March 2014

Improving Health and Patient Care through Community Pharmacy

A Call to Action

| representing **your** interests |

pda
the pharmacists' defence association

Contents

Introduction **03**

Question 1 – How can we create a culture where the public in England are aware of and utilise fully the range of services available from their local community pharmacy? **05**

Question 2 – How can the way we commission services from community pharmacy maximise the potential for community pharmacy to support patients to get the most from their medicines? **07**

Question 3 – How can we better integrate community pharmacy services into the patient care pathway? **10**

Question 4 – How can the use of a range of technologies increase the safety of dispensing? **11**

About the Pharmacists Defence Association **12**

Community Pharmacy or Pharmacy in the Community?

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 PDA defends members should they find themselves involved in a critical incident situation, such incidents are common, in 2013 alone, they exceeded more than 4,000. The majority of these incidents are employment related and a significant proportion are caused by conflicts between the commercial imperatives of community pharmacy employers and the focus upon professionalism and patient safety exercised by individual pharmacists. This provides us with a rich vein of up to date experiences that have informed our policies and future strategy. The answers to the questions being put in this NHS England Call to Action 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 focus groups and other forms of consultation undertaken by the PDA.

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 described as a significantly underutilised resource within primary care.

This Call to Action is looking at the possibility of the current community pharmacy offering being expanded so as to assist with the much greater pressures being placed upon the NHS and this is to be welcomed. Undoubtedly, community pharmacy can provide a much greater input than is currently the case. However, we believe that the outcome of this exercise can be far more beneficial if, rather than looking at solely the possibilities for an enhanced community pharmacy offering, that additionally, this Call to Action considers the possibility of pharmacy services being offered in the wider community by pharmacists as medicines experts in a way which does not require them to be the owners or employees of a community pharmacy.

Whilst the owners of pharmacies have invested in significant sums so as to be able to operate a 'bricks and mortar' community pharmacy and they deserve a return on that investment, individual pharmacists too have invested significantly in their professional, intellectual and clinical skills, they are providing increasingly clinical services and they attract inherent risks in doing so, they too deserve a return on that investment and the NHS must find a way so as to utilise these skills to best effect.

Many of the challenges being faced by the NHS revolve around the rapidly expanding demographic group of elderly and frail patients many of whom are on long term conditions and are on complex poly-pharmacy regimes. Unlike the more mobile members of the public, often, the frail and elderly are not able to easily access their local community pharmacy. Additionally, in areas of health inequality, there may not even be a community pharmacy. An overt focus by this NHS Call to Action upon purely the community pharmacy as a service offering may not be the ideal solution for these patients. Many of these patients could benefit tremendously from developing a relationship with their very own pharmacist who can act as their medicines champion and provide continuity of care as they move from primary to secondary care, are admitted to a care home, are then discharged back to their own home and who eventually may find themselves in a residential home. Such support does not rely upon the financial investment being made in a bricks and mortar pharmacy but upon the professional and intellectual skills, knowledge and training of the individual pharmacist and it is vital that this pharmacist can enjoy professional autonomy.

Exploring the possibilities of Pharmacy in the Community as opposed to just Community Pharmacy provides some very exciting options for NHS England. Pharmacy is a very adaptable and flexible profession, many thousands of pharmacists work on a self-employed basis and this enables them to embrace new models of practice very quickly. Additionally, the profession is ambitious in that it already has more than 2,000 independent prescribers within its ranks and currently many of these pharmacists do not use their prescribing qualifications in a way that benefits patients or in a way that delivers solutions to the current capacity problems being faced by the NHS.

We believe that whilst the integrity of the network of community pharmacies is crucial, pharmacy contracting arrangements should be undertaken in a way that enable the delivery of services that are more clinical and integrated within primary care to involve 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 and to work within new and more flexible contracting mechanisms that utilise the skills of pharmacists without necessarily requiring them to own or be employed by a community pharmacy. Many have highly ambitious and creative aspirations for providing vastly superior and much more clinical services to patients out in the community; helping to keep them out of hospitals. 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. 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 for them not be hampered by a commercial retailing agenda if they are to be able to develop clinical relationships with patients.

The concepts at the core of our thinking that relate to Pharmacy in the Community as opposed to just Community Pharmacy are contained within a detailed strategic proposal that we have called **the PDA Road Map – Reducing unnecessary A&E attendances and avoidable hospital admissions in England.**

www.the-pda.org/englishroadmap

The notion that pharmacists should be able to provide services in wider community is a concept that is enjoying a considerable groundswell of support within the profession. Recently, the Royal Pharmaceutical Society invited the Nuffield Foundation to undertake an independent strategic review of pharmacy. This exercise resulted in a policy document called **'Now or Never'** and it arrived at exactly the same conclusion as has the PDA on how best to exploit the as yet untapped skills of many pharmacist practitioners. It has proposed that pharmacist chambers are established enabling clinical services to be delivered by pharmacists in the wider community

www.rpharms.com/promoting-pharmacy-pdfs/moc-report-full.pdf

In Scotland, the concept of the individual named pharmacist becoming a medicines champion and providing Pharmaceutical Care in the community has also very recently become government policy and is described within a ten year government action plan called **'Prescription for Excellence'**

www.scotland.gov.uk/Resource/0043/00434053.pdf

The profession has arrived at a moment in time where such a proposal is entirely feasible and an expectation that pharmacists should be allowed to operate in this way is now well established within the pharmacist workforce. NHS England should consider the enormous possibilities and benefits that such an approach could have upon the challenges facing the NHS in England, the beneficial impact that it could have upon the medicines agenda and the additional capacity that it could create in GP surgeries. If this transformation is managed properly then it could result in a significant reduction in unnecessary A&E attendances and avoidable hospital admissions.

The answers provided in this Call to Action build strongly upon that ambition.

1. How can we create a culture where the public in England are aware of and utilise fully the range of services available from their local community pharmacy?

1.1 Change how community pharmacy is operated so that members of the public can enjoy a clinical and patient facing relationship with their pharmacist and not a transactional relationship with a retailer. To do this, the following measures would need to be considered;

- Radically change the image of community pharmacy so that it looks less like a retailer and more like a healthcare facility. In this way, the public that visit and the healthcare professionals that refer patients to the community pharmacy can see pharmacy as a fully integrated primary care team member.
- Allow pharmacists to operate with professional autonomy and concentrate on delivery of healthcare services– as do other healthcare professionals such as GPs. This means less pressure from employers to reach commercial/ retail sales targets.
- Ensure that the pharmacist can genuinely make a dynamic beneficial difference to a patient's journey. So for example, the current process around MURs involves patients being told to go back to the GP if there is an issue with their medication or where a change is required in their medicines regime. There has been a poor take up of MURs nationally and although there are some excellent examples of where MURs have been effective, equally there are very many examples of where MURs are not popular with pharmacists, GPs and patients. Should the pharmacist be able to make any required change directly, then this would make the pharmacist the agent for dynamic beneficial change, improve the patient's journey and it would remove the additional workload pressure upon the GP.

1.2 Recognise that pharmacists possess unique skills around the use of medicines and ensure that pharmacy practice and the supervision arrangements relating to medicines are changed so that the mechanics of dispensing rely more so on robotics and skill mix. As a consequence, the pharmacist should become much more patient facing and through this, the public can become much more exposed to the professional expertise that pharmacists have to offer.

1.3 Ensure that a pharmacist is always available in the community pharmacy.

1.4 Ensure that through skill mix, trained staff and proper pharmacist supervision, a proactive/reactive public health service can be fully operated in each community pharmacy. The healthy living pharmacy model is an excellent example of how the pharmacy can use its location in the community to deliver an important element of England's public health strategy. Pharmacists are uniquely placed as health professionals to interact with people who are well as well as those that are ill.

1.5 Centrally resource and widely publicise a national minor ailments scheme so as to make the community pharmacy the first port of call for patients expecting treatment from the NHS. This would help to reduce the pressure on GP surgeries and ultimately help to reduce the number of unnecessary A&E attendances. This has been proven through locally funded minor ailments scheme in parts of England.

1.6 There is a wealth of evidence that shows the extent to which the NHS relies on medicines as its most popular intervention. The evidence also points to significant clinical problems associated with poly pharmacy, non adherence, adverse drug reactions and even waste of medicines. It is now recognised that the cost of medicines is less important than the outcome of their use, and yet despite all of this, even patients in the high risk groups – the frail and elderly on complex poly pharmacy regimes, do not have a medicines champion. Work recently done in Scotland (a review of Pharmaceutical Care in Community Pharmacy; Wilson and Barber) involved a significant input from the public and patients and they indicated that they could benefit tremendously from having an individual named pharmacist as their medicines champion. Ostensibly, such a pharmacist would provide the greatest benefits to patients already diagnosed as having a long term condition by the GP. If they were an independent prescriber then they could fully deliver pharmaceutical care and would provide continuity of care as the patient moved between primary and secondary care. This pharmacist could follow the patient as they were discharged from the hospital and returned perhaps to their home as a housebound patient or are even admitted to a care home. Despite the fact

that local community pharmacies are accessible to 96% of the population by car or public transport, this relatively immobile section of society would not have easy access to the local community pharmacy and this demographic group is both very costly in the medicines sense and is set to grow significantly in size in the future. Such an individually named pharmacist would act as the medicines related bridge between the hospital and the GP, the hospital pharmacy, the residential home the other care related agencies and also with the local community pharmacy with whom there would be a continuing supply relationship. Such a specific proposal is less about developing community pharmacy as such and more about delivering pharmacy in thecommunity. Pharmacy as a profession is exceptionally adaptable and able to deliver such a transformational change very quickly. More than a third of the entire workforce is either already engaged in a portfolio career or is working with the flexibility of being a self-employed locum. Additionally, there are nearly 2,300 pharmacists qualified as Independent Prescribers, many of whom are currently not working in prescribing roles nor involved in delivering pharmaceutical care. The detail of such a proposal, how it would integrate with services provided by GPs and how it would result in a reduction in Accident and Emergency attendances is contained within the much more detailed PDA Road Map proposal for England

www.the-pda.org/englishroadmap

2. *How can the way we commission services from community pharmacy maximise the potential for community pharmacy to support patients to get the most from their medicines?*

2.1 The complexity of the current commissioning arrangements must be addressed as these hamper not just the provision of pharmacy services but the entire local health service provision for the population. In particular, we believe that there should be one local commissioner and not the current split between local authority and CCG.

2.2 The split between locally and nationally commissioned services has advantages and disadvantages. National commissioning can provide a standardised service specification which ensures that the public know what to expect wherever they go to a community pharmacy in the UK. However, the disadvantage of this approach is that if the national specification is of a poor quality – such as the example of MURs, then there is little opportunity to effect an improvement locally.

Conversely, local commissioning can produce a localised service that is much more beneficial or which meets the specific needs of the local population, but that is not widely available elsewhere and causes problems for the public when they move from one commissioning area to another. We believe that a range of nationally commissioned services should be agreed by stakeholders so as to ensure that they are available throughout the whole of the UK, but that these stakeholders are involved in making relevant changes and specification improvements as lessons from service delivery are learned. In this way the core of the service can be standardised and available to the wider public, but that regular improvements are made in light of experience. We also believe that local commissioners should still be able to make additional local commissioning arrangements in light of any local needs gleaned either from a Pharmaceutical Needs Assessment or from wider sources of information.

2.3 It is widely known that a better integration of primary care services (and by this we mean the breaking down of silo working between the various primary care professionals and in particular GPs and pharmacists) would improve efficiency, reduce waste and deliver a vast improvement to the patients journey. It is also known that the NHS will be much more efficient, if the professionals that work within it can spend more of their time on delivering skills that they are uniquely trained to deliver. Consequently, GP's should spend more time on diagnosing and pharmacists as experts on medicines should spend more time on prescribing. The community pharmacy could then be subsequently involved in maintaining any medicines regime that has already been initially established by an independent prescriber pharmacist, hospital consultant or GP. It therefore follows that there needs to be a much more integrated approach to commissioning. Both the GMS contract and the Community Pharmacy Contractual Framework (CPCF) must be much more closely aligned so as to ensure that silo working is reduced. An example might be that patients that have already been diagnosed with a long term condition and prescribed for by a hospital consultant are then discharged back into the community and placed under the care of their GP. The GP would then be incentivised through the GMS contract to refer such a patient to a named pharmacist independent prescriber (the medicines champion). This pharmacist may not be working in a community pharmacy as such, but, through the operation of pharmaceutical care clinics would take charge of that patient's medicines regime. This medicines champion would then explain all of the necessary medicines related issues to the local community pharmacy that is responsible for supplying the medicines to that patient and through a process of co-production involving the patient and other relevant parties to include the GP, would establish a service involving medicines for that particular patient. The community pharmacy through its contract would be incentivised to participate in a collaborative way in such a service and may even provide the location (via the consultation room) or even the pharmacist, to enable the pharmaceutical care clinic to be operated.

2.4 One issue that hampers the development of community pharmacy is the issue of workload. In a very large proportion of the community pharmacies the pharmacist is ensconced in the dispensary engaged in the mechanical act of dispensing and is not generally available to provide wider patient facing services. This is an example of not using the expertise of the pharmacist to best effect and occurs usually due to cost containment measures operated by some community pharmacy contractors. We believe that the CPCF must become more proscriptive about support staff so as to enable pharmacists to spend much more of their time in patient facing roles. We believe that the pharmacy contract should contain a requirement for community pharmacies to employ registered pharmacy technicians.

2.5 The CPCF should separate out the contractual payments for the supply of medicines and for the provision of services and these should be contracted for separately. Such an approach would have the benefit of enabling some pharmacies to concentrate their efforts on developing a range of services without the need to be too concerned about how the medicines are procured and dispensed – this could even be done elsewhere and then delivered to the pharmacy for distribution to the patient. This approach would stimulate novel solutions to the more mechanical process of medicines assembly and would create opportunities for those wishing to concentrate on procurement efficiencies and dispensing. Such an approach if done correctly would also improve safety for patients as it would see the introduction of large scale robotic dispensing and bar code checking – technology which is difficult to fund on a smaller local community pharmacy scale. More importantly, largely freed from the process of dispensing, the contractual payments for service provision would encourage community pharmacy to concentrate on changing its relationship with patients from that of supplier of product to that of healthcare service provider. Within such a framework, the potential for community pharmacy to support patients to get the most from their medicines could be much more easily maximised as this would be the focus of the services element of the contract. Another advantage of such an approach is that it could enable a pharmacy service to be provided in areas where there was a big demand for services or where there were healthcare inequalities, but where the volumes of prescriptions would be low.

2.6 One of the limiting factors pertaining to this Call to Action process is that it appears to be concentrating on the community pharmacy and it is not focussing upon pharmacy services provided in the wider community. Should pharmacy services in the wider community especially pharmaceutical care delivered by independent prescriber pharmacists be considered, then this introduces a very exciting and as yet untapped opportunity for the NHS. Such services will not rely upon the financial investment made in establishing a bricks and mortar pharmacy, but will rely upon the professional and intellectual investment and the professional risk undertaken by the individual pharmacist. To facilitate this, over and above the CPCF for community pharmacies, services should also be commissioned from pharmacists who are not necessarily owners of community pharmacies. This will enable group practices of pharmacists (and others) to be established so as to provide services related to medicines and their use in the wider community. Such an approach would enable quality pharmacy services such as pharmaceutical care to be provided in areas where there is no community pharmacy and where there is unlikely to be one. Additionally, it can enable services to be provided to those patients who are unable to attend their local community pharmacy – such as those who are bed bound in care homes.

2.7 The CPCF must also require contractors to demonstrate the following;

- That their employee pharmacists can work with professional autonomy so as to prevent commercialism from stifling professionalism in the community pharmacy.
- The Responsible Pharmacist (RP) regulations require the RP to be statutorily responsible for the safe and effective running of the pharmacy in so far as it relates to medicines. A contractual requirement should be that the requirements of the RP are demonstrably taken seriously by the employer.
- That their community pharmacies have the right number and quality of support staff employed to ensure that the public can receive a safe service and that the pharmacists are enabled to rely upon Skill Mix. The appropriate staffing levels for each pharmacy must be agreed with the Responsible Pharmacist and that this staffing level is available as a transparent record of what agreements on staff levels have been made.
- In light of the Francis Report, which described the use and the benefits of an organisational cultural barometer and its link to patient safety; that each community pharmacy must have an up to date cultural barometer that can be used to define the culture and the approach to professionalism and patient safety that exists.

3. How can we better integrate community pharmacy services into the patient care pathway?

3.1 This process would need to start with the design of the new and integrated primary care service as described in 2.3. However, this process would not only need to start with the patient in mind, it would need to directly involve patient representatives and primary care service providers in co-producing the service. Such an approach was used in the recent Scottish consultation which has resulted in an exciting ten year vision and action plan for the brand new community based pharmaceutical care service (Prescription for Excellence).

3.2 13.5% of total NHS budget is consumed by the cost medicines and this is the most common medical intervention. After staffing costs, medicines represent the second largest NHS cost item. Such are the challenges presented by medicines and also the scale of cost to the NHS budget that re-design would need to see (as a minimum requirement) the pharmacist, as the medicines expert, providing input at all levels of the primary care process and wherever the greatest medicines related challenges occurred within the system. Particularly in the GP surgery, in the community pharmacy, in the care home, in the residential home, on virtual wards (see 3.5) and much more proximate to frail and elderly patients many of whom do not have the ability to come to the local community pharmacy or indeed to any other healthcare facility.

3.3 All pharmacists working at the patient interface would have to have access on a read and write basis to the full records of patients. This would not only help to inform decisions being made about the medicines made by pharmacists making this safer, but would also allow the records to be updated in real time in the event that a pharmacist made a change or an intervention related to the medicines being taken by that patient. This would offer a really practical way in which the services provided by pharmacists would be integrated into the wider patient care pathway.

3.4 GPs referring caseloads of previously diagnosed patients on long term conditions involving poly pharmacy regimes to suitably qualified independent prescriber pharmacists on a named pharmacist patient registered basis would make a dramatic difference to the quality of the overall service and the patient journey. It would also generate capacity at the GP surgery enabling the GPs to spend more time on acute presentations and therefore reduce unnecessary A&E attendances. Suitably qualified independent prescriber pharmacists could take charge of the patients pharmaceutical care, titrate bloods, monitor and when required amend medication regimes. Furthermore, through the creation of a medicines champion for that patient, the patient is able to get much more involved in co-producing their medication plan and therefore take much more responsibility for their treatment.

3.5 Virtual Wards are now an increasing feature of patient care in the community. This is where a healthcare team, usually managed by an assertive senior nurse and involving the GP and other members of the healthcare team proactively manage a group of patients that have been selected through predictive risk computer systems as those on the GPs list that are most likely to be admitted to hospital. Recently, pharmacists have been integrated as members of some of these virtual ward teams where they are involved in deciding upon the pharmaceutical care elements. The results from such episodes have been dramatic, producing outcomes that have been very positive. In one such trial, the percentage of patients that was being re-admitted to hospital after discharge was reduced by more than 42% due to the delivery of pharmaceutical care by pharmacists. Virtual wards keep patients out of hospitals, they should be developed much more widely in the community setting and they should involve pharmacists in the provision of pharmaceutical care. As such, virtual wards would integrate pharmacy services directly into the patient care pathway producing highly beneficial results.

3.6 Referrals to specialist providers in the community have been a successful feature of the mental health service for some considerable time. Specialised services provided by pharmacists with special interests based on the use of medicines could be integrated into the wider care pathway in exactly the same way through referrals by other members of the wider healthcare team and other agencies besides. Examples of such services may include palliative care, pain management, diabetes and chronic arthritis.

4. How can the use of a range of technologies increase the safety of dispensing?

4.1 A top priority must be that pharmacists, regardless of setting should have read and write access to patient records. This would have a dramatic beneficial impact not only upon the service that can be provided by pharmacists, but also upon any other healthcare professionals who would be able to see the interventions being made by pharmacists. Access to patient records would improve the safety of dispensing because it would inform any clinical decisions being made by pharmacists during the dispensing process.

4.2 Electronic transfer of prescriptions will reduce the number of errors that emerge as a result of written and hand held prescriptions. However, electronic transfer of prescriptions also provides the perfect opportunity to simultaneously transfer the details of the condition that the patient is being treated for. This innovation is already used in some European countries, it will significantly reduce the number of error episodes and adverse drug reactions that could have been avoided had pharmacists known more about the rationale for prescribing in the first place. This provides a much greater opportunity for beneficial and perhaps even life- saving interventions by the pharmacist.

4.3 Robotics coupled with bar code accuracy checking would significantly improve dispensing accuracy. Furthermore, it would release a considerable amount of time enabling pharmacists to spend much more time on patient facing clinical roles.

4.4 Patient held IPhone applications could be used to encourage concordance with medication regimes. Such technology could also automatically update pharmacy records giving the community pharmacist an indication as to whether the patient was compliant with a dosage regime or not.

About the Pharmacists Defence Association

The Pharmacists' Defence Association (PDA) is a not for profit organisation which aims to act upon and support the needs of individual pharmacists and, when necessary, to defend their reputation. It currently has more than 22,000 individual pharmacist members. The PDA Union was inaugurated in May 2008 and achieved independent certification in 2011.

The primary aims of the PDA are to:

- Support pharmacists in their legal, practice and employment needs.
- Represent the individual or collective concerns of pharmacists in the most appropriate manner.
- Proactively seek to influence the professional, practice and employment agenda to support members.
- Lead and support initiatives designed to improve the knowledge and skills of pharmacists in managing risk and safe practices, so improving patient care.
- Work with like-minded organisations to further improve the membership benefits to individual pharmacists.
- Provide insurance cover to safeguard and defend the reputation of the individual pharmacist.

www.the-pda.org

The Pharmacists' Defence Association
The Old Fire Station
69 Albion Street
Birmingham
B1 3EA
Contact information
General Enquiries: 0121 694 7000
Fax: 0121 694 7001
Web: www.the-pda.org
Email: enquiries@the-pda.org

pda
the pharmacists' defence association