RPS in Scotland's response to Review of NHS Pharmaceutical Care of Patients In the Community - Scotland

Section 1: *Person-Centred* NHS Pharmaceutical Care

Quality Ambition

Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

Q1. What improvements should be made to ensure that the individual needs and values of patients receiving NHS pharmaceutical care are respected?

The focus of any outcomes and changes from this review should be on enabling pharmacists to spend more time in patient facing roles, improving the patient journey and providing appropriate pharmaceutical care for their needs.
The patient journey should be at the heart of pharmaceutical care with the emphasis on getting things right first time.

In order to provide patients with optimal pharmaceutical care, access to an accurate diagnosis and any ongoing management plan is required before individual pharmaceutical needs can be fully assessed and met.
Pharmacists currently obtain their diagnosis information from the patient or the patient's representative; this is not always accurate and can lead to misunderstandings.

The principles of *Releasing Time to Care* should be applied to pharmacy services and LEAN methodology used to streamline processes to enable pharmacists to have the time required to spend with patients. We should build on the CMS and have greater understanding of the barriers to its use.
Pharmacists require both the time and the skills to address patient needs with a person-centred approach. This will include:

- a change in culture with public education and increased awareness of the role of pharmacists
- increased focus on the need for quality rather than speed of service
- the correct location and environment to deliver care

- an awareness of any cultural and religious issues that may affect an individual's attitude and feelings about their medication and their condition
- access and input to one single electronic patient record
- practice management skills
- education and training in counselling and listening skills
- national post graduate training including clinical skills, accessible to all
- a review of the learning and practice developed within the Pharmaceutical Care Model Schemes and associated NES educational tools would support future practice development.

Relevant Terms of Reference Item: 1 and 4

Q2. What improvements should be made to ensure shared decision-making with patients and partnership working with patients and their families or carers?

Pharmacists should consider the concept that they are working in a community of people rather than community-based. They must explore the needs of the people around them and develop services that will link them more effectively with the community they serve. There needs to be a change in public perception of the pharmacist with increased awareness of the role of pharmaceutical care.

Pharmacists should be more proactive in establishing therapeutic partnerships with patients and their families or carers. All pharmacists involved in activity that may change treatment should do this as part of direct patient-facing roles. More time for consultations is required and greater sharing of good practice.
In the future, it will be helpful, when integrating with social care systems to include carers and care home providers in the decisions around pharmaceutical care when patients require support. Care must always be taken to address patient consent and confidentiality.

The recent RCGP Scotland and RPS Joint Statement: *Breaking down the barriers - how pharmacists and GPs can work together to improve patient care* states, "Building on the guidance for general practice, community pharmacists and staff should recognise the front-line role they have in identifying carers and ensuring that carers are signposted to appropriate support, and that GP practices are informed so that they may involve newly identified carers in patient care and provide ongoing support."

- Community pharmacists should formalise existing relationships with carers to address their needs, and to signpost them to the support available via their GP practices and local services.
- Prescriptions for new medicines and CMS consultations are ideal opportunities to provide counselling and to build therapeutic relationships. This will improve a patient's understanding of their medicines and condition and optimise their use by exploring any barriers and problems with adherence.

- Access and input into the appropriate part of the patient's healthcare record and care pathways is essential for shared decision making to be relevant, in tandem with the opportunity to input into care pathways.
- There should be recognised signposting and direct referral pathways to other health and social care professionals as appropriate.
- The inappropriate and overuse of MDS poses safety risks, adversely affects choice and is not person-centred. Introduction of a national multi-disciplinary adherence support tool that incorporates medication review and assessment of risk from medicines is essential.

Relevant Terms of Reference Item: 1, 3 and 4

Q3. What improvements can be made to pharmaceutical care to ensure that patients have appropriate medicine taking regimens, and that they are supported in achieving these regimens?

Pharmacists have the skills to optimise medicine regimens but community pharmacy practice does not allow their skills to be utilised. Pharmaceutical care can be opportunistic when there is a need for medicines reconciliation, medication review, and adherence support. It can be structured such at the point of the clinical check of prescriptions, through CMS or scheduled medication reviews.

Inclusion of community pharmacists in managed clinical networks and other integrated care pathways is required. Quality outcome markers for pharmacist contributions should be agreed in partnership with the GP, pharmacist and patient to optimise care. The AMS and CMS should be designed to enable this contribution.

Pharmacists should be in patient facing roles, ensuring people fully understand the need for their medicines, how to take them and what to expect from them. Improving pharmaceutical care of both acute and long term conditions requires changing operational practices and skill mix to allow greater use of accuracy checking technicians in the dispensary.

Support in the administrative management of pharmacies is also required. This could be a new role of Practice Manager similar to the GP practice model.

We need to identify and build on the strengths of both GP practices and pharmacists with a more strategic approach to dovetailing the care contributions. There needs to be a clear understanding and agreement of the different inputs to patient care.

Reasons for changes in regimen and other important patient information need to be shared and easily accessible by all healthcare providers to prevent re-admissions and minimise iatrogenic disease. The variance in including community pharmacists in discharge planning arrangements in particular poses a risk especially when the pharmacy is providing weekly dispensing or prescription collection services.

Pharmaceutical care can take both preventive and corrective approaches to patient care. To get it right pharmacists need:

- access and input to the appropriate parts of the patient healthcare record including monitoring, test results review and follow ups.
- agreement within the healthcare team to provide consistent medicine and health information to patients and the public.
- pharmacist prescribing as an integral part of CMS.
- a national multi-disciplinary adherence support tool that provides solutions based on patient rather than service need.
- consultation and brief intervention skills.
- better communication and integration between primary and secondary care.
- a support functions from secondary care pharmacists allowing clinical pharmacists to share their knowledge and expertise with community pharmacies to provide specialist input and mentoring.

Relevant Terms of Reference Item: 3 and 4

Q4. What changes to current practices, if any, would be required to support closer working between pharmacists, GPs and other healthcare professionals to meet patient needs?

The recent RCGP Scotland and RPS joint statement has recognised the need for changes in practice; “By working more closely together, general practices and pharmacists will be able to identify gaps in current service provision and deliver better healthcare to the working population”.

More integrated training with medical and pharmacy students at undergraduate and postgraduate levels is required to encourage mutual understanding of the different roles**.** Clinical placements earlier in the undergraduate syllabus would be useful.

Pharmacists should provide training to other health and social care professionals and this should be an accredited role. There should be quality standards to allow universities to place students in areas of best practice and these pharmacies should be accredited and acknowledged as training practices. The GP model of Quality Practice Awards (QPA) is to be commended and we should work towards having pharmacy centres of excellence which would be the preferred practice placements for pre-registration trainees and any work experience schemes for medical and pharmacy undergraduates.

To become fully integrated into the NHS pharmacists in primary care need to be more involved in individual patient care as well as overseeing governance of prescribing.

Where primary care pharmacists are working within GP practice RPS believes they should encourage better working practices between community pharmacies and GPs. Taking this forward may require a formal alignment of practice-based pharmacists to local community pharmacies.

Restrictions around requirements for supervision and the responsible pharmacist regulations make any absence from the pharmacy difficult in practice. Changes are required to the Medicines Act to allow community pharmacists the autonomy and flexibility to attend GP practice team meetings to discuss individual patient care, discuss relevant issues and access training.
Roles require clear definition; better ways of communicating between GPs and pharmacists should be explored. For example, the following may be considered:

- inclusion in the primary care protected time training sessions locally
- inclusion of community pharmacy in integrated care pathways
- shared critical event analyses
- periodic joint practice level meetings that include nurses and social care colleagues
- meetings between the Area Pharmaceutical Committee and the Local Medical Committee
- RCGP Scotland Faculties and RPS Local Practice Forums to meet to discuss health needs and how joint working can improve the provision of healthcare and encourage better self-care
- pharmacists should be involved in work with local patient support groups to identify their needs. This should be a collaborative effort with other healthcare providers
- shared access and input to one single electronic patient record.

Relevant Terms of Reference Item: 3 and 4

Q5. What changes, if any, may be required to ensure that patients receive continuity of their NHS pharmaceutical care by pharmacists?

Registration with a pharmacy of their choosing and the opportunity to consult with their own pharmacist whenever possible would benefit long term care. Developing effective therapeutic partnerships between pharmacists, their patients, GP practices, social care, secondary care and other healthcare providers requires time and consistency.

A group practice approach where a service does not entirely depend on one individual would improve continuity.

- There should be a shift in focus from dispensing volume to one of providing quality pharmaceutical care; operational procedures need to change to address this.
- Access and input to one single electronic patient record accessible as appropriate to all healthcare professionals is essential.
- There should be a career structure in community pharmacy which encourages retention in patient-facing roles.
- The PMR should have the functionality to quickly and accurately record all pharmaceutical care contributions and flag up any required follow up and review.

- Improved communication between primary and secondary care is required and community pharmacists should be included in discharge planning and information sharing.
- Case load sharing between pharmacists in all settings

Relevant Terms of Reference Item: 1, 3 and 4,5,8,9

Q6. How can NHS pharmaceutical care contribute to supporting self care?

The self care agenda in Scotland is of a magnitude that requires all possible opportunities for intervention to be used and the easy accessibility of community pharmacists and their support team offers them a role in this.

Building on the traditional informal patient care and interventions undertaken by pharmacists, self care could be further integrated into existing CMS, PHS, AMS, eMAS, and new medicines consultations. Pharmacy systems need to be able to record the details of care episodes quickly and efficiently and IT functionality needs to support this.

A contractual and cultural shift is required to encourage GP practices and other health services to raise awareness of community pharmacy services and refer people to them e.g. smoking cessation services or emergency hormonal contraception.

Pharmacies should be viewed as NHS public health outlets that are ideally placed to provide healthy living interventions and messages to the population as a whole to prevent ill health and disease or detect it early.

Pharmacists should consider the concept that they are working in a community of people rather than community-based. They must explore the needs of the people around them and develop services that will link them more effectively with the community they serve.

There are key messages and counselling points for every medication. There is wide variance in how and if GPs and pharmacists share this information with patients. Health care professionals should be more proactive in identifying the self care needs of individuals and there needs to be clear understanding of where everyone interacts on the patient journey. GPs and nursing colleagues should signpost patients to their pharmacist for consultations on their pharmaceutical care

- There should be better publicity to raise the general public's awareness of public health initiatives accessible through pharmacies
- In order to encourage more use of community pharmacies for advice of self-care and minor ailments, there should be more effective promotional campaigns targeting the public.
- There should be greater use of NHS Logos for pharmacy services.
- Pharmacists should be more proactive with outreach work to patient support groups and schools.

- Community Health and Social Care Partnerships should view pharmacies more as resources for other health and social care initiatives.
- Signposting to other services should be encouraged; information about local health and fitness opportunities and local support groups should be readily available from pharmacies.
- eMAS could be extended further to include common clinical conditions. RPS Scotland and RCGP Scotland will work together to identify self-limiting common conditions that could be treated by community pharmacist prescribers. The Pharmore pilot projects will inform this.
- Pharmacists must publicise their role through one to one consultations and using tools including pharmacy practice leaflets that detail pharmacy services.

Pharmacists require freedom from the dispensing accuracy function to:

- help people to recognise and monitor their own symptoms and ensure they recognise the triggers that indicate that their disease or symptoms are worsening
- involve people in understanding their medicines and interpreting their results to give them a better understanding of what action needs to be taken and why
- avoid harm from medicines themselves through the clinical check of prescriptions and advising on safe use of medicines, including alarm signs
- to further develop the public health role of pharmacists and their staff and integrate this into CMS and other routine consultations
- to increase pharmacist prescribing for long term conditions and clinical areas where patient access and convenience can be improved e.g. contraception.

Relevant Terms of Reference Item: 1

Q7. What would constitute optimal NHS pharmaceutical care in end of life care?

Over the past decade, NHS Boards and contractors have worked together to develop community pharmacy palliative care networks to ensure timely access of medicines use in palliative care and provide advice on how to use medicines appropriately. This network, and the lessons from it, can be built on to achieve the objectives of *Living and Dying Well.*

Much work has been done to engage pharmacists in symptom management by identifying and managing symptoms, thus supporting the person and their family and carers. However, lack of access to diagnosis has a negative impact on patient care as pharmacists have to guess that the person is palliative, or at the end of life, based on prescriptions for medicines used at that time.

Pharmacists need to become more involved in consultations with patients and carers and provide information to help avoid predictable side effects and to reduce the fear people often have in relation to medicines used in palliative care, e.g. taking opioid medication and the fear of addiction.

Consider the following changes:

- Diagnosis and prognosis should be shared with the community pharmacists involved in providing care.
- People should be encouraged to register with the CMS to allow structured review and follow up.
- Review the palliative care network with a view to identifying good practice in pharmaceutical care and create a practice framework that will support this to be delivered from all pharmacies.
- Community pharmacists involved in the palliative care network could act as practice leaders who can support the development of best practice locally. They would be supported by specialist palliative care pharmacists.
- There should be shared access to the Palliative Care Register and better collaborative working with GPs, district nurses and pharmacists, including involvement in anticipatory care pathways.
- Pharmacists' prescribing can be utilised to support timely symptom management.
- The inclusion of preferred community pharmacists' details in the Palliative Care Register and Liverpool Care Pathway (LCP).
- Practice models that allow pharmacists to identify deterioration as part of the clinical check of prescriptions are required. The Gold Standards Frameworks Prognostic Indicators provide the framework.
- Clinical decision software and frameworks for palliative and end of life care should be incorporated into the CMS. This would include prompts around safety in relation to high dose opioids, changes to formulation, and indicators of sub-optimal management of symptoms or side effects of medicines.
- Medication review, to rationalise medication, is an established part of good end of life care. Models to support pharmacists input to this are required.
- The care home may provide a population to test practice models.

Please refer to the NHS Greater Glasgow and Clyde Macmillan Pharmacist Facilitator Project Report for more background and recommendations.

http://www.palliativecareggc.org.uk/index.php?action=cms.pc_reps

Relevant Terms of Reference Item: 1, 3 and 4

Q8. At present pharmaceutical care services must be delivered through a registered pharmacy. Does this model always meet the needs of patients and communities? If not, which other models should be considered?

The current model does not always meet the needs of patients and communities. The increasing complexity of medications and the changing demographics of our aging population put current NHS services under increasing financial strain which is unsustainable and new ways of working will need to be found.

The Pharmaceutical Care Services plans of health boards should be re-examined to show where services are not providing for the needs of the population. This would

include how pharmacy services should differ depending on the degree of deprivation and the local population demographics

Where services do not provide for the local population, and where a community pharmacy is not viable, alternatives need to be explored. The workload might need to be shared to decrease volumes and free up pharmacist time for more interaction with hard to reach areas of the population such as those who do not attend GP practice clinics. A greater understanding of the pharmaceutical care needs of specific populations is required.

Novel methods of delivery are already being piloted including telehealth, remote access and vending machines. Other suggestions include mobile pharmacists and managed service pharmacists linked to dispensing doctors in remote areas. Delivery should focus on new ways to provide pharmaceutical care which is patient-centred and these should be further evaluated.

- We should consider delivery of pharmaceutical care for elderly housebound patients in their own homes.
- Pharmacists should communicate more pro-actively with patients using telephone consultations and other IT solutions particularly at vulnerable times such as post-discharge.
- An overall clinical check by pharmacists is at the core of safe practice but this could be delivered remotely.
- Access and input to patient healthcare records would be crucial to any remote access models.
- While dispensing can be automated, or off site, the supply of medicines should be a patient-facing role for the pharmacist to allow the pharmaceutical care needs of individuals to be identified and met during the hand out of prescriptions.

Relevant Terms of Reference Item: 4, 6 and 7

Section 2: *Safe* NHS Pharmaceutical Care

Quality Ambition

There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate clean and safe environment will be provided for the delivery of healthcare services at all times.

Q9. What would you consider the main priorities to ensure no avoidable injury or harm results from NHS pharmaceutical care?

Access to information and communication between patient settings is an important aspect of patient safety. Electronic discharge with start and stop dates, with explanations for changes to patient regimens, would be helpful to everyone along the patient journey. Continual improvement to practice through audit should be an integral part of all healthcare practice.

The recent joint statement between RCGP Scotland and RPS acknowledges the need for this, “There should be an integrated patient care record available for both primary and secondary care to allow up to date patient information to be accessible by the appropriate healthcare provider. This should include medicines prescribed by GPs and dispensed by pharmacists”.

As part of the clinical check of prescriptions, pharmacists intervene to identify prescribing errors, contra-indications, interactions between drugs and conditions, inappropriate medications, doses and strengths. This contribution is not routinely recorded, but should be in order to provide both an evidence base and opportunities for improving prescribing governance. This role should be more explicit and be part of a shared prescribing governance role between GPs and pharmacists. High risk medicines and conditions are well known and more could be done to improve safety.

The methodology of the Scottish Patient Safety Programme (SPSP) has been successful at reducing harm and variance within the acute setting. This methodology and practice should be applied to the community pharmacy setting. This initiative provides an opportunity to align GP practices and community pharmacy to a joint safety culture targeting specific high risk medications. It is disappointing that this alignment did not happen from the outset.

Suggested changes include:

- Community pharmacies should be included in the Scottish Patient Safety Programme (SPSP) roll out to primary care and any future initiative. Integration of the SPSP methodology into routine pharmaceutical care practice in the community would support practitioners.
- CMS Polypharmacy reviews supported by access and input to the appropriate parts of the patient healthcare record including monitoring and test results.
- Maximum use of digital technology, robotics and Accuracy Checking Technicians (ACT) in dispensing.
- Records of significant purchases and minor ailments should be inputted into the one single electronic patient record to improve patient safety.

- A safety culture that includes the benchmarking of the clinical check of prescriptions to identify and develop best practice. Pharmacists from all sectors can support this.
- Clinical audit and governance should be embedded into routine practice as part of a framework similar to the GP QOF.
- Error reporting and significant event analysis should be a robust and consistent core element of the pharmacy service. Errors are a learning opportunity that is best shared with others to minimise or remove future risk.
- Joint working across the primary care team with targeted approach to care where specific high risk areas are identified e.g. Working together to reduce the use of anti-psychotic medication in dementia.
- GP and Pharmacy systems should include review dates and monitoring information for all high risk medicines. This could be part of a joint GP and Pharmacy QOF.
- Pharmacist prescribers can prescribe additional medication to reduce risks.
- The inappropriate and over use of MDS poses safety risks. Introduction of a national multi-disciplinary adherence support tool that incorporates medication review and assessment of risk from medicines is essential.

Relevant Terms of Reference Item: 1, 3 to 5 and 9

Q10. What do you think constitutes an appropriate, clean and safe environment for the delivery of NHS pharmaceutical care?

Dispensing should be carried out in a clean and clinically appropriate environment. The General Pharmaceutical Council is currently consulting on the requirements for pharmacy premises.

Please refer to the National Patient Safety Agency. Design for Patient Safety. The Dispensing Environment. 2007.

http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59830

Confidentiality and accessibility are priorities.

Pharmaceutical care should be person-centred and could be delivered in any setting which facilitates interaction between the patient and pharmacist with access to the full patient's healthcare record. Adequate time to consult with patients is an important safety feature. There are successful examples of projects taking pharmaceutical care out of the traditional healthcare settings and into outreach work in the community.

Relevant Terms of Reference Item: 6

Q11. How could the delivery of NHS pharmaceutical care to care home residents be improved to ensure the safe and effective use of medicines? How could the current system be improved, particularly with respect to the various service providers working together for the good of the residents?

RPS Scotland's recently published report; "Improving Pharmaceutical Care in Care Homes" is a call to action. The recommendations include:

- dedicated integrated roles for both community and managed service pharmacists in care homes
- the Care Home Contract and Standards; this should include evidence of collaborative person-centred care with shared responsibility to achieve quality outcomes
- pharmacists working with their medical and nursing colleagues to reduce the use of psychoactive medication, inappropriate polypharmacy and a number of other clinical priorities. Both pharmacy and GP systems should include review dates and monitoring information
- a more robust contract system and service level agreement, this will be required between community pharmacy services and care home providers. This will allow robust service planning and the development of the therapeutic partnerships required between care home providers, community pharmacies, GP practices, district nursing teams, social care and specialists
- promotion of the alignment of one care home to one pharmacy and one GP practice with support from specialists based in primary or secondary care
- a model where four-way quality outcomes based contracts between NHS, community pharmacy, GP Practices and care home providers
- The promotion of original pack dispensing as standard in care homes to free up pharmacy team to provide pharmaceutical care to residents and reduce waste.

Moving forward the registration of residents with the community pharmacy that incorporates the appropriate consent to improve communication and integrated care would support better team work and long term care provision.

Please see the Royal Pharmaceutical Society Improving Pharmaceutical Care in Care Homes http://www.rpharms.com/promoting-pharmacy-pdfs/rpscarehomereportfinalmarch2012.pdf

Relevant Terms of Reference Item: 1, 3 and 4

Q12. There are a number of poor prescribing practices that may occur such as failure to monitor certain medicines, inappropriate polypharmacy, etc. How should pharmaceutical care be developed to identify and correct these practices?

An evidence base of all pharmacist interventions relating to safety and governance of prescribing is required. Within CMS and the PMR there should be functionality to record interventions which contribute to safer prescribing and improved pharmaceutical care. This could be linked to an outcome based

pharmacy QOF and would also facilitate learning within primary care initiatives including the SPSP.

Pharmacists must be more involved in the decision making process of prescribing. Prescribing support pharmacists are well placed to do this while working in GP surgeries and this role should be expanded to true partnership working. Pharmacist input in GP surgery must be more pro-active in preventing poor prescribing rather than correcting. Pharmacists input into patient care needs to be more visible to patient s to increase recognition of their role. Partnership working with GP and nursing colleagues with recognition of the unique role of the pharmacists and signposting to the pharmacy services for pharmaceutical care is essential.

- Access and input to one single electronic patient record including monitoring and test results would provide the information and tools.
- All pharmacist patient safety and pharmaceutical care interventions should be recorded.
- Pharmacy QOF to measure interventions and outcomes in patient care
- Increased training and support to challenge poor practice
- Develop joint working practices between the GP practice and community pharmacy which prompt review and allow access to data to ensure the review has been undertaken and it is safe to supply the medication.
- More involvement of primary care pharmacists in prescribing decisions within GP Practice.
- Promotion of new medicines service with understanding and support from other health professionals to promote increased patient understanding of their medicines.
- RPS and RCGP Scotland Joint Statement: “RPS Scotland and RCGP Scotland will work together to develop joint processes, guidance and standards for reviewing patients’ medication which will have greater clarity about roles and responsibilities and good communication pathways. This will link in with the Scottish Government Polypharmacy work.”

Relevant Terms of Reference Item: 1, 3 and 4, and 8 to 10

Q13. In what ways can the timely and accurate provision of information about medicines, and the associated pharmaceutical care, be improved when the patient moves between settings (for example entering or leaving hospital, moving to a different area of the country or moving into a care home?

Please refer to the RPS guidance on the Transfer of Care produced in June 2011. This is available on request.

Different models of accessing information should be explored including patient held records, smart cards and phone apps to ensure that all relevant information moves with the patient and is accessible to the health professionals involved in their care. Patients are most vulnerable when transferring between settings. More integrated care between pharmacy and nursing colleagues is required.

Integration of health and social care should ensure that patient care is discussed and agreed by all involved to provide a holistic approach with continuity of care across setting and avoiding duplication and repetition

- Access and input to a single shared electronic patient record is essential.
- Electronic discharge should be routine practice.
- National core data should include the contact details of the person's regular community pharmacy.
- Dispensing information available via the CMS can be used as part of the medicines reconciliation process.
- Discharge information should be provided directly to the patient's community pharmacist in the right format for speed of information transfer, safety, accuracy and to improve the patient journey. This is essential for those people who receive a weekly compliance aide or monitored dosage system from a community pharmacy. The safety risks associated with this should be recognised and solutions prioritised within NHS Scotland.
- Post discharge is an optimal time for medication reviews with patients to ensure they have full understanding of any changes to their medication
- Agreed minimum standards of care across all patient care settings
- Community pharmacy needs to be included in core data for national documentation.

Relevant Terms of Reference Item: 1, 3, and 8 to 10

Section 3: *Effective* NHS Pharmaceutical Care

Quality Ambition

The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

Q14. How should the planning and provision of pharmaceutical care services best be delivered within NHS Board areas?

Pharmaceutical Service Care Plans need to be improved and become recognised working documents to identify gaps in services which are then priority areas for action.

Resources should be targeted at areas of highest need to address inequalities. Workforce and capacity planning issues need to be addressed. Written contracts providing clinical services to health boards should be implemented. The merging of health and social care should be recognised as an opportunity to improve person centred care. There should be a national strategic approach which promotes similar models of care in different local authority areas and encourages continuity of care. Patients' families and carers should be involved in decisions to provide the pharmaceutical care tailed to their needs in different settings.

The current one size fits all volume based contract does not support optimal delivery of pharmaceutical care. Similar to the GP model, contractual arrangements should be sensitive to deprivation and demographics.

Relevant Terms of Reference Item: 2, 6, 7 and 10

Q15. The NHS in Scotland is based on cooperation, not competition. How can this be translated into effective and efficient NHS pharmaceutical care for patients in their communities?

There should be a culture of sharing best practice between health boards and between professions. The patient journey should be considered holistically with national standards to promote increased quality of care and cooperation between all health professionals. For pharmacy there should be less emphasis on volume and increased emphasis on quality. Pharmacists need to be recognised as equal partners in the healthcare team.

The recent RPS and RCGP joint statement and forthcoming action plan will encourage joint working between the two professions.

"General Practice and pharmacy should work together at local level to identify gaps in service provision and agree how best to meet the needs identified e.g. chronic pain and skin conditions. We recognise that to achieve this effectively, extra resource may be required. "

Closer collaboration between pharmacists and their district and practice nurse colleagues would improve the patient journey and increased understanding of the

different health professional roles. The contracts for all those involved in patient care should be more strategically planned to work together, fully utilising the skills, contributions and resources available

The promise of a high trust low bureaucracy model within the new community pharmacy contract has not been realised. Payment verification requirements can be burdensome and these must be minimised to allow time for clinical care. Community pharmacy practice would benefit from inclusion in NHS Scotland's Efficiency and Productivity Framework for SR10-2011-2015, including *Releasing Time to Care* and the use of LEAN methodology.

- Pharmaceutical Care Services Plans in each health board area should be actioned to identify gaps in service.
- Access and input to one single electronic patient record is essential.
- There should be increased collaboration between secondary and primary care pharmacists with the managed service supporting the needs of community pharmacy to deliver services. Medicines reconciliation is an area of priority.
- Competition for contracts within the care home sector needs to be removed to ensure continuity of patient care.
- Opportunities for benchmarking, peer review and significant event analysis between community pharmacy teams should be provided.

Relevant Terms of Reference Item: **1, 2, 6, 7 and 10** and 9

Q16. What are your views on pharmacists and/or pharmacies collaborating to provide some elements of NHS pharmaceutical care?

Cooperation and collaboration should be encouraged to address gaps in services. A group practice approach to provide stability and sustainability could be a way forward in some localities.

Where primary care pharmacists are working within GP practice RPS believes they should provide a link and improve working practices between community pharmacy and GP practice. Taking this forward may require a formal alignment of practice based pharmacists to local community pharmacies.

We need more models of generalists being supported by specialists to provide the best patient care possible. We have seen this model within the palliative care network and in other services including an NHS Board heart failure service where specialist pharmacists also provide leadership, training and mentoring. It is time to make this routine practice within all specialities and across all settings.

We would also like to see new models of working with the development of specialism in certain areas of practice within a locality where practice champions of specific conditions can support peer development and service improvement. This would be similar to GPs with special interest and clinical nurse specialists.

Ways of embedding increased collaboration into the pharmacy services contract to improve use of resources should be explored.

- Access and input to one single shared electronic patient record is essential.
- Cooperation and collaboration should focus on the needs of the population.
- Time spent in work exchanges would improve understanding of different roles and increase collaboration. This should include staff from GP practices, pharmacies, social care, the acute setting and district nursing teams.
- Community pharmacists should be active partners in the transfer of care between settings.
- Primary care pharmacists could spend some of their time based in community pharmacies.
- Pharmacy Practice managers could work over a number of pharmacies.

Relevant Terms of Reference Item: 1, 2, 6, 7 and 10

Q17. How should we optimise the use of pharmacist prescribers to improve pharmaceutical care?

The majority of pharmacist prescribing in community and primary care to date has focused on supporting the conditions in the GMS Quality Outcomes Framework. Although an enabler in early days of pharmacist prescribing, this model is vulnerable and may not be fulfilling the needs of local populations.

Lack of access to the clinical data required to undertake the prescribing role in the community has proven to be a major barrier. Practitioners have to visit GP practices to retrieve information before clinics and return to input data after clinics.

Although the development of pharmacists prescribing clinics has been an enabler for many, pharmacist prescribing is often practiced as a separate add on to the core function of individual practitioners. Lack of electronic access to clinical data and electronic prescribing has inhibited the development of practice models in community pharmacy.

The successful use of independent prescribers working in collaboration with family planning clinics to provide oral contraception services where gaps in service have been identified is an excellent example and this model should be expanded and built on to increase patient access to medicines. Pain and dermatology are other areas where gaps in services could be met.

Partnership working with CHCPs, GPs and nursing colleagues is essential to find gaps in service, and avoid duplication with other non medical prescribing (NMP) initiatives. The provision of pharmaceutical care should be determined by the population needs locally and within the pharmacy itself. Pharmacists need to be more assertive in championing prescribing to meet the needs of their pharmacy population.

- Access and input to one single electronic patient record is required.
- Electronic prescribing for all prescribers is essential to improve efficiency and patient safety.
- Develop systems for auditing outcomes from pharmacist prescribing services with best practice sharing across Scotland and practice research and audit being embedded into practice.

- Pharmacist prescribing should be integrated into routine practice. Pharmacists should be empowerment to initiate and stop therapy adjust prescriptions using their professional judgement. They should also use their expertise to optimise patient care in line with national standards and evidence base.
- Build on eMAS and the existing pharmacists prescribing clinics to identify and share best practice.
- NHS Boards committed to increasing the use of pharmacist prescribing and incorporating it into strategic planning.
- Dose adjustments, the ability to stop and start therapy can be incorporated within the CMS in the future.
- Re-introduction of pharmacy practice leaflets that include information about pharmacist prescribing services if offered.

Relevant Terms of Reference Item: 1, 2, 6, 7 and 10

Q18. How should pharmaceutical care be further developed to support care for substance misusers?

Please refer to the recommendations of the report *Prevention and treatment of substance misusers*; delivering *The Right Medicine: A strategy for Pharmaceutical Care in Scotland.*
http://www.scotland.gov.uk/Publications/2005/08/2590211/02124

Pharmaceutical care of substance misusers has developed in Scotland with many examples of good practice across the country and greater sharing across health board areas is required. This includes good examples of joint working between social and healthcare teams which have enabled fresh approaches to treatment to be developed, including pharmacist prescribing in community pharmacies and as part of Community Addiction Services Clinics. Links between Community Addiction teams, pharmacists and GPs should be strengthened and robust referral processes implemented locally via the use of three or four way contracts and care pathways.

In the RCGP/RPS Joint Statement the following recommendations was made "Pharmacists with the appropriate expertise, working with drug misusers, can help to increase retention within treatment programmes, and those with prescribing and drug misuse qualifications can contribute to community detoxification by adjusting doses".

Minimum national standards for services should be agreed and established. Joint education and training opportunities should be made available to allow pharmacists to further develop services including enhanced needle exchange services in line with the national guidelines on injecting equipment provision.

Community pharmacists are experienced in supervised self administration of methadone and buprenorphine preparations. This experience should be built on and extended to other medications where supervision has benefits for patient and public safety including for example developing supervision programmes to assist people to maintain abstinence from alcohol.

- Access and input to one single electronic patient record is essential

- Improved communication between health, social care, prison, and police personnel is required.
- Community pharmacists must be integrated into the health and social care teams and able to contribute their knowledge of the drug misuser acquired through daily contact to care planning and review of treatment objectives. This can be done face to face, electronically or via the telephone.
- Harm reduction and health education/promotion should be core to all pharmacy services for people with drug misuse problems.
- A move to a greater contribution of pharmacists to joint care planning and sign posting would further support this group of people. This may include specific support for pregnant women, chaotic drug users, those wanting to withdraw from methadone or those where a relaxation of daily supervision would be advantageous e.g. employment or study.
- The success of pharmacist prescribing models within drug misuse should be implemented further across Scotland.
- As the drug misuse population is ageing, many have co-morbid conditions – a holistic approach to care is required to ensure that they can access and receive the same care as everyone else. Registration for CMS should be encouraged.
- To improve standards of pharmaceutical care strategies and funding should be in place to enable pharmacists to integrate with local treatment and care services and to participate as partners in multidisciplinary care.
- Alcohol Brief Interventions (ABIs) should be extended to community pharmacies to maximise the potential due to the large number of daily pharmacy attendances.
- NHS Boards should undertake a gap analysis against the recommendations of the *Prevention and treatment of substance misusers*; delivering *The Right Medicine: A strategy for Pharmaceutical Care in Scotland* report and take the appropriate remedial action.
- Joint training between all stakeholders would support better working practices.

Relevant Terms of Reference Item: 1, 2, 6, 7 and 10

Q19. What changes, if any, may be required to support the professional focus and input of individual pharmacists delivering NHS pharmaceutical care to individual patients?

We need to build on the model we have, taking advantage of the accessibility of community pharmacies. Patient facing “hand over” of medicines and interaction in the pharmacy with the pharmacist should be retained and built on. A greater understanding and evidence base of how pharmacists currently contribute to safe and effective use of medicines is required. Any changes should be underpinned by national capture of outcome data. This may result in the freeing up of resources to support service development.

Operational models must change and workforce pressures and workloads must be addressed to decrease the dispensary load and bureaurocratic burden freeing up

pharmacist time to deliver pharmaceutical care. There should be more partnership working with GPs and other colleagues in both primary and secondary care.

There needs to be greater recognition by patients, the public and other health care providers that a good pharmacy service is about quality, safety and person centred care.

A re-invigoration and greater clarity is required about the duty care that pharmacists and all healthcare professionals have to their patients.

- More movement away from commercial to clinical focus with associated mapping across of resources.
- Pharmacy services should not require sales of non health related goods to subside the business model.
- Encourage patient registration with a pharmacy of their choice for all of their pharmaceutical care services rather than the current service specific registration.
- Decreased dispensing load to free time for increased patient facing time with the pharmacist.
- The use of bar coding and robotics should be the ambition for NHS pharmaceutical care services, particularly for high volume, repeat prescription management and in particular serial dispensing via the CMS.
- Greater understanding of the pharmacists' role and contribution to care is required by patients, the public and other healthcare professionals.
- Public health roles should be expanded and integrated into CMS and routine interventions by pharmacists, technicians and support staff should be recorded on electronic healthcare records.

Relevant Terms of Reference Item: 1, 6, 7 and 10

Section 4: Technology

The next two questions relate to technology - how technology could be used, now and in the future. Technologies may include, for example, robotics, bar-coding, electronic records (including their access and shared communication), decision support, tele-medicine, etc.

Q20. How may technology be used to improve the safety, effectiveness and efficiency of the delivery of pharmaceutical care?

RPS Information Management and Technology principles provide a framework for the future and are available on request.
Current providers and systems are disjointed and prohibit a coordinated approach. A review of IT is required to provide systems which are enabling and allow continuity of care. Decision making is devolved to health boards resulting in a variety of fractured systems across the country. People move across boundaries for different aspects of their care depending on location therefore a central hub approach which allows information input and retrieval between the different systems is required to improve patient journeys and patient safety.

RPS recognises that improvements to IT are expensive but they are vital to improve the safety, effectiveness and efficiency of the delivery of pharmaceutical care by community pharmacists.

In particular we require a coordinated approach between primary and secondary care where integration is paramount to patient safety. Community pharmacy needs to be included in discharge planning for people on repeat prescriptions.

The rollout of the CMS and use of serial dispensing will increase efficiency and reduce GP practice workload. Community pharmacists will be able to plan and manage their work load and patient consultations more efficiently.

The serial dispensing functionality within CMS may help to reduce bureaucracy and improve efficiency in the care home setting.

- Access and input to a single shared electronic shared is essential.
- Pharmacies should be included in one single shared electronic discharge.
- Electronic prescribing should be the norm for all prescribers.
- Auto-ID technology should be used during medicines dispensing processes to improve the safety and efficiency of the dispensing process.
- Digital technology can also be used in the care home setting to support original pack dispensing, safe administration and to support the review.
- Nationally agreed Clinical Decision Software similar to those used in GP systems should be available within pharmacy systems. NHS owned facilities would support this.
- Robotics should be used where possible to support the CMS and repeat dispensing management to create the time required at prescription hand out to identify and meet the pharmaceutical care needs of patients.

- Bar coding could provide additional patient safety features and protection form counterfeit medicines.
- IT systems should be designed to efficiently record pharmacist interventions, provide evidence of clinical outcomes and enable audit and practice research.
- A common drug dictionary should be used by all system providers.
- There should be a commonality of language between IT systems.

Relevant Terms of Reference Item: 8

Q21. How could current and future patient records, in pharmacy and elsewhere, be used to improve pharmaceutical care?

One single electronic patient record, available appropriately to everyone who inputs into patient healthcare is essential to provide continuity and patient safety .Pharmacists should have access to monitoring, review and test results and in particular an accurate diagnosis from which to provide pharmaceutical care. There should be:

- access and input to one shared electronic patient record
- patient held records to allow access as required
- eMAS and OTC purchases included in the patient record
- voluntary registration with one pharmacy of the patient's choice for all NHS pharmaceutical care services.
- IT systems which enable interventions at other pharmacies to be inputted and accessed into the registration pharmacy remotely
- nationally agreed Clinical Decision Software similar to those used in GP systems available within pharmacy systems. NHS owned facilities would support this.
- IT systems designed to efficiently record pharmacist interventions, provide evidence of clinical outcomes and enable audit and practice research.

Relevant Terms of Reference Item: 8

Section 5: Education and Training

Here we ask you to consider what ways should education and training be developed to ensure that practitioners delivering pharmaceutical care are person centred and have the appropriate skills, clinical and other, to deliver the integrated pharmaceutical care services of the future. Please consider, where appropriate, undergraduate education, taught postgraduate and continuing professional development.

Q22. What developments would you recommend for Pharmacists?

A structured clinical career pathway in the community similar to the hospital model is required. The vocational training developed for hospital pharmacists has been integral to the successful implementation of pharmaceutical care services in the hospital setting.

We would also like to see greater integration and portfolio working between primary and secondary care. This could be an extension of the pre - registration training scheme with a modular approach which would support portfolio working and foster cooperation and closer ways of working between secondary and primary care.

Pharmacists require more training in skills such as listening, counselling and management and should be supported to identify their own training needs.

Expectation of the pharmacists' role needs to be more clearly defined to inform the educational and development needs and pharmacists need to be equal partners in whichever setting they are providing pharmaceutical care.

- Operational practices need to change to free up pharmacist time for improving pharmaceutical care.
- Pharmacy undergraduates and pre-registration trainees should have access to more clinical experience in a similar model to other health professionals.
- Careers structures need to be developed to service the needs of patients and the NHS.
- There should be greater access and support to post-graduate diplomas in clinical pharmacy practice.
- E-learning tools, webinars and other IT developments should be used to share best practice and learning over multiple sites.
- The vocational training currently available only to hospital pharmacists could be reviewed and adapted for practice in the community. Resource will be required.
- There should be joint educational events with other health and social care colleagues.
- The support and development of mentoring and support networks. RPS provide this service to members

Terms of Reference Item: 5

Q23. What developments would you recommend for technicians, assistants and other support staff?

All technicians and support staff should have nationally recognised qualifications with quality assurance to allow delegation of duties within recognised competencies in the pharmacy. There should be a broadening of their roles to meet the needs of the pharmacy population
Existing roles should be recognised and formalised.

To improve joint working with GP practices, opportunities for work experience and role swapping between pharmacy and GP practice staff would enhance the understanding of their different but complementary roles.

- There should be more involvement in outreach work.
- Staff could be involved in undertaking adherence assessment and support tools.
- The role of the ACT and other support staff has to be developed in such a way to allow delegation of this part of the dispensing process. Best practice sharing between the hospital and community setting would support safe and effective practices.
- Technicians and support staff need to be supported to identify their own training needs.
- Technicians and support staff roles should be developed to support eMAS, lifestyle and public health interventions and input to specialist areas such as care homes, hospital at home and domiciliary visits, referring to pharmacists as required.
- Practice management roles need to be developed.
- There should be access to any relevant training provided for GP practice staff.
- Managed service technicians could spend some time based at community pharmacies to improve joint working and role sharing.
- Use the waiting times in community pharmacies as opportunities to identify and assess pharmaceutical care needs and for public health message and some aspects of pharmaceutical care.

Relevant Terms of Reference Item: 5

Q24. What developments would you recommend for multidisciplinary (multi professional) learning and how it may best be achieved?

NES should facilitate multi-disciplinary learning and this should become the preferred model wherever possible. The deanery model currently used for the medical profession could be adapted for pharmacy.

- Integrated training is required at undergraduate and postgraduate levels to encourage more understanding of the different roles, with a continuation into professional life at local levels.

- There should be joint CPD meetings locally whenever possible through medical faculties and local practice forums.
- More opportunities for joint learning with nursing colleagues are required.
- Contractual changes are required to allow protected learning time for community pharmacists and support staff during the working day to allow them to attend educational events.
- Health and social care professionals should be included and new initiatives taken forward jointly wherever possible.
- IT developments such as e-learning tools and webinars should be used to encourage joint learning opportunities over multiple sites.

Relevant Terms of Reference Item: 5

Section 6: Use of Resources

Q25. In what further ways should NHS pharmaceutical care ensure that patients are receiving cost effective treatment?

Pharmacists require to be empowered, with processes in place in order to challenge inappropriate prescribing and given jurisdiction to intervene and make therapeutic switches to ensure compliance with national standards and formulary.

There should be closer collaboration between the health professions to promote discussion around prescribing decisions that utilise the different skills of pharmacists, GPs and nursing colleagues.

Pharmacists need to be more involved in the decision making process of prescribing to promote “getting it right first time” for the patient. Hospital models, where pharmacists are present at the time of prescribing or can make changes after by direct involvement in the treatment plan and case notes, should be encouraged. Pharmacists are not always present when prescribing decisions are taken; therefore new models and ways of working require to be scoped out and explored to overcome this.

Primary care pharmacists in GPs practices and the use of technology to involve community pharmacist prescribers would further support cost-effective prescribing.

- The role of primary care pharmacists should be more focused on individual patient care at the point of diagnosis.
- The ability to intervene and make therapeutic switches should be included in a Pharmacy QOF which includes cost-effectiveness. This should be developed and integrated with the GP QOF to avoid duplication and enhance joint working.
- Discharge information should be sent directly to community pharmacists from secondary care to ensure that changes in prescribing are right first time to avoid waste and harm.

Relevant Terms of Reference Item: 10

Q26. What advancements in medical care will present new opportunities for NHS pharmaceutical care, and how should these opportunities be realised?

The delivery of complex medicines direct from hospital to the patient will produce new challenges for pharmaceutical care and good communication between secondary and primary care services is vital. These could include gene therapy and oral chemotherapy.

There are examples of the use of e-health technology in secondary care which should be extended to include GP practice and community pharmacy.
.
Pharmacists from secondary and primary care will be required to work more closely together. Crossover and portfolio working should be encouraged.

- One single shared electronic patient record accessible as appropriate will be necessary for patient safety.
- Integrated care pathways that allow effective contribution from all healthcare professionals and care providers will be required in tandem with clarity about roles and responsibilities.
- There will be a role for NES to provide training and CPD to up skill pharmacists and technicians in new technologies.
- For areas of high risk, care plans produced by hospital pharmacists for either inpatients or outpatients should be shared with the community pharmacy to allow safe and effective follow up. There are examples of the use of e-health technology to share patient care plans in secondary care which should be extended to include community pharmacy.

Relevant Terms of Reference Item: 6 and 10

Q27. Which aspects of NHS pharmaceutical care should be developed to help reduce waste?

Closer partnership working with GPs to improve medicines utilisation, cost-effectiveness and minimise waste has been agreed between RPS and RCGP in the recent joint statement “Partnership working and contracts for both professions which link together to minimise inappropriate supplies. “

In November 2010 the report from York Health Economics Consortium, University of York, and the School of Pharmacy, University of London (2010).
Evaluation of the Scale, Causes and Costs of Waste Medicines.
showed that a large proportion of waste cannot be avoided but that better understanding of their medicines contributed significantly to reducing waste.

We need to encourage better concordance and adherence through patient education and this requires more pharmacist time in clinical checks with patients at medicine handover and adhoc requests for pharmacist support from patients.

CMS is designed to address patient understanding of their medicines for long term conditions. Any pharmacist interventions that reduce waste as part of this service need to be recorded and recognised. We look to the e-pharmacy programme to support this functionality. The same principle applies to acute prescriptions, especially for new medicines.

Payment should be quality and outcome based.

Pharmacist prescribing should be integral to approaches which reduce waste allowing changes and adjustments to medication to be made and recorded in the same intervention; thus the potential for waste would be reduced overall.

- Consideration should be given to the length of prescribing and reduced to a maximum of 28 days, or less for new medicines.
- Access and input to a single electronic patient record is required.
- Pharmacist prescribing should be an integral part of patient care to optimise medicines use.
- Polypharmacy reviews by a pharmacist should be carried out with quality markers agreed between medical and pharmacy professions.
- Communications between GPs /pharmacists/nursing colleagues/ other health professionals and social care should be improved.
- Improved medicines reconciliation particularly on transfer between settings.
- A national assessment tool should be used to rationalise the use of MDS systems.
- Domiciliary visits for people on high numbers of medicines and use of technicians to widen this role.
- Adequate technician and support staff with recognised qualifications to allow operational procedures to change and give pharmacists more time for consultations.
- Pharmacy QOF incorporated into the contract dovetailing with the GP QOF to maximise results overall.
- Areas of waste within care home setting require particular focus as it is a relatively controlled and predictable environment. Care Home providers should commit to waste reduction within their contract with the NHS.

Relevant Terms of Reference Item: 6 and 10

Q28. Which aspects of the purchase of medicines could be improved to increase the efficiency and cost effectiveness of NHS pharmaceutical care?

Pharmacists presently spend a large proportion of their time sourcing medicines at the best price possible. More clarity and a simplified approach to the pricing structure of drugs for NHS use are required.
Consider:

- a national approach to an evidence based medicines formulary.
- removing drug tariff anomalies to free up time for professional input to clinical care.
- reviewing the eMAS service to use pharmacy as the recognised first port of call for common clinical conditions with a limited formulary range of medicines and encourage self care.
- savings should be mapped to pharmacy services
- that governance around prescribing should be the same for dispensing and non dispensing GP practices with adherence to national guidelines and evidence based medicine.

Relevant Terms of Reference Item: 10

Q29. What should be the role and contribution of pharmacist support staff to achieving high quality, sustainable NHS pharmaceutical care? How could this be achieved?

Pharmacy support staff can make a positive contribution to a change in culture of expectations from community pharmacy as illustrated in the success of healthy Living Pharmacies in England and some innovative pharmacies in Scotland. We suggest that the review looks at how the skill mix and roles in GP practices have evolved, supported and resourced as a framework for effective change.

This may include the inception of a pharmacy practice manager similar to the GP model. The two roles could link and work together which would help to integrate pharmacy into the primary care team. Pharmacy practice managers could manage group practices and work over more than one pharmacy.

Many public health roles can be successfully delegated to support staff and indeed this has been an important factor where there has been success in smoking cessation and Keep Well initiatives. The advantage of familiarity with the local community is an advantage which should be built on.

- Costs of providing an improved service should be recognised but could be shared in localities with a group practice approach.
- Use the waiting times in community pharmacies as opportunities to identify and assess pharmaceutical care needs and for public health messages and some aspects of pharmaceutical care.
- Empowered and recognised support staff working within effective practice management principles can contribute to continuity of service when the regular pharmacist is not available.
- Support staff could provide outreach services to patient's homes, supported care settings and care homes e.g. adherence assessment and follow up.
- The introduction of a national integrated multi-disciplinary adherence assessment tool would allow initial assessment to be carried out by support staff with referral to the pharmacist for a medication review where appropriate.

Relevant Terms of Reference Item: 1 and 10

Section 7: Access to NHS Pharmaceutical Services

Q30. What improvements might be needed to ensure that all people, wherever they live, have ready access to the full range of NHS pharmaceutical care?

People should have access to the level of pharmaceutical care appropriate to their needs. However the pressure of dispensing volumes, increasing annually allows increasing less time for pharmacists to engage with patients and provide optimum pharmaceutical care. Change is required. Operational practices, technician roles, low bureaucracy culture, legislation and career structures in community pharmacy must support a more patient facing role.

The level of pharmaceutical care can vary within different settings, with differing disease co-morbidities, age and complexity of clinical care. One model will not fit all and the current volume based contract is not sensitive enough to ensure that resources are available to provide care services based on the population needs. Unlike the GMS model, that, for example, includes deprivation, resources should be targeted at areas of need.

Health Board Pharmaceutical Care Services Plans should be implemented to identify and fill gaps in service and ensure that adequate provision of all aspects of pharmaceutical care is available.

Pharmacists in community require a framework of staff to support services which will enable them to deliver new models of care.

Pharmacists recognise that their availability in community is a powerful asset in providing patient care however pharmacists need to be assured that the pharmacy will run safely if they require to leave the premises. The current ways of working do not support this.
New models of care and integration into the primary care team are currently hampered by the Responsible Pharmacist regulations which, although technically allowing a period of absence from the pharmacy are presently not utilised since the current supervision regulations still require the presence of a pharmacist for most of the normal business of a community pharmacy.
We suggest that the following are required:

- improved communication between secondary and primary care
- access and input to one single shared electronic patient record
- sustainability of services through robust funding and infrastructure models
- group practice models with supporting services from staff similar to a GP model.
- peripatetic pharmacists to provide pharmaceutical care where full time community pharmacies are not viable.
- better use of skill mix with technicians to provide a wider range of services within their competencies
- Pharmaceutical Care Needs Assessment that provides a more robust gap analysis

Relevant Terms of Reference Item: 2, 6 and 7

Q31. How might GP practices providing a dispensing service to the community be supported to ensure that patients receive a full range of pharmaceutical care services?

The pharmacy profession and GPs should work in partnership to ensure that everyone receives the level of pharmaceutical care appropriate for their needs. Professional standards for the quality of the dispensing process should be the same in all settings. We advocate that a pharmacist should be linked with every GP practice to provide professional input as appropriate.

Currently the managed service has responsibility to ensure the provision of patient access to their medicines where traditional community pharmacy models are unsustainable and this could be expanded upon in the future.

Pharmaceutical care can be provided remotely and new models should be explored and evaluated using IT solutions in addition to improve services within current resources making more use of existing communication methods.

Relevant Terms of Reference Item: 2, 6 and 7

Section 8: Other

Q32. Is there anything else within the terms of reference that you would wish to add to the responses you have already made?

It has to be recognised that full integration into the health and social care team is required before pharmaceutical care outcomes can be fully realised. It is part of the team approach to care. This review should not be seen in isolation and any proposed changes must align with the health and social care integration work stream currently being undertaken by Scottish Government

Throughout this document we have made reference to various documents published by the Royal Pharmaceutical Society (RPS), all of which give examples of the Scottish Pharmacy Board's preferred direction of travel for the pharmacy profession and for improving pharmaceutical care for patients in Scotland. Together the documents provide answers to many of the questions asked in this consultation. These are listed below:

- RCGP Scotland and RPS Joint Statement – Breaking down the barriers – how pharmacists and GPs can work together to improve patient care
- RPS Scotland, Improving Pharmaceutical Care in care Homes march 2012
- Information Management and Technology principles
- RPS Clinical Check Quick Guidance

Relevant Terms of Reference Item: 1 to 10