Community Pharmacy Call to Action

NTW response

Q1 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 now and in the future?

1. The role and profile of pharmacists and their teams needs to be elevated; the perception of many people does not reflect the full role undertaken. Whilst the RPS has taken great strides in recent years to raise awareness of the pharmacy profession through the media, and via engagement with government, the image of community pharmacy has not necessarily changed.

2. There are a number of means which can be used to raise awareness of the role:
   - Local/national campaigns for "quick wins". The effect of these may be limited, but as part of a longer term strategy, they may begin to frame the key messages.
   - Promote positive role models on television. Characters portraying pharmacy, for example in soap dramas, are often inaccurate, or negative. It is interesting to note that a consultant pharmacist will feature in "*Holby City*", giving an opportunity to portray aspects of hospital pharmacists' work. Similar roles could be developed for community pharmacy. Perhaps also an opportunity for an updated version of the "*Victorian Pharmacy*"?
   - Longer term comms strategy to include features via the radio, local and national newspapers; co-ordination through RPS and Pharmacy Voice would be helpful.
   - Full use of social media, both at national and local level. For example, are pharmacies using Facebook/Twitter to promote public health campaigns or initiatives to treat early? Do they make use of text alerts in chronic disease, or for medicines use reviews?
   - Greater clarity and consistency to promote the functions on offer e.g. availability of confidential counselling rooms, use of leaflets and in-store signage. Greater clarity in definitions, for example, "medicines use reviews" could be described in a more personal and individual way e.g. "pharmacist review"?
   - Pharmacies to lead discussion or focus groups, targeted at the young, elderly, or those with specific disease states. Co-ordination with general practices, and with local services including libraries, social centres will assist with consistency of the message.
   - Undertaking practice development, publishing and disseminating results in the local community, as well as nationally. Capturing data on the "added value" provided through community pharmacy, for example through signposting or provision of brief public health interventions.

3. The public can be encouraged to utilise the range of services provided through the methods outlined above, but also aligned to changes in infrastructure and service delivery. For example:
    - Community pharmacy being seen as the gateway to NHS services, with appropriate referral mechanisms to general practice, social care, optometry and dentistry.
    - Providing support for self-care, and for patients with long-term conditions, **fully** aligned to services provided through general practice.
    - Providing access to patient information via technology – Summary Care Record as a minimum dataset, or use of chip & pin cards as is already common practice in other EU countries.
    - Using the skills and resources of the whole pharmacy team in providing health care.
    - Integrating the 'transfer of care' pathway for patients going into and coming out of secondary/tertiary care services; ensuring that IT infrastructure can be developed to support this.
    - Registration of patients, either with pharmacies or with individual pharmacists, may increase the profile of pharmacies or assist with the points noted above. Registration could be seen as a barrier to accessibility to a range of pharmacies, but can also be viewed as a potential strength, that is, maximise the use of both.
    - Making full use of pharmacy needs assessments within public health, aligned to local authority priorities and the needs of the community.
    - Ensure that opening hours of pharmacies meet the needs of the community, and are tied in with needs assessments.
    - Recognise that there will need to be a balance between high standards for all community pharmacies, and development of specialisation in certain areas – reflected in commissioning of specific services.
    - Maximise the current status and future uptake of Healthy Living Pharmacies, so that these become the norm.
    - It is also recognised that community pharmacy needs to "raise its game". Whilst there are many examples of good practice, there are also examples where practice is not to the same standard; this might be related to an over-reliance on the use of locum pharmacists within community pharmacy. Pharmacists need to be seen as the "medicines advocate" for the patient.

Q2 How can the way we commission services from community pharmacy maximise the potential for community pharmacy to support patients to get more from their medicines?

4. The key issue here is the means by which community pharmacy receives its income. There is a need to maximise the professional autonomy and judgement of pharmacists as healthcare professionals. Moreover, recent changes in commissioning have resulted in a more complicated picture, with pharmacies having to claim their income from a number of sources.

5. Currently, pharmacies are funded on the basis of "piece-work", for example number of prescriptions dispensed, or achievement of target numbers of medicines use reviews. As businesses, an emphasis will inevitably be placed upon maximising income from available income streams. Thus, dispensing volume remains of key importance, as opposed to medicines reviews and supporting adherence. Whilst there is remuneration for targeted medicine use reviews, this can become a "tick-box" exercise, and once the target is achieved, there is no incentive to undertake more. There is also a danger that quality can be compromised, if insufficient time is planned to undertake this activity.

6. Development of a "quality outcomes framework", similar to that developed for general practice, could provide additional incentives to support patients with medicines use, and demonstrate reductions in prescribing expenditure and dispensing costs.

7. Registration of patients, either with pharmacies or individual pharmacists, may assist commissioning of a patient focussed service, rather than a "dispensing plus" service. This will aid the provision of services for hard to reach patient groups, such as the frail elderly, the housebound and those with impaired mobility, who often cannot get to a community pharmacy. Moreover, the number of medicines reviews required will be determined by local health needs, rather than artificial targets.

8. We need to ensure that pharmacies are located in the right place, and open for sufficient hours for the communities they serve. Whilst it is notable that many pharmacies are located in deprived communities, there are examples where communities are not adequately provided for.

9. There needs to be a balance between nationally commissioned services and local requirements. For example, national approaches could be adopted for medicines use reviews, minor ailments schemes and emergency supply of medicines, with locally commissioned services to match the health needs of patients with long term conditions.

10. Similarly, there is a need to avoid unnecessary duplication of accreditation between localities, and provide a national mechanism for this.

11. Commissioned services must be aligned with services provided by GPs, supporting collaboration rather than competition e.g. use of smoking cessation clinics/clubs. There is no shortage of activity to be undertaken in health care – referral to services which have capacity makes good health care and economic sense.

12. Specialisation of roles for some community pharmacists may be of benefit, for example, to serve a local population with a high prevalence of COPD. Capacity of workforce and training requirements need to be considered in conjunction with plans to develop such roles, to reflect the skill-mix requirements of the whole team in a community pharmacy.

13. Sufficient resource needs to be provided to enable local area teams to co-ordinate the commissioning of services provided by community pharmacy, or simplify the commissioning structures to streamline this process.

Q3 How can we better integrate community pharmacy services into the patient care pathway?

14. Feedback emphasised that community pharmacy provides a key function for patients with long term conditions, but may be perceived to be peripheral to the care pathway. A number of developments would facilitate integration of community pharmacy within the care pathway:

- Patient registration with pharmacies, or individual pharmacists to strengthen and legitimise continuing patient relationships; increasing focus on a more personalised, holistic and outcome driven approach to care.
- Community pharmacists and team members need to provide care to vulnerable, housebound patients, and a contract of service should reflect this. At present, community pharmacists are dis-incentivised to undertake domiciliary visits, as there is no payment mechanism established in most areas.
- The structure of community pharmacy is based upon business ownership, but there may be merit in developing federations of pharmacies – across companies - to ensure that care through pharmacy is delivered consistently and to a high standard across localities. This will drive up standards of delivery, and also facilitate local commissioning of services.
- Closer integration between hospital and community pharmacies, to facilitate transfer of care, would not only improve patient care, but maximise the role of each in the patient care pathway. This is of particular importance for high risk medicines such as anticoagulants.
- Development of minor ailment schemes (perhaps better termed “common conditions”) will be key in establishing community pharmacy as the first port of call for common conditions, helping to manage the demand on general practice and A&E. Strong views were expressed that this should be a national scheme, but if not possible in a short timeframe, then should be developed across the boundaries of the local area team, at least.
- Siting community pharmacies in or near A&E centres, with a suitable range of opening times, may offer a wider choice of services and prevent unnecessary attendance to hospitals.
- IT infrastructure will be a key component of integration, including access to relevant patient information (SCR as minimum dataset). Similarly, NHS Mail access will facilitate collaboration across professional groups, provide an effective means of communication, and may facilitate referral processes noted above in question 1. There is also an option to widen ‘choose and book’ access through community pharmacy (a process used in other EU countries e.g. Bologna in Italy). Access to local intranets, for example, hospital Trusts, may facilitate understanding and dissemination of patient care pathways.

- Provide services through community pharmacy that are integral to patient pathways, for example clinics for anticoagulation, pain, long term conditions management, input to end of life care and locality patient groups such as those with diabetes.
- Provide a model of community pharmacy where pharmacists are “front of house” and pharmacy staffs are appropriately trained to deal with health enquiries, or refer potential concerns. Training will be key to ensure that there are no inappropriate referrals to A&E, or general practice, and community pharmacy truly provides a role in preventing unnecessary hospital admissions.
- Strike the balance between the retail side of community pharmacy and provision of healthcare, either by increasing the clinical services which pharmacy provides, or by selling floor space for other health care providers to use.

Q4 How can the use of a range of technologies increase the safety of dispensing?

15. Whilst it should be noted that different models are needs for different circumstances (e.g. pharmacies in rural areas, may provide different challenges to those based in urban environments), there are key developments which would improve the safety and efficiency of the dispensing process:

    - Use of robotic dispensing has been increasingly adopted in hospital practice. Adoption in community pharmacy may yield similar benefits, particularly for repeat dispensing of medicines at a central hub, with the pharmacist/patient interaction occurring at the local level. This personal interaction is considered to be vital to the provision of a pharmacy service. Increasing use of monitored dose systems also can be undertaken via robotics, reducing the labour intensity of this process. Patients should not perceive any differences between the supply of their medicines and the clinical input received,
    - Access to the patient record can reduce unnecessary questions to the patient/carer and communications with general practices. By improving the efficiency of this process, the likelihood of errors, also contributed to by time pressures, is reduced.
    - Electronic discharges from hospital, including community pharmacy in addition to general practice, can prevent unnecessary delays in communication regarding medication changes.
    - Development of electronic referrals, between hospital and community pharmacy, and general practice, can mean that patients are cared for at the centre of an integrated and co-ordinated care system.
    - Telehealth may provide options for review of patients in other locations, for example, housebound, or those attending other clinics/clubs.
    - Adherence can be monitored via the use of “medipacks” which record when the device is opened; this would trigger a personalised dialogue with patients about medicines use and the provision of advice on any issues they may be experiencing.

Richard Copeland
Chair – Local Pharmacy Network, Northumberland, Tyne and Wear
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N.B. Alongside a similar response from the Cumbria LPN, this also forms part of the response on behalf of the CNTW Area Team following a series of workshops and includes personal contributions by LPN members.