

HEALTH AND SPORT COMMITTEE. WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM Royal Pharmaceutical Society in Scotland

Considering the Health and Sport Committee's report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities?

Transformational change is required to address the challenges the NHS will face with an aging population living longer with more long term conditions. We have answered the committee's questions looking at where there are gaps in the current ways of working and how pharmacists can contribute more to prevention and treatment across our NHS.

The public report supports many of the areas where we have been advocating for change. This includes pharmacist led medication review, prescribing, monitoring of long term conditions, public health, improved referral systems and social prescribing. We are pleased to read that most people are happy to have their health records shared with pharmacists and to have consultations with other members of the healthcare team as well as their GP. It is important that the results of this report are translated to a national realisation of the broader nature of primary care.

Medicines are the third largest expenditure in the NHS, but we know that around 61,000ⁱ unplanned admissions to hospital are due to medicines. Pharmacists are the experts in addressing medicines related issues. They have an important role in working with other health and social care professionals to ensure safe systems are in place wherever medicines are used, and to maximise the investment the NHS makes in medicines. New models of care need to focus on providing the public with access to the pharmaceutical expertise to keep them safe, to self-manage and to prevent unnecessary admissions to hospital. To accomplish this there must be pharmacists wherever there are medicines, both strategically in planning services and operationally at local levels.

National Drivers for change

Progress has been made in recognising the contribution pharmacists can make to the NHS with new roles in GP practice, the recent commitment to extend the minor ailment service and initiatives such as Pharmacy First in community pharmacy.

There are many examples of innovative practice from vanguards of the profession, working with local GPs to integrate services, sometimes with more than one pharmacist on site to deliver the breadth of services community pharmacy has potential to achieve.

While there are many areas of exemplary practice, there is also variation and national drivers are not yet in place with to encourage a business and practice model which optimises the clinical expertise of pharmacists, particularly in the community sector.

The current system does not guarantee that a patient receives the pharmaceutical care required. GPs do not have time to always explain about medicines. There are two core roles for every patient facing pharmacist to keep patients safe and optimise their treatment:

- Clinically checking prescriptions to ensure that the prescription is correct, with the right dose for the patient, identifying issues with adherence, safety & effectiveness.
- Counselling patients on their medicines and ensuring they have all the information they require.

However, contractual incentives in community pharmacy still focus mainly on rewards for supply and items of service rather than a holistic package of care which ensures time spent advising patients.

Our members tell us that despite their commitment and best efforts they do not always have the time to spend with patients as they would like due to the volume of prescription items prescribed and their absolute focus on patient safety in the dispensary.

Patient care from community pharmacy should focus on the clinical care delivered along with supply and be resourced accordingly. Robotics, automation and more pharmacy technicians to support dispensing would free up pharmacists' time to be with patients and provide clinical care in keeping with their education and expertise.

Better use of existing resources

Advantage must be taken of all available resource and expertise. In future all patient facing pharmacists wherever they are practising will be independent prescribers. This expertise must be harnessed with integration across the wider primary care team.

Community pharmacy has potential to be a community health hub providing first access to the NHS. We know from the MINA studyⁱⁱ that outcomes for common clinical conditions are similar whether people are treated at A & E, GP appointments, or community pharmacy, which is more readily accessible and cost effective. This work has begun successfully with Pharmacy First but could be further expanded to provide the transformational change in services required. Co-location of NHS and voluntary sector services in community pharmacies would provide patients with an integrated approach to health and social care and provide social prescribing to local resources.

The link below shows just one example of how community pharmacy can be first port of call, triaging common clinical conditions, linking with NHS resources to support self-care, working with the local health board and GP practices to provide an integrated service. Robotics and innovative IT solutions have been used as well as up to three pharmacists in this model where the community pharmacy has been transformed to a community health hub. <https://www.cadhampharmacy.com/triage-clinic-award-winning-care> There are many more initiatives and examples of good work across Scotland, but national drivers are needed to incentivise best practice and encourage new models of care.

Public Health and Prevention

There is potential for community pharmacies to be public health and healthy living hubs, focusing on obesity management, lifestyle changes, social prescribing and vaccinations to increase capacity and uptake. Smoking cessation services have already been shown to be most successful where pharmacy support staff have been involved and this could be expanded to provide more public health and prevention initiatives. The new community pharmacy framework in England now has a quality payment for Healthy Living Pharmacies, extending the previous local successes to a national requirement for all pharmacies by 2020ⁱⁱⁱ.

Integrated Care

Community pharmacists need to work more closely with colleagues in GP practice and secondary care as well and the wider multidisciplinary team. Despite being based in a retail environment over 90% of community pharmacy business is NHS related. Work is required to fully integrate the pharmacy, dental and optical primary care contractor services into the NHS, more closely aligning with GP services and being resourced for clinical care provision. There are examples in practice where local services are provided from both GP

practice and community pharmacies to improve capacity, uptake and patient outcomes e.g. Asthma reviews.

3 people die every day in the UK from asthma and 2 of these could be prevented^{iv}. 368,000 people (1 in 14) are currently receiving treatment for asthma in Scotland. Only a third of people with asthma have an annual asthma review with inhaler check and a written action plan. People without an action plan are 4 x more likely to have an emergency admission to hospital.

In one local enhanced service people who have repeatedly not attended practice nurse annual reviews are reviewed in community pharmacy when picking up their next prescription, working to identical protocols as in GP practice. In addition, many pharmacist independent prescribers have targeted this group of patients to improve asthma management and outcomes. This type of integrated working could be formalised with synergy between GP and pharmacy contractual services and to target those other long term conditions where prevention is crucial e.g. diabetes.

There is also a greater need for more understanding of roles across health and social care professionals, so that everyone is clear on roles and responsibilities, and where the expertise lies at each point in the patient journey. This is equally important for the public who must realise that not always seeing a GP is an enhanced service rather than a diminished one. Health literacy in schools from an early age to inform around how to navigate the NHS will be essential in the longer term to improve public understanding.

Pharmacists are the best placed profession to work with the wider multidisciplinary team to provide the holistic expertise required to oversee the complex care regimens required to treat patients with several long-term conditions. Clinical guidelines focus on single therapeutic areas and are not always appropriate for patients with co-morbidity. This will become ever more important as our population ages and more people live longer with more long-term conditions.

IT and Sharing of Information

There are two disconnects in the current system; between health and social care and between primary and secondary care. Both need to be addressed in future models of care. Timely sharing of information between pharmacists in hospital, GP practice and community is essential and an important element of keeping people safe as the move with their medicines across our health and social care systems.

While we support the development of a national digital platform, the timescale for this is too long. Some essential steps need to be taken to decrease the risk to patient safety over the next ten years. Measures will need to be put in place as a priority to provide community pharmacists access to health records. Scotland is now lagging behind England and Wales in this respect. With several professions including pharmacists now independent prescribers it is becoming even more important that all the appropriate information is available before dispensing occurs. The AdastrA system could be adapted for a two way system between GPs and community pharmacy and other health care professionals. There is potential for smarter use of online platforms and technology for prescription ordering, appointment booking and patient self-management.

Community pharmacy is the only place where out of hours services will send patients for ongoing treatment without their summary information following them. Pharmacists will use their expertise in all aspects of medicines to ensure this high-risk area is minimised, but it is an avoidable risk which needs to be addressed. Sharing of information would support closer

monitoring of high-risk medicines where complications are most likely to arise and cause re-admissions to hospital. As treatment becomes ever more complex, good pharmaceutical care becomes even more essential and the system must acknowledge this to ensure ongoing patient safety.

Duplication of resources needs to be eliminated with protocols and information shared between healthcare professionals (HCPs). Often patients report having repeat tests and monitoring and having to relay their own information to different HCPs. Having shared information across the professions could substantially reduce the need for duplication.

Waste

We know that up to half of all medicines prescribed are not taken as the prescriber intended and that most waste results from changes in prescribing, changes in a patient's disease state and non-adherence to their prescribed regimen⁹. It has been shown that only about half of medicines waste can be avoided and this is most effective when linked to improving the quality of care and health outcomes. Addressing inappropriate polypharmacy has led to improved quality of care in our frail elderly but more could be done to encourage "de-prescribing" and joint decision making for patients on repeat medication with long term conditions, embracing the principles of the "Realistic Medicine" report delivered by the chief medical officer in 2016 and its follow up reports.

Enablers for new ways of working include:

- Sharing of information across the health and social care teams with one patient record providing read and write access as appropriate.
- Move to a model of remuneration for clinical services in community pharmacy practice with supply attached rather than focus on payment for supply and items of service only. "It's about the package of care not the package"
- Formalise ways of working between independent prescribers in community pharmacy providing the core contractual Care and Review service, working closely with GP practice colleagues, to provide a wraparound repeat prescribing service, focusing on patient safety and improving health outcomes.
- Annual medication reviews for long term conditions from community pharmacies as part of the Care and Review service. These are no longer a remunerated item in the new GMS contract and workload needs to be moved to ensure patient care. Further work could be done to synergise the pharmacy and GP contacts to maximise the expertise available from both professions.
- Incentivise appropriate "deprescribing" to remove unused items from repeat medication lists and reduce waste.
- Expansion of the role of pharmacy technicians in community practice and in the dispensary in a similar way to the hospital system, allowing pharmacists to focus on face to face pharmaceutical care with their patients.
- The clinical check for every new or changed prescription is a core element of pharmacy practice and should be formalised and resourced as such. It identifies prescribing errors, patient adherence, suboptimal treatment and the need to step down/reduce therapy.
- Patient registration with the community pharmacy of their choice for regular medication reviews with IT enabled to share information of services provided elsewhere.

- Appropriate skill mixes to provide the level of service commissioned by the NHS. In some places this could mean more than one pharmacist, supported by robotics, automation, pharmacy technicians and administrative support.
- Community dispensing of hospital discharge medication at a pharmacy of patient's choice.
- Direct referral systems to access treatment in hours as well as out of hours expanded to include referral to other HCPs as well as GPs and social care when required.
- Universal use of NHS Inform symptom algorithms by all front-line staff (community pharmacy counter staff, GP receptionists) could minimise variation in triage and improve referral systems

What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

Sharing of information and interoperable IT systems are required.

There is an opportunity to use digital solutions to have remote consultations with both community and GP practice pharmacists to save travel time. The advantages of this for care home patients were outlined in our recent report. "Putting Residents at the Centre of Care Home Services" This can also be beneficial in rural areas where travel time and availability of healthcare professionals can all be a barrier. IT could also be used in urban areas to improve access for housebound and working people who do not find it easy to access services during routine office hours.

Sustainability can depend on ensuring that changes in one part of the system do not have unexpected effects on other sectors. Recruitment has traditionally been an issue in rural areas as this is now also impinging in urban areas as well. The new GMS contract has encouraged movement across pharmacy sectors from community and hospital to work in GP practice which has potential to create shortages across the profession. Modelling on the requirements for the new GMS contract would indicate that there will be a substantial shortfall in the number of pharmacists and pharmacy technicians required to fulfil the new pharmacotherapy service. Anecdotally we are hearing that this is already adversely impacting on filling community and hospital posts in some areas.

How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

Evaluation of these elements of care will be long term and will also depend on many other determinants of health including housing, employment and demographics. Metrics can be used but will not deliver a complete picture. These could include:

Patient satisfaction with access to and quality of treatment; Hospital admissions; Calls to out of hours; Referral rates; Medicine related unplanned admissions to hospital; Inappropriate attendance at A and E departments; Changes in disease prevalence against time.

ⁱ Health Improvement Scotland, Scottish Patient Safety Programme. Pharmacy in Primary Care

ⁱⁱ Community Pharmacy Management of Minor Illness (MINA) Dr M. Watson, Final Report to Pharmacy

Research UK, January 2014

iii <https://www.gov.uk/government/publications/community-pharmacy-contractual-framework-2019-to-2024>
accessed 28/8/19

iv Asthma UK annual report 2018

v Evaluation of the Scale Causes and Costs of Waste Medicines, YHEC/School of Pharmacy, University of London, November 2010.