

# Commissioning services and the new community pharmacy contract: (4) Governance and performance management

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## Abstract

### Aim

To identify and describe governance and performance management activity in primary care trusts in England relating to the provision of pharmaceutical services.

### Design

A self-completion questionnaire.

### Subjects and setting

All PCTs in England.

### Results

The response rate was 74%. 55% of PCTs knew the names of clinical governance leads for all community pharmacies in their locality. Respondents estimated that, by the end of June 2006, 55% of community pharmacies would have been visited to monitor attainment or maintenance of essential service specifications and clinical governance requirements. National templates have been produced for 10 of the 19 enhanced services, but use of these has so far been low. Training and accreditation requirements and the setting of targets for service activity levels both varied considerably between individual enhanced services and PCTs.

### Conclusions

Progress on monitoring the new contract for community pharmacy has so far been variable and many pharmacies have still not received a monitoring visit.

Setting standards and monitoring performance activity are central to the delivery of quality and equitable health services. Clinical governance was introduced through NHS policy in the late 1990s as part of a wider agenda to improve quality within the NHS. The clinical governance framework was designed to guarantee that minimum standards of care were met and to promote continuous improvement.<sup>1</sup>

Following the publication of "A first class service: quality in the new NHS",<sup>2</sup> which set out the proposed clinical governance framework, resources were made available to assist NHS organisations to execute their clinical governance function. With relation to pharmacy policy, the Royal Pharmaceutical Society published its strategy for clinical governance in pharmacy.<sup>3</sup> "Pharmacy in the future" then made recommendations to support clinical governance in community pharmacy<sup>4</sup> and pledged to encourage and reward quality pharmacy services, and the Department of Health published guidelines for implementing clinical governance in community pharmacy.<sup>5</sup> The strategy required primary care trusts to fulfil a number of actions by April 2002, including identifying a PCT community pharmacy clinical governance lead and ensuring that clinical governance requirements were built into services commissioned locally.

Thus, before the new contractual framework for community pharmacy was introduced, PCTs were already responsible for certain clinical governance functions, but there were no official requirements for community pharmacies to participate in the arrangements, although voluntary activity was encouraged. Clinical governance has continued to evolve and respond to developments in the wider health agenda such as the focus on a patient-centred NHS. Strategies such as "Building a safer NHS for patients"<sup>6</sup> make clear a requirement for professionals to be accountable for their work.

More recently, the new national contractual framework for community pharmacy sets out requirements for all essential and advanced services via the service specifications. The contract is supported by a clinical governance infrastructure which underpins the provision of all services. This framework incorporates a number of components, including the requirement that every community

pharmacy must have an identifiable clinical governance lead.

PCTs have had responsibility for monitoring the implementation of essential and advanced services since 1 October 2005. This is usually expected to be carried out through an annual visit to each community pharmacy. The NHS Primary Care Contracting team produced a guide to assist PCTs undertaking these "monitoring visits".<sup>7</sup> National templates have been developed to assist PCTs with the process of commissioning services locally through the enhanced services tier. These templates provide service descriptions and aims and suggest appropriate quality indicators, but do not specify standards. They exist for PCTs either to follow, or to adapt as appropriate when commissioning services locally. To date, templates have been developed for 10 of the 19 enhanced services.<sup>8</sup>

The aim of this paper is to identify and describe governance and performance management activity in PCTs in England relating to the provision of pharmaceutical services. Training and accreditation requirements for the providers of services and the setting of targets for service activity levels were used as indicators of clinical governance activity and performance management activity.

## Method

A questionnaire about the commissioning of community pharmacy services was sent to all PCTs in England in March 2006. Detailed descriptions of the research method, sample and topics covered have been provided previously.<sup>9</sup>

This paper presents findings from the questionnaire relating to clinical governance and performance management activity. Respondents were asked to state the number of community pharmacies for which the name of the clinical governance lead was known to the PCT and the number visited to monitor attainment or maintenance of essential service specifications and clinical governance requirements. Figures for the monitoring visits were collected at three different points in time — the end of December 2005, the end of March 2006 and the end of June 2006. The survey was distributed in March, so responses to these questions were based on visits that had taken place, as well as the number of the visits that the PCT planned to undertake at a future date (some

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of the March figures and all of the June figures).

For each enhanced service commissioned, respondents were asked to state whether the national template had been used. Details were also collected on whether service providers were required to undertake training, needed to be accredited or assessed, and whether targets for service activity levels had been set for each service.

Data were entered into SPSS v13.0 for analysis and explored using frequency counts and basic descriptive statistics.

## Results

Two hundred and sixteen PCTs returned completed questionnaires, giving a response rate of 74 per cent.

### Monitoring essential and advanced services

In total, the names of 5,324 community pharmacy clinical governance leads (70 per cent) were known to PCTs. One hundred and thirteen PCTs (54.9 per cent) knew the names of the clinical governance leads for all community pharmacies in their locality, while 23 (11 per cent) knew none.

By the end of December 2005, a total of 591 community pharmacies across all respondent PCTs (8 per cent) had been visited to monitor attainment or maintenance of essential service specifications and clinical governance requirements. Respondents estimated that by the end of March 2006 the figure would be 2,362 (31 per cent) and, by the end of June 2006, 4,168 (55 per cent).

In terms of PCT monitoring activity, eight PCTs (4 per cent) had visited all their local community pharmacies by the end of December 2005. The figures for March and June 2006 were 42 (20 per cent) and 94 (44 per cent), respectively. At the end of December 2005, 174 PCTs (81 per cent) had not undertaken any monitoring visits. The es-

**Table 1: Commissioning of enhanced services and use (and non-use) of national templates by primary care trusts**

Enhanced service	PCTs commissioning service		Not using template		Using template	
	N	%	N	%	N	%
On demand availability of specialist drugs	90	96.6	86	95.6	4	4.4
Out-of-hours	138	92.8	128	92.8	10	7.2
Minor ailments	111	90.1	100	90.1	11	9.9
Medicines assessment and compliance support	38	89.5	34	89.5	4	10.5
Supervised administration	189	87.3	165	87.3	24	12.7
Stop smoking	166	86.7	144	86.7	22	13.3
Needle and syringe exchange	184	85.3	157	85.3	27	14.7
Care homes	139	84.2	117	84.2	22	15.8
Medication review	29	82.8	24	82.8	5	17.2
Supplementary prescribing	11	62.5	5	62.5	3	37.5

timated respective figures were 89 PCTs (42 per cent) for March 2006 and 37 (17 per cent) for June 2006.

### Use and non-use of national templates for enhanced services

Table 1 shows the number of PCTs that had commissioned each enhanced service for which a national template was available, and the number of PCTs using and not using this. Non-use of templates was high, with a mean figure across all services of 86 per cent. On-demand availability of specialist drugs services had the highest figure, with 96 per cent of PCTs not using the national template, while the lowest figure was for supplementary prescribing, at 63 per cent. The average number of these services commissioned per PCT was five, with a range of one to 10. The proportion of commissioned services for which a PCT had not used templates ranged from zero to 100 per cent and the mean was 78 per cent.

In general, the more commonly commissioned services had slightly higher levels of template use than the less frequently commissioned ones, with the notable exceptions being supplementary prescribing and medica-

tion review services, which were the least commissioned services, but with the highest proportions of PCTs using templates (27 per cent and 17 per cent, respectively).

### Training, accreditation and target-setting for enhanced services

Table 2 shows the number and percentage of PCTs which had commissioned each of the 19 enhanced services, and the extent of use of locally agreed training for providers, accreditation of pharmacies and setting of service activity targets for each service.

Across all services, the average proportion of PCTs requiring providers to undertake local training was 56 per cent. The highest proportion (100 per cent) was found for anticoagulant monitoring.

On the whole, PCTs had fewer requirements for accreditation and assessment than for provider training, with a mean of 35 per cent across all services, while patient group directions (PGD) had the highest figure at 76 per cent.

Service activity level targets were not routinely set for the majority of commissioned enhanced services. The highest proportion

**Table 2: Performance management techniques used by primary care trusts commissioning enhanced services**

Enhanced service	No of PCTs providing service		Locally agreed training required		Locally agreed accreditation required		Local targets set for service activity levels	
	N	%	N	%	N	%	N	%
Anticoagulant monitoring	6	2.8	6	100.0	4	66.7	1	16.7
Care homes	139	64.4	97	69.8	54	38.8	32	23.0
Disease specific medicines management	10	4.6	7	70.0	5	50.0	1	10.0
Gluten-free foods supply	4	1.9	1	25.0	0	0.0	0	0.0
Home delivery	4	1.9	0	0.0	0	0.0	0	0.0
Language access	13	6	2	15.4	1	7.7	1	7.7
Medication review	29	13.4	19	65.5	15	51.7	9	31.0
Medicines assessment and compliance support	38	17.6	19	50.0	10	26.3	7	18.4
Minor ailments	111	51.4	81	73.0	67	60.4	18	16.2
Needle and syringe exchange	184	85.2	112	60.9	53	28.8	18	9.8
On demand availability of specialist drugs	90	41.7	23	25.6	21	23.3	6	6.7
Out-of-hours	138	63.9	8	5.8	13	9.4	12	8.7
Patient group direction	149	69.0	127	85.2	113	75.8	17	11.4
Prescriber support	17	7.9	9	52.9	6	35.3	2	11.8
Schools	2	0.9	0	0.0	0	0.0	0	0.0
Screening	12	5.6	8	66.7	3	25.0	3	25.0
Stop smoking	166	76.9	129	77.7	100	60.2	58	34.9
Supervised administration	189	87.5	120	63.5	79	41.8	16	8.5
Supplementary prescribing	11	5.1	7	63.6	7	63.6	0	0.0

was for stop smoking services, for which 35 per cent of PCTs had set targets (mean 14 per cent).

Across PCTs, the proportion of commissioned services for which PCTs required providers to be trained and accredited ranged between zero and 100 per cent, with the averages being 59 per cent and 41 per cent, respectively. The results of the survey showed that the setting of targets for service activity levels ranged from zero to 80 per cent, with an average of 15 per cent.

Training and accreditation requirements and the setting of targets for service activity levels varied between and within the 19 commissioned services. All services except home delivery and schools services had at least one of the three measures in place in some PCTs, but no service had consistent levels of all three in place.

## Discussion

Progress on monitoring the essential services in the new contract for community pharmacy has so far been variable. Nine months after becoming responsible for monitoring the contract, most community pharmacy clinical governance leads had been notified to PCTs, and visits had been conducted at over half of all pharmacies within the respondent PCT areas. However, 3,406 pharmacies were yet to be visited, and 17 per cent of PCTs had not begun the process. Previously, we have reported that PCT capacity, in terms of staff numbers, was a major barrier to the commissioning of pharmaceutical services.<sup>10</sup> As a result, commissioning staff may have found it difficult to meet the monitoring demands of the new contract. A comparison can be drawn with our findings and an earlier study of clinical governance in primary care, which identified a lack of sufficient staffing as a barrier to the successful implementation of clinical governance.<sup>11</sup> The authors contend that effective management of new directives in health care do not happen quickly but need realistic timescales. PCTs have only been required to monitor the new contractual framework for community pharmacy for just over 10 months. Therefore there is considerable scope for monitoring and governance activity to develop over time as the new contract beds down.

National templates are available for 10 of the enhanced services, but their use so far has been notably low. However, as over 80 per cent of enhanced services currently being provided were commissioned before April 2005<sup>12</sup> and the templates were not produced until September 2005, this is perhaps not so surprising. Local training is required for over half of enhanced services commissioned by PCTs and accreditation of providers is also fairly common. However, the setting of targets for service activity levels is much more limited. Parallels can be drawn here with the local pharmaceutical services contract experience, where, although commissioners of LPS pilots were required to set targets for services in the contracts, most LPS pilot sites failed to

meet their targets during the first 12 months of operation. Several PCTs commissioning services via the LPS contract had opted to shoulder the bulk of the financial risk for services.<sup>11</sup> Although this survey did not address the ways in which targets had been set or how successfully they are being met, financial outlay remains a pertinent risk for PCTs when commissioning enhanced services in particular because, unlike for essential and advanced services, there is no central funding available.

Most enhanced-level services were commissioned before the implementation of the new contract.<sup>13</sup> Generally, PCTs are more likely to require prior training and assessment of pharmacists and accreditation of providers for the services that are the most novel or involve the greatest risk. The level of inconsistency in commissioning criteria between PCTs, however, does raise questions about the quality assurance of enhanced-level services across England.

It is estimated that nearly half of community pharmacies still have to receive their first governance review related to the provision of essential services 15 months after the implementation of the new contract. Service targets have also not been set by most PCTs for the majority of enhanced-level pharmaceutical services.

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## The Society's museum

The Museum of the Royal Pharmaceutical Society maintains important collections representing the history, science and practice of pharmacy and the development of pharmacy as a profession in Britain. Since the Museum's establishment in 1842, the collections have grown to about 45,000 items.

Representative items from the museum collections are displayed in showcases in selected parts of the Society's headquarters building. Members and their guests can access these displays.

The collections also form an invaluable resource for researchers. They include:

- A fine collection of English pharmaceutical delftware
- Other ceramic items, including feeders, leech jars, advertising models and pot lids
- An extensive collection of mortars, including outstanding examples of bell-metal mortars bequeathed from the collection of the late Edward Saville Peck
- Pharmaceutical glassware, silver, pewter and treen used for storage, dispensing and display
- Instruments used for weighing and measuring in pharmacy
- Prints, paintings, photographs and ephemera illustrating a variety of pharmaceutical and medical subjects
- Parts of the reference collection of materia medica for which the collection was originally formed in 1842

Most of the items in the collections are kept off-site, safely stored for future generations. However, the museum's plans for the future focus on developing the collection's potential as a resource for learning, for schoolchildren, university students, community groups and web-users and through loans to other museums.

Since January 2002 the museum's collecting policy has also taken a new direction, to enable the collection's relevance to be maintained for now and the future. This new focus means concentrating on the collection of historical and contemporary proprietary medicinal products and material.

Further information on the museum and its services can be obtained from the museum office (tel 020 7572 2210; e-mail [museum@rpsgb.org](mailto:museum@rpsgb.org)).