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Innovators' Forum:

Integrating pharmacists into primary care

Report of June 2016 meeting

OCTOBER 2016

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1. EXECUTIVE SUMMARY

On 9 June 2016 we held a meeting of the Innovators' Forum to consider the issues surrounding the integration of pharmacists into the new models of care. This is a report of that meeting. We began by hearing about the different types of models of care as part of the vanguard programme and then heard from presenters in more detail about how pharmacists were being involved and engaged in a particular model of care. In the afternoon we heard about the Pharmacy Integration Fund (PhIF) and had some discussion about the integration of pharmacists into the new models of care.

From the presentations and our deliberations on the day, 7 themes emerged each with actions that can be considered to support the integration of pharmacists into the new models of care. The themes are:

1. **Pharmacy involvement in local structures**
2. **Ensure IT infrastructures support integration of pharmacists into primary care**
3. **Integration of pharmacists into new models of care**
4. **Workforce Development**
5. **Integration across the profession**
6. **Contractual structure**
7. **Evaluation**

Pharmacists are experts in medicines and their use. As medicines are the most common intervention made in the delivery of health care then we believe that pharmacists should be integral to all of the new models of care in order to optimise patient outcomes from the better use of medicines.

"There are many good examples of innovative practice in primary care and secondary care that integrate the skills of pharmacists as part of coordinated care to improve patient outcomes and safety. Medicines are the most common healthcare intervention and as such pharmacists need to be an integral part of all new models of care being delivered by vanguards. It is not surprising therefore that vanguard sites now include pharmacists within their structures in supporting service development and delivery. Equally whilst some pharmacists are in the planning stages, there are many areas where pharmacists are still very much an afterthought. Clearly this is an area where there needs to be change to effectively capture the positive value pharmacists can demonstrate alongside the benefits they can bring to deliver the safest and best patient care and improved health outcomes. This would mean all commissioners involve pharmacists at every level and good practice is shared across all vanguard and other new models of care sites."

Dr Mahendra G Patel PhD FRPharmS FHEA,
English Pharmacy Board member,
Royal Pharmaceutical Society
and co-chair of the Innovators' Forum.

Prof Claire Anderson, Vice Chair,
English Pharmacy Board,
Royal Pharmaceutical Society
and co-chair of the Innovators' Forum

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2. INTRODUCTION

In November 2013 the Royal Pharmaceutical Society published *Now or Never: shaping pharmacy for the future* (http://www.rpharms.com/models-of-care/report.asp), the report of the independently chaired Commission on future models of care delivered through pharmacy. The report highlighted the need for the pharmacy profession to increasingly assume the role of supporting patients with effective medicines use so that they are seen as providers of care to patients rather than suppliers of medicines to the health system. To support this vision the report recommended that the Royal Pharmaceutical Society: "*should consider drawing together a leaders' forum made up of those committed to reshaping pharmacy as a care giving profession of equal status and profile to medicine and nursing.*"

The innovators' forum gives an opportunity for keen and innovative individuals and leaders from across the profession who share the vision of the pharmacy team as care givers to come together. The Forum helps to develop the narrative for the future of the pharmacy profession by supporting and identifying innovative practice with most chance for spread and identifying mechanisms for further spread. They also help to develop support and tools for commissioners, providers and practitioners to help them develop innovative services.

The forum also provides the opportunity to develop links across sectors, to provide networking opportunities to share good practice and spread optimism and inspire local networks of professionals and pharmacy teams to bring about change by spreading innovation and good practice.

The forum first met in February 2014 and the first resource, 'Hospital referral to community pharmacy: An Innovators' Toolkit to support the NHS in England' (http://www.rpharms.com/unsecure-support-resources/referral-toolkit.asp?) was published in December 2014. A referral service between hospital and community pharmacies has been established in a number of areas and is continuing to be adopted and spread.

The RPS would like to thank the speakers who attended the Innovators' Forum meeting in June 2016 for their contributions on the day.

- Susanna Taylor - Clinical Associate, New Care Models, NHS England
- Nicola Harker - Primary and Acute Care System Pharmacy Team, Northumbria Healthcare NHS Trust
- Pauline Walton - Associate Director Pharmacy and Medicines Optimisation, East and North Hertfordshire CCG
- Mike Maguire - LPN Chair Durham, Darlington and Tees
- Alan Bloomer – Interface Pharmacist, Blackpool Teaching Hospitals
- Anne Joshua - Head of Community Pharmacy Strategy, NHS England

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3. NEW CARE MODELS PROGRAMME

Susanna Taylor
(Clinical Associate, New Care Models, NHS England)

The new care models (NCM) were first mentioned in the Five Year Forward View (https://www.england.nhs.uk/ourwork/futurenhs/) (FYFV) which was a shared vision for the NHS across seven national bodies. The vision focuses on care services in general and not just the NHS.

The FYFV was set out to address the three major gaps in the NHS (care and quality, funding and health and wellbeing). The NCM are all about developing a menu of care models which can be offered to localities and offer some flexibility on approach. The NCMs aim to deliver efficiency savings but to do this they require upfront investment.

The core values of the NCM programme mean that processes are as transparent as possible and that any decisions that are made are based on evidence. The core values are clinical engagement, patient involvement, local ownership and national support.

The 50 NCM vanguard sites are spread across the country but there are some areas of clustering where different types of models are in the same locality, and this will enable comparison and spread. The NCMs are about managing systems of care and will be replicable across the country.

- The 9 Primary and Acute Care System (PAC) models are about sharing risk for a defined population across a partnership and these models are mainly focused on prevention and self-care.
- The 14 Multispeciality Community Provider (MCP) models are a blend of primary and specialist services (coming into the community) and each model covers a population of at least 30,000. They are about utilising multidisciplinary teams.
- The 6 Enhanced Health in Care Homes models are exploring multi-agency support for people in care homes and the use of technology to support them.
- The 8 Urgent and Emergency Care (U&E) models are redesigning systems around the expectations of people who need U&E care and aiming to decrease the pressure on Accident and Emergency (A&E) departments.
- The 13 Acute Care Collaboration (ACC) models are developing new ways to deliver quality and efficiency of hospital services looking at clinical and financial viability.

The NCMs have been operating between 6-12 months depending on the type of model and are supported by the NCM team at NHS England. Support is provided to the vanguard sites in 10 different areas and there is a small workforce behind each of these 10 areas. The vanguards received an initial allocation of funding and have recently received a further resource related to their strength of planning, integration into the community and sharing of good practice.

There are 17 clinical associates as part of the NMC team and they come from a wide range of backgrounds and have a variety of skills and experiences. They support the vanguards and help to share learning across the new models of care.

Susanna Taylor is trying to understand what is happening in the vanguards in relation to pharmacy across the 50 sites and she is working with The Royal Pharmaceutical Society (RPS) to do this. Some pharmacists have been involved in vanguards since their inception and other vanguards plan to involve pharmacy in the future.

Opportunities for pharmacists in the NCM exist and include medicines optimisation, prevention of ill health, personal care and non-medical prescribing. The benefits of pharmacists working as part of a multidisciplinary team have been proven.

A number of the models have already engaged pharmacists in the delivery of care for patients.

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4. PRIMARY AND ACUTE CARE SYSTEMS (PACS): NORTHUMBERLAND VANGUARD

Nicola Harker on behalf of the Primary and Acute Care System Pharmacy team

This vanguard has the first specialist emergency care hospital in the UK. The trust is seeking to create a single 'accountable care organisation' (ACO) with responsibility for all primary, secondary and social care across Northumberland.

It is early days for the pharmacy element of the vanguard team as they are just setting up and the whole team is not yet in place. Wasim Baqir heads up the team and all of the team members, including pharmacists and pharmacy technicians, work across primary and secondary care to ensure integration occurs.

A number of 'hubs' are being created which will have joint accountability for the health and social care needs of their local population. The GPs in the first hub are working in networks to provide care to their patients (and working towards including out of hours period) and their aim is to look after patients in their own homes and prevent admissions to hospital and the pharmacy vanguard team are there to support this.

The Blyth hub is formed from four GP practices coming together and a number of the pharmacy team are based within this hub supporting the GP's and nursing teams. The ultimate aim of the Blyth hub team is to be co-located with the community nursing team at Blyth Community Hospital, supporting the four GP practices.

Substantive data collection is taking place within this hub to demonstrate the benefit of the work they do. The pharmacists are part of a home visiting service where any calls for a home visit are evaluated and then the most relevant healthcare professional is chosen to visit that patient in their own home, as well as conducting complex medication reviews in care homes (replicating the SHINE mode - http://www.health.org.uk/programmes/shine-2012/projects/multidisciplinary-review-medication-nursing-homes-clinico-ethical) and reviews of complex high risk patients within their own homes.

Hubs to support GPs and their patients are also being planned in other areas of Northumberland with a North hub (Alnwick/Amble) led by Nicola Harker being developed in September 2016.

The vanguard is developing seven work packages – see High Level Driver Diagram on following page.

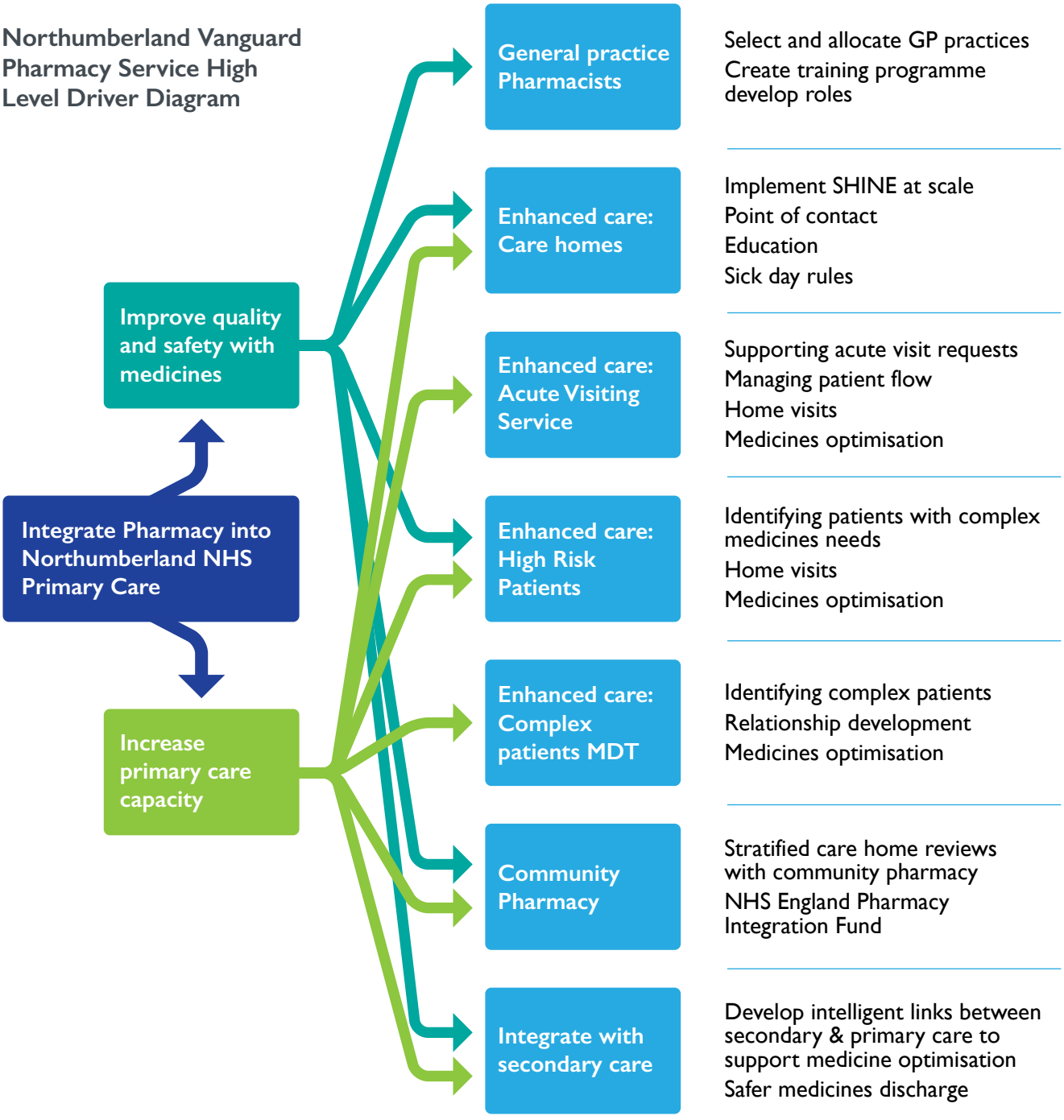
Offers have gone out to GP practices in Northumberland to integrate junior pharmacists within GP practices. Over a 3 year period as the experience of the pharmacist increases, the expectation of what the pharmacist will do within the practice will increase. As part of this workforce development the GPs in the nominated practices will provide training and support to the pharmacists who will progress towards becoming independent prescribers.

The GP pharmacist workstream has started with 12 junior pharmacists allocated to 6 general medical practices. The pharmacists will have an integrated role across general practice and hospital pharmacy. A programme using Centre for Postgraduate Pharmacy Education (CPPE) and in-house resources is being developed. Each pharmacist has a GP mentor who will support them over the coming years. The programme is co-funded with general practice and will see the pharmacists on a clinical diploma in the first two years followed by independent prescribing.

One of the really important keys for the pharmacy vanguard team is to ensure there is close working

between themselves and community pharmacy colleagues across all of the work packages and also ensure community pharmacists are linked to the local hubs. A number of community pharmacy initiatives are being planned with support from the Local Professional Network (LPN).

Northumberland Vanguard Pharmacy Service High Level Driver Diagram



5. ENHANCING HEALTH IN CARE HOMES

East and North Hertfordshire CCG Vanguard – Pauline Walton (Associate Director Pharmacy and Medicines Optimisation)

Pharmacy involvement in this vanguard is based on the previous work of using pharmacists from the Clinical Support Unit (CSU) in care homes. This was funded via the CCGs.

In the E&N Hertfordshire area there are 125 community pharmacies and the CCG is working in partnership with the County Council and care home providers. The area covers 92 care homes with 3,200 beds looking after 3,000 residents at any one time. In 2012/13 £49 million was spent on care home residents. The A&E attendance rate is 0.96 per 100 population in the over 65 age group residing in care homes. This compares to 0.34 A&E attendances per 100 population of the general over 65s population.

By 2030 the number of older people with care needs is predicted to rise by 61% and 2,000 extra carers will be needed year on year to meet the increase in demand.

The care home pharmacy team consist of 8a banded pharmacists and a pharmacy technician. The team carries out a number of roles:

- Individual patient medicine reviews with access to patient records and care plans and administration records
- Support with medicines management within the care home
- Facilitation of close links between GP, care home and community pharmacy
- Support to care home staff
- Links with CCG quality and Local Authority compliance teams
- Staff development including staff training

Workforce is one of the major issues in care homes; the ability to attract and sustain carers is an issue. The CCG have introduced a complex care premium where care home staff are provided with training in six specific areas such as nutrition and hydration, dementia. The care home is then paid an additional premium for each complex care resident the care home receives, once the staff have completed the training.

Some of the enablers that have supported the care home pharmacy team and the work they are doing are:

- They are based in the care homes and can view Medicine Administration Record charts and discuss patients with care home staff
- Each care home has one nominated GP practice
- IT solutions enable pharmacy team to view notes there and then i.e. each team member has a laptop and they can access the internet and see the patient records via SystmOne
- Effective GP engagement through face to face in situ discussions where the pharmacist and GP and care home staff discuss recommendations and agree actions
- Previous evidenced pilot work demonstrated patient benefit
- Vanguard supports and encourages integrated working
- Information sharing via a SharePoint system, a shared portal, which all can access and update in real time

A medicines optimisation dashboard has been developed locally which shows that the pharmacy team to date are working across 14 care homes (7 completed, 5 current and 2 awaiting a ward round). To date 402 patients have been seen by a pharmacist and 3,388 medicines have been reviewed. 1,105 interventions have been actioned leading to 445 medicines being stopped (65 of these increased the risk of falls). In total there has been £50,276 savings which equates to £125.06 per resident reviewed.

The main challenge is that the resident is currently only reviewed once and this needs to be undertaken more regularly. The RIO score is used to link interventions with prevented admissions but this tool has not yet been validated, although many areas are using it.

In the future the CCG hopes to expand the scheme to cover more care homes in the area and develop the pharmacists to become independent prescribers. They would also like to apply the principles they are using for care home residents to home care services for their vulnerable housebound residents.

> " To deliver an enhanced model of health and social care to support frail elderly patients, and those with multiple complex long term conditions in the community in a planned, proactive and preventative way"

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6. URGENT AND EMERGENCY CARE: NORTH EAST VANGUARD

Mike Maguire (LPN Chair Durham, Darlington and Tees)

Innovation is easy to do if everyone is in the same place but this is rarely the case. There are a number of challenges with innovation, such as:

- Other people are unlikely to be at the same stage in their journey as you are in your journey
- There is by definition, little or no evidence for any innovation and we live in an evidence-based NHS
- The more people involved in making strong leadership decisions with innovation, the slower the process becomes, especially when the decision-makers aren't the driver of the innovation

The North East region includes 12 CCGs and a couple of pharmacy led U&E care services have been planned by commissioners i.e. Pharmacy Emergency Repeat Medication Supply Service (PERMSS) and Community Pharmacy Minor Illness Service (CPMIS). Both of these are regional services involving a system-wide comprehensive referral process and including self-presenting patients.

The PERMSS service was piloted from 15 Dec 2014 until 7 April 2015 and demonstrated an estimated cost saving of £327,025 per annum as well as providing value to patients. In total 3,420 patients received an emergency supply of their repeat medicine across the 12 CCG areas. This service was moved into the North East vanguard in December 2015.

The CPMIS raises the question around whether the GP surgery is the best place for low acuity patients to go. If pharmacists could deal with these patients this would reduce the pressure on GP practices. However, the infrastructure, systems and processes, need to support the integration of pharmacy services, for example, NHS 111 Directory of Services (DoS).

Unfortunately the vanguard didn't receive the expected funding so both PERMSS and CPMIS businesses cases will have to start again at the Northern CCG Forum.

South of Tees CCG implemented PERMSS successfully over Easter 2016 and are now considering the CPMIS model for South of Tees and potentially all of Tees. The next step is to go ahead with preparing the NHS 111 DoS across the North East to ensure the infrastructure is ready for the services to go live.

> "The biggest danger for most of us is not that our aim is too high and we miss it, but rather that our aim is too low and we reach it"
> Michelangelo

7. MULTISPECIALITY COMMUNITY PROVIDER (MCP): FLYDE COAST VANGUARD

Alan Bloomer (Interface Pharmacist, Blackpool Teaching Hospitals)

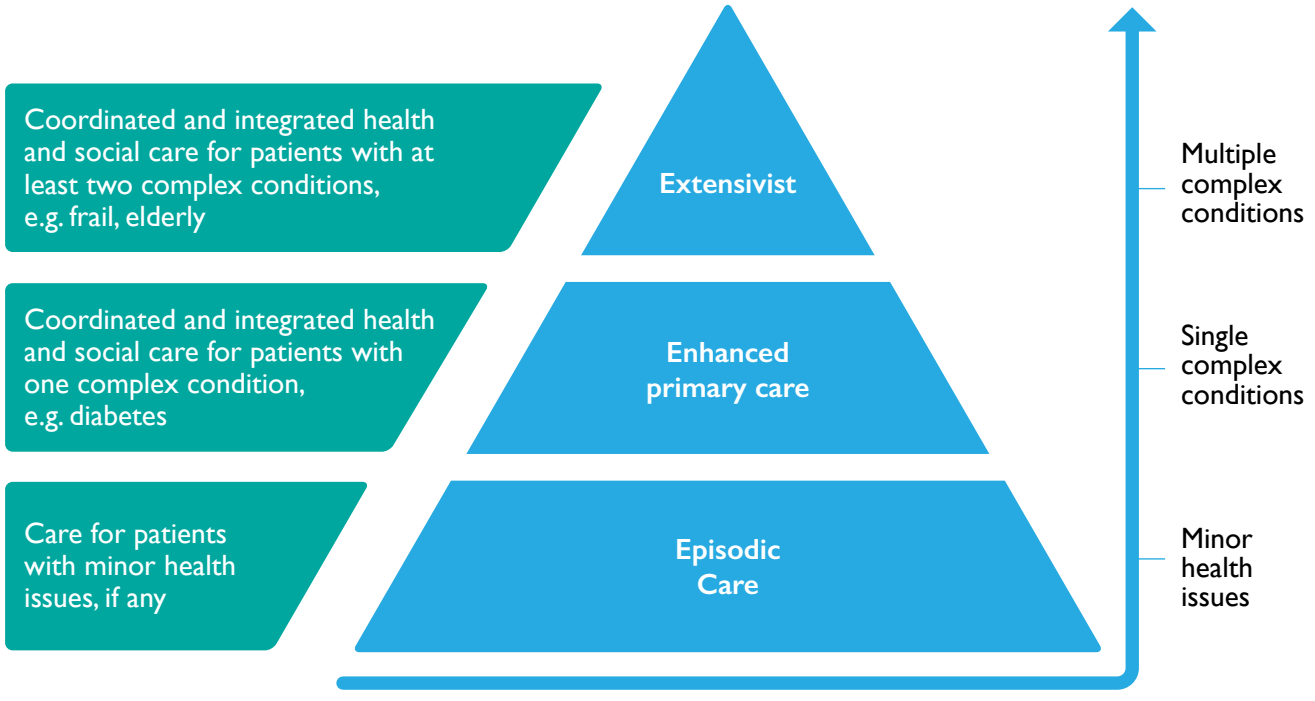
Back in 2014 a Clinical Design Team was established, which included a pharmacist. This was significant as it helped guide (navigate) and model the pharmacy elements of the vanguard.

Locally it has been shown there is a patient cohort with multiple complex conditions (top 3%) who spend 48% of the health budget, by better management of this top 3% it was forecast it would lead to financial savings and improved health and wellbeing for the patients.

In Blackpool they have launched a MCP vanguard called the Extensive Care service. This is a coordinated and integrated health and social care service for patients who are over the age of 60 and have two or more of the following long-term conditions (LTCs): coronary artery disease, atrial fibrillation, diabetes, dementia, congestive heart failure and chronic obstructive pulmonary disorder.

The Extensive care service team comprises of an Extensivist (Geriatrician / Physician / GP); Advanced practitioner, a Pharmacist, a Care Coordinator, a Wellbeing worker (who develops close relationship with the patient and is first point of contact), Administrators and most recently recruited to support the pharmacists is a small team of pharmacy technicians. The patient's GP refers the patient into the service, with the patient's consent, and care is wrapped around the needs and goals of the patient, this includes

MCP model showing placement of extensivist service



prescribing and medicines optimisation (due to demand, pathways and lack of IT interoperability patients' repeat items are still managed by the patients' own GP practice).

The package of care delivered by the team is tailored to the individual patient and enables them to manage their LTCs especially in a crisis and to achieve patient centered goals. The patient's care is coordinated by one team who have access to the GP record (read and write). The support is tailored to meet the patient's specific needs and helps them to improve their understanding of their health problems, improve the management of their condition and make informed decisions about their care. It supports the patient to keep well for longer and a crisis that requires hospital admission is more likely to be avoided. At the end of a session the patient is supported to formulate their health goals. The patient typically spends around 4-6 months in the service, but this can be lifelong and there is an overall cultural shift to de-medicalise patients.

The pharmacist's role as part of the team is focused on medicines optimisation and involves:

- Aiming to understand the patient's experience
- Clinical decision making on LTC treatment
- Evidence based choice of medicines
- Ensuring safe use of medicines
- Polypharmacy and potentially deprescribing of medicines
- Supporting and improving adherence
- Educating other staff to increase holistic approach to patient management

The service has full access to patient's GP record (EMIS), read and write and prescribing functionality if required. They also have access to hospital records including discharge information, outpatients, pathology etc. However, currently there is no link to mental health or social services. The GP practice retains responsibility to manage repeat prescriptions; they made this decision before 'go live' due to the IT systems available and clinical concerns around interoperability of the systems used.

Pharmacist clinics are now available at 4 sites (4,000 patient capacity per year). The cost saving for the first 35 patients seen by the pharmacist has resulted in a reduction of £49.54 per patient due to inappropriate polypharmacy/ pill burden. Additional costs due to appropriate prescribing are £8.72.

Some of the key messages in relation to pharmacist involvement in the model are:

- Pharmacist involvement in design from the beginning
- Hospital medics value the role and reviews of pharmacists especially around medication safety
- Secondary care were unfamiliar with complexity of primary care prescribing and supply pathway
- Design group had limited knowledge of benefits pharmacist/pharmacy technicians can bring to holistic care - 'need to shout from rooftops'
- Need robust tools to evaluate pharmacy input
- Adherence; patient experience; admission avoidance; deprescribing

There is also a huge opportunity for pharmacists to get involved when patients are first diagnosed with a LTC to support them to get the most from their medicines, ensuring the medicines are appropriate for them and their lifestyle, as well as supporting prevention of ill health.

8. PHARMACY INTEGRATION FUND

Anne Joshua (Head of Community Pharmacy Strategy, NHS England)

The Pharmacy Integration Fund (PhIF) is a separate fund and NHS England are responsible and accountable for its administration. Since the launch of the consultation on the community pharmacy reforms in December 2015 NHS England have received over 140 responses related to the use of the PhIF. Further announcements on the PhIF are expected soon.

It is expected that changes in the community pharmacy contract will be implemented in October 2016 and there will be a formal consultation on such change prior to this.

The PhIF is about supporting pharmacists working in a wider context within primary care and examples of this include pharmacists in care homes, pharmacists in GP practices, pharmacists in U&E care provision and community pharmacists. It is about integrating the practice of pharmacy across the whole of primary care.

This also sits alongside changes in secondary care with the publication of the Carter review and the ongoing hospital transformation programme. Bearing this in mind, interface issues also need to be considered.

It is recognised that community pharmacies also undertake a role in the public health arena and NHS England are working with Public Health England (PHE) to develop a value proposition.

The development of the pharmacy workforce is a key area of focus for the PhIF as is the development of the IT infrastructure to support the clinical roles.

Up to 5% of the PhIF will be used for evaluation and Anne is working with the evaluation team within NHS England to help develop and frame the strategy for evaluation. They would like to be able to use tools that are already validated.

The fund cannot be used to completely fund new models of care as this would not be sustainable, but it will be used to change business as usual so that once the fund has gone the work will continue. There are also additional funding pots available such as the transformation funds allocated to the 44 Health and Care organisations i.e. Sustainability and Transformation Plans (STPs). The aim is to embed changing practice, for example one model could be match funding to ensure local ownership and commitment.

Year one of the PhIF is mainly focused on the governance issues and in year 2 there is likely to be funding available to fund local services. The team need to set a process to bid for funding to develop key strategic models.

Work is already under way around pharmacists in care homes, pharmacists in integrated urgent care clinical hubs and for the clinical services review.

The PhIF will focus on primary care as the Carter Review is focused on secondary care but the two will acknowledge the interfaces that exist and what the two sectors can do to support and help each other. An example is providing specialist care in the community.

9. EMERGING THEMES AND CONSIDERATIONS

Emerging themes and considerations for integration of pharmacists into primary care.

Here we share the main themes that emerged from the meeting, along with a series of potential actions that could be considered.

1. PHARMACY INVOLVEMENT IN LOCAL STRUCTURES

Pharmacists were previously more integrated into the local structures prior to the April 2013 reforms, they were a part of Primary Care Trusts which were the local commissioners at the time. Since the development of Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards (HWBs) there is a varied involvement of pharmacy. Also, now the 44 health and care organisations are developing their STPs the involvement of pharmacy and pharmacists may become even more varied and disparate.

For consideration: Facilitate pharmacist involvement in the development and delivery of STPs.

2. ENSURE IT INFRASTRUCTURES SUPPORT INTEGRATION OF PHARMACISTS INTO PRIMARY CARE

Pharmacists working in the community are capable of delivering minor ailment services and repeat urgent medicines but the current IT infrastructure does not enable this process. There needs to be better integration with NHS 111 and the Directory of Services (DoS) need to be robust and up to date so that call handlers can refer to pharmacists for urgent care with confidence.

For consideration: Develop the DoS and ensure pharmacists are integrated into NHS 111 and other out of hours service provision systems.

IT solutions that enable transfer of information between care homes and community pharmacies would facilitate better care for patients. This would improve care for patients as well as decrease the time spent on medicines processes.

For consideration: A secure email system, that can be implemented and used nationally, needs to be established to facilitate communication between care homes and community pharmacies.

Some systems do currently allow access to patient records across interfaces and enable practitioners to make real time changes to medicines but there are a number of issues associated with this and the systems do not yet link with mental health records or social care records.

3. INTEGRATION OF PHARMACISTS INTO NEW MODELS OF CARE

Some of the vanguard sites have already included pharmacists and pharmacy teams in their new structures and services and some are planning to do so. However, in some cases pharmacists are still very much an afterthought.

Where pharmacists are involved and demonstrating value and benefits for patients, more needs to be done to make this visible to commissioners. Good practice needs to be shared across the different vanguard sites

For consideration: Develop a narrative which outlines the benefits of pharmacists' involvement in the new models of care.

4. WORKFORCE DEVELOPMENT

For pharmacists to deliver medicines optimisation and truly improve patient care there needs to be some workforce development. Different models and providers of training need to be considered so the burden is not just placed on one organisation. National criteria should be set.

We need to build the skills and confidence of pharmacists for the benefit of patients and the NHS. This in turn may provide a shift in the way the system operates. As pharmacists develop their skills and competencies they will be able to support the management of more complex care.

For consideration: Develop national criteria for the development of the pharmacy workforce.

5. INTEGRATION ACROSS THE PROFESSION

Pharmacists work across all sectors of health care, yet as a profession we are not particularly good at communicating with one another. We need to think about how practice pharmacists work more closely with their community pharmacists and their medicines management colleagues in primary care as well as the pharmacists working in secondary care. Community and hospital pharmacists should know who their colleagues are in the different sectors, and be able to discuss individual patients when they are transferred between settings.

For consideration: Develop a thought piece on integration of the pharmacy profession.

6. CONTRACTUAL STRUCTURE

The contract needs to support the emerging roles for community pharmacists and be an enabler rather than a barrier. The ideal would be to have an outcomes based contract alongside confidence in sustainability. The incentivisation within the current system needs to shift and there needs to be investment in a future model.

An example could be that a community pharmacy is sub contracted by a GP federation to provide medicines optimisation outcomes for a defined cohort of patients.

We need to consider what the new model for community pharmacy might look like and how community pharmacy fits into the wider health and care system. A debate around population based commissioning or payment for itemised episodes of care needs to happen. The NHS needs to value the service provided by pharmacists.

For consideration: Undertake a pilot of a future model based on payment by outcomes.

7. EVALUATION

A number of services provided used a variety of different tools to evaluate the services, many of these are not validated. Whilst commissioners were happy for such tools to be used to demonstrate benefits, many of the pharmacists would like to see the tools validated. As this is quite a long process suggestions were made that the research arm of RPS could make recommendations on how such tools, if they were being used, could be used in the right way.

For consideration: Pharmacy Research UK (PRUK) / RPS to consider developing guidance to help support the use of evaluation tools that are not validated.

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THE FINAL WORD

There was huge enthusiasm and energy in the room. There was a real desire to make the future of pharmacists something that was inspirational and to bring together assets that enabled pharmacists to deliver the best care for patients.

Not everything discussed at the meeting was new, many of the examples were something that pharmacists had been doing for a long time but had not been recognised for. But pharmacists do need to consider what they are delivering for patients and what the outcomes are. Changes need to be doable, deliverable and tangible.

There was a recognition that, as a profession, we need to get better at spreading innovation and what's already happening and the knowledge we already have.

The profession itself needs a clear vision with defined outcomes, across all sectors.

The meeting focused on exploring what was currently happening and the next meeting will focus more on the enablers to make the change happen.

What are the elements that need to change to facilitate the future of the pharmacy profession?

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ATTENDEES

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