Improving Health and Patient Care through Community Pharmacy – A Call to Action
Royal Pharmaceutical Society (RPS) response

We believe that the purpose of the pharmacy profession is the safe and effective supply of medicines, while also ensuring that medicines are optimised for the individual and that patients are supported to get the best possible outcomes from their medicines. Additionally pharmacy has a key role to play in improving the public’s health as it is a point of contact for those who are generally in good health but could benefit from a better understanding of elements that could cause ill health in the future.

The case for the improvement of outcomes for patients and to reduce downstream health costs through the optimisation of medicines has been widely made. Making this happen though will require a stepwise change and we are pleased that the call to action seeks radical new thinking with the foreword from NHS England’s Call to Action which states:

*This is not about unnecessary structural change; it is about finding ways of doing things differently: harnessing technology to fundamentally improve productivity; putting people in charge of their own health and care; integrating more health and care services; and much more besides. It’s about changing the physiology of the NHS, not its anatomy.*

Every patient receiving a medicine should have equitable access to pharmaceutical care provided by a pharmacist irrespective of the care setting they are in. The NHS Constitution for England clearly states that patients should have equity of access and consistency in quality.

In light of the case for medicines optimisation, the need for radical new approaches to health delivery and the continued commitment to equitable access, the RPS report “Now or Never: Shaping Pharmacy for the Future” provides an authoritative description of the many ways that the third largest health profession can address the Call to Action.

The key changes we would like to see as a result of this Call to Action are:

- A national commitment to and support for an enhanced clinical role for pharmacists in the community. Such a commitment should be NHS policy, supported by the other members of the multidisciplinary team. Such a role should incorporate clarity about the governance arrangements for the oversight of all aspects of medicines use in the community.
- A sustained programme of enablers that will make better utilisation of the knowledge, skills of, and access to pharmacists in the community to provide direct patient care wherever those patients may be situated e.g. care homes, GP practices, patient’s own homes, community pharmacies etc.
- These enablers include:
  - A programme that will integrate pharmacists into the wider primary care team by moving the pharmacy contractual framework to a clinical focus and by requiring engagement in multidisciplinary teams across all primary and community care
  - Clarity about future prescribing by pharmacists. Such clarity will incorporate:
    - Pharmacists able to annotate and alter prescriptions independently when there is appropriate need

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4 [www.rpharms.com/future models](http://www.rpharms.com/future models)
- Pharmacists will be able to supply, via an NHS service, all medicines unless specifically excluded by ingredient and form.
- All pharmacists will be enabled to develop their prescribing skills
- Pharmacists managing and prescribing for patients with long term conditions (LTCs) who only have intermittent requirement for medical input
  - A sustained programme to reduce the isolation of individual pharmacists working in single handed pharmacies
  - A simplification of commissioning for pharmacy
  - A funding of secondary care that enables pharmacists and other healthcare professionals working in the community to call upon and jointly work with secondary care pharmacists, enabling the community pharmacist to be part of a seamless medicines pathway and substantially altering the responsibility of all pharmacists to work as an integrated team around the needs of the patient
  - Substantial investment in the IT support for pharmacy that ensures that all the pharmacists working across the medicines pathways (including clinical trials) have access to and can participate in the patient record. This includes access to laboratory results, GP systems and hospital systems
  - Local commissioning to evidenced national standards which would include service specifications and education and training requirements
  - Implementation of the opportunities for improved services identified in the ‘Now or Never’ report
  - Those services that are best commissioned nationally are commissioned nationally e.g. National commissioning of a common ailment service and the provision of emergency hormonal contraception, and those that should be commissioned locally are commissioned exclusively for the needs of that local population
  - Alignment of primary care contracts at a national level to ensure collaborative working
  - A restatement of the role of primary care pharmacists currently working in GP practices as having a fundamental responsibility to work collaboratively and in partnership with community and secondary care pharmacists rather than solely on financial aspects of the practice
  - A clear funding stream that enables pharmacists to become a part of the multidisciplinary teams in care homes and GP surgeries
  - A contract that requires pharmacists working together across a locality to deliver better patient care
  - A sustained programme of mentorship and support that ensures pharmacists take greater accountability for the use of medicines and outcomes from medicines. Such a programme should assist pharmacists to take on the care of people with LTCs which could be supported by patient registration with a named pharmacist
  - Develop undergraduate and postgraduate training to enable the pharmacy workforce to work across pathways and boundaries.

Within community pharmacy there is a fear that too radical a change to the current contract will lead to a loss of the community pharmacy network that provides such a valuable resource to local communities. There is also a fear that allowing a degree of separation of the clinical roles from the supply roles will reduce the attractiveness of community pharmacy as an occupation. However there are too many patients for whom a higher level of input to the choice and optimisation of medicines is necessary and are not able to access that level of support within the current contract. This is not the fault of any particular group of pharmacists or any particular pharmacy organisation but a universal failure to include pharmacy and medicines management in the planning of such community arrangements. Most of these patients groups are those for whom hospital care would
have been expected in the past. They include the most vulnerable, those requiring complex care, those whose care is currently overseen by secondary care teams (but not secondary care pharmacists), those living at home with a high degree of support and many others with specialist conditions. These patients are currently a priority group for the NHS in its desire to keep people out of hospitals. Also studies of care homes, admissions to hospital, and audits of polypharmacy demonstrate that these groups are most likely to suffer a high level of medicine errors at every stage. To improve this situation requires that community pharmacy is not seen in isolation but that every stage of the medicines pathway is clarified so that all the parts work together, are supportive of overall care and the individual sectors do not feel threatened. The changes that are required are:

a. A responsibility on secondary care pharmacists to work collaboratively with community pharmacists to enable oversight of the medicines for up to a three month period following discharge to ensure that the necessary changes to the person’s medicines have been followed through

b. Community teams are many and varied. They may be a part of outreach from acute hospital trusts, mental health trusts, primary care organisations or associated with homecare. Every community based clinical team having a pharmacist as a member will reduce the likelihood of errors. In addition they must have a specific responsibility to assist the community pharmacist and the GP practice with their management of the medicines while they are being managed by the team. It is expected that such pharmacists would be specialists

c. For every GP practice to have the level of pharmacist input similar to that currently expected by hospital wards must be the norm. They also must have a specific responsibility to assist the community pharmacists with problems with prescriptions

d. All parts of this pathway must have common access to all clinical records

e. The responsibility for ensuring the medicines pathway is linked as described above should be a key responsibility of the clinical commissioning groups. Every clinical commissioning group (CCG) must appoint a pharmacist with responsibility for the medicines pathway and ensuring that all parts are integrated and collaborating.

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?

Changing the culture of 53 million English people will be hard. There are three key groups of people that should be addressed each of whose need to change will be different.

1. Pharmacists themselves will need to embrace and promote the new services that can be provided and pharmacy owners must provide the resources and appropriate environment from where this can be done professionally. These include the advanced services such as Medicine Use Review (MUR) and New Medicine Service (NMS) as well as vaccination programmes that support the public’s health. Pharmacists must be their own advocates for the profession and for what they can provide to patients. They should ensure that the patient’s and public’s perception of them is that of a vital healthcare professional.

2. The NHS itself must see community pharmacy to be an integral part of primary care and more importantly to treat it as such:
   • Community pharmacy must be utilised increasingly as the first point of contact for the public with formal NHS care
   • Funding to enable community pharmacy to support and develop an emerging evidence data base must be available
• Services such as a common ailment scheme and the provision of emergency hormonal contraception must be commissioned at a national level so there is consistency across the country, and as new services develop a positive evidence base they are incorporated in the contract. This will help the public to feel confident about a range of services that they know they will be able to access universally and delivered to a consistent standard and quality.

• Patients must be guided towards community pharmacy through a variety of mechanisms at the disposal of the NHS. Pharmacists are ideally placed as highly qualified medicines experts who have experience in advising and triaging people with common ailments, exacerbations of long term conditions and acute illness. Pharmacies must deliver a consistent core offering which simplifies for patients an understanding of the services that will be provided from all pharmacies. A current problem is the variation in the offer beyond the current contractual framework which means the public are unsure of what they can get and therefore are unaware of the potential that pharmacy offers.
  o A universal disposition for NHS 111. Currently NHS Pathways do not direct patients to pharmacies in the same way that NHS Direct did, leading to inappropriate referrals to GP out of hours services for situations that could be dealt with by a pharmacist.
  o Direction of patients towards local community pharmacy by GP out of hours phone messages.
  o Public campaigns such as ‘the earlier the better’ and ‘dispensing health’ and further developing pharmacy as a first point of contact for health and wellbeing.

• Better utilisation of pharmacy in urgent care. We propose the creation of a number of local ‘emergency pharmacies’ i.e. with pharmacists trained by the college of emergency medicine and open 24 hours. These pharmacies would be able to provide 24 hour pharmaceutical care and also deal with minor injuries.

• The adoption of Pharmacy as a health and wellbeing centre should be universal.

• Community pharmacies to be a prime outlet for public health messages, to play a key part in prevention and health protection, such as vaccination programmes, and to improve the health and wellbeing of their communities.

• Community pharmacies to be developed, supported and promoted as key delivery sites for health research and trials, ensuring that patients and the public get better access to research.

• Many people do not interact with a pharmacist until later on in life when they may develop a condition that requires regular medicines. Pharmacists should be part of the education system and work with schools to provide an opportunity to pupils and teachers to discuss their medicines and any issues they may be having with them.

3. There must be a sustained campaign to change the expectations of the public of pharmacy and pharmacists. In the short term this benefit will be predominantly the speed and convenience of health services provided at times and from places that are easily accessible. This will be further enhanced by their continuing experience of community pharmacy as the natural front line of health advice and primary access to formal health services.
  • Improving the quality of patient care needs to be at the heart of changes to the provision of services through pharmacy. Asking the public and patients what support they need to stay well and then thinking through how this can be provided through pharmacy or pharmacists. The Royal Pharmaceutical Society (RPS) has started this process by holding an event with patients and representatives from patient groups and charities to clarify what they would like to see from their community pharmacy.
How can the way we commission services from community pharmacy maximise the potential for community pharmacy to support patients to get the most from their medicines?

Commissioning of health services from community pharmacy is complex and must to be clarified for all of those involved. NHS England has the ability to develop essential and advanced level services through the contractual framework. Others such as CCGs, Area Teams and Local Government have the ability to make local decisions. For such a system to work there must be a clear roadmap which shows the timeline of how the national contractual framework will evolve and also which services should be the province of local decision-making. This will allow for capacity building within the profession (e.g. increasing numbers of independent prescribers) and give confidence to local commissioners that they would not be duplicating with planned national provision.

The commissioning of services must be contained within the wider provision of healthcare, i.e. it enables pharmacists to provide care at the point in the patient pathway that gives most benefit to patients. Usually this is around the time of medication supply or for the planned treatment of long term conditions or as a provider of healthcare advice. This ensures that the community pharmacy service is embedded within primary care service provision and not just bolted on.

To ensure consistent high quality services a series of national standards must be made available to local commissioners based on the evidence for delivering outcomes. These standards would include service specification templates (including evaluation templates) as well as an education and training element to ensure the workforce is competent to deliver and evaluate the service. These are only changed locally if there is local evidence that change would create a more effective service. The recently published public health standards from the Royal Pharmaceutical Society provide a basis for any locally commissioned public health services through pharmacy.

In order for this to be realised:

1. NHS England must change the community pharmacy contractual framework (CPCF) in a way that requires community pharmacists to spend more time on patient care and provision of clinical services. Bold commissioning of services from community pharmacists as well as ensuring incentives encourage integration with other health and social care providers is imperative.
   - Community pharmacies deliver a safe and cost effective medicines supply service for the NHS. We know that 99% of patients can access a pharmacy within 20 minutes by car, 96% by walking or using public transport and this local supply service should continue. We currently have a world class network of community pharmacies delivering a fast, effective and safe supply of medicines to the public; we now need to build on this to ensure medicines adherence, minimal medicines waste, reduced unplanned admissions and integration of the community pharmacist within the primary care team
   - Currently only around 3% of the national funding for the CPCF is spent on clinical services (NMS and MUR). There must be a radical shift in funding so that at least 50% is linked to direct patient care which would enable pharmacists to provide an opportunity to speak to every recipient about their medicines at the point of supply.
   - The current community pharmacy contract still mainly focuses on rewarding the supply of medicines or the quantity of MURs undertaken. Whilst we recognise the safe and effective supply of medicines is critical to the NHS the contractual framework must change to enable pharmacists to deliver real patient benefits and

5 http://www.rpharms.com/unsecure-support-resources/professional-standards-for-public-health.asp
outcomes through individual optimisation of medicines. The opportunity for pharmacists to be paid on real patient outcomes must be explored

- For pharmacists to manage the long term and overall care of people with long term illnesses registration with a community pharmacy is essential
- The reconciliation of medicines must be included in the MUR (MUR plus). This means that a pharmacist determines what medicines the patient is actually being prescribed and taking. The process is not just about taking a medication history but also ensuring that medicines are appropriate and safe for patients. This includes recommendations to stop medicines such as when there is poor renal function or falls risk
- MUR provision must be universal and not be limited to a defined number per pharmacy. For example, under the current system the 401st patient coming into a pharmacy who would benefit from an MUR may not be offered one as the current limit for that pharmacy has been reached
- NMS and other adherence enhancing tools must become a consistent service in every pharmacy for every patient who is started on a new medicine for a long term condition
- When a patient undergoes an MUR or NMS they still have to sign a consent form and often they find this difficult to understand as they don’t get asked to do this in other settings such as general practice. There must be a level playing field and when pharmacists are providing services in the future there should be implied consent once the patient accepts and receives the service
- At the moment the funding for the supply of a prescription medicine from a community pharmacy does not distinguish between the ongoing supply of a single low risk medicine to an otherwise fit and healthy young adult from the supply of a tenth and high risk medicine to an elderly person with multiple pathologies. The contractual framework must enable pharmacists to take a risk based approach to supporting the patients they provide medicines
- The CPCF must enable and encourage the optimal use of skill mix within a pharmacy. This will vary from pharmacy to pharmacy dependent on the services that the pharmacy provides. However, the contract must encourage the use of pharmacy technicians to undertake the technical aspects of the dispensing process thereby enabling the pharmacist to speak to patients and the public
- Every pharmacist working in the community either independently or within the community pharmacy should have read and write access to the electronic patient record. In the first instance this would be access to the Summary Care Record (SCR) as this would enable the provision of safer and high quality patient care (see Appendix A)
- The use of automation needs to be more fully explored and investigated to see if it can free up pharmacists’ time to enable them to spend more time on clinical services – see our response to Question 4.

2. There has to be a structure that clarifies the responsibilities of all healthcare professionals and organisations and then invests in making that work across the entire patient pathway. However efficient the profession becomes in responding to the contractual framework, and similarly however efficient GP practices become in delivering the GMS contract, major paradigm shifts in efficiency will be lost if the two contracts continue to be separate and foster competing drivers. NHS England has a responsibility to review primary care contracts and ensure that they are aligned to support truly integrated working. NHS England needs to facilitate integration through the local structures such as CCGs and local authorities.
• GPs should be encouraged to start patients on the repeat dispensing scheme that is already available. However, patients need to experience that this is a different service and pharmacists need to ask the questions about the patient’s medicines as per the service specification. This information should be added to the shared patient record so patients have confidence that appropriate information is shared between clinicians who have responsibility for supporting their care.

• Pharmacists are the experts in medicines and their use and should be responsible and accountable for the pharmaceutical care of patients. This includes medicines adherence and safe and effective treatment with medicines. This care should encompass the monitoring of the patient’s response to treatment, covering side effects and the monitoring and use of laboratory results to optimise the use of medication for the patient. Future models and information flows should enable and support pharmacists to do this.

3. There is currently a healthy network of community pharmacies where high level care is delivered to patients and the public. The location of community pharmacies supports local communities and usually pharmacies are sited in towns and communities with high levels of deprivation, higher than average morbidity and low levels of health literacy where there is little other healthcare provision. Community pharmacy also has a unique role in that it is one of the three essential businesses that ensure the economic prosperity in a community, the other two being a GP surgery and a source of cash (usually a post office). However, it is recognised that in some areas there may be an over provision of pharmacies so federations and different models using the expertise of pharmacists in other settings may need to be considered.

• The contract must enable individual pharmacists or organisations of pharmacists to contract for provision of clinical services to a Care Home, a GP practice or directly to patients in their own homes.

• The potential of pharmacist prescribing is currently underutilised. Pharmacists being enabled to prescribe for urgent care and to manage the medicines of patients with LTCs in collaboration with GP colleagues will increase the number of pharmacist independent prescribers. There must be clearer routes to becoming a pharmacist prescriber. If community pharmacists were also independent prescribers they must be able to make changes to prescribed medicines where doses need to be adjusted, prescribe P and GSL medicines for common ailments or short term symptomatic relief which would enable more efficacious medicines to be available to the public without the need for a GP appointment. New models need to be examined such as competency base approaches following foundation years practice as in Alberta, Canada and HEE recommendations regarding the MPharm should be revisited as the integrated MPharms rolls out.

• The pharmacy profession is unique in that a large proportion of pharmacists work in isolation. Many other professions have come together to form large practices and this allows increasing specialisation and brings economies of scale. This type of model also provides peer support and closer iniprofessional working. There may be opportunities for pharmacies to federate and also to be part of larger primary care federations. This model could also enable the development of closer working relationships between pharmacists working in community pharmacies and specialist colleagues working in secondary care.

4. NHS England must work closely with Public Health England to ensure the system does not become fragmented as community pharmacies often deliver services that cross the public and NHS service spectrum.
• The Pharmaceutical Needs Assessment (PNA) has not valued or assessed the clinical role of pharmacists. There is a concern as the Health and Wellbeing Boards (HWBs) have little or no experience of these. These were developed as a control of entry tool, and support must be provided to HWBs to ensure that the PNAs are robust and fit for purpose.

• Pharmacists must be fully enabled to provide immunisation to patients, such as flu vaccinations but also travel and other vaccinations such as MMR and pneumonia for the public. This provides greater choice, access and flexibility for patients and the public. Pharmacists must obtain access to patient records so that national immunisation records are kept up to date.

• Pharmacists must be enabled to use pharmacogenomic testing as part of early detection of malignancy.

• There should be a national campaign to increase the early detection of cancer. The UK cancer survival rates are worse than other European countries and this is because many people are diagnosed too late. Community pharmacists and their staff are ideally placed to raise awareness of symptoms of cancer amongst the public, identify symptoms in at-risk individuals and ultimately facilitate early diagnosis through formal referral pathways. This could be developed as a new essential service for the CPCF.

• The contract must ensure pharmacists record data on a more regular basis and the analysis of such data at a national level come a vital source of practice data. Pharmacies are sitting on a wealth of data that is not currently shared with the wider NHS. Data could be used to inform medicines optimisation benchmarking locally.

5. If individuals or companies own community pharmacies providing NHS Services then they must ensure their pharmacists and pharmacy teams spend more time with patients providing clinical input and care around medicines and healthy living. The CPCF and regulatory standards set by the General Pharmaceutical Council (GPhC), as well as overarching legislation must be aligned to mandate the following:

• Pharmacists are professionally empowered to make decisions to ensure a safe environment for patients. Organisational systems must assure patient safety and the nurturing of a caring and compassionate culture by ensuring that staff feel valued, respected, engaged and supported.

• A proportionate response to single dispensing errors as defined in the Berwick report must become a reality to enable pharmacists to integrate into the reporting and learning system across the NHS and encourage sharing of any lessons across the profession.

• The boards and leaders of pharmacy providers need to have detailed understanding of the workforce of their organisations. We believe pharmacy providers need to follow best practice and understand in real time the staffing of their organisations and be able to set this against best available evidence based guidance. Openly and transparently publishing data about staffing levels is an important way of providing assurance to the public and staff themselves about safety.

• NICE must include pharmacists within their ongoing programme of guidance for safe staffing levels within acute and community settings as part of the drive to improve safety and quality of care. NHS England as the commissioner of community pharmacy services must re-examine the requirements relating to staffing levels within the CPCF and explore how the transparency of staffing levels could be improved. Staffing levels is a particular issue in pharmacies as pharmacists employed by others may also be subject to demands on their time which may not be related to...
NHS service provision. Pharmacists need to have their time protected for provision of patient care over and above other tasks and we think NHS England should make this a priority

- Research is “everybody’s business” in the NHS and community pharmacy is no exception. Individual or company owners need to ensure they are aligned with existing research governance procedures to support research and avoid the creation of a third tier approval system which inhibits patient access to research in this setting.

How can we better integrate community pharmacy services into the patient care pathway?
There are many ways in which community pharmacy services can be better integrated into the patient care pathway. Bearing in mind what we have said above, we would also like to emphasise the following points:

- All pharmacists in the community must have read and write access to the electronic patient record. This will enable pharmacists to ensure the care they are providing complements, rather than duplicates, that being offered by other healthcare providers. One of the means to do this may be to empower patients to have access to their records and they can then consent to sharing their record with their pharmacist. (see appendix A)
- Care offered by pharmacists working in the community must be part of integrated pathways to ensure that patients receive consistent and joined up care. Pharmacists need to be part of the teams that develop the integrated care pathways to ensure the services they offer are part of the pathway and not just added on at the end
- Pharmacists must have responsibility for long term follow up to ensure desired outcomes from medicines are achieved. We strongly believe it’s time to build a fully functioning multidisciplinary team in primary care to properly address the needs of the growing number of people with two, three or more long term conditions. The clinical skill-mix of this team needs careful consideration with clearly defined roles for doctors, nurses and pharmacists working coherently. The needs of older people and those who take many medicines often for many different conditions must be at the heart of this thinking. We need to ensure that older people and those taking many medicines, who are most at risk of adverse events from medicines, are given access to regular patient centred clinical medication reviews by pharmacists. Pharmacists must be seen as having formal responsibility to refer to appropriate alternate clinicians to embed pharmacists as an integrated member of the healthcare team
  - Every care home has a named pharmacist to ensure safe and effective use of medicines with a risk analysis by the pharmacist to ensure that this is at an appropriate level. The pharmacist would be responsible for all the medicines activity of that home including clinical medicine reviews supporting those patients who are frail, elderly and vulnerable. This would encompass a robust clinical review which could result in medicines being stopped as well as started or adjusted
  - We believe that every GP practice should have input from a clinical pharmacist, potentially as a partner or sessional professional of an individual practice or working across a number of practices, to manage and optimise medicines. Every GP practice should include the clinical expertise in a team similar to that in hospitals with the responsibility for the optimisation of medicines within the practice being with the pharmacist. Ideally this pharmacist is an independent prescriber
- Pharmacists working in the community must play a significant role in supporting older people to live independently and this could be a key focus for developing a new pharmacy service. Pharmacists are well placed to support patients to continue to live in their own homes
- Polypharmacy is a well-recognised issue⁶. We believe that a full medication review of patients who are experiencing polypharmacy by a pharmacist, working alongside a multidisciplinary team, would go some way to addressing these issues.

- A small proportion of community pharmacies run specialised clinics such as anticoagulation clinics and pain clinics. This type of model should be implemented, where appropriate, across the pharmacy profession, whether that be in community pharmacy, GP practice or outreach secondary care settings. The model could also be expanded to include medicines optimisation clinics or medicine adherence clinics, where clinical reviews of ambulatory patient’s medicines and prescribing are carried out for LTCs such as diabetes and HIV
- As we move more services out of hospitals we need to develop the community sector using the expertise of the secondary care sector. The pharmacy profession needs to work in an integrated way with generalist pharmacists utilising and harnessing the skills of appropriate specialist pharmacists. This could be a mechanism for continuous education and training to enhance generalist skills as medicines and care acquire greater complexity, which is reflected in the RPS Faculty
- Community pharmacists must link with the primary care pharmacists locally and be more involved in the implementation of medicines commissioning decisions such as development and implementation of joint formularies
- There must be more training for pharmacists to move across boundaries of secondary and primary care (the mandate to Health Education England requires that to happen for medics and nurses but not for pharmacists as yet).
- The role of pharmacist prescribers must be encouraged across all settings. This will be encouraged by including the educational elements of the prescribing education within the undergraduate course and the practical elements within the foundation / early years training. An alternative is to use the RPS Faculty as an indicator that a pharmacist is ‘fit to prescribe’ such that if a pharmacist is recognised as having reached Stage 1 of the Faculty they would be seen as fit to prescribe
- Community pharmacy and secondary care pharmacy need to work together and share expertise in relation to clinical trial delivery, ensuring that patients get access to medicines in a place that is most convenient to them.

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

IT systems have the potential to improve the safety of patient care as well as improve the efficiency and quality of such care. The use of IT systems to support the efficient prescribing and supply of medicines will enable pharmacists to spend more time working with patients on the more clinical aspects of their care. This would enable community pharmacists to spend more time with patients providing services for the treatment of common ailments, the review of medicines and the treatment and monitoring of LTCs, thereby supporting Domains 2 and 3 of the NHS England Operating Framework.

We believe that as a result of this Call to Action, those responsible for the NHS IT architecture at NHS England should work collaboratively with the commissioners and users of community pharmacy IT

systems and the providers of those systems in the development of appropriate interfaces to the various databases and systems covered in this response. This should be done within an appropriate timescale from specification to go-live for development, testing and deployment to meet the needs of community pharmacists and the wider NHS.

In addition there is a need for appropriate training on IT systems used in pharmacy to improve IT literacy in all grades of staff and to ensure optimum adoption and use of technologies. NHS England should ensure that all parties to a technology should be supported fairly in making it work in practice.

1. The government has committed to introduce fully portable electronic health records by 2015 and a paperless NHS in 2018. Registered pharmacy professionals should have access to the patient health record to improve patient care and safety. Consented access to the patient health record will allow pharmacists to make informed clinical decisions, in partnership with patients, about pharmaceutical care, improve medicines safety and adherence and help address some of the drug bill inefficiencies which currently exist within the NHS. Access to the patient health record by community pharmacists would:
   - Support urgent and emergency care provision
   - Create a more robust record system where healthcare professionals would be aware of all interactions with the patient
   - Enable a complete patient record to be formulated from the information submitted by different prescribers and providers of care, thereby countering errors arising from missing information
   - Facilitate transfer of information across care settings and prevent errors arising due to important information not being transferred
   - Facilitate research for patient and public benefit.

See appendix A

2. Community pharmacies should be information providers for patients and the public. Web and mobile application (app) based technologies have the potential to provide high quality medicines information to patients, carers and health professionals as well as provide information in a number of different formats (audio, different languages etc). Ways that community pharmacies could become more involved in information provision include:
   - The pharmacy could provide an information hub for patients e.g. touch screens in pharmacies with internet access and signposting to reliable websites for information. They could also signpost to information apps with medicines
   - The community pharmacy could provide more information and advice about long term conditions and survivorship
   - The pharmacist and pharmacy staff could signpost and refer patients to local third sector organisations
   - The pharmacy could provide information evenings to family members and carers of patients with particular long term conditions.

3. Mobile and telecare technology has advanced and its use is widespread in current society. Having conversations with people remotely is now commonplace for a large number of people. Community pharmacies could make better use of the technology available such as:
   - Utilising telecare to provide healthcare consultations and services to patients remotely at home. This may be of particular benefit in rural areas or with hard to reach patient groups
• Social media could also bring together expertise which may be located in settings remote from each other
• Using text alerts to remind patients that repeat prescriptions are ready or to offer additional services
• Use of mobile apps to assist disease monitoring such as recording of blood glucose levels, adherence support or health education. Apps could be expanded to improve medicines optimisation in patients with LTCs.

4. There needs to better integration of systems throughout the NHS to facilitate the sharing of information between different providers of care. NHS England needs to ensure that the systems are joined up and communicate with one another to ensure patient safety. We believe that GP, hospital and pharmacy IT systems must be required to develop electronic communication interfaces to enable the sharing of information to promote integrated care. The national use of standardised clinical record standards will support this in practice. There is a lack of a robust information flow between primary and secondary care. It is at this point when care is transferred where the most changes are made and where the majority of the problems with medicines happen. There are initiatives being undertaken which enable transfer of patient and medicine information from a hospital pharmacy to a community pharmacy. We believe these should be standardised and rolled out across the country. In the future it should be usual practice for the handover of the pharmaceutical care of a patient to be provided from one pharmacist to another in addition to the GP, as is current practice.

5. Pharmacists routinely help patients throughout their working day, unfortunately the profession has no culture of recording the thousands of daily interventions made, and consequently the evidence base for the added value that pharmacists bring to achieve better outcomes for patients is not routinely collected or recorded. This would, in part, be addressed through access to patient records. However there needs to be changes to the contracts which encourage pharmacists to record data on a more regular basis and enable the analysis of such data at a national level.

6. The automation of the dispensing systems in hospitals has provided benefits to the pharmacy team in freeing up time and reducing errors and similar automation could be adopted in primary care. The business case is different but we do anticipate greater use of automation in community pharmacies over time.

7. The implementation of the Falsified Medicines Directive needs to be fully utilised to support the dispensing process. We believe that
• the Directive must eliminate falsified medicines from the supply chain and further enhance patient safety
• there must be no unacceptable delay in the supply of medicines to patients
• the system is fully tested before introduction, fully compatible and fully integrated with existing pharmacy software systems
• working practice is integrated with existing pharmacy work streams, to minimise pharmacy workforce pressure, add professional value and enhance patient care
• patient confidentiality is secured through adherence to NHS and professional guidance at all points in any new processes and procedures
• any new commercially sensitive data generated or accessed within the pharmacy must remain confidential and secure
• patient safety and confidence in their medicines would be further enhanced by extending the use of original packs with tamper proof seals
the potential patient benefits of the verification system should not be compromised by a lack of support and resources
• the point of authentication should be decided locally in the best interests of the patient.

8. It is likely that in the future, patients will order their medicines online. Community pharmacies would not necessarily dispense the medicines; this could be carried out in a large dispensing warehouse and either sent directly to the patient’s home (if patients chose this option) or via the community pharmacy. Regardless of where the prescriptions are assembled, there must be an opportunity for a pharmacist to clinically assess the prescriptions prior to the assembly process commencing. Additionally, regardless of whether medicines are being delivered through a community pharmacy or direct to a patient, where a review was needed or a new medicine started or if there was a change in medicines, such as dosage changes then there must be the opportunity for the patient to converse with a pharmacist at the point of supply, or otherwise prior to the supply of the medicine.

Our ambition for the development of pharmacy services provided in the community is clear in the report ‘Now or Never: Shaping the future of pharmacy’. This call to action must be more than just another opportunity to exchange ideas. It must be followed by a significant commitment from NHS England to make pharmacists key players in the clinical management of care in the community. It signifies that pharmacists have left the crossroads and are clear that the future direction is clinical. Although competition and commercialism are key drivers for pharmacy for pharmacists other drivers such as collaboration, cooperation, coordination, compassion and all leading to improved patient care are the way forward.

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For further information or any queries you may have on our consultation response please contact Heidi Wright heidi.wright@rpharms.com 0207 572 2602
Appendix A

**Professional Position Statement: Access to the Patient Health Record (England)**

The Pharmacy IM&T Strategy group wants all registered pharmacy professionals to have full access (read and write) to the patient health record to improve patient safety.

Information is key to reducing medicine errors, improving medicines adherence and delivering safe and more effective care to patients

**Background**

The Caldicott 2 Information Governance Review recommended that ‘for the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the patient’ (recommendation 2).

Pharmacists and pharmacy technicians, as registered and regulated healthcare professionals, should, therefore have access to the relevant parts of a patient’s record when providing direct care to the patient.

The recent government response to the Caldicott review states that ‘sharing information to support care is essential. It is not acceptable that the care a patient or service user receives might be undermined because the different organisations providing health and care to an individual do not share information effectively.’

All of the 26 recommendations proposed in the Caldicott Review have been accepted in principle by the Government.

In a letter dated 6 Nov 2013, Jeremy Hunt, Secretary of State for Health, wrote ‘I am aware of the important role that pharmacists play in supporting the rest of the healthcare system, and am keen to explore how this role could be developed through electronic record sharing. I think it is important that the Department, in partnership with NHS England, look strategically at how pharmacy can support the rest of the healthcare system, in the context of working towards more integrated care and a paperless NHS by 2018. In particular I would like to see if, when a patient gives permission, it would be possible for a pharmacist to access a GP record in order to give the best possible advice. There are many other areas to consider as well, and I look forward to discussion.’

Around 40% of hospital pharmacies currently have access to the Summary Care Record (SCR) and this has shown in audits and service evaluations conducted by a number of hospital trusts to have a huge positive impact on the ability to undertake effective medicines reconciliation when a patient comes into the hospital (medicines reconciliation is a process which ensures clinicians know what medicines a patient is currently taking). Hospital pharmacy teams have found that access to the SCR has assisted in improving patient safety and identifying adherence issues. Some prisons also have access to the SCR, and again, this has improved patient safety.

This service evaluation has shown that one out of every five patients assessed on a Medical Assessment Unit had an intervention that improved prescribing when the SCR was made available to Pharmacy staff. (Northumbria Healthcare NHS Foundation Trust)

The results of this audit demonstrate the following benefits of SCR
- SCR is used for more complex cases
- Time taken to complete a medication history is quicker when SCR is used.
- There is a reduction in communication time, resources and effort between health care providers
- SCR increases the number of discrepancies identified, thereby improving accuracy

(Basildon and Thurrock University Hospital NHS Foundation Trust)
There are currently very few community pharmacies that have access to the SCR. Those that do generally have a direct IT link from a local GP practice; a system wide approach is lacking. A community pharmacy in Sheffield that has been piloting access to the SCR has found that 95% of views occur outside GP practice opening hours and that the majority of views were to assist in the delivery of medicines optimisation services, ensuring patients get the most from their medicines. In all cases the patient consented to the pharmacist viewing their record (link to final report once published)

We believe that all hospital and community pharmacies should have, as a first step, access to a patients’ SCR. Ultimately, registered pharmacy professionals should have appropriate read and write access to the patient health record in the interest of high quality safe patient care.

**What are the benefits to patients?**

- **Patients would be provided with a fuller service via their community pharmacies.** Currently within a pharmacy setting face to face encounters are the norm, either directly with a patient or their representative or carer. These encounters are either part of provision of an NHS service or involve supporting people to self care via a private sale of over the counter medicines and / or provision of advice, and are often conducted without access to all the relevant facts regarding the individual’s health. This situation can be addressed through technology and a commitment to allow registered pharmacy professionals to have access to a patient health record within a framework of appropriate consent and confidentiality.

- **Pharmacists are experts in medicines and their use** but do not currently have consistent access to the full details of which medicines a patient is being prescribed. The number of patients with long term conditions is increasing and community pharmacists already play a major role in supporting these patients, but more support could be provided to patients with appropriate access to the patient health record. For example, community pharmacists could access a patient health record during a patient’s regular visit to the community pharmacy to check whether the relevant condition or medicine monitoring is occurring. An audit carried out in 2,773 community pharmacies looking into the use of methotrexate, warfarin & lithium\(^7\) demonstrated the difference pharmacy teams can make in improving patient care. Addressing many of the issues identified would have been much easier with access to the relevant information regarding monitoring and tests. Read and write access to the patient health record will enable registered pharmacy professionals to check diagnoses and care plans, record advice given to patients on medicines and check / advise other professionals on medicines monitoring issues.

**What are the benefits to the wider NHS?**

The NHS Information Strategy states that information should be recorded once and shared securely with those providing care to a patient. It also suggests that there should be consistent use of information standards in order to enable data to flow between systems (interoperability) while keeping confidential information safe and secure.

The Secretary of State reaffirmed this strategy in early 2013 by committing to a fully portable electronic health record in one region of England by the time of the 2015 general election, and a paperless NHS in 2018.

- **Urgent and emergency care:** In the evenings, at weekends and during holiday periods pharmacists often get requests for medication when patients have run out. Around 2% of out-of-hours appointments and 4% of Bank Holiday out-of-hours appointments with a doctor are taken up by

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\(^7\) Pharmacy Voice (2013) Practice Based Audit 2012/13. Available at www.pharmacyvoice.com
requests for a prescription for repeat medicines. Patients themselves do not always have accurate information about their medication and expect the pharmacist to be able to access their personal health records. Allowing such access would facilitate supplies of the right medicines in such circumstances. There is a possibility that serious patient safety incidents can occur when a patient presents at a new pharmacy. For example, an urgent request for warfarin (a blood thinning agent) requires a tailored dose within a narrow window between therapeutic activity and toxicity. Making a mistake with doses in this instance could be extremely serious.

- **More robust records:** Currently a GP is limited in their ability to know if a patient is taking a medicine that they have been prescribed, or even if that medicine has been dispensed. With the roll out of a variety of services such as the chronic medication service in Scotland, medicines use reviews (MURs) and the new medicine services in England and MURs and the discharge medication service in Wales more information on pharmaceutical care issues is being recorded and stored in community pharmacy patient medication record systems. This could be transferred back to the GP as required, but currently there is no link between the pharmacy record and the GP record. As a result there is no facility for a community pharmacist to access any part of the patient’s health record which is stored at the GP practice (or vice versa in terms of the pharmacy’s patient medication record).

- **Multiplicity of prescribers and providers of care:** There are now many non-medical prescribers including pharmacist prescribers operating in Britain and consequently at any time a number of different practitioners may be prescribing for a single patient. Access to and input into the electronic patient record, providing an up to date overview of a patient’s clinical condition, treatment, tests, drug history, allergies and adverse reactions is important for patient safety and for the provision of efficient patient centred care.

- **Transfer of information across care settings:** Patients are extremely vulnerable when moving between care settings. Currently IT systems that operate in primary and secondary care do not generally support transfer of information between different care settings. As a result information on changes to a patient’s medicines does not automatically follow them. This may mean that changes to a patient’s medicines in secondary care are not always continued in primary care. Community pharmacists that have access to hospital discharge summaries are able to check that medication changes recommended in secondary care have occurred and are safe and effective for the patient. In extreme cases errors and delays in information transfer can result in re-admission to hospital.

- **Participation in research:** For community pharmacy to support the health and wealth agenda and play their part in increasing access to research, they require access to patient health records to help identify appropriate patients for studies. They also require access to ensure the safe care of patients who are participating in studies, particularly those on trial medications. Having access to patient health records will enable pharmacists to track patients and understand where the interventions they made have impacted upon patient outcomes which is important for the effectiveness, cost effectiveness and improvements agendas.

Up to 7% of unplanned admissions are the result of drug-related events; this can increase to 20% in the frail elderly population. It has been shown that adverse drug events occur in up to 20% of patients after discharge, and it is estimated that 11–22% of hospitalisation for exacerbations of chronic disease are as a direct result of non-adherence to prescribed medication. Pharmacist access to patients’ records would facilitate a more proactive approach to monitoring and supporting adherence to medicines and the sharing of more information with other health professionals involved in a patient’s care. Improved medicines adherence would mean fewer hospital admissions, a reduction in medicines wasted and a reduction in adverse effects.

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8 Local Care Direct and Yorkshire Ambulance Service (NHS111) Data
9 South Western Ambulance Service NHS Foundation Trust Data
Confidentiality and security of patient information

Pharmacy has long held the trust of the public as a guardian of confidential patient-identifiable information, both paper-based data such as prescriptions, and data held on computers such as patient medication records. Registered pharmacy professionals are responsible and accountable for their actions and the quality of their practice and are held to account through legal obligations and professional standards of conduct, ethics and performance. All staff employed in pharmacies have contractual duties relating to patient confidentiality.

The Health and Social Care Information Centre (HSCIC) have also published guidance on confidentiality in health and social care which apply to registered pharmacy professionals as well as all other health and social care professionals. Pharmacies conform to the same Information Governance standards and guidance as other parts of primary care.

As with other health professionals, in pharmacy our aim is to achieve an appropriate balance between the protection of patient information and the use and sharing of information to improve patient care. We seek appropriate access for registered pharmacy professionals to the patient’s health record only when more information is needed to ensure the provision of safe pharmaceutical care for a patient.

Making it happen

Pharmacy is an independent, trusted resource for health, well-being and social support for patients. Pharmacy’s professional role is not limited to the dispensing of medicines, but also embraces prescribing, diagnosis, health literacy, counselling and education, patient pharmaceutical care management and healthcare leadership. Pharmacy professionals are the patients’ advocates for medicines safety and medicines optimisation. To properly fulfil this role, innovative and creative new ways of working that embrace new technologies and allow read and write access to patient health records are urgently needed.

Pharmacists and pharmacy technicians, as registered healthcare professionals should have access to the patient’s healthcare record in order to provide better and safer care to the patient.

A position of “access to health records in the patient’s interest” must be adopted. Registered pharmacy professionals have a legitimate need to access patient health records as the more information available to them when providing care to patients, the better the outcome for patients.

We are calling on NHS England and the HSCIC to make this a reality for the community pharmacy network that dispense over 1 billion prescription items a year.

Summary

- Registered pharmacy professionals should have access to the patient health record to improve patient care and patient safety.

- Access to the patient health record will allow pharmacists to make more informed clinical decisions, in partnership with patients, about the pharmaceutical care that patients receive. This will improve medicines adherence, supporting improvement in the treatment of individual patients and helping the NHS to maximise the value of the significant investment it makes in medicines. The ability to access the patient health record will allow pharmacists to play an even greater role in the provision of unscheduled care by improving their ability to respond to emergency requests for medication safely.