All-Party Parliamentary Group on Pharmacy. Inquiry into the future of pharmacy: submission by the Royal Pharmaceutical Society of GB

4 December 2006

About the RPSGB

The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional and regulatory body for pharmacists in England, Scotland and Wales. It also regulates pharmacy technicians on a voluntary basis, which is expected to become statutory in England and Wales under anticipated legislation. The objectives of the RPSGB are to lead, regulate, develop and represent the profession of pharmacy[1]. The RPSGB leads and supports the development of the profession within the context of the public benefit. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums. The RPSGB has responsibility for a wide range of functions that combine to assure competence and fitness to practise. These include controlled entry into the profession, education, registration, setting and enforcing professional standards, promoting good practice, providing support for improvement, dealing with poor performance, dealing with misconduct and removal from the register.

The RPSGB has a role in promoting the safe and effective use of medicines to the public and to health professionals. The RPSGB runs public health campaigns, often in partnership with other organisations promoting health[2]. The RPSGB is also developing a strategy for patient and public involvement[3] which aims to integrate into the RPSGB's major functions and decision-making processes. As a publisher of scientific journals and books on a range of topics related to the use of medicines, the RPSGB helps promote high standards of treatment.

The RPSGB is currently engaged on a programme to reform its constitution, powers and ways of working in order to bring it in line with best practice and create an organisation that is truly accountable and fit for modern purpose. The RPSGB was granted a new Royal Charter in October 2004[4] and awaits imminent new enabling legislation under Section 60 of the Health Act, which together provide a framework to support safe and effective pharmacy practice as part of a modernised NHS in England, Scotland and Wales. The RPSGB is in the process of establishing national boards to meet the challenge of practice development and professional support in each country of Great Britain.

[1] http://www.rpsgb.org/
[2] Examples include: Ask about medicines leaflets on Sexual health and Antibiotics; Men's health campaign leaflet *Pop down your local*; *Know your medicines.* Available from http://www.rpsgb.org/worldofpharmacy/useofmedicines/
[3] http://www.rpsgb.org/societyfunctions/aboutthesociety/patientandpublicinvolvement.html
[4] http://www.rpsgb.org.uk/societyfunctions/aboutthesociety/makingthesocietyfitforthefuture.html

All Party Pharmacy Group Inquiry Questionnaire

The RPSGB welcomes the opportunity to contribute to the All-Party Pharmacy Group inquiry into the future of pharmacy.

1. Pharmacy Services

1.1 With the devolution of healthcare, the role of pharmacists in shaping and delivering services is developing in different ways in England, Scotland and Wales. The tools that pharmacists need to deliver and the barriers to engagement all translate into the context of health and social care delivery in each country.

The Government has set out a vision that is based on realising the potential of pharmacy to deliver clinical services to patients at a local level. This vision has been bought into by the pharmacy profession and largely reflects the ambitions that the pharmacy profession set out in "Pharmacy in a New Age" ten years ago. In "Pharmacy in a New Age" the profession set itself a number of goals all of which are now seen in current government policy in England, Wales and Scotland. However, this has not translated into consistent delivery in an NHS challenged with funding crises and almost constant reorganisation.

1.2 The RPSGB recognises the vote of confidence in the profession of pharmacy inherent in significant new developments: such as the pharmaceutical public health strategies; independent prescribing by pharmacists and the new community pharmacy contracts. Community pharmacy is the most visible segment of primary care pharmacy and the RPSGB's concerns over achieving the goals in the Department of Health White Paper *Our health, our care, our say* were presented in written evidence to the All-Party Parliamentary Groups on Primary care and Public Health and Social Care. With the right support, pharmacists can deliver new models of care to patients.

1.3 *Our health, our care, our say – a new direction for community services* ("the White Paper") developed a strategy to integrate health and social care for England, to improve choice and to deliver greater capacity in general practice. This needs to be carefully considered against the backdrop of a health system that has been subject to an unprecedented programme of reform over the last 10 years.

1.4 The NHS is transforming from the sole/majority provider of care to commissioner of care from multiple providers: public, private and voluntary sector, both in the UK and internationally. There are also blurring demarcations between professions, the emergence of new health occupations, "hybrid" practitioners and multiple support grades for many professions. As a result, pharmacists are taking greater personal and professional responsibility for the clinical care of patients and the health and well-being of the public than at any time in the past. In the hospital setting, pharmacists have long been working as fully integrated members of the healthcare team and hospital pharmacy has developed in recent years to free the pharmacist from the dispensary to work on the wards and technicians are also now taking up medicines management roles. In community pharmacy, new roles are emerging, aligned to new community pharmacy contracts.

1.5 Community pharmacy is the most visible segment of primary care pharmacy, providing services from around 9,700[5] community pharmacies in England and Wales, staffed and managed by around 16,600[6] pharmacists who choose to work in this, the largest sector of pharmacy practice. These pharmacists dispense around 1.6m prescriptions every day, provide advice without appointment, perform a critical role in supporting the health and social care needs and provide a lynchpin of local economic communities[7]. Every pharmacy invests in excess of £400,000 of private capital in the establishment of the pharmacy. In addition to pharmacists working in community pharmacy, primary care is also served by around 1,800[8] pharmacists working with the English primary care trusts (PCTs) and GPs to develop local medicines policies, optimise the use of medicines at a population level and to provide some face-to-face patient services.

1.6 The new contract for community pharmacy in England and Wales heralded a significant change in the way in which community pharmacy is paid for and enhanced the range of services that patients can expect to receive from their community pharmacist[9]. It built on the foundations of a highly efficient and effective community pharmacy service that has seen a 52% growth in workload over the last ten years accommodated by a network of pharmacies that has virtually stayed static in number[10]. As the contract is implemented, we can expect patients to benefit from advice on how to get the best from their medicines, easier ways to order and manage their repeat prescriptions and support to get and stay healthy.

1.7 The workload for pharmacy is increasing steadily. The recently published figures for the volume of prescriptions dispensed in England shows an increase in the number of items dispensed from 686 million in 2004 to 720 million in 2005. Over a ten year period, the number of items dispensed has increased by over 50%. The workload for dispensing is likely to continue to increase at the same rate. At the same time, pharmacists are taking on new clinical roles that change the way in which they work.

1.8 Community pharmacists are already working to release capacity in general practice. In East London, for example, patients can walk into their local pharmacy and get advice and NHS treatment for a range of over 20 common ailments. This service helps to reduce demand for GP appointments for minor illnesses which in turn helps to release some of the capacity that GPs will require in order to deliver some of the new services being transferred out of hospitals. Around 40%[11] of all GP appointments are for minor or self-limiting conditions. Community pharmacy provision of minor illness support is considered to be similar or less expensive than GP provision. In 2004, 36%[12] of all PCTs in England

[5] Department of Health. General Pharmaceutical Services in England and Wales 19954-95 to 2004-2005. DH London 2006
[6] Hassell K. Pharmacy workforce census 2003: Main findings. RPSGB July 2004
[7] New Economics Foundation. Ghost Town Britain II. NEF, London. March 2003
[8] ibid
[9] Department of Health. New Community Pharmacy Contractual Framework. DH. London. 2005
[10] Numbers of pharmacies in England have reduced by 0.5% in the period 1995 - 2005
[11] Whittington Z, Hassell K, Cantrill J, Noyce P. (2001) Care at the Chemist: A Question of Access. Report to the Community Pharmacy Research Consortium.
[12] Celino GJ, Gray NJ, Blenkinsopp A, Dhalla M. What is driving community pharmacy service development. Health Services Research and Pharmacy Practice Conference 2004

commissioned this service from their community pharmacists. In Scotland, the service forms part of the new community pharmacy contract.

1.9 Community pharmacists are already working to improve access to services in primary care. In Islington PCT and Bridgend Local Health Board (LHB), to cite two examples among many, women can walk into their local pharmacy and obtain emergency hormonal contraception without an appointment. In this way, community pharmacies, with their extended opening hours, provide much needed and improved access to this most time-sensitive of services. Recent research demonstrated that emergency hormonal contraception may be obtained through pharmacies significantly faster than obtaining it through family planning clinics (16 hours versus 41 hours post-unprotected sex)[13]. In 2004, 63% PCTs in England commissioned this service from their community pharmacists.

1.10 Community pharmacists are already working to support the delivery of improved public health. In Lambeth PCT, as another example among many, community pharmacists are working to help GPs and local drug services to treat more drug users by offering supervised consumption of methadone, the safe destruction of used injecting equipment and the supply of clean injecting equipment. Without this support, GPs would not be able to manage drug users in their practice, clinics would be over run with demand and drug users who want to move out of the vicious circle of crime and drug taking would not be able to do so. In 2004, 83% of PCTs commissioned this service from their community pharmacists.

1.11 Linked to the LTC agenda is the potential for community pharmacy to support the integration between social and health care. Community pharmacists come into contact with formal and informal carers on a day-to-day basis. In fact, it may be that the community pharmacist is the only health professional whom the carer will see on a regular basis. Informal carers, typically spouses and children, rely on the community pharmacist to help them to balance their carer role with their own needs. Research has shown that a significant burden falls on these carers to manage medicines related issues for those in their care [14]. These carers tell us that there is more that the community pharmacist could do to help them manage this burden, however the opportunities to provide this support are limited. To build on the existing relationships and to realise the potential of community pharmacy to support carers in their role, we need to find local and national levers to drive change both in terms of commissioning and of change management to support the profession to develop new services.

[13] Lewington G & Marshall K. Access to emergency hormonal contraception from community pharmacies and family planning clinics BrJ Clin Pharmacol 2006 61:5, 605-8

[14] Francis S, Smith F, Gray N et al. The roles of informal carers in the management of medication for older care-recipients Int J Pharm Pract 2002:3:1-10

1.12 We have noted considerable variation between PCTs in what and how many services are commissioned from community pharmacy. The table below illustrates the variation using the most commonly commissioned enhanced services from community pharmacy.

Enhanced Service	Percentage of PCTs commissioning in 2003	Percentage of PCTs commissioning in 2004
Minor ailment scheme	15.08%	35.57%
Nicotine replacement therapy	25.13%	31.89%
Prescription intervention	28.79%	33.16%
Emergency contraception	47.52%	62.63%
Smoking cessation advice	51.50%	56.99%
Supervised consumption of methadone	73.23%	83.33%
Needle and syringe exchange	83.59%	80.95%

(Source: Webstar Health / Keele University Survey of PCT Community Pharmacy Development 2003 and 2004. 2003 n=203, 2004 n=195)

1.13 The RPSGB recently produced a Parliamentary Briefing on hospital pharmacy in the 21st Century. This briefing outlined a number of issues. Hospital pharmacists need to be reassured that their role continues to be recognised as a vital part of the NHS through a Government commitment to pharmacy education, access to fully integrated information technology, and the development of pharmacy skill-mix to ensure that pharmacists' time is used to provide the best treatment outcomes for patients. **The new opportunities for pharmacists to prescribe, and to delegate some of their tasks to technicians, means that many new services can be developed in the hospital setting with pharmacists directly prescribing and advising patients on their medicine use. This will, in the long term, have a beneficial effect on the individual management of patients' medicine regimen, promoting better self care, and a more expert group of patients. The full briefing can be found at: - http://www.rpsgb.org/pdfs/hosppharm21cbrief.pdf**

1.14 The advent of consultant pharmacists in secondary care and pharmacists with a special interest in primary care reflects increasing specialisation in pharmacy. This specialisation means that pharmacists now run clinics in hospitals, prisons, community pharmacies and in GP practices. The clinics will often cover a therapeutic area such as hypertension or be related to an individual medicine that requires special monitoring such as warfarin or lithium. **Both Consultant pharmacists and Pharmacists with a Special Interest are likely to be at the forefront of pharmacist prescribers and will be in a good position to make full use of their ability to prescribe medicines. The RPSGB welcomes**

these developments which will allow these pharmacists to extend their scope of practice into new and exciting areas.

2. Perceptions of pharmacy

2.1 **The perception of community pharmacy among consumers is illustrated by the response that the APPG had from Which?. This stated that for consumers, "the pharmacy is primarily the gateway to medicines and there is high regard for pharmacists as a trusted source of information about medicines." This is reflected in much of the consumer research that shows a high regard for and trust of pharmacists as the healthcare professional on the high street.**

2.2 However, Which?'s research indicated that "pharmacies are not widely regarded as the natural first-stop for general healthcare and advice by most consumers." This illustrates the perception gap between the traditional role of the pharmacist as a source of medicines and information about medicines and the lack of understanding of the broader role as a source of general health advice.

2.3 There is also good acceptance of the widening role of pharmacists regarding repeat dispensing, extended opening hours, etc compared with unease about widening prescribing rights to non-medical staff. Which? put this difference down to a lack of appreciation of the training and competence of pharmacists.

2.4 We believe that many of these perceptions are mirrored among GPs who may have little awareness of the breadth of the pharmacist's training or role and may view the retail part of a community pharmacy business with some suspicion. There is evidence that some GPs are concerned about the new MUR service and view it with some suspicion. This may be based on a mis-perception of what MURs are or on the inconvenience of receiving a long form that does not easily integrate with the GP computerised patient records.

2.5 **The perception of hospital pharmacists among hospital doctors is good**. They are generally seen as fellow professionals who are a part of the clinical team. For example, many of the hospital pharmacists who have become prescribers have had considerable support and encouragement from local consultants to undertake this step.

3. Financial Arrangements

3.1 We are concerned that the NHS overspend has resulted in a reduction in the number of enhanced services being commissioned at a time when we would expect an expansion of such services as the new contractual framework has bedded in. We are also aware of pharmacist posts in the managed service (both secondary and primary care) under threat of redundancy. We feel that this is short-sighted and could adversely affect patient care.

3.2 Pharmacists are required to dispense the exact amount of medicine specified on the prescription whether an appropriate pack size is available or not. This frequently results in pharmacists cutting up packs of tablets to dispense the quantity prescribed. Pharmacists up and down the country believe that the Government should instruct clinicians to prescribe to the nearest pack size, usually 28 or 30 doses, or allow pharmacists to dispense the nearest number of whole packs. This is because the supply of an odd number of tablets can be confusing for patients, which means that often tablets are wasted, and creates a significant level of additional paperwork for the pharmacist.

Each patient pack comes with its own patient information leaflet, which the pharmacist must, by law, provide to the patient. Once packs start to be split up, these leaflets then have to be photocopied or reprinted. With an array of over 700 different drugs available in each pharmacy the paperwork involved in this process is immense, and certainly not in the patients' interest. A huge amount of a pharmacists' time is wasted on this basic administration, which is, in the view of the profession, almost wholly unnecessary.

3.3 There are also patient safety issues, particularly when odd numbers of tablets are prescribed. Not only do pharmacists have to spend time "snipping" up blister packs, but there have been occasions when patients, presented with a single tablet, have swallowed the surrounding blister pack as well. An agreement between Government and the medical profession to prescribe in line with standard pack sizes would ameliorate these issues and save community pharmacists a good deal of time, which could be spent more profitably elsewhere. **The Department of Health held a consultation process which covered this area last year. It was entitled Proposals to simplify the reimbursement arrangements for NHS dispensing contractors and it concluded on November 30th 2005, but the Department has yet to respond[15]. The Department of Health needs to fast track the implementation of the results of the consultation. A change in these arrangements is unlikely to adversely affect the overall costs to the NHS but would save a significantly amount of pharmacists' time and enable them to apply their skills and knowledge to other patient services.**

4. NHS reforms

4.1 The lack of awareness of the contribution of community pharmacy needs a higher level of engagement from those in the Department of Health and PCTs with responsibility for commissioning. There are lots of examples of good practice and the Primary Care Contracting (PCC) bulletin highlighted a number of these. We would like to see a concerted effort by senior figures in the Department of Health to promulgate these examples through the commissioning networks.

4.2 The White Paper sets out, in broad terms, the intention for our health and social services to: focus on promoting better health; improve capacity in general practice; support people with long term conditions and transfer services from hospital to the community. Community pharmacy has already done much to make this intention a reality and has tremendous potential to drive the pace of change. However there is a risk that, without adequate funding and effort to integrate community pharmacy with the newly emerging structures in primary care commissioning, this potential will not be realised. The engagement of community pharmacy with Practice Based Commissioning needs more than simple exhortation to be effective. The recently published PCC bulletin about the engagement with community pharmacy made a good case for engagement, but stopped short of requiring such engagement to take place. **Our experience with LHBs in Wales and subsequently with PECs in England, suggests that there needs to be a requirement to involve community pharmacy in practice based commissioning (PBC) in order for the issue to be taken seriously.**

4.3 The White Paper also reiterates the government's commitment to introducing choice in primary care by introducing levers in the way in which GPs are paid; by ensuring that

[15] Proposals to simplify the reimbursement arrangements for NHS dispensing contractors Department of Health 2005

money follows the patient and through opening the market in primary care to new providers. Community pharmacy is no stranger to this approach; indeed community pharmacy has delivered services to NHS patients in a competitive environment since the inception of the NHS. Exercising choice in terms of pharmaceutical services is, for most patients, a matter of whether the patient turns left or right on their high street. Money follows the patient, with most of community pharmacy's NHS income being linked to the number of patients who choose to walk through the door to have a prescription dispensed. Patients vote with their feet and community pharmacists have had to work hard to survive in this environment.

4.4 The RPSGB's self-care strategy, which was published earlier in 2006, sets out the potential for pharmacists in all sectors of primary care to make a meaningful contribution to supporting patients with self-care [16]. As the White Paper correctly points out, community pharmacy is already making effective strides to support patients with health advice and to manage minor illnesses: the first two levels of self care ("proactive self care" and "facilitated self care"). **The challenge that the White Paper sets is to make progress into the third level of self care, namely "supported self care". This will involve the pharmacist in providing support to patients to manage their medicines, to recognise unwanted side effects and to know what to do when these arise. If we are to meet the aspirations for supporting patients in this way, then we must have a concerted effort to create linkages between both sets of primary care contracts - exhortation is not enough.**

4.5 The level of awareness of medicines related problems does not seem to be as high as that of issues such as the cost of prescribing. This is not surprising given the need to manage PCT overspends. However, we believe that PCTs need to take ownership of these problems at Board level in order to manage the true cost of prescribing, including the costs of avoidable hospital admissions, etc. The Healthcare Commission is currently reviewing medicines management as part of their Acute Hospital Portfolio. This review is looking at the systems in place to manage medicine use within the hospital setting. A similar study in primary care would raise awareness of medicines related issues and give PCTs a means of comparing their performance against best practice.

4.6 Research shows that about 6.5% of admissions to hospital are related to an adverse drug reaction (ADR) and an estimated cost of £466 million per year[17]. Most of these are avoidable reactions. Community pharmacists have the skills and knowledge to be able to detect ADRs[18] but they do not have access to sufficient patient information to be able to systematically use their knowledge and skills. The sharing of appropriate information about the patient and the targeting of pharmacists' skills could significantly reduce the impact of ADRs on hospital admissions and reduce associated morbidity.

4.7 Carers reported undertaking between 1 and 10 medicine-related tasks for those in their care (median = 6) ranging from contact with surgeries and pharmacies to clinical

[16] Royal Pharmaceutical Society of Great Britain. The Self Care Challenge. A strategy for pharmacists in England. RPSGB, London 2006.
[17] Pirmohamed M et al Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients. BMJ 2004;329:15-19
[18] Paulino EI et al. Drug related problems identified by European community pharmacists in patients discharged from hospital. Pharm World Sci. 2004 Dec;26(6):353-60.

decision-making in the home. Different levels of involvement in, and approaches to, medication-related activities were described by carers in the context of their relationship with the care-recipient. The total number of medication-related activities was positively correlated with carer stress and negatively correlated with social functioning and mental health.

4.8 The recent report from the Commission for Social Care Inspection *Handled with Care?* (2006) highlighted the problems that exist in care homes relating to poor medicines management. It went on to say that care providers' need more support from healthcare professionals to develop safe working practices and recommended that this support should be commissioned from community pharmacists by PCTs [19].

4.9 Non-compliance in medicine taking is a long-standing problem in all therapeutic areas, including the treatment of cancer, arthritis and depression, the prevention of transplant rejection, and the lowering of heart attack and stroke risks. There is strong evidence that, despite the introduction of new medicines which have fewer side effects and are more convenient to use, many people still do not take them as prescribed – even when not doing so can have life-threatening consequences[20].

4.10 Medicines prescribed for preventive purposes are especially likely not to be taken as prescribed. This may be because people do not feel immediately threatened and, in the case of symptomless conditions such as raised cholesterol levels and hypertension, feel no obvious benefit at the time when the medicines are taken.

4.11 Up to 80% of patients may be "non-compliant" in their medicine taking, although the actual figure varies significantly between patient groups and types of illness. The figure is normally very much lower in contexts where there is an immediate risk of harm. Non-compliance in medicine taking can lead to significant morbidity and treatment failure. It is under-recognised as having a serious impact on healthcare.

4.12 Poor compliance with medication can jeopardise treatment, and increase the risk of admission, or re-admission, to hospital. A number of studies have implicated the occurrence of adverse drug reactions with admission to hospital, particularly in elderly patients. Recent studies have completed the "circle" between admission and discharge, identifying that between 19% and 23% of patients discharged experience an adverse event after discharge[21]. It is thought that almost 60% of unplanned readmissions could be avoided by more effective action at the time of discharge[26].

4.13 Several studies have looked at providing GPs and/or community pharmacists with either a simple discharge information form, or a copy of the discharge prescription. Both of the studies, which had investigated discrepancies in post-discharge medication, recommended providing community pharmacists with a copy of the discharge prescription[22]. The authors of one of these studies later tested the effect of providing

[19] Commission for Social Care Inspection. Handled with Care? Managing medication for residents of care homes and children's homes – a follow up study. London 2006
[20] A question of choice: compliance in medicine taking Medicines Partnership London 2005
[21] Moving patients, Moving Medicines, Moving Safely Guidance on Discharge and Transfer Planning RPSGB 2006
[22] Cochrane R, Mandel A, Ledger-Scott M, Walker R. Changes in drug treatment after discharge from hospital in geriatric patients. Br Med J 1992; **305**: 694-696.

community pharmacists with copies of information regarding medicines prescribed at discharge[23]. Discharge summaries, hand-delivered by the patient or their carer, have been shown to accelerate communication between hospitals and general practitioners. The impact of various formats of discharge summary have been investigated and generally shown to reduce the number of medication related issues that arose [26].

4.14 It has taken hard work and dedication by community pharmacists working with local people and the NHS to build up the relationships and trust necessary to secure the commissioning of new services. However, the nature of these relationships is about to change as PCTs relinquish their commissioning role to PBC structures. **Worryingly, evidence suggests that there is very little engagement between emerging PBC structures and local community pharmacists[24]. Furthermore there seems to be some reluctance by GPs to engage with the PBC process at all[25]. There is a real risk that the potential benefits to the population will be lost and that the good work to date will be undone without proper local clinical engagement involving community pharmacists.**

4.15 Unfortunately, given the way that PCTs were set up, it has been hard for community pharmacists to demonstrate their value at a strategic level. However, in Wales, community pharmacists have always had reserved places on Local Health Groups and later on LHBs. They have clearly demonstrated the value of their involvement and there are now two LHBs that are chaired by pharmacists. In Scotland, community pharmacists are designated members of Community Health Partnerships.

4.16 It is important that commissioners appreciate that community pharmacy needs sustainable contracts in order to fully invest in new services. Community pharmacists are a prime example of a profession that uses private finance to invest in NHS care. Each service development requires an investment of time, private capital and resources to support it. Community pharmacy has often invested in new services only to see the funding for them withdrawn, often because the commissioning authority has budgetary constraints. This, in turn, is demoralising for the pharmacists who have invested in and developed new services and, inevitably, makes them wary of further investment or future commitment.

4.17 The complexity of negotiating with a number of different local community pharmacy contractors, especially when some of them belong to large national companies, may be an additional barrier to effective local commissioning. It is always going to be more complex to negotiate with a multiplicity of pharmacy contractors than with one single company, leading to a temptation to negotiate with one or other of the large multiples directly rather than attempt to engage all local community pharmacies in new initiatives. This is evidenced by both the national level negotiation that Boots has had over Chlamydia screening and locating GP surgeries in Boots stores. The Local

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Duggan C, Bates I, Hough J. Discrepancies in prescribing - where do they occur? Pharm J 1996; **256**: 65-67.

[23] Duggan C, Feldman R, Hough J, Bates I. Reducing adverse prescribing discrepancies following hospital discharge. Int J Pharm Pract 1998; **6**: 77-82.

[24] Blenkinsopp A, Celino G. Community pharmacy's contribution to the management of long term conditions. RPSGB 2006. Report 2

[25] Meldrum H. Bring GPs on to the pitch. Speech to BMA Conference 2006

Pharmaceutical Committees (LPCs) play a vital role in local negotiation and should be better utilised.

5. Collaborative working

5.1 The vision that we have set out for a greater range of clinical services provided through pharmacies requires close collaboration between pharmacists and other healthcare professionals. This has largely been achieved in secondary care where the pharmacist is an accepted member of the clinical team. There is still variation in practice in secondary care that needs addressing as was highlighted in the Audit Commissions report "A Spoonful of Sugar" [26] and the Healthcare Commission's Acute Hospital Portfolio review of Medicines Management (http://www.healthcarecommission.org.uk/serviceproviderinformation/reviewsandinspections/acutehospitalportfolio/medicinesmanagement2005/2006.cfm).

5.2 The new primary care contracts have driven through a significant change in the focus of the work of both GPs and community pharmacists. To realise the potential of community pharmacy and for community pharmacy to make a meaningful contribution to the delivery of the White Paper will require a fundamental change in the way in which community pharmacy and general practice work together. However GP, pharmacy and NHS stakeholders have all observed that the new contracts do not offer opportunities or incentives for the two professions to integrate their ways of working in a way which would realise the full potential of practice in both sectors[27]. Without active monitoring and practical encouragement for further integration, the aspirations of the White Paper cannot be met.

5.3 As recent work, published by the RPSGB in September 2006, shows, community pharmacy, with the right support and opportunity, can make an important contribution to the care of patients with long-term medical conditions (LTCs). After all, the community pharmacy is often the healthcare setting most frequently accessed by patients with LTCs. Our work to understand the potential contribution of the community pharmacist to the management of LTCs raises some concerns that go to the heart of the question of integration. While community pharmacists and GPs work in the same communities, caring for the same populations, we have yet to see examples of truly joined up integrated working. Again, without joined-up working, community pharmacy's contribution will be diminished. The RPSGB LTC report also highlighted the lack of integration between the new contracts. The contribution of community pharmacy needs to be valued in its own right as "additional care" and not "alternative care". Specifically attempts to fund work by community pharmacists by redirecting funding intended for GPs is seen as divisive.

5.4 If we are to meet the aspirations for supporting patients with LTCs, then we must have a concerted effort to create linkages between both sets of primary care contracts. Exhortation is not enough, a crucial factor will be to ensure that GPs and pharmacists are able to share and access information about their patients and this must be backed up by investment to facilitate change.

[26] Audit Commission. A Spoonful of Sugar – medicines management in NHS hospitals 2001
[27] Blenkinsopp A, Celino G. Community pharmacy's contribution to the management of long term conditions. RPSGB 2006. Report 2

6. Location and access to community pharmacy services

6.1 The coming together of GP practices in England and Wales into large primary care centres raises the prospect that community pharmacies that are located away from these centres would lose the majority of their prescription business and hence become unviable. The combination of the centralisation of general practice and loss of community pharmacies would leave large areas devoid of local healthcare support. The effects of the loss of local pharmacies in a community were highlighted in the New Economics Foundation report "A lethal prescription – Ghost Town Britain"[28][29]. These effects included the closure of many secondary parades and subsequent degeneration of the area.

6.2 With regards to the Control of Entry regulations, the views of the Society are based on the principle that any reforms do not damage the network of local community pharmacies that exist and serve the public not only in areas in which they shop, but also in areas in which they live and work. The concern of the Society has always been that changes to the entry controls must not result in people from less commercially attractive areas having reduced access to a local pharmacist, particularly vulnerable patients who may not be in a position to travel, such as the elderly or those with long-term illness. The Society has also always been concerned that an increase in pharmacies opening more than 100 hours a week does not result in a destabilisation of the local community pharmacy network and place additional, unmanageable strains on the pharmacy workforce. These concerns also apply to the exemptions that apply to one-stop primary care centres.

6.3 One of the intentions of the reforms was to promote an increase in consumer choice but the Society has yet to see any evidence that this has occurred, other than a rise in the number of applications for new pharmacies mostly in urban areas. According to recent research, 70% of recent applications met criteria exempting them from the 'necessary and desirable' test. The Society's concern is the effect that these new 'exempt' pharmacies might have on the existing community pharmacy network.

6.4 This community pharmacy network already provides a substantial public health role. The Government recognised this in *Choosing Health through Pharmacy* (Department of Health, 2005) when it quoted research that showed 94% of the population visits a pharmacy at least once a year and that priority groups such as older people, families with young children and those living in inner cities or rural areas are amongst the most frequent visitors. The Government paper acknowledges these groups are likely to have greater health needs, may not have access to a car and rely on local pharmacies to meet their need. In order to capitalise on this unique public health role the paper advises that PCTs "should consider the location of pharmacies in relation to areas of social deprivation and health need, and review the range and distribution of pharmacy services". The new regulations have introduced an instability into the marketplace that risks destroying this valuable public health network in favour of one where pharmacies exist only in clusters around more 'profitable' areas further increasing health inequalities.

[28] New Economics Foundation. Ghost Town Britain II. NEF, London. March 2003

[29] Francis S, Smith F, Gray N et al. The roles of informal carers in the management of medication for older care-recipients Int J Pharm Pract 2002:3:1-10

6.5 The coming together of GP practices into large primary care centres has the potential to exacerbate the effect of the 100 hour pharmacies. There are real fears that community pharmacies that are located away from these centres would lose the majority of their prescription business and hence become unviable. The combination of the centralisation of general practice and loss of community pharmacies would leave large areas devoid of local healthcare support. The effects of the loss of local pharmacies in a community was highlighted in the New Economics Foundation report "A lethal prescription – Ghost Town Britain". The Society's concern about automatic exemptions is that they only serve the users of that particular outlet and encourages the opening of new pharmacies based on their ability to be commercially successful and not on their ability to serve the interests of the whole of a locality. The awarding of a single contract cannot be considered in isolation, as these exemptions allow, but must be considered in the context of pharmaceutical services across a whole health economy. The Society would like to see these exemptions to the 'necessary and desirable' test removed.

6.6 **Under the new legislation PCTs have been asked to perform pharmaceutical needs assessment. Recent research highlights the fact that while most PCTs have carried out a pharmaceutical needs assessment, many of them have not made direct use of them in their commissioning.** There is little point to these assessments if PCTs cannot develop the local community pharmacy network to meet identified and future needs because existing pharmacies are being rendered unviable from the awarding of contracts exempt from the 'necessary and desirable' test.

6.7 **The Society is also concerned about the assumption that increased competition automatically equates to increased benefit for the patient (rather than the consumer). In its report, the New Economics Foundation warns against equating a free market with wider accessibility. While the argument that an increase in competition may lead to cheaper over-the-counter medicine it ignores the social function that the current community pharmacy network fulfils. Looking at pharmacies from the limited perspective of retail potential misses their central purpose.** This purpose is identified in the Department of Health introduction to the new contractual framework for community pharmacy which states "The New Community Pharmacy Contractual Framework will improve the quality and range of services that pharmacists offer. For members of the public it will mean a greater choice of health provider, and improved access to services. In addition, the new contractual framework will help to support people with long-term conditions and will promote health improvement through the introduction of signposting to other service providers, support for self-care and provision of healthy lifestyle advice. In all of these ways, the new framework will help to shift the focus of the health service towards health improvement, self-care and disease prevention".

7. Regulatory matters

7.1 The RPSGB has long campaigned for changes in working practices in community pharmacies to allow pharmacists to make best use of their skills and expertise for the benefit of the public. The RPSGB welcomes the fact that the Health Act 2006 addresses many of the issue of concern relating to requirements about supervision and responsibility in a pharmacy.

7.2 Legislation has required a pharmacist to be present in a community pharmacy at all times that medicines are supplied or sold. This has inhibited the ability of the pharmacist to leave the pharmacy in order to meet with GPs or to undertake any professional duties

outside of the pharmacy unless a locum pharmacist is engaged to provide cover. The Health Act 2006 provides for some changes to this to be developed. **The Health Act is largely enabling with most of the detail being written into regulations. The RPSGB wishes for some flexibility to be built into the system while not adversely affecting patient safety and has been assured by Westminster Government that our concerns will inform the regulations under the Act[30].**

7.3 We are pleased that the Government has listened to our views on developing the concept of the 'responsible' pharmacist, which will enable some aspects of the pharmacist's role to be carried out by other staff members and which will free pharmacists to begin to provide some of the other services set out in the newly negotiated community pharmacy contract. The Medicines Act currently requires the pharmacist to be in 'personal control' of key pharmacy functions. This effectively prevents the pharmacist from leaving the pharmacy, even for a short period, during the opening hours of the pharmacy. It also deters appropriate delegation and acts as a barrier to modern working practices. The Act replaces this requirement with a provision for a 'responsible pharmacist' who will have professional accountability for all processes in the pharmacy. This allows the pharmacist to be temporarily absent from the pharmacy in order to carry out professional duties such as visiting housebound patients, meeting with local GPs etc. Another provision is for the supervision of certain activities to be delegated to appropriately trained registered pharmacy technicians. Allowing suitably trained and registered staff working in a pharmacy to supervise the preparation, dispensing, sale and supply of medicines without direct supervision of a pharmacist will help ensure that pharmacists can use their skills and training to offer a wider range of services.

7.4 The Act allows for much of the detail of these changes to be written into Regulations. These detailed Regulations will need careful consideration if they are to deliver benefits while maintaining patient safety. While the RPSGB would have preferred to have seen the new measures set down on the face of the Act, it is seeking to be actively involved in the process of drawing up the regulations through which the obligations of the pharmacist and the framework for responsibility are clarified.

7.5 The RPSGB takes the view that the legislation should clearly define those activities that can only be undertaken when the responsible pharmacist is present and should include:

- **Clear lines of accountability;**
- **Provisions for the responsible pharmacists to be contactable when absent and in a position to return without undue delay;**
- **Provisions for the responsible pharmacist to have to justify any absence from the pharmacy.**

7.6 The RPSGB had a number of concerns about the wording of the legislation. For example, the RPSGB believes that it is vital that the responsible pharmacist is responsible for no more than one pharmacy in other than very exceptional cases, such as in an emergency. There could be significant financial incentives that could mean that a loosely-worded or –policed exception could become the rule in practice. In addition, the RPSGB notes the provisions to allow the responsible pharmacist to remotely

[30] Briefing to Peers at Grand Committee Stage of the Health Bill 2006 http://www.rpsgb.org/pdfs/healthbillgcstagebrief.pdf

supervise in another pharmacy. Again, the RPSGB believes that this level of supervision should only apply in very exceptional circumstances as there is a risk that patient care could be compromised if pharmacists were trying to supervise both the activities in the pharmacy in which they were present and a remote pharmacy.

7.7 The RPSGB has responded to the public consultations on proposals for changes to healthcare regulation: "Good doctors, safer patients" and "The Regulation of Non-medical Healthcare Professionals" in detail and our response can be found at http://www.rpsgb.org.uk/pdfs/consdoc1209.pdf .

8. Pharmacy education and training

8.1 Are pharmacy degree courses producing pharmacists who can deliver a new range of services? Yes they are because syllabi are dynamic and because we make it a requirement that schools build in major developments into the final year to ensure students leave with up-to-date knowledge. That said, **schools cannot provide as much clinical exposure for students as we and they would wish because of funding constraints. Pharmacy and the MPharm is part-scientific (i.e. lab-based) and part-clinical but the funding is entirely scientific. In concrete terms, of the 4 years of an MPharm all are funded at the Higher Education Funding Council for England's Band B (lab-based) but to provide much more (and meaningful) clinical work we need two of those years to be funded at Band A levels.** The funding differential is over 100%. Much clinical exposure is achieved through non- or part-funded local arrangements which are, inevitably, vulnerable. **Teacher-practitioners (pharmacists working part in practice and part in schools of pharmacy) need to be funded on clinical pay scales (as do some pharmacy practice staff) to attract them out of other sectors into academia. Currently they can earn more elsewhere and are doing so.**

8.2 The question of what changes need to be made in pharmacy degree courses to ensure new pharmacists can meet the requirements of the NHS, is the same as for the last question: the syllabi are fine but clinical exposure is lacking (and it is perhaps more acute in terms of exposing students to secondary care practice). The current uncertainty around NHS funding more generally is not helping and schools do not know whether or not they can rely on current arrangements with external partners in the future. Schools will have to cut their coat according to their cloth (as always) but there could be less of it in future.

8.3 The Society is undertaking a review of both the MPharm and preregistration standards i.e. the indicative syllabus and criteria, the preregistration programme performance standards and the registration exam syllabus. Implementation will be taken forward as part of the introduction in 2008 of the education rules under the S60 Order. Implementation will include an overhaul of the Society's quality assurance processes as they relate to the preregistration year i.e. the approval of tutors, premises and programmes. The lack of comprehensive fully integrated quality management infrastructure in pharmacy, comparable with the Deanery network in medical education, may limit the speed with which increases in quality assurance of the preregistration year can be implemented by the Society.

8.4 As part of the new legislation the Society will have increased responsibilities in relation to regulating advanced and specialist practice – it will build on the established approaches to annotating its register in relation to supplementary and more recently independent

prescribing. This will also have implications for the structure, funding and quality assurance of pharmacy education.

8.5 The profession has a relatively new framework for CPD that has been introduced by the Society in response to the views of its members. These views were expressed through a consultation on Pharmacy in a New Age a strategy for the development of the profession published in 1996 and confirmed through a second consultation on the details of the CPD scheme in 2003. The framework complies with Government expectations for all health professionals to participate in CPD.

8.6 A major principle of the Society's CPD scheme is that it requires the pharmacist (or pharmacy technician) to learn and maintain their competence for the job that they do. So the CPD framework is applicable to all members and registrants who use their professional skills and knowledge at work. It applies equally to pharmacists in patient facing roles and those who work in industry, academia and government. Unlike the CPD schemes in some other professions, there is no requirement for a member to participate in a particular type of learning activity. Pharmacists may participate in traditional continuing education activities such as workshops and distance learning as well as learning through experience at work, giving lectures, research etc. The most important feature of CPD as implemented in pharmacy is that a pharmacist must identify how their learning has benefited their practice as a pharmacist.

8.7 The profession has been well served by the Government sponsored Centres for Pharmacy Postgraduate Education. These centres provide a wide range of continuing education materials and opportunities. These focus on the updating and application of professional knowledge and skills and also on the major professional changes required by new health service and policy initiatives such as the new pharmacy contracts. The majority of pharmacists have access to postgraduate education at a local university and this provision is especially important for the development of pharmacists in the hospital sector. The availability of postgraduate education and training for pharmacist prescribers is another example of the profession and the higher education sector responding to meet a new professional and policy need.

8.8 In the future, with practice based commissioning in England and the development of new services accredited by local health service organisations, pharmacists will be undertaking professional development to achieve locally defined competences. The professional regulator, while informed and cooperating in these initiatives will not be setting professional standards for locally designed services. The major priority in these circumstances will be that the education, training and accreditation of pharmacists by local NHS organisations are fit for purpose and consistent with patient safety.

8.9 It is also worth noting that similar approaches will be applied to pharmacy technician education once the register of pharmacy technicians becomes mandatory and technicians become members of regulated profession alongside their pharmacists' colleagues.

9. Information technology

9.1 The NHS IT programmes should engage with community pharmacy to ensure that solutions are delivered that enable community pharmacy to deliver new services, such as prescribing, public health interventions, etc. from their pharmacies. This

requires significant development of both the infrastructure to achieve connectivity and of the pharmacy software required to support these developments. Currently, the engagement in England is focusing almost exclusively on the electronic transfer of prescriptions, but is largely ignoring wider engagement.

9.2 The development of electronic care records would allow the sharing of patient specific information between healthcare professionals in a number of different settings. This would include information about the patient's medical conditions and problems; their current medication history and other important aspects of their care. As previously mentioned the sharing of appropriate information about the patient and the targeting of pharmacists' skills could significantly reduce the impact of ADRs on hospital admissions and reduce associated morbidity.

9.3 Currently, pharmacists in community pharmacy only have access to the information included on the prescription that they dispense and any previous prescriptions that they have dispensed for the same patient. However, if the patient obtains some of their prescriptions from other pharmacies or from secondary care, the pharmacist may not have a full picture of all the medicines being prescribed for the patient. They will also have little information about the condition being treated. This makes it difficult to assess the appropriateness of the medicines prescribed or whether they may interact with other medicines that the patient is taking. In turn, it is difficult to fully advise the patient about their medicines without an understanding of which medicines are being used to treat which condition.

9.4 Pharmacists undertaking medicines usage reviews will often receive information that would be helpful to the GP caring for the patient. The lack of good IT integration prevents the pharmacist from sending information in a form that can be easily integrated into the patient's medical records. This hampers the doctor in reviewing the information supplied by the pharmacist.

10 Blue Sky Thinking

10.1 In 1995, the RPSGB undertook a future mapping project, *Pharmacy in a New Age*[31], and many of its conclusions are now enshrined in health policy in all three countries of Great Britain. **The RPSGB is about to embark on its Pharmacy 2020 project[32], which aims to identify the challenges and drivers that affect the profession's ability to fulfil its potential in health care provision, to identify good practice in pharmacy and to prepare a forward strategy to take pharmacy to the year 2020.**

10.2 The RPSGB has been working to realise some key new professional developments including pharmacist prescribing, medicines management and the pharmacist's role in public health. The RPSGB has embarked on several major programmes of work to ensure that the pharmacy workforce of the future has the knowledge, skills, attitudes and regulatory and practice framework to deliver the services of the future. **For the profession to achieve its full potential is of immense importance not only to the profession but to society, the public and patients, to the Government in delivering its policies for the NHS.** The RPSGB recognises the complexity of its leadership role and acknowledges the challenges of taking the profession into new territory. The

[31] http://www.pjonline.com/Editorial/20060826/articles/p256piana.html
[32] http://www.pjonline.com/Editorial/20060826/society/p260pharmacy2020.html

RPSGB is taking forward a number of initiatives to improve the ways it regulates pharmacists and guides and supports them to provide the best possible care.

10.3 A key element of this work is a root and branch review of pharmacy education and training policy. The programme will focus on different aspects of the education process for both pharmacists and technicians, including: setting policy for post registration education and revalidation (including registration policy relating to advanced/specialist practice); reviewing education standards and quality assurance systems; and developing an implementation programme.

10.4 A fundamental review of the codes of ethics for pharmacists and pharmacy technicians is being conducted[33]. Pharmacists and pharmacy technicians work in a range of different settings and their roles, responsibilities and ways of working are constantly evolving. In this changing environment, pharmacists and pharmacy technicians need to be able to use their professional judgement and be accountable for the decisions they make. The revised codes of ethics will support this. It will reflect modern pharmacy practice and continues to ensure patient safety and public confidence in the pharmacy profession.

10.5 The RPSGB provides enabling professional frameworks to facilitate pharmacists' involvement in health planning and commissioning. It has recently launched a publication explaining how community pharmacists in England can make a greater contribution to the care of people with long-term medical conditions (LTCs) [34]. It is a practical guide for use by commissioners, pharmacists and others with an interest in improving the care and clinical outcomes of people with long-term medical conditions. It outlines practical ways in which, by working more closely with local GPs, the potential contribution of community pharmacy can be realised to better manage long-term conditions such as asthma, diabetes and coronary heart disease.

10.6 Pharmacy is going through a period of critical change to move into a significantly increased clinical role. The new NHS contracts demand certain changes and the aims of the White Paper require further change if they are to be fulfilled. This requires a change in the culture of pharmacy and a change in direction in order to both take on an increased clinical role and to effectively delegate many of the tasks that they currently undertake. While general practice has had significant support with change management to implement the new NHS contract, community pharmacy has had little support from government for change management. If the potential of community pharmacy is to be realised, the profession and the Departments of Health need to work together to put in place the support for the organisational change management and clinical leadership development that community pharmacy needs.

10.7 The Departments of Health should play a key role in working with the profession to support pharmacy through a significant period of change. In England and Wales, there is an opportunity to divert some of the money that is likely to be underspent from the first year of the new community pharmacy contract to provide this support.

[33] http://www.rpsgb.org/pdfs/coeconsbackground.pdf
[34] http://www.rpsgb.org/pdfs/ltcondintegcommphsumm.pdf

10.8 The RPSGB has piloted a clinical leadership programme for pharmacists. We have taken pharmacists working in PCOs, community pharmacy and hospital pharmacy and developed them as a team. We took this approach because pharmacists were not being offered multi-disciplinary leadership programmes and we saw this as an essential first step to widespread change. The evaluation shows the success of the approach in both developing the individuals and in solving local problems. We would like to see this programme used to develop the local leaders to lead community pharmacists through professional change. We are in the process of talking to the Chief Pharmaceutical Officer for England and the Chief Pharmaceutical Adviser in Wales about how this programme could be used to support the implementation of the new contract.

11. Summary

More than at any time in the past, there is a real prospect of pharmacists being able to meet their own professional aspirations by providing new, effective services to patients that deliver the NHS agenda.

The RPSGB is working at many levels to help the pharmacists of the future deliver the services of the future.

We welcome the opportunity of the All-Party Pharmacy Group's inquiry, which gives the RPSGB the opportunity to highlight key issues that we feel will be of interest to the Group in its investigations.

We would be happy to discuss any aspect of our submission with the All-Party Pharmacy Group.

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