

PCTs' experiences of monitoring

Since October 2005, primary care trusts have had the responsibility of monitoring the implementation of essential and advanced services under the new community pharmacy contract. Dawn Connelly talks to primary care trusts about their experiences so far

For the past six months primary care trusts have been tasked with monitoring contractors' compliance with the new community pharmacy contract. The importance of differentiating this role from that of pharmacy inspectors has been something PCTs have been acutely aware of during the implementation process.

John Carr, professional executive committee pharmacist at East Staffordshire Primary Care Trust, along with the PCT's primary care manager, has conducted eight monitoring visits so far. He sees the visits as an extension of clinical governance, not as inspections. "We were sensitive to this feeling of threat, fear and anxiety that we were experiencing from group meetings with community pharmacists," he says. "The monitoring visit is purely to make sure that the service is being dealt with. The PCT cannot withdraw a contract on the basis of a visit," he adds. He believes that it is important to gain people's confidence and says that the worst thing PCTs can do is to go in with a "we can close you if you are not up to scratch" approach.

Shailen Rao, medicines management pharmacist at Hillingdon Primary Care Trust, is the lead for community pharmacy contract monitoring for the PCT and has accompanied the PCT's pharmacy development manager on monitoring visits. He advises PCTs to keep visits simple and be realistic about their expectations. "There is a real danger of being perceived as being heavy handed if we are not careful. We need to differentiate the role of the Society inspector and our obligations in the contractual monitoring process — it is difficult to separate the two."

Pilot visits

Mr Carr decided to conduct pilot visits before rolling out monitoring to the rest of the PCT, a strategy that he recommends to other PCTs. "Go to a friendly, knowledgeable pharmacist with whom you have a good relationship and who you are confident is likely to be an exemplar," he suggests. His first visit was to a pharmacy owned by the chairman of the local pharmaceutical committee. During the visit, Mr Carr used a document that combined the NHS Primary Care Contracting community pharmacy assurance framework (available from www.primarycarecontracting.nhs.uk) with a framework that had already been developed by the LPC. "That was one of the first things we changed. There was a lot of duplication across the whole document and the first visit took four hours," explains Mr Carr. He revised and consolidated the framework and developed a detailed portfolio of evidence that he would need to look for during each visit.

Both the framework and the evidence portfolio are sent to each contractor before the monitoring visit takes place and Mr Carr offers to visit pharmacies informally to explain the process. He also asks contractors to fill in the self-assessment tool (available as part of the community pharmacy assurance framework) before the visit. This is not essential but it does speed up the process, he says. He would also advise PCTs to read the "Top ten tips for conducting visits" available from the NHS Primary Care Contracting website.

During the visit, Mr Carr and his colleague work through the questions in the toolkit, examine the evidence provided and talk to members of staff. This is followed by a brief discussion and verbal feedback. Verbal feedback is backed up with a written report, which must be signed by the contractor and returned. "The very organised pharmacies we can now do in about two and a half hours," he says.

Issues arising from visits

"Issues that have arisen so far have generally been minor and have usually involved missing standard operating procedures," explains Mr Carr. He advises those monitoring the contract to make sure that SOPs are not just pieces of paper that are left on the shelf.

No major problems have been identified during the Hillingdon PCT visits, either. However, Mr Rao comments: "I get the feeling that pharmacists are starting to do things that they have never done before. Some of the systems are there but it is quite apparent that they are newly set up. I think in future years we will expect to see a bit more evidence that they are actually being followed."

He believes that although pharmacists may have been following the correct procedures before, it has been fairly informal. "Some clinical governance issues have already been highlighted, particularly around standard operating procedures for errors and incident reporting," he says.

Action points

Pharmacy contractors receive a written report which details any action that needs to be taken. Both PCTs say that the timeframe for this action is dependent on the nature of the missing evidence.

Mr Carr will revisit a pharmacy only if it is perceived that there is a danger to patients. "Unless we see something dangerous there would be no further action or immediate follow up," says Mr Carr.

Hillingdon PCT allows contractors three months to comply with any action points; less time if a serious omission has been identified.

Improvements

"I have heard of visits taking seven or eight hours, where PCTs have gone through every SOP in great detail. I do not think that is our role. If people start setting up processes this year then that is enough for a first step," says Mr Rao.

Mr Carr is convinced that the process of monitoring visits has changed pharmacy services for the better. "I believe that a lot of pharmacy services have improved by virtue of the preparatory work they have done for this because they have recognised what they do well, and what they did not do so well, and have addressed these issues."

IT developments

Some PCTs plan to use webtools in order to make the monitoring process more efficient. Hillingdon PCT has a secure website, which can be accessed via NHSnet. It was originally set up so that community pharmacists could update information about their services for the PCT's pharmaceutical needs assessment but has been developed further and is now used as a forum for sharing information. "All of the pharmacies in the PCT have access to the forum," he says. It is used to post all new information, such as strategies, advice, documents and tools, and for the pharmacists to communicate with the PCT and with each other, he adds.

The PCT also plans to transfer all paperwork relating to pharmacy services on to the website, including monitoring documentation, such as the community pharmacy assurance framework and the Pharmaceutical Services Negotiating Committee new contract workbook. Mr Rao explains that pharmacists will be able to log on with a password and fill in a pre-assessment form in advance of a monitoring visit. The PCT will then be able to update this form during the visit, and later produce an action plan electronically. "The website can also be used to share examples of good practice, such as SOPs, with other pharmacists within the PCT," says Mr Rao. He hopes to begin using the site for monitoring purposes during the next financial year.

A similar approach is being developed by Pritpal Thind of Caregrange Pharmacy in London. Pharmacies are able to record information about services they offer under the new pharmacy contract and submit that information to their PCT via a secure website. One benefit for PCTs is that much of the monitoring work can be undertaken before the visit and data provided by pharmacies does not have to be re-entered. For pharmacies, another version of the tool can be used to manage aspects of the contract that are subject to monitoring, such as recording and auditing clinical governance requirements or developing and updating SOPs.