



The
pda
Road Map

October 2013

Reducing unnecessary A&E attendances and avoidable hospital admissions in England

A proposal by the Pharmacists' Defence Association

| representing **your** interests |

Foreword

The PDA's Road Map

The good news is that despite demographic changes in society that will create even greater pressures upon the healthcare system, the NHS has signalled its commitment to delivering high quality care for all, now and for future generations and consequently, it is prepared to develop new and radical approaches to delivering high quality services for patients.

Sir David Nicholson has stated that some people, who present at A&E, would have more appropriate care and a better patient experience if they were seen in a primary or a community care setting. These may be people with long term conditions that need careful management, or people who are having problems getting an appointment at their local GP surgery.

In views expressed by both the Royal College of General Practitioners and the British Medical Association, they have stated that Practice capacity will be critical in determining practices' ability to improve patients' experience of urgent care.

I completely agree, and I believe that this submission from pharmacists will go some considerable way in assisting.

This proposal concerns itself with a dramatically improved primary care capacity which focuses upon reducing unnecessary A&E attendances and avoidable hospital admissions. Whilst it dwells upon the improved contribution made by pharmacists, it is in fact a much broader proposal that seeks to increase the capacity of both secondary care and especially primary care by a better integration of the services provided by GPs, pharmacists and other healthcare professionals.

The evidence shows that one in six emergency admissions to hospital in England at a cost of £1.42bn a year could have been successfully managed in primary care. The effect of this proposal would be to allow far more of these patients to be cared for in the much more convenient and far less costly primary care setting.

Most importantly of all, these proposals if taken up could lead to a vast improvement in the patient journey.

The Rationale

The members of the PDA are not the owners of pharmacy businesses, they are the employee and locum pharmacists who each day, find themselves at the very cutting edge of direct patient care. Historically, the government, when it considered pharmacy, usually placed 'pharmacy premises' and the important location that they occupy within the community at the core of its thinking. Although this is to be celebrated, a much wider and more strategic consideration of pharmacy service provision, one freed from solely a dependency upon ownership of a pharmacy premises, reveals the exciting opportunities offered by the many thousands of highly specialised individual practitioners. Such a consideration offers additional and much more powerful possibilities for the NHS and for patient care.

Many of these pharmacists have specialist qualifications and more than 2,000 of them are qualified as independent prescribers and yet few of them are currently utilising these qualifications.

The professional and intellectual skill and expert knowledge held by these individual pharmacists is a valuable but underutilised NHS asset, which the NHS must now harness for the benefit of patients.

The current A&E crisis represents a major opportunity to develop improved and more integrated primary care contracting arrangements which would see individual pharmacists making a more comprehensive contribution to the delivery of the Government's vision of an improved NHS and in providing sustainable high quality healthcare for patients into the future.



Mike Sobanja

Co Founder and Policy Director
NHS Alliance

Introduction

How pharmacists can make a much greater contribution to the challenges faced by the NHS

The Pharmacists' Defence Association (PDA) is a not for profit defence association and trade union for pharmacists. We are the only organisation that exclusively looks after the interests of employee and locum pharmacists across all sectors of pharmacy, and we currently have more than 22,000 individual pharmacists in membership, the majority are working in the community pharmacy setting.

The activities of the PDA in defending our members should they find themselves involved in a critical incident situation, provide us with a rich vein of up to date experiences that have informed our policies and future strategy. The proposals put in this document are largely built upon this experience, they are overlaid onto the current challenges facing the NHS and they are also reliant upon the views of other healthcare professionals and patients gathered through consultation.

We believe that patients receive the best healthcare when the healthcare professionals charged with their care are able to perform to the highest standards of professionalism and in a system that allows them to apply their unique skills to best effect. Consequently, wherever possible, any systems that create unnecessary barriers need to be re-designed and any impediments to professionalism should be removed. This proposal seeks to enable that, by underpinning professionalism through new contracting arrangements and by being built upon a much more integrated primary healthcare service platform than has hitherto been the case.

In recent years, a large number of new initiatives have been delivered by community pharmacies on a walk in basis; an excellent example of this would be the healthy living pharmacy programme. Despite this however, pharmacy is still seen as a significantly underutilised resource within primary care.

We believe that the integrity of the network of community pharmacies is crucial. However, the existing pharmacy contracting arrangements should be complimented by additional ones that enable services that are much more clinical and integrated within the primary care system to be delivered by individual pharmacist practitioners probably through independent group practices created by pharmacists. As well as providing improved care for patients, the integrated nature of these new services would release significant GP capacity helping surgeries to be able to better handle acute presentations and to operate virtual wards therefore reducing the pressure on secondary care.

Surveys of PDA members indicate that many of them relish the prospect of being able to take greater clinical responsibility for their patients. Many have highly ambitious and creative aspirations for providing vastly superior and much more clinical services to patients out in the community than they are able to currently; helping to keep them out of hospital. These aspirations, if harnessed properly could go a long way in assisting with the significant challenges faced by the NHS both in the short and long term. However, these pharmacists will need much greater professional autonomy and flexibility than they currently enjoy as predominantly retail employees if they are to achieve this. It is important that they are not hampered by a corporate retailing agenda if they are to be able to develop clinical relationships with patients.

The proposals put in this submission build strongly upon that ambition. They describe practical measures that are specifically directed at trying to prevent unnecessary attendances to A&E and at preventing avoidable hospital admissions.



Mark Koziol

Chairman

The Pharmacists' Defence Association

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> Section 1 – Summary of our proposals

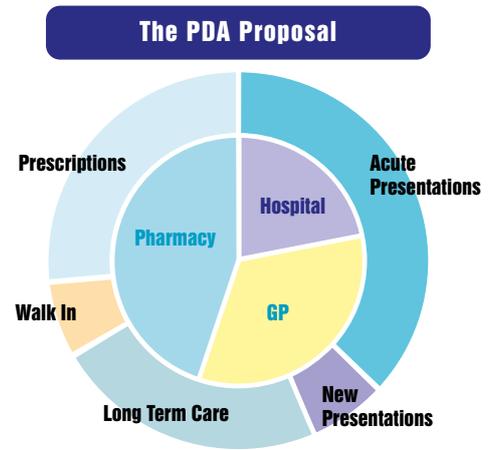
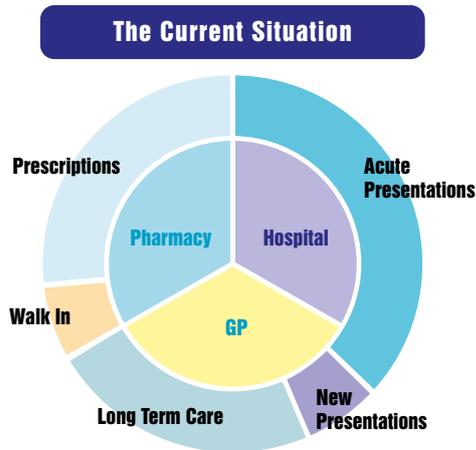
This section provides a high level overview of our proposals and the thinking that underpins them.

Our proposals – a summary overview

- 1.1** As NHS England starts to look at how it addresses the rising pressure on A&E and begins to review the GP contract¹ and then potentially the wider primary care contracting, we believe that the time is right for it to consider the part that Pharmacists should play. We have been developing our thinking for strategic change in community pharmacy over the last two years and we have called this initiative the PDA Road Map. We strongly believe that redesigning services to include a more structured input from Pharmacists will play a part in reducing A&E attendances, hospital admissions, improve primary care outcomes and assist in creating more capacity in primary care.
- 1.2** There are three key areas of thinking that underpin the PDA proposals. Firstly there is the current underutilisation of the skills of primary care healthcare team members, including GPs, but especially pharmacists' clinical skills in dealing with the public. In part this is seen as a consequence of the current pharmaceutical service contracting arrangements. They have been largely in place for over 20 years and until relatively recently, when the concept of 'supply plus' services was introduced, focused largely on the act of dispensing prescriptions. Over time the shift has been from contracts held by independents to contracts held predominantly by large corporate pharmacy multiples, supermarkets or chain stores. And with that has come an increasing focus on commercial/financial return factors, rather than the provision of professional or clinical services for the benefit of patients and the public at large.
- 1.3** Secondly, the lack of collaboration and integration between community pharmacy and general medical services, which has led to failures in continuity of patient care leading to unnecessary hospital admissions and increased adverse drug reactions/medicines wastage.
- 1.4** Thirdly, our proposals are also predicated on a much more efficient and effective use, by both the NHS and patients, of the physical buildings that currently make up GP surgeries and community pharmacies.
- 1.5** In short, the PDA proposal is for specialist Pharmaceutical Care Services (PCS) to be provided through a separate contractual mechanism that is independent of the current community pharmacy contract for medicines supply. A range of new and more integrated services would be provided by a new two tier categorisation of community pharmacists, i.e. 'patient facing' and 'clinic' pharmacists. The focus of this proposal would be to enable the 'patient facing' pharmacist to provide a reactive and proactive service to patients walking into the pharmacy without an appointment, and for the 'clinic pharmacist' to provide more detailed Pharmaceutical Care Services to people with long term conditions (LTCs) on a registered patient appointment-led basis.
- 1.6** The 'patient facing pharmacist' would become much more accessible to the public and would be able to operate a national Minor Ailments Scheme, providing medicines and advice on minor ailments to the public through the NHS.
- 1.7** The 'clinic pharmacist', who would be an independent (non-medical) prescriber, would provide a range of professional and specialist Pharmaceutical Care Services to patients that have previously been diagnosed by the GP and that at present are largely handled in general practice, but which under new arrangements would be passed on a caseload basis to the 'clinic pharmacist'. The pharmaceutical care services provided by the 'clinic pharmacist', would not simply seek to substitute the services currently being provided by the GP or practice nurse, but they would deliver detailed pharmaceutical care providing significant added value to the interaction through an expert focus upon the medicines being taken by the patient leading to an improved patient journey.

References

1. Praities N. GP contract to undergo 'fundamental review' this year, says NHS England chair. 1 May 2013. Available at: <http://www.pulsetoday.co.uk/your-practice/practice-topics/practice-income/gp-contract-to-undergo-fundamental-review-this-year-says-nhs-england-chair/20002833>.article (accessed 13 August 2013).



- 1.8 It is this combined transfer of service responsibility and accountability which serves to release GP capacity that is at the core of these proposals. This will enable GPs to use their skills to much better effect by providing greater front line attention to patients with more complex conditions, those 'at risk' of hospital admission and orientating their surgeries so that they can become more responsive to acute presentations.
- 1.9 The funding of these proposals is predicated on the fact that they seek to reduce the number of unnecessary A&E attendances and avoidable hospital admissions and other benefits besides and in so doing they transfer patient care from secondary care into the much less costly primary care setting.
- 1.10 Delivery of this vision will require genuine collaboration, integration and then contractual alignment across the medical and pharmaceutical professions in primary care. It will be supported by the already much more clinically orientated education and training of pharmacists at both undergraduate and practice levels. This vision will also need to be linked to revised mechanisms for service provision and workforce planning. This submission includes proposals to these ends and, importantly, to ensure that the benefits of the new approach extend to the areas of residential care homes and persons living in remote and rural areas.
- 1.11 The submission has been split into sections. Some issues or topics will feature in one or more sections, so for ease of reference the section summaries are collectively provided below.

Section 1 – Summary of our proposals: provides a high level overview of the proposals and the thinking that underpins them.

Section 2 – Background: sets out the financial and strategic background against which the PDA proposals have been developed, and the need for change to the current community pharmacy contractual arrangements.

Section 3 – Foundations for the PDA Road Map: sets out the basic tenets upon which the PDA Road Map is built. It highlights the need for multidisciplinary co-operation in the primary care sector, provides a definition of pharmaceutical care services, and summarises the pharmacy workforce structure to underpin their delivery.

Section 4 – Utilising released and new healthcare service capacity: expands on how and where the released and new service capacity outlined in Section 3 could be utilised. It describes how that capacity should be used to improve care regimes for patients with long term conditions and increase the focus on preventing hospital admissions, through a combination of close monitoring of 'at risk' patients, adopting a 'virtual ward' approach, and reducing the incidence of adverse drug reactions and medicines wastage.

Section 5 – Contracting for Pharmaceutical Care Services: argues the case for new contractual arrangements in primary care, based on the need for clear professional autonomy and the removal of conflicts between a contractor's commercial and a pharmacist's professional interests. It calls for separate contracts for supply and pharmaceutical care services, sets out the principles underpinning this approach, and provides a number of contract models for delivering Pharmaceutical Care services.

Section 6 – Other contracting issues: expands on Section 5 by detailing a number of specific issues that should be addressed through Clinical Commissioning Groups (CCGs) overall contract and service planning arrangements. These are:

- The need to make better use of, and to further develop, the effectiveness of the existing pharmacy premises network
- Greater cross-collaboration between pharmacies and collaboration with dispensing doctors
- Improved service availability and access in remote and rural areas
- Dedicated PCS for people in residential care homes
- ‘Clinic pharmacists’ accredited in the delivery of specialist services.

Section 7 – Information sharing and IT: endorses Royal Pharmaceutical Society (RPS) and Royal College of General Practitioners (RCGP) statements regarding the need for GP/pharmacist collaboration in redistributing the workload for the benefit of patients and in working more closely on integrated training and service development. It considers sharing patient data, further IT development of data access and transfer facilities, and provides a number of IT development areas worthy of priority for pharmacy and wider NHS use.

Section 8 – A patient focus: summarises the patient benefits that would accrue from the introduction of ‘clinic’ and ‘patient facing’ pharmacist services and consequential increase in GP capacity. It supports the complementary development of ‘pharmacy walk-in services’, and outlines the patient safety needs in terms of self-care and the community pharmacy environment.

Section 9 – Workforce, education and training: outlines the current workforce position and the need to build upon current pharmacy education and training to underpin the PDA’s proposed Road Map approach. It describes a clinical career pathway and its postgraduate support and development requirements, and the need for these to be on a multidisciplinary footing with other healthcare professionals. Finally it outlines the education and training needs for pharmacy technicians and support staff.

Section 10 – Finance: summarises the areas of investment and possible savings associated with the PDA Road Map proposals, and provides a high level indication of the financial implications. This is based on the assumption the proposals will be subject to detailed cost analysis by NHS England.

> Summary of the main recommendations

The following is an edited summary of the underpinning key recommendations:

1. Pharmaceutical Care is defined as:

“A patient-centred practice in which the practitioner assumes responsibility for a patient’s medicines-related needs and is held accountable for this commitment.”², (Paragraph 3.11)

2. There needs to be a fundamental enhancement in the current skill mix and workforce structure within community pharmacy resting on three categories of personnel, i.e. registered pharmacy technician, patient facing pharmacist and clinic pharmacist (working within a structured career/quality framework). (3.17)

Increasing capacity through innovation and collaborative working (Sections 3 and 6).

We recommend:

3. A nationally funded Minor Ailments Scheme (MAS) is established in England and that this scheme is publicised widely so as to encourage the transfer of patients currently visiting their GP surgery or their local A&E department to receive their advice and medicines for minor ailments from the local community pharmacy. (3.10)

4. That Pharmaceutical Needs assessments (PNAs) undertaken by Health and Well Being Boards take account of the need for Pharmaceutical Care Services and highlight possible contract and service provision changes that may be required and... (3.18)

5. That the PNAs identify where, in geographical terms, the services of clinic pharmacists should be made available to the public, stipulating the number and grade requirements to meet both general Pharmaceutical Care Services (PCS) (providing Pharmaceutical Care to patients on long term conditions) and the more specialist patient needs such as end of life care around care homes and hospice locations. (3.19, 6.5, 6.12)

6. That over and above the English Community Pharmacy Contractual Framework (CPCF) there should be three additional services provided; A Minor Ailments Scheme (MAS), a Public Health Service (PHS) and a Pharmaceutical Care Service (PCS). (3.22)

7. Whereas MAS and PHS may be commissioned nationally to be provided by patient facing pharmacists employed by CPCF holders, PCS should specifically detail two distinct areas which would be provided exclusively by appropriately qualified ‘clinic pharmacists’ working under separate local contractual arrangements. These are patients in the community who have relatively stable long term conditions (LTCs), and patients in residential care homes. (3.22, 3.23, 3.24, 3.25, 6.9, 6.10)

8. The PNAs should also provide for one or more clinic pharmacists to serve a wider geographical area by working across a number of pharmacies, and even other locations such as residential homes on different days. (6.5)

Utilising released and new healthcare service capacity (Section 4)

9. Encouraging collaborative management of long term conditions by pharmacists building up a list of registered patients and delivering Pharmaceutical Care by either GP referral or direct patient registration. The pharmacist will be responsible for delivering continuity of care through developing clinical relationships and establishing care plans co-designed with individual patients that are subject to regular review. (4.2); and that...

10. PCS is taken forward through a combination of new contractual structures that seek to make individual pharmacists (and not large corporate retailing organisations) both responsible and accountable for patients’ pharmaceutical care needs, and promote more integrated and collaborative working between GPs, pharmacists, and other members of the primary healthcare team. (4.4)

Incentives to reduce hospital admissions

11. That the 2012 QOF initiative to produce plans for reducing hospital admissions should be further encouraged by being subject to continuing QOF or healthcare quality targets. (4.6)

References

2. Cipolle RJ, Strand LM, Morley PC. Pharmaceutical care practice: the clinicians guide. 2nd ed. New York: McGraw-Hill; 2004.

Avoiding unnecessary A&E attendances through greater access to urgent care

12. Surgeries should become more orientated to handling acute presentations and so prevent patients from presenting to A&E departments unnecessarily. ; (4.7) and that...

13. The initiative as a whole is incentivised through new and improved contractual arrangements for GPs – supported by a strategy and funding to provide for the establishment or upgrading of suitable premises; (4.7) and thereafter...

14. Availability of GPs' urgent care service is subject to a high profile public information campaign. (4.7)

Preventing hospital admissions through smarter care of patients

15. Use enhanced general practice capacity in a proactive way to operate a virtual ward approach across the whole of England; (4.8, 4.9, 4.10)

16. A clinic pharmacist is actively involved in the virtual ward team, (4.9) aided by...

17. The national development of a combined predictive tool/model to underpin the necessary risk stratification requirements. (4.11)

18. GPs to refer patients already diagnosed with LTCs to suitably qualified clinic pharmacists and that the QOF point system for GPs is used to incentivise this. (4.6, 4.12)

Reducing adverse drug reactions through Pharmaceutical Care

19. Clinic pharmacists through Pharmaceutical Care to provide educational information, medicines use optimisation services and support to patients enabling them to take greater control of their medicines regimes. Such interventions would aim to support patients in enabling them to take greater control of their medicines regimes. (4.16)

Reducing medicines wastage through Pharmaceutical Care

20. Emphasis should be on health outcomes rather than waste reduction alone. (4.21) To this end...

21. Future QOF indicators proposed at (4.6), and outcome measures in both the GPs' and community pharmacy contracts, should focus initially on the following therapeutic areas: asthma, diabetes, raised blood pressure, vascular disease and care of people with schizophrenia. (4.20, 4.21)

Contracting for Pharmaceutical Care Services (Section 5)

22. Contracts for detailed pharmaceutical care services (PCS) should rest either with individuals who are pharmacists – or with vehicles that are independent of the corporate retailing culture that currently prevails within community pharmacy. (5.7) And...

23. Such contracts should, through commissioning principles, commit contractors to high standards of professional healthcare delivery and be supportive of professional independence of pharmacists. (5.7)

24. Separating the contract for supply (and 'supply plus' services that are directly associated with the supply) from the contract for the delivery of Pharmaceutical Care Services (PCS) (5.8).

Note – a full list of recommended principles to underpin this contractual approach is found at 5.12.

Other Contracting Issues (Section 6)

25. The creation of a modernised pharmacy network through the further development of consultation rooms in community pharmacies to host a wide range of healthcare services. (6.2)

26. Collaboration between clinic pharmacists and community pharmacies in terms of shared access to, and between, pharmacy premises. (6.3 and 6.4)

Information sharing and IT (Section 7)

27. Patient facing and clinic pharmacists to have formal IT access to key patient records that lie outside the pharmacy, e.g. laboratory results, discharge letters, etc. (7.1)

28. Increased sharing of patient information between general practice and pharmacists. (7.2)

29. Integrated patient care records available for both primary and secondary care that are readily accessible through IT to all appropriate healthcare providers. (7.2)

Workforce, education and training (Section 9)

30. Redesigning pharmacy training via a new five year training programme that seeks to integrate work placement, educational teaching and practical patient-facing clinical experience, as well as training which is more integrated with that provided to future doctors and nurses. (9.10)

A clinical career in community pharmacy

31. The introduction of a structured career framework in community pharmacy with financial incentives for skills and competency development through training. (9.11)

32. Pharmacists being able to work at practitioner, advanced practitioner, specialist and consultant levels. (9.13)

Postgraduate development

33. Patient facing and clinic pharmacists to have ready access to a central resource centre coupled to on-going support and peer review access to maintain and develop specialist skills and career progression. (9.14)

34. Widen the current approach for support and peer review to include other health professionals as the delivery of community care becomes more collaborative and integrated. (9.16)

Finance (Section 10)

35. A nationally co-ordinated and well promoted media campaign, should aim to transfer 40 per cent of GP minor ailment consultations to community pharmacies, i.e. 470,000 consultations per week. (10.5)

36. The clinic pharmacist service would rely on LTC patient registration via GP and wider care pathway referrals. The additional capacity created for GPs would need to be used to re-orientate their services to make them more responsive to acute presentations and to further focus their attention upon avoidance and prevention of hospitalisation through a virtual ward approach. (10.2)

37. The management of a wider transfer of patients with minor ailments from GPs to pharmacists would require some investment in the pharmacy workforce through skill mix to allow registered pharmacy technicians to deal with the mechanics of dispensing, whilst releasing pharmacists to be able to spend most of their time in a much more patient facing role. (10.6)

38. The PDA's Road Map proposals are subjected to detailed cost analysis within NHS England. (10.19)

> Section 2 – Background

This section sets out the financial and strategic background against which the PDA proposals have been developed, and the need for change to the current community pharmacy contract arrangements.

Healthcare – the big picture

2.1 The Government's strategy for the NHS is set out in the white paper "Equity and excellence: Liberating the NHS".³ The reorganisation of primary care with the abolition of PCTs and the creation of Primary Care Commissioning Groups is an enabler of the more fundamental objectives, specifically;

- Putting patients and public first
- Improving health outcomes
- Empowering health professionals and making them more accountable for the results they achieve.

This strategy is set within the context of rising demand and patient expectations; however public spending is constrained as a result of historic debt and a slow economic recovery.

2.2 NHS England's healthcare budget for 2013-14 is £95.6 billion, an increase of 2.6 per cent on the previous year, 0.6% in real terms.⁴ In addition to the planned increase in funding the NHS is expected to achieve substantial efficiency savings (£20 billion by 2014) and reduce administration costs by 45%.⁵

2.3 Whilst the Government is committed to real terms increases in NHS funding, issues such as the ageing population, new technology and the cost of drugs mean that the NHS will still face considerable budget pressures. The treatment and care of people with long-term conditions (LTCs) was estimated to account for 70% of the total health and social care spend in England in 2010, so large increases in the number of older people with LTCs will create significant extra costs; total net public expenditure on social services and continuing health care for older people is projected to increase in real terms

by 37% from 2010 figures by the year 2022, thus a substantial rise in cost is anticipated just to keep pace with demographic change.^{6,7,8} Rapid innovation in the way that services are designed, delivered and rolled out is required.

Primary Care Services

2.4 The cost of the Medical and Pharmacy services in 2011-12 was approximately £19.7 billion, of which £8.4 bn was on General Medical Services (GMS); £8.8 bn was on prescribing costs; and £2.5 bn on Pharmaceutical Services.⁹ This is a considerable proportion of the overall healthcare budget and, together with the Government's Strategy objectives, presents a significant challenge in considering the future service and contractual needs for community pharmacy and GMS.

Community pharmacy contracts

2.5 Today more than 90 per cent of pharmacists are either employees or self-employed locums, and only a very small minority of pharmacists actually own a community pharmacy.^{10,11} This means that the professional skills and ambitions of many community pharmacists may well be restricted by the commercially conflicting interests of their employers and it has become increasingly difficult to empower pharmacists professionally and hence make them accountable for the results they achieve. Therefore the PDA approach is radical in parts and freed from the desire to protect existing business models. Nevertheless, we share substantial common ground with the pharmacy bodies that represent owners of pharmacies and our proposals are predicated on the need for a strong community pharmacy network

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- Equity and excellence: Liberating the NHS. Department of Health, July 2010.
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- Ready for Ageing? Select Committee on Public Service and Demographic Change, House of Lords, March 2013.
- Community pharmacy contractual framework (CPCF) funding settlement 2011/12. Department of Health, Gateway reference: 16606, 8 September 2011.
- Seston E, Hassell K. Pharmacy Workforce Census 2008: Main findings. RPSGB, 2009.
- Register of Pharmacy Premises. General Pharmaceutical Council, 2013.

- 2.6** At a macro level the current community pharmacy contract arrangements comprise two combined elements – the procurement, dispensing and supply of prescribed medicines, and the provision of professional medicines related advice as and when required. It has been this way for over 20 years, albeit with operational and service enhancements introduced by the government along the way. In particular, successive governments have:
- Incrementally honed medicines procurement and GP prescribing practices to secure better value for money and at the same time deliver more effective patient outcomes.
 - Made considerable financial investment in pharmacies' infrastructure, notably in the provision of IT through the roll out of EPS1 and EPS2.
 - Developed the concept of additional 'supply plus' services that have been provided alongside the supply function, i.e. services that are more patient focused with emphasis placed on providing professional advice/support so as to support compliance with medication regimes.
- 2.7** Over time the development of the pharmacy network has delivered probably the most efficient supply of prescription medication in Europe. However, significant weaknesses remain in the system:
- (i) The potential conflict between a contractor's commercial and a pharmacist's professional interests – particularly in the case of contracts held by large corporate retail multiple or chain stores, many of whom are also wholesalers, some of whom are supermarkets, and in one case backed by a venture capital company. The risk is that services are delivered in such a way as to achieve maximum financial return, rather than in a way that truly matches individual patient needs and those of the wider healthcare service. This in turn can result in employee/employer conflicts and ultimately patient detriment.
 - (ii) Although in recent years there has been a change in emphasis, the contract's reimbursement and remuneration framework is still largely geared towards rewarding transaction volume rather than predominantly focusing on patients' care needs, service efficiency and quality.
 - (iii) Largely as a consequence of (i) and (ii), the intellectual and professional skills of individual pharmacists have been insufficiently utilised in delivering quality care and support at an individual patient level. This has generally mitigated against the development by pharmacists of clinical relationships with patients and also in the provision of continuity of care.
 - (iv) From an overall patient perspective, community pharmacy and general practice have failed to integrate or work collaboratively enough on care service design and delivery; they are working hard but not working smart. In the main their respective contracts have been developed in separate silos. The consequence is an underutilisation of their respective and unique professional skills, meaning they focus more on routine matters than those that best serve the patient's journey, e.g. to spend more time with patients with complex or acute needs to optimise their use of medicines, thus preventing unnecessary hospital admission, reducing Adverse Drug Reactions (ADRs)s and minimising medicines wastage.
 - (v) Community pharmacy premises are underutilised for patient consultation purposes. With around 8,230 GP premises in England¹² and over 11,200 community pharmacies¹³, most with suitable patient consultation facilities – more effective use of the community pharmacy network could lead to a significant improvement in overall primary care capacity enabling both GPs and pharmacists to focus their unique skills in benefiting patients in a much more patient centred way.
 - (vi) The current community pharmacy contract arrangements make no special provision for the needs of people resident in care homes, or those who reside in remote or rural areas where no local community pharmacy or services are available.
- 2.8** But key is the fact that the intellectual and professional investment made by individual pharmacists in their practice is an extremely valuable asset that the NHS does not exploit sufficiently for the benefit of patients and the NHS generally. In the community pharmacy setting this is to the detriment of patients, the profession and the wider NHS.

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12. Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants – Population Overview Report for the Office of Fair Trading. GHK with ICM Research, August 2011.
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- 2.9** Our proposals seek to encourage the existing corporate pharmacy model to deliver improved quality and outcomes. In part this will be through the development of significantly enhanced and more specialist clinical services led by appropriately qualified pharmacists who seek to develop much deeper clinical relationships and continuity of care with the patients they care for.

> Section 3 – Foundations for the PDA Road Map

This section sets out the basic tenets on which the PDA Road Map is built. It highlights the need for multidisciplinary co-operation in the primary care sector, provides a definition of Pharmaceutical Care Services (PCS) and summarises the pharmacy workforce structure to underpin their delivery and the structure required to support it.

Increasing capacity through innovation and collaborative working

3.1 The public continues to be concerned by the fact that often, once they have contacted the surgery with a problem it then often takes several days before they are given an appointment to see their GP. Even if they receive an appointment sooner because they stress the urgency of their situation, upon arrival at the surgery at their allotted time, they often find a waiting room that is filled to capacity, they are rarely seen at the time that was agreed and when they do finally see the GP or nurse, it is usually for only a few short minutes. Currently, because general practice is dealing with a large amount of routine care of patients with LTCs, or dealing with minor ailments, that could easily be handled elsewhere in the system; the capacity to respond to those with more complex needs or acute presentations is reduced.

It is therefore unsurprising that many patients feel that they have no alternative but to present at the local A&E department. Parents in particular are increasingly bypassing their GP and taking children to the emergency department for common childhood ailments.¹⁴

A transfer of the LTC patients and minor ailments away from GP surgeries and into community pharmacies on a national scale would significantly alleviate the surgery log jam. Increasing surgery capacity in this way would enable GPs to gear their practices to being able to handle the more acute presentations so that patients would not have to resort to A&E attendance for urgent care. Even a relatively small percentage change in people's service use would have a significant financial impact on the whole system. Additionally, this capacity could also be used in some areas and in specific situations to enable the involvement of GP's in those A&E departments that are acutely short of appropriately experienced practitioners.

3.2 Core to our thinking is that the rate limiting factor to improving healthcare delivery in the community and therefore reducing unnecessary hospital admissions is a lack of primary care capacity. The consequence is increased pressure on the secondary care sector, which has its own capacity and cost issues. If clinical commissioning is going to deliver transformational change, a key part of the solution will be having flexible capacity to develop enhanced care services in both general practice and community pharmacy. However this will require, and we therefore recommend, more collaborative working between primary healthcare providers than has hitherto been the case.

3.3 Pharmacy services have historically been designed and developed in isolation from other primary care services and with little involvement from GPs. To a degree, the same could be said with regard to general medical services and GPs' involvement with pharmacists. Either way, until recently, constructive dialogue between the two professions has tended to be overshadowed by differences of opinion about, for example, dispensing rights and the scope of the services introduced under the new community pharmacy contract, e.g. Medicines Use Review (MUR) and New Medicines Service (NMS)

3.4 It is therefore encouraging to see the February 2012 joint Royal Pharmaceutical Society (RPS) and Royal College of General Practitioners (RCGP) statement entitled 'Breaking down the barriers – how pharmacists and GPs can work together to improve patient care.'¹⁵ It confirms that both professions are now coming to appreciate the potential benefits of closer and more integrated working and hence the need for greater communication between the two.

References

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15. Breaking down the barriers – how pharmacists and GPs can work together to improve patient care. RCGP and RPS Joint Statement, 2012.

3.5 In addition to a number of recommendations it identifies key 'building blocks' that need to underpin closer working between the two professions, notably:

- Increased sharing of patient information facilitated by improving inter-professional IT links with clear safeguards for consent and confidentiality.
- GP practices and community pharmacies should work together to ensure consistency of service for the public.
- Joint education and training at undergraduate and postgraduate levels to build greater trust and understanding of the professions' respective and complementary roles, skills and expertise. Both bodies will work together to explore continued opportunities for joint learning.
- Acknowledging the importance for joint working to improve care, safety and better use of medicines.

3.6 Building on these synergies is vital. For it is only by adopting a more collaborative approach across community pharmacy and general practice that significant additional capacity for primary care innovation, and delivery of services historically provided in secondary care, can be achieved.

3.7 A key aim in the PDA proposals is to see a reduction in unplanned patient attendances at hospitals. Ways to achieve this are covered in Section 4 but the basic tenet is to do so by increasing and using the skill capacity in the primary care sector much more effectively. Such a shift would release capacity in the secondary care sector, which would help the NHS to take on the increasing demographic challenges on the near horizon. Ultimately, we seek to achieve this through service redesign and innovation, and a much better use of the highly skilled workforce and NHS resources generally.

Increasing Capacity through a national Minor Ailments Scheme

3.8 Around 57 million GP consultations annually (approximately 20% of all GP consultations) concern minor ailments; which in many cases could be

dealt with in a community pharmacy.¹⁶ If more patients with minor ailments received pharmacy consultations then this would reduce the number of GP presentations and would significantly improve general practice capacity.

3.9 In England, Minor Ailments Schemes were commissioned locally by erstwhile PCTs to different specifications and variable levels of commitment; more recently many of these locally commissioned services have either been decommissioned in order to save costs, or are operating on a much reduced scale. This has impacted detrimentally upon the perception of the availability of such a scheme nationally and has unsurprisingly not had a huge impact upon the transfer of patients from GP surgeries into community pharmacies.

Evaluations of locally operated Minor Ailment Schemes in England have found that treatment of common ailments in a pharmacy setting can be cost effective and can avoid GP appointments.¹⁷ However, studies have found that there is a lack of awareness of this service.

By contrast, in 2012, the then Health Minister for Wales Lesley Griffiths revealed the Welsh Governments plan to roll out a Minor Ailments Scheme across the whole of Wales in 2014.

She said:

“A key commitment in our Programme for Government is to make better use of pharmacists to improve access to services... This [Minor Ailments Scheme] will free up GP time for dealing with more complex conditions, and may also decrease waiting times for appointments.”¹⁸

Scotland has established a successful Minor Ailments Scheme (MAS) to which 17% of the population have already registered.¹⁹ The Scottish MAS provides an advice and free medicine/appliance supply (from a limited formulary) to persons entitled to prescription charge exemption under the pre-April 2011 prescription charge regime.

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19. Prescribing & Medicines: Minor Ailments Service (MAS); Financial Year 2012/13. Information Services Division Scotland, 25 June 2013. Available at: <http://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Publications/2013-06-25/2013-06-25-Prescribing-MinorAilmentsService-Report.pdf?15064638854> (accessed on 22 August 2013).

3.10 We recommend that a nationally funded Minor Ailments Scheme (MAS) is established in England and that this scheme is publicised widely so as to encourage the transfer of patients currently visiting their GP surgery or their local A&E department to receive their advice and medicines for minor ailments from the local community pharmacy.

Increasing Capacity through Pharmaceutical Care

Pharmaceutical Care – a definition

3.11 Our aim is to see enhanced care services across the community care sector. From a community pharmacy perspective it is important to focus on what this means. To that end we rely upon the internationally accepted definition of Pharmaceutical Care:

“A patient-centred practice in which the practitioner assumes responsibility for a patient’s medicines-related needs and is held accountable for this commitment.”²⁰

3.12 Pharmaceutical Care is a highly developed practice which is seen in secondary care, but it is very rarely seen in the community setting or in the community pharmacy.

In a practical sense, this means that Pharmaceutical Care practitioners would need to develop the same kind of clinical relationship with a patient in a consultation room on a registered patient basis as would a GP or a practice nurse in a surgery. Pharmacists delivering Pharmaceutical Care would need to be able to interact with the patient on a one to one basis and develop (with others) and then support a care plan and provide continuing support to the patient with their ongoing drug therapy. During the course of the care plan, Pharmaceutical Care practitioners would deliver continuity of care, liaise with other healthcare professionals, communicate with the patient and / or their carer as necessary and continuously assess the patients’ response to drug therapy taking remedial measures where necessary. If required, the Pharmaceutical Care practitioner would change either the dosages of the patients medication or even the entire medicines regime; dealing with any questions that emerge along the way.

3.13 Pharmaceutical Care is especially useful in situations where patients that have already been diagnosed elsewhere such as in a GP surgery, in particular, those with Long Term Conditions that have been prescribed a combination of medicines or those that have been discharged from hospital on complex medication regimes, especially the frail and elderly. Pharmaceutical Care seeks to support patients in self-managing their own conditions whilst simultaneously providing the patients with their very own highly specialised medicines champion available to provide advice and support of a very detailed nature. Focus groups with patients have indicated that this is a service that they would truly value. That this is needed is not in doubt, evidence shows that only 12 per cent of this large cohort of patients (with Long Term Conditions) have been told that they even have a care plan.^{21,22} Many patients with Long Term Conditions find it difficult to access the busy GP surgery for regular assessments and when they do, the surgery log jams that are created mean that patients with more acute presentations chose to attend the A&E department instead.

3.14 We seek to develop the concept of Pharmaceutical Care, because we do not believe that the transformations alluded to can be delivered by simply building upon the ‘supply plus’ style services that are already in place in the community pharmacy as these services merely identify problems with medicines and then send the patients back to the GP surgery for resolution. Pharmaceutical Care as properly defined is a detailed process undertaken by independent (non medical) prescriber pharmacists and it is a discipline based upon the development of a one to one clinical relationship between the patient and pharmacist. This is precisely the situation in which the unique knowledge possessed by the pharmacist can be properly deployed for the benefit of the patient. The care provided results in much more than just a referral back to the GP, since the pharmaceutical care provider assumes responsibility for the patient’s medicines-related needs. This means that the pharmacist involved must be able to practise at a level of professional expertise and autonomy that allows them to prescribe medication and to be held accountable for their prescribing.

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Proper Pharmaceutical Care cannot be delivered via an ad hoc, opportunistic over the counter style service such as is the current position with the 'supply plus' style services such as Medicines Use Reviews that are already in place. Pharmaceutical Care practitioners would take responsibility for resolving any problems with patients' medicines themselves; as such they would keep patients out of the GP surgery and as a consequence improve GP surgery capacity. Pharmaceutical Care would also keep patients out of secondary care by identifying and resolving medicines related issues before they escalated into problems requiring hospitalisation.

- 3.15** In England a range of services purporting to be Pharmaceutical Care but being something well short of that, have hampered the development of pharmacy. These services, designed to retain value within the Community Pharmacy Contractual Framework, have done little to aid inter-professional cooperation and have had little impact on patients.^{23,24}
- 3.16** Introducing and developing Pharmaceutical Care effectively will require some change to the current skill mix and workforce structure within community pharmacy. The following paragraph summarises the PDA proposals in this regard.

Community pharmacy workforce

3.17 The PDA proposals are predicated on a workforce structure that comprises the following:

- (i) Registered pharmacy technician** – whose primary responsibility is preparing prescription medicines for dispensing. If pharmacists are to be released from the mechanical aspects of dispensing then a much greater reliance will need to be placed upon the registered pharmacy technician in the dispensary, working under the supervision and personal control of a pharmacist through revised skill mix arrangements.
- (ii) Patient facing pharmacist** – whose primary responsibility is to be available to the public at the front counter of the community pharmacy providing both reactive and proactive advice to the public, to include health promotion and a range of low level clinical interventions, e.g. minor ailments. At all times, the 'patient facing pharmacist' would also

be providing the clinical and professional checks to support the dispensing service. The patient facing pharmacist will be both visible and accessible to the public, providing opportunistic and reactive services directly without the need for an appointment. Freed from the physical act of dispensing, this pharmacist will be ideally placed to focus on tackling medicines waste, adverse drug reactions and the compliance agenda, so delivering improved benefits to patients.

- (iii) Clinic pharmacist** – with responsibility for delivering the Pharmaceutical Care and for providing a more comprehensive clinical bridge between the pharmacy, the GP surgery and the wider NHS. We propose differing grades of clinic pharmacist (detailed at Section 9) but the focus will be on patients with relatively stable long term conditions who, by definition, have more complex medication regimes. The clinic pharmacist will spend more time with patients than currently the GP or nurse would be able to do in a surgery or home care setting, providing a service which is specifically focussed upon the most appropriate use of medicines. The service will be on a registered patient and planned care basis, using care pathways supported by local protocols derived from national guidelines. All decisions thus made would directly involve the patient.

Pharmaceutical Care Services (PCS) Planning

- 3.18** Fundamental to effective provision across England is a clear and authoritative plan of PCS requirements. In 2011 PCTs were required to produce a Pharmaceutical Needs Assessment (PNA) for their areas. From April 2013 this duty transferred to Health and Wellbeing Boards (HWBs); they have to publish their own revised PNA by 1st April 2015. **We recommend that PNAs take account of PCS and highlight possible contract and service provision changes that may be required.**
- 3.19** As a consequence of the PDA proposals **we would recommend that the plans identify where, in geographical terms, the Pharmaceutical Care Services of clinic pharmacists should be made available to the public, stipulating the number and grade requirements of clinic pharmacists to meet both general PCS (providing Pharmaceutical Care to patients on Long Term Conditions) and**

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the more specialist needs, e.g. end of life care around care homes and hospice locations, substance misuse in areas of deprivation, etc.

Delivery

3.20 We recommend that service needs are detailed under three main categories over and above the Essential Services (ES), Advanced Services (AS) and Enhanced Services (EnhS) of the English Community Pharmacy Contractual Framework (CPCF). These services within the CPCF ensure: the safe procurement of the stock of required NHS medicines and storing them appropriately for subsequent dispensing on prescription in a regulated manner (ES); the provision of basic support for effective medicines use (AS); and flexibility to provide locally specified services to targeted patient groups (EnhS)

3.21 However we believe that the supply section of the ES contract should be secured at two levels, i.e. supplying medicines directly to the public as now, and supplying medicines to residential and care homes where, due to the nature and needs of residential homes, the specification would be different and remunerated accordingly.

3.22 We recommend that over and above the English Community Pharmacy Contractual Framework (CPCF) there should be three additional services that should be provided as follows (in summary):

(i) A Minor Ailments Scheme (MAS). A single national specification and national funding designed in collaboration with GP representatives to replace a number of locally commissioned schemes of variable value. This service will be provided by the 'patient facing' pharmacist.

(ii) Public Health Service (PHS). Although some element of "public health" is included in the CPCF it is at a very basic level. HWBs now have greater responsibilities and scope and they should seek to add more content and services for which additional funding would be required. PHS will be provided by the 'patient facing' pharmacist.

(iii) Pharmaceutical Care Service (PCS).
We recommend that this service should cover two distinct areas and be provided by appropriately qualified clinic pharmacists working under separate contractual arrangements.

3.23 The first area would be for patients in the community who have relatively stable long term conditions (LTCs). Within this group would be patients that register (a pre-requirement) with their PCS provider without a GP referral for on-going medicines-related care and support for their LTC condition(s). These may include patients referred by a patient facing pharmacist following a MUR or those recently discharged from hospital. It would also include LTC patients referred by their GP to the PCS provider of the patient's choice for the full Pharmaceutical Care service. The full PCS would also inherently provide a care plan agreed with the patient (the carer) and GP, as well as associated on-going prescribing. Under both arrangements the clinic pharmacist as the PCS provider would work from a dispensing contractor's premises or from a location more convenient to the patient but would do so under a separate contractual arrangement with one or more Primary Care Commissioning Group (PCCG).

3.24 The second area would be patients in residential care homes. This service would provide individual care home residents with a Pharmaceutical Care Service as outlined in 3.23. However, as described in 3.21, due to the differing needs and arrangements in residential care homes, the service specification would be different in so far as it would require a service that was integrated with the residential care home management.

3.25 There are two contract models here but in either event the service would be provided through a contract between the clinic pharmacist(s) and the PCCG. Under the first model it would be for the individual patient, their carer or family (or the GP or another healthcare practitioner) to select their clinic pharmacist from a list of PCCG approved contractors. And under the second model, it would be for the residential care home to select the clinic pharmacist from a list of approved contractors. The service would then be provided by that clinic pharmacist under a PCCG contract to all patients residing in the care home that needed such a service. Such an arrangement would mean that the supply service to that residential care home could remain flexible and be provided by a community pharmacy contractor, or even a series of community pharmacy contractors over time (as long as they held a contract with the PCCG to supply services to residential care homes), whilst the continuity of Pharmaceutical Care at patient level would be separately contracted and provided by the clinic pharmacist.

> Section 4 – Utilising released and new healthcare service capacity

This section expands on how and where the released and new service capacity outlined in Section 3 should be utilised. It describes how that capacity should be used to improve the care regimes for patients with long term conditions and increase the focus on preventing unnecessary A&E attendances and avoidable hospital admissions through a combination of close monitoring of 'at risk' patients, adopting a 'virtual ward' approach, and reducing the incidence of adverse drug reactions and medicines wastage.

Encourage collaborative management of long term conditions

4.1 Patients with LTCs represent the majority of those cared for by the NHS – both in primary and secondary care.²⁵ They account for more than 50 per cent of all GP appointments, and over 70 per cent of all inpatient bed days.²⁶ People with LTCs are also high users of pharmacy services, but it is GPs and practice nurses that currently undertake the majority of their routine care. This care takes up considerable amounts of surgery time and patients can wait several days for a routine appointment. Feedback from our meetings with patients indicates that when people with LTCs get to see their GP or practice nurse, they often feel they have insufficient time to properly discuss their needs or that their specific questions about their medication have not been addressed. Paradoxically, those patients requiring immediate access to their GP due to an acute presentation often feel that they cannot get an urgent appointment, and even if they do attend the surgery, often there appears to be a log jam of patients waiting to see the GP. Research literature indicates that there are several ways in which avoidable admissions to hospital can be reduced.²⁷ These include;

- Identifying which admissions are potentially avoidable
- Improving continuity of care with a GP (for which we substitute a pharmacist prescriber)
- Encouraging self-management
- Developing a personalised health care programme
- Structure the discharge planning

4.2 Section 3 outlined the establishment of an appointment-led service by a clinic pharmacist whose responsibility would be to provide a more comprehensive bridge between the pharmacy, GP surgery and wider NHS for patients with recognised LTCs or continuing care needs. **By building up a list of registered patients and delivering Pharmaceutical Care by either GP referral or direct patient registration, the pharmacist will be responsible for delivering continuity of care through developing clinical relationships and establishing care plans co-designed with individual patients that are subject to regular review.** In this way the patient is guaranteed continuity of care, a focus upon Pharmaceutical Care, and a significantly improved patient journey.

4.3 This transfer of routine LTC patients away from GP surgeries will build primary care capacity, enabling GP practice based teams to devote more time to delivering continuity of care for the remainder of their patients – especially those with the most complex and acute care needs and thereby at higher risk of hospital admission.

4.4 It is recognised that focusing attention and care on people with LTCs in both community pharmacy and general practice settings is an objective to be aimed at; on a limited scale and at a local level PCSs have been shown to be effective. However, adoption and implementation of PCS to date has been done only on an experimental basis and it is not part of any widespread contractual arrangement. **We recommend that the way to take the overall objective forward is through a combination of new contractual structures that seek to make individual pharmacists (as opposed to**

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large corporate retailing organisations) both responsible and accountable for the patients Pharmaceutical Care. Individual professional accountability is the very essence of Pharmaceutical Care. **The new contractual arrangements must additionally promote more integrated and collaborative working between GPs, pharmacists, and other members of the primary healthcare team.**

Focus on reducing unnecessary A&E attendances

4.5 Data from the Health and Social Care Information Centre show that 18.3 million people attended A & E departments between March 2012 and February 2013²⁸ – a rise of more than a million over the previous year.²⁹ In a report on Emergency Departments (EDs) in the UK, including data from nearly 60 per cent of all EDs in England, the College of Emergency Medicine revealed that 20 per cent of patients were over 65 and 8 per cent were over 80.³⁰ Other sources demonstrate that the fastest growth rate in A & E attendance is in the age group 80-90.³¹

By 2021, the number of people aged over 65 is projected to rise by 23.6 per cent from 2011 figures.³² Given these rates of attendance and growth for the older population, if the current system is not made more efficient then the future impact on emergency departments will be significant. The College of Emergency Medicine recommends a substantial increase in funding for A & E departments including more use of co-located GPs and more, and better qualified, nurses and doctors.³³

We believe that there are other ways of tackling the problem; collaboration between GPs and pharmacists should reduce workload by preventing some of the unnecessary attendances and avoiding some of the medicine related problems.

Incentives to reduce unnecessary A&E attendances

4.6 A supportive step in tackling this situation has already been taken with the April 2012 introduction of new QOF indicators for GPs aimed at reducing avoidable A&E attendances – with a specific focus on older patients with co-morbidities at high risk of admission.³⁴ The indicators are planned to cover 2012-13 and should result in the production of service improvement plans, the delivery of which should be greatly assisted by the additional capacity proposals outlined in this submission. However, **we recommend that the delivery of these plans should be further encouraged by being subject to continuing QOF or healthcare quality targets.** We highlight below a number of areas where this could be beneficial in both cost and health outcome terms. **In particular, we believe that GPs should be incentivised via the QOF system to refer patients with LTCs to suitably qualified clinic pharmacists.**

Avoiding unnecessary A&E attendances through greater access to urgent care

4.7 **Surgeries with enhanced capacity could become more orientated to handling acute presentations and so prevent patients from presenting to A&E departments unnecessarily.** It is acknowledged that this would require a whole system re-orientation but we recommend the initiative as whole is incentivised through new and improved contractual arrangements for GPs, supported by a strategy and funding to provide for the establishment or upgrading of suitable premises. **We would also recommend that the enhanced access to the GPs' urgent care service is subject to a high profile public information campaign, indeed this would be a necessity.**

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Preventing avoidable hospital admissions through smarter care of patients

a) The Virtual Ward approach

- 4.8** A classic demonstration of how using the skills of the existing team to much better effect would be to **use enhanced General Practice capacity in a proactive way to operate a virtual ward approach**. In essence this is a way of using IT to locate patients with the most complex medical and social needs and focusing support in the community upon them. It employs the systems and skill mix of a hospital ward without the physical building and provides preventative care for people in their own homes.
- 4.9** Using risk stratification, patients are identified by their likelihood to require admission into hospital within the next year – by practice or a group of practices – or by the number of long term conditions they have. Medical input to the virtual ward is provided by the GP. The virtual ward team meets weekly with the GP practice to discuss patients on the case load. The team is also able to book surgery appointments for the patient to see their usual GP. The day-to-day clinical work of the ward is usually led by a senior nurse who may be an assertive case manager or a community matron. Other staff include: a social worker, health visitor, community nurses and other allied health professionals. **We recommend that a clinic pharmacist is actively involved in the virtual ward team.**
- 4.10** The provision of Pharmaceutical Care in a virtual ward style arrangement is an extremely important ingredient in the reduction of avoidable hospital admissions. Evidence of this has been demonstrated in the work being undertaken in Croydon, Devon and Wandsworth³⁵ and the SG Change Fund supported work in Lothian in Scotland. The latter includes the piloting of poly-pharmacy reviews involving community, hospital and managed sector pharmacists for selected patients' medication. Initial results from this virtual ward initiative suggest it is achieving a reduction in hospital re-admissions of around 40 per cent.

- 4.11** The virtual ward approach has already been adopted in parts of the NHS in England and we would recommend that steps be taken to further encourage the adoption of this initiative. As well as the possible lack of primary care capacity, this low adoption may come from the absence a nationally developed combined predictive tool/model to underpin risk stratification. **We therefore recommend that the national development of a combined predictive tool/model to underpin risk stratification is made part of an initiative to promote virtual ward practice in England.**

b) By referring patients with LTCs to clinic pharmacists

- 4.12** At the core of these proposals lies the recommendation that GPs are better able to utilise their skills by passing their routine operations to other suitably qualified members of the primary healthcare team. **Once a patient has been diagnosed with a LTC and once that condition is stabilised, it would be of benefit for that patient to be referred by the GP to a clinic pharmacist who could properly meet the Pharmaceutical Care needs of that patient.**

Reducing adverse drug reactions through Pharmaceutical Care

- 4.13** As many research articles report, medicines use optimisation has the potential to result in better and more cost effective prescribing in primary care, as well as helping patients to manage medications better.^{36,37,38} Around 7 per cent of all hospital admissions have been attributed to, or associated with, adverse drug reactions (ADRs). Interactions have been found to be responsible for one in six ADRs implicated in these admissions.³⁹ Between 11-30 per cent of hospital admissions result from patients not using their medicines as recommended by the prescriber.^{40,41}

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- 4.14** The National Patient Safety Agency estimates that hospital admissions due to ADRs cost the NHS in England around £363 million per year if the costs of litigation are included.⁴² These admissions are caused by patients being harmed by their medicines, rather than them not taking them in the intended way. Even a relatively small reduction in this total would result in substantial cost savings and improvements in patient well-being.
- 4.15** Adverse drug reactions are particularly common among vulnerable groups, such as the elderly and frail and older patients in residential and care homes. This group will become much larger in the foreseeable future (paragraph 2.1), we therefore recommend that a quality focus on this important group is made a priority.
- 4.16** **Clinic pharmacist led Pharmaceutical Care interventions will provide educational information and medicines use optimisation services** to this high user group in the community and have the potential to reduce prescribing and monitoring errors among other high-risk patients. This would improve compliance and reduce the frequency of adverse drug reactions, ensuring that patients feel more confident and able to understand and adhere to their medication regimes, thus improving outcomes. **Such interventions would aim to support patients in enabling them to take greater control of their medicines regimes.**
- Reducing medicines wastage through Pharmaceutical Care**
- 4.17** Whilst reducing medicines wastage is not in itself a directly contributable factor in reducing hospital admissions, it should result from an increased focus under PCS on inappropriate medicine regimes and the early intervention on same. It is therefore apposite to consider the issue in this Section.
- 4.18** The 2010 York University report 'Evaluation of the Scale, Causes and Costs of Waste Medicines'⁴³ indicates that the gross annual cost of NHS primary and community care prescription medicines wastage in England is currently in the order of £300 million. This sum represents approximately £1 in every £25 spent on primary care and community pharmaceutical and allied products use, and 0.3 per cent of total NHS outlays. It includes an estimated £90 million worth of unused prescription medicines that are retained in individuals' homes at any one time, £110 million returned to community pharmacies over the course of a year, and £50 million worth of NHS supplied medicines that are disposed of unused by care homes.
- 4.19** The York Report states that net savings from investing further resources in reducing waste per se are likely to be less than 50 per cent of the £300 million figure – in part because a root cause is illness progression and associated treatment changes. This again points to the benefit of the proposed clinic pharmacist role to undertake more focussed regular Pharmaceutical Care reviews with early change interventions where necessary.
- 4.20** However, The York Report also states that over twice the level of identified avoidable waste costs, i.e. up to £500 million in England, could be generated in just **five therapeutic areas (asthma, diabetes, raised blood pressure, vascular disease and care of people with schizophrenia)** if medicines were used in an optimal manner.
- 4.21** In short, **the emphasis should be on health outcomes rather than waste reduction alone.** We would therefore recommend that the **future QOF indicators proposed at paragraph 4.6, and outcome measures in both the GPs' and community pharmacy contracts, should focus initially on these therapeutic areas.**

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> Section 5 – Contracting for Pharmaceutical Care Services (PCS)

This section argues the case for new contractual arrangements in primary care, based on the need for clear professional autonomy and the removal of conflicts between a pharmacy owner's commercial and a pharmacist's professional interests. It calls for separate contracts for dispensing/supply and pharmaceutical care services, sets out the principles to underpin the approach and provides a number of contract models for delivering Pharmaceutical Care Services.

Professional autonomy – the rationale for new contractual arrangements in primary care

- 5.1** The greatest benefit that can be bestowed upon a patient by a healthcare professional is where their unique skill and expertise enables them to make a professional judgement for the benefit of that patient. For this to occur, professional autonomy is an important pre-requisite; it is also essential if Pharmaceutical Care is to be delivered effectively. The pharmacist must be answerable to the patient and other members of the healthcare team – this cannot occur if the commercial demands of an employer primarily involved in retail sales and supplies are allowed to over-ride the individual practitioner's professional judgement. The NHS will not obtain maximum benefit unless the pharmacist can act in the patient's best interest rather than that of their employer – pharmacists need to be able to act with appropriate levels of professional autonomy.
- 5.2** Today, fewer than 10 per cent of pharmacists own pharmacies, and most of the profession is made up of employees or self-employed locums.⁴⁴ The vast majority of community pharmacies are owned by large corporations, supermarkets, multiple high street chains and wholesalers, and even venture capital companies.⁴⁵ These businesses are understandably driven by the need to deliver a significant return on investment for their shareholders and financiers. In recent years in particular, alongside the corporatisation of community pharmacy the pharmacist's professional autonomy has been eroded to the extent that employees and locums are under intense pressure to comply with employers' commercial imperatives.⁴⁶

- 5.3** As a trade union and defence association, the PDA sees many examples where the erosion of this autonomy occurs and where it is treated as a burdensome expense by some employers. Often this erosion detrimentally affects patients. In 2012 alone PDA dealt with more than 4,000 incidents in which members were defended in a wide range of situations, but over half were episodes of employee/employer conflict. Often these disputes occurred because the decisions and actions of pharmacists were primarily being driven by the professional interest and the interest of the patient, whilst those of the employer were being driven by the commercial interest and the interests of the employer/shareholder. This is demonstrated by a recent regulatory Fitness to Practice hearing.⁴⁷ The disciplining committee expressed a concern about an area manager of one of the largest retail multiples who showed a concentration on profit to the exclusion of patient benefit.
- 5.4** In a significant number of cases, conflicts between employers and pharmacist employees occur because pharmacists prefer to put patients' interests ahead of the financial interests of their employers.

Professional autonomy and the law: the European Court

- 5.5** The principle that the dilution of professional autonomy in community pharmacy is detrimental to the public interest has been confirmed in the European Court of Justice, when it ruled on an issue of whether the ownership of pharmacies should be restricted solely to pharmacists.
- 5.6** In the case of C-531/06 Commission v Italy [2009] ECR I-04103, paragraph 105, the European Court

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of Justice affirmed that central to its concerns were situations relating to medicines where employers could not be prevented from exerting influence over their employed pharmacists.

The Court ruled that:

“In particular, a Member State may take the view that there is a risk that legislative rules protecting the professional independence of pharmacists will not be observed or will be circumvented in practice.”

We do not seek in this submission to revolutionise the ownership profile of community pharmacies in the UK. However, we firmly believe that the principles put by the Court which deal with the supply of medicines to the public are even more pertinent to patient interest when applied to the provision of Pharmaceutical Care Services. We see many examples of situations where the independence of pharmacists is systematically circumvented in practice.

- 5.7** If new Pharmaceutical Care Services are to develop then, in light of our experience with employee/ employer conflicts to date, **we recommend that contracts for Pharmaceutical Care Services should rest either with individuals who are pharmacists – some of whom may also be the owners of pharmacies – or with vehicles that are independent of the retailing culture that currently prevails within community pharmacy.** And that those **contracts should, through commissioning principles, commit contractors to high standards of professional healthcare delivery and be supportive of professional independence of pharmacists.**
- 5.8** The PDA believes there is a need to fundamentally revisit and design new commissioning strategies and contractual arrangements that manage these conflicts in a way which is beneficial to patients. We therefore **recommend separating the contract for supply (and those services directly associated with the supply) from the contract for the delivery of Pharmaceutical Care Services.** We believe that new contractual mechanisms which place the key focus upon the Pharmaceutical Care needs of the patient will significantly improve clinical care and the overall patient journey.

PDA contracting proposals

- 5.9** Although the current pharmacy contract has been effective at delivering a low cost, volume based supply service, we believe that a volume based approach will not drive quality improvement and a person centred approach through Pharmaceutical Care.
- 5.10** The establishment of NHS England and its planned review of the GP contract¹ and then, potentially the wider primary care contracting should be taken as an opportunity to review the pharmacy contract at the same time with a view to considering the contractual arrangements needed to enable pharmacists to deliver a high quality clinical service to patients.
- 5.11** As argued above, the PDA considers it highly appropriate to separate the contracts for dispensing and the associated supply service from the much more clinically orientated Pharmaceutical Care service. Our proposals would create not only professional autonomy but also commissioning flexibility to meet the needs of local populations in line with Government policy as set out in “Equity and Excellence”.⁴⁸ At their heart lies the flexibility to commission PCS from named individuals (or other vehicles) without the requirement to own a pharmacy premises.
- Additionally, such proposals mean that new contracting arrangements can become patient centric and not pharmacy centric as is currently the case, which means that whilst Pharmaceutical Care Services can be delivered primarily in a community pharmacy, they may additionally be provided in a range of alternative locations based on the needs of patients such as in residential homes, hospices, clinics or even in the homes of patients.
- 5.12** While it will be important for any such new contractual arrangements to be co-designed by a wide range of stakeholders, **we recommend the following principles are necessary to underpin the proposed contractual approach:**
- Pharmacists providing Pharmaceutical Care to patients must be able to do so with professional autonomy so that professional practice is not

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48. Equity and excellence: Liberating the NHS. Department of Health, July 2010.

compromised by commercial retailing/wholesaling considerations.

- Dispensing and Pharmaceutical Care Services should be commissioned separately and provided in parallel to each other.
- Community pharmacies are a vital part of local communities so any new contracting arrangements must stabilise the existing asset this network represents.
- Individuals or organisations that have invested in the provision of services must enjoy a fair return on that investment and risk, i.e. on the financial investment and risk for operating a community pharmacy, or an intellectual investment and professional risk for operating Pharmaceutical Care Services.
- Individual pharmacists should be named in Pharmaceutical Care Services contracts and be accountable for quality and outcomes against a nationally agreed NHS Outcomes Framework.
- Patient registration should be considered in a way that preserves patient choice AND facilitates continuity of Pharmaceutical Care and accountability for outcomes – particularly for those on the more complex medicines regimes associated with LTCs.
- The model should be simple and flexible enough to meet the needs of patients, commissioners, a range of service providers and professionals.
- The pharmacist delivering Pharmaceutical Care Services will mainly be in one-to-one consultation with patients – usually in the consultation room. Consequently, this pharmacist should not be the Responsible Pharmacist simultaneously charged with the important task of securing and managing the safe and effective running of the pharmacy. It will be important to ensure that patients walking into the pharmacy without an appointment to receive a dispensing service and others seeking advice can enjoy ready access to the available Responsible Pharmacist.
- Outcomes should link to remuneration. A Quality and Outcomes Framework (QOF), similar to that in the GMS contract should be developed for clinic pharmacists.

5.13 Within these principles we have developed several broad options. They are not mutually exclusive and are essentially a starting point for discussions with all relevant stakeholders.

(a) Independent clinic pharmacist

A pharmacist is contracted by the NHS to provide Pharmaceutical Care Services to a population of patients registered with a pharmacy. The pharmacy owner holds the dispensing contract and the clinic pharmacist holds the local contract for providing the Pharmaceutical Care Service that is operated from the pharmacy. The clinic service would be commissioned on a sessional basis (e.g. in half day blocks) and would broadly be informed by the number of patient registrations. The clinic pharmacist is accountable for achieving measurable outcomes for registered patients. Under the clinic pharmacist's local contract a fee would be paid to the clinic pharmacist, part of which may be paid by them to the owner of the pharmacy for use of the consultation room and facilities. Contracting arrangements would define and protect the independence of the clinic pharmacist from any financial interests associated with dispensing /sale or supply of medicines or wholesaling.

(b) Group practice

A group of suitably qualified pharmacists – any one of whom could provide services on a sessional basis – join together to form a group practice. The contract is held with the practice and the practice as a whole is accountable for achieving outcomes and maintaining standards. Similar financial arrangements and operational independence would operate as in (a) above.

(c) Pharmaceutical Care Services provided by an existing pharmacy contractor

The pharmacist pharmacy contractor owns the premises and holds both the dispensing contract and the Pharmaceutical Care Services contract. The contractor is accountable via two contractual routes, which have different outcome measures. Governance, monitoring and review ensure that Pharmaceutical Care activities are high quality and operate free of constraints from financial interests in dispensing or other forms of medicines supply. That principle could be reinforced by professional ethics. This option may be particularly suitable for suitably qualified pharmacist independents in quieter pharmacies, who wish to specialise and both dispense and provide Pharmaceutical Care Services. This approach is one that would be supported by the European Court of Justice's ruling referred to earlier in this submission.

(d) Franchise model

This would see a corporate pharmacy provider harnessing the asset of its brand and developing a Pharmaceutical Care Service offer that individual suitably qualified clinic pharmacists could buy into. It could include advertising and facilities as well as being able to provide a registered patient population. This model has parallels with the model that operates in some supermarket pharmacies and other supermarket franchise providers and is already seen in other areas of healthcare provision e.g. dentistry and optical services.

- And it will reassure health care professionals, including GPs, that clinic pharmacists operating from the community pharmacy can do so freed from the direct and relentless pressures of retailing activity.

(e) Specialist provider

A company probably established by a Pharmaceutical Care specialist holds the contract for the delivery of Pharmaceutical Care and is responsible for quality and outcomes. The company employs suitably qualified pharmacists to deliver services. It also provides the clinical governance framework and is accountable for the service specification. It is responsible for recruiting and training pharmacists and for monitoring and maintaining their performance.

(f) Social Enterprise

As well as commercial business models, there are opportunities for pharmacy businesses to expand and develop as social enterprises, employing a range of business models from co-operatives through to community interest companies. Many of these models already exist within the sector, with a co-operative provider being one of the largest pharmacy businesses currently.

5.14 We believe that the separation of contracts for Pharmaceutical Care and dispensing services will offer many benefits:

- It will stimulate the provider market.
- It will deliver a wider range of more flexible contracting options when commissioners identify communities with unmet Pharmaceutical Care needs in their Pharmaceutical Care Needs Plans – as outlined in Section 3.
- It will offer pharmacists more career options in community pharmacy.

> Section 6 – Other contracting issues

This section expands on the discussion at Section 5 by detailing a number of specific issues that should be addressed through PCCGs' overall contract and service planning arrangements, namely:

- The need to make better use of, and to further develop, the effectiveness of the existing pharmacy premises network.
- To that end to have greater cross-collaboration between pharmacies and collaboration with dispensing doctors.
- To improve service availability and access in remote and rural areas.
- To have dedicated Pharmaceutical Care Services for people in residential care homes.
- For clinic pharmacists to be accredited in the delivery of specialist services.
- GP 'branch' clinics
- Practice nurse clinics
- Community nursing services
- Counselling services, e.g. cognitive behavioural therapy
- Health trainers
- Substance misuse services
- Consultant services in the community
- Physiotherapy and other rehabilitation services
- Podiatry.

To a limited degree all of these services have been trialled in pharmacies in England and have been found to be popular with patients.

The creation of a further modernised pharmacy network

6.1 An estimated 1.6 million people visit a pharmacy each day in England, and of these, 1.2 million do so for health-related reasons.⁴⁹ This is twice the number of people who consult a GP.⁵⁰ Pharmacies are open at weekends, evenings and bank holidays. This makes pharmacy a highly accessible primary care service and currently, an underutilised primary care asset.

6.2 Currently most pharmacies in England have some form of consultation room, which suggests that community pharmacies are already in a position to operate clinics for patients with LTCs without the need to invest in substantial capital programmes. Nevertheless, **we recommend the further development of consultation rooms in community pharmacies to facilitate the development of community pharmacies as a much more comprehensive community resource, hosting a wide range of healthcare services.** This would considerably bolster the current NHS facilities infrastructure. The modern pharmacy could, for example, host:

Collaboration between pharmacies

6.3 The primary model within these PDA proposals is that clinic pharmacists work largely out of existing community pharmacies but under separate contractual terms. Not every pharmacy will require or be physically capable of hosting the clinic pharmacist's services. Therefore there needs to be, and **we recommend collaboration between clinic pharmacists and community pharmacies in terms of shared access to and between pharmacy premises.**

6.4 A second element of how cooperation may provide Pharmaceutical Care is where two or more pharmacies combine their practice into one larger central location. A pre-condition of such an arrangement would have to be that it would not harm the existing pharmacy network or the availability of pharmacy services to the community. Consequently a small town that has three pharmacies all located in the high street may provide just such an opportunity. Consolidation would allow the three pharmacists

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hitherto employed in the three pharmacies to work in a more collaborative and clinical fashion to deliver Pharmaceutical Care, whilst still guaranteeing a high quality supply service.

- 6.5** In both cases the PCCGs' planning process (Section 3 paragraphs 3.12 and 3.13) should address the need for individual pharmacies to share premises/facilities for the delivery of clinical PCS in defined localities. **The PNA should also provide for one or more clinic pharmacists to serve a wider geographical area by working across a number of pharmacies and even other locations such as residential homes on different days.**

Collaboration between community pharmacists and dispensing doctors in remote and rural areas

- 6.6** Once the supply function is contracted separately to a Pharmaceutical Care Service, it becomes possible to complement the dispensing service currently provided by dispensing doctors in the more remote areas by a Pharmaceutical Care Service provided by a clinic pharmacist. This would be done in exactly the same way as the pharmacist would operate from a community pharmacy or other suitable location. As described before, the PCCG would contract one or more clinic pharmacists to provide Pharmaceutical Care Services to patients that otherwise would have no access to that level of healthcare and they would provide those services directly to patients in the dispensing doctors' practices in the more remote and rural areas. Such an arrangement would provide all of the benefits of collaboration, integration, reduced professional isolation and most importantly of all a significant improvement in patient experience.

Residential care homes

- 6.9** The PDA proposal includes the introduction, through PCCG contracts, of clinic pharmacist services to care homes, separate to the supply contracts for medicines and appliances. In practical terms this would provide for a full Pharmaceutical Care Service for those residents with long term conditions. It will require close co-ordination and communication between the homes' nursing/care staff and the individual residents' GPs.

- 6.10** These arrangements would allow the residential home to develop a relationship for the supply of medicines with a pharmacy of their choice; for the residents of the home and their families/carers to develop a clinical relationship with their clinic pharmacist; and for the clinic pharmacist to develop a clinical and care relationship role with care home management teams for the benefit of the wider residential home service.

- 6.11** As indicated above, the general supply and storage review/maintenance of prescribed and OTC etc. medicines to residential care homes would be under separate contractual arrangements. These could be with one or more local community pharmacies.

Specialist Pharmaceutical Care Services

- 6.12** The PDA proposals at Section 9 call for a structured career framework based on four grades of pharmacist, namely – practitioner, advanced practitioner, specialist and consultant. The intention is that **within this graded structure pharmacists will be accredited to practice on a range of specialist programmes, e.g. end of life care, palliative care, substance misuse, diabetes, etc.**
- 6.13** **The PCCG's response to the HWB PNA plans should identify where such specialist services are required.** Having done so, they would contract with the clinic pharmacists who have the recognised specialty skills or knowledge in those areas. In such a way, one specialist clinic pharmacist could deliver continuity of care to a large number of 'like patients' across a distinct geographical area, provided in different locations on different days depending upon need.

> Section 7 – Information sharing and IT

This section endorses Royal Pharmaceutical Society (RPS) and Royal College of General Practitioners (RCGP) statements regarding the need for GP/pharmacist collaboration in sharing patient data and for the further IT development of data access and transfer facilities. It also provides a number of IT development areas that are considered worthy of priority for pharmacy and wider NHS use.

Collaboration and development priorities

- 7.1 A key need for both the patient facing and clinic pharmacist is formal access to patient records that lie outside the pharmacy**, e.g. in GP surgeries, the out of hours service, laboratory results, patient discharge letters – all ideally through computer links into the pharmacy.
- 7.2 One of the building blocks for change** in the Joint statement by RPS and RCGP – commented on at Section 3 – **is the need for increased sharing of patient information** facilitated by improving inter-professional IT links with clear safeguards for consent and confidentiality. **Integrated patient care records available for both primary and secondary care that are readily accessible through IT to all appropriate healthcare providers would provide a powerful and beneficial tool.** The successful roll out of EPS1 and EPS2 through community pharmacies in England demonstrates pharmacy's capability in adopting and applying new systems with high standards of information governance.
- 7.3** We are aware that the Government's IT strategy is substantial and is "work in progress". We welcome the fact that patients will be able to access their medical records from 2015 and hope that this will lead the way to better pharmacy access to the same records. We believe that some additional functionality would aid inter professional communication and promote better patient care. We realise that the agenda is already large and growing and we have to be realistic about the priority that will be attached to community pharmacy in the full scheme of things. However, there are a number of information/IT developments that we would flag as meriting rank in any priority order that we could influence:
- Patient records to include details of patients' carers and their levels of support and decision making abilities.
 - The remote capture and relay of physiological measurements/data from patients' homes for clinical review by the pharmacist – to enable early intervention to adjust medicine regimes where necessary, or to refer on to another healthcare professional.
 - Video consultation facilities – particularly in remote and rural areas – for routine appointments between clinic pharmacists and their registered LTC patients. Would also allow pharmacist/GP dialogue to support diagnosis, medicine decisions and raising prescriptions.
 - Robotic dispensing – again particularly beneficial for enabling key healthcare staff to focus their unique skills upon patient care and become less involved in the mechanics of dispensing.

> Section 8 – The patient focus

This section summarises the patient benefits that would accrue from the introduction of clinic and patient facing pharmacist services and consequential increase in GP capacity. It supports the complementary development of 'pharmacy walk-in services' and outlines the patient safety needs in terms of self-care and the community pharmacy environment.

Patient benefits

- 8.1** Encouraging patients to take ownership of their treatment, especially those with LTCs, lies at the very heart of the PDA proposals and this factor is known to contribute to reducing hospital admissions.⁵¹ Embedded within the proposals is a focus upon shared decision making that involves patients and carers at all times. Allowing LTC patients to co-produce their care plans with their care team will generate a sense of self control and personal responsibility for their health, which in turn will deliver better outcomes.
- 8.2** Focus group work undertaken by the PDA has indicated that many patients feel unable to spend adequate amounts of time with their GP due to the burden of surgery work. As a consequence they often leave the surgery with a complex medicinal regime about which they have many unanswered questions. As evidenced earlier in this submission, this has been shown to result in poor compliance and added waste. The service we describe would allow patients to spend much more time discussing their medicines with an expert in medicines, and they would become much more proximate to the pharmacist. Furthermore, because the service would be provided on a managed and patient registered basis, it would provide the continuity of care that currently evades much of the current community pharmacy offering – especially that provided by the large corporate multiples.
- 8.3** Further additional and wider benefits of this redistribution of healthcare delivery would primarily flow from the release of significant time for GPs – as proposed at Section 4. If LTC patients were able to receive a quality Pharmaceutical Care Service away from the GP surgery, far fewer would need to attend the surgery.⁵² This would lead to improved capacity and responsiveness of GPs and their staff, enabling them to deal with the more complex and acute presentations. Under this scenario, it becomes

possible to encourage many more patients to present at the GP surgery for urgent treatment, rather than to attend the local A&E department with conditions that could easily be treated in the less costly primary care setting. This would be a far more attractive proposition for patients, and would be seen as a huge improvement of their NHS care provision.

Pharmacy walk-in services

- 8.4** The above focuses predominately on the benefits of introducing a clinic pharmacist service. However, the public in general would benefit from the proposed expansion of the 'patient facing' service that provides opportunistic and reactive healthcare advice directly to people coming into a pharmacy – without the need for an appointment.
- 8.5** We are aware that there are many examples of broader healthcare services available in pharmacies across England; these include nurse led minor ailment clinics; GP "overflow" clinics; sexual health services etc. They also offer more convenient opening times, including extended evening and weekend opening hours, and in most cases operate without the need for an appointment. This welcomed approach is entirely consistent with the PDA proposals which, if adopted, would increase its adoption across a much wider area of England.

Patient safety

- 8.6** With an increased use of community pharmacies for both 'off the street', and appointment-led consultations, generated by the patient facing and clinic pharmacists, there is a need to ensure that people are seen – and are encouraged to manage their own self-care – in an appropriate and safe environment.

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- 8.7** In the more specialised ‘clinic pharmacist’ scenario the focus would be on planned care using care pathways supported by local protocols, derived from jointly agreed national guidelines, that include risk management measures to reduce the risk of avoidable injury or harm.

Confidentiality

- 8.8** Confidentiality will be an important issue; it will require appropriate privacy and secure storage arrangements especially in so far as it relates to the use of patient information.

I am John - *A patient journey*

Ever since my GP told me that I was a diabetic, nearly twenty years ago, I've often felt poorly and I get a bit confused with all the tablets I have to take. As well as the sugar tablets I take every day, I used to take three other medicines for my blood pressure and also one because sometimes, I get a little dizzy.

A year ago I had a hip replacement and the pain tablets that the GP prescribed for my arthritis used to change all of the time. I noticed that, some of them, especially the blue ones gave me lots of trouble with my stomach, I mentioned this to the surgery and they gave me something for that. After a scare recently when I had pains in my chest, I had to go to hospital again and when I came back home, I noticed that I was having problems with my breathing and getting chest infections. So they've given me a pharmacist that comes to my house and it's been a real help.

The pharmacist checked over the list of tablets that the hospital had given me when I left and also all the others that I've been taking before. It was just as well, as there had been a bit of a mix up. We had a good chat about all my medicines and I found out that she had spoken about me with the hospital and with my GP. We've drawn up a plan, she has answered many questions and I've learned a few new things along the way – I've got my own medicines champion!

It turns out that I didn't need to take three different tablets for my blood pressure; I only need one to do the job. My pharmacist told me that this change would also stop the dizzy spells so I wouldn't need the dizziness tablets – she was right about that. I was worried about walking around outside by myself before, but I'm much happier about that now.

My pharmacist prescribed me some antibiotic tablets to use as a standby in case my chest infection flared

up again. This has really helped because I would usually wait until it was pretty bad before I went to see the GP as I know that he is very busy and it's difficult to get an appointment.

Because I live alone, me and my family thought it best for me to move into a home for the elderly. It's not bad here, and even though I have moved to another part of town my pharmacist still comes to see me. She spends a lot of time working behind the scenes, talking to my GP and others. Two months ago, she told me that she'd been checking my notes and had had a good chat with the hospital consultant about my hip replacement and the GP about my arthritis. She asked me if I would be happy to take this new red tablet for my arthritis because it has a special coating which means that it won't harm my stomach if I swallow it whole. I agreed, so she wrote me a prescription and she even spoke to the pharmacist in the local chemist to make sure that he ordered the special one for me. The good news is that I've stopped taking the blue and the white tablets and because my stomach has been OK, I don't take the pink medicine either.

Next week my pharmacist has arranged a talk about diabetes for all us residents, she will be talking about medicines and she has arranged for a nurse to talk about healthy diets; there's a chiroprapist coming too. It should be interesting; the staff are all coming as it turns out that quite a few of us residents have diabetes.

I am a lot happier now about my health as I know a lot more about what's going on. I have fewer worries about my medicines as I know I can always talk to my pharmacist as she is at the home at least once a month and she also runs a clinic at the local chemist shop. I also know that whenever I need to, I can always go and see my GP.

> Section 9 – Workforce, education and training

This section outlines the current pharmacy workforce position and the need to introduce a structured career framework within the community pharmacy sector so as to underpin the PDA's proposed Road Map approach. It describes a clinical career pathway and the postgraduate support and development requirements, and the need for these to be on a multidisciplinary footing with other healthcare professionals. Finally it outlines the education and training needs for registered pharmacy technicians and support staff.

Workforce capacity and capability – the current workforce position

- 9.1** Structural barriers, including regulation, contract design and the burden of dealing with the relentless growth in dispensing workload, have slowed progress. Once these can be overcome, the pace of adoption of new roles will accelerate as pharmacists see that fundamental change is not only possible but that it is a highly desirable outcome.
- 9.2** We believe that there is sufficient capacity and premises within pharmacy to move to the new arrangements on a large scale within a two to three year transition period.
- 9.3** The number of community pharmacies in England has risen by about 15% in the last ten years; we believe that the introduction of PNAs and the withdrawal of exemptions from control of entry will see the number stabilise at around 11,000.⁵³ However there are a number of dynamics currently in play within the pharmacy workforce situation that are worthy of consideration:
- 9.4** The pharmacy workforce is broadly split into four distinct sectors: community, hospital, primary care (GP surgeries), and 'other' e.g. academia, research, industry, organisational etc. The kind of activity being proposed for the clinic pharmacist is already being undertaken by pharmacists working in hospital and primary care pharmacy settings. It is worthy of note that there are over 2,000 independent pharmacist prescribers in the UK⁵⁴ and yet, due to the current paucity of roles for pharmacists requiring such a skill, very few of these are involved in roles where such a prescribing qualification is necessary; and
- those who do not have a primary focus on Pharmaceutical Care, ensuring continuity of care and a reduction of unnecessary A&E attendances and avoidable hospital admissions.
- 9.5** For a variety of reasons, but at the PDA it is felt largely due to the current dissatisfaction amongst community pharmacy employees with regards to the de-professionalisation of the sector, significant numbers of pharmacists have left their employed position and work as self-employed locums often across a range of sectors (known as portfolio career development). The most recent survey of pharmacists undertaken by the Royal Pharmaceutical Society of Great Britain indicated that 37 per cent of all community pharmacists are locums.⁵⁵ Some employers and commissioners view locum and portfolio working as problematic. They feel it has led to a lack of continuity of patient care and it may hamper the consistent delivery of enhanced services that require individual accreditation. This may only be the case however, if the current static 'pharmacy centric' contractual model persists. Should new professionally led 'patient centric' contractual arrangements become available, then the flexibility and dynamism offered by such a numerically large group within the profession will prove to be a great strength and it will provide the capacity to grasp the new opportunities that we are proposing in a relatively short period of time.

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- 9.6** The number of pharmacy schools in England and Northern Ireland has dramatically increased and three more schools are due to open within the next two years. In the ten years between 1999 and 2009, the pharmacy undergraduate population rose from 4,200 to 9,800.⁵⁶ These dynamics are already creating pressure on jobs for pharmacists, and this is set to increase in the short term. Notably, the graduates of today are all completing a Masters degree, which means that in both quality and quantity the pharmacist population is predisposed to some large scale role enhancement.
- 9.7** In England there have recently been some major re-organisations at Primary Care Trust level and this means that a significant number of primary care pharmacists – many of whom are qualified as pharmacist prescribers – are seeking more stability and new roles.
- 9.8** There are currently around 4,000 pharmacists involved in primary care pharmacy in the UK, of which more than half are in PDA membership. Some work full-time or on an exclusive basis, but for many this is part of a portfolio career that involves different jobs and responsibilities that may straddle several sectors of pharmacy.
- 9.9** Beyond these important sources, other pharmacists would require a degree of retraining and investment by the NHS and the postgraduate system generally. The rate of progress will be driven primarily by the modernisation of contracting systems and the willingness of the profession to adopt new roles. From numerous surveys and focus groups involving large numbers of pharmacists we have learnt that 30 per cent of our members are willing to engage in these new roles in the short term – subject to guidance and support structures being in place; 35 per cent feel willing to engage, but would need re-training first, and 35 per cent would prefer to remain involved in their more traditional and important current roles.

Re-designing pharmacy training

- 9.10** **We recommend that consideration is given to a new five year pharmacy training programme that would include a much more integrated work placement element that blends educational teaching and practical patient-facing clinical experience.⁵⁷ Additionally, we advocate undergraduate training that is more integrated with that provided to future doctors and nurses.** The aim would be to produce pharmacists that are able to take on significantly more complex clinical roles as soon as they qualify. Added to this would be the creation of a structured career framework in the community sector as described below.

A clinical career in community pharmacy

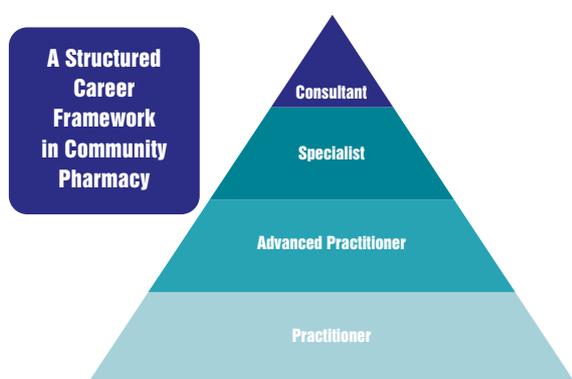
- 9.11** PDA members tell us that a structured career pathway in community pharmacy would make their professional activities much more fulfilling and rewarding. The hospital and primary care settings offer transparent, structured career frameworks, linked to financial incentives for skills and competency development through training. This is the case not just for pharmacists, but also for the nursing and the medical profession. **A structured career framework can act as a significant incentive for healthcare professionals and this can be linked to beneficial patient outcomes.**
- 9.12** No such structured career framework currently exists in the community pharmacy setting – even though it employs around two thirds of all pharmacists.⁵⁸ Linking a career structure to the requirements of the NHS in the community setting would be a powerful tool for change underpinning quality and outcomes.
- 9.13** We believe that the proposed clinic pharmacist model could allow career progression by linking clinical competence and qualifications to both service type and grade. **We recommend a career structure similar to that seen in secondary care, to include pharmacy grades in community pharmacy of:**

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- **Practitioner**
- **Advanced practitioner**
- **Specialist**
- **Consultant.**

We would expect a patient facing pharmacist to operate at practitioner and advanced practitioner level, whereas the more demanding clinical work required of the clinic pharmacist would require specialist and consultant level competence. Such a framework would both accommodate additional initiatives such as pharmacists with a special interest and provide a valuable vehicle for focused post graduate education.



Postgraduate development

- 9.14** We recommend that once qualified under the proposed new structure, patient facing and clinic **pharmacists are given ready access to a central resource centre coupled to on-going support and peer review to both maintain and develop their specialist skills/knowledge for career progression.** This should be conducted within a framework of regulatory guidance supported by the use of case studies, and the provision of practical advice on more generic matters such as risk management and professional indemnity etc.
- 9.15** Many of these support mechanisms are already available through existing NHS structures and/or pharmacy organisations. In particular, the Royal Pharmaceutical Society has recently launched its Faculty which will focus upon providing support tools and enable accreditation of advanced and specialist practice. Experience of specialist practice

development in the past suggests that many of the new practitioners will also seek to establish their own peer support groups – possibly with the support of the Royal Pharmaceutical Society and its new Faculty.

Multidisciplinary learning

- 9.16** **We recommend that the general approach for support and peer review needs to be widened to include other health professionals as the delivery of community healthcare becomes more collaborative and integrated, particularly as new working practices, such as virtual wards, are developed.** Review ‘groups’ would comprise of not only community pharmacists and GPs but members of the nursing team and, where clinically appropriate, relevant hospital specialists. In June 2012 the RCGP published a strategy about enhanced GP training, in which it clearly laid out its case for enhancing and extending GP training through multidisciplinary education and co-development between GPs and community pharmacists.⁵⁹ The proposals made in this submission provide the ideal operational platform upon which GPs and pharmacists can engage in multidisciplinary learning.

Pharmacy technicians and support staff

- 9.17** For pharmacists to be able to fully apply their skills and knowledge they will require the routine mechanics of dispensing and other pharmacy functions to be undertaken by support staff. The role and the contribution of pharmacist support staff should be to make pharmacists more available to the public in the pharmacy so that they can deliver their professional skills and judgements for the benefit of the public and any new supervision regime should support that concept.
- 9.18** A consequence of our patient facing and clinic pharmacist proposals is the need for greater reliance on registered technicians, and upon support staff generally. It will be important to ensure such a development is underpinned by appropriate regulation to define supervisory roles and responsibilities and importantly to offer public protection through a regulatory regime.^{60,61}

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> Section 10 – Finance

This section sets out to demonstrate the considerable financial headroom within which the concepts described in the PDA Road Map proposal may operate. This section is not a definitive financial assessment of the exact financial impact as it is generally accepted that a precise analysis of NHS costs is difficult to undertake, rather it is a financial indicator of how a more integrated delivery of healthcare and the application of Pharmaceutical Care can deliver very considerable improvements in the efficiency of the NHS in England. This analysis is based on the assumption that these proposals, will be subject to detailed cost analysis within NHS England.

10.1 In summary, the proposals in this submission demonstrate how a focus upon Pharmaceutical Care will result in:

- A much more appropriate and efficient use of the unique skills possessed by key NHS personnel.
- A meaningful focus upon the medicines use optimisation, medicines waste and adverse drug reaction agenda.
- A transfer of appropriate secondary care activities into the less costly setting of primary care with a particular focus upon reducing unnecessary A&E attendances and avoidable hospital admissions.
- The creation of significant capacity at the GP surgery.

The following paragraphs expand on the cost and saving implications contained within each on an illustrative basis only.

Cost of the clinic pharmacist service

10.2 This service will revolve around delivering Pharmaceutical Care through optimising the use of medicines and the management of patients who have previously been diagnosed as having a long term condition (LTC), either by their GP or through a secondary care pathway. Alternatively for those patients that have been recently discharged from hospital. Our indicative model relies on the fact that:

- i) **The clinic pharmacist service** is taken up on a scale large enough to reduce the numbers of LTC patients currently presenting themselves at GP surgeries so as to increase the capacity of GP surgeries. **This would rely on LTC patients registering with clinic pharmacist services independently and/or also via GP and wider care pathway referrals.**

- ii) **That GPs use the additional capacity to re-orientate their services to make them more responsive to acute presentations and to further focus their attention upon avoidance and prevention of hospitalisation through, for example a virtual ward approach.**

This proposal uses 40 per cent of pharmacies as its indicative (full time equivalent) base line (40 per cent of 11,000 = 4,400 pharmacies) and uses the following cost assumptions for illustrative purposes.

£20,000 is paid to the clinic pharmacist to cover the cost of a premises fee(s) which they then use to pay to the owner(s) of the pharmacies for the use of the consultation room and operating the appointments service and other premises related activities.
4,400 X £20,000 = **£88m**

£60,000 is paid to the clinic pharmacist and would include (for example) salary, PAYE, a contribution towards the costs of on-going training, CPD, clinical governance frameworks and certain operational costs such as membership of the appropriate organisations, professional indemnity and hardware/software support costs.
4,400 X £60,000 = **£264m**

A total of £352m investment required

- 10.3** Currently data suggests that people with LTCs account for more than 50 per cent of GP appointments in England,⁶² which on 2008-09 data equates to more than 150m appointments (50 per cent of 303.9m⁶³). We expect that a clinic pharmacist could see in the region of 12-16 LTC patients per day, depending on whether this was an initial meeting or a follow-up. Based on our 40 per cent of all pharmacies model, this equates to approximately 18 million clinic pharmacist patient consultations. **We believe that due to an improvement in continuity of care and a greater**

amount of time spent with these patients by the clinic pharmacist than is currently the case with the GP practice based personnel, these clinic pharmacist consultations will result in an annual reduction of considerably more than 18 million GP consultations from this significant LTC cohort of patients

Cost of the patient facing pharmacist service

10.4 In England Minor Ailments Schemes were commissioned locally by erstwhile PCTs to different specifications and variable levels of commitment; more recently many of these services have been decommissioned locally in order to save costs. Thus providing an estimate of cost & benefit using English models is very difficult. However Scotland recently established a successful Minor Ailments Scheme (MAS)⁶⁴ that provides an advice and free medicine/appliance supply (from a limited formulary) to persons entitled to prescription charge exemption under the pre-April 2011 prescription charge regime. Information Services Division of NHS National Services Scotland (ISD) data reports that in March 2013 some 893,396 persons (17% of the Scottish population) were registered for MAS, with professional fees to pharmacies in 2012 totalling £14.5m. More generally, ISD reports that on average community pharmacists deliver over 11,500 consultations each day in Scotland on the treatment of minor ailments. Using the Scottish MAS as a basis and scaling this up to represent what could feasibly be seen in England⁶⁵ gives:-

- 9m patients registered for MAS
- 116,000 consultations each day

10.5 Data from wider sources suggest that around 20 per cent of GP/practice and nurse consultations can be attributed to minor ailments.⁶⁶ The number of GP/PN consultations in England in 2008-09 was estimated to approximate 303.9m, which equates to over 60m consultations relating to minor ailments in total, or nearly 1.2m consultations per week. Our indicative model assumes that, **through a nationally co-ordinated and well promoted media campaign, 40 per cent of these minor ailment consultations could transfer to community pharmacies, i.e. over 24m, or some 470,000 consultations per week.**

10.6 The current remuneration structure leaves many community pharmacists spending most of their time ensconced in the dispensary involved in the mechanics of dispensing. **The management of a much wider transfer of patients with minor ailments from GPs to pharmacists would require some investment in the pharmacy workforce through skill mix to allow registered pharmacy technicians to deal with the mechanics of dispensing, whilst releasing pharmacists to be able to spend most of their time in a much more patient facing role.**

Assuming that uptake, cost and usage would proportionally be seen on a similar scale to Scotland we arrive at an annual cost of approximately £146m to operate a Minor Ailments Scheme across England.

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10.7 The 2010 Bow Group report 'Delivering Enhanced Pharmacy Services in a Modern NHS ...'⁶⁷ quotes the cost of a GP consultation as £32 compared to that at a community pharmacy as £17.75 – a difference of £14.25 per consultation. This indicates that a financial saving can potentially be made with the development of a MAS scheme. However, we believe that the real significance of transferring patients from GPs to pharmacists is not due to savings on the comparative costs of the minor ailment consultations but due to the beneficial impact of creating additional capacity for GPs, which is then used more effectively to reduce unnecessary A&E attendances and avoidable hospital admissions.

We strongly advocate the development of a properly promoted national Minor Ailments scheme (MAS). Within such a scheme and as part of a more integrated primary care service, a patient facing pharmacist service could reduce the annual number of GP consultations for minor ailments by more than 24 million.

A total of £146m investment required

Savings and resources released

10.8 The clinic pharmacist and patient facing pharmacist proposals require a significant investment cost for wide scale development (£352million plus £146million through MAS). It is important, however, to consider that the consequence of the PDA Road Map proposal is that it ultimately delivers both cash savings (through a reduction in medicines waste, an improvement in concordance and a reduction in drug related hospital admissions) and an increase in GP capacity. This means that many more services can be provided in the less costly environment of primary care, rather than in the more costly environment of secondary care. All of these benefits are in addition to the delivery of a vastly improved patient journey, to which we have not attributed any figures in this financial analysis.

10.9 This section does not set out to provide anything more than an indicative picture of the cost consequences of the PDA proposals. The following section simply illustrates the significant headroom within which they could comfortably operate.

Reduced hospital admissions (general)

10.10 It is estimated that one in six emergency hospital admissions, which in 2009-10 represented 816,433 emergency admissions at a cost of £1.42 billion a year (£1,739 per admission), is avoidable.^{69,70,71} Between May 2012 and April 2013, these numbers will have increased to 875,000 as there were now more than 15 million hospital admissions of which around 35% were emergency admissions.⁶⁸ There is therefore scope for some very considerable savings to be made through a focus upon reducing avoidable emergency hospital admissions.

An increased GP capacity

10.11 Our assumption is that with the extra capacity provided (we estimate in the region of 50 million GP consultations released), GPs would be able to spend more time focussing on 'patients at risk of hospitalisation' through for example the operation of virtual wards and additionally, it would enable them to orientate their surgeries to be able to handle acute presentations and hence prevent unnecessary A&E attendances. We expect that the new clinic pharmacist interface with LTC patients would also lead to an overall reduction in hospital admissions. We have assumed that this combination would lead to a 20% reduction in the 875,000 emergency admissions in the short term.

- $875,000 \times 20\% = 175,000 \times £1,739 =$
£304 million cost reduction

NB. This assumption simply attributes savings strictly to reductions in emergency hospital admissions in 'at risk' cases, it does not attribute any financial benefit to the wider 'at risk' patient benefit that is not related to hospital admissions.

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Additionally, it is felt that in the longer term, the extra GP capacity, coupled with the Pharmaceutical Care input from 'clinic pharmacists' upon LTC patients would have a beneficial impact upon ordinary admissions although no financial benefit has been attributed to this factor.

A reduction in Adverse Drug Reactions (ADRs)

10.12 In 2007, the National Patient Safety Agency estimated that the cost of adverse drug reactions and harm caused by medicines in terms of hospital admissions added to the cost of litigation, was more than £363 million.⁷² Bearing in mind that this cost excluded ADR episodes in the primary care setting which did not result in hospitalisation and also the fact that litigation costs have dramatically increased since 2007, this figure is a very significant underestimate. On a very conservative basis we assume that the effect of both the new clinic pharmacist and patient facing pharmacist service upon medicines use will produce an overall 15 per cent reduction in the cost of preventable ADRs (in terms of hospital admissions and litigation costs at 2007 levels), i.e.

- £363 million X 15 per cent =
£54 million cost reduction

Reduced A&E attendances

10.13 Another consequence of increased GP capacity to focus on at risk patients, and premises upgrades to increase surgeries' capacity to deal with minor injuries and ailments, would be a reduction in unnecessary A&E attendances. With A&E attendances costing around £2bn per annum,⁷³ a reduction of only 10 per cent in presentations would yield an illustrative saving of around **£200m per annum**.

Alternatively, it would generate an extra 10 per cent in A&E capacity enabling it to improve its service level and allowing it to handle the ever growing number of genuine emergency presentations.

We expect though that GPs would need to be able to fund the capital cost of premises upgrades.

From anecdotal evidence gathered from focus groups of PDA members that work in commissioning support roles and in hospitals, some patients attend A&E departments presenting with minor ailments merely because they cannot attend the GP surgery with a prospect of a prompt consultation and a free medicine on the NHS. They therefore attend the A&E department in the belief that they are likely to receive a consultation and medicines at no cost and that they will be able to do so without an appointment. We believe that one added advantage of a properly promoted Minor Ailments Scheme is that it would result in fewer A&E attendances from this cohort of patients. As part of the conservative approach that we have taken to the cost vs. benefit analysis, we do not attribute any costs savings to this benefit.

Reduced medicines wastage

10.14 Using the York & London University report as a proxy, the estimated net savings from investing further resources to reduce medicines waste is expected to be less than 50 per cent of the projected cost of £300m.⁷⁴ Therefore an estimate of a net 10 per cent reduction from the amounts ultimately available by the combination of the clinic and patient facing pharmacists could yield a **saving of £30m per annum**.

Improved outcomes

10.15 The York & London report also estimated the opportunity cost of the health gains foregone because of incorrect or inadequate medicines taking in just five therapeutic contexts to be in excess of £500 million per annum, albeit that realising such gains would – to the extent that effective interventions exist – involve additional costs. Thus, even a 10 per cent 'benefit' from the new clinic and patient facing pharmacist services in these areas could yield a **saving of £50m**.

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10.16 Summary (rounded)

Strategic area	Additional cost	Resource release/saving
Clinic pharmacist	£352m	
Patient facing pharmacist	£146m (via MAS)	
Increased GP Capacity		Around 50million consultations (an additional 15-18% GP capacity increase)
Reduced hospital admissions (general)		£304m
Reduced hospital admissions (ADR)		£54m
Reduced A&E attendances		£200m
Reduced medicines waste		£30m
Improved outcomes		£50m
	£498m	£638m

10.17 Our proposals are not driven by a plan to reduce NHS expenditure; rather we are seeking to improve the lives of people living in England through an improved and more efficient delivery of healthcare. We are also seeking to establish processes that are sustainable in the future and that make better use of healthcare professionals both in secondary care but especially in primary care, with pharmacists properly integrated into the primary care team alongside GPs and nurses. Nevertheless, it will be necessary for NHS England to be able to make an informed estimate of what it can expect to get in return for an investment in any new process that is established. While it will never be possible to provide precise data in this respect in advance of a launch of the proposed service re-design, the PDA Road Map proposal has been intentionally built on a very conservative financial cost vs. financial benefits analysis so as to demonstrate the significant financial headroom available even at relatively low level of penetration. We have illustrated how a £498 million investment will pay for itself in terms of the savings it generates through improved service provision. Additionally, it will also produce a significant increase in GP capacity enabling primary care to be much better able to reduce the stress upon and the costs incurred in secondary care.

10.18 Our wider and more strategic approach has meant that we have not focussed upon the cost savings associated with the delivery of Pharmaceutical Care as such. However, work done internationally using a variety of approaches to Pharmaceutical Care, demonstrates that the return on investment on Pharmaceutical Care is as high as 12:1⁷⁵ and an average of 3:1 to 5:1.⁷⁶ Even these estimates are probably lower than actual, because it is difficult to estimate the overall beneficial impact upon a patient's life.

10.19 The proposals made in the PDA Road Map proposal operate within a significant financial headroom and additionally potentially deliver many benefits to the healthcare system. However, we believe that their most important benefit is that they will lead to a significantly improved patient journey. As a first step, **we recommend that the PDA's Road Map proposals are subjected to detailed cost analysis within NHS England.**

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Section 12 – Glossary of terms

A & E	Accident and Emergency Since 2003/4 the definition of Accident and Emergency units encompasses major hospital based emergency departments, walk in centres, minor injury units and specialist emergency units.	EnhS	Enhanced Services See "Community Pharmacy Contractual Framework".
ADR	Adverse Drug Reaction An unwanted or harmful reaction experienced following the administration of a drug or combination of drugs under normal conditions of use, which is suspected to be related to the drug.	EPS1	Electronic Prescription Service release 1. Under EPS1 patients receive a bar coded prescription which allows the dispenser to download an electric copy of the prescription and dispense from this electronic version. In all other respects the prescription is treated in the same way as an old style FP10.
AS	Advanced Services See "Community Pharmacy Contractual Framework".	EPS2	Electronic Prescription Service release 2. Under EPS2 prescriptions can be sent electronically to the pharmacy that the patient has nominated to receive the prescription. The prescription can be dispensed from the electronic message; the pharmacy can inform the prescriber that the prescription has been dispensed and claim payment by electronic message.
BMA	The British Medical Association The BMA is a trade union and professional body for doctors in all sectors of practice. It supports its members individually and collectively on employment issues and it is responsible for negotiating doctors' contracts at national and local levels.	ES	Essential Services See "Community Pharmacy Contractual Framework".
Clinic pharmacist	For the purposes of this document "Clinic Pharmacist (CP)" describes a pharmacists with advanced knowledge and skills working under contract to a GCG or HWB and providing Pharmaceutical Care Services to patients or groups of patients in the community. Services may be provided through the community pharmacy network, GP surgeries or residential homes.	GMS	General Medical Services The UK-wide contract between general practices and primary care organisations (PCO), for delivering primary care services to local communities.
CPCF	Community Pharmacy Contractual Framework The contract under which pharmacies in England provide services to the NHS. It consists of three levels of service <ul style="list-style-type: none"> • Essential Services (ES) which are provided by all pharmacy contractors and are commissioned by NHS England. • Advanced Services (AS) which can be provided by all contractors once accreditation requirements have been met and are commissioned by NHS England. At the time of writing there were 4 Advances Services: Medicines Use Review (MUR); New Medicines Services (NMS) ; Appliance Use Review (AUR); and Stoma Appliance Customisation (SAC). Few community pharmacies are providing AUR (1%) and SAC (15%) (The Health and Social Care Information Centre, Prescribing and Primary Care 2012) • Enhanced Services (EnhS) which were commissioned locally by PCTs and since the abolition of PCTs are specified and commissioned by Local Authorities, Clinical Commissioning Groups and NHS England. Of 20 services commissioned in 2012 only two were provided by 50% of all pharmacies and only eight were provided by more than 10% of pharmacies. The total number of services commissioned fell by 5.4%. 	GP	General Practitioner A family doctor and gatekeeper to broader NHS and secondary care services.
		GPhC	General Pharmaceutical Council The regulatory body for pharmacies and pharmacists.
		HWB	Health & Wellbeing Board A forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. The HWB is responsible for drawing up the PNA through which the need for a range of pharmacy services are assessed and commissioned. The PNA is also the document against which applications for new pharmacy contracts are judged.
		LTC	Long Term Conditions Those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. The life of a person with a LTC is forever altered – there is no return to 'normal'. (Department of Health).

MAS	Minor Ailment Scheme	<p>Minor Ailment Schemes or services are designed to ease the burden on GP surgeries by providing free medicines for minor ailments for patients who do not pay prescription charges. The schemes operate differently in England and Scotland</p> <p>In England MAS is a locally commissioned Enhanced Service (see Community Pharmacy Contractual Framework). As such the specification of the service varies between commissioning groups as does the payment to pharmacies. Provision is patchy and many services have been decommissioned as PCTs sought to reduced costs.</p> <p>In Scotland MAS is a nationally specified and commissioned service available to all eligible patients. Patients register with a pharmacy and may receive free medication following a consultation in the pharmacy</p> <p>In this document a new MAS is envisioned closer to the model specified for Scotland.</p>	PCS	Pharmaceutical Care Services	<p>For the purposes of this document Pharmaceutical care is defines as “A patient-centred practice in which the practitioner assumes responsibility for a patient’s medicines-related needs and is held accountable for this commitment.” Pharmaceutical Care Services are services specified to deliver one or more aspects of Pharmaceutical Care to particular groups of patients.</p>
MUR	Medicines Use Review	<p>An Advanced Service in the Community Pharmacy Contractual Framework. Overt commercialisation through application of targets has resulted in criticism of the way the service is delivered.</p>	PDA	The Pharmacists’ Defence Association	<p>The PDA is a not-for-profit defence association and trade union for employee pharmacists and locums. It represents the interests of, and where necessary defends the reputation of, over 22,000 members. It is the only organisation to provide such services exclusively to employee pharmacists.</p>
NMS	New Medicines Service	<p>An Advanced Service in the Community Pharmacy Contractual Framework. At time of publication, this service had no commitment to funding beyond September 2013.</p>	PHS	Public Health Services	<p>Services designed to assist in the improvement of local Public Health issues; these might include sexual health; obesity; healthy eating; alcohol and drug misuse.</p>
NPSA	National Patient Safety Agency	<p>The NPSA aimed to identify and reduce risks to patients receiving NHS care and led on national initiatives to improve patient safety.</p> <p>The key functions and expertise for patient safety developed by the NPSA transferred to the NHS Commissioning Board Special Health Authority in 2012.</p>	PNA	Pharmaceutical Needs Assessment	<p>A PNA is a statement of the needs for pharmaceutical services of the population in the area of an HWB. PNAs are used by the NHS to make decisions on which NHS funded services need to be provided by local community pharmacies. They are also used to decide whether applications for new pharmacies will be granted.</p>
Patient facing pharmacist	<p>For the purposes of this document the “Patient Facing Pharmacist” describes a further development of the role of the community pharmacist. Employed by the community pharmacy they provide both reactive and proactive advice to the public, including health promotion and a range of low level clinical interventions.</p>	PSNC	Pharmaceutical Services Negotiating Committee	<p>The organisation that represents pharmacy contractors in negotiations with the Department of Health.</p>	
PCCG	Primary Care Commissioning Group	<p>The organisation responsible for commissioning secondary and community care services for their local populations. They consist of a representatives from all of the General Practices in the area together with representatives from a number of other health professions.</p>	QOF	Quality Outcomes Framework.	<p>A voluntary annual reward and incentive programme for all GP surgeries in England. It details clinical and organisational targets and allocates payments according to results.</p>
RCGP	Royal College of General Practitioners	<p>A professional body for GPs in the UK working to promote excellence in primary healthcare.</p>	Residential Care Homes	<p>A residential setting where a number of older people live, usually in single rooms, and have access to on-site care services – help with washing, dressing and giving medication. For the purposes of this document the meaning also encompasses homes which provide 24 hour nursing care for people who are physically or mentally frail or people who need regular attention from a nurse.</p>	

RPSGB The Royal Pharmaceutical Society of Great Britain

The erstwhile professional and regulatory body for pharmacists and pharmacy in England, Scotland and Wales. Its purpose is to enhance the reputation and develop the role of pharmacy. In 2010, the RPSGB lost its regulatory role and became the Royal Pharmaceutical Society (RPS).

Virtual Ward

A team activity providing support in the community to people with the most complex medical and social needs. Health and social care professionals work together to provide patients with multidisciplinary, preventive care at home using the same coordination as that of a hospital ward team. The Virtual Ward team meets together for 'ward rounds', they use the same notes for documentation, and have an administrator called a 'ward clerk' to keep them organised and to pass on messages.

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