

Implementing a national framework for Pharmacists with Special Interests

Summary of contributions from participants at national launch events in November 2006

Over 150 participants attended the two national PhwSI launch events in Manchester and London, and many useful ideas and suggestions emerged during discussion. This paper attempts to capture and summarise this rich and valuable feedback, and we would like to thank all involved for their contributions. We hope that this information (and in particular the proposed solutions and action plans) will be of interest to those now considering how to implement the new framework.

Please note that a new suite of DH publications titled *'Implementing care closer to home – providing convenient quality care for patients'* is expected to be launched shortly, and will address some of the queries raised. It aims to support the implementation of services delivered by Practitioners with Special Interests (PwSIs) and is in three parts:

- Part One: *Introduction to commissioning more specialised care closer to home*
- Part Two: *Step-by-step guide to commissioning more specialised care delivered by accredited Practitioners with Special Interests in community settings*
- Part Three: *National Guidelines for the Accreditation of GPs and Pharmacists with Special Interests*

A series of five free half day events to introduce these new resources will be held from late April and places can be booked now at www.pcc.nhs.uk. Primary Care Contracting will continue to offer PhwSI implementation support. This currently includes promotion of the framework to NHS and wider audiences, networking with early adopters, and work with special interest groups on specialist guidelines relevant to PhwSIs. Ideas from these events for additional implementation tools will also be considered.

Further resources and implementation updates on PhwSI and links to PwSI developments are available at <http://www.pcc.nhs.uk/119.php>.
Beth Taylor beth.taylor@southwarkpct.nhs.uk March 2007

Note: The views expressed in this paper reflect opinions of participants at these events, and not those of the author or NHS Primary care Contracting.

Manchester 7th November 2006 60 delegates

Knowledge and skills: averages			
Before	After	Change (number)	Change (percent)
2.95	7.29	4.34	147.12%

London 23rd November 2006 70 delegates

Knowledge and skills: averages			
Before	After	Change (number)	Change (percent)
3.68	7.47	3.79	102.99%

Commissioning and finance

Commissioner perspectives

- Who is the commissioner, and how do we get their ear?
- Who is commissioned- individual pharmacist or employer?
- How can PCTs be persuaded to review current enhanced services and identify how PwSI would improve this?
- Is there a level playing field for commissioning?
- Commissioning is becoming very complex- unclear where the money is
- Commissioning in NHS is too inward looking and too GP led
- Commissioning boards – need to be multidisciplinary.
- Is a PhwSI service PCT commissioned or PBC cluster commissioned? Could be both, depending on need
- New Pharmacy contract still “volume” based- this is a perversity!
- Need to ensure that commissioners identify the whole service-e.g. admin support; follow-up; communication etc. Many pharmacists not currently set up for this.
- Must be pragmatic about what community pharmacists can currently take on.
- Potential for mismatch of pharmacists interests with local need
- Analysis of need – avoid waste of time training and meeting competencies if no PCT need
- Clouding of enhanced service re PhwSI?

Practice Based Commissioning

- Is it a threat or an opportunity?
- What will GP attitude to PhwSI be ? This may reflect community pharmacy involvement of PBC executive lead
- Engagement in PBC locality groups is difficult for pharmacists.
- Practice based commissioning in many areas is a barrier – still seen as GP commissioning & GPs as providers. Solution- Ensure DH guidance clearly highlights commissioning from community pharmacies and others.
- GPs already refer to pharmacists e.g. Blood pressure testing, smoking cessation.
- Consider what can pharmacies offer that GPs can't? e.g. approachability, access, sell medicines, consultation rooms, no appointment
- Solution include in planning, joint working, interface role
- GPs will have the funding for PBC . Why should they give money up to PhwSI when they could keep it for GPs or GPwSI?
- Big problem to prove our worth and value for money

Finance/funding/VFM

- Financial constraints
- Costing of the service – benchmarking of PhwSI service fee? Monitoring and measuring impact?
- Commissioning- Do you go where there is greatest need or where you will gain most benefit? Need to get VFM.
- Administration of payment?-per clinic -per patient + put through PCT or PPD of NHS Business Services Authority?
- Will the early adopters have to take a ‘financial risk?’
- How can we access financial saving from 2° to 1° care shift?
- Do you have to be paid by person getting financial benefit eg via PBC – helping to reach targets
- Service model- is this subject to a tendering process?

Suggested Solutions

- Future of pharmacy – commissioning on clinical knowledge (because dispensing factories will kill traditional off)
- Find out who are on the commissioning groups to influence
- Get involved in care pathways development
- Networking events
- Promote services with a strong business case – eg long term savings
- Pharmacists should sell themselves- be creative- the sky is the limit
- Are champions/leaders in pharmacy (PEC pharmacist, local PCT pharm) on decision-making commissioning bodies?
- Will often need to be taken forward as part of a multidisciplinary team
- Raising profile of PhwSI model
- Pharmacists need to be proactive – don't overestimate others' knowledge of new pharmacy contract and data on activity in pharmacies
- Tier 2 services – pharmacists invited to join nurse and doctor, then if at right meeting-> restructuring service redesign-> options for future

Accreditation

Note: Many of these queries will be addressed in forthcoming national guidance on accreditation of PhwSIs and GPwSIs (expected shortly)

Issues

- How could re-accreditation work?
- Who will train commissioners to assess portfolios?
- Do GPs have competencies and accreditation?
- SHA accreditation process-must be standardised.
- Can PCTs/SHAs sub-contract accreditation to another body?
- Duration of accreditation/revalidation/peer review
- Must accredit regular locums
- What about levels of accreditation of services like e.g. LES level1/ level 2/ level 3
- Maintaining competence - any extra CPD expectation – network of peers.
- Are accredited pharmacists expected to work across several community pharmacies?
- If part of the aim is to ensure quality and consistency how will local variations in robustness of accreditation be dealt with?
- How to ensure commissioners are able to adopt generic competency framework to specific services? Possible solution- ensure organisation with experience in using competency framework are involved in accreditation process?
- Accreditation- has workload implications
- An accredited PhwSI in London running a clinic may not be needed when they move to Manchester?

Solution/action

- Harmonisation of accreditation eg in NHS Northwest
- Develop skills/knowledge/experience/qualifications/ portfolio including reflective practice, critical and significant events
- Are PCT pharmacists more appropriately banded as commissioning specialists or pharmacy clinical service providers
- Integration within MDT will work best for some specialties

Service models

Issues

- Can you become a specialist in more than one area - with PhwSI how will you decide what to specialise in – eg houseman year?
- PhwSI may lead /develop a service where gaps exist – what happens if when that PhwSI moves on/not available – locum in charge so does the service stop?
- Referral to a community PwSI – is this direction of prescriptions?
- Continuity of accredited individual vs locums
- Does the patient 'belong' to the GP – in terms of being referred by GP
- Training time lag re commissioning of service - it takes a while to commission and set up a service eg anticoagulation
- Pharmacy influencers- don't exclude
- Indemnity insurance for PhwSIs - Can multiples still provide blanket cover?
- Need space for consultation
- PhwSI may need to be prescribing in all cases
- Local 'issues' are usually operational, not knowledge, competency based etc
- Workload in community pharmacy continues to be a problem
- PCT wide or patchy provided by individuals, which leads to inequality in access
- Service model – unfair bias toward multiples in funding/development
- Conflict if using secondary care to train and service being transferred
- Challenge for continuity of service when it's the pharmacist who is accredited and not the pharmacy, so must develop a service model where several pharmacists are accredited

Solutions

- Consider iterative process eg developing MURs into PhwSI: MUR →build confidence→needs assessment→enhanced service→PwSI
- Go for clinical areas not popular with GPs therefore opportunity for pharmacies - sexual health, substance abuse, dermatology
- Will need to establish links to 2° care for effective integration of primary care services with PhwSI lead or inclusion
- Develop and strengthen referral routes for PhwSI – eg to/from consultant, case manager, community nurse, GP, GPwSI
- Cover for clinical negligence is OK if NHS employed
- Promote hospital pharmacists becoming a 'PhwSI' as would act at interface and follow patient
- Patients with resp disease who don't go to GP /nurse asthma clinics but do see pharmacist to get repeat prescriptions
- Providing services in other locations eg health clinics, surgeries, WIC, day care centres, (MacDonalds for obesity clinic??)
- Community pharmacists taking prescribing roles
- Services linked to the next steps of 'extended' MURs linked to a specific clinical area, eg diabetes, COPD etc.
- Getting referrals/identifying pts - targeted campaign
- Have an accredited PhwSI who is contracted by local pharmacists to do sessions in their pharmacy (peripatetic) + tel support for advice
- Possible PhwSI development process:
 - identify need for service,
 - check with commissioners if service required locally
 - develop service model
 - competencies to provide service
- Identify existing champions + move them (may be in different PCTs)
- Pro-actively identify pharmacists to run these services

Competency and training (1)

Issues

- To what level academically do PhwSI need to be trained to? – for accreditation
- Who decides what competencies are?
- E and T costs – will these be reimbursed?
- Availability of training, adequate facilities for advanced level training, access to courses
- Attitude of new pharmacists – difficulty of owning a pharmacy to get autonomy therefore apathy of pharmacists – could exploit this to excite clinically using PhwSI
- Will there be accreditation criteria for each special interest?
- How do we credit/recognise pharmacists' experience
- How do pharmacists develop portfolios to demonstrate competency?
- Too much paperwork stifles initiative – enthusiastic amateurs may not wish to go through an accreditation process
- What is appropriate CPD?
- Who will monitor competencies?
- How do you develop competencies unless you are already a PhwSI?
- HEIs to support commissioners in producing a framework for assessing competence?
- PROBLEM- too much duplication of portfolios, experience training etc
- There will be a need for an independent assessment for e.g. for clinical skills CPP etc- think about local conflict of interest
- Who has the skills to accredit PhwSI?
- DANGER- don't make it too difficult to become a PhwSI. Community pharmacists are not familiar with competency approach.
- How does competency travel with the individual to different geographies? "Mobile Portfolio"
- Pharmacists, PCTs need support on the basis of a competency approach.
- May restrict development and competencies because not "asked" by PCT.
- Will courses develop that are recognised nationally?
- Too many different sets of competency – causes confusion
- Is this formalising current models and putting "Quality Assurance" measures in place?
- Difficult to get a portfolio unless already doing it. But can't do unless 'accredited'

Workforce issues

- Need a wider workforce push → need better use of whole pharmacy workforce
- For an anticoagulation service - when does it need to be provided by PhwSI
- What makes PhwSI special?
- Workforce → not enough pharmacists
- Retain general role as well as specialist is important
- Will there be a register of PhwSI - local or national?

Specialist competencies

- How to ensure commissioners are able to adopt generic competency framework to specific services?
- Possible solution → ensure organisation with experience of using comp frameworks is involved in acc process?
- Engage clinical experts in field to develop specialist competencies nationally
- National set of competencies for each specialist area in addition to generic framework

Competency and training (2)

Training

- Funding for training + “chicken and egg” situation if you have to get accreditation before service is commissioned.
- Training support and funding for pharmacist prescribing (e.g. backfill) is difficult in PCT.
- Issues over cost of training e.g. dermatology + spending time in hospital clinic → backfill costs and salary costs.
- Standard of courses – will they vary from organisation to organisation?
- There may be an (undesirable) lag time for pharmacists to train after agreement by commissioners

Solutions

- As PhwSI numbers are likely to be low, need regional/ area wide networks of support for competency or portfolio, sharing models of care
- Develop a career structure in community pharmacy
- Support from large companies
- Involve SHA and/ or multi-professional Deanery
- Investment in training
- Nurture the ‘passion’
- Inclusion of the pioneers to accreditation state rather than excluding them by the accreditation process
- Joint training with GPs/ pharmacists/ hospital staff
- National training curriculum/competencies shared by GPs and pharmacists?
- Ensure minimise risk of “turning off pharmacists” i.e. don’t make it too complex
- Pharmacists need to be pushy. We need training in these skills, and a leadership programme
- Work up competencies from existing services
- We have a competency framework for general level service in pharmacy.
- Align all competencies to PhwSI (CoDEG) ones
- Mapping current skills and interests & local pharmacists- feeding into needs assessment process
- Mentorship
- PCT may need to facilitate linking with doctors – maybe GPwSI with prospective PhwSI
- Dermatology example of levels of practice:
 - Practitioner level: general OK skin advice
 - Enhanced service: offer advanced service with knowledge advice to GPs and pts
 - PhwSI level: monitor and prescribe
- Need minimum experience at core competencies before progression to PhwSI.
- Developing learning and experience skills.
- Ideally, would want nationally agreed core competencies & be able to adapt them locally

Examples of follow up action plans

- Develop the service to drug misusers/ visit the CPPE website/ confirm if my PCT is interested in specialist pharmacists
- Think about skills necessary to actually become a PhwSI personally
- Look at what services could be provided in primary care and discuss with the commissioning manager.
- Discuss with colleagues how we can adapt our development ideas to include PhwSI.
- Explain concept to pharmacists who have the potential to develop into a PhwSI.
- Feedback to manager/ build internal colleagues understanding of the role/ consider fit with service development strategy
- Get closer to commissioners/ link work on consultant pharmacists with PhwSI networks/ Identify local "early adopters"
- I have put my name forward and, hopefully, can build a case for consideration by the commissioners. As a "coal-face" worker, I have been too preoccupied in acquiring and honing clinical skills with little regard to the all-pervading politics. I realise that I will now have to give this some attention.
- Encourage pharmacists and PCTs to develop existing models into models including PhwSIs/ encourage pharmacists and PCTs to be patient on this development given the current climate but to exploit opportunities rapidly
- Sharing the info with the LPC/ sharing the concepts with PCT FHS staff for consideration when looking at service delivery/ consider whether this would be a way forward for me
- Identify PCT priorities for PhwSIs/ identify potential pharmacists/ identify suitable training courses for pharmacists
- Explore further how PhwSI can fit into existing and future enhanced services
- Feedback to my local PBC group/ identification of funding and implementation plan
- Relating PhwSI to the current list of enhanced services and identifying which types of "standard" services these might relate to/ Identifying examples of multidisciplinary services where PhwSI might apply
- Discuss joint accreditation and support for implementation across my patch/ consider portfolio/accreditation requirements and mechanisms
- Engage with LPC to link in with PBC clusters/ discuss with local networks where this framework could be useful in future
- Better understanding of the accreditation process for PhwSI when guidance published
- Look at how the University can support accreditation for PhwSI/ visit PhwSI website to read more
- Supporting the training and development needs for PhwSIs and towards a portfolio of learning for future accreditation
- Look at service redesign to explore where PhwSI can add value/ revise Pharmaceutical Needs Assessment accordingly
- Inform commissioning of the additional tool available to commission services in the community/ provide advice to the PCT on how this agenda can support the Business Plan of the PCT.
- Shared learning from established service models in PhwSI national framework/ clarity around service provision versus commissioning process
- Sell the idea to the commissioners/ ensure that it is cost effective to use PwSI/ link with supplementary prescribing