




NOW OR NEVER: SHAPING PHARMACY FOR THE FUTURE

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The Report of the
**Commission on future models of care
delivered through pharmacy**

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Sally Williams and Mita Shah provided a sound basis of evidence for the early work of the Commission with their excellent literature review. The full review is available on the Royal Pharmaceutical Society website at www.rpharms.com/futuremodels

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KEY POINTS

Recent NHS reforms, along with an unprecedented era of economic, demographic and technological change, present both challenges and opportunities for the pharmacy profession. There are many visions for pharmacy in circulation, and many new models of practice have been developed by pharmacists across England. However, as yet there has been little to knit these together in a coherent narrative for the profession's future role in the English NHS.

With this in mind, the Royal Pharmaceutical Society set up a Commission on future models of care, chaired by Dr Judith Smith, Director of Policy at the Nuffield Trust. The Commission has brought together expertise from across pharmacy, the wider health care sector, and patients and the public to develop practical ideas about how future models of care can be delivered through pharmacy. The Commission has now completed its work, and this paper provides a summary of the key findings and recommendations from its work.

- The traditional model of community pharmacy will be challenged as economic austerity in the NHS, a crowded market of local pharmacies, increasing use of technicians and automated technology to undertake dispensing, and the use of online and e-prescribing bear down on community pharmacies' income and drive change. A broader role for pharmacists as caregivers will be central to securing the future of community pharmacy.
- The NHS is engaged in an urgent search for ways to provide better standards of care in the face of unprecedented pressure on budgets, and justifiably intense scrutiny of quality. Only by adapting to the needs of patients with long-term conditions and preventable illnesses can this be achieved. Pharmacists have a vital role in helping the NHS make the shift from acute to integrated care, and fulfilling the pressing need to do more for less.
- Some patients, carers and members of the public have access to a broader range of services and care from pharmacy than the traditional dispensing and supply of medicines. Pharmacists increasingly provide services that help people stay well and use their medicines to best effect. However, the pace of change remains slow, and financial and structural incentives are not sufficiently aligned to support it.
- Pharmacists are working more closely with patients and healthcare colleagues in hospitals, outreach teams, patients' homes, residential care, hospices, and general practice, as well as in community pharmacies. They are helping patients to manage their own conditions, providing health checks, supporting best use of medicines, and detecting early deterioration in patients' conditions.
- High street presence and long opening hours mean that community pharmacy has the potential to play a crucial role in new models of out-of-hours primary and urgent care. Access by pharmacists to integrated patient records will be a key enabler of this, as will the active engagement of pharmacists in local primary care federations, networks and super-partnerships.
- Despite its potential, pharmacy – and particularly community pharmacy – is marginalised in the health and social care system at both local and national level. It is seen by others as a rather insular profession, busy with its own concerns and missing out on debates and decisions in other health and social care organisations and the wider world of health policy.
- Alongside this, there is insufficient public awareness of the range of services pharmacists can offer. There is a pressing need to de-mystify pharmacy so that patients, the public and the rest of the health service understand the extent of the role that pharmacists can and do have in providing direct care.
- Focused, outward-looking local and national leadership of pharmacy will be needed to change this. Leaders within pharmacy need to work with national and local commissioners and providers of other care services to ensure a shift in the balance of funding, contracts and service provision away from dispensing and supply, towards using the professional expertise of pharmacists to enable people to get the most from their medicines and stay healthy.
- To enable such a shift, there will be a need for a significant rethink of the models of care through which pharmacy is delivered, as a prerequisite to developing new approaches to contracting and funding that include the possibility of specific contracts with groups of pharmacists to deliver patient services; and population-based contracts for new larger primary care organisations that include pharmacists in their membership along with GPs, nurses and others.

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I. INTRODUCTION

The Commission

In April 2013, the English Pharmacy Board of the Royal Pharmaceutical Society launched a Commission on future models of care delivered through pharmacy. The independent Chair of the Commission was Dr Judith Smith, Director of Policy at the Nuffield Trust, an independent charitable health research foundation.

The Commission was supported by a project secretariat led by Catherine Picton, and established an expert advisory group whose membership is set out in Appendix 2.

The Commission was asked by the Royal Pharmaceutical Society to do the following:

- make the case for change in relation to the role that pharmacy can play in the delivery of care
- articulate the benefits to patients of involving pharmacists in the delivery of a wider range of services
- identify the range of models of care involving pharmacy that are starting to emerge in the UK and overseas
- examine what has helped or hindered the development of such models of care
- identify what needs to be done to enable and support the spread of such models of care
- consider the implications of the Commission's findings for policy and practice in the English NHS and more widely.

The intention on the part of the Royal Pharmaceutical Society was to undertake work that could help the Society in setting direction for the role and position of pharmacy within the wider development of the NHS and its services.

How we worked

The Commission approached its task by focusing primarily on the current and projected needs of patients and the population in the NHS in England. To this end, we ensured that we had effective patient and professional involvement in the work of the Commission, and we undertook extensive engagement work including:

- a launch event in London attended by over 100 people from across pharmacy, primary care, national health policy organisations, and patient groups
- an online consultation, via a survey questionnaire that was open for eight weeks and yielded over 130 responses. A list of those who made submissions is set out in Appendix 1
- two stakeholder workshops with a wider range of pharmacy, other health professional and patient groups, one in Manchester and one in Birmingham
- three meetings of the Commission's expert advisory group, and an additional two meetings of a sub-group that focused on detailed analysis of submissions received
- interviews carried out by the Chair of the Commission with key stakeholders involved in the development of services involving pharmacy, in the UK and overseas. A list of those interviewed is set out in Appendix 1
- interviews and meetings carried out by Judith Smith and Catherine Picton to follow up emerging models, ideas and themes
- presentation to and discussion with delegates at the Royal Pharmaceutical Society annual conference in Birmingham.

A review was commissioned of literature on models of care delivered through pharmacy, and this was undertaken by Sally Williams and Mita Shah. This covered the five years since 'Pharmacy in England: Building on strengths – delivering the future' (2008) and examined the health policy context to pharmacy services in England, the range of models of care involving pharmacy that are in place or being developed in the UK and overseas, and evidence about the effectiveness of such models of care. The full literature review is available on the RPS website (www.rpharms.com/futuremodels).

This report

This report sets out the conclusions of the Commission, based on analysis of submissions made through the on-line consultation, ideas presented and discussed at stakeholder workshops and in individual interviews, debate within the expert advisory group, and reflections on feedback given generously by those who reviewed a draft of this report.

The report starts with an examination of the challenges facing the NHS, with a particular focus on the financial context and the need to assure and improve the quality of care. This context is critical to any consideration of future models of care involving pharmacy, and is used as a way of highlighting how pharmacy can position itself to be part of the answer to difficult policy and organisational questions facing the NHS.

An examination is then made of how the role of pharmacy is changing, with a particular focus on the shift from dispensing and supply towards services that help people to get the most from their medicines and stay well. This is followed by a consideration of the range of models of care involving pharmacy that are emerging in the NHS, and an analysis of why it is that such models remain relatively thinly spread.

The final sections of the report focus on what needs to be done if pharmacists are to increasingly assume the role of supporting patients with effective medicines use and by serving as care-givers in the health system, working in close partnership with other health and social care professionals as well as with patients. The report concludes with a set of recommendations for NHS England, Public Health England, the Department of Health, local commissioners, leaders of pharmacy, and pharmacists themselves.

The decision to appoint an independent Chair of the Commission was taken by the Royal Pharmaceutical Society on the basis that they wanted a fresh and external critique of the current and potential role of pharmacy in delivering models of care. The conclusions are set out in that spirit and are ultimately those drawn by Judith Smith as independent Chair of the Commission, and any errors or misunderstandings remain her responsibility.

2. THE CHALLENGES FACING THE NHS

Pharmacy within the wider NHS

Future models of care delivered through pharmacy depend fundamentally on what is happening, and likely to happen, in the wider NHS. The NHS, like all public services, faces profound challenges, most notably in respect of the economic context and significantly constrained funding, and the requirement to assure and improve the quality of care for patients, and in particular for those living with long-term conditions experiencing frailty.

Economic austerity

Since its foundation in 1948, the NHS has enjoyed more or less continuous growth in its budget, both as a proportion of public spending and Britain's GDP. Since 2009/10 however, this trend has come to a halt. It is highly unlikely that the

budget will increase at all up to 2015-16, and even if increases in spending return after this it is likely to be at a considerably lower rate.¹ Demand for health care continues to grow at the same pace or even faster, meaning that the NHS has to find ways of becoming increasingly productive. Studies suggest that by 2021–22, the NHS budget will be between £34 billion and £48 billion per year too small to meet the projected needs of the population, assuming no change in population trends, productivity, or efficiency. This gap is created by long-term trends such as technological change and an ageing population living with more long-term conditions (see Figure 1).

To date, the NHS has met its targets associated with this productivity challenge largely by making cuts in real terms to pay, administrative efficiencies, and reductions in the 'tariff' price paid to hospitals for their services. Many bodies, including the National Audit Office² and the

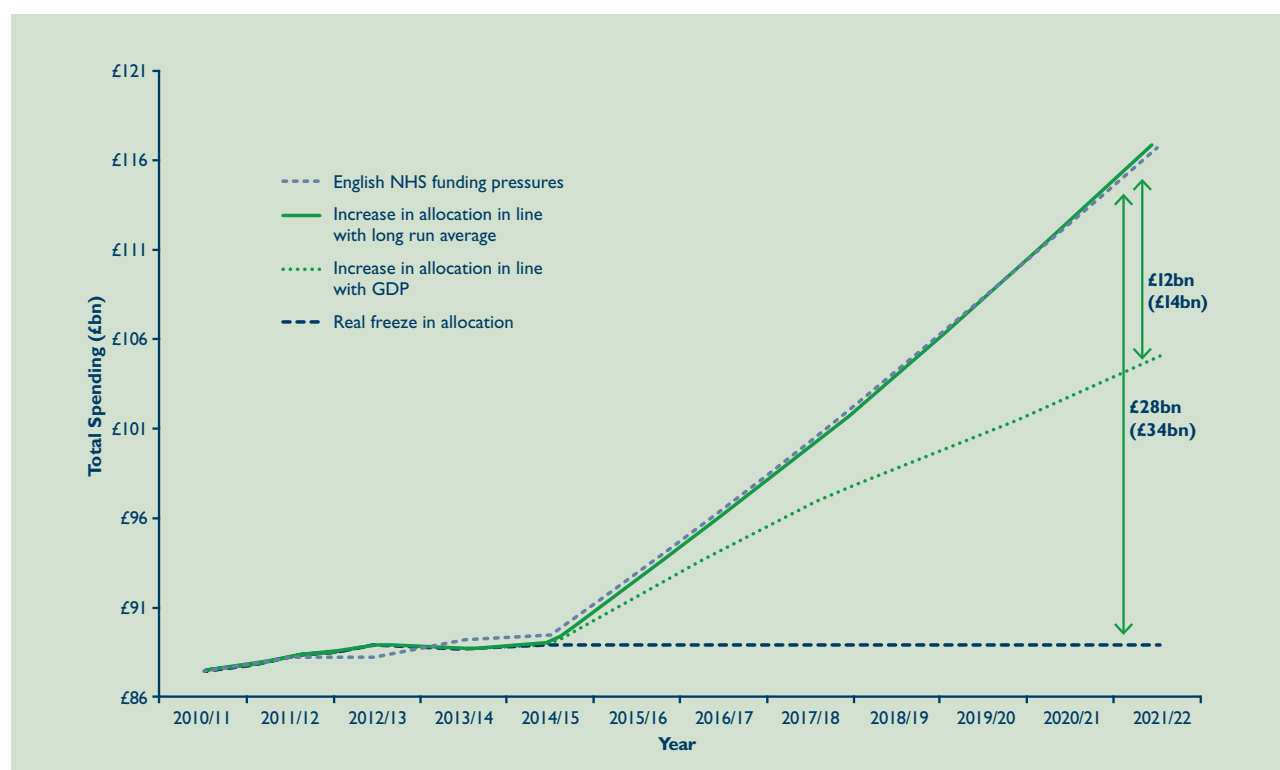


FIGURE 1: FUNDING PRESSURE IN RELATION TO THREE POSSIBLE FUNDING SCENARIOS FOR THE NHS IN ENGLAND

1. Roberts A, Marshall L and Charlesworth A (2012) *The funding pressures facing the NHS from 2010/11 to 2021/22 A Decade of Austerity?* London: Nuffield Trust www.nuffieldtrust.org.uk/sites/files/nuffield/121203_a_decade_of_austerity_full_report_1.pdf
2. National Audit Office (2012) *Progress in making NHS efficiency savings* London: Stationery Office www.nao.org.uk/wp-content/uploads/2012/12/1213686.pdf

Health Select Committee,³ have raised concerns that these relatively straightforward, if painful, changes will not provide sufficient savings over the remainder of this decade.

A crucial part of achieving sustainable changes will be to ensure that resources and professionals are being used to optimum capacity, and in ways that have the greatest positive impact for patients, and pharmacy will be examined in this light. Government, independent researchers, and NHS England have all suggested that progress could be made by improving the treatment, across the system as a whole, of vulnerable older people and those with long-term conditions in particular.⁴

Importantly, even a return to economic growth would leave limited room for the NHS budget to expand at past rates. The Nuffield Trust has estimated that even if growth recovered fully, returning to NHS budget growth of 4% from 2015–16 to 2021–22 would require either freezing all other government departmental budgets for this seven-year period, or £10 billion of extra taxation or borrowing.⁵

Quality in the spotlight

Alongside financial austerity, the quality of health care has become a prominent issue, particularly in the wake of the appalling lapses in safety, treatment and patient experience uncovered at Mid Staffordshire NHS Foundation Trust.⁶ While meeting the economic challenges outlined above, the NHS must find new ways to guarantee that patients are treated with compassion and dignity, that they do not come to harm, and that the care they receive meaningfully improves their health and wellbeing. This includes the pharmaceutical elements of patients' care, a fact that has been fully acknowledged by the Royal Pharmaceutical Society in its response to the Francis Inquiry into the events at Mid Staffordshire.⁷

The response from central government to the Francis Inquiry has been a series of programmes designed to increase transparency and accountability of NHS services. This includes an emerging system of published ratings, which will aggregate quality indicators and the results of inspections, in order to class providers as 'unsatisfactory', 'requires improvement', 'good' or 'excellent'. This system will be delivered by Chief Inspectors of Hospitals, General Practice and Social Care, working within the Care Quality Commission (CQC). The CQC has also announced that it will be changing some registration criteria to improve the strength of accountability across all providers, most notably by introducing a 'duty of candour' and simpler, more robust fundamental standards of care.⁸

The General Pharmaceutical Council is the independent regulator for pharmacists, pharmacy technicians and pharmacy premises in Great Britain. The General Pharmaceutical Council is responsible for establishing and promoting standards for the safe and effective practice of pharmacy at registered pharmacies. In 2012 new standards for these registered pharmacies were introduced that set out the outcomes that the General Pharmaceutical Council expects pharmacy owners and superintendent pharmacists⁹ to achieve for patients and the public. The General Pharmaceutical Council will begin inspecting against the new standards later in 2013 using a prototype model. Once the inspection model is finalised, inspection reports will be made public and pharmacies will be rated as poor", "satisfactory", "good" or "excellent". After consultation, the General Pharmaceutical Council's powers of enforcement for poorly performing pharmacies are due to be confirmed in law after a parliamentary review.

The Department of Health, NHS England and regulators will continue to use all the levers available to them to attempt to generate pressure on health providers to guarantee and improve standards of quality. Pharmacy has a central role to play in assuring safe and consistent care, in primary, community, social and acute care.

3. Health Select Committee (2013) *Eleventh Report – Public Expenditure on Health and Care Services* London: Stationery Office www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/651/65102.htm

4. Select Committee on Public Service and Demographic Change (2013) *Report of Session 2012–13: Ready for Ageing?* London: Stationery Office www.publications.parliament.uk/pa/ld201213/ldselect/ldpublic/140/140.pdf

5. Roberts A, Marshall L and Charlesworth A (2012) *The funding pressures facing the NHS from 2010/11 to 2021/22 A Decade of Austerity?* London: Nuffield Trust www.nuffieldtrust.org.uk/sites/files/nuffield/121203_a_decade_of_austerity_full_report_1.pdf

6. Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* London: Stationery Office www.midstaffspublicinquiry.com/report

7. Royal Pharmaceutical Society (2013) *Responding to the Francis Inquiry* online document available at www.rpharms.com/promoting-pharmacy/responding-to-the-francis-inquiry.asp

8. Care Quality Commission (2013) *A new start: Consultation on changes to the way CQC regulates, inspects and monitors care* London www.cqc.org.uk/sites/default/files/media/documents/cqc_consultation_2013_tagged_0.pdf

9. If a registered pharmacy is owned by a 'body corporate' (for example a company or NHS organisation) the superintendent pharmacist also carries responsibility for the regulatory standards

Meeting the needs of people with long-term conditions

The core business of today's NHS is meeting the needs of people with long-term conditions and very often more than one of them, such as asthma (and chronic obstructive pulmonary disease, COPD), diabetes, hypertension, heart failure and dementia. Long-term conditions generally cannot be cured by successful treatment, but by managing them, it is possible for health professionals and patients themselves to alleviate symptoms and reduce the need for invasive, costly and disruptive medical treatment. There is evidence that the likelihood of people with long-term conditions requiring inpatient or emergency care can be reduced by lifestyle change;¹⁰ using medicines and treatments correctly;¹¹ support to live independently;¹² the ability to understand, monitor and manage their condition;¹³ and contact with professionals able to assess the degree of illness progression and recommend the most appropriate treatment.^{14 15}

These services are largely provided outside hospital, through general practice, social care, pharmacy, community care and the third sector. The NHS has, since the 1990s, made it a key priority to substitute these interventions for hospital care earlier in the progression of chronic illness, and to encourage improved coordination of care across services and organisations. Recent summaries of evidence by the Nuffield Trust¹⁶ and the King's Fund,¹⁷ however, have suggested that this has not yet happened to as great an extent as should be possible.

To take advantage of the opportunities for better care, improved coordination and greater efficiency generated, joint working needs to be built around a shared commitment towards improving ultimate outcomes for patients. Different health providers must innovate to show that they have a distinctive role to play in an integrated system, and the future will be dominated by those able to demonstrate that they could do more to help those with long-term conditions to stay healthy for longer.

Assuring access

Access to care, the dominant issue of the previous decade under New Labour, remains a vital issue for the NHS. The focus has shifted from reducing waiting times for elective care to finding ways to provide more accessible care in emergencies, including out-of-hours outside hospital,¹⁸ and making sure that people have easy access to a full range of primary care services wherever they live and regardless of their condition.

A recent House of Commons Select Committee report¹⁹ confirmed that pressure on emergency services appears to be growing. It expressed concern that the current system of urgent care was not monitored closely enough for the underlying causes to be established. The report echoed NHS England's Urgent and Emergency Care Review²⁰ in questioning whether poor co-ordination with primary and social care might be leading to patients ending up unnecessarily in accident and emergency departments. It has also been suggested that the new NHS 111 helpline has, in some areas, failed to earn enough public trust to become a recognised alternative to local GP out-of-hours

10. Billings J, Dixon J et al (2006) *Case finding for patients at risk of readmission to hospital: development of algorithm to identify high risk patients* published in *British Medical Journal* London: Vol 333 (7563) pp.327–330 www.bmj.com/content/333/7563/327
11. Howard RL, Avery AJ et al (2007) in *British Journal of Clinical Pharmacology* London: Vol 63, Issue 2, pp.136–147
12. National Patient Safety Agency (2007) *Safety in doses: medication safety incidents in the NHS* London: NPSA www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61392
13. Begum N, Donald M et al (2011) *Hospital admissions, emergency department utilisation and patient activation for self-management among people with diabetes* published in *Diabetes Research and Clinical Practice* Vol 93 (2) pp.260–7 www.ncbi.nlm.nih.gov/pubmed/21684030
14. Goodwin N, Curry N et al (2010) *Managing people with long-term conditions* London: The King's Fund www.kingsfund.org.uk/sites/files/kf/field/field_document/managing-people-long-term-conditions-gp-inquiry-research-paper-mar11.pdf
15. Purdy S (2010) *Avoiding hospital admissions: What does the research evidence say?* London: The King's Fund www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf
16. Bardsley M, Blunt I et al (2013) *Is secondary preventive care improving? Observational study of 10-year trends in emergency admissions for conditions amenable to ambulatory care* published in *BMJ Open* Vol 3 (1) bmjopen.bmj.com/content/3/1/e002007?cpetoc
17. Tian Y, Dixon A and Gao H (2012) *Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions* London: The King's Fund www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf
18. Goodwin N, Smith J et al (2012) *Integrated care for patients and populations: Improving outcomes by working together* London: The King's Fund www.kingsfund.org.uk/sites/files/kf/integrated-care-patients-populations-paper-nuffield-trust-kings-fund-january-2012.pdf
19. Health Select Committee (2013) *Second report: Urgent and Emergency Care Services* London: Stationery Office www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/17102.htm
20. NHS England (2013) *Urgent and Emergency Care Review – Evidence Base Engagement Document* Leeds: NHS England www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf

services or accident and emergency departments. While statistics suggest that rising pressure on accident and emergency services predates these developments, the desire to give primary care (including pharmacy) an increased role in out-of-hours services is likely to become a growing priority.

Finally, access often lies at the heart of the controversial question of hospital reconfiguration. Attempts to move towards a smaller number of hospitals, or wards for certain conditions are typically driven by evidence that hospitals with full-time consultant cover have better outcomes for patients,²¹ as well as in some cases by a desire to find solutions to financial problems. Local resistance to reconfiguration plans is often rooted in fear that access to care will suffer if local hospital provision is scaled back. If future reconfigurations reduce local hospital capacity, public concern will need to be met by guaranteeing high-quality, accessible care from other primary or community providers.

Working with the NHS reforms

Taken together, these challenges of money, quality, long-term conditions and access suggest an NHS which:

- is much more proactive in its approach to addressing risk of ill-health through prevention and public health;
- prevents costly and intrusive hospital admissions by managing chronic illness more effectively;
- provides rapid 24/7 access to high quality advice, diagnosis and support, particularly for people living with long-term conditions;
- improves collaborative working across community, primary and social care; and
- makes this shift in the place of care based on a strong case about improving care outcomes for patients, and putting in place accessible alternative services.

Commissioners will need to drive improvements and reform that can meet the challenges of finance, quality and long-term conditions. The responsibility for commissioning services in the NHS in England is now subject to considerable fragmentation – and in the case of community pharmacy services, a lack of clarity on the ground. NHS England is responsible for commissioning primary care (including community pharmacy) and specialised health services; clinical commissioning groups commission other acute, mental and community care; and local authorities purchase social care and public health services. Additional and enhanced services may be commissioned by any of these bodies. This is set in the context of a general move toward local commissioning for local populations. This creates a system in which the creation of new models of care which work across provider boundaries is most easily achieved by providers and commissioners taking initiative at local level, helped by supportive central bodies.

Particularly in primary care, there is a need to consider new structures which can ensure that professionals have the flexibility and capacity to innovate, and to do this in ways that bring together general practice, community pharmacy and other professionals. Networks or federations of general practices are forming across the NHS, and community pharmacies and/or pharmacists are well-placed to become part of these, as we explore later in this report.

Given the wider financial context, it is likely that those providers most ready to prove and improve their case to deliver new models of care will find larger roles in the future. Those who are unwilling, unable or too slow to change may find that their services will not be commissioned in the longer term.

21. Academy of Medical Royal Colleges (2012) *The benefits of consultant-delivered care* London www.aomrc.org.uk/about-us/news/item/benefits-of-consultant-delivered-care.html

KEY POINTS

- Future models of care delivered through pharmacy depend fundamentally on what is happening, and likely to happen, in the wider NHS
- The NHS faces a decade of flat funding whilst demand for health services, especially for people with long-term conditions, continues to rise. Pressure to deliver care in different ways will increase, and service developments will have to be made through productivity gains
- With a £12billion annual investment in medicines the NHS has to make sure that it gets the best possible value out of medicines use, something which it is not doing at present
- Following the Francis Inquiry report, there is a stronger focus on assuring and improving the quality of care – all health care providers must get better at finding out what patients want and need, and delivering this with safety, consistency and compassion
- Pharmacy, as the third largest health profession, with universally available and accessible community service, has a central role to play in assuring the safe and consistent use of medicines and as a provider of wider care, in primary, social and acute care
- Pharmacy will have to make its case for delivering new models of care, based on evidence of cost and clinical effectiveness, and the ways in which it can help address the core problems facing the NHS.

3. THE CHALLENGES FACING PHARMACY

From supply of medicines to the provision of care

Medicines are the backbone of modern health care.

Undoubtedly, medicines enhance quality of life and improve patient outcomes, but the complexities of ensuring optimal use of medicines cannot be underestimated, and are arguably increasing. There is a significant body of evidence emerging that demonstrates that medicines use in practice is currently less than optimal to the detriment of patient outcomes.²²

The English policy response to the opportunities for improved use of medicines has been to pursue a strategy of 'medicines optimisation'. NHS England is currently developing a strategy for medicines use that focuses on achieving improved outcomes from medicines by engaging patients effectively in understanding how to take their medicines, as opposed to just focusing on the cost of medicine itself. This work is exploring the development of services that support patients in taking their medicines as intended, reduce medicines waste, and reduce admissions to hospital caused by issues with medicines. The strategy will build on the clinical guideline on medicines optimisation being developed by the National Institute for health and Care Excellence (NICE)²³ and the Royal Pharmaceutical Society Medicines Optimisation principles.²⁴

Internationally, health systems are increasingly recognising the role of pharmacists in providing *pharmaceutical care*,^{25 26} a philosophy that emphasises that the pharmacist's responsibility is for the outcome of treatment not just its supply.²⁷ Pharmaceutical care aims to help patients get the most benefit from their medicines and to minimise the associated risks. This is done by identifying, resolving and preventing medicine-related problems so the patient understands and gets the desired therapeutic goal for each medical condition being treated.

Explaining this to the wider world

This Commission has been struck by the difficulty experienced by pharmacy in expressing clearly to the wider world (health and social care professionals, policy makers, patients, the population) what is meant by terms such as 'pharmaceutical care' and 'medicines optimisation'. Whilst hotly debated within pharmacy circles, the terms mean very little to even informed health policy and management experts, let alone the wider public. Given the conclusion of this Commission that pharmacy faces a significant challenge in making a case (and hence being commissioned and funded) for the provision of a greater degree of patient services aimed at improving the use of medicines and helping address wider NHS service problems, it is vital that pharmacy as a profession finds clear and accessible ways of expressing what it can and should be giving by way of additional patient services.

Services delivered by pharmacy

Pharmacists delivering care to patients can be broadly separated into community pharmacists, hospital pharmacists and primary care pharmacists. The majority of pharmacists work in the community pharmacy sector. Community pharmacy is generally thought of as the shops we see on the high street, and increasingly we find community pharmacies situated in supermarkets, and health centres. Community pharmacies operate with a range of different skill mixes and in addition to the pharmacist, the pharmacy team may comprise some or none of the following: a healthcare assistant, a registered pharmacy technician, a dispensing assistant, and a delivery driver.

The major component of the pharmacist's role has traditionally been to oversee the safe and effective dispensing of prescription medicines. However community pharmacists

22. Royal Pharmaceutical Society (2013) *Medicines Optimisation: Helping patients to make the most of medicines* London

www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf

23. NICE (2013) *Medicines optimisation: scope consultation* published online at guidance.nice.org.uk/CG/Wave0/676/ScopeConsultation

24. Royal Pharmaceutical Society (2013) *Medicines Optimisation: Helping patients to make the most of medicines* London

www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf

25. Pharmaceutical Care (2012) *Policies and Practices for a Safer, More Responsible and Cost-effective Health System*. European Directorate for the Quality of Medicines & HealthCare, EDQM www.edqm.eu/en/pharmaceutical-care-1517.html

26. Scottish Government (2013) *Prescription for Excellence: A Vision and Action Plan for the Right Pharmaceutical Care through Integrated Partnerships and Innovation* Edinburgh: Scottish Government www.scotland.gov.uk/Publications/2013/09/3025

27. Hepler DD and Strand LM (1990) *Opportunities and responsibilities in pharmaceutical care* published in *American Journal of Hospital Pharmacy* Vol 47 pp.533–543

have always been available to offer advice to patients on wellbeing, the treatment of illnesses, and if appropriate to sell 'over the counter' remedies, as well as counselling patients on the use of their prescription medicines.

Medicines should only be given to patients if a pharmacist has first checked that the medicine is safe and effective for that particular patient – this is a critical part of a pharmacist's role. However, the technical dispensing of the medicine can be done by other trained members of the pharmacy team, and where skill mix is used effectively alongside technical innovation, this has the potential to release pharmacists' time to provide other services that are more in tune with the philosophy of providing better care to patients. In recent years, community pharmacy has been commissioned to provide more structured services aimed at supporting patients in the use of their medicines (see Box 1).

This is with the aim of moving to a system (highlighted in Figure 2) where the 1.6 million people visiting a community pharmacy each day should expect to:

- See their pharmacist more often and have more opportunities to discuss their health and wellbeing and early detection of serious illness
- Be signposted to community services and facilities aimed at helping to address some of the underlying determinants of health

- Have diabetes checks, blood pressure tests, flu vaccinations and a range of other patient services offered at convenient times in their local community pharmacy
- Access services like smoking cessation, weight management and sexual health
- Use community pharmacy as a first point of contact for advice on minor illnesses.

People with a long-term condition should expect:

- Pharmacists and GPs working in partnership to ensure the best possible care, with linked IT systems
- Pharmacists to help them to manage their medicines needs on an ongoing basis
- Support from pharmacists and their teams to self-manage their conditions so that they can stay well and out of hospital
- Early detection of problems or deterioration in their condition through routine monitoring
- Pharmacists to consult with them in a range of settings appropriate and convenient to them. For example, pharmacy consulting rooms, GP practices, home visits, Skype or telephone calls.

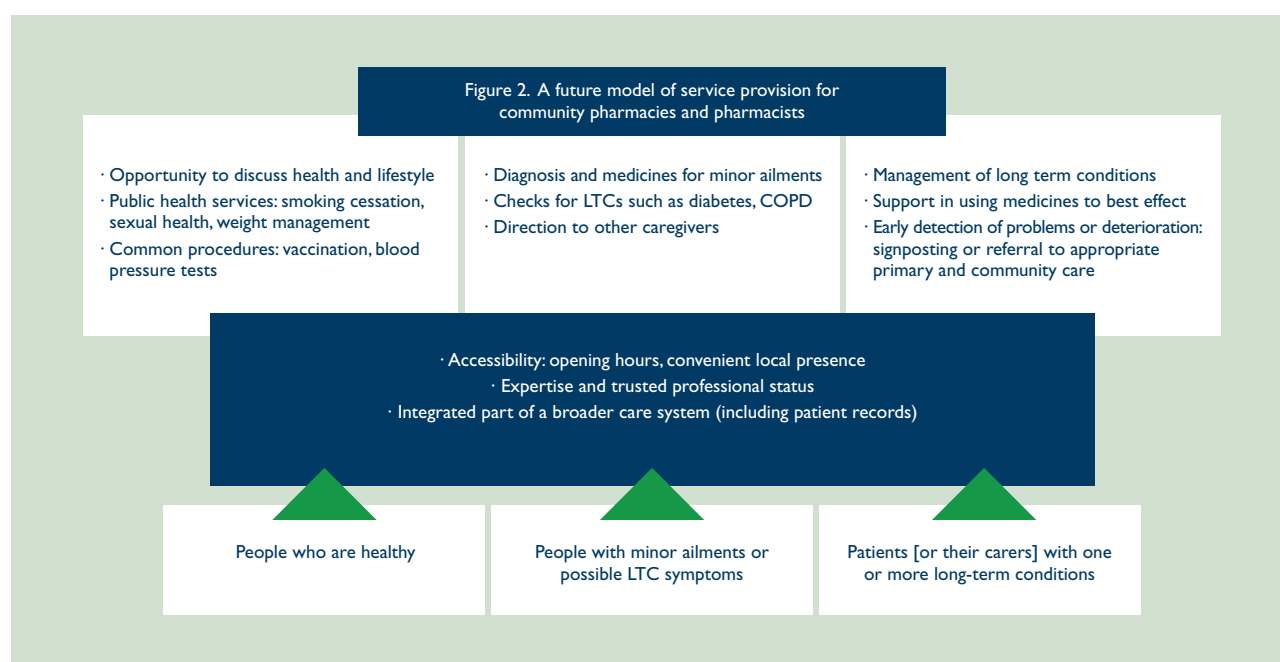


FIGURE 2: A FUTURE MODEL OF SERVICE PROVISION FOR COMMUNITY PHARMACIES AND PHARMACISTS

BOX 1: SERVICES COMMISSIONED NATIONALLY FROM COMMUNITY PHARMACISTS TO SUPPORT PATIENTS IN THEIR MEDICINES USE IN ENGLAND

To encourage community pharmacists to support patients with effective medicines use, two services are commissioned in England as part of the *national pharmacy contract*. The Medicines Use Review service and the New Medicines Service both provide a mechanism by which community pharmacies* can be reimbursed for supporting patients in their medicines use.

MEDICINES USE REVIEW

Since 2005 community pharmacists have been paid a set fee for 'medicines use reviews'. The medicines use reviews are consultations with patients aimed at helping patients to get the best out of their medicines. Community pharmacies are paid a set fee for up to 400 medicines use reviews per year of which since 2011, 50% must be targeted at patient groups thought most likely to gain from additional support. The targeted groups are: patients taking specific high risk medicines; patients recently discharged from hospital who have had a change in medicines during their hospital stay; and patients with respiratory disease (asthma and COPD) taking specific medicines. Whilst medicines use reviews undoubtedly provide benefits to patients when used in an integrated way, there have been criticisms levelled at the way in which the national commissioning of the service focuses on bald numbers of reviews, and not on any assessment of patient outcomes, nor integration with other local primary care services (Bradley et al (2008)

Determinants of the uptake of medicines use reviews (MURs) by community pharmacies in England: A multi-method study. Health Policy Vol 88 pp.258-268).

THE NEW MEDICINES SERVICE

The new medicine service was introduced in 2011 and is for patients with long-term conditions (primarily asthma; COPD, type 2 diabetes, antiplatelet/anticoagulant therapy, and hypertension) who have been prescribed new medicines. Patients can be offered the service when they present with a prescription for a new medicine in a community pharmacy, or may be referred to the service by GPs or hospital pharmacy teams. The new medicines service is an 'after care service' to support patients in using their new medicines most effectively. The aim is to help people adhere to their treatment, engage with their condition and their medicines, and reduce the likelihood of unnecessary hospital admissions due to adverse events associated with their medicines. The new medicines service is an advanced service so pharmacies can choose whether or not to provide it. The service has been commissioned until the end of 2013 and an evaluation of the service is due to be published in 2014. How or if this service will be commissioned in the longer-term is not clear.

**for both the new medicines service and the medicines use review service the national contract is with the community pharmacy as opposed to the individual pharmacist.*

By contrast to community pharmacy, hospital teams are much bigger and typically comprise large numbers of pharmacists, as well as a significant number of pharmacy technicians and other support staff (see Box 2). Hospitals have long used automation and skill mix to release pharmacists from dispensaries, driven by the need to demonstrate efficient resource use and to target scarce pharmacist input where it can be most effective. Hospital clinical pharmacists are

generally well integrated into ward teams to provide generalist or highly specialist pharmaceutical input into individual patient care. Hospital pharmacists also have a much wider remit in ensuring the safe and effective use of medicines including: provision of expertise to medical and nursing staff through training and information services; leadership of electronic prescribing initiatives; implementation of guidance from the National Institute for Health and

Care Excellence and safety alerts; ensuring responsible use of antimicrobials (through antibiotic stewardship);²⁸ overseeing the safe and secure handling of medicines across the hospital; and the manufacture of specialist pharmaceutical products.²⁹

However hospitals and the pharmacy teams within them also face challenges to make sure that they can deliver safe and high quality services in the future.³⁰ Delivering pharmacy services seven days a week, ensuring that e-prescribing and decision support is implemented effectively, and improving the transfer of information about medicines and the support that patients receive when they leave hospital and return back to their home setting are all significant challenges, as is ensuring that skill mix is fully utilised across hospitals with pharmacist prescribers and pharmacy teams fully

integrated into accident and emergency departments and admissions wards.

A small but influential group of pharmacists are collectively known as 'primary care' pharmacists. These are pharmacists usually based within clinical commissioning groups or commissioning support units, typically having been transferred across from the former primary care trusts. Pharmacists working in the community services organisations that emerged from the splitting off of primary care trust's provider units also form part of this group. Along with hospital pharmacy, this sector has led the way in helping to develop new roles for pharmacists and pharmacy technicians. These range from practice-based pharmacists working in GP surgeries (employed either by the surgery or clinical commissioning groups – see Box 9 Chapter 4) to

BOX 2: PHARMACY IN NORTHUMBRIA HEALTHCARE FOUNDATION TRUST

The pharmacy team at Northumbria Healthcare Foundation Trust has 148 members, including 49 pharmacists, 47 pharmacy technicians and 52 other technical and support staff. The pharmacy team has embraced technology and skill mix to enable pharmacists and ward based technical staff to maximise the time they have available to provide direct care and support for patients.

Medicines stock supply is centralised and automated using a robot in the pharmacy department at North Tyneside General Hospital; supply services are managed and delivered by pharmacy technicians and assistants. Automated medicines storage cabinets (Omniceil) are located in the accident and emergency departments and in emergency care units at the trust's acute sites. As well as improving medicines safety and security, this has freed up of pharmacy and nursing staff time which has been redirected towards more patient facing roles.

All pharmacists are required to undertake post graduate development with an expectation to progress beyond clinical diploma training to achieve a prescribing qualification. Pharmacists are currently prescribing for 44% of all patients admitted to the hospital. All managers and middle grade pharmacists, and technical managers are required to undergo management and leadership development. Ward-based pharmacy technicians support pharmacists and the wider health care team with medicines reconciliation, patient counselling, medicines supply and clinical audit. Pharmacy provides a clinical service to all its wards, as well as a seven-day service to the trust's emergency medical admissions unit. In the emergency care setting, pharmacy staff routinely use patients' GP summary care records. Support from pharmacy extends into primary care, with pharmacists identifying and managing elderly patients at risk of readmission before and after discharge. The trust also employs the region's only consultant pharmacist for oncology.

28. Department of Health (2013) *Annual Report of the Chief Medical Officer Volume Two, Infections and the rise of antimicrobial resistance*. London www.gov.uk/government/uploads/system/uploads/attachment_data/file/138331/CMO_Annual_Report_Volume_2_2011.pdf

29. Royal Pharmaceutical Society (2013) *Professional standards for hospital pharmacy services; optimising patient outcomes from medicines* <http://www.rpharms.com/unsecure-support-resources/professional-standards-for-hospital-pharmacy.asp>

30. Future Hospital Commission to the Royal College of Physicians (2013). *Future Hospital. Caring for medical patients* London www.rcplondon.ac.uk/sites/default/files/future-hospital-commission-report.pdf

provide targeted care to specific patient groups (including prescribing), through to the teams working in clinical commissioning groups and commissioning support units to develop strategies and initiatives locally to ensure optimal use of medicines. By being based in general practice or commissioning organisations, these primary care pharmacists have been able to push at the boundaries of local models of care. The recent reforms have however been a time of significant upheaval for primary care pharmacists and the loss of expertise and networks has impacted on their ability to act as enablers of service development.

There is a broad consensus both in the UK and internationally that pharmacists, as the experts in medicines and their use, are an underutilised resource and that their skills could be used to better effect to help people stay healthy for longer and at home longer (see Figure 2). In England, Government policy is promoting a shift in emphasis from pharmacists dispensing prescriptions to providing pharmaceutical, health and social care services. But how might this look in practice? In parts of England some people are experiencing all of these visions of pharmacist involvement in their care however this is by no means the norm, and we examine the reasons for this patchy development in Chapter 5.

The impact of technology

To enable pharmacists to take on these new roles in patient services, especially in community pharmacy, traditional models of NHS pharmacy provision will have to change, as has been the case in much of hospital pharmacy. The current business model of community pharmacy is already being challenged by technological developments that enable new forms of dispensing, such as the use of robotics, something which has become widespread within hospital pharmacy, and in community pharmacy in some countries such as the Netherlands. Use of the internet to supply pharmaceuticals on an Amazon-type basis is also in its infancy in the UK, compared to other countries and retail sectors.

The likely growth of robotic and online dispensing threatens an NHS community pharmacy business model which is funded mainly through dispensing activity and purchase profits (see Box 3). While these technological developments

will not remove the need for pharmacists to check that the medicine is safe and effective for that particular patient, they will likely lead to pharmacy technicians running much of the day-to-day business of dispensing (as they already do in hospitals). The challenge to pharmacists is how they shape a new role in giving pharmaceutical care and optimising the use of medicines, and persuade commissioners to purchase this care. Without this, there is a risk that technology will reduce the perceived need for pharmacists, and that employers will seek to cut costs by reducing the number of pharmacists.

At the same time, there are signs that innovation in the creation of medicines is moving towards products which require clinically complex delivery in both hospitals and the home. It should be noted that the emergence of fewer major new pharmaceutical product lines has been linked to an overall flat-lining of primary care medicine sales by value.^{31 32}

Constrained funding

Meanwhile, the funding settlement in the NHS overall is being keenly felt in community pharmacy, which on average relies on the health service for funding the supply of medicines (a per item dispensing fee) to the tune of 85% of turnover. Extended NHS patient services such as support for patients starting on some new medicines, or reviews of medication where patients are on a number of different drugs, represent a small percentage of community pharmacy income (see Box 4). It should be noted that while the introduction of extended services to the new pharmacy contract from 2005 resulted in expenditure for these pharmaceutical services rising quickly through to 2010, the latest figures show that spending has now become flat.³³ This has occurred partly through a drive to make savings from the increasing prevalence of generics, which has seen the Department of Health claw back from pharmacists around 20% of profits under the 'category M' component of drug pricing which guarantees income for generic dispensing. At the same time, pharmacy faces similar demand growth as other NHS-funded services for activity related to long-term conditions, and prescription volume continues to rise at around 4% per year.³⁶

31. Thomas M and Plimley J (2012) *The future of community pharmacy in England* London: AT Kearney
www.atkearney.com/documents/10192/649132/The+Future+of+Community+Pharmacy.pdf/1838dede-b95a-4989-8600-6b435bd00171

32. PSNC (2013) *NHS Statistics* available online at psnc.org.uk/funding-and-statistics/nhs-statistics/

33. Jones NM and Charlesworth A (2013) *The Anatomy of Health Spending 2011/12* London: Nuffield Trust
www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130305_anatomy-health-spending_0.pdf

34. The Audit Commission. *A spoonful of sugar. Medicines management in NHS hospitals*. 2001.

www.archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/AuditCommissionReports/NationalStudies/nrspoonfulsugar.pdf

BOX 3: AUTOMATION IN PHARMACIES

In 2001, the Audit Commission published a review of how medicines were managed in NHS hospitals in England and Wales (A Spoonful of Sugar).³⁴

It recommended that dispensing be automated to improve the safety and efficiency of the process, and to release pharmacists' time for clinical care. Since the 2001 report, robots have been widely adopted in hospitals across the UK with demonstrable benefits to patient care. The adoption of robots in community pharmacy has been much slower, although a small number of community pharmacies

are now investing in robots to gain much needed efficiencies in their dispensing processes.

One example is Thackers pharmacy in Manchester where the installation of a dispensing robot speeded up their dispensing times, improved their stock control and saved on space to enable the construction of three patient consultation rooms. The robot also released pharmacists' time enabling them to focus on more clinical services including weight loss clinics, the new medicines services and medicines use reviews.

BOX 4: THE COMMUNITY PHARMACY CONTRACT IN ENGLAND – HOW THE FUNDING FLOWS³⁵

- A global sum is negotiated for community pharmacy – in 2011/12 it was £2 billion.
- The pharmacy contract also allows for an additional £500 million for 'retained buying margin' which is the profit community pharmacies are allowed to retain through the cost effective purchasing of prescribed medicines for the NHS.
- The global sum is allocated through a system of fees and allowances.
- The largest proportion of the fees and allowances are directly linked to the volume of prescriptions dispensed – approximately £1.5 billion in 2011/12.
- The fees and allowances available for advanced services provided through pharmacy, including medicines use reviews and the new medicines service, amounted to around £74 million in 2011/12.

35. psnc.org.uk/funding-and-statistics/structure-of-pharmacy-funding/

36. Health and Social Care Information Centre (2012) *General Pharmaceutical Services in England: 2002–03 to 2011–12* available online at www.hscic.gov.uk/searchcatalogue?productid=9731&q=title%3a%22General+Pharmaceutical+Services%22&sort=Relevance&size=10&page=1#top

An overcrowded market

A further challenge facing community pharmacy is the increase in the number of registered providers which occurred following the introduction of new regulations in 2005 which exempted four categories of pharmacy, including 100-hour suppliers, from the test of necessity and expediency, resulting in a 15% rise in the number of community pharmacies in England. While the new regulations on entry to the NHS pharmaceutical market introduced by the Department of Health in 2012 are considerably tighter,³⁷ and growth may slow in future figures, pharmacy numbers grew as quickly as ever between 2010-11 and 2011-12.³⁸ This means that effectively more pharmacies are competing for the same pot of money (the global sum – see Box 4). As a result, at a time when income is being squeezed and technology is changing, pharmacies also face intense competition in an arguably overcrowded market.

Taken together, the management consultancy group AT Kearney estimates that these factors will result in the profits of an average pharmacy falling by 33% by 2016.³⁹ Large pharmacy groups (often referred to as 'multiples') are expected to be able to respond more quickly to the need to take advantage of technology to streamline dispensing and supply, and, if they are incentivised to do so, to move into the pharmaceutical care market. The AT Kearney study estimates that, as a result, 900 community pharmacies, or 7.5% of the total in England, will be forced to close. As it becomes increasingly clear that the squeeze on community pharmacy from technological, financial and workforce factors will continue well beyond 2016, we can expect to see even higher estimates of pharmacy closures in future, unless pharmacy is able to create a new extended role in patient care and persuade commissioners to purchase this as part of wider programmes of public health, common ailments, care for people with long-term conditions and so forth.

The pharmacy workforce also faces particular challenges. The number of qualified pharmacists is rising, exceeding the rate at which new employment opportunities arise. A recent study by the Centre for Workforce Intelligence⁴⁰ projected a considerable oversupply of pharmacists under almost any future conditions, representing a threat to employment and salary. However, the Centre for Workforce Intelligence research estimates that a substantial reduction in the gap between supply and demand could be achieved in scenarios where pharmacists assume a broader role in providing care. This projected increase in pharmacist numbers is in stark contrast to the projections for general practice and primary care nursing where a projected shortfall in the current decade is imminent due to the retirement of both GPs and practice nurses. Despite this shortfall the number of GP trainees is well below the government target.⁴¹ The ready availability of a highly trained pharmacy workforce could be seen as an opportunity to take some of the pressure off general practice by integrating pharmacists more effectively into primary care teams, and redirecting some patient demand.

The potential to do more

For almost thirty years, studies of pharmacy have suggested that pharmacists have the capacity to take on this broader role, and in particular in relation to the care of people with long-term conditions, the management of medicines for people taking multiple drugs, the provision of advice for minor ailments, and the delivery of public health services such as weight management, sexual health, and smoking cessation.^{42 43 44} This is reflected in the current proposed changes to the undergraduate curriculum for pharmacists that will see pharmacy become a five-year integrated programme that focuses more on pharmacists as providers of clinical care that improve the use of medicines and help people to stay well.⁴⁵

37. Department of Health (2012) *New regulations on entry to the NHS pharmaceutical market*

www.gov.uk/government/publications/new-regulations-on-entry-to-the-nhs-pharmaceutical-market

38. Davies J (2010) *Telepharmacy — opportunity or threat?* published in *The British Journal of Clinical Pharmacy* available online at www.clinicalpharmacy.org.uk/volume1_2/2010/july/july10_commentary.pdf

39. Thomas M and Anscombe J (2012) *The future of community pharmacy in England* London: AT Kearney www.atkearney.com/documents/10192/649132/The+Future+of+Community+Pharmacy.pdf/1838dede-b95a-4989-8600-6b435bd00171

40. Centre for Workforce Intelligence (2013) *A strategic review of the future pharmacist workforce* London: published online at www.cfwl.org.uk/publications/a-strategic-review-of-the-future-pharmacist-workforce/@@publication-detail

41. The Kings Fund and the Nuffield Trust 2013 *Securing the future of General Practice: new models of primary care* London www.nuffieldtrust.org.uk/publications/securing-future-general-practice

42. Clucas K (1986) *Pharmacy. The Report of a Committee of Inquiry Appointed by the Nuffield Foundation* London: Nuffield Foundation

43. The Royal Pharmaceutical Society of Great Britain (1996) *Pharmacy in a New Age: The New Horizon* London: The Royal Pharmaceutical Society of Great Britain.

44. Department of Health (2008) *Pharmacy in England: Building on Strengths – Delivering the Future* London: Stationery Office www.official-documents.gov.uk/document/cm73/7341/7341.pdf

45. Smith A and Darracott R (2011) *Review of pharmacist undergraduate education and pre-registration training and proposals for reform* London: Medical Education England hee.nhs.uk/healtheducationengland/files/2012/10/Pharmacist-pre-registration-training-proposals-for-reform.pdf

As highlighted earlier with the introduction in England of NHS funding for two national services that support patients to use medicines (medicines use reviews in 2005 and the new medicines service in 2011 – see Box 1 for details), as well as locally commissioned services such as smoking cessation and flu vaccinations, there are signs of some progress in this shift towards community pharmacists also assuming a broader role in care.

However, community pharmacy in England remains far from reaching its potential: the scope of work already being done at the most innovative edge of the profession (and highlighted in Chapter 4) demonstrates how much more is possible. It is of note that in contrast the Scottish Government has committed to a policy of developing comprehensive pharmaceutical care, and has more fundamentally altered the balance of the global sum available to community pharmacy to reflect its decision

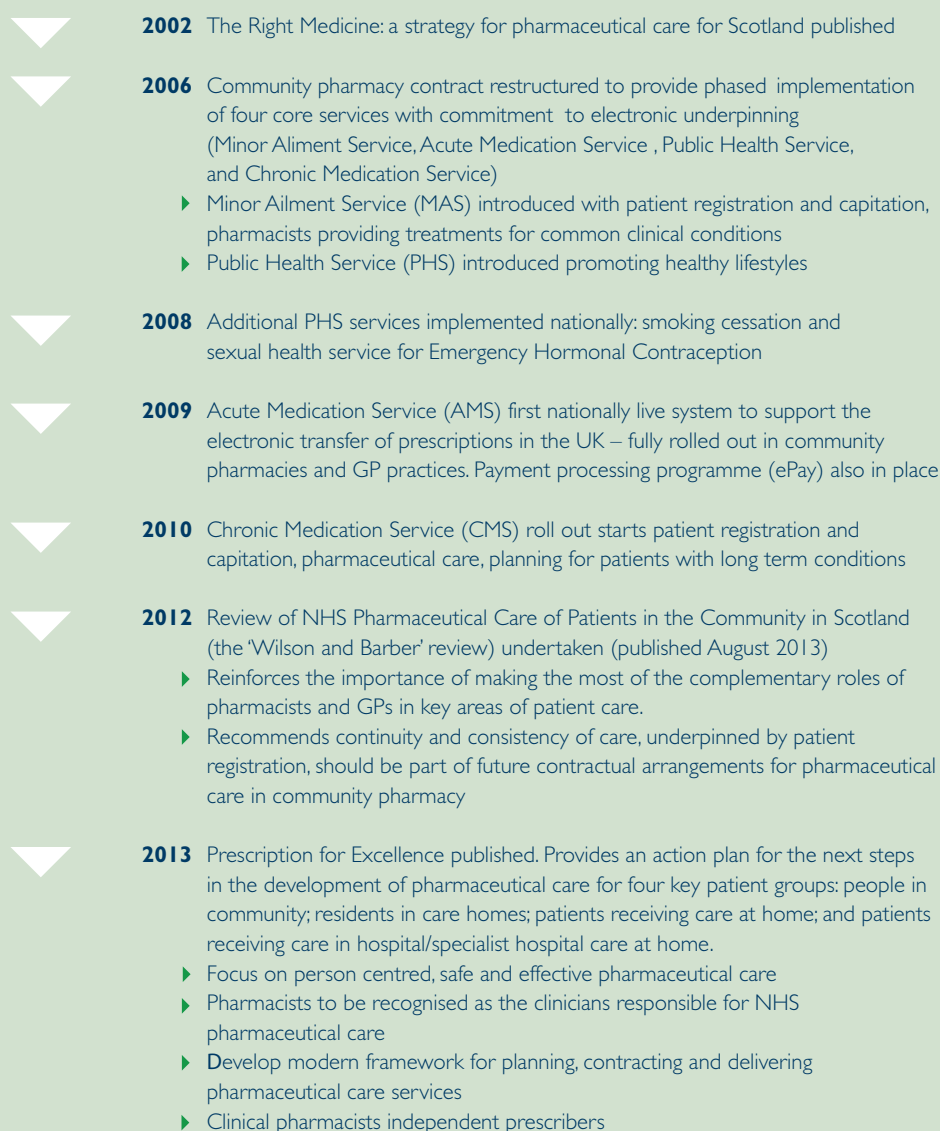
- 
- 2002** The Right Medicine: a strategy for pharmaceutical care for Scotland published
 - 2006** Community pharmacy contract restructured to provide phased implementation of four core services with commitment to electronic underpinning (Minor Ailment Service, Acute Medication Service, Public Health Service, and Chronic Medication Service)
 - ▶ Minor Ailment Service (MAS) introduced with patient registration and capitation, pharmacists providing treatments for common clinical conditions
 - ▶ Public Health Service (PHS) introduced promoting healthy lifestyles
 - 2008** Additional PHS services implemented nationally; smoking cessation and sexual health service for Emergency Hormonal Contraception
 - 2009** Acute Medication Service (AMS) first nationally live system to support the electronic transfer of prescriptions in the UK – fully rolled out in community pharmacies and GP practices. Payment processing programme (ePay) also in place
 - 2010** Chronic Medication Service (CMS) roll out starts patient registration and capitation, pharmaceutical care, planning for patients with long term conditions
 - 2012** Review of NHS Pharmaceutical Care of Patients in the Community in Scotland (the 'Wilson and Barber' review) undertaken (published August 2013)
 - ▶ Reinforces the importance of making the most of the complementary roles of pharmacists and GPs in key areas of patient care.
 - ▶ Recommends continuity and consistency of care, underpinned by patient registration, should be part of future contractual arrangements for pharmaceutical care in community pharmacy
 - 2013** Prescription for Excellence published. Provides an action plan for the next steps in the development of pharmaceutical care for four key patient groups: people in community; residents in care homes; patients receiving care at home; and patients receiving care in hospital/specialist hospital care at home.
 - ▶ Focus on person centred, safe and effective pharmaceutical care
 - ▶ Pharmacists to be recognised as the clinicians responsible for NHS pharmaceutical care
 - ▶ Develop modern framework for planning, contracting and delivering pharmaceutical care services
 - ▶ Clinical pharmacists independent prescribers

FIGURE 3: THE DEVELOPMENT OF SCOTTISH POLICY ON PHARMACEUTICAL CARE FOR PATIENTS

to spend more on patient-facing services from pharmacies and a lesser proportion on dispensing and supply – see Figure 3 and Box 5.

Improved monitoring of patients' use of medicines – something which is within pharmacy's core competency – could also make a direct contribution to reducing the time that patients have to spend consulting their GP, or staying in hospital following an unplanned admission: 8-10% of all hospital admissions are medicines related.⁴⁶

There is much more that pharmacy could do to support people in making optimal use of their medicines, as shown by some of the innovative services in Chapter 4. To reach an integrated system of care where effective use and review of medicines forms a core part of people's care, the collection, transfer and use of patient information must improve. Within traditional community pharmacy services, access to patient medication records or the summary care record could be used to support a medicines optimisation service for over-the-counter drugs, improving safety and effectiveness. More ambitious uses of data could include pharmacy teams undertaking predictive risk analysis of a local population of patients in order to identify and target patients considered at risk of developing complications in conditions like asthma, or when taking high risk medicines.

Providing a proactive public health service to people coming into pharmacies is the other area where pharmacists have the potential to help reduce demands on the NHS. Only by preventing ill-health and helping people to stay healthy can the NHS hope to manage demand on overstretched services. Exercise, diet, infectious disease, drug use and sexual health are key determinants of the occurrence and severity of most of the ill health facing the NHS. The advice and support needed to secure improvement in these areas should be easily available and widely advertised and offered (it is not enough to have a notice in the window – pharmacists have to actively offer services to people coming into the pharmacy) wherever it is most convenient and visible to the public. As accessible professionals with a high street presence, and increasingly found in supermarkets,

community pharmacists can play an important role in providing these public health services. In Scotland, a nationally commissioned public health service has seen the delivery of smoking cessation services through community pharmacies become the norm.⁴⁷

Workforce and skill mix

Crucial to making this broader, care-giving role possible are the size and expertise of the profession itself. With over 40,000 registered pharmacists in England alone, pharmacy is the third largest health profession after medicine and nursing. All pharmacists study a range of health sciences as part of their qualifying degrees, focusing on advanced study of pharmacology and medicines management. In recognition of this status as broadly educated experts in medicines, almost 3000 pharmacists have now been accredited as Pharmacist Independent Prescribers following extra training. This confers full powers to prescribe any drugs for all conditions within the pharmacist's competence except for certain addiction treatments, enhancing their capacity to take responsibility for treating minor illnesses, and the on-going care of people with long-term conditions.

There are indications however that the core skills of pharmacists are not being fully utilised in the English NHS. Studies of different diseases show that 30-50% of medication is still not used according to prescriber instructions.⁴⁸ This is an international problem, particularly prevalent for many long-term conditions associated with higher risk of hospitalisation including diabetes, depression and asthma. At the same time, error rates are high in general practice with a recent study for the General Medical Council finding that one in eight patients have prescribing or monitoring errors.⁴⁹

These factors present an opportunity for pharmacists to assume a much more active role alongside other health professionals within integrated care pathways designed to manage long-term illness.

46. Sharpe S (2013) *From Making Medicines to Optimising Health*. Lecture – available online at psnc.org.uk/wp-content/uploads/2013/08/UCL_Lecture.pdf

47. Scottish Government (2013) *Creating a tobacco-free generation: A Tobacco Control Strategy for Scotland* Edinburgh: Scottish Government www.scotland.gov.uk/Resource/0041/00417331.pdf pp.30

48. Carroll R, Hewittson M and Carroll S (2010) *Delivering Enhanced Pharmacy Services in a Modern NHS: Improving Outcomes in Public Health and Long-Term Conditions* London: Bow Group www.bowgroup.org/sites/bowgroup.uat.pleasetest.co.uk/files/Delivering%2520Enhanced%2520Pharmacy%2520Services%2520%252016%252009%252010%2520FINAL_0.pdf

49. Avery A, Barber N, Ghaleb M et al (2012) *Investigating the prevalence and causes of prescribing errors in general practice: The PRACtICE Study, A report for the GMC*, www.gmc-uk.org/Investigating_the_prevalence_and_causes_of_prescribing_errors_in_general_practice___The_PRACtICE_study_Report_May_2012_48605085.pdf

The opportunity presented by access

The nature and frequency of contact between patients and community pharmacists provides significant opportunities for the provision of a wider range of health and care services. Pharmacies often open well beyond standard working hours and are located close to where people live and shop, making them easy to access. In 2008, the Department of Health estimated that 96% of people in England could reach a pharmacy within 20 minutes on foot or using public transport.⁵⁰ Unlike general practice and most other community health services, community pharmacies do not require appointments or extended waiting times, although as the range and number of patient services grows, pharmacies typically seek to have booked appointments for certain categories of patients.

Each year, 84% of adults in England visit a pharmacy at least once, 78% of these attendances being for health related reasons. While medicines use reviews, appliance use reviews, and the new medicines service for certain chronic illnesses are now widely available in pharmacies, some pharmacies are still not taking full advantage of the opportunities for advice, diagnosis, medicine support and public health services presented by the local and accessible nature of community pharmacy.⁵¹

The accessible expertise of NHS community pharmacists makes them ideally situated to play an expanded role in direct patient care. Yet while a 2008 consumer survey found that 43% of people would consider consulting a pharmacist for tests related to their long-term condition, only 6% had actually done so.⁵² This raises very important questions about the actual availability and profile of

BOX 5: SCOTTISH 'PHARMACEUTICAL CARE' SERVICES

THE CHRONIC MEDICATION SERVICE

The Chronic Medication Service (CMS) introduced in 2010 is a service for patients in Scotland with long-term conditions that enables a community pharmacy of their choice to manage their pharmaceutical care. The patient must choose to opt into the service. Once a patient registered for the service the community pharmacy IT system alerts the patient's GP. A pharmaceutical care plan is developed by the pharmacist and the patient that includes details of review and monitoring arrangements. GPs can also choose to enter into a shared care arrangement with the pharmacist that allows the patient's GP to produce a serial prescription for up to 48 weeks and which is dispensed at appropriate time intervals to be determined by the patient's GP. Patients can choose to opt out of the service at any point or change to a different pharmacy.

MINOR AILMENT SERVICE

The Minor Ailment Service, introduced in Scotland in 2006, aims to support the provision of direct pharmaceutical care on the NHS by community pharmacists to members of the public presenting with a common illness. Utilising IT to support registration with a specific pharmacy the Minor Ailments Service requires people to register with and use their community pharmacy as the first port of call for the consultation and treatment of common illnesses. The pharmacist advises, treats or refers the patient according to their needs.

COMMUNITY PHARMACY PRESCRIBING CLINICS

Community pharmacists, working in partnership with GPs have since 2007 had access to Scottish government funding for community pharmacy supplementary and independent prescribing clinics.

50. Department of Health (2008) *Pharmacy in England: Building on strengths – delivering the future*. London: The Stationery Office. Johnson A (2008)

51. Health and Social Care Information Centre (2012) *General Pharmaceutical Services in England: 2002–03 to 2011–12* available online at

www.hscic.gov.uk/searchcatalogue?productid=9731&q=title%3a%22General+Pharmaceutical+Services%22&sort=Relevance&size=10&page=1#top

52. Which? (2008) *A test of your own medicine* October pp.12–15

services that pharmacists can provide for patients, in comparison with the assertions often made about the potential of pharmacy to deliver such care.

Alongside long-term conditions, minor ailments are another significant pressure on out-of-hours medical care. This is another area where pharmacy could be commissioned to deliver a proportion of first-line diagnosis, advice and care, forming a core part of local out-of-hours care networks. At a time when general practice faces enormous pressure and increasingly recognises the need to focus on treating people with complex and multiple conditions, alternative approaches to dealing with minor ailments have to be found. It has been estimated that around 18% of GP consultations involve minor ailments which could be dealt with by a pharmacist.⁵³

A minor ailments service has been commissioned from pharmacies across Scotland for over seven years. Pharmacists register patients to be part of the service and then receive funding to deliver this care – some 2 million people are now registered (see Box 5). The Welsh NHS now also has such a service that like the national Scottish service, requires patient registration with their local community pharmacy.⁵⁴

Commissioning in transition

It is a source of concern that the most recent figures from the Health and Social Care Information Centre show that the number of local enhanced services provided by community pharmacies has been falling since the start of the financial squeeze in 2010, sharply reversing an earlier upward trend.⁵⁵ This likely reflects the abolition of primary care trusts, (and the resulting upheaval to primary care pharmacists), which were the local commissioners of pharmacy and other services, and the organisational hiatus caused by major reforms to the NHS which are only now, in 2013, starting to bed down. There still appears however to be confusion in the system about who has responsibility for commissioning some community pharmacy services.

The commissioning landscape for community pharmacies has changed significantly since April 2013. Community pharmacy services (essential, advanced and some local enhanced services – see Box 6) are now commissioned

nationally by NHS England through its local area teams. Some local services are commissioned directly through local authorities and it is expected that clinical commissioning groups will wish to do the same in due course. Local health economies now face a challenge as to how they will design and commission pharmaceutical care services to support wider programmes of care for the local population. It is likely that local pharmacy services will increasingly be commissioned directly through clinical commissioning groups (using the standard NHS contract) and local authorities. Whilst this represents an opportunity for pharmacy, community pharmacies will likely need support in working with commissioners, designing service offers, preparing tenders, and hence taking advantage of the opportunities.

Indeed, as we explore in Chapter 6, commissioners will largely rely on offers of services and care designed by groups of local pharmacists – waiting for commissions will be a fruitless task on the part of community pharmacy, for other health services will be approached first and will inevitably take priority with policy makers and commissioners.

It is important to note that in the English health system, pharmacy-provided services are not generally incentivised or evaluated against the outcomes they achieve for populations as a whole. The main metrics applied to community pharmacy services continue to focus on numbers of items dispensed, and numbers of medicines use reviews (or other such services) undertaken. This also reflects the relatively under-developed approach to the commissioning of pharmacy services in the English NHS, a factor to which we return in Chapter 6.

It is of note that the longest section of this chapter is the one focusing on the potential of pharmacy to do more, and that this has been a central theme to the work of this Commission. In the next chapter, we explore some of the many examples of innovative models of care delivered through pharmacy that were submitted to the Commission, before moving on to ask the tough questions of: what has prevented these models of care becoming widespread in the NHS in England? And what needs to be done now, if pharmacy is to reach its potential and make the contribution to health and social care that is so desperately needed?

53. Tisman A (2008) *Driving the self care agenda* London: PAGB www.pagb.co.uk/information/PDFs/AndyTismanarticle.pdf

54. Griffiths L (2012) *Establishment of a National Minor Ailments Scheme in Wales* The Welsh Government wales.gov.uk/about/cabinet/cabinetstatements/2012/minorailments/?lang=en

55. Health and Social Care Information Centre (2012) *General Pharmaceutical Services in England: 2002–03 to 2011–12* available online at www.hscic.gov.uk/searchcatalogue?productid=9731&q=title%3a%22General+Pharmaceutical+Services%22&sort=Relevance&size=10&page=1#top

BOX 6: WHO COMMISSIONS THE SERVICES IN THE CURRENT COMMUNITY PHARMACY CONTRACT IN ENGLAND?

The community pharmacy contract currently has three tiers of services – essential, advanced and local enhanced. Essential and advanced services are commissioned by NHS England. The local enhanced services are currently commissioned by local authorities (for public health services) and by NHS England area teams.*

Essential services: under the community pharmacy contractual framework, each community pharmacy must provide essential services – dispensing and repeat dispensing services, health promotion and healthy lifestyle advice, signposting to other services, support for self care and disposal of medicines.

**It is unlikely that in the longer term that area teams will want to develop and commission local pharmaceutical services and that the commissioning of the majority of local services will move to local authorities and clinical commissioning groups.*

Advanced services: There are four nationally commissioned advanced services that community pharmacies can supply: medicines use review service; the new medicines service (see Box 1); appliance use reviews; and stoma appliance customisation.

Local enhanced services: These are locally commissioned services. Examples of common services include stop smoking schemes, supervised administration of methadone, emergency contraception, nicotine replacement therapy, and minor ailment schemes.

KEY POINTS

- Pharmacy has long talked about its potential to assume a broader role in patient care, moving from a service largely based on the dispensing and supply of medicines to one focused on helping people to make the most of their medicines, supporting their clinical care and helping them to stay well.
- Technology is driving change in pharmacy, as robotics and electronic prescribing are used to reshape the dispensing function, and this has the potential, with judicious use of skill mix, to release pharmacists to undertake more patient-oriented care.
- Community pharmacy is under pressure as NHS funding for dispensing and other services is constrained, reimbursement of drug costs is less remunerative than in the past, non-pharmaceutical sales are falling, and the over-supply of pharmacies and pharmacists starts to bite.
- Pharmacy has a once-in-a-generation opportunity to capitalise on its highly trained professional workforce, local and accessible premises, and understanding of local communities to offer commissioners a range of pharmaceutical services that form part of the solution to wider NHS concerns such as delivering clinically and cost-effective urgent and out-of-hours care, long term condition management, and the promotion of healthy lifestyle choices.

4. MODELS OF CARE DELIVERED THROUGH PHARMACY

The future is already here

This chapter highlights the range of models of care received by the Commission, and the ways in which pharmacists and pharmacy are extending the scope and reach of their services. We give a snapshot rather than a comprehensive summary of the submissions received by the Commission, for the volume of submissions meant that we could only ever use them in a selective manner to support our wider conclusions and recommendations. The examples given reflect the general themes deduced through the literature review that framed the early part of the Commission's work.⁵⁶ It should however be noted that most of the models of care cited are local 'one-off' developments and/or remain at proof of concept stage. We found few examples of innovative care delivery that had been rolled out consistently and at scale across a district or region.

This apparent inability on the part of pharmacy to persuade local and national commissioners of the value of extended pharmaceutical care services, and to embed new service developments within funded networks of care with other providers, raises important questions about the ways in which pharmacy is able to operate and influence within the wider NHS, a topic we address in Chapter 6.

The models of care set out in this chapter (and illustrated in Figure 4) offer potential solutions to some of the more pressing problems facing the NHS, such as: access to out-of-hours diagnosis, advice and care; long-term condition management; care of older and vulnerable people; preventing unnecessary admissions to hospital; and providing local public health services.

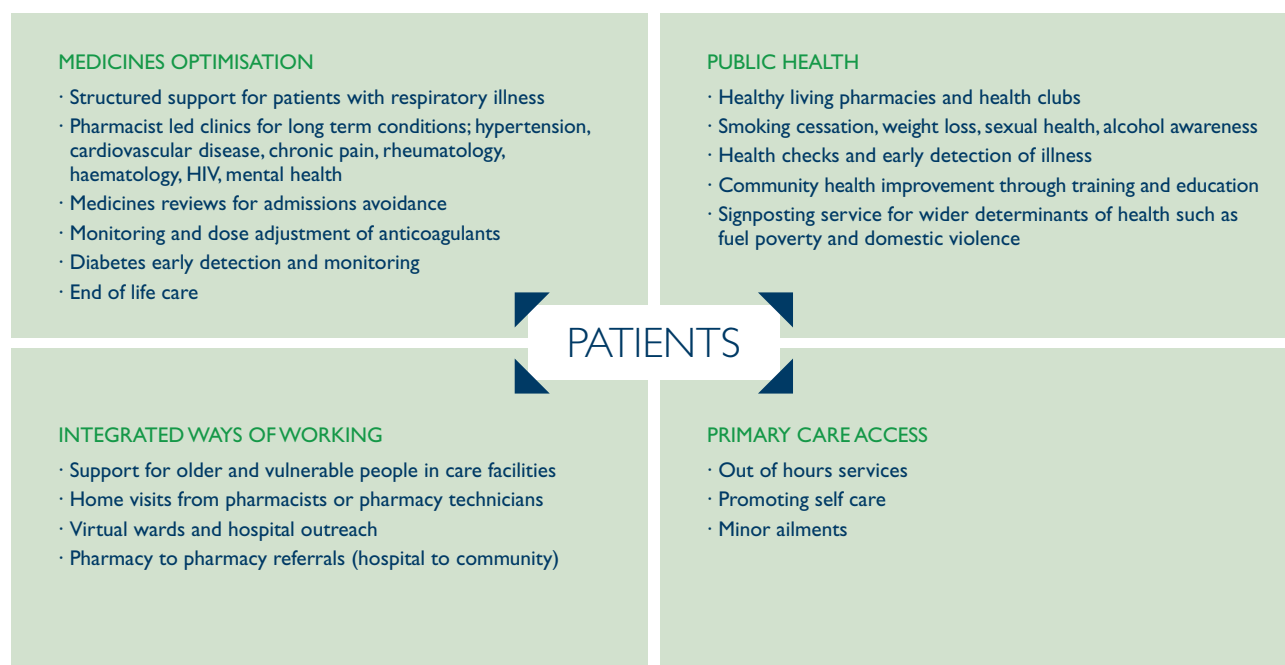


FIGURE 4: OVERVIEW OF THE HIGHLIGHTED MODELS OF CARE

56. The Royal Pharmaceutical Society England (2013) *New models of pharmacy: what is emerging and what is possible. A review of the literature* London www.rpharms.com/futuremodels

Access for advice and minor ailments

Using community pharmacies as a first port of call for minor self-limiting conditions, and having pharmacists help people to manage these condition themselves, has long been seen as a way of reducing the demand on general practice.⁵⁷

The 'minor ailments service' was commissioned locally by primary care trusts in some areas of England and is designed to encourage people to use community pharmacies as the first point of contact for a range of self-limiting conditions. Minor ailments services provide an effective alternative to general practice consultations and are less expensive. The number of consultations and prescribing for minor ailments at general practices often declines following the introduction of minor ailment schemes.⁵⁸

In some parts of England, primary care trusts (prior to April 2013) coordinated activity to ensure that common ailments services with similar specifications could be commissioned across a wider geographical area (for example, the Lancashire PCTs). This allowed for consistency of access for a local population, and enabled local health professionals to give a clear and consistent message to people about the merit of attending community pharmacies for a range of common ailments such as head lice, coughs, colds, flu and hay fever. In other areas of the country however, availability of common ailments services in pharmacies is patchy, because the former primary care trusts chose not to commission such care from pharmacies, capped services to manage budgets or commissioned these services only on a pilot or occasional basis.

Other than this, there has been little attempt in England to utilise community pharmacy as a first point of contact for out-of-hours patient services. Indeed even when it would be appropriate for a patient to be directed to a community pharmacy (for example, for emergency hormonal contraception over the weekend) NHS 111 services do not consistently signpost the service, nor do they signpost patients to their pharmacy when they have run out of their

regular medicines. Given the current strain on health service urgent care, this is surprising.

There are however local examples of more effective and co-ordinated approaches to involving pharmacy in out-of-hours care. For example, in Bromley-by-Bow in London, an NHS walk-in centre is co-located with a Green Light Pharmacy, and the walk-in centre triages people who do not need to see a doctor or nurse to the pharmacy for advice and self-care (see Box 7).

Integrated long-term conditions management

Finding clinically and cost-effective ways of managing long-term conditions (and often multi-morbidity) is possibly the biggest challenge faced by the NHS. Health and care systems need to get better at supporting people with long-term conditions to manage their own care, and as part of this to use their medicines more effectively on an on-going basis.⁵⁹ Pharmacists are beginning to play a much bigger part in helping patients get the best from their use of medicines, and there is ample evidence to suggest that this is a fruitful direction for pharmacists and the wider NHS to pursue.^{60 61 62} This Commission has heard of several examples where community pharmacists are supporting people with asthma and/or chronic obstructive airways disease (COPD) to use their medicines more effectively – see Box 8 for an example.

The nationally commissioned medicines use review service (see Box 1) is being used in a number of localities in England as a mechanism to provide support to patients with asthma and COPD in a more consistent way. A range of initiatives set up by former primary care trusts or strategic health authorities entailed standardised training for community pharmacists to deliver structured interventions for patients with asthma and/or COPD, sometimes linked to public health interventions such as stop smoking initiatives, with the intention of improving care and reducing hospital admissions.⁶³

57. Health Select Committee (2013) *Written evidence from Pharmacy Voice (ES11)* London: Stationery Office www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/171vw07.htm

58. Paudyal V, Watson MC et al (2013) *Are pharmacy-based minor ailment schemes a substitute for other service providers? A systematic review* *The British Journal of General Practice* Vol 63 (612) pp.472–481 www.ncbi.nlm.nih.gov/pubmed/23834884

59. Royal Pharmaceutical Society (2013) *Medicines Optimisation: Helping patients to make the most of medicines* London www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf

60. Barber N, Parsons J et al (2004) *Patients' problems with new medication for chronic conditions*. *Quality and Safety in Health Care* Vol 13 pp.172–175 qualitysafety.bmj.com/search?author1=R+Horne&sortspec=date&submit=Submit

61. York Health Economics Consortium and The School of Pharmacy, University of London (2012) *Evaluation of the Scale, Causes and Costs of Waste Medicines*. eprints.pharmacy.ac.uk/2605/1/Evaluation_of_NHS_Medicines_Waste_web_publication_version.pdf

62. Pirmohamed M, James S et al (2004) *Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients* *BMJ* Vol 329 pp.15–19

63. The Cambridge Consortium (2012) *Evaluation of Inhaler Technique Improvement Project* www.networks.nhs.uk/nhs-networks/innovation-south-central/documents/120904%20CIEM_ITIP_HIEC_Evaluation.pdf

BOX 7: GREEN LIGHT PHARMACY AND ST ANDREWS WALK-IN CENTRE

Green Light Pharmacy and the walk in centre are co-located with a GP practice. Co-location has enabled the pharmacy team to work closely with all members of the general practice team (both clinical and administration). The good working relationships and excellent communication benefit the pharmacy, the GPs, the walk-in centre and ultimately the walk-in centre patients.

People who don't need to see a doctor or nurse are signposted to the pharmacy for self-care, either for advice, to buy medicines or to obtain them through the local minor ailments scheme (Pharmacy First). Patients through Pharmacy First do not need to pay for medicines that they would otherwise have needed a prescription from the GP/nurse to obtain free of charge. The triage to pharmacy for self care and the Pharmacy First scheme frees up walk-in centre appointments for people with greater need, which in turn prevents

them from having to go to the local accident and emergency department.

Green Light's relationship with the local surgery is all about the organic development of local networks which they have proactively formed over the first year of operation. They were specifically commissioned as a Local Pharmaceutical Services pharmacy with the expectation that they would integrate within the primary care network. To support this objective further they have been commissioned to deliver a programme of clinical leadership to develop local community pharmacy leaders. Under this programme these clinical leaders will provide leadership on medicines optimisation and also ensure Pharmacist input in clinical pathways design with the Clinical Commissioning Group and Health and Wellbeing Board.

BOX 8: COMMUNITY PHARMACISTS HELPING IMPROVE OUTCOMES FOR PEOPLE WITH COPD

On the Wirral, four of the large pharmacy multiple groups, Boots, Co-operative Pharmacy, Lloyds and Rowlands have come together with independent and supermarket pharmacies in a pilot to provide a programme of structured practical support for patients to help them get the best outcomes from their medicines and thus support their condition.

Patients undergo an initial assessment once they have joined the service. This involves a COPD test (COPD Assessment Test) and dyspnoea score. Public health advice and information on lung health, diet, exercise and lifestyle are provided and interventions such as smoking cessation signposted where appropriate. Patients' symptoms and

adherence with medication are monitored regularly to improve medicine optimisation and inhaler technique is checked to ensure they are receiving maximum benefit. This typically happens when patients come into the pharmacy for their prescriptions. A patient held personal record card is provided and this is checked and updated. Targeted medicines use reviews are provided as part of the service and the provision of a rescue pack for rapid intervention is provided if necessary. Patients undertake an annual health assessment with measurement of outcomes and patient satisfaction, alongside appropriate seasonal interventions, for example flu vaccinations.

Several of the larger pharmacy chains have developed their own services for patients with asthma or COPD. For example, after a pilot that demonstrated a structured medicines use review led to better symptom control for people with COPD, Rowlands now offer a standardised inhaler service in all of their pharmacies. Any patient using an inhaler can have a medicines use review appointment in a Rowlands Pharmacy, along with counselling about how best to use their inhalers. A symptom control check is undertaken at the initial review and repeated by the community pharmacist as necessary.

Across a range of other long-term conditions, a model of care which is becoming more common is the use of pharmacist-led clinics in both primary and hospital care. This model has developed primarily for patients where medicines are fundamental to how they manage their conditions on a day-to-day basis. In primary care, examples include GPs referring patients to their own practice-based pharmacist for on-going management of hypertension and cardiovascular disease; and referring patients with chronic pain to a community pharmacy-based chronic pain management clinic (see Box 9).

BOX 9: PHARMACIST-LED CLINICS

LONG-TERM CONDITIONS CLINIC IN A GP PRACTICE

At Hartland Way Surgery in Croydon a pharmacist prescriber (who is also a partner in the practice) runs clinics twice a week for patients with long-term conditions (cardiovascular disease, respiratory disease and hypertension). The clinics aim to optimise the patient's medicines use by providing structured support that gives them a better understanding of their condition, improves the way they take their medicines, reduces their chances of hospital admission, allows for timely intervention if their condition deteriorates or relapses, and provides appropriate referral to other agencies when needed. The pharmacist also manages medicines issues related to any hospital admissions, ensuring that on discharge from hospital, any changes to the patient's medicines, or queries about medications, are picked up early.

CHRONIC PAIN MANAGEMENT CLINIC IN A COMMUNITY PHARMACY

A pharmacist prescriber with a specialism in pain management ran an NHS pain management clinic from a community pharmacy in Essex (one year pilot). Patients were referred to the clinic by GPs

from a local health centre. Patients referred had unresolved chronic pain and would normally have been referred to a secondary care pain team. The community pharmacist had full access to the patient record (via a laptop pre-load with System-One software) and could issue printed NHS prescriptions for repeat medication or initiate new medication as appropriate. Patients prescribed a new medicine during the clinic had the option to see the pharmacist during the day without an appointment to discuss any follow-up issues.

The clinic gave patients quicker and more convenient local access to care than the alternative of travelling to, and waiting for, a hospital out-patient appointment. It reduced the number of GP appointments for patients with chronic pain and patients who previously would have used A&E accessed the pharmacy as the first port of call.

The pharmacy pain clinic has not been commissioned as the CCG is re-commissioning its musculoskeletal pathway using a lead accountable provider model. It will be critical for services such as the pharmacy pain clinic to demonstrate how their service can support the lead accountable provider to deliver the (pain) pathway and achieve the outcomes required of their contract.

In a hospital setting, we have seen examples that include: rheumatologists referring patients to pharmacist-led clinics for support in the choice and use of specialist medicines to help control rheumatoid arthritis; haematologists and nurses referring patients on chemotherapy to a pharmacist-led symptom control clinic; pharmacist-led clinics for patients with HIV where the pharmacist provides assessment, prescribing and support for medicines taken; and pharmacists running clinics for adults with attention deficit disorder.

Similarly, in some areas community mental health teams are able to refer patients based in the community directly to specialist mental health pharmacists for advice, review and prescribing.⁶⁴

The Commission has also heard of examples of pharmacists working with hospices and with patients to support them with medicines use as they near the end of life; for example, in Hull, Macmillan pharmacists are working in a specialist community palliative care clinic, and with the local hospice and hospital to ensure best use of medicines and seamless transfer of care for patients between these settings.⁶⁵

Another emerging model of care by pharmacists for people with long-term conditions is to offer blood monitoring services that were more traditionally delivered by hospital outpatient departments. For example in Brighton, patients taking an anticoagulant medication that requires regular blood test monitoring are able to choose a local community pharmacy at which to have their blood tests, review of

results, and modification of dosage – see Box 10. Similarly, some community pharmacies now offer blood tests to help identify people at risk of diabetes as well as regular blood sugar monitoring services (for HbA1c levels) and support for people with diagnosed diabetes.

Support for older and vulnerable people at home or in care

Care for older and vulnerable people will increasingly involve helping them to take their medicines effectively, in order to maintain their health and avoid hospital admissions. This is whether they are living independently in their own homes, in care homes or sheltered housing. There is ample evidence that for older people living in care homes their medicines are frequently given incorrectly⁶⁶ and infrequently monitored or reviewed. The Commission heard of several models of care where pharmacists and pharmacy technicians have been integrated into multidisciplinary teams to help ensure that older people are supported to take the medicines appropriate for them (see Box 11).

The Commission heard of other examples where pharmacy teams working in social enterprises or private companies have been commissioned by a former primary care trust or a new clinical commissioning group to provide medicines support to patients in local care homes, either

BOX 10: ON-GOING MONITORING: QUICK AND CONVENIENT ACCESS FOR PATIENTS

Patients taking an anticoagulation medication can choose one of seventeen pharmacies in Brighton for their regular blood test with appointments available at flexible times that include one early morning and on alternate weeks either a late evening or a Saturday clinic. The pharmacist tests the patient's blood levels of medication and can adjust the dosage of medication there and then if necessary. Appointments usually last around ten minutes. The previous hospital service required

patients to make an appointment at a hospital with limited opening times, blood was taken in one part of the hospital and then the patient had to go to another department to have their levels interpreted. The service is commissioned using a community service contract with Boots as the lead provider and the other community pharmacies as sub-contractors. It is supported by a team of general practitioners with a special interest in anticoagulation.

64. Parker C, Duggan C. Developing a pharmacist-led medicines management service for mental health patients. *British Journal of Clinical Pharmacy*. 2011; 3; 182–4.

65. Royal Pharmaceutical Society (2013) Submission cited in the final report of the RPS Future Models of Care Commission. London <http://www.rpharms.com/futuremodels>

66. Barber ND, Alldred DP et al (2009) *Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people* Quality and Safety in Health Care Vol 18 pp.341–346 www.ncbi.nlm.nih.gov/pubmed/19812095

BOX 11: ENFIELD COUNCIL AND ENFIELD CLINICAL COMMISSIONING GROUP SUPPORT FOR CARE HOMES

Enfield has one of the highest populations of older people in London, with 30,000 people aged 65 or older, and the borough has 110 different residential care facilities. Enfield Council and Enfield Clinical Commissioning Group jointly employ a pharmacist who sits in the CCG's medicines management team and who both provide pharmaceutical care to residents and respond to safeguarding alerts relating to medicines in any of the care facilities.

The pharmacists' clinical priorities are to ensure that all residents have medication reviews and to

make sure that the medicines they are taking are all still needed, can be taken together, and are optimal for the individual patient. At the same time the pharmacist offers education and training for care home staff to help improve the use and handling of medicines.

When a safeguarding alert related to medicines is raised, the pharmacist carries out a risk assessment on the care facility. An implementation plan to correct problems with medicines governance is developed and the home is followed up against the plan.

on a time-limited basis to review the homes' systems and processes for storing and administering medicines, or on a regular footing to review patients' medication, train and support care staff, and provide on-going advice and supervision about the safe use of medicines. This points to the potential for pharmacists of forming networks, chambers or companies, as a basis for bidding for and delivering specific pharmaceutical services that are sought by clinical commissioning groups, local authorities, or indeed GP federations or networks – the latter may sub-contract for medicines optimisation and other services as part of plans to extend urgent and long-term conditions care. We return to this topic in Chapter 6.

For older or vulnerable people who are housebound, the model of domiciliary pharmacist or pharmacy technician visits is beginning to emerge as a means of offering medicines management support. In North West London, domiciliary medicines reviews for older patients taking four or more medicines are commissioned from Central London Community healthcare to support patients' medicines use. Commissioned through the integrated care pathway, using innovation monies, it is hoped that this service will ultimately be funded by the CCG once the results of the evaluation are available. The Commission heard of several examples where community pharmacists visit patients in their home to support them in their medicines use (see Box 12 for an example).

In an approach that links health and social care, Northern Devon Healthcare NHS Trust has pharmacists and pharmacy technicians as core members of multidisciplinary complex care teams comprising health and social care staff. The pharmacy team provides a domiciliary medicines optimisation service to adult patients to try to reduce medicine-related hospital admissions and improve patients' use of their medicines and their understanding of why they are taking them. Interventions made by the pharmacy team are fed back to the patient's GP and a follow up visit or telephone call is arranged where necessary.

The Commission has revealed that in the area of long-term conditions care, and the provision of support for older and vulnerable people, there is a wealth of examples of innovative services involving pharmacists, pharmacy technicians, and pharmacies. There is a strong focus on helping people and their carers get the most out of the medicines they are prescribed, and in providing advice, expertise and safety monitoring to wider pathways of care.

The patchy provision of these new services is again striking, as is the prevalence of pilots and short-term projects, and an overall sense of innovation happening in a rather haphazard and opportunistic manner. There is less of a sense of a strategic plan for the role of pharmacy teams in long-term conditions and medicines management. One other striking feature however is the way in which groups of pharmacists are often responsible for the development

BOX 12: HOME VISITS FOR PEOPLE WHO NEED MEDICINES SUPPORT

In Croydon the local authority has commissioned local community pharmacists to visit people at home to undertake medicines use reviews. Housebound patients who need additional support with medicines use are identified by the community pharmacist or by the GP, who refers directly to the community pharmacist. Patients are also identified by teams in the local hospital (accident and emergency nurses and the pharmacy team) who are referred initially to the pharmaceutical team at the clinical commissioning group, who then refer patients to the community pharmacist if adherence to medicines has been highlighted as a possible issue.

The contract for the domiciliary medicines use review service is funded by the local authority and managed by the CCG. The service is open to any community pharmacist who has attended the training and is accredited to deliver the reviews. The impact of the service has been demonstrated by recording the interventions made as part of the medicines use review, and assessing whether the intervention could have avoided an emergency hospital admission. The interventions are peer reviewed and then quantified in terms of cost avoidance using current cost of an emergency admission in Croydon.

and 'selling' to commissioners of new services. Whether through the emergence of social enterprises or companies comprised of groups of pharmacists, or the pharmacy teams in hospitals or community service providers, there is clearly a desire on the part of pharmacists to contract locally for services, and to do this as a group of professionals, rather than necessarily as pharmacies.

Helping people to get or stay out of hospital

The Commission heard of outreach pharmacists employed by hospitals or community services, these professionals forming part of the care team for frail older people in particular; working with patients to ensure that medicines are not the reason that they remain in hospital unnecessarily or find themselves readmitted. For example, the reablement service for patients leaving the Whittington Hospital in North London has a pharmacist as a core member of the team, attending twice weekly multidisciplinary team meetings at which the care of frail hospital patients is discussed. From this, the pharmacists pick up referrals and visit these patients post-discharge in their own homes, to pick up any problems or difficulties with medicines use. Similarly, Guy's and St Thomas' Community Services team have pharmacists as core members, working with nurses and others to manage complex patients in the community to avoid unnecessary admissions or readmissions.

Community pharmacists are often described as the missing link in the transfer of hospital discharge information and some models of care submitted to the Commission are trying to integrate pharmacists more routinely into the care pathway of patients discharged from hospital. Lack of IT and lack of electronic communication has been a significant barrier to ensuring that patients are safely discharged into the community. One example of this being tackled is at East Lancashire Hospitals – see Box 13.

Providing local public health services

The potential role that community pharmacy can play in improving and maintaining the public's health is consistently identified as being underutilised.⁶⁷ Community pharmacies are accessible, open long hours and present in communities across the country including areas of deprivation. Primary care trusts typically commissioned public health services from pharmacies as local enhanced services. However, because services were commissioned locally the scope and availability was variable across England, and contracts were often short-term. This has limited the ability of community pharmacies to deliver services on a larger scale, and to make investments in facilities and staff to support extended service provision.⁶⁸ The commissioning of all public health enhanced pharmacy services is now the responsibility of local authorities and this presents an opportunity to scale up the commissioning of pharmacy-based public health services, if groups of pharmacists and/or pharmacies can persuade cash-strapped local authorities that pharmacies are cost-effective organisations for the delivery of services aimed at improving people's health.

Although the availability of public health and preventative services varies across England, the Commission heard about a wide range of initiatives delivered through community pharmacies. Examples included:

- smoking cessation services
- substance misuse services (e.g. supervised administration of medication, syringe exchange)
- flu immunisations (and potentially other immunisation programmes) – see Box 14
- weight management services and nutritional advice (for example for infants and children)
- NHS health checks (in some cases with specific focus on hard to reach groups e.g. cardiovascular checks for younger men)
- alcohol awareness and brief interventions with onward referral if necessary
- sexual health services (including emergency contraception, chlamydia screening and treatment, ongoing supply of contraception)
- screening services (for example for hepatitis B, HIV)
- referral for early detection of bowel and skin cancer

BOX 13: PROVIDING MEDICINES SUPPORT TO PATIENTS DISCHARGED FROM HOSPITAL

In East Lancashire Hospitals patients who need additional support with their medicines are given the opportunity to have a direct referral of their medicines information and care from the hospital pharmacy team to a community pharmacist of their choice. A newly developed system for the Trust called Refer-to-Pharmacy allows patients to identify their local community pharmacy, and a referral, together with a copy of their hospital discharge summary, is sent directly to the community pharmacy. Patients are asked to give consent and shown a short film to inform them of why the

system has been developed, and what benefits they can expect to gain (this can be viewed at www.elht.nhs.uk/refer). The referral will then be followed up by the community pharmacist. An audit function allows the hospital team and community pharmacists to monitor performance and analyse the effect of referral on re-admissions to hospital. Refer to pharmacy e-referral links the care patients receive in hospital to that in the community to help them get the best from their medicines and stay healthy at home.

67. The Royal Pharmaceutical Society England (2013) *New models of pharmacy: what is emerging and what is possible. A review of the literature* London www.rpharmc.com/futuremodels

68. NHS Confederation (2013) *Health on the high street. Rethinking the role of community pharmacy* London www.nhsconfed.org/Publications/reports/Pages/Health-on-high-street-rethinking-community-pharmacy.aspx

BOX 14: FLU VACCINATIONS IN COMMUNITY PHARMACY

In 2012-13, following accredited training, 24 community pharmacies in Sheffield were commissioned by the local primary care trust to provide flu vaccination services for difficult-to-reach groups identified as being at risk. An evaluation provided clear evidence that the programme succeeded in reaching individuals beyond the reach of general practice. Twenty per cent, in a survey with a high response rate, said that they would not otherwise have received vaccination. Fifty-eight per cent expressed convenience as the main reason that they had chosen to visit a pharmacy for the service.⁶⁹

The ability of pharmacists to vaccinate hard to reach groups is being increasingly recognised, for example, in London there is now a pan – London Community Pharmacy Flu Vaccination service. This means that people who live, work or access services in any of the London Boroughs will be able to have their flu vaccine from a participating pharmacy.⁷⁰

As a framework for the delivery of public health services, disease prevention and the promotion of healthy living there is considerable interest in encouraging community pharmacies to act as a 'health hub'. This approach is demonstrated by the growth of the Healthy Living Pharmacy programme (see Box 15). A local initiative that started in Portsmouth and is now spreading across England, encouraging community pharmacies to support healthy living in a proactive way that makes the most of the pharmacy team and location of the pharmacy in the centre of a community.

In some areas, there is interest in pharmacies helping to tackle the social determinants of health as in Wigan, where community pharmacies have been used innovatively to help address two key public health challenges in the area: fuel poverty and supporting people at risk of domestic abuse.⁷¹ Similarly, there is an increasing imperative to improve the extent to which people have the capacity to obtain, process, and understand basic health information (health literacy) pharmacists clearly have a role to play here in their interactions with patients.⁷²

Building on their position as providers of health and wellbeing services on the high street some community pharmacies are beginning to partner with local organisations to help improve the health of their local communities – see Box 16.

There is also some evidence to suggest that pharmacists can become trusted figures for patients and those receiving help to remain healthy. The Wells Family Challenge, a small pilot programme carried out in Sainsbury's pharmacies through 2011-12, saw pharmacists help those with risk factors for cardiovascular disease to improve their health through lifestyle change. Evaluation of their interactions saw pharmacists quickly become trusted 'mentor' figures. In many cases, people who were already aware of ways to improve their lifestyle reported that hearing the same thing from a pharmacist made them more likely to follow recommendations.⁷³

69. NHS Sheffield (2013) NHS Sheffield Community Pharmacy Seasonal Flu Vaccination Programme for hard to reach at risk groups 2012-13 (and catch up campaign for over 65s). Service Evaluation psnc.org.uk/sheffield-lpc/wp-content/uploads/sites/79/2013/06/I-Evaluation-of-Pharmacy-Flu-Service-2012-13-1.pdf

70. Pharmacy London (2013) London Community Pharmacy Seasonal Flu Vaccination Enhanced Service 2013-14 Service Guidance. psnc.org.uk/city-and-hackney-lpc/wp-content/uploads/sites/69/2013/08/Pharmacy-London-Community-Pharmacy-Seasonal-Flu-Vaccination-Enhanced-Service-v31.pdf

71. Royal Pharmaceutical Society (2013) Submission cited in the final report of the RPS Future Models of Care Commission. London www.rpharms.com/futuremodels

72. Research in Social and Administrative Pharmacy Volume 9, Issue 5, September 2013

73. Royal Pharmaceutical Society (2013) Submission cited in the final report of the RPS Future Models of Care Commission. London www.rpharms.com/futuremodels

BOX 15: HEALTHY LIVING PHARMACIES⁷⁴

The Healthy Living Pharmacy programme was originally developed by Portsmouth Primary Care Trust and the Hampshire and Isle of Wight Local Pharmaceutical Committee. It aimed to create pharmacies committed to provide public health and lifestyle improvement services, commissioned on the basis of local need. The services provided included smoking cessation, sexual health advice, and guidance on lifestyle changes to combat obesity. A key theme was building on the essential and advanced services already being provided. Leadership training was provided for pharmacists, each pharmacy was required to have a team member trained as a Health Champion to Royal Society of Public Health standard, and consultation rooms were equipped to deal with new services. The regularity of contact with the public in community pharmacy was used to give

health advice at every opportunity. The programme showed significant results, particularly in smoking cessation and related illnesses. Seventy per cent of patients with a respiratory condition showed improvement in their ability to manage their illness, with the total number of people stopping smoking exceeding agreed targets by 42%.

The Healthy Living Pharmacy concept has now been rolled out to 721 pathfinders nationwide. A recent evaluation found evidence that similar gains were made for populations served by the wider group of Healthy Living Pharmacies. These data also show that it is not only pharmacists who can provide effective Stop Smoking services, with similar quit rates achieved by other trained pharmacy team members, allowing more effective use of skill mix for this service.

BOX 16: HEALTHY LIVING PHARMACIES

Green Light Pharmacy in Euston is a partner in the West Euston Healthy Communities Project which is supported by the New Opportunities Fund (now the Big Lottery). It operates a training programme for volunteers, who then encourage local people to complete a series of questions about their health. Based on the results of the questionnaire, individuals may then be invited to the pharmacy for health checks and health education, for example, about diet and smoking cessation.

Jhoot's pharmacy chain is a key partner in a social enterprise (community interest company) called Innovation Health and Wellbeing. The partnership includes Walsall Council, Walsall Housing Group,

Jobcentre Plus and Walsall College and brings together the expertise of all partners in the development of interventions that aim to improve the health and wellbeing of local communities. As part of this aim a Life Style and Weight Management Qualification has been jointly developed and piloted jointly by Walsall College, Jhoots Pharmacy and Walsall Housing Group within local communities and will soon be accredited for wider national use. It aims to improve residents own health, but also for those interested in a health-centred career, to provide them with a qualification that will help them with their ambition to secure employment.

74. UCL Institute of Health Equity (2013) *Evaluation of the Healthy Living Pharmacy Pathfinder Work Programme 2011–2012*

Learning from these models of care

The Commission was extremely impressed by the number and nature of submissions received from across the NHS, describing different models of care involving pharmacy. This chapter has set out a summary of these models of care, examined within the thematic framework that was developed via the literature review undertaken for the Commission. What is clear is that pharmacists in the community, primary care, social care and the acute sector are keen to develop innovative ways of delivering services to patients, in particular those that come under the banner of 'medicines optimisation', integrated care and public health. It is also evident that in these many examples, people have been able to overcome the barriers to innovation and service development that are often cited, and which we examine in more detail in the following chapter.

The most striking aspect of our analysis of these many models of care is that they remain exceptional and hence 'innovative' when arguably the majority could and should be mainstream, given presenting health needs, years of discussion and writing about broadening the role of pharmacists (especially in the community), and the apparent hunger within pharmacy to ensure that skills and experience are used to maximum patient and population benefit. In the next chapter, we explore what it is that seems to hinder the implementation at scale of new models of care delivered through pharmacy.

KEY POINTS

- Over 100 examples of models of care delivered through pharmacy were submitted to this Commission during the call for evidence.
- These models of care reflect the categories of patient-oriented services and care deduced from the review of literature undertaken to inform this Commission: access to medicines, advice and care; optimising the use of medicines; improving public health; and new integrated ways of working.
- The models of care are striking in that they have been put in place despite the barriers so often reported as being the reason for the relative lack of development of the pharmacist as a care giver.
- Pharmacists are forming new networks and organisations, often in collaboration with other health professionals, to design, bid for and deliver new models of care. In this they reflect trends elsewhere in primary and wider care.
- Perhaps the most disheartening aspect of the work of this Commission has been the fact that there is widespread consensus that pharmacists should engage much more widely in the delivery of direct patient and population health services, yet examples of such care remain relatively rare and considered 'innovative'.
- After many years of describing visions of future pharmaceutical care provision and more recently medicines optimisation, and the desire of pharmacists to use their skills more fully, there is clearly much that remains to be done to move from visions and strategies to plans and implementation.

5. WHY AREN'T THESE NEW MODELS OF CARE WIDELY AVAILABLE?

In this chapter we set out our analysis of the reasons why new models of care delivered through pharmacy have been slow to spread beyond a relatively small number of projects, schemes and pilots. This is based on what we heard during our work as a Commission, for in our call for evidence, we asked people to comment on barriers to implementing new models of care involving pharmacy, and this issue was also explored in Commission workshops, interviews and meetings of the expert advisory group.

Pharmacy is marginalised within the NHS

Despite calls from many pharmacy organisations and in numerous policy documents for pharmacists to make better use of their clinical skills and take on a broader care-giving role, there is still a sense that community pharmacies in particular, and the pharmacists who work within them, sit outside the NHS and are primarily suppliers of medicines to patients, rather than core members of local integrated health and social care teams. Whilst there have unquestionably been some developments in the services that patients access through community pharmacies (as evidenced by the models of care submitted to the Commission and summarised in Chapter 4), the proper integration of community pharmacists into the primary and community care team still remains for the most part an aspiration.

In hospitals, and for pharmacists working in primary care either in GP practices or for clinical commissioning groups, there has been more progress in integrating pharmacists into core teams. Indeed there have recently been calls from the NHS Alliance to embed medicines optimisation within general practice through the employment or attachment of medicines optimisation pharmacists to practices.⁷⁵ This, along with evidence that demonstrates the impact

pharmacists can have on improving medicines use⁷⁶ is testament to the increasing acceptance of the role of primary care pharmacists.

There is poor public understanding of the role of pharmacists

Whilst the public in general has a high regard for pharmacists, there is a low awareness of the range and benefits of services that pharmacists can offer.⁷⁷ During the work of the Commission, we heard from patient groups of the need to 'demystify' pharmacy in the eyes of the public, and of the importance of putting in place services that demonstrate to people the potential of medicines optimisation and direct patient care – and these need to be explained in much clearer lay terms. The need to build a strong and straightforward narrative about the role pharmacists can play in people's care and the services that they can offer was asserted to be critical; in particular in the management of long-term conditions, self care and public health. Furthermore, we heard of the need for such services to be offered proactively to people – a list of services in a pharmacy window will not suffice – pharmacists need to be out at the front of pharmacies actively engaging in conversation with people and offering services to those coming in.

Pharmacy lacks leadership and consistent vision

We have been told repeatedly that pharmacy as a profession has suffered from a lack of strong and consistent leadership. The many bodies that claim to represent pharmacy are fractured and frequently pulling in different directions. The major employers of pharmacists are private enterprises who understandably have their own agendas. This means

75. NHS Alliance (2013) *Breaking boundaries. A manifesto for primary care by the NHS Alliance* www.nhsalliance.org/wp-content/uploads/2013/03/NHS-Alliance-Manifesto-FINAL.pdf

76. Avery AJ, Rodgers S et al (2012) A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis *The Lancet* Vol 379 (9823) pp.1310-1319

77. Department of Health (2008) Speech by the Rt Hon Alan Johnson MP, Secretary of State for Health NHS Confederation Primary Care Network webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/Speeches/Speecheslist/DH_083369

that it appears to have been difficult to unite the pharmacy profession around a single coherent narrative and direction for the future. In our work for the Commission, we heard of people's encouragement in relation to the developing role of the Royal Pharmaceutical Society as a professional leadership body, which was considered to have made sound progress in setting out direction for the profession. There was however a strong message that this now needed to be taken to the next level, with a focus on influencing the wider world of health policy and management, and other health professions.

In addition, at a national policy level pharmacy appears to be punching below its weight, often missing from significant discussions about the future of commissioning, primary care, integrated care, the 24/7 hospital and urgent care. There may be structural reasons for some of this, within NHS England and the Department of Health, related to the other roles that pharmacy leaders have to play. However, in the realm of mainstream service development, pharmacy clearly needs to find more effective presence, direction and representation.

This Commission has heard of many local pharmacy leaders who are developing pockets of excellent practice, but we have been struck by the apparently few mechanisms by which these local leaders can be mentored and developed alongside the wider community of clinical and managerial leaders, and given the skills to help propel the profession forward to develop, take on, and relish new roles.

Pharmacy needs a more structured development pathway

The lack of a structured programme and national resource to support pharmacists in the development of new roles has been reported to this Commission as a significant inhibitor to the development of new models of care. Hospital pharmacy has moved toward providing more structured career progression, although this still needs further development. In community pharmacy however, there has to date been no structured pathway to support the development of new roles in giving patient care. This

lack of professional development for pharmacists currently in practice will be important to address as this is the workforce that will largely be providing new roles and models of care.

The Commission heard of the positive reception being given to the new Royal Pharmaceutical Society Faculty, and this clearly has potential to be used to underpin the next phase of developing both the clinical and leadership capacity required for future models of care. The lack of pharmacist prescribers being used actively in primary care to support extended roles is testament to the fact that providing skills development is not enough.

Enabling pharmacists to have the skills and leadership to negotiate and secure funding for new roles and services is equally important, and yet more difficult to deliver, given the history of pharmacists being relatively isolated from wider management and leadership development in the NHS. The examples of where pharmacists are actively prescribing in hospital, primary care and more rarely community pharmacy provide a strong basis on which the roles of pharmacists as prescribers can be further explored with GP colleagues and clinical commissioning groups.

In hospitals and primary care, where arguably pharmacists have made most progress toward fulfilling their potential, the role of the pharmacy technician has developed in parallel. In many hospitals, technicians have taken on more of the dispensing and supply function, and in some areas other functions that pharmacists traditionally performed. This has freed up pharmacists to develop their clinical role, including as consultant pharmacists in areas of specialist care, and as core members of hospital clinical teams. There has however been little or no comparable change to the use of skill mix in community pharmacy, which is in any case harder to do in smaller organisations. Although there are no national data on community pharmacy workforce and skill mix, we heard that in many pharmacies, pharmacists still spend a considerable amount of time dispensing and checking medicines,⁷⁸ rather than providing patient services such as those set out in Chapter 4 of this report. Only with effective use of skill mix in community pharmacies will pharmacists and the businesses that they work for be able to free up the time to deliver a wider range of clinical services.

78. Davies JE, Taylor DG, and Barber N. (2012). What do community pharmacists do? Results from a work sampling study in London. *International Journal of Pharmacy Practice* 20: p40. [Abstract at HSRPP Conference, University College Cork, Ireland]

Community pharmacists are often professionally isolated

Historically community pharmacists have been poorly integrated into local clinical teams and there is often a corresponding lack of awareness amongst other professionals about the potential impact that pharmacists can have on patients' medicines management, care and health improvement. This is exacerbated by the lack of integrated IT systems. This means that when local managers, clinicians and patient groups embark on a programme of service redesign (for example for the care of people with dementia or diabetes) pharmacists are frequently overlooked or only considered in relation to supply.

In recent years there has been work to try and improve relationships and stimulate joint working between community pharmacists and general practitioners.⁷⁹ This is in recognition of the fact that this key professional relationship is often under-developed locally. This may in part be a consequence of the turnover in community pharmacy employees that has detracted from the establishment of longer term working relationships across the professions in primary care. There have also been suggestions made to this Commission that pharmacists can be reluctant to engage in clinical discussions with their medical peers on an equal footing, remaining somewhat unknown and isolated. On the other hand, we have heard of community pharmacists who regularly reach out to local practices, commissioning forums and groups, and thus have been able to establish themselves as important local players in the development of services.

Primary care pharmacists (those based formerly in primary care trusts and now in clinical commissioning groups or commissioning support units) have done a lot already to break down barriers between GPs and pharmacists by working in an integrated way with GPs, nurses and the wider primary care team. Examples reported to this Commission included pharmacists working with multidisciplinary teams to review GPs' patients identified as at high risk of admission to hospital because of their medicines, or working with practices to ensure that people with heart disease are on

the optimum combination of medicines (and at the same time helping GP's achieve their quality and outcomes framework points). There were also examples of pharmacists more strategically helping practices to ensure that their medicines processes are robust so that changes made to patients' medicines in hospitals are safely reconciled onto the GP's prescribing system.

Community pharmacists are less likely to have experienced working in these collective or networked ways, being focused on the delivery of services in their pharmacies (which we have noted earlier are under significant economic pressure) and struggling to find the time and space to get out and develop relationships that in time could lead to the commissioning and funding of other services. This pressure seems to apply equally to pharmacists who own their business, and those working as employees of large companies or pharmacy groups.

It is of note that this 'treadmill' effect reported by community pharmacy is something that is also reported in general medical practice when exhorted to move into federated or networked models of care. This underlines the importance of pharmacy making sure that it is part of wider discussions about care futures, rather than seeking to solve its care and funding problems in isolation. Creating the time and capacity for pharmacists and GPs to get together and work on local solutions will be critical to achieving this and the Royal Pharmaceutical Society and Royal College of General Practitioners joint working offers one way of starting to address this.⁸⁰

The last two decades have seen community pharmacy slowly become more dominated by the largest provider groups.⁸¹ At the same time, the number of locums in the workforce has grown as has the turnover rate of staff. This means that the majority of community pharmacists are now employees or locums.

The pharmacy profession should be keenly aware of factors that risk undermining local relationships, continuity of care and accessibility which are among pharmacy's key assets, and which are critical to new forms of long-term conditions care.

79. Royal Pharmaceutical Society and Royal College of General Practitioners (2011) *Breaking down the barriers- how community pharmacists and GPs can work together to improve patient care* www.rpharms.com/public-affairs-pdfs/RPSRCGPjointstatement.pdf

80. Royal Pharmaceutical Society and Royal College of General Practitioners (2011) *Breaking down the barriers- how community pharmacists and GPs can work together to improve patient care* www.rpharms.com/public-affairs-pdfs/RPSRCGPjointstatement.pdf

81. Health and Social Care Information Centre (2012) *General Pharmaceutical Services in England: 2002-03 to 2011-12* available online at www.hscic.gov.uk/searchcatalogue?productid=9731&q=title%3a%22General+Pharmaceutical+Services%22&sort=Relevance&size=10&page=1#top

Given these factors, it is crucial to have professional leadership which understands the importance of local relationships and can facilitate the development of local networks, alongside a support system that recognises employed pharmacists are often professionally isolated in what can be a highly competitive retail environment.

Pharmacy services are not well commissioned

The absence of a coherent, strategic approach to commissioning pharmacy services, and in particular community pharmacy services, appears to have hampered the development of pharmacists in taking on a broader care-giving role. This is in contrast to the approach taken in Scotland where a systematic national policy of developing pharmaceutical care has been pursued for over a decade, with a clear intention to integrate pharmacists into the NHS as providers of patient care in areas such as minor ailments and chronic disease.

In England, whilst progress has been made in developing local services delivered through pharmacy (twenty nine thousand local enhanced services were commissioned in England in 2012-2013)⁸², and some additional services have been included in the national pharmacy contract, local pilots or proof of concept initiatives have typically been subject to short-term funding that makes it difficult to move even the best initiatives forward. This has clearly been exacerbated by the periodic reorganisation of commissioning arrangements in the English NHS – something that is strikingly different from the organisational stability enjoyed in the Scottish NHS in recent years.

For a profession that struggles to make its voice heard at health policy tables, the recent restructuring of the English NHS has the potential to hamper development further. However, the opportunities offered by such far reaching change should not be ignored. If pharmacists locally can be supported with guidance and strong leadership there may be opportunities for pharmacy that can be levered through new contracting mechanisms and the presence of multiple commissioners of pharmacy services (NHS England, CCGs and local authorities).

Incentives and funding are not aligned to best effect

The nationally negotiated community pharmacy contract is often cited as a barrier to the development of community pharmacy. As box 4 highlights, pharmacy owners are paid a fee for every item they dispense, plus the cost of the medicines, as set by a national tariff. The bulk of the contract is activity-based, so the more medicines a pharmacy supplies the more money it makes. Whilst attempts have been made to introduce patient-focused services through the funding of medicines use reviews and the new medicines service, these have not to date been outcome-based and the medicines use reviews in particular have attracted criticisms of being quantity, rather than quality driven, and having little focus on patient outcomes.

There have been calls for the national pharmacy contract to be better aligned with the general medical services contract used for GPs, and for the quality and outcomes framework of the general medical services contract to be extended to community pharmacy. The lack of aligned incentives can lead to perceived competition and protectionism between GPs and community pharmacists. In primary care, there can also be perceptions that pharmacists are there to save GPs money on medicines expenditure rather than improve patient care, and this perception may have held pharmacists back from working with primary care teams to design and deliver new models of care. We return to the issue of commissioning pharmacy care in Chapter 6 of this report.

82. Health and Social Care Information Centre (2012) *General Pharmaceutical Services in England: 2002-03 to 2011-12* available online at www.hscic.gov.uk/searchcatalogue?productid=9731&q=title%3a%22General+Pharmaceutical+Services%22&sort=Relevance&size=10&page=1#top

KEY POINTS

- Pharmacists, and community pharmacists in particular, are marginalised within the NHS, and not sufficiently integrated into care teams
- There is a poor level of understanding among the public, and within the NHS, of the potential role of pharmacists, and the range of services they can provide
- Pharmacy appears to have suffered from a lack of national and local leadership, which is not helped by its tendency as a profession to have multiple groups and factions, and to talk to itself more than to the wider NHS world
- Much has been done to strengthen and extend the training and education of pharmacists and their teams, but this Commission has heard lots about the lack of fulfilling career opportunities for new graduates and of their subsequent frustration
- At a local level, pharmacists often find themselves professionally isolated from the wider primary care team, and lacking time (or permission if employed) to engage in local health service design and development work
- Community pharmacy suffers from poor commissioning of its services, with a lack of courage to fund and incentivise a strategic direction (away from reliance on dispensing and supply towards the delivery of pharmaceutical care) that appears to this Commission to be broadly supported across the profession and NHS
- Pharmacy is similarly marginalised in respect of its funding and contract, with little alignment of its objectives, services and future with that of general practice and other community health providers.

6. WHAT NEEDS TO BE DONE

Pharmacy must advocate for its own future

The public has a high regard for pharmacy, but considers it first and foremost a service for supplying and dispensing medications, this being what most people see and experience. There is low awareness of the range of services that pharmacies increasingly provide, such as advice on minor ailments, prescribing, support for managing long-term conditions such as asthma and hypertension, and public health interventions such as smoking cessation, sexual health advice, and weight management.

This limited awareness of the existing and potential role of pharmacy is not confined to the public. There is evidence that many other health professions lack understanding of the shift that is taking place within pharmacy from a focus on the supply of medicines to a role as giver of care. Where health professionals work closely with pharmacists, as in hospital services or when pharmacists are employed by general practice or clinical commissioning groups, the potential of pharmacy to enhance patient care and wider professional practice is appreciated and understood. Without such direct experience, however, pharmacy remains something of an unknown and misunderstood profession.

The work of this Commission has revealed the relative lack of knowledge about pharmacy within mainstream health policy and management circles. One has to conclude that pharmacy in England has to date struggled to have an impact on the broader health service and policy stage. In interviews with non-pharmacy stakeholders, we heard repeatedly of the marginal nature of pharmacy as a profession, and the fact that pharmacy seems to spend too much time 'talking to itself'. This is easy for pharmacy to do, given the many organisations claiming to represent its interests. The large number of groups arguably gives the profession the ability to distract itself with complex internal politics and debates, thus avoiding the challenge of taking up leadership of the profession and its core purpose at a local and national level. It was however striking that in the work of this Commission, there was a strong sense of consensus from across the pharmacy profession about the importance of focusing on the provision of a wider range of pharmaceutical care services. This makes the lack of

impact by pharmacy in the wider health policy and organisational world even more puzzling – the vision seems to be shared, yet implementation seems to have been just too difficult to make happen.

It is pharmacy itself that has to address this lack of public, professional and policy understanding of its role, purpose and potential by providing a strong, clear and consistent narrative. Local and national leaders of pharmacy have to spell out relentlessly, in practical terms (and using language that non-pharmacists readily understand), the nature of 'pharmaceutical care' or 'medicines optimisation', explaining the services people should expect to receive from pharmacists in the community and in hospital. People need to know that they can have their blood pressure tested and monitored by a pharmacist, medication reviewed and re-prescribed, smoking cessation advice and treatment given, flu jab administered, asthma inhaler technique reviewed and support given, and use the community pharmacy as the first port of call for minor ailments and common health issues.

This narrative of pharmacists as care-givers has to become the 'golden thread' running through all policy and organisational announcements made about pharmacy's future. It is not sufficient for this to be in one or two Department of Health or Royal Pharmaceutical Society policy documents, it has to be at the core of the story that pharmacists tell the public, patients, carers, and health and social care professionals, at every available opportunity. Only if pharmacy believes and owns this view of its future will others understand and sign up to it.

Pharmacy must continue to develop the provision of direct patient services

However powerful and clear the narrative, what will enable people to understand the wider and future role of pharmacy will be experience of a broader range of services. Pharmacy has to find ways to deliver its future, with a much stronger focus on care-giving (health, social care and public health), a modern approach to dispensing and supply that takes full advantage of new technology and skill-mix, and working

constantly to find ways of becoming better integrated into primary, secondary and social care teams.

There are plenty of documents stretching back to the 1970s that set out a vision for pharmacy. What it needs now is to focus on putting this into practice (and not waiting for permission to do this), using the many tools, contracts, and policies available. The fact that so many hospitals, primary care organisations and community pharmacies have developed the models of care described in Chapter 4 shows that as William Gibson said 'the future is here, it's just not very evenly distributed'.⁸³

The current NHS policy context of constrained funding, concerns about quality and safety, rising incidence of long-term conditions, and debate about access to effective out-of-hours and urgent care provides pharmacy with an excellent opportunity to propose and enact local and national service solutions.

To take full advantage of this wider policy context, local leaders of pharmacy (such as those on the new local professional networks established by NHS England)⁸⁴ need to make sure that they work closely with urgent care boards, clinical commissioning groups, and local area teams of NHS England in designing and procuring new forms of urgent and out-of-hours care. Pharmacists in primary, community and secondary care need to be ready, alongside GP, nursing, consultant, ambulance and social care colleagues to bid for contracts to provide new local services. This entails pharmacists forming local provider networks (as groups of pharmacists, or in collectives with other health professionals such as GP or primary care federations) as the entity that can bid and deliver new services. Pharmacy needs to be proactive in setting out what it can do, how and for what resource – waiting to be asked will not work.

Community pharmacy is open long hours (some for 100 hours a week), and is considered accessible to the public, being present in most communities, including those very deprived areas where general practice may be absent. Pharmacies must currently have a pharmacist present in order to supply medicines, and although this means that a highly trained professional is on site for 100 hours a week, the pharmacist will only have time and capacity to deliver care services if more judicious use is made of skill-mix, for example by combining robotic dispensing with the use of accredited technicians. With thoughtful use of technology

and skill-mix, pharmacists can be freed up to become a more extensive care giver, and pharmacies could assume the role of 'local health hub', ideally within a wider primary and urgent care network.

Stronger local and national leadership of pharmacy is needed

Pharmacy is crying out for strong, assertive and consistent leadership at a national and local level. The President of the Royal Pharmaceutical Society, and the Chair of the English Pharmacy Board, need to have the presence and reputations of presidents and chairs of a major medical royal college, representing as they do the third largest group of health professionals in the NHS. The lack of presence and standing of the profession within health policy and management circles reveals an absence of effective direction for and influence by the profession in what is a crowded and complicated policy arena. What is not however needed is a blame game by the many different organisations claiming to lead or represent pharmacy.

Instead, the Royal Pharmaceutical Society should seize the opportunity presented by its establishment of this Commission to draw together a 'leaders' forum' of those willing innovative individuals from different parts of the profession who share the vision of pharmacists as care-givers, and are enthused about getting on and making this happen across health and social care. This forum should lead the development of a narrative for the future of pharmacy, support the roll-out of new models of care, take every opportunity to engage actively in health policy and management circles, and accept that such leadership will not always be popular, but is critical to assure a vibrant future for pharmacy as a caring profession much less reliant on the supply and dispensing of medicines.

Local leadership is equally as important as national leadership, and the new local professional networks established by NHS England offer a real opportunity here, especially given the loss of former pharmacy networks that occurred during the 2013 NHS reforms. Local professional networks must be formed of innovative, risk-taking pharmacists who share the vision of pharmacists as advocates of better medicines use and direct service providers in the NHS and social care. These local leaders

83. The Economist, December 4, 2003

84. Geddes D and Pritchard S (2012) Local Professional Networks (LPNs) NHS England available online at www.england.nhs.uk/ourwork/d-com/primary-care-comm/lpn/

are the ones who can share that vision with GPs, consultants, nurses and allied health professionals, spotting opportunities to design, bid for and provide new forms of health and social care involving pharmacy.

This Commission has been very struck by the relative lack of investment in and development of leaders within pharmacy, and the under-representation of pharmacists on (and ineligibility of community pharmacists to apply for) national leadership development programmes such as the extensive new suite of programmes recently established by the NHS Leadership Academy.⁸⁵ There is an urgent need for investment in leadership development for a new cohort of pharmacy leaders emerging through local professional networks and new models of care, and for professional facilitation and coaching support to be offered to them, including the provision of advice and skills development in how to work with and in wider health care teams, and support in how to design, bid for and deliver new forms of service. These local leaders should be encouraged and supported to explore ways in which they might develop pharmacy consortia or networks, or join GP federations and networks, for this offers significant promise for pharmacists (like GPs) to gain the economies and benefits of providing new forms of care at scale.⁸⁶

Bold commissioning of pharmacy services is vital

There is a need for bold commissioning of pharmacy services that focuses on the delivery of care within a wider strategy for the future of primary and community health and social care. In pragmatic terms, this could start to be put in place initially through locally commissioned (enhanced) and nationally commissioned advanced services (e.g. for common ailments) as part of the current community pharmacy contract.

Subsequent to this, there will likely be a need for bold decisions on the part of NHS England and the Department of Health (the Department of Health retains responsibility for reimbursement of community pharmacies) about how national contracting for community pharmacy will go forward, and how the balance of dispensing and supply, compared with medicines optimisation services will be

struck within a newly commissioned modern pharmacy service that can meet the health needs of the population in a changing and financially constrained NHS. In the medium to long term there will likely be a need for a new outcomes-based alternative contract for general practice and primary care – and pharmacy needs to consider being a core part of this, rather than remaining to one side and potentially becoming further marginalised – that can be assumed by a group or network of primary care professionals (including pharmacists) to deliver a set of local health services for a population, or services for a specific condition (e.g. asthma) or client group (frail elderly housebound). This could perhaps draw on recent King's Fund and Nuffield Trust work on design principles for primary care, focusing on the needs of patients and the population in determining the shape of services to be commissioned.⁸⁷

Any new contract for community pharmacy should be developed in tandem with changes to, or an alternative, general medical services contract that gives local doctors, pharmacists and other professionals the scope to assume population-based funding with which to deliver a wider range of primary and other care. Commissioners at NHS England and in clinical commissioning groups will need detailed advice from local professional networks on how to commission care delivered through pharmacy as part of wider plans for primary, long-term conditions and urgent care.

There is currently significant interest in a new or revised contract for general practice, and in the strategic development of primary and integrated care. This presents a particular opportunity for pharmacy to either align its own contract and funding to the strategic direction of other primary care, or to even plan how to form part of a wider primary care contract. Pharmacy will however find itself side-lined in the development of new services and contracts for primary care, unless pharmacists at both local and national level engage actively in advocacy and influencing, offering specifications for services that can be offered and solutions to local health and funding problems. Large multiple pharmacy providers have an important role to play here, given their organisational capacity to plan and put in place significantly different models of care at scale and pace. But if pharmacy waits to be asked to the negotiating and policy development table, it will be waiting for a long time.

85. NHS Leadership Academy www.leadershipacademy.nhs.uk/grow/leadership-development-programmes/

86. Smith J, Holder H et al (2013) *Securing the future of general practice: new models of primary care* London: Nuffield Trust www.nuffieldtrust.org.uk/publications/securing-future-general-practice

87. Smith J, Holder H et al (2013) *Securing the future of general practice: new models of primary care* London: Nuffield Trust www.nuffieldtrust.org.uk/publications/securing-future-general-practice

There is a range of contractual opportunities for pharmacists

The policy of 'Any Qualified Provider' offers the potential for consortia of pharmacists (either from community pharmacy, or from a mix of hospital, community and primary care) to make offers to local health and social care commissioners, or bid for contracts to deliver services such as minor ailments, obesity management, alcohol advice, sexual health, and smoking cessation. Pharmacists should make such offers to local authorities, NHS England area teams and clinical commissioning groups, and use the health and wellbeing board as a forum to advocate for what pharmacy can do with and for health and social care. It is worth noting that other contractual arrangements, such as local pharmaceutical services,⁸⁸ remain on the statute book and could be used to commission new extended local services.

Pharmacies are registered with the General Pharmaceutical Council as providers of NHS care, so are legitimate bidders for Any Qualified Provider, and also local pharmaceutical services contracts. They are located at the heart of local shopping areas, close to general practices, open typically long hours, and have to have a pharmacist present on the premises, thus offering a professionally-led and accessible primary care service. This can be extended using Any Qualified Provider contracts alongside locally commissioned enhanced services. The challenge for pharmacists is to work in local professional networks and consortia to determine how best to secure funding for services not usually associated with pharmacy. Local professional networks need to focus on how they can design, fund and deliver extended local services, and avoid the temptation of being drawn into endless commentary on the plans of others in the commissioning system. Local professional networks, and national bodies such as the Royal Pharmaceutical Society, with the support of trade bodies and pharmacy owners, should assume a role in advising local groups of pharmacists in how to design, bid for and manage new forms of care.

Commissioning through Any Qualified Provider, and any new alternative contract for primary care or pharmacy should have the possibility of being undertaken with

individual primary, community and/or hospital pharmacists (acting as consortia, community interest companies, partnerships etc.) as well as with pharmacy employers or provider groups (known as 'multiples'). Pharmacists need to be able to regain status as individual professionals, and to do this, may wish to form professional chambers, companies or networks in the way that barristers and other professionals operate, and some GPs are starting to do for the purpose of securing contracts for service provision. This may entail different pharmacy contracts for supply and care. Indeed, the future may see two 'tiers' of pharmacists, those who focus on the supply and dispensing of medicines, and those who take on additional care-giving roles, including prescribing, public health work, and management of long-term conditions and common ailments.

Local authorities are important new commissioners of services

Pharmacy has the potential to be commissioned by local government social services and/or clinical commissioning groups to provide bespoke pharmaceutical care to vulnerable older people in nursing and residential homes, and to those served by home care agencies. This could include support when prescribed new drugs, on-going review and supervision of medicines, repeat prescribing, training for social and nursing care staff, and advice to care providers on medicines use, side effects, and storage.

There is a powerful case to be made by pharmacists for such a role, based on the error rate for medicines in residential and nursing home care,⁸⁹ and the potential of offering tailored pharmaceutical care services to social care and its staff. Whilst many pharmacies already deliver medicines to older people's homes, there is not often any follow-up supervision in respect of whether the drugs are taken properly, monitoring of side effects, advice to carers about medicines use as part of wider primary care for an individual.

Pharmacy can increasingly become a local public health provider, being located in many communities, open long hours, and trusted by the public. Between them, local authorities and clinical commissioning groups could commission pharmacies (individually or in consortia)

88. National Health Service (Primary Care) Act 1997

www.legislation.gov.uk/ukpga/1997/46/part/III/crossheading/pharmaceutical-services

89. Barber ND, Alldred DP et al (2009) *Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people* Quality and Safety in Health Care Vol 18 pp.341-346

to deliver a range of preventive, lifestyle and long-term conditions services. Pharmacy thus can become a 'local health hub' as part of a wider primary and community health network, and a form core part of neighbourhood renewal if it works more closely with communities to engage disadvantaged and marginalised people.

New roles and consortia must be developed by pharmacists

Primary care pharmacists in general practice, the former primary care trusts, and now clinical commissioning groups and commissioning support units, have shown how new roles can be developed which offer professional autonomy, significant team working with other health professionals, and the ability to influence care at a patient and population level. Local professional networks need to explore how to extend primary care pharmacist roles within GP federations and networks, namely within the provision, as well as commissioning domain of general practice.

Some 'scaled up' general practice organisations such as super-partnerships (e.g. the Vitality Partnership in Birmingham and the Own Health Partnership in Sandwell), multi-practice organisations (e.g. the Hurley Group in London) and community health organisations (e.g. Bromley-by-Bow in Tower Hamlets) have elected to employ or contract with pharmacists to deliver medicines management and other advice and support to both professionals and patients within the population covered by these organisations.

Community pharmacy may in some cases become the 'health hub' for the local population, employing or contracting for sessions of other health professionals' time, including nurses, doctors, podiatrists and health educators. In other cases, pharmacists will need to move into general practice and become co-located with, or employed by or contracted to, local primary care teams.

Secondary care pharmacy has to some extent led the way in terms of developing pharmacy services, modernising supply and dispensing, demonstrating clinical and business effectiveness, and gaining clinical and managerial stature within NHS trusts and foundation trusts. As primary

care 'scales up' to meet the challenges of the decade of austerity, improved care quality, and rising demand for out-of-hospital care, so primary care pharmacists need to be at the heart of planning new general practice, pharmacy and other primary care services for local populations.

Federations or consortia offer pharmacists the same benefits offered to GPs by these provider networks.

The autonomy of individual practitioners or organisations can be preserved, whilst gaining benefits of scale such as support for clinical governance, management infrastructure to bid for and run new service contracts, and a population base to deliver a wider range of services across the network.

NHS and foundation trusts can become providers of community and primary care pharmacy

There is potential for NHS trusts and foundation trusts to develop local primary care pharmacy services (especially if community pharmacy proves unable or unwilling to do so), extending trust pharmacy services into the community, especially for frail older people, as has been the case in Northumbria and at the Whittington Hospital in London. Commissioners and local professional networks, as well as hospital providers themselves, should explore the option of trusts and foundation trusts as providers of primary care pharmacy services, using any alternative contract that is developed for pharmacy and general medical services.

The boundaries between community and hospital health services are blurring as a result of the Transforming Community Services policy⁹⁰ which has seen many hospital or mental health providers take on the management of community health care. In a similar vein, some pharmacy groups (the 'multiples') are running aspects of (usually outpatient) hospital pharmacy services.⁹¹ Just as there will likely be variation in how community pharmacy and general practice develop more integrated services (perhaps with more pharmacists becoming employed by or partners in general practice – see Box 9), so we may see different approaches to the development of pharmaceutical and other care across the hospital and community sectors.

90. Department of Health (2006) *Our health, our care, our say: a new direction for community services* London: The Stationery Office
www.official-documents.gov.uk/document/cm67/6737/6737.pdf

91. Royal Pharmaceutical Society (2013) Submission cited in the final report of the RPS Future Models of Care Commission. London www.rpharms.com/futuremodels

Pharmacists must seize the opportunities of technology and skill-mix

Technology is already changing the structure of the supply and dispensing role of pharmacy, as electronic prescribing, robotic dispensing, and new forms of supply chain become widespread. Change of this nature is likely to lead to major structural and skill-mix changes to community pharmacy services, with strong similarities to what has happened with local bookshops and travel agents as a result of on-line sale, supply and distribution. Technology is the potential saviour of community pharmacy, if the profession is able to design and embrace new forms of supply and dispensing and roles for staff, whilst advocating for, and persuading commissioners to purchase, its role in advice and support on medicines use, prescribing, management of long-term conditions, treatment of minor ailments, and support for public health work.

Many of the services and models of care submitted to the Commission call for integration of patient records as the basis for enabling pharmacy to assume a fuller role within integrated pathways of care for patients. The Commission has heard that the technology is already available that allows pharmacists working from a laptop access to the patient's GP record (see Box 9), and it is of note that in Scotland, community pharmacies and GP practices are all electronically linked and that this is being used for the management of medicines in patients with long-term conditions, and for the minor ailments service (see Box 5).

It will be important for pharmacists to embrace opportunities offered by the many routes of communication now available. Skype, text messaging and the telephone are all tools that pharmacists could use to provide support services. In 2008, one in three Finnish community pharmacies were offering their patients the opportunity for medication counselling by email.⁹² Similarly some pharmacy chains in the United States are offering people the opportunity to 'live chat' with a pharmacist on their internet sites. The opportunity to 'live chat' with pharmacists (about contraception or colds and flu) will also form part of a new online service to be launched by NHS England.⁹³

There are lessons to be drawn from the US in this regard, where pharmacists in Walgreens outlets are being brought out to the front of pharmacy stores to offer patient-facing care and advice alongside care navigators, whilst technicians dispense drugs with the support of new robotic technology. Walgreens are also partners in some accountable care organisation pilots, these being pilots where groups of health providers take on a risk-based capitated budget with which to give health care to a defined population. This points again the way to how pharmacies in England could form consortia or federations with GPs and others to assume responsibility for managing care for a population or client group, especially if freed from some of the current workload associated with dispensing and supply of medicines.

If NHS England is prepared to commission a different balance of dispensing, supply and pharmaceutical care, pharmacy employers will need to ensure that they craft roles and careers that are professionally satisfying and assure autonomy for pharmacists in becoming care givers, consultants, prescribers, and public health professionals. This applies equally to hospitals, community pharmacy employers, clinical commissioning groups, general practice organisations and independent pharmacies, for care is increasingly delivered across organisational boundaries, and the dominant health policy direction at present is that of enabling more integrated care for people with complex needs, whether elderly, in a vulnerable family, or living with mental health problems.

There has been more than enough analysis of pharmacy – now action is needed

Pharmacy is in some ways its own worst enemy, having spent over 20 years pointing out that it is under-utilised, writing plans and visions for the future, yet seeming unable to influence in a significant manner the commissioning and implementation of this alternative world.

The work of this Commission has revealed many examples of innovative new services delivered through pharmacy, these having been put in place using existing funding and contractual mechanisms. They bear witness to the

92. Pohjanoksa-Mäntylä MK et al (2008) Email medication counseling services provided by Finnish community pharmacies *Ann Pharmacother* Vol 42(12) pp 1782-90. www.ncbi.nlm.nih.gov/pubmed/19033478

93. e Health Insider (2013) Supply options outlined for renamed ICSP. www.ehi.co.uk/news/primary-care/8888/supply-options-outlined-for-renamed-icsp

initiative of individual pharmacists and their teams, bold local commissioners, and a local culture of 'let's just do it'. This 'can-do' approach needs to be adopted by pharmacy at a local and national level, with strong advocacy about how pharmacy is changing (and is ready to change further) to meet technological, service and professional needs, and how new services will be experienced by patients and the wider population.

Advocacy has however to be supported by action, and pharmacy must get on with this, influencing NHS England, clinical commissioning groups and local authorities to fund new services, using existing contractual mechanisms where possible, and pushing at the boundaries of innovation in organisation and management to call for new funding and contractual approaches alongside GPs and others.

There are important changes required at a national policy level to support pharmacy to rebalance its work to focus more strongly on medicines management and other direct patient care. These include a new alternative contract for population-based care (either for pharmacy, or along with GPs and others), the ability for pharmacists (as individuals or in groups) rather than owners/employers to hold contracts for pharmaceutical care, a national primary care strategy that embraces the potential of pharmacy alongside that of general practice and nursing, and bold and imaginative commissioning that supports new models of integrated patient care.

The main challenge from this Commission is however for pharmacy itself. The profession has to strengthen its leadership at a local and national level, and advocate for its actual and potential role in giving care to a much wider range of people. Pharmacy and its leaders need to achieve the visibility of national medical and nursing organisations in the media and across the NHS, and at a local level, use all available funding and contractual mechanisms to set up new services focused on pharmaceutical care. Only then will the public and other health professionals understand the full potential offered by pharmacy.

7. RECOMMENDATIONS

The Commission found widespread support for the idea of pharmacy extending its role and focusing more on the provision of services to patients and the public. Analysis by pharmacy of what this might look like has not been in short supply over the years, the direction of travel is clear, and yet progress in making change remains far too slow.

Drawing on submissions to the Commission, published research, and conversations with pharmacists and others in the broader health and care system, we set out here what needs to be done to enable the shift towards a greater role for pharmacy in delivering patient care. The Commission has developed recommendations about the changes needed if pharmacy is to flourish in the future and offer the population the range of services it should rightly expect.

Recommendations to pharmacists

Pharmacists and their employers must recognise the imperative to shift their focus away from dispensing and supply of medicines towards providing a broader range of services. They must see their ultimate goal as helping people get the most from their medicines and keeping them healthy.

Pharmacists and employers should not wait for national solutions but should drive change at a local level, proving their case for service provision to clinical commissioning groups, local area teams and local government commissioners by making and winning tenders.

Pharmacists must appreciate the financial constraint and intense scrutiny of quality facing the NHS. They must show how they can meet patient needs better and more efficiently than many existing providers. This will have to be done by developing new services through reallocation of existing funding; there will be no new money.

Pharmacists must collaborate with each other across community, social, secondary and tertiary care and with other healthcare professions, to develop models of care which enable commissioners to deliver integrated patient pathways, and ensure patients have consistent access to support with medicines use as they move between care settings.

Pharmacists should develop networks or professional 'chambers' to pool the expertise, influence and managerial capacity they will need to develop proposals, deliver larger scale services, and work with the increasingly influential federations, networks and super-partnerships in general practice.

Recommendations to NHS England, Public Health England, and the Department of Health

NHS England and Public Health England should work with the Royal Pharmaceutical Society and other leaders of the profession to drive a consistent vision of the future of pharmacy.

NHS England and Public Health England must include pharmacy in plans for the future of out-of-hours and urgent care, public health, and the management of long-term conditions. They will likely need the help of pharmacy leaders here, and should consider seconding innovative local pharmacy leaders into central organisations to provide support.

The Department of Health must take account of the role that pharmacy can play when planning initiatives such as the Integration Transformation fund and the 2014-15 Accident and Emergency fund.

Nationally and locally, NHS England and its local area teams should convene relevant bodies to support and share pilots of new models of care that involve pharmacy. Their goal should be to demonstrate how existing mechanisms such as local pharmaceutical services, enhanced services, any qualified provider, and clinical commissioning group and local government contracts can be used to deliver alternative forms of care.

NHS England should use its national commissioning role for pharmacy to continue changing the balance of funding from dispensing and supply towards medicines optimisation and the provision of new forms of patient care. This may include the possibility of community pharmacy having separate core contracts for dispensing and supply on the one hand, and for service provision in a broader primary care context on the other.

There should be openness by NHS England to pharmacists holding these contracts as professionals, perhaps through networks or chambers, rather than through their employers.

NHS England must be bold in thinking about how pharmacy can form part of any new local population-based contract for primary medical and other care and how the incentives in pharmacy and medical contracts can be aligned. This should include giving full backing to primary care federations, networks and super-partnerships which include pharmacists.

NHS England's pharmacy team needs to ensure that pharmacy forms a core part of discussions and plans about integrated patient records, so that pharmacists can be a central part of new models of urgent, out-of-hours and long-term conditions care in particular.

The Department of Health should work with the NHS Leadership Academy and NHS England to ensure that pharmacists (and those in the community in particular) have full access to the leadership programmes and resources available to other clinical professions.

Recommendations to local commissioners

Clinical commissioning groups should draw on the potential of pharmacy to improve local services, particularly in response to challenges such as urgent care, out-of-hours primary care, and the need to coordinate care for frail elderly (and other) people living with multiple conditions.

Local authorities and health and wellbeing boards should study the best examples of provision by pharmacy as they commission public health and social care services. Pharmacy has a central role to play in the delivery of safe and high quality care to people in nursing and residential homes, and to those receiving domiciliary social care.

Recommendations to the Royal Pharmaceutical Society and leaders of the profession

The Royal Pharmaceutical Society and other leaders of the profession (and there are many of these) should unite around a clear narrative of the role, purpose and potential of pharmacy.

The Royal Pharmaceutical Society must raise public and wider NHS and social care awareness of what people should expect from pharmacy, at the same time making the case for a shift in the focus of funding from dispensing and supply to services that support the effective use of medicines and help people stay healthy.

Pharmacists need stronger, more focused professional leadership, nationally and locally. The Royal Pharmaceutical Society should work with other innovative pharmacy leaders to support networks of emerging pharmacy leaders. It 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 Royal Pharmaceutical Society should accept accountability for moving the profession forward towards a future focused on care delivery, and influencing commissioners and policy makers to enable this. As part of this, it should ask this Commission to reconvene in six months, and again in twelve months, to review progress against these recommendations and to report publicly on this.

APPENDIX I.

CONTRIBUTORS TO THE REPORT

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Submissions to the ‘tell us what you think’ submissions process

All the submissions to the Commission that can be made public (as determined by the individual submitting) are available on the RPS website. The submissions cited in the report are also available in a separate document. We thank all the individuals and organisations who submitted.

The individual names and organisations submitting are listed here.

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APPENDIX 2.

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NOTES

THE ROYAL PHARMACEUTICAL SOCIETY

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain.

The Royal Pharmaceutical Society Future Models of Care Commission brought together expertise from across health and social care to provide a coherent narrative for the pharmacy profession's role in the reformed NHS in England.

You can find out more at
www.rpharms.com/futuremodels

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