PharmacyVoice
Speaking up for community pharmacy

BRIEFING:
June 2015

LOCAL COMMISSIONING LANDSCAPE UPDATE

Introduction

In the last parliament, as a consequence of the Health and Social Care Act 2012 the coalition government of Conservatives and Liberal Democrats oversaw radical change in the powers and duties of the Secretary of State and Department of Health and in the organisation of health and social care commissioning in England. At the time Pharmacy Voice produced a series of "Landscape" documents to help our members and colleagues across the pharmacy sector understand the changes that were taking place at national and local levels. Their purpose was to help pharmacy contractors and their representatives maximise opportunities to influence and develop new relationships with commissioners and to ensure the value of community pharmacy's contribution to better care was recognised.

A new Conservative majority government has formed after the general election in May 2015, and the previous Secretary of State for Health has retained his position. This means that a further round of top-down structural reorganisation of the health and care system is unlikely in the near future. While there will inevitably be an evolution of the existing policy framework, its broad parameters stand for now. The Conservative manifesto pledges - including those to continue to integrate the health and social care systems building on the Better Care Fund initiative, and to extend access to GP surgeries from 8am to 8pm, 7 days a week by 2020 - are expected to be progressed. The government has also signalled a commitment to support implementation of the Five Year Forward View (5YFV) for the NHS that was published by the national health bodies in October 2014.

This does not, however, mean 'business as usual' for the health and care system. The direction of travel prior to the election was already pointing to significant changes in the way that services are commissioned and delivered. The 5YFV itself has prompted a series of national initiatives to test a set of New Care Models (NCMs). This includes alternative approaches to disease prevention and health service organisation, in an attempt to start bridging the gap between the demands that will be placed on the system over the coming years, and the increasingly limited resources available to meet them. Just as significantly, plans to pool £6 billion of health and social care funding in Greater Manchester as part of the devolution of powers to a 'Northern Powerhouse' have far-reaching implications for commissioners and providers across the whole country.

The community pharmacy network has a vital role to play in both shaping and supporting these changes. In a policy environment focussed on improving public health, integrating out of hospital care and supporting people to maintain their own health and wellbeing, community pharmacy has a great deal to offer. To ensure this is recognised, the pharmacy sector itself needs to acknowledge and understand the changes that are occurring, and find new and better ways of responding to them. The challenge is to demonstrate the wider value the community pharmacy network brings to healthy living and person-centred care in the new commissioning and provider landscape. To do that, 'big conversations' need to happen at national level within the pharmacy sector and across professional and organisational boundaries. However, in a system that continues - and potentially extends - decentralised decision-making and funding, local conversations are just, if not more, important.

The purpose of this document is to help make sense of current health and care policy drivers, service developments and organisational structures, and to encourage greater involvement of community pharmacy leaders in both national programmes and local initiatives. It sets out some key messages, commitments and recommendations on what needs to happen to enable this, and to ensure

community pharmacy has a seat at every table where health and care reform is debated and designed.

The paper has been developed with input from members and local community pharmacy leaders. Pharmacy Voice would welcome feedback on the content and how useful it is, on how local pharmacy teams are getting involved in new ways of working, and on the recommendations for action at a local and national level.

Response of Community Pharmacy to the changing health and care landscape: Key commitments and recommendations

Pharmacy Voice will:

- Work alongside other national pharmacy bodies to promote and support community pharmacy engagement in emerging new service delivery models, and to help create a conducive commissioning environment for pharmacy contractors
- Work alongside other national pharmacy bodies to ensure the whole community pharmacy workforce and team is considered in the re-design of services so that the right person, in the right place, at the right time, delivers high quality support and care
- Work with national stakeholders to design and support robust implementation plans for service transformation involving community pharmacy teams, focussing in particular on the development of urgent and emergency care systems
- Collaborate with other primary care partners and patient groups to help demonstrate the wider value the community pharmacy network brings to health promotion and person-centred care in the new commissioning and provider landscape.

Local pharmacy representatives (including LPCs and LPNs) should:

- Identify strategic stakeholders in their local health and care system, and develop plans to ensure effective representation for community pharmacy in key planning and decision-making fora
- Develop a local strategy for community pharmacy engagement that aligns with the emergence of new care models. This includes working with all colleagues taking forward local transformation plans whether or not they have 'vanguard' status.
- Work collaboratively across regions to gather intelligence about the whole system transformation that is taking place in the wider health economy.
- Share and learn from each other to spread good practice, find better ways of influencing, and develop effective relationships with local commissioners.

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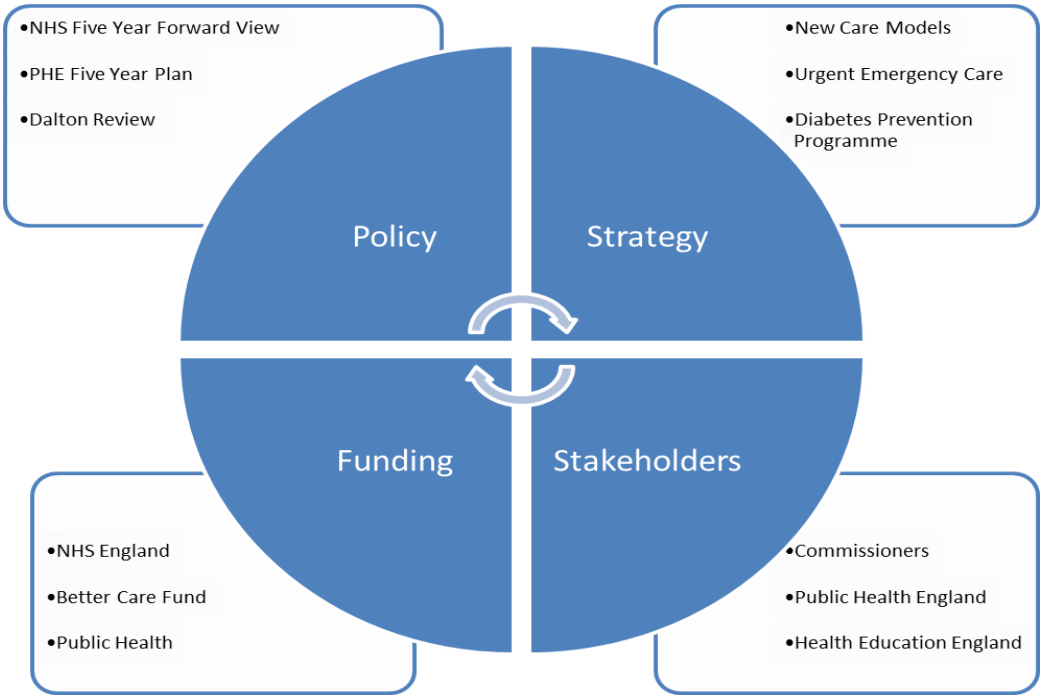
Actions: Share this briefing document with teams and colleagues and provide feedback to Pharmacy Voice

- How useful is the content of this paper?
- What kind of information about the health health and care system would you like more of, to help you understand and engage in new service developments?
- How are you getting involved in influencing, planning and delivering New Care Models?
- What would you like to see Pharmacy Voice and other national pharmacy bodies doing or saying, to help create the right environment for community pharmacy to maximise its potential?

Diagram 1 Key elements of the health policy landscape



National policy context

There are several major policy programmes currently being implemented in England that impact on community pharmacy. The **Five Year Forward View** for the NHS (published jointly by NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority in October 2014) provides the overarching framework for many of these, bringing together a number of existing and new strands of policy and converting them into a strategy for the system.

The 5YFV sets out a clear sense of direction for the way services need to change and improve in order to address three potentially widening gaps in:

- Health and wellbeing
- Care and quality
- Funding and efficiency

The 5YFV outlines a vision for the future in which there is a radical upgrade in prevention and public health; patients have far greater control of their own care and the NHS has taken decisive steps to break down the barriers in how care is provided.

In terms of upgrading prevention and public health, the 5YFV aligns with **From evidence into action: opportunities to protect and improve the nation's health**, Public Health England (PHE)'s 5-year strategy, which includes objectives for tackling obesity, smoking and harmful drinking and reducing dementia risk. The 5YFV also introduced the **National Diabetes Prevention Programme,** a joint initiative between NHS England, Public Health England (PHE) and Diabetes UK, aiming to significantly reduce the four million people in England otherwise expected to have Type 2 diabetes by 2025.

The financial pressures facing the health and care system form the backdrop to the 5YFV, which emphasises that in order to ensure the NHS is financially sustainable now and in the future, fundamental change and radical action need to be taken. It is estimated that the NHS will have to make up a £22 billion shortfall between projected funding and demand, through increasing efficiency and productivity and changing ways of working (assuming additional investment is also made to enable that transformation). This presents the NHS with an unprecedented challenge, in a context where productivity plans have not been met in the past two years, waiting times have risen and quality and finances have suffered, and where NHS hospitals are expected to record an overspend of at least £800 million in 2014/15[1].

New Care Models

One key element of the 5YFV strategy for achieving transformation across the health and care system is the development, testing and roll-out of a number of New Care Models (NCMs). These are proposed approaches to organising the commissioning and delivery of care in ways designed to dissolve traditional organisational boundaries and silos, embed whole-system working and integrate services around people and communities.

The 5YFV states that England is too diverse for a 'one size fits all' care model to apply everywhere, and it is acknowledged that new models for commissioning and delivering services should be adapted to fit local needs. However, in the belief that simply 'letting a thousand flowers bloom' across the NHS is not the best route to rapid transformation and improvement either, a national programme of 'vanguard' sites has been initiated to test a limited number of potential organisational forms and service configurations. New models are being tested for:

- Multispeciality Community Providers (MCPs)
- Primary and Acute Care Systems (PACS)
- Enhanced health in care homes

[1] John Appleby, Chief Economist, Health Policy at The King's Fund

In recent weeks, NHSE have invited organisations to express an interest in two New Care Models (NCMs), one covering work between acute care collaboration of providers and the other covering urgent and emergency care.

The developments initially most relevant to community pharmacy are likely to be:

- **Multispecialty Community Providers (MCP):** developments of federations and networks of GP practices that come together with community services, other primary care providers including pharmacists, hospital specialists and potentially mental health and social care to create integrated out of hospital care organisations. *Could in time take on delegated responsibility for managing the health (and social care) budget for their registered population.*
- **Primary and Acute Care Systems (PACS):** 'vertically integrated' organisations providing both list-based GP services and hospital services, together with mental health and community care. *These might be formed in a number of ways including hospitals opening their own GP surgeries with registered lists, or MCPs taking over the running of hospitals as they mature and develop.*
- **Urgent and Emergency Care Networks:** scalable and replicable urgent and emergency care models that implement best practice and national policy expectations from the national Urgent and Emergency Care Review. *This will include, implementing integrated NHS 111 and out of hours services; extending evening and weekend access to GPs or nurses working from community bases; and developing networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres.*

National and local organisations have been asked to express their interest in becoming 'vanguard sites' in waves, starting with applications to trial MCPs, PACS and enhanced care home services in February 2015. There were 268 submissions in this phase, of which 63 bids were shortlisted and from which 29 organisation were identified as vanguard sites in March 2015. Click here for details.

The purpose of identifying and supporting local vanguard sites to lead the way in developing these new ways of working is to enable rapid testing and learning about what needs to happen to make the new models work, so that roll-out of effective approaches can be cascaded at scale and pace across England.

Other programmes and initiatives

While there has been a particular focus recently on the New Care Models programme emerging from the 5YFV, there are a wide range of other initiatives being rolled out across the country that were already being developed or implemented, or have since emerged. These include:

- **Better Care Fund projects** - announced by the Government in June 2013, and designed to promote a transformation in integrated health and social care, the Better Care Fund (BCF) was hailed as one of the most ambitious programmes ever run across the NHS and Local Government. The BCF programme is not actually a 'fund' (it did not introduce any new resources into the system) but created a requirement for the NHS and local government to pool certain health and social budgets and work more closely together to support individuals and communities. Local BCF initiatives are focussed on enabling service integration, maintaining adult social care services, reducing emergency admissions and bringing down overall costs. This year £3.8 billion will be spent jointly by the NHS and local authorities through their BCF plans.

- **Prime Ministers' Challenge Fund pilots -** In October 2013, the Prime Minister announced a 'Challenge Fund' to improve access to general practice by implementing transformational change at a local level. 20 pilots were launched in March 2013 and in October 2014 further funding was allocated for a second wave of pilot schemes. The first two cohorts of 57 projects covered a population of over 18m (a third of the country) in over 2,500 practices. The schemes were set up to trial a wide variety of ideas on how to improve convenience and access to GP services to fit round work and family life, for example with more appointments in the evenings and at weekends, and through options for video, email and telephone consultations and better use of telecare and health apps. Primary Care Infrastructure Fund money was also added to the scheme to enable improvements in areas such as IT and GP premises.

  Some LPCs have been successful in bidding for PMCF monies and community pharmacies have been involved in related initiatives including:
  - "Pharmacy First", winter ailments and emergency supply services
  - Schemes to identify and support high risk vulnerable patients
  - Extended Primary Integrated Care
  - Domiciliary Medicines Use Reviews (MURs)

  Nottinghamshire has a Challenge Fund project on 'Unlocking the potential of community pharmacy', which involves testing a new way of working between community pharmacists and GPs.

- **Whole-Systems Integrated Care pioneer programme**
  In May 2013, national partners announced the 'pioneers' programme, inviting local areas to demonstrate the use of ambitious and innovative approaches to deliver person-centred, co-ordinated care and support. There are 14 pioneering initiatives where the aim is to make health and social care services work together to provide better support at home, and earlier treatment in the community to prevent people needing emergency care in hospital or care homes. The aims and objectives of this programme are very similar to the Better Care Fund projects and the Prime Minister's Challenge Fund.

- **Integrated Personal Commissioning (IPC) programme –** In March 2015, NHS England and the Local Government Association (LGA) announced the names of the first eight sites that will implement integrated personal commissioning. This involves blending comprehensive health and social care funding for some 10,000 people with complex needs, and giving them greater power to decide how their own combined health and social care budget is spent. Four groups of high need individuals – older people with long-term conditions, children with disabilities and their families, people with learning disabilities, and people living with serious mental illness – will be able to take control of their budget to deliver an agreed care plan.

- **Co-commissioning pilots –** In May 2014, NHS England invited Clinical Commissioning Groups (CCGs) to come forward with expressions of interest to take on an increased role in the commissioning of primary care services (which is the responsibility of NHS England). Over 70 percent of CCGs will take on greater commissioning responsibility for GP services in 2015/16 under delegated and joint commissioning arrangements. The ambition in some CCGs is to take on a greater level of responsibility in the commissioning of dental, eye health and community pharmacy services and NHS England will be looking into this for 2016/17, "*with full and proper engagement of the relevant professional groups"*. Co-commissioning is seen as a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local

populations. It is also expected to drive the development of NCMs such as Multispecialty Community Providers and Primary and Acute Care Systems.

- **The Dalton Review** – published in late 2014, this review considered a number of potential organisational forms for providers of NHS care, including federations, joint ventures, service level chains, management contracts, integrated care organisations and multi-service chains or Foundation Groups. While the review focussed on NHS trusts and Foundation trusts, the development of new approaches emerging from the review has the potential to impact on other providers.

- **'Devo-Manchester' –** On 3rd November 2014 the Chancellor of the Exchequer and leaders of the Greater Manchester Combined Authority (GMCA) signed a devolution agreement giving new powers, responsibilities and resources to the Greater Manchester city-region. The developments in Manchester are being seen as a test-bed for new models of decentralised political engagement, industrial strategy and economic growth. The agreement included options for GMCA and Greater Manchester Clinical Commissioning Groups to develop plans for the integration of health and social care across Greater Manchester, based on control of existing health and social care budgets. The intention to devolve responsibilities for health and social care to statutory organisations in Greater Manchester from April 2016 was confirmed in February this year. A memorandum of understanding has been published setting out how the entire health and social care system in Greater Manchester will work together to develop plans for improving health and wellbeing, using their combined resources of c. £6 billion. The agreement brings together the 10 local authorities, 12 Clinical Commissioning Groups, 15 NHS providers, and NHS England.

  The plans for integration fit with the place-based approach to health and care reform articulated in the 5YFV, and there are significant opportunities for radical change if local authorities and their NHS partners use the opportunity to go beyond the integration of care to focus on improving population health. Devolution is intended to enable decisions to be taken much closer to, and in partnership with, the communities being served by statutory bodies, with local politicians having a bigger influence on future decisions. Questions remain over how much freedom public sector leaders will have to depart from national policies when it comes to NHS resource and services. However, Devo-Manchester does signal a potential trend toward more local commissioning and funding arrangements in the future.

  The LPCs across Greater Manchester, through Community Pharmacy Greater Manchester (CPGM), are working together to ensure community pharmacy is part of the transformation programme.

In this complex landscape, it is easy to lose track of all the various programmes, pilots and initiatives that are happening locally. **The appendix to this briefing summarises information about emerging NCMs and participation in national programmes across each LPC and NHS England region.** Being aware of the initiatives CCGs and their partners are driving locally should help LPCs and other pharmacy representatives engage with their plans, and demonstrate the valuable contribution of community pharmacy to better patient care.

The members of Pharmacy Voice directly and indirectly employ 30,000 pharmacists and more than 50,000 other highly trained pharmacy staff members in the community. The community pharmacy sector invests significantly in neighbourhoods, towns, areas of deprivation and rural communities. A vibrant, sustainable and confident pharmacy market is important to both the local and national

economies and central to implementation of all aspects of the 5YFV. It is essential that local and national pharmacy leaders are engaged in disucssions about all of the emerging NCMs.

Commissioning models and approaches

One of the issues being considered within the various new service models and working arrangements developing across health and local government is the optimal approach to commissioning and contracting. With pressure on their own management costs and capacity, commissioners - including NHS England, CCGs and Local Authorities (LAs) - want to contract services from providers through the simplest and most efficient means. In many areas this is leading to consideration of lead provider and alliance contracting models, where strategic commissioners contract with a 'prime vendor' which then coordinates a network of comprehensive, integrated services to be delivered to whole populations, rather than contracting directly with multiple different providers for particular services or parts of pathways.

Commissioners are also increasingly focussed on articulating and contracting for the outcomes they want to see for their patients and communities, rather than on specifying service inputs and outputs. In this context there are various approaches and tools that commissioners may refer to which community pharmacy providers should be aware of.

Outcome-based commissioning (OBC) is an approach intended to drive transformation and secure better outcomes, service integration and value for specific populations or groups (e.g. frail older people with multiple, complex problems), and re-balance incentives by paying for outcomes rather than activities. Common to OBC models are:

- Identifiable & measurable outcomes (clinical; experience; financial; population-level)
- Desired behaviour changes that can be incentivised through payment systems
- Whole-system approaches managed at-scale across large populations
- More mature & long-term relationships with providers (e.g. 7+ year contracts)
- 'Lead provider' or 'Alliance' contracting approaches

Commissioning for Value is about identifying priority programmes which offer the best opportunities to improve healthcare for populations; improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system.

The Commissioning for Value programme is designed to help clinicians and commissioners transform the way care is delivered for their patients and populations. There are currently 13 patient pathways analysed including diabetes, heart disease, Chronic Obstructive Pulmonary Disease (COPD) and asthma, where a suite of materials has been developed to support effective 'commissioning for value'. This includes a range of comprehensive data packs and online tools. (Click here)

Contracting models

- **Traditional contracting model:** a commissioner secures different elements of a care pathway, or services for the care for a particular population, through a series of separate contracts with individual providers.

- **Lead provider model:** a commissioner enters into a contract with a single organisation (the prime contractor or lead provider) for a set of services delivered by multiple providers. That contract allocates risk and reward between the commissioner and the prime contractor. The prime contractor then sub-contracts specific roles and responsibilities (and allocates risk associated with their performance) to the other providers. The prime contractor remains responsible to the commissioner for the delivery of the entire service, and for the co-ordination of its 'supply chain' (i.e. its sub-contractor providers) in order to ensure that it can and does deliver that entire service. The prime contractor is likely to be a provider of clinical services itself, but it can sub-contract all but the co-ordination role.

- **Integrated pathway model:** commissioners enter into separate contracts with a number of providers, all of whom contribute towards the delivery of an integrated service. One of the providers (the Integrated Pathway Hub (IPH) provider) assumes responsibility for the co-ordination and management of the integrated service, and risks and rewards are allocated between the commissioner and the IPH provider in relation to the integration and management function. The IPH provider may be a provider of clinical services itself, but may just take on the non-clinical co-ordination and management role. No one provider is responsible for the delivery of the entire integrated pathway

- **Alliance contracting model:** covers a number of different contracting models (including prime contractor and IPH structures). In other sectors, an alliance contract will typically bring together a number of separate providers under a single contract, but the term is often used in a broader sense, where multiple parallel contracts are put in place. In either case, key characteristics of alliance contracting are said to be alignment of objectives and incentives amongst providers; sharing of risks; success being judged on the performance of all, with collective accountability, contracting for outcomes, and an expectation of innovation.

Key stakeholders across the commissioning landscape

As well as a being aware of a variety of different commissioning and contracting approaches, community pharmacy providers need to engage with a number of different commissioning organisations. The commissioning of health care and public health services fragmented in 2013 when Primary Care Trusts were abolished and NHS England, Clinical Commissioning Groups (CCGs), Local Authorities and Public Health England took up their responsibilities. As a result there are now over 350 organisations that have a significant responsibility for directly commissioning services or influencing commissioning strategies and plans. There are 4 Regions, 13 regional offices, 27 Local Professional Networks and 12 clinical senates across NHS England; 9 Commissioning Support Units; 209 Clinical Commissioning Groups (CCGs); 353 Local Authorities in England (including county, district, metropolitan, shires and London boroughs), 154 Health and Wellbeing Boards (HWBs) and 13 Local Education and Training Boards (LEBTs).

A significant challenge for all providers is the ability to influence and shape commissioning decisions. Identifying who's who and establishing relationships are essential, but it takes time to build trust. Effective representation, maximising networks and being in the room around the table with key decision makers and influencers is the goal of pharmacy's local and national representatives.

It is worth noting that when it comes to community pharmacy, different commissioners commission the same or similar services in different areas, for example – in Doncaster the CCG commissions MAS and emergency supply, whereas in Nottinghamshire regional teams commission these services.

Public Health

Public health is about helping people to stay healthy, and protecting them from threats to their health. There are significant opportunities for community pharmacy to help improve public health services and outcomes. From April 2013, responsibility for public health transferred from the NHS to local government and Public Health England (PHE).

Local Authorities (LA)

Local authorities are now responsible for public health commissioning and have appointed Directors of Public Health (DPH). Local government also now has a much greater role shaping all health and care provision through Health and Wellbeing Boards.

In relation to their public health responsibilities local authorities are mandated to provide four services: the National Child Measurement Programme, Health Checks, sexual health services and a public health advice service to Clinical Commissioning Groups. Local Authorities could commission the following types of public health services from community pharmacy, using their own contracts or the standard public health contract:

- Sexual health
- Alcohol and drug misuse
- Stop smoking
- Flu vaccination
- NHS health checks
- Weight management

Health and Wellbeing Boards were introduced as statutory committees of all upper-tier local authorities under the 2012 Act. There are 154 HWBs with responsibility to improve the health and wellbeing of the people in their area, reduce health inequalities, and promote the integration of services.

The role of each HWB is to assess local health needs through the Joint Strategic Needs Assessment (JSNA), produce and implement a Joint Health and Wellbeing Strategy (JHWS), and promote joint commissioning with CCGs and NHS England. The aim is to improve the health and wellbeing of the local community and reduce inequalities for all ages. Local authorities and CCGs have an equal and joint duty to prepare JSNAs and JHWSs, through the Health and Wellbeing Board.

The statutory responsibility for developing and publishing Pharmaceutical Needs Assessments (PNAs) also lies with HWBs. The PNA will help in the commissioning of pharmaceutical services in the context of local priorities, and will be used by NHS England when making decisions on applications to open new pharmacies.

Local Government is a strong advocate for devolution and decentralisation of policy and funding decisions, and believes local authorities should have a greater role in health care planning and commissioning. The Local Government Association (LGA) has argued for the commissioning of primary, secondary and social care services to be joined up through Health and Wellbeing Boards, and for full integration of funding for the commissioning of adult social care and health. The LGA wants to see a "radical re-thinking of public services, led by local communities, to enable people to help themselves and one another."

In this context, maximising the impact of community pharmacy requires local leaders to familiarise themselves with local government and meet with the influencers within local authorities. Inviting new councillors to visit community pharmacy to showcase public health services in action might be a good place to start.

Identifying who's who in LAs and HWBs can be difficult. The Regional Voice website is a good tool to help identify and make contact with the right person (Click here). Attending public HWB meetings or accessing public board papers can also provide useful insights into local priorities and influencing opportunities.

Public Health England (PHE)

PHE supports local authorities, and through them Clinical Commissioning Groups, by providing evidence and knowledge on local health needs, as well as practical and professional advice on what to do to improve health.

PHE has advocated for greater involvement of community pharmacy in public health provision, and hosts the Pharmacy and Public Health Forum. This Forum has two key purposes: firstly, to provide leadership for the development, implementation and evaluation of pharmacy public health practice; and secondly to champion pharmacy's unique offering in improving the health of people in England. The Forum aims to support and challenge the health system so that more people and families in England will be able to access a range of public health services through their local pharmacy. Pharmacy Voice represents community pharmacy providers on the Forum.

Community pharmacy can make a contribution to all of Public Health England's priorities, which include plans to:

- Tackle obesity
- Reduce smoking
- Reduce the harm from alcohol
- Secure the best start in life for children
- Transform a generation's risk of dementia
- Achieve decline in tuberculosis incidence
- Tackle antimicrobial resistance
- Tackle high blood pressure
- Support Be Clear on Cancer awareness campaigns
- Develop a national Diabetes Prevention Programme.

Health Services

Clinical Commissioning Groups

Clinical Commissioning Groups (CCGs) are overseen by NHS England and all GP practices belong to a CCG. They are responsible for commissioning or buying most of the hospital and community NHS services in the local areas for which they are responsible, including:

- Elective hospital care
- Rehabilitation care
- Urgent and emergency care
- Most community health services
- Mental health and learning disability services

CCGs are also responsible for expenditure on primary care prescribing, which represents 10% of the overall health budget and 30% of a CCG's budget. There is significant focus by NHSE and CCGs to reduce waste in the prescribing budget and increase the value of medicines.

There has been a great deal of discussion about how the pharmacy sector can contribute to reducing the impact of winter pressures on the NHS and how better utilisation of the pharmacy workforce will improve the quality and access to care by the right people, in the right place at the right time. Many CCGs therefore commission local pharmacy services such as:

- Minor Aliment Schemes
- Pharmacy Urgent Repeat Medicine Service
- Flu vaccinations service

NHS England (NHSE)

One of the main operational roles of NHS England is the commissioning responsibility for independent contractor services, including GP services, primary dental services, community pharmacy and NHS sight tests. This means NHS England is responsible for maintaining, improving and managing the national community pharmacy contractual framework.

As well as commissioning the pharmacy services provided under the national contract, NHS England teams can also commission community pharmacy to provide locally determined services such as flu vaccinations for at-risk groups.

NHS England is also responsible for Local Professional Networks (LPNs) for pharmacy, which can facilitate dialogue between colleagues in NHS England, CCGs, local government and community pharmacy to help:

- identify where progress is being made in terms of community pharmacy contributing to national priorities, and how to share innovation
- recommend initiatives that can be driven forward locally and nationally that will have the biggest impact
- support communication and engagement between commissioners and providers

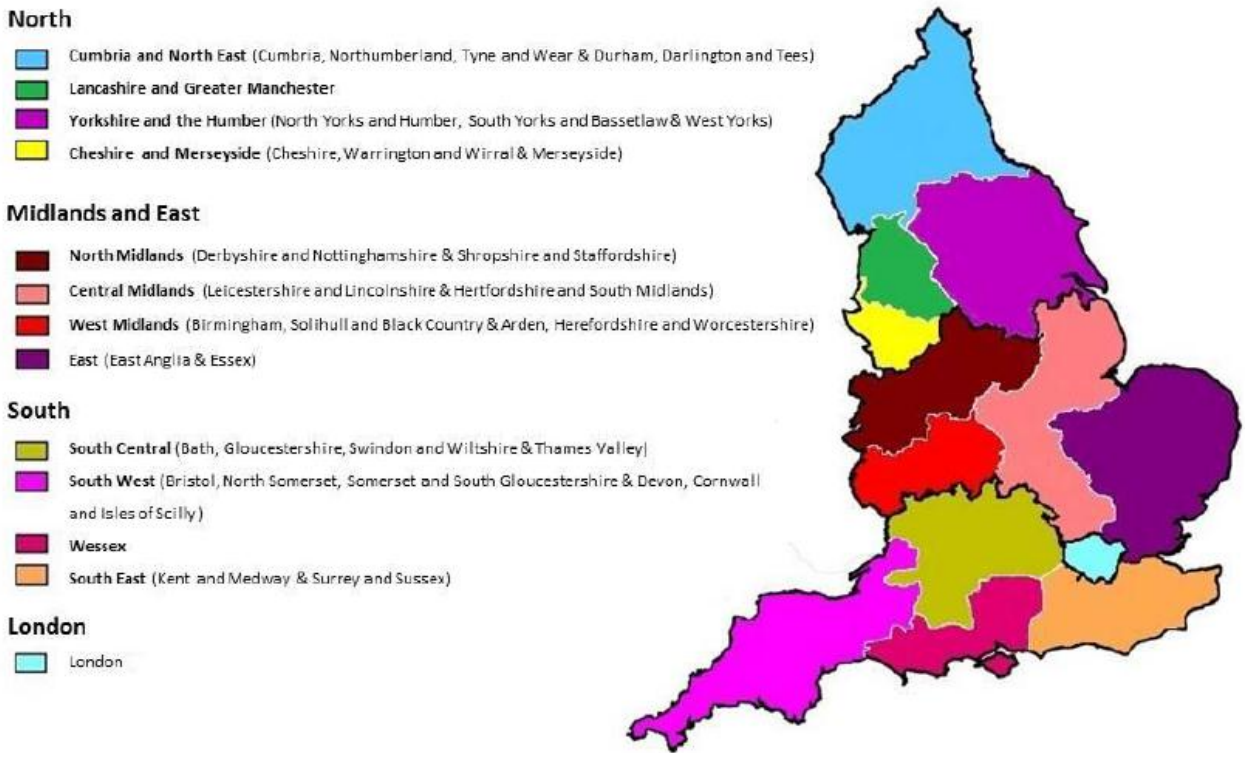
The role of LPNs has been set down in the Standard Operating Model and the key functions for LPN pharmacy leads are to:

- Support local authorities who lead on the development of the Pharmaceutical Needs Assessment which NHS England will use in commissioning pharmaceutical services
- Support the development of new programmes of work to promote self-care and improve long term conditions
- Work with CCGs to develop and implement the primary care strategy
- Work with patients and other health care professionals (outside of pharmacy) to develop a comprehensive programme of work aimed at ensuring medicines optimisation
- Support the sharing of learning from medication incidents and Serious Incidents Requiring Investigation (SIRIs)
- Develop multi professional working to address the items above
- Provide leadership to ensure robust commissioning of all locally enhanced services

There has been a 10% reduction in NHS England's running costs as the result of the recent review of the Organisation's Alignment and Capability Process (OACP).

NHS England before the review	NHS England , after the review, April 2015
4 Regions: North, Midlands and East, South and London	4 Regions
27 Area Teams	13 Regional offices , Area Team no longer exist
27 Local Professional Networks	27 Local Professional Networks, no change

A single, integrated team for each of the current regions has been developed. Four geographical locations have been identified in each region, taking into account factors such as numbers of relationships with CCGs, Trusts, Local Authorities, population size and patients flows.



NHS England Business Plan 2015-2016

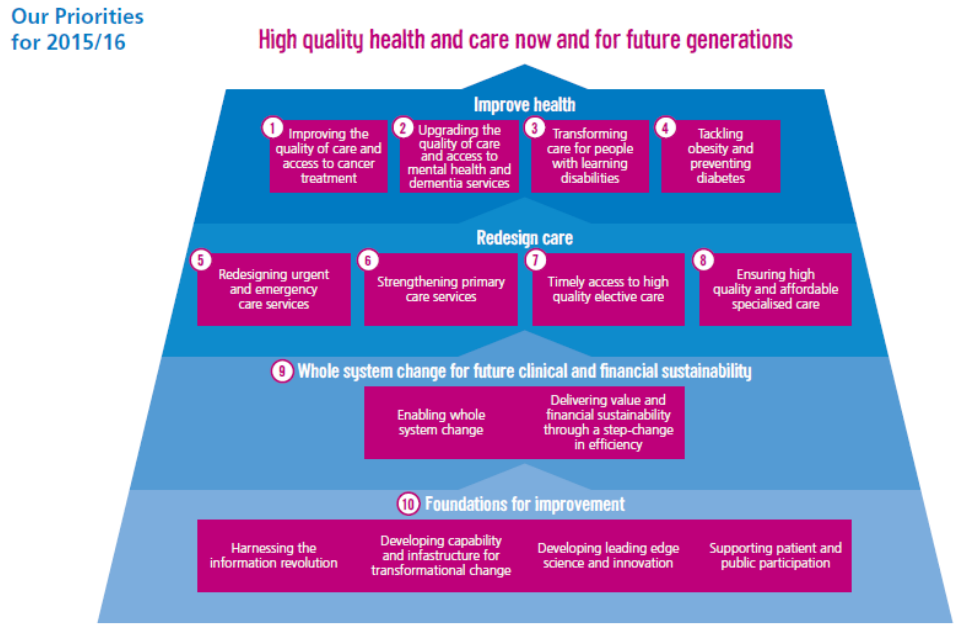
NHS England's Business Plan for 2015/16 sets out the priorities for action if the 5YFV vision is to be achieved. NHS England has set out 10 key priorities for the year (see diagram 3), and community pharmacy has a clear contribution to make in the following six areas:

- Improving health
    - Cancer – prevention, earlier diagnosis and better care
    - Mental health – better access to services and improve funding
    - Learning difficulties – more support and care required
    - Obesity prevention – see National Diabetes Prevention Programme (DPP)
- Redesigning care
    - Strengthen primary care – the foundation for personalised NHS care
    - Urgent and emergency care – reshape and respond effectively to increasing demand

When LPCs are making the case for community pharmacy with commissioners they should consider how they can present evidence of the pharmacy contribution improving health and/or redesigning care in these areas. Demonstrating how community pharmacy aligns with the NHS Business Plan is a critical success factor in securing greater commissioning of services.

The last section of this document expands on how community pharmacy can contribute to just one of NHS England's current priorities – urgent and emergency care redesign – as an example of the way the sector needs to be embedded across them all.

Diagram 3 NHS England Business Plan priorities for 2015/16



Workforce

Health Education England is a nationwide organisation, with local leadership and delivery managed through 13 Local Education and Training Boards (LETBs). HEE's mandate is set by the Department of Health, and for 2015/16 reflects strategic objectives around workforce planning, health education, and training and development. Health Education England have published their second **Workforce Plan for England**, setting out the £5bn worth of investments in education and training programmes it will make in 2015/16.

However, while the 5YFV outlines a national strategy for service transformation, we do not yet have a corresponding national commissioning strategy for workforce. This disconnect between workforce planning and service strategy needs to be resolved as a priority.

As part of this, the pharmacy sector at national and local levels needs to understand how its own workforce, and that of other professions, is developing, and how new roles are integrated into local pathways. This intelligence can then be shared with regional and national HEE to support strategy development.

Pharmacy Voice is working closely with HEE on the pharmacist education reform programme through our Pharmacy Workforce Development Group meetings and representation on HEE's task & finish groups. Pharmacy Voice has also supported HEE in surveying the community pharmacy workforce to identify current capacity and skills of the sector.

The role of community pharmacy in urgent and emergency care services (UEC)

Following the pressure experienced by the NHS during the winter of 2012/13, NHS England brought together various agencies to develop plans to respond more effectively to the demands being made on the system. One of the conclusions from the Urgent and Emergency Care Review was that

community pharmacy must be a key component in the delivery of the urgent and emergency care system of the future.

Consequently, NHS England published two documents designed to promote greater use of pharmacies as part of local urgent care pathways. *Community pharmacy: helping provide better quality and resilient urgent care* and its appendix[2] focuses on three services for commissioners to consider: flu vaccination; emergency supplies of repeat medicines; and a minor ailment service to support low income families or patients in areas of social deprivation to self-care.

Another recommendation from the Urgent and Emergency Care Review was that local health and social care systems co-develop strategies and collaboratively plan safe, efficient services for patients. The working groups bringing together stakeholders to do this are called **System Resilience Groups (SRGs).** SRGs are responsible for allocating 'winter pressures' funds. In January 2015 Pharmacy Voice analysed information on where funds for 2014/15 had been spent on pharmaceutical services, which showed this was mainly in the hospital sector.

The resilience planning guidance to CCGs for this year identifies eight 'high impact interventions' that every SRG is expected to address, and one of these specifically involves pharmacy:

> **Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management of falls without conveyance to hospital where appropriate**.

We recommended LPCs contact their SRG chair, CCG and LPN pharmacy leads to discuss how local contractors can support the winter pressures service in 2015/16, both in relation to this requirement, and other ways in which community pharmacy can contribute to U&EC transformation programmes. This might be through:

- **Self-management programmes:** Pharmacy First and Flu vaccination service
- **Reducing avoidable admissions to A&E**: Targeted Medicine Use Reviews, domiciliary services
- **Falls prevention:** (see e.g. medicines falls risk assessment in Doncaster (Click here)
- **Medicines management**: Pharmacy Urgent Repeat Medicines supply service
- **Managing emergency activity**: discharge planning and post-discharge support

Pharmacy Voice is working closely with colleagues in NHS England to identify and support opportunities for community pharmacy to maximise its contribution to improving urgent and emergency care, and to ensure there is a clear implementation plan for the sector. This includes supporting the goals of integrating community pharmacy into NHS 111 and local Directories of Services, and securing pharmacy access to Summary Care Records.

[2] http://www.england.nhs.uk/wp-content/uploads/2014/11/comm-pharm-better-quality-resilient-urgent-care.pdf and http://www.england.nhs.uk/wp-content/uploads/2014/11/comm-pharm-app-1.pdf

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Conclusion

This document has provided a brief overview of some of the policy drivers, organisational structures and service re-design initiatives currently shaping local strategies and decision-making arrangements across the health and care system. It is intended to provide pharmacy owners and local leaders with some insight and ideas on how to ensure community pharmacy is included in all discussions on how to transform health care and health outcomes over the next few years.

The Pharmacy Voice team would welcome feedback and comments on how useful this briefing is, what other information and support we could provide, and how pharmacy teams are engaging with local partners to implement new care models and approaches to health improvement.

About Pharmacy Voice

Pharmacy Voice is an association of trade bodies which brings together and speaks on behalf of community pharmacy. Formed by the three largest community pharmacy owner associations, together we are a stronger, unified voice for community pharmacy.

For more information about Pharmacy Voice visit our website: www.pharmacyvoice.com

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