. If NMP development were to be included a decision would need to be taken regards whether part or all of the 285 hours would be paid for by the CCG/practices who would be accessing pre-paid for courses and providing mentors to the pharmacists.

7. CONCLUSIONS

7.1 Provision of approximately 2 WTE per neighbourhoods, adjusted on a per capita basis – total cost £604,500. This is roughly in line with the figure quoted in the GP forward view a pharmacist per 30,000 population and supports the Integrated Neighbourhood offer.

7.2 There is much evidence nationally and locally to promote the benefit of using the skills of clinical pharmacists in general practice and community teams. Our proposed approach, which if supported we will take through the appropriate Single Commission and Care Together governance, is that we 'top slice' any GM transformation funding awarded to the Integrated Neighbourhood model to enable us to commission a 'Neighbourhood Pharmacy Support Team' to work across all 5 Neighbourhoods. The benefits of this approach would include:

- Ability to deliver key pharmacy interventions providing financial and clinical efficiency in our prescribing
- Delivery of an identified priority for Integrated Neighbourhoods
- Improve the recruitment and retention of pharmacists
- Cover for all ages and not just specific age groups
- Release of BCF funding to support other Neighbourhood based initiatives
- Foundation for wider development and further expansion of pharmacy support as a key function / intervention for the ICO – potential to work across primary and secondary care.

1 NHS England, Care Quality Commission, Health Education England, Monitor, Public Health England, Trust Development Authority (2014). NHS five year forward view. London: NHS England. Available at: www.england.nhs.uk/ourwork/futurenhs/
2. Primary Care Workforce Commission. The future of primary care Creating teams for tomorrow. July 2015. Available at http://hee.nhs.uk/wp-content/blogs.dir/321/files/2015/07/The-future-of-primary-care.pdf

3. NHS England, Royal College of general practitioners. BMA, HEE. Building the Workforce – the New Deal for General Practice, January 2015. Available at http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/building-the-workforce-new-deal-gp.pdf

4. NHS England. Pharmaceutical waste reduction in the NHS. June 2015. Available at http://www.england.nhs.uk/wp-content/uploads/2015/06/pharmaceutical-waste-reduction.pdf

5. Royal pharmaceutical society England. Pharmacists and GP surgeries. September 2014. Available at http://www.rpharms.com/policy-pdfs/pharmacists-and-gp-surgeries.pdf

6 The scale of repeat prescribing – time for an update; D R Petty, A G Zermansky & DPAlldred. Available at http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-76