ROYAL PHARMACEUTICAL SOCIETY

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The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain. We represent all sectors of pharmacy and lead and support the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

Its functions and services include:

Leadership: representation and advocacy -promoting the status of the pharmacy profession and ensuring that pharmacy's voice is heard by governments, the media and the public.

Professional development: education and support - helping pharmacists to advance their careers through professional advancement, career advice and guidance on good practice.

Professional networking and publications: creating a series of communication channels to enable pharmacists to discuss areas of common interest.

RCGP Consultation - Better care for patients: defining the role of general practice in 2022- a call for action

We are pleased to respond to this consultation and are extremely supportive of the need for general practitioners in our communities to provide high quality, integrated and cost effective services in primary care. We are pleased that the RCGP acknowledges that collaborative working with pharmacists and other health and social care professionals is a key driver in delivering optimum patient services in primary care and we will continue to work together to ensure this vision is aligned to Government priorities and patient focused care. The RCGP's commitment to work alongside others involved in primary care will foster a culture of support and collaboration which will benefit patients and health professionals alike.

Professional Leadership

The RPS has a leadership role to play with its members and is supportive of the RCGP's need for a vision of how General Practice can be a driving force in shaping changes. As a professional body, we encourage an ethos of collaborative working between our members and general practitioners to provide integrated health care to the local population they jointly care for. Pharmacists and GPs can improve patient care by creating an enhanced partnership between their two professions.

Primary care has changed dramatically over the last fifteen years and will do so more in the future. It is therefore timely to address this by modernising working relationships and changing the way we work. The changing demographics of more older patients with long term conditions and more complex treatment in primary care requires new models of care. RCGP and RPS have acknowledged this in our joint statement "Breaking down the Barriers - how pharmacists and GPs can work together to improve patient care" which looks at new ways of working

together. We believe that GPs and pharmacists working together can more fully utilise the complementary clinical skills of both professions.

Our joint statement identifies a need for shared standards and joint working practices as well as the necessary building blocks for change. This includes sharing patient information in a secure manner, creating opportunities for joint education and training, both at undergraduate and postgraduate levels, and Continuing Professional Development (CPD), linking the work of GP practices with pharmacies in the same community. We believe this initiative will lead to better outcomes for patients with long-term conditions, safer use of medicines and better self-care for common conditions.

Dovetailing of primary care contracts

Ideally, we would like to reach a point in primary care healthcare delivery where pharmacists and GP dovetail their services and advice, making best use of the complementary skills of each profession and ensuring a streamline, integrated patient care pathway. To improve patient outcomes we need to focus on person-centred multidisciplinary care.

The original intention of fusing the primary care contracts to provide a holistic care opportunity in the community is not happening currently across most of GB. The General Medical Services (GMS) contract's Quality and Outcomes Framework (QoF) and the community pharmacy contractual framework (CPCF) are viewed as separate opportunities for service planning and the opportunity for joint service planning and service development is not being implemented. The contracts were not intended to be competitive in nature but rather synergistic in service delivery. However, in reality, a narrow view of service planning has taken place and there is anecdotal evidence that, where there is an element of a service in one contract, the other contractor is not being supported to deliver a different or enhanced service. For example, although the medicine review forms part of QoF, it is does not necessarily check a patient's understanding of how to take their medicines. Medication reviews are one area where pharmacist expertise would benefit patients and alleviate the GPs' workload, and is currently vastly underused. With current contracts creating a competitive environment rather than one that promotes synergy, there are many challenges to joint working. Real change will need more innovative levers and incentives that view healthcare provision as a holistic endeavour with all practitioners working together towards a common goal.

Furthermore, individual professionals need to understand the nuances of the two contracts to foster mutual respect for each other's roles in service provision, to benefit patients and aid the strategic aim of moving more services into primary care. Our ongoing collaboration and joint working action plans will help facilitate this.

Question 1: **From your experience, do you agree that there is a need for longer patient consultations?**

It is difficult to put an abstract time to a patient appointment, as it is dependent on several factors and varies with individual patient needs. We support the need for GPs to be able to have longer appointment times for complex cases, and to enable this, we would encourage GPs to make better use of the skill mix available in primary care. Patients should be encouraged to use their GP when appropriate and have enough time to fully discuss their concerns, but for minor conditions and self limiting ailments they should be directed to community pharmacy.

Question 2: **Please comment on any major challenges for general practice that we have not identified.**

We believe putting collaborative working into practice is a major challenge and this will require a cultural change in service planning and professional delivery of services. As outlined in our joint statement we would encourage joint educational programmes at both undergraduate and postgraduate levels to foster greater understanding of the pharmacy and medical roles and remits from an early stage.

Future integration with social care will further highlight the need for collaborative working, with a holistic approach to care and the need to share appropriate patient information in a manner that maintains patient confidentiality. To ensure streamlined patient journeys and no duplication of resources both professions will be required to agree common standards to ensure the smooth transition of patients between practitioners.

An additional challenge is the need to shift services to non medical prescribers where appropriate. Pharmacist prescribers, working closely with GPs and nursing colleagues can contribute to improving patient care and can also help improve the quality and clinical outcomes for patients with a range of long-term conditions. Pharmacist prescribers are now providing services in such areas as substance misuse, many long term conditions and minor ailments. More structured referral systems and closer IT links would help facilitate and foster this relationship.

The emerging challenge of polypharmacy requires to be addressed and there are examples of pilot projects which have evaluated the success in reducing unnecessary medications in the frail older population using either a single health professional or a multidisciplinary approach, the latter proving more successful.

A more successful approach to improving health inequalities has also proved challenging and will continue to do so. Targeting resources at areas where gaps in service have been identified and varying contractual priorities accordingly would be helpful in addressing these challenges, again using a multidisciplinary approach to utilise all skills available.

Question 3: **Do you agree that we should plan for all GPs to be able to develop and utilise additional specialist expertise to help shape and deliver the services of the future?**

We are supportive of the model of generalists utilising the skills of specialists when required. There is a need for more integrated services between primary and secondary care. IT links and a single electronic patient record would greatly improve patient safety when more than one practitioner is inputting to patient care.

GPs with extended roles can provide a valuable information resource in primary care and enhance the patient journey by mimimising the need for travel to other centres of care. We support this model in the same way as we encourage pharmacists to extend their roles, believe that ideal models of care would ensure specialist services were available locally for as many therapeutic areas as possible. We believe that pharmacists have a role in providing expert advice to enable GPs to prescribe evidence based and cost effective medicine for their patients.

Question 4: **Do you agree that the new roles identified above are suitable for general practice to be taking on? Are there others we have missed?**

In order to take on new roles GPs will have to free up more time. As outlined above there are many ways this could be done in partnership with other professions. Shared decision making and encouraging self care will be important elements of any new ways of working. Clarification of who provides what on the patient journey with regards to their medicines would avoid duplication of resources and promote the benefits of pharmaceutical care/medicines optimisation.

Where commissioning is being established we would like to see commissioners make best use of all the complementary skills available in the primary care team and this would allow GPs to take up new roles and dedicate more time to those requiring more complex care.

Proposals for Health and Social Care Integration will provide opportunity for new models of care. We are supportive of local planning initiatives using GP clusters and local pharmacies working together in a hub and spoke model to provide continuity of care to local populations.

We are supportive of more research and audit to identify areas of need in primary care. GPs and pharmacists working together can identify gaps to target resources most efficiently.

Question 5: **From your experience, to what extent does general practice have the workforce capacity to take on the new roles envisaged in this section?**

We would defer to the RCGP's view on whether GPs are in a position to deal with the additional capacity. However we do understand that GPs are currently 16% understaffed.

Question 6: **Do you agree, if other professionals were trained to take on some elements of GPs' current work, as has happened with some shift to nurses and healthcare assistants, this would: - A reduce GPs' workload. B. enhance the service.**

Yes, as outlined in Q2 above. There are many traditional reasons why the GP surgery has been the default point of access but this must change to both reduce workload and enhance services. With the anticipated flow of services from secondary care into GPs surgeries, newer, more efficient methods of working must be utilised.

Medical expertise is in diagnosis and pharmacists' is in medicines. We know that prescribing errors happen and improvements could be made by making better use of the expertise available in both professions. Primary care should work towards the model used in hospitals with more input from pharmacists at the point of prescribing.

Many pharmacists are already providing services in a confidential environment. There are excellent examples of best practice such as pharmacist prescribers delivering hypertension or diabetes clinics which allow for titration of doses as required and facilitate integrated care. Additionally, pharmacist-led services also deliver pharmaceutical care for those with complex medication regimens. Integrated care pharmacists can bridge the gap between secondary and primary care.

Some GP appointments are taken up solely in order to access free prescriptions or for routine repeats in long term conditions. Repeat dispensing and minor ailments services would alleviate some of this pressure on surgery time. As more patients are encouraged to self care and there is more focus on disease prevention, utlising the pharmacist in these areas could increase capacity.

Community pharmacists are in a position to provide services for hard to reach people who do not regularly attend GP practices for their chronic disease management. Where this is an issue, joint service commissioning on a local level would support greater access and better care for people.

Question 7: **Please describe any aspects of how GPs will need to work differently in future with each other and with other professionals that you think we have not captured.**

We know that iatrogenic disease is a major contributor to unplanned hospital admissions and we need to work together to reduce this and to improve anticipatory care. Closer communication links and working practices are essential. Improved links would also help identify local gaps in service provision which would then lead to commissioning of services tailored to local needs and maximise patient outcomes.

Our recent joint statement and ongoing partnership working will form the basis for new ways of working together as we go forward. In particular, the exchange of patient information between GPs and pharmacists with new initiatives such as the Chronic Medication Service (Scotland) and New Medicines Service (England) will facilitate and encourage this. I.T. and the infrastructure which assists GPs and pharmacists to deliver higher levels of support to patients taking medicines should be developed & supported by the NHS.

These measures are necessary in tandem with more robust referral systems between all health professionals and shared care arrangements for vulnerable groups, including frail older people and those with chronic conditions known to be at increased risk of hospitalisation. Going forward, with the health and social care agendas, referral systems to social care colleagues will also need to be strengthened.

Initiatives such as pharmacist prescribing clinics in community and primary care, targeting specific therapeutic areas with appropriate monitoring in place and efficient communication links with GPs should be commissioned locally. Routine inclusion of pharmacists from both primary care and community in practice teams with attendance at primary care meetings and patient case meetings should be encouraged. We would like to see more pharmacists from both primary care and community overseeing the pharmaceutical care of their own case load of patients. Working together on these initiatives would foster greater understanding of the different skill sets of both professions.

The preferred RCGP model of generalists in community supported by specialists can be paralleled in pharmacy. Both pharmacists and GPs should make more use of the expertise available to them from specialist clinical pharmacists based in secondary care as well as those in primary care who have extended their training in specific therapeutic areas. For instance, we have examples of specialist pharmacists supporting the reduction of antipsychotic use in people with dementia and work to date has highlighted the role of pharmacists in polypharmacy reviews. In an aging population with increasing multi morbidities this will be increasingly important. This work has been done in collaboration with GPs and pharmacists.

These links would also encourage better integration between primary and secondary care.

There should be opportunities for GPs and community pharmacists to participate in joint research activity, adopting the 'Research Ready' programme already used by RCGP.

Question 8: **Do you agree that, to meet the challenges of the next 5-10 years, we need to recruit and retain more GPs?**

We defer to the RCGP for details of workforce pressure but ask that all avenues to alleviate pressure on GPs by closer working with other professions are explored as outlined in our responses above.

Question 9: To what extent do you support the vision for general practice outlined in the consultation document?

As outlined in our answers above we support the need for high quality services from all health professionals in primary care and the need to change the service models we now have to adapt and be ready for the challenges of the next ten years. We support this vision which is acknowledging the need for generalists in primary care to work together with specialist input from other professions, and other sectors of health and social care, putting the patients at the centre of all service provision in a truly holistic approach.

Question 10: **Do you have any other comments?**

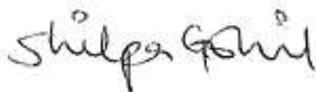
Local NHS planners/commissioners should ensure that clear and specific service specifications are agreed with their local NHS providers. These need to link with quality standards based on patient experience and appropriate clinical outcomes. We need to have consensus around messages to patients, particularly in the care of long term conditions and to improve self care and self management. Local referral systems between all health and social care professionals need to be efficient.

Our joint statement and action plan is working towards providing joint learning opportunities for GPs and pharmacists and we will need to work with educational stakeholders such as National Health Education for Scotland (NES), the Centre for Pharmacy Postgraduate Education (CPPE), the Welsh Centre for Pharmacy Professional Education (WCPPE) and their medical equivalents to ensure these opportunities are available nationwide. We need to look at ways pre-reg trainees/early year's community pharmacists and GP registrars can interact more to foster closer working ties early on in careers, following on from joint learning undertaken at undergraduate level.

Joint working will help us to face the challenges in the NHS over the next ten years and beyond and it is important that we have a cohesive approach. We know that we need to make changes to improve patient outcomes. We support the RCGP goal to improve the services and care we can deliver for our patients and the need to work with other organisations to deliver this over the next decade

We are pleased that we have started this process with our joint statements already in place. RCGP and RPS can use the statements and the 2022 vision as building blocks across GB to scope out new ways of working more closely; working with other health professionals and social care colleagues to improve patient care and we look forward to taking this forward together.

Kind regards,



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