Gateshead & South Tyneside Local Pharmaceutical Committee
Passionate about pharmacy

Sunderland Local Pharmaceutical Committee
Delivering local pharmacy solutions in Sunderland

Chair David Carter Secretary Louise Lydon **Chair Umesh Patel Secretary Jim Smith**

NHS ENGLAND CALL TO ACTION: IMPROVING HEALTH AND PATIENT CARE THROUGH COMMUNITY PHARMACY

RESPONSE FROM GATESHEAD & SOUTH TYNESIDE AND SUNDERLAND LOCAL PHARMACEUTICAL COMMITTEES

Introduction

1. Our local pharmaceutical committees (LPCs) represent community pharmacy contractors in Gateshead Metropolitan Borough, South Tyneside Metropolitan Borough and the City of Sunderland. The total population of 615,000 is served by 155 community pharmacies. The area is characterised by high levels of socio-economic deprivation and health need and, consequently, poor health outcomes. Provision of primary, secondary and tertiary health care services, however, is considered to be good.

2. The LPCs represent a mixed pharmaceutical economy of pharmacies owned by national chains, independents, supermarkets and smaller regional multiples. Geographical coverage of pharmacies is generally good and is recognised as such in the respective NHS pharmaceutical needs assessments (PNAs). Pharmacies in the area work well together through the LPCs and other forums to collaborate in service planning and commissioning with clinical commissioning groups (CCGs), NHS England Cumbria, Northumberland, Tyne and Wear area team, the three local authorities and the recently established local professional network for pharmacy (LPN).

3. Given the health status of our populations, a priority in recent years has been to commission and deliver public health, health protection and health improvement services. We have also worked to improve support provided through pharmacies for people with acute and long-term conditions.

4. There has been steady growth in the provision and effectiveness of these services, but we believe strongly that much more needs to be done, and done efficiently and effectively in the context of national and regional economic constraints. We therefore welcome NHS England's Call to Action for community pharmacy, which is both timely and well articulated.

5. We recognise the picture set out by NHS England of health care services that are increasingly difficult to sustain in the face of demographic and social change, ever increasing public expectations and the steady flow of new and

often expensive interventions (often medicines) that can improve life expectancy and quality but whose introduction must be managed. Our members and their staff experience these pressures in their daily work in the community, frequently having to support patients in making treatment choices and accessing appropriate care.

6. The NHS England consultation pack addresses a wide range of issues, all important and all identifying areas where innovative development of pharmacy services can improve safety, clinical outcomes, efficiency or patient experience. We have worked on these in well-attended consultation events with our local area team and the LPN; our LPN Chair, Richard Copeland, is coordinating feedback from these. In this response from our joint LPCs, we would like to focus on a number of themes that our members believe are particularly important.

How best to secure pharmacy expertise in the care of vulnerable people

7. Despite decades of research and service development the NHS and social care systems as a whole still sometimes fail people with long-term conditions in the community, sometimes with tragic results. There is too much avoidable ill health and, in consequence, there are unnecessary hospital admissions. The causes are often medicines-related, and most community pharmacists can give graphic examples of where things have gone wrong. An elderly lady in our area became very ill and spent a totally avoidable month in hospital simply because no one at her GP practice was looking at the routine lab reports (or understood the data) on her electrolytes while on diuretic therapy.

8. Community pharmacists have the expertise to monitor therapy and are already doing much in this area. We need to find ways to formalise this input into care of people with long-term conditions. Domiciliary medicines use reviews (MURs) are already happening, albeit not as a formalised service in most places. But there is good evidence of benefits and savings, for example in the Croydon project. The MUR service should be strengthened and focused on vulnerable people, expanded to encompass clinical monitoring of therapy, and extended to include reviews in patients' homes. Domiciliary MURs could also be of great value in follow up of patients' medications on discharge from hospital, where errors and confusion are commonplace. Similar considerations apply to people in care homes.

9. It will be important in developing these services to minimise the bureaucracy around pharmacy services. For example, we are aware that fully trained and accredited pharmacists have been reprimanded for performing domiciliary influenza vaccinations when this was clearly in the best interests of vulnerable housebound patients. There is a need more generally to maximise the professional autonomy and judgement of pharmacists. Current regulations on community pharmacy are unduly restrictive. Pharmacists should have more freedom to make sensible changes to patient therapy

(e.g., to change to an equivalent product if prescribed item is unavailable and vary dosages where appropriate). We hope that the Chief Pharmaceutical Officer's work on the burden of pharmacy legislation will yield progress on these issues.

Community pharmacy teams as first port of call for minor ailments

10. Demand on GP and accident & emergency services is rising steadily and such episodes of care are often inappropriate or unnecessary (although we should recognise that they may seem entirely rational from the patient's perspective). Community pharmacists and their staff have worked to develop minor ailments schemes (MAS), with much success in helping to manage such demand. There is much scope for further development and consolidation of pharmacy as a true first port of call and integral part of the care pathway.

11. Existing training in schools of pharmacy and through CPPE is good but should be strengthened. We recognise that sometimes patients are referred unnecessarily to GPs or A&E, which is self-defeating and can discredit schemes with patients and doctors. To put schemes on a proper footing and increase confidence of doctors and patients there needs to be a higher level of training so that pharmacy staff are able to triage people and treat or refer appropriately and confidently. We recognise that MAS must deliver value for money and that benefits and costs need to be carefully monitored.

12. Commissioning of MAS is currently fragmented and services vary greatly, often in neighbouring areas. Formularies are variable and are sometimes too restrictive. We are strongly of the view that to achieve maximum impact, MAS should be commissioned nationally as an essential service. However, we recognise that this may be counter to current policy on devolution of decision-making and budgets. But we would urge that commissioning of MAS be undertaken at a supra-CCG level. We would support the NHS England area teams and LPNs in leading work with CCGs and other stakeholders to establish a regional MAS.

Balance of medicines supply role and provision of clinical services

13. Clinical community pharmacy services have developed rapidly since the 2005 contractual framework was introduced and have provided great benefit to patients. They have evolved alongside the well-established supply function and are closely integrated with it, for example, MUR or new medicines service interventions are usually triggered by a patient or carer presenting a prescription.

14. Notwithstanding the sometimes serious problem of shortages, the medicines supply chain is generally very efficient; patients get the medicines they need, usually very promptly, with appropriate clinical advice, and the NHS achieves value for money. We recognise that developments in

information technology and robotics may offer further efficiencies. However, we would urge caution in this area. The concept of centralised supply hubs, supported by electronic prescriptions, robotic dispensing and possibly 'telepharmacy' seems attractive.

15. Such developments, unless managed very carefully indeed, could threaten the community pharmacy business model that has served the NHS so well. Pharmacies are at the heart of communities, in the high street, in retail centres, and on housing estates. This localism is the platform from which our services are provided and they are, of course, funded in part by reimbursement margins on the supply function.

16. But the network is fragile and susceptible to market pressures, reimbursement changes, and local commissioning decisions. The Department for Communities and Local Government aims to support sustainable communities – "to create strong, attractive and thriving neighbourhoods". The local pharmacy is often a key element in the community, providing support far beyond its strict contractual obligations. Just as GPs often describe themselves as "social workers", so it is with pharmacies. In any move to explore new ways of medicines supply, these social benefits must be recognised and sustained.

17. And, as we touched on above, pharmacy clinical services are frequently closely linked with the supply function. In one of the patient stories cited in the Call to Action consultation pack, the pharmacist is able to offer stop smoking advice triggered by dispensing an inhaler to the patient. Such opportunistic 'brief interventions' are recognised as an effective public health intervention; we must ensure that their provision is not jeopardised.

18. We would stress that we are not opposed to all supply chain innovations. Rather, we are arguing for caution. But any developments must ensure that resources are provided for the local clinical services that pharmacists have worked so hard to develop in recent years. It is difficult at present to see how this could be achieved; there is no clear model of how such funding could work.

Commissioning frameworks

19. We have indicated above that our preference is for national commissioning of key services, for example minor ailments schemes or domiciliary MURs. We believe that this approach will guarantee standards of service, provide equity of access for the public, and help sustain the community pharmacy network.

20. However, if services are commissioned locally we believe that they should be commissioned at a supra-CCG level. CCGs in the North East are already collaborating on a number of commissioning issues and this could be extended to pharmacy services. We would like to see a rational

commissioning process locally with a level playing field for GPs and pharmacists – at present we are often in competition – that makes best use of skills and resources. We would welcome the opportunity to work with NHS England, the LPN and all stakeholders to take this concept forward.

Conclusion

In summary, we welcome the call to action and the opportunity to submit our thinking on the best way forward. We support the analysis set out in the consultation pack and we believe that community pharmacy can offer much more to patients and the NHS. Our committees look forward to working with NHS England and our partners locally to realise these improvements in care.

David Carter FRPharmS
Chair
Gateshead and South Tyneside Local Pharmaceutical Committee

Umesh Patel MBE DL FRPharmS
Chair
Sunderland Local Pharmaceutical Committee

March 2014