How can primary care organisations better support community pharmacy development?

By Julie Morgan, Kelvin Cheung and Fiona Thorp

The community pharmacy contractual framework, introduced in April 2005, was designed to provide the foundation structure to support the modernisation of community pharmacy and pharmaceutical services. Pharmacy contracts also moved to being held locally by primary care organisations. PCOs thus became responsible for monitoring community pharmacies against the contract and for commissioning local pharmaceutical services under its enhanced services tier.

The 2008 White Paper “Pharmacy in England — building on strengths, delivering the future” sets out a national vision for pharmacy. It is clear that in order to be well placed to deliver this vision, pharmacies need to be meeting the contract’s essential services requirements as a minimum.

The purpose of our project was to evaluate the support offered by one Yorkshire primary care trust to its local community pharmacy providers in relation to contract and core contract essential services requirements.

Communication between PCOs and pharmacies is vital. The main methods of communication in use in the PCT involved in this study included a newsletter, quarterly pharmacy forum evening meetings and contract assurance monitoring annual self-assessments with periodic visits. The newsletter is published by the PCT every two months and covers current news, including practical issues relating to the community pharmacy contract.

The forum meetings are designed to encourage discussion about how best to tackle pharmacy contract challenges, service developments and to obtain opinions and feedback from the attendees. A formal overall evaluation of communication between the PCT and pharmacies had not previously been undertaken.

Repeat dispensing can be convenient for patients and improve their access to medicines. The Pharmacy Practice Research Trust reported in 2007 that repeat dispensing only accounted for around 1 per cent of total prescriptions dispensed. Primary Care Contracting (PCC) has nationally identified a topic for audit — the development of a repeat dispensing service; they include lack of start-up resource, patients and GPs not fully understanding the benefits of the service, reluctance to change practice, variations in staff competence and competing priorities. These barriers have also been echoed by a number of other publications.

Our study aims to explore PCO roles in supporting community pharmacy development. The primary care trust to its local community pharmacy counterparts and these differences may need to be recognised and addressed by commissioning PCOs. Good working relationships between pharmacists and GPs are essential and PCOs can help to facilitate this. Raising awareness of community pharmacy with patients and the public is also key and PCOs should support this. PCOs should be clear with community pharmacy providers regarding their roles and boundaries as commissioners of services.

The authors

Julie D. Morgan, PhD, MRPharmS, is lecturer in pharmacy practice at the University of Bradford.
Kelvin W. Y. Cheung and Fiona C. Thorp were undergraduate pharmacy students at Bradford University at the time of writing.

Correspondence to: Dr Morgan at Division of Pharmacy Practice, School of Pharmacy, University of Bradford, Richmond Road, Bradford BD7 1DP (e-mail j.d.morgan1@bradford.ac.uk)

Abstract

The Community Pharmacy Patient Questionnaire (CPPQ) is part of the clinical governance requirements of the contractual framework. Each community pharmacy is required to undertake a CPPQ annually, with the minimum sample size determined according to dispensing volume. Pharmacies are required to share key CPPQ findings with their local PCO.

Currently there is little published work relating to the CPPQ and we hope our study will help to further understanding of this topic.

Every year pharmacies are required to complete a minimum of two clinical audits as part of the clinical governance essential service, with the aim of continually improving their services — one multidisciplinary audit (topic determined by the PCO) and one practice-specific audit (topic determined by the individual pharmacy). The Pharmacy Practice Research Trust in 2007 found that only 67 per cent of contractors completed the practice-specific audit and 55 per cent the PCO-determined multidisciplinary audit.

Audit was also one of the three most commonly cited training needs in an evaluation of the community pharmacy contract in 2007.

Our study aims to explore PCO roles in pharmacy clinical audit by obtaining opinions from pharmacists.

Pharmacist and pharmacy support staff skill development is an important part of clinical governance. Which? magazine recently reported poor advice being given in one-third of pharmacies tested, indicating staff training gaps. Research was recently conducted by Schafheutle et al about pharmacy support staff in community pharmacy. The study identified that pharmacy support staff aged under 40 years had a greater interest in further training and career progression than older staff. Poor salaries were also identified as potential barrier to further training. As the roles of and services provided by pharmacies are evolving, the need for further training and development is increasing, so we have explored opinions regarding this in our study.

Public health campaigns are also part of the essential services in the community pharmacy contract, with each pharmacy expected to participate in up to six PCT-identified campaigns annually. It is the role of the PCO to determine the topics of the campaigns and to provide appropriate resources (eg, patient literature) to support them. We hope our study will help to clarify how PCOs can further support the implementation of such campaigns.

Aim
To determine how primary care organisations might better support community pharmacies in delivering contractual essential services.

Design
Postal questionnaire.

Subjects and setting
All 111 community pharmacies in one Yorkshire primary care trust.

Results
43% of pharmacies responded. Around 80% believed that PCT communication was adequate. One-fifth reported not having staff fully trained to provide repeat dispensing and 54% reported problems with implementing this service, including multidisciplinary communication issues. Problems conducting the Community Pharmacy Patient Questionnaire were reported by 24% and 38% did not feel adequately supported in this by the PCT (significantly more independents than multiples). Clinical audit remains an area in which pharmacists and staff would like more support/training. A need was expressed for more flexible pharmacist/staff training. Two-thirds of pharmacies felt adequately supported by the PCT for public health campaigns.

Conclusion
Many independent pharmacies require more support than their multiple pharmacy counterparts and these differences may need to be recognised and addressed by commissioning PCOs. Good working relationships between pharmacists and GPs are essential and PCOs can help to facilitate this. Raising awareness of community pharmacy with patients and the public is also key and PCOs should support this. PCOs should be clear with community pharmacy providers regarding their roles and boundaries as commissioners of services.
In April 2009, the Department of Health published the document “World class commissioning [WCC]: primary care and community services — improving pharmaceutical services”1. Following on from the 2008 White Paper,2 this document identifies how PCOs can and should apply the WCC competencies to the commissioning of pharmaceutical services. This is resulting in further changes to how pharmaceutical services are commissioned and the roles of PCOs within this.

The overall aim of our research was to determine how the PCT studied could better support its local community pharmacies in delivering the contract’s essential services, commissioning and the roles of PCOs within this.

We hope that our study will help to address some of the existing gaps in the published literature on this topic and we offer some advice to other PCOs accordingly.

Method

Our study comprised a structured postal questionnaire, with a mixture of closed and open questions in seven subsections – communication, repeat dispensing, CPPQ, clinical audit, staff training, public health campaigns and demographic information. The questionnaire was developed in conjunction with the PCT and with input from the local pharmaceutical committee. The draft questionnaire was then sent to 11 community pharmacists outside the area as a pilot, following which a number of minor amendments were made to the questionnaire structure and wording. Ethical approval for the study was obtained from the University of Bradford Ethics Committee.

The study population was all 111 community pharmacies in one Yorkshire PCT. Prior approval was sought via letter from superintendent pharmacists of all multiples, pharmacy committees and pharmacies in one Yorkshire PCT. Approval was also sought from pharmacy committees and pharmacies outside the area as a pilot, following which a number of minor amendments were made to the questionnaire, enabling non-responders to be identified and followed up. Any pharmacies not responding eight weeks after the initial mailing were classed as non-responders.

Data from the closed questions were inputted into a SPSS database. Descriptive statistics were used to determine the frequency of response to questions. Chi-squared tests were used to determine any significant correlations; Fisher’s exact test was used where numbers were too small to use chi-squared. Data from the open questions was entered into a Microsoft Excel database; responses were then categorised and tabulated where appropriate.

Results

A response rate of 43.0 per cent (37/86) was achieved. Of the pharmacies responding 16 (43.2 per cent) are situated in an urban area, 15 (40.5 per cent) suburban, four (10.8 per cent) rural, and two (5.4 per cent) undisclosed. The responses reflected the pharmacy demographics of the area (65 per cent multiples and 35 per cent independents).

The PCT pharmacy newsletter was perceived as an effective method of communication by 29 respondents (78.4 per cent). Table 1 shows attendance at the regular PCT-run evening “Pharmacy forum” meetings. Attendance by pharmacists working in multiple and independent pharmacies is not significantly different (P=0.953, Fisher’s Exact test). These meetings were deemed to be relevant by seven of eight pharmacy owners (87.5 per cent), 17 of 22 pharmacy managers (77.3 per cent), three of three employed pharmacists (100 per cent) and two of four locum pharmacists (50 per cent). Suggestions to improve PCT communication with community pharmacies included the “use of electronic communication” (nine respondents) and “direct contact with a dedicated PCT pharmacist for queries and help with new initiatives” (four respondents). Another suggestion was that “pharmacists should be able to gain access to the NHS intranet” (two respondents) to enhance communication between groups.

Dispensing staff were reported to be adequately trained in repeat dispensing by 78.4 per cent of the 37 respondents. Of the multiples responding 75.0 per cent reported that staff were adequately trained as opposed to 85.0 per cent of independents, although this difference did not reach statistical significance (P=0.182, Fisher’s Exact test). Overall, 36.1 per cent of respondents believed they were adequately supported by the PCT in the repeat dispensing service; an equal proportion thought they were not adequately supported and 27.8 per cent had no opinion. Problems with repeat dispensing were reported by 54.1 per cent of pharmacists — 38.3 per cent of multiples and 46.2 per cent of independents (P=0.478, chi-squared test). The main problems reported were “low uptake from GP surgeries” (18 respondents) and “low patient awareness” (three respondents).

Problems with implementing the CPPQ were reported by 24.3 per cent of respondents. Table 1 shows the percentage of pharmacies encountering problems by pharmacy type; these differences were not statistically significant (P=0.501, chi-squared test). Table 1 also shows the opinions of PCT support for implementation of the CPPQ. Overall, this was not thought to be adequate by 37.8 per cent of pharmacies — 29.2 per cent of multiples and 53.8 per cent of independents; this difference was significant (P=0.047, chi-squared test). The most commonly reported problems were the design and process of the CPPQ (four respondents), the “reluctance of patients to complete the questionnaires” (three respondents) and the fact that the CPPQ is “time consuming” (three respondents). Suggested improvements included “shorter questionnaires” (two respondents) and a “lower target response rate” (four respondents).

The most common recent pharmacy-specific audit topics included:

- Prescription interventions (16 respondents)
- Warfarin and clopidogrel prescribing (six respondents)
- Waiting times (four respondents)

Improvements suggested in PCT support for clinical audit in community pharmacy included the following:

- Improve clinical audit design and process (seven respondents)
- PCT/pharmacists to suggest clinical audit topics (five respondents)
- Topic relevant to community pharmacy (three respondents)
- Better support/direct contact/helpline (four respondents)
- Staff training (three respondents)
- Administration and monetary support (three respondents)
- Receive feedback on outcomes (two respondents)
- More notice before audit (two respondents)

A wide variety of suggestions was made with regards to future topics for multidisciplinary clinical audits. The most popular suggestions included “returned medicines” (three respondents), “prescribing for asthma and chronic obstructive pulmonary disease patients against National Institute for Health and Clinical Excellence guidelines” (three respondents), and “patient brand requirements” (two respondents).
Staff training was perceived to be supported adequately by the PCT by only 18.9 per cent of pharmacies; 37.8 per cent did not feel adequately supported and 43.2 per cent had no opinion. Table 1 shows a breakdown of the perceived PCT support for training of pharmacy support staff by pharmacy type. PCT support was not felt to be adequate by 25.0 per cent of multiples and 61.5 per cent of independents, although this difference did not reach statistical significance ($P = 0.136$, Fisher’s Exact test). A number of suggestions were given regarding ways in which the PCT could improve support for training of pharmacy support staff. Key themes were as follows:

- **Timing of training (10 respondents) —** eg, repeat sessions, flexible dates, evening training.
- **Type of training (10 respondents) —** eg, online training packs, in-pharmacy training.
- **PCT interface (five respondents) —** eg, dedicated PCT pharmacist for support and contact, newsletters for support staff.
- **Who the training is for or aimed at (four respondents) —** eg, independent pharmacies, counter staff, technicians, locums.

The questionnaire responses showed that 67.6 per cent of respondents felt supported by the PCT for public health campaigns; 77 per cent of independents and 63 per cent of multiples (Fisher’s Exact test). Only 8.1 per cent of respondents did not feel supported by the PCT for public health campaigns and 24.3 per cent had no opinion.

A number of comments, both positive and negative, were made regarding the perceived support from the PCT for public health campaigns. The main problem identified was “targeting and engaging with the public.” (four respondents). Suggestions for improvement included “more and varied types of publicity material” (two respondents), and “more instructions on how to carry out the campaign” (two respondents). Most respondents (67.6 per cent) thought campaign topics were relevant to their local populations; only 9.4 per cent though campaigns were not relevant and 27 per cent had no opinion. Analysis by pharmacy location and type did not reveal any significant differences in these opinions (Fisher’s Exact test).

**Discussion**

The response rate of 43 per cent was in keeping with average response rates for postal questionnaires. There were difficulties in obtaining superintendent pharmacist approval for the questionnaires to be sent to some multiple pharmacies, including one who refused to participate. The proportion of responses reflected the local split of multiple versus independent pharmacies and it is thus hoped that they are reasonably representative of the area studied.

Communication between the PCT and community pharmacies was generally perceived positively. Four-fifths of respondents agreed that a regular written newsletter is an effective method of communication; quarterly evening “Pharmacy Forum” meetings were also well received. Responses demonstrated that pharmacists value some face-to-face communication in addition to written methods. Communication could be further improved by making better use of electronic media, particularly the PCT website and some PCOs have already successfully done this.

Half of pharmacies reported encountering problems with the repeat dispensing contractual service and a fifth of pharmacies reported not having appropriately trained dispensers to deliver repeat dispensing. Although not statistically significant, more difficulties with repeat dispensing appeared to be encountered by multiple pharmacies than independents. It is possible the discrepancy is due to a higher turnover of staff, although further work would be needed to confirm this. The main barriers perceived included low uptake of the service by GPs, issues around pharmacy-GP communication and lack of awareness of the service by patients. These findings are consistent with other studies and are highlighted in the White Paper.

There were calls for the PCT to further support the implementation of repeat dispensing by facilitating increased collaboration between GPs and community pharmacists and promoting the service to healthcare professionals and the public. There is also an expectation that this is something that PCOs’ successes in implementing repeat dispensing have also highlighted the PCT’s role in supporting local initiatives.

A number of comments, both positive and negative, were made regarding the perceived role of the PCT in supporting training and development — both of which are national and local resources to support audit and practice-based audit support pack in addition to the national Royal Pharmaceutical Society audit templates (available via www.rpsgb.org) but some of the pharmacists responding to the questionnaire did not appear to be aware of these resources. It is noteworthy that this finding appears to contradict the largely positive views on communication between the PCT and pharmacies. Awareness-raising of existing national and local resources to support audit may help to further improve engagement with and quality of clinical audit in community pharmacy.

Almost two-fifths of respondents thought that the PCT did not provide adequate support for pharmacy staff training and development; more than half of independents but only a quarter of multiples. This discrepancy is likely to be due to multiple pharmacies receiving in-house staff training and support, whereas independents are more likely to need to seek external training support. Although the role of PCOs as commissioners — in relation to staff training and development — is now limited, PCOs have a role in signposting pharmacies and their staff to other existing sources of training and development opportunities, for example, through the Centre for Pharmacy Postgraduate Education, the National Pharmacy Association, local pharmaceutical committees and independent companies. There were calls for the provision of flexible, face-to-face training (offering options of daytime and evening sessions, and where possible in-pharmacy training) and distance learning and online training. Organisations and institutions offering training and CPD support to pharmacists, technicians and pharmacy support staff may wish to consider this as part of their development plans.

PCT support for public health campaigns was perceived as good, with only three and two respondents, respectively, disagreeing with the views that support is adequate and that the campaign topics are relevant to the local population. From the comments it appears that pharmacies particularly value relevant information that is sent out in good time.
before each campaign. Suggestions for further improvement included: use of more novel resources (in addition to posters and leaflets), tailoring messages to different communities (e.g., different socio-economic areas, use of community languages) and synchronising public health campaigns across different healthcare professions. Although some pharmacists liked the many and varied topics and linkage to national campaigns others believed more effort should be made to determine the needs of the target population in their local areas. This may well reflect the high diversity of the local population in this PCT. These findings echo those of an evaluation of pharmacy public health campaigns in Leicester, which has a similar diverse population to the PCT in this study.11 The findings also fit with current national strategy in using social marketing techniques to influence health-related behaviour. A good example of this is the targeting of public health campaigns to particular populations.

The local LPC was closely involved in this project, from the stage of questionnaire design right through to sharing of the findings. This was invaluable, both in facilitating the smooth running of the project and in disseminating and acting upon the findings. Importantly, it also enabled further consolidation of the PCT-LPC relationship.

It would be interesting to perform a similar study in other PCOs to determine whether there was a representative of community pharmacists’ opinions nationally. It is also possible that some of the trends towards differences seen would have reached statistical significance if the sample size were larger. Additionally, some of the issues identified may be worth further exploration, for example, via interviews or focus groups, to elicit more detail than is possible via a postal questionnaire alone.

Finally repeating this study in the future, following implementation of some of the recommendations, would enable the effectiveness of the interventions to be determined. Repetition of this exercise could also help the PCO to examine its progress against some of the pharmacy WCC competencies.7

Conclusion

Although some of the findings are specific to the area in which the study was conducted, it is likely that others will be more widely representative. There were some important differences noted between multiple and independent pharmacies, not all of which were expected. To recognise these differences in the context of provider development, PCOs may wish to consider more explicitly recognising, and where appropriate addressing, the different needs of multiple and independent pharmacies. It appears that some independent pharmacies look to the PCO to provide the kind of support that is provided by “head office” functions in multiple pharmacies (e.g., staff training, clinical audit, CPPQ support). The apparent confusion regarding the role of PCOs in relation to nationally negotiated services included in the core contract (notably CPPQ and clinical audit) highlights the understanding of some pharmacies about the deliverables included in the essential services part of the contract. This needs to be addressed by PCOs working towards pharmacy WCC competencies, particularly competencies 8 and 10. The importance of fostering good working relationships between community pharmacists and other healthcare professionals (most notably with GPs for repeat dispensing) was underlined and PCOs should prioritise this. Our study also further highlighted the importance of raising awareness of community pharmacy with patients and the public — particularly around repeat dispensing, the CPPQ and public health campaigns.

The relationship of PCOs with independent contractors, including community pharmacies, is evolving in line with the development of world class commissioning. We hope that the key findings from our study prove helpful to other PCOs when planning and reviewing their approaches to community pharmacy commissioning. In particular the tool of surveying community pharmacy contractors, with LPC involvement and support, and using the findings to inform PCO planning in relation to provider development has proved useful. We recommend that all PCOs consider conducting a similar survey of community pharmacy providers, perhaps on an annual basis, as part of the WCC assurance process and to that end we have provided some tips to improve community pharmacy commissioning (see Panel).

Top tips for improving pharmacy commissioning

Overall

- Support and facilitate the further development of closer working between community pharmacy and general medical practice
- Help to raise public awareness of community pharmacy, its role and services
- Undertake regular surveys of pharmacy service providers as part of the world class commissioning assurance process

Communication

- Face-to-face communication is important in addition to written methods
- Appropriate use of electronic forms of communication to community pharmacies (e.g., via e-mail, e-newsletters and newsletters)
- Ensure the PCO website includes up-to-date information and is easy to navigate

Repeat dispensing

- Facilitate increasing awareness of and support for repeat dispensing among general medical practitioners and the public, including promotion of the benefits of this service

Community Pharmacy Patient Questionnaire

- Consider ways of providing support for the CPPQ, especially for independent pharmacies (e.g., facilitate sharing of ideas between pharmacies)
- Consider providing pharmacies with feedback about overall CPPQ findings locally to enable pharmacies to benchmark themselves against others
- Raise awareness of the CPPQ and its importance with the public

Clinical audit

- Further raise awareness of national and local resources to support clinical audit

Staff training

- Signpost pharmacists and their staff to existing sources of training and development opportunities, and work with these organisations and institutions to help tailor support to your local needs

Public health campaigns

- Consider using more novel resources, ie, instead of or in addition to posters and leaflets
- In PCOs with high population diversity — consider tailoring campaign topics to local sub-populations as opposed to taking a PCO-wide approach

ACKNOWLEDGEMENTS

We thank the other members of the project team (Rasheda Khatun, Ashraf Manjotu, Sheryar Noor and Shamas Ul Haq), the pharmacists who participated in the study and Bradford LPC.

References