

Pharmacy in England

Building on strengths – delivering the future





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Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

April 2008

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Foreword by the Minister of State for Public Health



As the Minister with responsibility for pharmacy, I am able to see how pharmacists make a strong contribution to delivering patient care – offering much more than the safe and effective dispensing

of prescriptions. As Minister of State for Public Health, I value greatly the part that pharmacists play in promoting health and wellbeing. Pharmacies offer readily available professional advice – without an appointment – on self care and the safe use of medicines and, increasingly, services that identify potential health problems (such as health screening) and support healthier lifestyles (such as stopping smoking).

I can also see that pharmacy has the potential to offer so much more. We can build on pharmacy's strengths – in the community, where pharmacies offer healthcare on every high street and in hospitals, where pharmacists are already demonstrating their important role in clinical teams that deliver safe, high quality care to patients.

I know that pharmacists and pharmacy organisations want to be at the heart of plans to deliver a safe, effective and more personalised NHS. We have listened to what pharmacists have to say. This White Paper reflects the views, ideas and innovative working of pharmacists across the country and demonstrates our support and our commitment to working with pharmacy

and others to deliver a practical, achievable programme for future NHS pharmaceutical services. Building on strengths, it sets out how providers will, in time:

- become 'healthy living' centres – promoting health and helping more people to take care of themselves;
- offer NHS treatment for many minor ailments (e.g. coughs, colds, stomach problems) for people who do not need to go to their local GP;
- provide specific support for people who are starting out on a new course of treatment for long term conditions such as high blood pressure or high cholesterol;
- offer screening for those at risk of vascular disease – an area where there are significant variations in access to services and life expectancy around the country;
- use new technologies to expand choice and improve care in hospitals and the community, with a greater focus on research; and
- be commissioned based on the range and quality of services they deliver.

To support this important programme, two new clinical leaders will be appointed who will champion change in hospitals and in the community. This White Paper heralds some major changes. The Government welcomes the views and opinions of the public, patients, consumers, the NHS and the professionals on these changes, and how the proposals here link closely with the forthcoming primary and community care strategy due in the summer. A further consultation document on some of

the key proposals in this White Paper will be published later this year when that strategy is complete, including future requirements for setting up pharmacies that are open for 100 hours per week and proposals for reforming the way in which the NHS contracts for services.

We need to ensure that pharmacists' clinical skills and expertise are an integral part of delivering better services to patients and of work to tackle health inequalities and promote healthier lifestyles.

I am pleased to set out a White Paper which showcases what pharmacy offers now and how it can offer more. The focus is on community pharmacy, but it also covers the important role of pharmacy in other sectors and the services provided by dispensing doctors and appliance contractors.

Finally, I welcome the opportunity to continue working with pharmacy in a way that is open to change and demonstrates that pharmacy delivers effective, high quality and value-for-money services.

A handwritten signature in black ink, reading "Dawn Primarolo". The signature is written in a cursive, flowing style.

DAWN PRIMAROLO MP
Minister of State for Public Health
3 April 2008

Executive summary



1. This White Paper sets out a vision for building on the strengths of pharmacy, using the sector's capacity and capability to deliver further improvements in pharmaceutical services over the coming years as part of an overall strategy to ensure safe, effective, fairer and more personalised patient care. It includes the Government's response to the review of NHS pharmaceutical contractual arrangements conducted by Anne Galbraith, former chair of the Prescription Pricing Authority, which the Government commissioned in 2007. It also considers, where appropriate, views put forward by the All-Party Pharmacy Group's report *The Future of Pharmacy* (published in 2007), and considers the complementary but important work of dispensing doctors and appliance contractors.
2. **Chapter 1** outlines the major role that pharmacists, pharmacy technicians and other pharmacy staff currently play in delivering services in the community, in hospitals, in GP surgeries and clinics, in research and education and in the pharmaceutical industry. It sets out pharmacy's strengths and achievements, and identifies further potential for pharmacy to contribute to high quality patient care and improve the population's health and wellbeing.
3. **Chapter 2** sets out some of the major health and social challenges we continue to face in addressing health inequalities and securing improved health and wellbeing for everyone. It identifies the reforms, designed to create an NHS that promotes good health and both prevents and treats illness, as well as the impact these reforms will have on pharmacy and the delivery of pharmaceutical services. It highlights some key changes, including the important focus on better commissioning of services to meet local population needs, making better and more effective use of resources to deliver the best outcomes and the need to harness new and developing technologies, such as the Electronic Prescription Service (EPS). Annex 1 identifies how and where pharmacy can contribute by providing additional services and support in tackling some of the more pressing challenges.
4. **Chapter 3** looks at how pharmacists – health professionals who have specific expertise in the use of medicines – and their staff are helping to improve access to medicines and to promote their safe and effective use. However, there remains room for improvement in how patients and the NHS can make better use of medicines. A range of proposals are put forward to improve the targeting of medicines use reviews (MURs) and the health outcomes achieved, to achieve further progress on repeat dispensing and to improve the use of medicines. Proposals are put forward

to broaden access to over-the-counter medicines for people in rural areas, and the position of appliance contractors is considered. Pharmacists can play a critical role in promoting the safe use of medicines, in reducing inappropriate hospital admissions and in ensuring that integrated care supports patients as they move between hospital and the community. Pharmacists' expertise can also be capitalised on to tackle persistent problems relating to adverse effects and poor use of medicines, including the costs associated with unused medicines and their safe disposal. Local 'health community clinical pharmacy teams' can make a significant contribution in this respect.

5. **Chapter 4** sets out a vision for service development in the future – one that the Government believes will help to deliver more choice and more modern, effective and world-class pharmaceutical services. This includes pharmacies as centres promoting and supporting healthy living and health literacy, which offer patients – and the wider public – healthy lifestyle advice and support on self care and a range of pressing public health concerns. The Government wants to see pharmacies expand and improve the range of clinical services they offer to people, particularly offering new services for those with minor ailments and long term conditions – e.g. through routine monitoring, vascular risk assessment and support for making the best use of their medicines. To support this new direction, two new clinical leaders will be appointed to champion the development of pharmaceutical services in the community and in hospitals.
6. It is clear that the public has a high regard for pharmacy, yet there remains a need to raise awareness of the many and varied services and benefits offered by pharmacies and pharmacists. **Chapter 5** outlines proposals to develop a communications programme, to support the delivery of key messages to patients, the public, the NHS and others and to improve awareness and understanding of the role of pharmacy in providing services. It also sets out the Government's plans to commission and develop further research into the extent and pattern of use of pharmacy services. In addition, a working group will promote closer working between GPs and pharmacists, through a shared understanding of how their respective clinical roles can help deliver more personalised and effective care for their patients.
7. **Chapter 6** looks at proposals to support research and innovative pharmacy practice, and to promote the development of a sound evidence base that underpins and demonstrates how pharmacy delivers effective, high quality, value-for-money services. The Chief Pharmaceutical Officer will convene an expert panel to advise on research priorities and feed these into the National Institute for Health Research prioritisation processes. It also identifies the need for pharmacy to be open to new ways of working, building on good progress in the use of new technologies and systems in hospital pharmacy and on the experience in community pharmacy of the roll-out of EPS and other initiatives.

8. In **Chapter 7**, the Government makes clear its conviction that, as health professionals, pharmacists remain a significant untapped resource for delivering accessible services to the people who need them most. As such, the approach to the regulation of pharmacists must be similar to that for other clinical professions – that is, in a way that safeguards patients and the public and supports the strategic development of high quality pharmacy practice. The chapter sets out:
- action to establish a new professional regulator, the General Pharmaceutical Council (GPhC);
 - how the Government looks to the profession itself to develop strong professional leadership to support and sustain pharmacy at this critical time of change, including opportunities now available to pharmacists to become prescribers, to develop special interests in defined clinical areas or to practise as consultant pharmacists; and
 - changes in education and training that will help to ensure that pharmacists have the clinical competencies to deliver the types of services needed in the future.
9. To support the deployment of pharmacists' clinical skills, the Government is taking forward legislative changes that promote the better use of the pharmacy workforce – pharmacists, pharmacy technicians and other pharmacy staff. The Government will begin discussions with representative bodies on professional standards for appliance contractors.
10. The Government is inviting views on how, with others, it can support and help deliver this vision for pharmacy. **Chapter 8** puts forward a number of proposals for changing the current structure to enable and lever change. These include the Government's response to Anne Galbraith's review of NHS pharmaceutical services contractual arrangements. The Government's intention is to refocus commissioning away from dispensing services – important as these remain – to a system which rewards high quality and innovative pharmaceutical services. The chapter also sets out the Government's proposals to revise arrangements for new 100 hours per week pharmacies and its preferred option for reform, and considers the special position of market entry arrangements for dispensing doctors and appliance contractors. These will be subject to full consultation later in 2008.
11. Finally, **Chapter 9** sets out the Government's programme to support and deliver change, including further consultation on the detail of some proposals outlined in this White Paper, working in partnership with pharmacists and other health professionals, the public and the NHS. An action plan at Annex 2 describes how the Government will monitor future progress on these commitments.

1

Background



Introduction

- 1.1 In England, most people's first – and sometimes only – contact with a pharmacist is through their local community pharmacy. This can be on the high street, in a shopping centre, round the corner from their GP surgery or where people live or work. The work of dispensing doctors and appliance contractors complements the delivery of pharmaceutical services.
- 1.2 Yet pharmacists, pharmacy technicians and other support staff play a major role across the whole of the NHS – in hospitals and clinics, in GP practices, local primary care trusts (PCTs) and strategic health authorities (SHAs), in education and research and in the pharmaceutical industry.
- 1.3 As the Rt Hon Alan Johnson, the Secretary of State for Health, said in his NHS Confederation Primary Care Network speech on 5 March 2008:
- 'Those who work in primary care – GPs, community and practice nurses, pharmacists, physios, speech therapists and many other professionals – are on the frontline in the battle for better health and wellbeing. If we want an NHS that can prevent as well as diagnose and treat, then this part of the system requires concentrated attention.'
- 1.4 This White Paper sets out the Government's programme for a 21st-century pharmaceutical service. It identifies practical, achievable ways in which pharmacists and their teams can contribute to improving patient care through delivering personalised pharmaceutical services and care in the coming years. It builds on *A Vision for Pharmacy in the New NHS* launched in July 2003 and *Our health, our care, our say: a new direction for community services*, published in January 2006.
- 1.5 The programme has been developed to align closely with the NHS Next Stage Review led by Lord Darzi and the development of a new primary and community care strategy as announced in the interim report in October 2007. The strategy is to be published later this year and will inform development of the proposals set out here, which the Government will continue to review and refine.
- 1.6 The White Paper also provides the Government's response to the review of NHS pharmaceutical contractual arrangements commissioned in 2007 and conducted by Anne Galbraith. Her report is published alongside the White Paper today. In addition, the White Paper takes account of the recommendations of the All-Party Pharmacy Group's report *The Future of Pharmacy*, published in June 2007.
- 1.7 As part of the development work to align pharmacy with the primary and community care strategy, the Government intends to publish, for consultation later in 2008, fuller information on a number of proposals for structural change that are set out in Chapter 8.

1.8 That consultation will comprise both actions to be taken in the medium term – including any necessary revisions to primary legislation – and actions to reform the current regulatory system pending those revisions.

Strengths of the current system

1.9 The Government believes that current arrangements have a number of key strengths which are important to maintain and develop further in taking forward reforms:

- There is a readily available network of trusted health professionals and their teams based in the heart of communities to promote health and wellbeing, help people look after themselves better, prevent illness and provide essential treatments for those with short or long term illnesses. People can readily access a wide range of medicines and other healthcare products and advice over the counter.
- Community pharmacies are easily accessible. The latest information shows that 99% of the population – even those living in the most deprived areas – can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport. The position has improved substantially for those in the 10% most deprived areas,¹ suggesting that pharmacies have opened in or near deprived areas that previously had poorer access.
- Pharmacies are open at times which suit patients and consumers – many late into the evenings or at weekends. Since April 2005, over 400 new pharmacies have been approved to open for at least 100 hours per week, every week of the year.
- People receive their prescribed medicines promptly, safely and efficiently. Over 750 million items were dispensed in 2006 – more than one item a month for every person in England – and the number is growing by about 5% per year.²
- Pharmacies provide a convenient and less formal environment for those who cannot easily access or do not choose to access other kinds of health service, or who simply want readily available, sound professional advice and help to deal with everyday health concerns and problems. Many pharmacies now have dedicated consultation areas specifically for private discussions.

1 As at 31 March 2007, 96% of the population in the 10% most deprived areas could reach a pharmacy within 10 minutes by walking or public transport, compared with 84% at 31 March 2006. Almost 100% are now within 20 minutes of a pharmacy.

2 NHS Information Centre. *Prescriptions Dispensed in the Community – Statistics for 1996 to 2006: England, 2007*

Recent survey results on use and perceptions of pharmacies³

- Most adults use pharmacies. The term 'pharmacy' is well understood.
- 84% of adults visit a pharmacy – 78% for health-related reasons – at least once a year. Three-quarters of people have visited in the last six months.
- Excluding those who report never visiting a pharmacy, an adult visits a pharmacy 16 times a year, of which 13 visits are for health related reasons.
- An estimated 1.6 million visits take place daily, of which 1.2 million are for health-related reasons.
- Women, those aged over 35 and those with a long term health condition or disability are frequent users.

- England has a highly trained and experienced pharmacy workforce. Pharmacists and their staff have greatly expanded their clinical knowledge and expertise in recent years and continue to do so, but they still have science at the core of their training.
- A new contractual framework for community pharmacy – in place for three years now – began putting a key ambition into practice. That is, for pharmacies not simply to dispense

and supply medicines – essential and important as that is and will remain – but to offer an ever-expanding range of clinical services. This reflects what has already happened with hospital pharmacy services.

- Hospital chief pharmacists are recognised as leading on the safe use of medicines across their organisations. For example, they have put systems in place to ensure the appropriate continuation of medicines on admission to, and on transferring care from, hospital, and for promoting the safe and effective prescribing and administration of medicines during a patient's stay.
- Many hospital pharmacists have developed specialist expertise. This includes prescribing and the best use of medicines for particular groups of patients. It also extends to the preparation of complex medicines, or those that require special environments for assembly, such as cancer chemotherapy or gene therapies.

1.10 The Government believes that these strengths must be cherished and enhanced. They provide a solid foundation on which to build future developments.

³ Community pharmacy use; market research report: www.dh.gov.uk

CASE STUDY**PROVIDING AN INFLUENZA VACCINATION SERVICE**

Spring Pharmacy in London is providing an influenza vaccination service in Hackney – part of a service provided by a number of pharmacies locally. The service helps local GPs to reach their targets for immunising the over-65s and at-risk groups. Community pharmacists have also provided this service to the majority of PCT staff wanting vaccination. Specific training was given to pharmacists about injection and resuscitation techniques, should someone suffer an anaphylactic shock.

Feedback from people has been very positive. They value the convenience of popping into their local pharmacy, which is open for longer hours and at weekends, and not having to wait a long time for an appointment, as they do for an influenza vaccination at the GP surgery. The quality of the pharmacy service has been commended equally by customers and PCT staff.

The service has allowed the pharmacy to support local GPs in looking after the local population's health for the last three years, and has helped the PCT to meet targets. Due to its huge success with people and other healthcare providers, the PCT is now considering using community pharmacies as part of other immunisation activities.

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Pharmacy's potential

- 1.11 Pharmacy has much to offer in helping to meet rising expectations – not only in promoting better health and preventing illness but also in contributing to the effective delivery of care closer to home and in the community.
- 1.12 Therefore, much of this White Paper considers the contribution that community pharmacy can make in order to achieve these goals. However, this is not to understate the valuable and leading role of hospital pharmacists, pharmacy technicians and other pharmacy staff working in other healthcare sectors or in education, research or the pharmaceutical industry, and their continuing contribution to improving the health of the population – either through the use of medicines or through promoting healthy lifestyles.
- 1.13 The White Paper also sets out proposals for reforming those aspects of service delivery by dispensing doctors and appliance contractors, where these correlate with our plans for pharmacy.
- 1.14 Dispensing doctors provide services to patients chiefly in rural areas, meeting the need for dispensing in places where a pharmacy may otherwise be unviable. Their important role in maintaining comprehensive access to medicines for all patients is not to be overlooked. As the role of the community pharmacist develops, so complementary improvements in the work of dispensing doctors should also take place. Appliance contractors – while not able to supply medicines – do, like pharmacies, supply various products such as incontinence

and stoma care aids and their role should develop likewise.

1.15 The Government believes there is still a considerable way to go to improve understanding and knowledge of how providers of pharmaceutical services can contribute even more to everyone's health and wellbeing.

1.16 Further improvements would include:

- promoting better access to pharmacists' expertise on medicines, so that pharmacists and their staff support prompt, safe and effective use of medicines;
- expanding the range of medicines available over the counter to treat the conditions that pharmacists can be involved in;
- pharmacies treating more people for common minor ailments (such as coughs, colds, minor stomach and skin problems) on the NHS;
- recommending the use of the NHS LifeCheck service to help people to assess their own health and undertake behaviour change to support a healthier future;
- timely and opportunistic advice on eating a healthy diet, increasing physical activity, weight management and reducing alcohol intake;
- taking on a much more visible and active role in improving the public's health through provision of stop smoking services, sexual health services such as chlamydia screening and access to contraception, including emergency hormonal contraception (EHC), involvement in immunisation

services, including administration of vaccines, and playing a crucial role in influenza pandemic preparation and crisis;

- supporting people with long term conditions (LTCs) (e.g. diabetes or asthma) to improve their quality of life, health and wellbeing and to lead as independent a life as possible by supporting self care;
- supporting better use of medicines – particularly for those newly starting a medicine for an LTC;
- better choice of services, with pharmacists recognised for their clinical skills and contribution, e.g. blood testing and interpretation of results for cholesterol levels, and helping to deliver screening programmes within national and local guidelines following UK National Screening Committee (UK NSC) recommendations;
- advancing patient care by developing the higher-level competencies of consultant pharmacists, pharmacists with special interests, independent and supplementary prescribers or pharmacists registered as defined specialists on the UK Public Health Register;
- close involvement in developing clinical pathways that support integrated care;

- improving patient safety in hospitals and in the community through pharmacy's leadership on the safe and effective use of medicines; and
- enhancing pharmacy's role in innovation, research and development to improve service delivery.

1.17 Significant progress has been made across many of these fronts over the last ten years. Nevertheless, there is much still to be achieved. The NHS faces pressing health challenges and increasing demands – both now and in the future. There is an urgent need to quicken the pace of change within pharmacy to keep step with developments in medicines, technology and science (particularly genetics and pharmacogenomics) and as the wider NHS itself adapts to meet these challenges and to focus as much on promoting health as it does on treatment. At the same time, providers of pharmaceutical services and their staff need a better understanding of the needs of those to whom they provide services by having processes in place which help them to shape service provision.

What this White Paper does

1.18 This White Paper sets out a reinvigorated vision of pharmacy's potential to contribute further to a fair, personalised, safe and effective NHS. A vision that demonstrates how pharmacy can continue to expand further its role in an NHS that focuses as much on prevention as it does on treating sick people, helping to reduce health inequalities, supporting healthy choices and promoting wellbeing for patients and public alike.

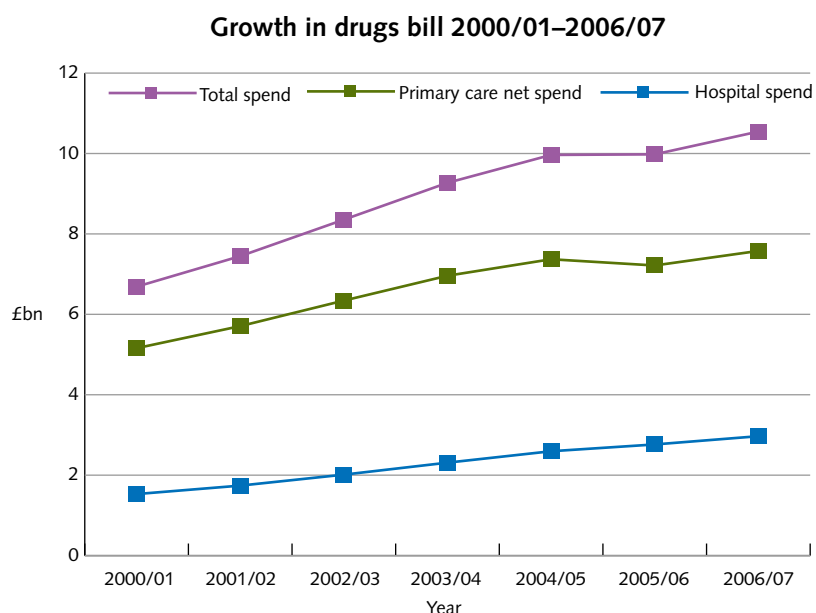
In the community, there are three groups of contractors that provide NHS pharmaceutical services:

- more than 10,000 community pharmacies
- 1,170 dispensing practices with 4,300 dispensing doctors – chiefly for patients who live in rural areas
- 128 appliance contractors (suppliers of appliances such as incontinence and stoma aids, etc. – not medicines).⁴

In 2006, pharmacies and appliance contractors accounted for over 90% of the 752 million prescription items dispensed annually in the community. Dispensing doctors dispensed around 7% of prescriptions.⁵ The remainder were items personally administered by GPs, which lie outside the scope of this White Paper.⁶

The total drugs budget in 2006/07 was approximately £10.6 billion. Of this, around £7.6 billion was spent in primary care and £3 billion in hospital care.⁷

In the last decade, expenditure on primary care drugs has increased by over 60%, or an average of 4.8% in real terms, each year. The volume of medicines prescribed in primary care rose by an average of 4.5% each year. These increases are likely to continue as more medicines come onto the market and care shifts to the primary sector.



4 NHS Information Centre. *General Pharmaceutical Services in England and Wales 1997–98 to 2006–07*.

5 Prescription Pricing Division (PPD) of the NHS Business Services Authority (NHSBSA) England.

6 Prescription Pricing Division (PPD) of the NHS Business Services Authority (NHSBSA) England.

7 The primary care figures are actual costs rather than just net ingredient costs.

A new contractual framework for community pharmacy

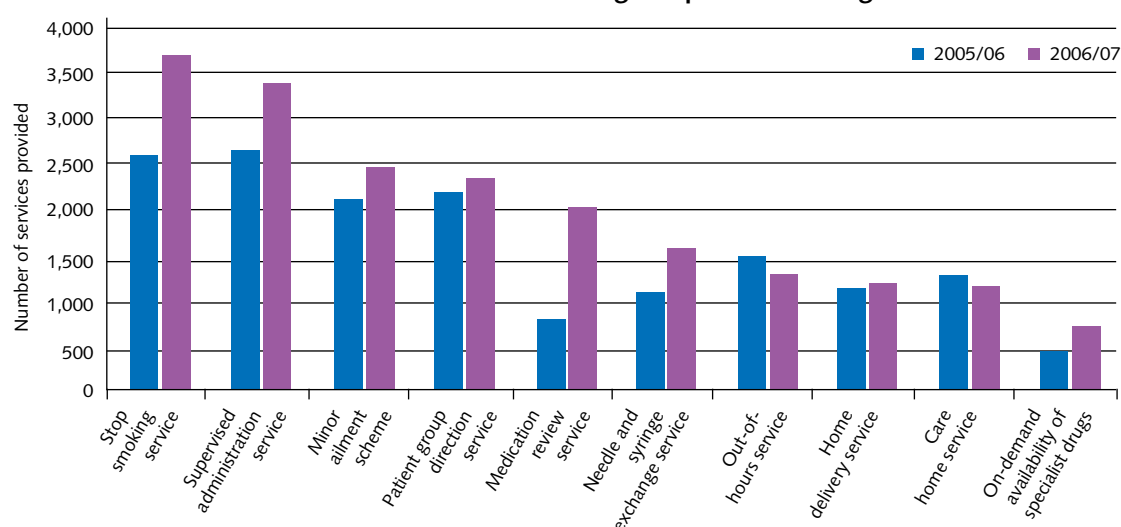
Since April 2005, most community pharmacies have provided services under a new contractual framework with three tiers of services – essential, advanced and local enhanced.⁸ A few have direct contracts with their PCT, known as local pharmaceutical services (LPS) contracts. These arrangements do not apply to dispensing doctors or appliance contractors.

Since October 2005, under the new 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).

Providing the pharmacist and premises are suitably accredited, a pharmacy can also provide **advanced** services. There is one currently – the nationally agreed medicines use review (MUR) service. A pharmacist reviews a person's use of their medicines, offers advice on appropriate use to promote adherence and may make recommendations for changes to the person's GP. Over 1.25 million MURs have been conducted as at February 2008.

A pharmacy can also provide **local enhanced** services, which are commissioned by PCTs. The most common in 2006/07 were stop smoking schemes; supervised administration (of methadone for drug misusers); patient group directions (PGDs), for example to supply emergency hormonal contraception (EHC) or nicotine replacement therapy (NRT); and minor ailment schemes, where someone with conditions like a cough or cold, who would otherwise have visited a GP, can visit a pharmacy for NHS treatment without the need to see their GP for a prescription.

Ten local enhanced services with the highest provision in England in 2006/07



⁸ The relevant legislative provisions are set out in Chapter 7 of the National Health Service Act 2006 and the NHS (Pharmaceutical Services) Regulations 2005 as amended, together with the directions to PCTs set out in the *Drug Tariff* (published monthly by the Prescription Pricing Division of the NHS Business Services Authority).

2

The context for change



CHAPTER SUMMARY

This chapter sets out some of the major health and social challenges we continue to face in addressing health inequalities and securing improved health and wellbeing for everyone. The chapter:

- identifies the reforms, designed to create an NHS that promotes good health and both prevents and treats illness, as well as the impact these reforms will have on pharmacy and the delivery of pharmaceutical services; and
- highlights some key changes, including the important focus on better commissioning of services to meet local population needs, making better and more effective use of resources to deliver the best outcomes and the need to harness new and developing technologies, such as the Electronic Prescription Service (EPS).

Annex 1 identifies how and where pharmacy can contribute by providing additional services and support in tackling some of the more pressing health challenges ahead.

NHS reform

2.1 *Our health, our care, our say*⁹ set a new direction for NHS and social care services to improve the health and wellbeing of the population. It focused on a strategic shift to locate more services in local communities, closer to people's homes. Both the NHS and the healthcare professions are undergoing reforms to ensure that service provision and future systems reflect the importance of an NHS that promotes good health and prevents as well as treats illness. These reforms also impact on pharmacists and the delivery of pharmaceutical services.

2.2 The NHS Next Stage Review interim report, published in October 2007, builds on the progress made in delivering this vision. The focus is on an NHS that is clinically driven, patient-centred

and responsive to the needs of local communities. It sets out a vision for a primary care and community services strategy to match these ambitions, with actions to:

Dr David Colin-Thomé OBE – National Director for Primary Care:

“I have long believed that community pharmacy is an underutilised source of patient care, for example in helping and monitoring patients with long term conditions. I am sure that this White Paper, alongside the forthcoming primary and community care strategy, will begin to unlock some of that capacity so that pharmacy can take its rightful place as part of the primary care team.”

⁹ Department of Health. *Our health, our care, our say: a new direction for community services*, 2006: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453

CASE STUDY

'HEART MOT' SERVICE

There is a gap in male life expectancy (MLE) in Birmingham against comparative city areas in England, and improving MLE is a major challenge for the city. Supported by the Birmingham Health and Wellbeing Partnership and on behalf of Birmingham primary care trusts (PCTs), South Birmingham PCT commissioned a community pharmacy opportunistic testing service for vascular disease – a 'heart MOT'. The service was developed and piloted with Lloydspharmacy and has now extended to 24 pharmacies, including independently owned pharmacies.

The heart MOT service is targeted towards those aged over 40 years old in the local population and aims to identify individuals with an increased vascular risk. The service measures the risk of developing vascular disease over the next 10 years and takes into consideration multiple risk factors including age, gender, ethnicity, total and high-density lipoprotein (HDL) cholesterol, blood pressure, blood glucose, body mass index (BMI) and waist circumference.

Vascular disease risk is calculated and the pharmacist discusses the results with the patient. Lifestyle advice is provided and all patients are given an information pack containing advice on a healthy diet, getting active, sensible drinking and stopping smoking. If appropriate, the person is referred to their GP practice.

Of those people who have attended the service to date:

- 57% were male (with a high level of uptake in deprived areas with poor male life expectancy);
- 2% of patients were not previously registered with the NHS or a GP;
- 49% were referred to their GP practice; and
- 28% were referred to their GP practice due to a high vascular disease risk (of which 82% were male).

These initial results confirm both the value and need for the service, and the valuable role community pharmacy can play in helping to address health inequalities by providing access to a service in hard-to-reach communities.¹⁰

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- address health inequalities;
- promote good health and prevent ill health;
- build services around the people's needs; and
- drive up standards and quality and promote an environment that rewards improvement.

¹⁰ The Government is bringing forward plans to build on activities like this and introduce a universal programme covering a broader range of vascular conditions.

Commissioning for health and wellbeing

- 2.3 An important strand to underpin the strategy is a focus on better commissioning. Commissioning must shift towards achieving more personalised services that promote health and wellbeing, proactively prevent ill health and work in partnership to reduce health inequalities and achieve the best outcomes for all.
- 2.4 In December 2007, the Government published the vision and competencies for World Class Commissioning with the overall aim of delivering outstanding performance in the way health services are commissioned. These comprehensive documents were developed with both the NHS and key stakeholders. Work is underway to develop a nationally consistent assurance system, to be overseen by Strategic Health Authorities, to assess and develop PCTs as they move towards World Class Commissioners. Supporting documents and tools will help PCTs with the process. Ultimately, World Class Commissioning will deliver better health and well being, care and value for all.
- 2.5 As part of the world class commissioning programme, **the Government will work with the NHS and relevant partners to identify how to apply the world-class commissioning competencies to the commissioning of pharmaceutical services, and how to support PCTs in developing their capability and capacity accordingly.** This will help PCTs to ensure that all those involved in commissioning pharmaceutical services, including pharmacists, have the necessary skills

and competencies and that primary care is properly reflected in the assurance framework and in the support and development framework for PCTs.

Ensuring value for money

- 2.6 Investment in the NHS is at record levels. In the last decade, services have been transformed, with more staff, reduced waiting times and new treatments available. NHS funding has seen unprecedented growth, and will reach £110 billion by 2009/10, representing some 9% of public spending. However, the rate of growth will not be as great from now on and for the foreseeable future. Therefore, the need to ensure best use of these resources to meet the challenges and increasing demands in the future means that the NHS must be in a position to ensure that it buys the best services to deliver the best outcomes. Pharmacy is no exception.
- 2.7 If pharmacy is to thrive in this environment, it will need to be aware of developments in wider NHS healthcare provision, but particularly its impact locally, and have processes in place to understand the likely impact on skills and service provision. This is clear from the Birmingham example opposite, in terms of the additional referrals to local GP services that improved access to the 'heart MOT' is resulting in. In addition, improvements in access to services through pharmacy carry potential increased costs that may not be realised through efficiencies and savings in other parts of the system. Therefore, it is not enough to operate simply by providing a minimum level of service; what is needed is pharmacy's active involvement

and planning at all the relevant stages of interaction with the patient.

Information technology

2.8 The National Programme for IT in the NHS, being delivered by NHS Connecting for Health, is helping the NHS – including community pharmacy – to increase efficiency and effectiveness via new services such as the Electronic Prescription Service (EPS). Further, it will enable clinicians to deliver better and safer care to patients, with services such as the NHS Care Records Service giving healthcare professionals access to patient information in a secure and timely manner.

- 2.9 EPS, in particular, will deliver significant benefits for patients, prescribers and dispensers by:
- making it more convenient for patients to get their medicines, by reducing the need to visit the GP surgery to collect repeat prescriptions;
 - replacing paper prescriptions with electronic ones so that pharmacists and others can dispense against them and, in time, submit them to claim payments due; and
 - improve patient safety by reducing illegible or incomplete prescriptions.

2.10 EPS is an essential service to be provided by all NHS community pharmacies under their contractual framework. Progress continues to be made, with more than 73 million electronic prescription messages transmitted so far, and 79% of community pharmacies and 64% of GP practices now able to operate Release 1 of the EPS.

The health challenges ahead

2.11 The health of the population has improved substantially over the last decade, with life expectancy at its highest recorded level. The premature mortality rate from vascular disease has fallen by more than 40% since 1996 and from cancer by almost 17%.

2.12 However, changes in society create new challenges and some problems remain stubbornly in place.

Tackling health inequalities

2.13 Action to halt widening health inequalities is the key priority for the immediate future. Such inequalities persist and can show up in different ways, for example in terms of variable rates of life expectancy, how easy it is to access services and the quality of services when they are accessed. There is a risk that these inequalities will become entrenched if action is not taken now to address these. For example:

- death rates from coronary heart disease in people aged 35–64 in the lowest socio-economic groups are almost double those of people in the highest;
- men in the highest socio-economic groups live, on average, eight years longer than those in the lowest; and
- the prevalence of long term conditions across the country correlates with a range of factors that includes age and deprivation.

CASE STUDY

SETTING UP A MEN'S HEALTH SERVICE

Knowsley PCT, where life expectancy for men is three years below the national average, has set up and funded a men's 'health check' service, initially designed for men aged 50 to 65, through local pharmacies. The pharmacies offer a range of health checks, such as blood pressure, blood glucose monitoring and a BMI assessment, as well as general advice on diet, alcohol consumption, stopping smoking and exercise. The PCT provides pharmacies with all the testing equipment and disposables, as well as a training day on the health issues and hands-on use of the equipment. Posters and healthy lifestyle leaflets advertise the service locally.

From a survey carried out immediately after the health check, it was established that of those who participated:

- 96% made lifestyle changes – often such simple changes such as drinking more water or taking more exercise;
- 65% of respondents found getting health advice in a pharmacy to be a new experience; and
- almost 100% said they were very or quite likely to attend a follow-up health check, and would recommend health checks in pharmacies to other men.

As a result, health checks in pharmacies are now being rolled out across the PCT. Participating pharmacies offer free health checks to both men and women aged between 40 and 75 years. More than 1,000 health checks have been undertaken across 14 pharmacies, and the PCT has made a commitment to continue funding the health checks as an enhanced community pharmacy service.

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2.14 The table in Annex 1 describes some of the major challenges and illustrates the increasing role pharmacy can play. These include support for people with long term conditions, including vascular disease, better sexual health and weight management.

3

Expanding access and choice through more help with medicines



CHAPTER SUMMARY

This chapter looks at how pharmacists – health professionals who have specific expertise in the use of medicines – and their staff are helping to improve access to medicines and to promote their safe and effective use. However, there remains room for improvement in how patients and the NHS can make better use of medicines. A range of proposals are put forward:

- to improve the targeting of medicines use reviews (MURs) and the health outcomes achieved;
- to achieve further progress on repeat dispensing; and
- to improve the use of medicines.

Proposals are put forward to broaden access to over-the-counter (OTC) medicines for people in rural areas, and the position of appliance contractors is considered.

Pharmacists can play a critical role in promoting the safe use of medicines, in reducing inappropriate hospital admissions and in ensuring that integrated care supports patients as they move between hospital and the community. Pharmacists' expertise can also be capitalised on to tackle persistent problems relating to adverse effects and poor use of medicines, including the costs associated with unused medicines and their safe disposal. Local 'health community clinical pharmacy teams' can make a significant contribution in this respect.

Introduction

3.1 This chapter sets out the developments in improving access to medicines, support and information for people so they can take their medicines to best effect and the provision of more integrated services to benefit patients and their carers. Among the challenges that need to be addressed are:

- ensuring the more effective use of medicines;
- people who need urgent access to medicines not always getting them when needed;
- accessing the right medicines at the right time, which is of crucial importance for people at all stages of their lives and especially in end of life care;

- preventing the one in twenty hospital admissions that can be avoided with proper medicines use; and
- too many problems with medicines for people leaving hospital and returning home.

3.2 By constantly striving to improve these areas, the Government believes that considerable progress can be made to reduce the persistent problems of poor use and wastage of medicines, of unintended side effects which deter people from taking their medicines as intended and of inappropriate hospital admissions.

CASE STUDY

MEDICINES MANAGEMENT IN CARE HOMES

Care home residents have significant health needs and can require a great deal of support from both primary and secondary care services. In November 2004, Chorley and South Ribble (now Central Lancashire) Primary Care Trust (PCT) identified four care homes in a defined area of South Preston that are mainly supported by three GP practices. Louise Winstanley, a pharmacist practitioner (also qualified as a supplementary prescriber) and Wendy Brennan, a nurse practitioner (also qualified as an independent and supplementary prescriber) took a proactive approach in developing a support service for these care homes. One of the care homes is mixed residential and nursing, two are residential and the fourth is a nursing home. The nurse clinician spends half a day each week in each home and is available for urgent visits within normal office hours. She requests tests, can refer residents to other health professionals, regularly monitors the residents and liaises between the care home and the GP practice. The pharmacist practitioner provides medication review, undertaken jointly with the resident, care home staff and the nurse clinician. In this way, there is proactive three-monthly monitoring and review of medicines for those living in these care homes.

All the main parties have welcomed the service and found it to be helpful, effective and informative, especially the GPs and the care home staff. Audit data have shown:

- a reduction in GP callout of 96.2% for Practice 1, 93.6% for Practice 2 and 89.7% for Practice 3 (these figures do not include GP visits where the homes have contacted the surgeries directly. The estimated cost of a GP callout is around £50, so the cost of health professionals was more than compensated for by savings in GP time);
- a 7% reduction in hospital admissions, with potential saving of £18,564;
- a reduction in the total number of falls by an average of 32%; and
- a reduction in the number of fractures of 60% for total fractures and 80% for hip fractures – four fewer hip fractures give a saving of £56,160.

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Tackling problems to ensure the effective use of medicines

Better use of medicines

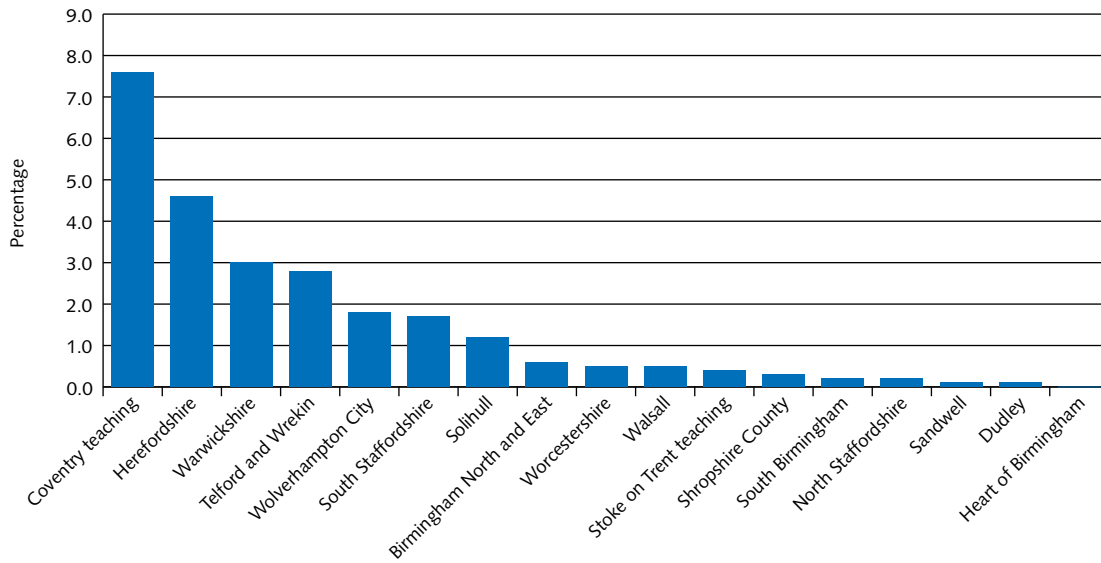
3.3 Within the current community pharmacy contractual framework, services at a national level that are particularly designed to help people to use their medicines effectively are medicines use reviews (MURs) and repeat dispensing.

3.4 A number of concerns have been identified in delivering these services. This section sets out what action the Government proposes to undertake in order to develop the contractual framework further.

Medicines use reviews

- 3.5 MURs are one-to-one conversations between people and pharmacists that are designed to identify any problems a person is experiencing with their medicines (e.g. remembering which medicines to take when and in what order, or any difficulty with swallowing pills). If appropriate, the pharmacist will make recommendations to the patient as to how they can get more benefit from their medicines, or will make recommendations for change to the person's prescriber.
- 3.6 MURs provide the opportunity to improve people's use of their medicines, reducing wastage, improving their health and reducing unnecessary hospital admissions. However, funding, while capped, currently rewards the volume of MURs undertaken, leading to PCTs being concerned that they are not being targeted to local needs and patient priorities, and that the quality of MURs is inconsistent.
- 3.7 Yet pharmacies have invested in facilities and training to carry out MURs. As at February 2008, more than 1.25 million MURs have been conducted, at a cost of some £30 million. While these are early days, research shows mixed results. Many people report satisfaction with the service, but at this stage, the longer term impact of MURs on improved compliance with prescribed medicines (and therefore better outcomes) cannot be assessed. This will therefore be one of the priorities for the new Expert Panel on Health Services Research in Pharmacy, to be led by the Chief Pharmaceutical Officer.
- 3.8 In the meantime, the Government proposes two areas within the current structure of the service that should be addressed:
- To make stronger provision for PCTs to prioritise MURs to meet their health priorities locally, including health improvement, and to monitor service delivery more effectively.
 - The funding structure should better ensure that the service is delivering to those who might best benefit, and reward the health outcomes that are achieved.
- 3.9 **The Government believes it is necessary for MUR services to be prioritised to meet health needs and has asked NHS Employers to discuss with the PSNC a mechanism for delivering this and ensuring funding rewards health outcomes.**
- 3.10 Further, the Government wishes to see new arrangements developed to include continuous improvements in service quality via mechanisms such as a peer review audit of MURs and related continuing professional development. There also needs to be effective means for PCTs to monitor delivery and outcomes, so that PCTs are able to decommission these services from pharmacies that consistently fail to meet the minimum agreed quality standards.

Proportion of prescription items as repeat dispensing for PCTs in the West Midlands, Q2 2007/08



Repeat dispensing

3.11 Repeat dispensing is an essential service under the current contractual framework. It is estimated that as many as 70% of all prescription items (or over 500 million) issued annually are repeats. It has a number of proven benefits:

- **Increased patient choice** – people no longer have to go back regularly to the GP practice for a further prescription.
- **More opportunity for early interventions** – before the person receives their next regular supply, the pharmacy ensures that the person is not experiencing any adverse effects and is using medicines correctly and effectively.
- **Less medicines wastage** – the pharmacy carries out regular checks that the person’s medicines are still needed, and if not, liaises with the GP so the medicine can either be stopped or altered.
- **Reduction in GP administration of repeat prescriptions** – reduces the time-consuming administration of repeat prescriptions in GP surgeries.
- **Pharmacists’ integration** – supports pharmacists’ integration as part of the healthcare team.
- **Support and feedback** – encourages greater support for GP practices, with feedback to the GP practice if problems arise, reinforcing confidence that the pharmacy is providing the appropriate service to benefit patients.

- 3.12 Where GPs and pharmacists work closely together, there has been successful introduction of repeat dispensing, and in some areas – e.g. Bristol – around 20% of prescriptions are now being supplied in this way. Other areas are not so advanced. The graph on page 30 shows, for example, the range of repeat dispensing rates across the West Midlands in one quarter in 2007/08.
- 3.13 Nationally, the picture is disappointing. Latest data suggest that only around 1.5% of all prescriptions are issued to be dispensed in instalments through repeat dispensing.
- 3.14 The Government is concerned about this disappointing response particularly as, in the past, GPs have drawn attention to the burden of issuing paper prescriptions. In 2002¹¹ it was estimated that more than two million GP hours could be saved every year by reducing the bureaucracy of issuing prescriptions, and those hours could be spent more effectively in delivering healthcare to patients.
- 3.15 Seminars in early 2008 on implementation identified a number of areas for improvement, including further multi-disciplinary training, support for change management, a national communications programme and resource packs on how to implement these changes.
- 3.16 These seminars also identified the issue that many prescribers were waiting for the deployment of Release 2 of the Electronic Prescription Service (EPS) before initiating repeatable prescriptions. While the Government recognises the benefits that EPS will bring to administering repeatable prescriptions, there are some elements that still need to be considered further, such as patient recruitment and communication between prescribers and dispensers, that need to be addressed locally – whether prescriptions are issued on paper or electronically. Joint working between prescribers and dispensers locally to address these issues will also help with the introduction of EPS more generally.
- 3.17 Therefore, part of the remit for the working group to be convened by NHS Employers, including pharmacy and medical representatives to develop professional working (see Chapter 5), will be to identify and agree mechanisms that can support further incremental implementation of repeat dispensing.**
- Unused medicines**
- 3.18 It is estimated that the current cost of unused or unwanted medicines exceeds £100 million annually. However, robust or up-to-date information on the scale of wasted medicines or a good understanding of why people do not take their medicines as intended is not currently available.
- 3.19 There is significant cost associated with the safe disposal of unwanted medicines. The environmental impact of medicines that are not returned to pharmacies

11 Department of Health/Cabinet Office. *Making a Difference: Reducing Burdens on General Practitioners (GPs) – Second Report*, 2002: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4002904

or GP practices for safe disposal and which end up in landfill sites is also an important consideration.

3.20 One of the recommendations of The National Audit Office (NAO) Report *Prescribing costs in primary care*, published in May 2007 (www.nao.org.uk) is that the Department of Health should update the 1996 survey of unused medicines.¹² The NAO considered that this would help to provide a more robust estimate of the scale of medicines wastage in England, as well as better information on why people do not take their medicines. To date, the limited evidence available seems to suggest that there is no single reliable predictor of adherence.

3.21 The Government is therefore commissioning research, to be undertaken in 2008/09, to establish the extent to which medicines are not used and to determine the varied and complex reasons why people do not take their medicines as intended. The outcome of this research, which will be available in 2009, will inform what future action needs to be taken to reduce waste.

Other initiatives to support people's adherence to medicines

3.22 A significant proportion of medicines is estimated to be wasted due to intentional or unintentional non-adherence. The reasons can be simple. For example, a person forgets to take their medicines at the right time or in

the right order, or is confused about which medicine is to be taken when or for which condition. Equally, the reasons can be complex – affected by a person's individual beliefs, perceptions and understanding of medicines.

3.23 While the community pharmacy contractual framework funding makes provision for pharmacies to supply compliance support such as monitored dosage systems to help people who have a disability, compliance support is needed more widely. A number of PCTs commission extra services for their local populations to meet this need; there were 329 such services in 2006/07. In addition, many GPs are asked to prescribe on a weekly basis. This supports the provision of a monitored dosage system where medicines are supplied in blister packs which show the day and time the medicine should be taken.

3.24 However, a monitored dosage system is not always the best way to provide people with support to improve medicines adherence. Some people may prefer a medicines administration chart or an alarm that reminds them to take their medicines.

3.25 Furthermore, monitored dosage systems require medicines to be taken out of their original packaging. Yet using original patient packs supports the provision of information about the medicine to the patient through the manufacturer's patient information leaflet and reduces the time the pharmacist and their staff spend

12 Woolf M. *Residual Medicines*, OPCS Omnibus Survey Publications Report 4.

dispensing medicines in monitored dosage systems.

- 3.26 This issue is not straightforward. Crucially, patients and the public have a key interest, as do the pharmaceutical industry and social care. **The Government considers further work is needed to strengthen the commissioning of services to support adherence to medicines and will therefore take forward, in partnership with interested parties, discussions on appropriate measures.** This will take account of the suitability of original packaging to support people, together with any implications for wider social care.

Professor Sir George Alberti – Clinical Director for Service Design:

“During all my discussions on reforming the way urgent care is delivered to patients, the availability of medicines out of normal hours has always come up as a critical issue. This White Paper will begin to help solve this problem so that patients can quickly get the medicines they need irrespective of when they might need them.”

Access to urgent care and urgently needed medicines

- 3.27 The Government considers pharmacy to be a key provider of urgent care and out-of-hours services to people.

Pharmacy should be considered an important provider of PCTs' integrated urgent care systems locally. Pharmacy can, among other things, provide people with advice and treatment for minor ailments, as well as access to prescription and other medicines. PCTs, as planners and commissioners of urgent care services, should ensure that pharmacy is playing a key role in a set of integrated, easily accessible services that best meet the needs and wishes of its local communities. Pharmacy itself also has a role in ensuring that it develops robust interfaces between other providers of urgent care services, such as general practice, community hospitals and out-of-hours service providers to ensure that people receive a seamless service.

Urgently needed medicines

- 3.28 As long ago as 2000, the Carson review of GP out-of-hours services¹³ identified that patients and their carers sometimes encounter difficulties in securing prompt, easy access to medicines when their pharmacy is closed. It recommended that all providers of out-of-hours services ensure that, where the person needs to start a course of treatment without delay, the full course of medicines should be provided at the same time and place as the consultation. This recommendation was supported in *A Vision for Pharmacy in the New NHS* and more fully developed in *Securing Proper Access to Medicines in the Out-of-Hours Period*.¹⁴

¹³ Department of Health. *Raising Standards for Patients: New Partnerships in Out-of-Hours Care* 2000,

¹⁴ Department of Health. *Delivering the Out-of-Hours Review: Securing Proper Access to Medicines in the Out-of-Hours Period – guidance for PCTs and organised providers*, 2004: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134236

3.29 Urgent access to medicines continues to present problems for some people, especially outside normal working hours. A 2007 survey of people's out-of-hours experience reported that access to medicines was the single most important shortcoming in current service provision.

3.30 Therefore the NHS Next Stage Review interim report in October 2007 gave a commitment to identifying how pharmacies can best support seamless urgent care for people, stating:

'We know that people continue to have concerns about prompt and easy access to medicines, including access to urgent repeat medicines.' (page 27)

3.31 In February and March 2008, the Chief Pharmaceutical Officer, with the Royal Pharmaceutical Society of Great Britain (RPSGB), hosted events in London and Manchester where pharmacists considered this issue in depth. Paragraphs 3.32 and 3.33 summarise the options that were discussed.

3.32 People having access to their routine medicines before it becomes an emergency can be facilitated by:

- making it easier to obtain repeat prescriptions through:
 - allowing patients or carers to telephone a request to their GP practice. In some areas GP practices have established automated telephone requests using a code;
 - developing new ways of enabling patients and carers to order repeat prescriptions electronically;

- further promotion of collection and delivery services by a pharmacy, with the agreement of the patient;
- synchronising renewal of individual medicines on the prescription; and
- moving from repeat prescribing to repeat dispensing, minimising unnecessary trips to the GP surgery, empowering people and enabling community pharmacy to take over supply of medicines on a repeat basis; and

- publicity campaigns to remind people to check their stocks of repeat medicines and to order them in a timely manner – this could be especially helpful during bank holiday periods.

3.33 Medicines that are needed in an emergency or out of normal opening hours may either be medicines that people have been supplied before or ones that are required as a result of an acute/urgent condition.

- Where medicines have been supplied before (for example, people have run out of routine medicines or are on holiday and have left their medicines at home), PCTs, depending on the demand, could consider commissioning from local pharmacies:
 - a supply of repeat medicines under a protocol to be developed between the PCT and the pharmacy; or
 - an emergency supply at the request of the person at NHS expense, provided the pharmacist can be assured that this medicine is the appropriate one for the person.

- Where medicines are needed to treat an acute/urgent condition and the person is not familiar with the medicines, PCTs may wish to consider:
 - expediting the dispensing of an 'urgent' prescription;
 - using local contracting routes to ensure co-location of pharmacies either in an urgent care centre or in accident and emergency; and
 - at times of high demand, sessional support from pharmacists at the out-of-hours or urgent care centres.

3.34 These options – and others – require further debate. PCTs and providers may possibly need to consider a menu of options to meet reasonable needs and circumstances adequately and conveniently.

3.35 A further consideration concerns the Medicines Act 1968, with which supply of any medicine has to comply. The Act does allow for the emergency supply of medicines at the request of the patient without a prescription if the pharmacist is of the opinion that there is an immediate need for the prescription-only medicine (POM), the patient has been prescribed the medicine before and it is impractical to obtain a prescription without undue delay. Even if the supply is considered appropriate, the pharmacist can usually supply five days' worth of medicine. **The Government will consider extending the provision of emergency supply to enable a 28-day supply to be made, subject to full consultation.**

End-of-life care

3.36 In line with the Government's end-of-life care policy to give people the choice to die at home, if that is what they wish, there is increasing use of controlled drugs for pain management in people's homes, as part of symptomatic relief.

3.37 It is important that safe systems are in place to ensure the safety of controlled drugs in the home without compromising pain management in the last days of a person's life, when usage is likely to be greatest. Any process of checking must cause the minimum disturbance or distress to people and family members at such a difficult time, while also ensuring that misuse and harm caused by controlled drugs is minimised.

3.38 A pilot of patient drug record cards (PDRCs) conducted by the University of Birmingham is being undertaken in seven PCTs. This creates a stronger audit trail for controlled drugs in the community. PDRCs are issued with the drugs by the pharmacy on dispensing and completed in the home by healthcare professionals. The cards are then returned to the pharmacy and reconciled at local level and nationally.

3.39 The evaluation report for the PDRC study will be completed by summer 2008. **The Government will consider the findings of the evaluation of PDRCs to determine what, if any, further action needs to be taken.**

- 3.40 Pharmacists in the community, hospitals and hospices are increasingly making a significant contribution to end-of-life care. They are influencing and contributing to the development of pain management and other guidelines. Some pharmacists, especially in the community, support people by advising them about their medicines and suggesting changes to their treatment so that they do not suffer unnecessary side effects and are as comfortable as possible.
- 3.41 Some PCTs are commissioning services from specific community pharmacies in their locality so that they stock medicines that people at the end of their life may need. The pharmacist is expected to provide information, advice and support to patients, carers and clinicians. These pharmacists are also being trained to support nurses and other professionals in the safe use of, for example, syringe drivers. Pharmacists may also refer people to specialist centres, support groups and other health and social care professionals where appropriate.
- Dispensing doctors**
- 3.42 Dispensing doctors provide services to people chiefly in rural areas, meeting the need for dispensing in places where a pharmacy may otherwise be unviable. While this addresses people's needs in relation to prescribed medicines, it can still leave some rural communities travelling substantial distances to access OTC medicines. This is a barrier to self care in these areas and leads to increased pressure on GP appointments that could be alleviated if the person could purchase everyday medicines.
- 3.43 Medicines can generally be broken down into three groupings under the Medicines Act 1968:
- general sale list (GSL) – Section 51;
 - pharmacy only ('P') – those not categorised as GSL or POM; and
 - POM – Section 58.
- 3.44 The first two categories are commonly referred to as OTC. GSL medicines can be sold by anyone, subject to a small number of conditions (Section 53 of the Medicines Act); in particular, the products must come pre-packaged and the premises must be capable of being closed to exclude the public. 'P' medicines have conditions attached to their sale – broadly, they must be sold through a retail pharmacy outlet by or under the supervision of a pharmacist (Section 52 of the Medicines Act).
- 3.45 The restrictions on the sale of OTC medicines in Sections 52 and 53 of the Medicines Act do not apply to doctors in respect of sales to their patients. However, GPs are prevented from selling OTC medicines to their patients through conditions placed in their NHS primary medical services contracts – primarily because the sale of such medicines could be seen as generating a profit linked to a course of treatment recommended by the GP.

- 3.46 While these procedures do offer an element of protection for people, the effect is a system that allows a local filling station or newsagent to sell a packet of paracetamol but prevents the local GP surgery doing the same thing. The position becomes even less tenable when that GP surgery doubles as the local dispensary.
- 3.47 Relaxing this restriction would provide better services for dispensing patients, particularly in relation to 'P' medicines that cannot be bought through ordinary retail outlets.
- 3.48 **The Government believes that there are sufficient grounds to reform arrangements for selling OTC medicines where the GP practice has consent to dispense. This needs to be linked to the broader reforms of dispensing by doctors – see Chapter 8.**
- 20 years. Consequently, the Government has been reviewing the arrangements for the provision of dressings, incontinence appliances, stoma appliances, chemical reagents and other appliances listed in Part IX of the *Drug Tariff* since October 2005.
- 3.51 The aim of the exercise has therefore been to maintain – and where appropriate improve – the current quality of patient care, to ensure that arrangements are fair and equitable and represent value for money for the NHS and taxpayers. Changes in respect of chemical reagents (blood glucose-testing strips) and dressings have already been implemented.
- 3.52 The review work on the supply arrangements for incontinence and stoma appliances is ongoing. It aims to secure good-quality services for people and value for money for the NHS.

Appliance contractors

- 3.49 As already highlighted, appliance contractors, while representing a relatively small part of the pharmaceutical market, nonetheless provide highly personalised services for many people. As Anne Galbraith reported:
- 'These providers are active in what could be deemed a niche market. Whilst patient numbers are fewer, the appliances they provide are critical to quality of life.'¹⁵
- 3.53 It would be inappropriate, in advance of this work being concluded and allowing any finalised new arrangements to bed down, to consider further changes or additional services in relation to incontinence and stoma appliances.
- 3.54 However, it is important that many of the principles outlined in this White Paper in relation to pharmacies should also apply to appliance contractors – for example, ensuring that services are appropriate to local needs, are of high
- 3.50 However, the arrangements for the payments of these items and services had remained largely unchanged for

15 Galbraith A. Review of NHS pharmaceutical contractual arrangements, 2008: www.dh.gov.uk (page 25).

quality and have robust governance arrangements.

Medicines and the transfer of care

3.55 Research has shown that medicines reconciliation will reduce unintended mismatches between people's usual treatment and that prescribed on hospital admission.¹⁶ Hospital pharmacists and their teams therefore need to lead good practice, in line with the National Institute for Clinical Excellence (NICE) and the National Patient Safety Agency (NPSA) technical patient safety guidance on medicines reconciliation for adults admitted to hospital. The National Prescribing Centre has recently published a guide to implementing medicines reconciliation (www.npci.org.uk/medicines_management/safety/reconcil/library/guide_reconciliation.php), which extends the concept to include other transfer of care situations.

3.56 Problems can also arise on discharge from hospital. Ill health does not recognise organisational interfaces and so medicines-related services need to be redesigned to meet patients' needs.

Research has shown that providing people with a written summary of their discharge medicines and encouraging them to share this information with their community pharmacist can lead to a significant improvement in the continuity of medicines-related care.¹⁷ In addition, where primary care and acute providers share a common view on the medicines to be prescribed in certain conditions, the scope for unintended variations in a patient's treatment is likely to be reduced.

¹⁶ School of Health and Related Research, University of Sheffield. *Systematic review of the effectiveness and cost-effectiveness of interventions aimed at preventing medication error at hospital admission*, September 2007.

¹⁷ Duggan C et al. Reducing adverse prescribing discrepancies following hospital discharge, *International Journal of Pharmacy Practice*, 1998, 6: 77–82.

CASE STUDY**TRAFFORD MEDICINES PARTNERSHIP**

The Trafford Medicines Partnership piloted sending a patient discharge summary by eFax – from the hospital pharmacy to a nominated community pharmacy – to help improve adherence and reduce risks.

By receiving this information at such an early stage, the pharmacists are able to ensure that the person receives the most up-to-date medicines and are then able to communicate and explain these changes and any associated information to the care home, the patient's carer or home careworker immediately. The Partnership has developed an assessment tool to establish the most appropriate adjustment for the person's needs. The community pharmacist will discuss the recommendations from the assessment with the patient/carer/social services and inform the GP of the outcome. On a number of occasions, the interventions have raised highly significant clinical issues such as the prevention of a potential overdose of a high-risk medicine.

From April 2008, the hospital expects to eFax 60 discharge summaries a month to 15 local pharmacies, and the next phase of the programme will be to roll this out across Trafford to all pharmacies.

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- 3.57 Arrangements for the transfer of care from hospital back to the community should therefore include communication about new or discontinued medicines and changed dosages. People who are encouraged to share this information with their doctor and community pharmacist should encounter fewer problems with their continuing treatment – in particular, a reduction in discrepancies between the intended treatment regime, the medicines that the person has at home and those that they actually take.
- 3.58 Later in the spring of 2008, the National Prescribing Centre will also issue updated guides on medication review and modernising medicines management. *Towards Personalising Medicines Management* will be a resource for commissioners, organisations and practitioners to support the review and development of services within and across primary, secondary and integrated healthcare settings.
- 3.59 The Government will ask the two new clinical leaders (outlined in Chapter 4) to support NHS Employers and consider the optimal way in which services involving the transfer of care can best be commissioned within the current contractual framework.**
- 3.58 Later in the spring of 2008, the National Prescribing Centre will also issue updated guides on medication review and

CASE STUDY**DISCHARGE BOOKLET (SECONDARY TO PRIMARY CARE)**

The pharmacy team at Darlington Memorial Hospital has designed an award-winning booklet for patients that records all aspects of their disease management and treatment. This has resulted in a dramatic drop in the medication error rate when patients move between primary and secondary care. The booklet actively involves the patient in their disease management and gives the patient the responsibility for ensuring that information is entered by healthcare professionals and is accurate and current.

Prior to introduction of the booklet a study of 300 post-discharged patients at follow-up visits to secondary care had shown that 72% of patients had one or more unintentional changes made to their discharge medicines; of these, 42% had dose variations, 29% had at least one omission error (deletion of a new drug started during hospital stay) and 39% had at least one commission error (addition of a drug discontinued during hospital stay). Twelve months after the introduction of the booklet, less than 2% of patients had experienced unintentional discrepancies from their discharge medication regime due to medication errors – a highly significant reduction ($p < 0.0001$). All types of medication error had been significantly reduced. The use of the booklet also improved therapeutic outcomes and reduced hospital admissions in these patients by 71%.

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Community-based pharmaceutical care

3.60 Over and above this, there needs to be a greater drive to provide more focused pharmaceutical care for those who would benefit most in the community. A number of outcomes can be deployed in commissioning such a service, based not only in terms of improved use of medicines, knowledge and satisfaction but also in terms of prevention and improved health, reduced admissions to hospitals, fewer adverse reactions and greater cost efficiency. Anne Galbraith's report termed this a 'pharmaceutical care management service' (pages 29–30) drawing on evidence presented by the Independent Pharmacy Federation.

A full description of the pharmaceutical care management service can be found in Chapter 4 of Anne Galbraith's report. However, elements include a full medication review aligned with NICE guidance and local prescribing advice and policies, optimisation of the drug regime including reference to the use of OTCs and eradication of food/drug interactions.

3.61 The Government considers that these more sophisticated models of patient-centred care could be developed as an early expansion of the services people should expect to receive, including on being discharged from hospital. However, it requires joint working across primary

and secondary care and hence across services that are commissioned differently.

- 3.62 The Government believes that new alliances between hospital and community pharmacists can and should go further. In the 20 years since the publication of *The Way Forward for Hospital Pharmaceutical Services*¹⁸ in 1988, and its recognition that clinical pharmacy should be practised in hospitals, hospital pharmacy has completed the transition from a service with a product and supply focus to one that is focused on patients and underpinned by clinical practice. Clinical pharmacy brings together the science of pharmacy and the skills of the practitioner to enable patients to receive – and to help other professionals deliver – safer care and more effective treatment. For commissioners, clinical pharmacy also brings the assurance of clinical and cost-effective treatment.
- 3.63 Therefore, if the first transition was to move pharmacists from their dispensaries into the clinical environment of the hospital, the next transition will involve making that clinical expertise available in the location where care is delivered most appropriately. In some cases, this transition will involve hospital pharmacists practising in settings closer to people's homes. In other cases, it will involve hospital pharmacists supporting others to undertake this role. This clinical expertise can be used more widely to help create new 'health community clinical pharmacy teams'.
- 3.64 These 'virtual' teams will build clinical networks to provide an infrastructure for

hospital and community pharmacists, primary care pharmacists, pharmacy technicians and, potentially, other healthcare professionals to oversee and monitor medicines usage and effectiveness. The teams will bring together the expertise and experience needed to support people with long term conditions and provide an overview of medicines and health-related care across both primary and secondary care sectors. Such teams can impact on the number of admissions caused by problems with medicines.

CASE STUDY

TOWARDS A HEALTH COMMUNITY CLINICAL PHARMACY TEAM

In Lambeth and Southwark PCTs, Helen Williams, a pharmacist independent prescriber with a specialisation in cardiac medicines and a background in hospital pharmacy, is working with prescribing community pharmacists to manage the care of patients who have not achieved sufficient control of their hypertension.

In the first five months of the new service, 104 patients were referred, of whom 81 attended a clinic. To date, there have been 81 new consultations and 31 follow-ups.

At referral, just over 20% of the patients had achieved control in line with the Quality and Outcomes Framework's blood pressure targets. This increased to 52% after the first visit, and currently nearly 60% have gained control. The service has been well received by patients, GPs, nurses and other practice staff.

Contact: Helen Williams –
helen.williams11@nhs.net

18 Department of Health *Health Services Management: the way forward for hospital pharmaceutical services*, HC (88) 54.

- 3.65 Wherever clinical pharmacy is practised, the key goals will be patient safety, personalised care, clinical and cost-effective use of medicines and better value. To achieve these in a consistent and equitable manner will require strong leadership to both advance the scope of professional practice and ensure that it is underpinned by appropriate systems of training and succession planning. **The clinical leaders for hospital and community pharmacy (see Chapter 4) will therefore be asked to devise appropriate mechanisms to support implementation in PCTs and to work with NHS Employers on appropriate commissioning arrangements.**

Professor Mike Richards CBE – National Clinical Director for Cancer:

‘I am delighted to support this White Paper on pharmacy. From my own clinical experience as a medical oncologist I know that pharmacy staff have a vital role in ensuring that chemotherapy is delivered safely and effectively. I am sure all cancer teams across the NHS would share that view. Looking forward, I want to see community pharmacy taking a more prominent role in prevention and early detection of cancers.’

Pharmaceutical care for people with cancer

- 3.66 Hospital pharmacy departments have for many years supported the safe care of patients with cancer. For example, chemotherapy is typically a complex regimen of potent medicines. It is critical that the medicines involved are prepared and dispensed accurately, safely and efficiently, through dedicated specialised facilities in hospital pharmacies. Hospital pharmacists and their teams now also play an important role in the strategic planning of cancer services, for example through membership of cancer networks, as well as supporting research.
- 3.67 At present, most chemotherapy is given as an injection requiring these specialised facilities. However, some new chemotherapies are available in tablet form. While all chemotherapy requires very careful prescribing, dispensing, administering and monitoring, it is possible within a multidisciplinary clinical network for oral chemotherapy to be safely dispensed in the community. This saves patients' time, is more convenient for those who may have difficulty getting to their clinic and enables patients to have easier control of their therapy.
- 3.68 **Therefore, the Government expects PCTs to commission well-designed, safe services that comply with the requirements of the *Manual for Cancer Services*¹⁹ and the NPSA Rapid Response Report on oral anti-cancer chemotherapy,²⁰ to meet the needs of people with cancer who can benefit from receiving oral chemotherapy from their community pharmacy.**

19 Available at: www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Cancer/DH_4135595

20 NPSA. *Risks of incorrect dosing of oral anti-cancer medicines*, 2008, RRR001: www.npsa.nhs.uk

Tackling unintended hospital admissions

3.69 As well as the problems some people encounter on a daily basis in being able to take their medicines appropriately, some people may experience more serious complications that result in hospital admission, which could have been prevented.

3.70 The current prevalence of preventable medicines-related hospital admissions is estimated at between 4% and 5% of all admissions.²¹ Yet simple measures can prove effective in reducing medication-related morbidity and the anxiety, inconvenience and costs associated with admission to hospital.

CASE STUDY

REDUCING ADMISSIONS THROUGH TAILORED MEDICINES MANAGEMENT SUPPORT

The medicines management team at Bournemouth and Poole PCT provides a tailored support service to vulnerable people in their own home. The team develops pharmaceutical care plans, which enable people with long term conditions to administer their own highly complex treatments safely. The team accepts referrals from all health and social care professionals and from any member of the public who encounters an older person who, unaided, is unable to take their medicines correctly. The service is supported through a service level agreement with local community pharmacies, who provide enhanced services to support people taking their medicines with aids such as organisers and reminders. The benefits of the service include the following:

- People remain in their own home, avoiding admissions to hospital or long term care.
- People receive education about their medicines and long term conditions, which contributes to compliance with therapy and hence better outcomes.
- Reduction in wasted medicines as people's own medicines are utilised before new supplies of medicines are issued.
- Pharmacies take over the ordering of medicines on a 28-day cycle, preventing people from stockpiling medicines in their own homes.
- Pharmacies all work to an agreed quality standard so that people receive the same level and type of service.
- Support for people on high-risk medicines such as warfarin.
- Prevention of overdose using secure supply methods and assistive technology.

Data from 2004 and 2006 show a reduction in emergency admissions to hospital of 18% and 25% respectively among the client group. In 2006/07, annual prescribing cost savings for the service were £25,631. The annual cost per patient for the service in 2006/07 was £430. The service only needs to prevent a two-day stay in hospital for each patient in order to cover its running costs.

Contact: Pam Grant – pam.grant@bp-pct.nhs.uk

21 Pirmohamed M et al. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients, *British Medical Journal*. 2004, 329: 15–19.

Safety in delivery of services

- 3.71 In pursuing new paths, it is paramount that services are provided within the robust standards and requirements for safety that the public rightly demands of any NHS service. This is a core principle underpinning service delivery.
- 3.72 Through measures being taken forward in the Health and Social Care Bill, not least the creation of the new Care Quality Commission, patients and service users will have an assurance of safety and quality – wherever they choose to be treated across the health and adult social care system.
- 3.73 Health and social care providers – including, for the first time, NHS providers – will be required to register with the Care Quality Commission in order to provide services. The requirements that all registered providers must meet will be consistent across both health and adult social care. Focusing regulation on the levels of safety and quality that those who use services care most about will help to ensure that patients, users and vulnerable groups are protected.
- 3.74 When mistakes occur, they can have serious consequences for people and their families and are distressing for the people involved. Pharmacy will want to assure itself that it is doing everything necessary to address errors, in order to maintain public confidence in services as a whole. This includes ensuring that staff have the right training and support to deliver services to specific standards, such as understanding of and compliance with operational standards for hand hygiene where near-patient testing or the taking of body fluids are concerned. People must be confident that the services they receive are as safe as they possibly can be, that prompt action is taken to deal with specific safety problems and alerts and that pharmacists and pharmacy staff are open with people when things go wrong.
- 3.75 Pharmacy has a good track record here, built on decades of applying and revising high professional standards and principles to ensure that safe operational systems are maintained, continuously improved upon and, where important lessons are learnt, further developed. The Government supports pharmacies through both the NPSA system for the reporting of (and learning from) patient safety incidents and the Yellow Card Scheme for reporting adverse drug reactions, which is operated by the Commission on Human Medicines and the Medicines and Healthcare products Regulatory Agency (MHRA). Pharmacists can continue to support the Yellow Card Scheme by reporting suspected adverse drug reactions themselves and encouraging members of the public to do so. The scheme has now been widened formally to accept patient reports. In addition, MHRA provides drug alerts and drug recall notification when problems with medicines are identified. Pharmacists play an important role in the collection of safety information through discussing with patients the potential adverse effects of their medicines.

- 3.76 The NPSA operates the National Reporting and Learning System. This provides an anonymous reporting system for health professionals. The fourth report of the Patient Safety Observatory suggests that overall preventable harm from medicines could cost more than £750 million each year in England.²²
- 3.77 Hospital pharmacy provides reports via their local NHS trust risk management system (or other local protocol). Community pharmacies provide reports direct, via their local PCT or through their head office. These confidential data are analysed to identify patient safety trends and priorities, and to inform practical solutions. As a result, the NPSA produces alerts, directives and guidance. This includes guidance on designing safe pharmacy services, and, jointly with NICE, guidance for medicines reconciliation on admission to hospital.
- 3.78 Rapid Response Reports are a new type of NPSA publication produced more quickly to reflect the seriousness of the risk they cover. Recent Rapid Response Reports provide recommendations on the safer dosing of oral cancer chemotherapy²³ and reducing the fire hazard associated with topical paraffin products. As pharmacy as a whole increases its clinical contribution to patient care, just as it has in hospitals, so it must contribute to these reporting and learning systems and demonstrate its activities comply with safety requirements.
- 3.79 The NPSA issued five patient safety alerts as part of the 2007/08 work programme on safe medication practice. These covered anticoagulants, liquid medicines, injectable medicines, epidural injections and infusions and intravenous infusions in children (www.npsa.nhs.uk/patientsafety/alerts-and-directives/alerts).
- 3.80 **The Government considers that chief pharmacists of provider organisations, PCTs and other commissioners should have the lead role in ensuring that safe medication practices are embedded in patient care. This includes them:**
- **working with patients, senior managers and other health professionals, including professional bodies, to identify, introduce and evaluate systems designed to reduce unintended hospital admissions related to medicines; and**
 - **working with other senior health professionals, senior managers and Safety Alert Broadcast System liaison officers to ensure that organisations respond to the NPSA and other alerts efficiently and in good time, thereby reducing risk to patients.**
- 3.81 In addition, **the Government has asked the NPSA to host an event later in 2008 to ensure that learning from best practice in the implementation of safety alerts informs future responses.**

22 NPSA. *Safety in doses: medication safety incidents in the NHS: The fourth report from the Patient Safety Observatory*, 2007.

23 NPSA. *Risks of incorrect dosing of oral anti-cancer medicines*, 2008, RRR001: www.npsa.nhs.uk

4

More pharmacy services supporting healthy living and better care



CHAPTER SUMMARY

This chapter sets out a vision for service development in the future – one that the Government believes will help to deliver more choice and more modern, effective and world-class pharmaceutical services. This includes pharmacies:

- as centres promoting and supporting healthy living and health literacy;
- offering patients and the public healthy lifestyle advice and support on self care and a range of pressing public health concerns, including influenza; and
- treating minor ailments.

The Government wants to see pharmacies expand and improve the range of clinical services they offer to people, in particular to those with long term conditions – through routine monitoring, screening and support in making the best use of their medicines. In addition, pharmacies will offer vascular risk assessments. To support this new direction, two new clinical leaders will be appointed to champion the development of pharmaceutical services in the community and in hospitals.

Introduction

- 4.1 This chapter sets out how the Government sees services developing to benefit people in the future, in particular supporting healthy living and improving access to medicines and provision of a more integrated service to people who are taking medicines to help them with long term conditions (LTCs). This will require considerable and sustained effort, determination and resources. The Government believes this is the right way forward to achieve our longer term goal of modern, effective, world-class pharmaceutical services.
- 4.2 How the Government sees this vision developing can be summarised as follows, with pharmacies:
- being repositioned, recognised and valued by all as healthy living and health-promoting centres, promoting health literacy and NHS LifeCheck services, offering opportunistic and prescription-linked healthy lifestyle advice, and providing support for self care and pressing public health concerns, such as smoking, sexual health, diet and nutrition – with public perceptions of the potential contribution being transformed;
 - directing their focus to delivering to people with expanded access to clinical services – especially for those in the most deprived areas – through new, widespread services, such as treating minor ailments and offering vascular risk assessments; and
 - providing more support for people with LTCs – with routine check-ups and monitoring, available on a drop-in basis, together with a new service for those who are starting to take regular medicines to treat their condition for the first time.
- 4.3 Chapter 1 highlighted a number of key strengths in the current system and the significant progress that has been made in just a few years. This represents a

valuable asset bank on which future reforms must build. Nevertheless, there are significant health challenges which have major resonance for pharmacy services and providers, and where pharmacy can and should be a much more visible contributor.

4.4 Anne Galbraith's report describes a pharmaceutical service for the future and what it might offer patients and consumers (see extract below).

4.5 Following publication of Lord Darzi's interim report, *Our NHS, Our Future*, published in October 2007, an Advisory Board was established to help devise a strategy for primary and community care. Ministers appointed the pharmacy director of Lloydspharmacy to the Advisory Board. A pharmacy reference group supported his input. The reference group has, for example, identified how pharmacy could potentially contribute to the various levels of patient care (see figure opposite).

Attributes of a good pharmaceutical service

Accurate

Correct medicine: dosage, patient

Knowledgeable

National and local health policy, ongoing training

Providing value for money

Best use of medicines, concordance and compliance

Professional

Clinical services conform to Royal Pharmaceutical Society of Great Britain Code of Ethics, etc.

Supporting patients

Self care, advice, safety

Convenient service

Commonly prescribed medicines in stock

Personal

Individual advice, confidential, private areas

Informative

NHS branding, notice of services available

Integrated

Working relationships with other professionals, helpful signposting

Accessible

User-friendly, no appointment needed

Evaluation

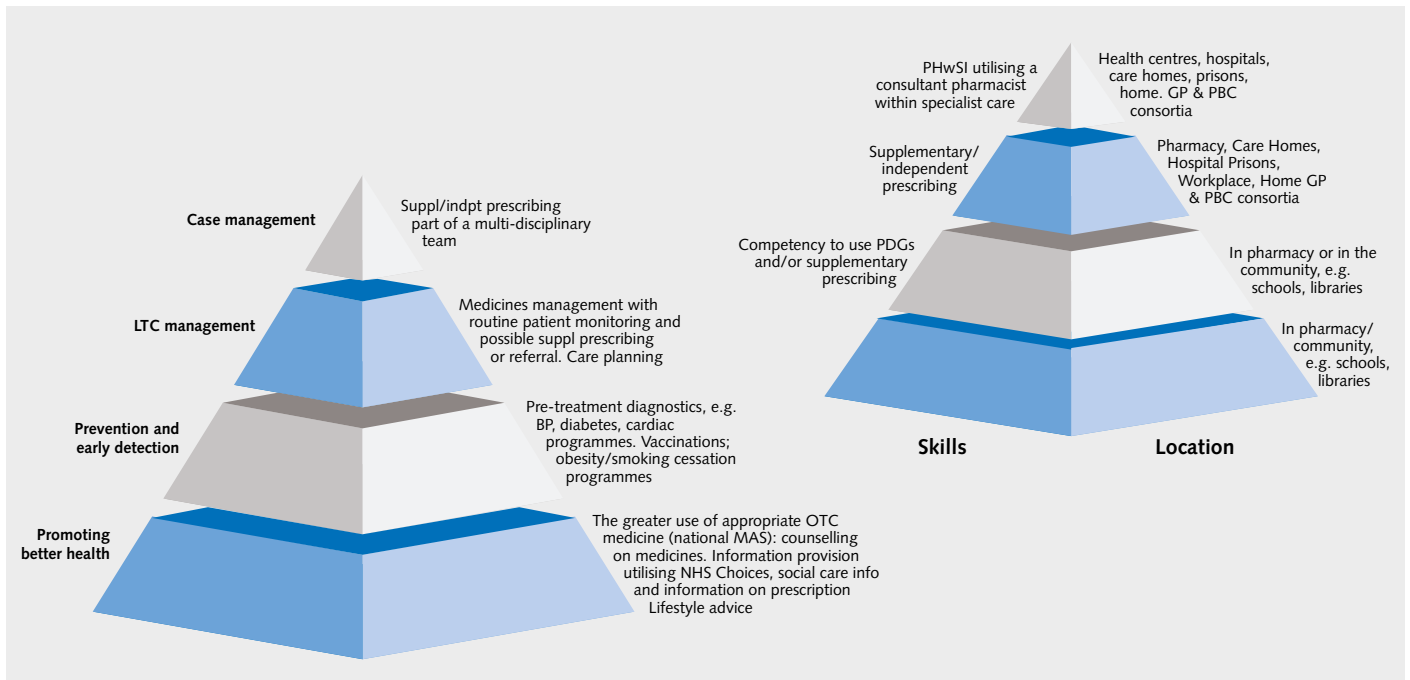
Patient satisfaction surveys, learning from complaints

Full service

All essential services, including advice and public health support

Source: extract from a review of NHS pharmaceutical contractual arrangements – report for the Government by Anne Galbraith.

The potential contribution of pharmacy to various levels of patient care



'Healthy living' centres supporting self care

- 4.6 People have long used pharmacies to get immediate advice and treatment for a range of common conditions. Earlier surveys have reported that many people want a wider range of professionals, such as pharmacists, to provide more support to help them take better care of themselves and their wellbeing. They also want the NHS – as a service – to focus more on prevention, as well as providing treatment and care when needed.
- 4.7 Self care describes the actions people take for themselves, their children and families to stay fit and maintain good physical and mental health. It helps meet social and psychological needs, prevents illness and accidents, and enables appropriate care for minor ailments and LTCs. Self care also maintains health and wellbeing after an acute illness or discharge from hospital. Many people, especially those with chronic conditions, do not want to spend any more time than is necessary visiting their GPs and going to hospital, and many are experts on their own conditions. However, people like to have appropriate support, when needed, to look after themselves. Pharmacists are ideally placed, in the communities that they serve, to provide this support and information. Many pharmacies now have information access points, and the provision of good-quality information is central to help people make informed decisions and better manage their own health.
- 4.8 The survey of public use and attitudes conducted for this White Paper²⁴ found that 14% of people had used pharmacies to treat one-off common conditions, such as colds, coughs, aches and pains, and stomach problems. Pharmacy contractors and commissioners can capitalise on this health intelligence, by providing advice

24 Community pharmacy use; market research report: www.dh.gov.uk

TARGETING HARD-TO-REACH COMMUNITIES WITH PUBLIC HEALTH MESSAGES

Getting health promotion messages to the right people can be challenging. Typically, people who feel well do not visit health centres, clinics and hospitals, so the NHS must look to other outlets to convey messages. In Lambeth and Southwark, community pharmacists are taking part in a local campaign to raise awareness among hard-to-reach groups, particularly men and people from ethnic minorities, about the dangers of untreated hypertension. The campaign uses direct interventions by the pharmacist, backed up with leaflets and posters, to explain how lifestyle changes can reduce the risk of hypertension and to signpost 'at risk' people to local services. The initiative, prompted by research that showed that people in Lambeth and Southwark were 33% more likely to suffer from hypertension than the rest of the population, capitalises upon the core knowledge and skills of community pharmacists, the facilities available in pharmacy premises, and the access that pharmacists have to the 'healthy' population and hard-to-reach groups.

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on safe use when medicines are handed out to help treat the condition or, more opportunistically, when people seek information to help them stay well.

- 4.9 In the last decade, more medicines have become available without the need for a prescription. Providing that patient safety is assured at all times, the Government is keen to develop this further, by reclassifying medicines not only to treat acute, short term, self-limiting conditions but also for chronic disease management, such as:
- the prevention of heart disease – simvastatin is the first medicine to be reclassified for this purpose;
 - the treatment of migraine – of which sumatriptan is the first medicine to be reclassified for this purpose; and

- eye infections – of which chloramphenicol eye drops and eye ointment are the first medicines to be reclassified for this purpose.

4.10 In these ways, a world-class pharmacy will have several distinguishing features. It will be known in local communities:

- as a primary source of accessible, up-to-date, trusted and reliable health advice and information;
- for helping people to stay healthy and to improve their health where needed;
- for routinely promoting self care and for being associated with key public health initiatives, such as influenza immunisation and preventing heart disease;

- for providing new services to help people with acute conditions and LTCs;
- for skilled, knowledgeable, competent and considerate staff;
- as part of a strong local network of health improvement services and 'local leaders' for health in the community; and
- as a wider 'information retailer', helping people to interpret and decide about the many sources of information now available about medicines, as well as providing information about broader health, wellbeing and social matters such as sustainable development.

4.11 How pharmacies individually contribute will often depend on local needs and circumstances. The ways in which pharmacists can contribute include:

- advice when selling products such as stop smoking medicines or dietary products;
- raising awareness of the harmful effects of excess drinking and informing people of recognised sensible limits;
- advice about increasing physical activity easily by, for example, physical exercise, walking up and down stairs, or getting off public transport one or two stops early; and
- information about a healthy diet, helping people to lose weight if necessary.

Dr Fiona Adshead – Deputy Chief Medical Officer, Chief Government Adviser, Health Inequalities:

“I have always been of the view that pharmacists can do more on public health. Pharmacies are located at the heart of communities, and I have no doubt that they will play an important role in helping to reduce health inequalities, as part of pharmacy’s growing contribution to improving the public’s health.”

4.12 In this way, the Government believes that pharmacies will:

- be appreciated and accepted by a much wider range of people as 'natural' local resource centres for their health and wellbeing, especially at times when other service providers are unavailable;
- be well integrated with other health and social care providers and will be part of a local network;
- build stronger local bonds with their customers by promoting a culture of greater health literacy for all – particularly for those who live in areas of greater social deprivation or where significant health inequalities persist; and
- take on a community leadership role, providing positive action that makes a significant contribution to tackling the root causes of health inequalities, by considering wider health determinants, such as fuel poverty and benefits uptake and signposting

to services or hosting other service providers in pharmacy premises.

- 4.13 To support this, **the Public Health Leadership Forum for Pharmacy, co-chaired by the Chief Pharmaceutical Officer and the Head of Public Health Workforce, will identify a work programme for 2008–10 to accelerate pharmacy's ongoing and expanding contribution to health, how it contributes to reducing health inequalities and with a particular focus on community leadership and sustainable development.**

- 4.14 A Public Health Skills and Career Framework has been launched, which describes the knowledge and skills necessary to strengthen the public health competence of the wider workforce, including community pharmacists. It is available at www.skillsforhealth.org.uk/js/uploaded/PHSCF_14Feb08-1.pdf
- 4.15 A draft NHS carbon reduction strategy, due to be published in April 2008 and aimed at all organisations, including NHS pharmacists, highlights the need for all NHS organisations to measure, monitor and reduce carbon emissions.

CASE STUDY

PHARMACY IN THE HEART OF THE COMMUNITY

Tina Cooke has developed her pharmacy as a model example of how a modern pharmacy should support the local community. Her pharmacy, in Sheffield, has been trading in a very socially deprived area for 18 years and is widely viewed as the 'centre of the community'. The area where the pharmacy is located has a high incidence of coronary heart disease, diabetes, chronic obstructive pulmonary disease and asthma and a much lower life expectancy than the more affluent areas of the city. A large proportion of the population are unemployed. The area also has a substantial drug misuse problem.

The pharmacy has a consultation area and diagnostic testing areas, including a private consultation room and a room used for supervised administration of methadone. In July 2005, the local Drug Action Team funded a large controlled drugs cabinet so that staff could extend the number of daily supervised doses of methadone or Subutex. The local 'Turning Point' community drug workers' mobile unit is available close to the pharmacy once a week. In this way, the community receives more services than just supervised administration or needle exchange.

The pharmacy provides all of the PCT's local enhanced services, working alongside a broad range of other healthcare professionals who use the pharmacy's premises and facilities. In this way, the pharmacy is seen by the local community as a leader in healthcare. The pharmacy has received awards from the Sheffield Stop Smoking Service for its local stop smoking service, which led to increased awareness of the service through good media coverage.

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- 4.16 Educational resources on sustainable development will be developed by summer 2008, to help pharmacists work towards a community leadership role. Other resources under development address mental health and sexual health services.
- 4.17 **To help further identify community pharmacists' contribution to public health, the Government will ask NHS Connecting for Health to scope arrangements for electronically capturing information centrally about interventions made or advice given by pharmacists as part of the promotion of healthy lifestyles essential service.** Provision of central electronic data capture arrangements will not be immediate. Local work needs to start now on how best to support the recording of information using, for example, appropriate patient information where needed (such as the NHS number) and recognised clinical coding, such as the Dictionary of Medicines and Devices (dm+d) and Systematised Nomenclature of Medicines (SNOMED²⁵).
- 4.18 If people are to be helped to make informed choices about their health and lifestyle, pharmacists and their staff will want to ensure that their skills and training in brief interventions and behaviour change are up to date. Such skills and knowledge could be incorporated into pharmacists' undergraduate curriculum. This could be achieved by providing input into the Royal Pharmaceutical Society of Great Britain (RPSGB) consultation on the undergraduate curriculum.
- 4.19 The Centre for Postgraduate Pharmacy Education's (CPPE's) continuing professional development programme has used accredited health trainers and CPPE tutors to show how competencies in brief interventions and behaviour change can be used by pharmacists and their staff.
- 4.20 More pharmacy staff can be expected in future to want to become accredited health trainers. However, there may be gaps between the competencies developed in existing pharmacist assistant training programmes and those of accredited health trainers. **The Government will invite pharmacy bodies and employers to consider and come forward with proposals on how they can support pharmacy staff to become health trainers, making appropriate links to the Skills for Health's National Occupational Standards for Health Trainers and the British Psychological Society's Health Trainer handbook.**

Training and health trainers

- 4.18 If people are to be helped to make informed choices about their health and lifestyle, pharmacists and their staff will want to ensure that their skills and training in brief interventions and behaviour change are up to date. Such skills and knowledge could be incorporated into pharmacists' undergraduate curriculum. This could

A minor ailments service

- 4.21 Pharmacy's ready availability in more deprived areas offers enormous potential on which to capitalise and expand access to healthcare services for more disadvantaged groups or those who do not regularly use other health services. In its simplest terms, pharmacies are open later than many GP practices – with

²⁵ This is a common computerised language that will be used by all computers in the NHS to facilitate communications between professionals in clear and unambiguous terms.

many already matching or exceeding the opening hours for new GP-led health centres currently being commissioned.

- 4.22 From the survey of public use and attitudes conducted for this White Paper,²⁶ it is also clear that public knowledge and confidence in what pharmacy has to offer in terms of improved clinical services and facilities needs gradual build-up.
- 4.23 Improved services must therefore be part of a sustained development programme, which in turn must be built on an understanding of the needs of those to whom the service is provided and clarity and agreement of objectives. For example, all pharmacies provide a range of over-the-counter (OTC) medicines to treat minor ailments – for headaches, coughs, colds, etc. Through new products coming on the market and an expanded range of medicines which can now be sold over the counter, pharmacies' contribution to supporting effective self care will grow.
- 4.24 A natural extension is to enable people to access easily a 'minor ailments' service from pharmacies on the NHS. Such a service can include treatment not only for headaches and colds but also for other conditions, such as allergies, head lice, minor skin conditions and common fungal infections (such as thrush), simple viral infections (such as cold sores), eye infections, and pains and strains. As at March 2007, 24% of all pharmacies held such contracts. PCTs, particularly

in deprived areas, have commissioned this service to manage demand on GPs, especially for those people exempt from prescription charges. People are able to visit their local pharmacy and obtain the appropriate medicines on the NHS that would otherwise have been prescribed by their GP.

- 4.25 Such a scheme applied more widely could yield several benefits. People will not need to spend time booking and then waiting for an appointment at their local GP surgery. Some 57 million GP consultations per year are estimated to involve minor ailments and take up to the equivalent of one hour of a GP's time.²⁷ Therefore, such a service, while not releasing cash to use elsewhere, could help reduce pressures on surgeries and free up time for GPs and their staff to treat people with more complex needs. **The Government will examine with PSNC and NHS Employers how best minor ailments schemes can be incorporated within the community pharmacy contractual framework.** Further scrutiny of the evidence is required, before details of this scheme can be finalised – for example, in exploring the likely extent of take-up and how such schemes can be introduced most cost-effectively. However, analysis so far indicates that the cost of medicines supplied by pharmacies for minor ailments may be less than the cost of medicines prescribed by GPs, and that introduction of such a scheme can both meet people's requirements and be cost efficient.²⁸

26 Community pharmacy use; market research report: www.dh.gov.uk

27 Joint paper submitted to the Department of Health by the PSNC and the Proprietary Association of Great Britain, December 2007.

28 Details of the Scottish minor ailments scheme can be found at: www.isdscotland.org

4.26 The Government's proposals for reforming contractual arrangements to introduce this service, subject to this further work, are set out in Chapter 8.

Stop smoking services

4.27 While it is hoped that smoking is set to decline – and significant progress has been made in reducing how many people do smoke – smoking remains the principal avoidable cause of premature death and ill health today. Smoking causes 87,000 premature deaths each year in England, making it the country's single biggest preventable cause of death.

4.28 Action to warn people about the dangers of smoking and encourage those who smoke to give up must therefore continue. Pharmacies have made – and can continue to make – a significant contribution by:

- supporting self care and providing brief advice;
- providing individual support in partnership with local NHS Stop Smoking Services;
- signposting to local NHS Stop Smoking Services; or
- supplying stop smoking medicines under patient group directions.

4.29 In 2006/07, 36% of all pharmacies were commissioned to provide these kinds of services. Just as in other areas of pharmaceutical activity, primary care trusts (PCTs) will increasingly turn to good-quality, comprehensive data and information about their local NHS Stop Smoking Services and how effective they are. This will help them determine the best kind of support to provide locally for smokers who want to quit.

4.30 To support this, the Government:

- has published updated guidance for NHS Stop Smoking Services which includes a clear set of quality principles for service delivery and tighter definitions to be used when determining how many people have quit at four weeks;
- has introduced new data collection items to the quarterly monitoring system, to improve the data available on the performance of local NHS Stop Smoking Services; and
- is considering the viability of establishing a national centre to enhance the standards and consistency of stop smoking training programmes and to aid NHS service development.
- has distributed to all community pharmacies in England educational materials to provide brief advice on stopping smoking to members of the public.

4.31 Increasingly, the Government anticipates local stop smoking contracts will be offered on the basis of clear criteria for service delivery and data reporting requirements. Building on pharmacy's extensive experience in providing stop smoking services and the *NHS Stop Smoking Services: Service and Monitoring Guidance* (published by the Department of Health in October 2007), and *Towards a smokefree England: Brief interventions for stopping smoking by pharmacists and their staff* (published by the Department of Health and PharmacyHealthLink in July 2007) **the Government will ask NHS Employers to examine any further necessary steps to strengthen contractual arrangements so that stop smoking services provided**

in pharmacies show clear evidence of close partnership with local NHS Stop Smoking Services. In this way, service provision will be in line with the quality principles set out in that guidance and will comply with the data definitions and reporting procedures required.

NICE guidance

The National Institute for Health and Clinical Excellence (NICE) published a quick reference guide for stop smoking services in February 2008,²⁹ which provides recommendations for stop smoking services in primary care, pharmacies, local authorities and workplaces, particularly focusing on manual working groups, pregnant women and hard-to-reach communities.

Action to reduce smoking prevalence among people in routine and manual groups where smoking prevalence is above the national average, among some minority ethnic groups and among disadvantaged communities will help to reduce health inequalities more than any other measure to improve the population's health.

Sexual health services

- 4.32 Pharmacies have long provided sexual healthcare. There is growing evidence for their role in chlamydia screening and they are already a primary source of emergency hormonal contraception (EHC).
- 4.33 Genital chlamydia trachomatis is the most commonly diagnosed sexually transmitted infection in the UK. Young people aged under 25 are at highest risk. As most people are asymptomatic, a large number of cases go undiagnosed. Untreated chlamydial infection may have serious long term consequences, especially in women, in whom it is a well-established cause of pelvic inflammatory disease, ectopic pregnancy and infertility.
- 4.34 Independent evaluation of a pilot screening scheme across London in partnership with Boots the Chemist since November 2005 shows considerable promise, with 87% of young people reporting that they would recommend the service. The full report is at: www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/Sexualhealthgeneralinformation/DH_4084098. **Drawing on this evaluation, the Government will publish a national template later in 2008 to support PCTs' commissioning of chlamydia screening from community pharmacies as part of the National Chlamydia Screening Programme.**
- 4.35 In addition, £26.8 million of new funding has been announced for 2008/09 to improve access to the full range of contraceptive methods, to help reduce unintended pregnancies, particularly teenage pregnancy. Strategic health authorities (SHAs) are selecting potential sites with PCTs. **In doing so, the Government will ask SHAs to ensure that pharmacies are included within local schemes. The Government will evaluate these schemes and publish findings to improve access to sexual health services generally and to ensure that robust standards are in place.**

²⁹ NICE. *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities*, February 2008: www.nice.org.uk/nicemedia/pdf/PH010quickrefguide.pdf

Vascular checks

4.36 In his speech on health in January 2008, the Prime Minister announced the development of plans to introduce a system of vascular risk assessment. The aim of the vascular checks programme is to offer a risk assessment for diseases affecting the vascular system, including diabetes and chronic kidney disease, to everyone over a specified age. Analysis carried out by the Government indicates that a programme to reach everybody between the ages of 40 and 74, to assess their risk and to offer individually tailored prevention, will be both clinically effective and cost-effective. This programme should have a significant impact, reducing premature death, disease and disability. It should also make a positive impact on reducing health inequalities, as vascular disease contributes significantly to the mortality gap between the most deprived and least deprived communities in England.

Professor Roger Boyle CBE – National Director for Heart Disease and Stroke:

“*Delivering good healthcare is dependent on the skills of many professionals in the healthcare team. We are planning to introduce vascular risk assessment, and I am delighted that we will be able to use suitable high street pharmacies. Patients will find this very convenient, but it remains important that all healthcare professionals work together to deliver the best care for patients.*”

- 4.37 While some vascular checks already take place in general practice, pharmacies are also well placed to play a key role. The aim of the risk assessment and management programme is to identify the risk of vascular disease in the population early and then to help people reduce or avoid it. **The Government has, therefore, announced a universal programme for vascular checks for everyone between the ages of 40 and 74.** Pharmacies offer an excellent point of contact with the general population, and also offer a place of access to services for groups who may not be registered with GPs.
- 4.38 Vascular checks will be based on straightforward questions (age, gender, smoking, family history, medicines), measurements (height, weight, blood pressure) and a routine blood test for lipids and other factors when indicated. Then, depending on the results, a range of options would be deployed. These would range from offering general lifestyle advice for those assessed as being at low risk, through specific programmes such as weight management and stopping smoking for those at higher risk, to advise to consult a GP without delay for those at the highest levels of risk.

4.39 It is important that pharmacies' work is placed in the context of a risk assessment and management programme, and that pharmacies have clear guidelines about how to move individuals onto whatever stage of support or treatment is indicated for that individual. The National Screening Committee's *Vascular Risk Assessment* handbook³⁰ explains where pharmacy-based screening can fit into overall vascular risk assessment and management, sets out the role of pharmacists and gives practical advice on how pharmacy can support an individual's self-assessment of risk.

4.40 **As the vascular risk assessment programme develops, the Government will discuss with stakeholders, including pharmacies, what delivery arrangements best support implementation to ensure wide availability of this service as soon as possible.** The Government is already working with the PSNC and NHS Employers to develop a national template for a service specification for vascular risk assessment and management as a locally commissioned enhanced service.

Diabetes testing

4.41 Many pharmacies already carry out diabetes testing and the *Vascular Risk Assessment* handbook describes the FINDRISC diabetes risk tool that people can complete with the support of their pharmacist. While testing or risk

assessment are important first steps, they are only part of the story and need to be positioned carefully within an integrated diagnosis, treatment and care plan. **The National Clinical Director for Diabetes and the Chief Pharmaceutical Officer are currently considering how best to maximise the safe and effective contribution of pharmacy, within a team environment, to the care of people with diabetes.**

NHS LifeCheck

4.42 The vascular check could also be accompanied by the offer of NHS Mid-life LifeChecks in pharmacies. The online NHS Mid-life LifeCheck will complement and reinforce the vascular risk assessment, by undertaking a comprehensive lifestyle risk assessment,

Dr Sue Roberts – National Clinical Director for Diabetes:

Diabetes, like other long term conditions, is a disease which needs a team approach to the holistic care and support of patients and their families. Whether signposting to other social or health advice or services, through to working with other practitioners to monitor some of the clinical aspects of diabetes, I am sure pharmacists will have a growing role in helping people with diabetes.]

³⁰ University of Leicester for the UK National Screening Committee. *The Handbook for Vascular Risk Assessment, Risk Reduction and Risk Management*, March 2008: www.screening.nhs.uk/vascular/VascularRiskAssessment.pdf

and will assist users in choosing and undertaking key behaviour changes. Pharmacies can either refer or signpost users to undertake an NHS Mid-life LifeCheck or, where appropriate, assist them in interpreting the information received or in undertaking a LifeCheck at the pharmacy.

NHS LifeCheck

NHS LifeCheck is a new service to be rolled out during 2008 to help users comprehensively assess how their current lifestyle is affecting their health. By using a straightforward computer-based assessment, the NHS LifeCheck helps people to identify what aspects of their lives they need to change, and how to change, and supports them in undertaking that change to protect their health.

A range of pilots are in development, including piloting the NHS Mid-life LifeCheck in the hospital pharmacy of Guy's and St Thomas' NHS Foundation Trust, where people do a LifeCheck on terminals in the waiting room.

The NHS Teen LifeCheck will be piloted in pharmacy settings in summer 2008, where pharmacists and their staff will be asked to recommend a LifeCheck when young people ask for EHC. The NHS Teen LifeCheck assists teenagers in setting behaviour goals to change alcohol use and adopt safer sex.

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People with long term conditions (LTCs)

- 4.43 *Our health, our care, our say* (Department of Health, 2006) made a commitment to improve services for people with LTCs to lead to greater independence, health and wellbeing and more choice. These improvements include: a major focus on support for self care and self-management; the development of an information prescription; established joint health and social care teams; and, underpinning this, improved assessment and care planning. There was also a commitment that, by 2008, everyone with long term health and social care needs would be expected to have an integrated care plan, if they want one. By 2010, everyone with LTCs could expect to be offered a care plan.
- 4.44 LTCs are conditions that at present cannot be cured, but can be controlled by medicines and other therapies. The life of a person with a LTC is forever altered – there is no return to 'normal'.
- 4.45 Over 15 million people – or around one in three of the population – have a LTC. With an ageing population, this figure is set to increase by some 25% over the next 20 years. Many of these people want to play an active role in caring for the condition themselves, with 75% saying that if they had guidance and support from a professional or peer, they would feel far more confident about taking care of their own health. People with LTCs want services that will support them to remain independent and healthy and to have increased choice. They want more services to be delivered safely and

CASE STUDY

SUPPORTING THE MANAGEMENT OF PEOPLE WITH ASTHMA THROUGH THE ASTHMA MEDICINES SUPPORT SERVICE

Many people with asthma accept symptoms as a normal part of living with the condition, and many are unaware of the steps they can take to gain better control of the condition. While primary care makes considerable effort to manage these people, a City and Hackney PCT initiative has demonstrated how community pharmacy makes a direct and meaningful contribution to the management of people with asthma.

The service aims to identify people who are experiencing difficulties with controlling their asthma. It combines the use of a short series of questions, an Asthma Control Test (ACT), with a focused medicines use review.

Of those people reviewed:

- 96% experienced daytime symptoms of asthma;
- 56% were using their reliever inhaler too frequently;
- 41% were forgetting to use their preventer inhaler;
- 52% required further patient information and education;
- 22% needed help with inhaler technique;
- 38% were identified as having poor control due to therapeutic inefficiency; and
- 26% were referred to their GP practice.

At follow-up to reassess asthma control using the ACT, people whose asthma was:

- 'well controlled' increased from 5% to 9%;
- 'reasonably controlled' increased from 36% to 46%; and
- 'not controlled' decreased from 59% to 45%.

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effectively in the community or at home, and they want seamless, proactive and integrated services tailored to their needs. They also want more healthcare professionals, such as pharmacists, to provide them with support and information to help them look after themselves.

4.46 The Government has taken this into account to develop high-level outcomes for people with LTCs. The outcomes are that:

- people have improved quality of life, health and wellbeing and are enabled to be more independent;
- people are supported and enabled to self care and to have active involvement in decisions about their care and support;

- people have choice and control over their care and support, so services are built around the needs of individuals and carers;
- people can design their care around health and social care services that are integrated, flexible, proactive and responsive to individuals needs; and
- people are offered health and social care services that are high quality, efficient and sustainable.

4.47 A framework for commissioners on personalised and integrated care planning will be published later in 2008. This will describe a holistic process that puts the person at the centre and ensures that people, especially those with complex needs, receive co-ordinated care packages delivered by multidisciplinary teams. The framework will describe how information and support for self care and self-management are crucial to the care planning process, and how pharmacists can play an important role as part of the multidisciplinary team, providing information and advice on self care for people with LTCs.

4.48 This is important, as the Government has estimated that the treatment and care of people with LTCs account for 69% of the total health and social care spend

in England.³¹ Research in 1996 reported that repeat prescriptions accounted for 75% of all prescription items and 81% of all prescribing costs.³² For example, 7.1 million people with hypertension and heart disease received 47.7 million prescription items in 2006 with a reimbursement value of £502 million. Approximately two million people with diabetes in England in 2006 received 28 million prescription items with a reimbursement value of £563 million. As roughly half of all people with LTCs do not have a clear plan that lays out what they can do for themselves to manage their condition better, a significant proportion of all medicines are not taken as intended.³³ Pharmacist-led improvements in medicines management may therefore generate significant savings from reduced medicines waste, as well as delivering improved health and wellbeing.

4.49 A 2003 World Health Organization report³⁴ states that there is growing evidence to suggest that: 'increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments'.³⁵ An RPSGB report³⁶ on LTCs indicates convincing evidence of the impact that community pharmacy can have in the care of people with

31 DH. *Raising the Profile of Long Term Conditions Care: A Compendium of Information*, 2008: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082069

32 Harris CM and Dajda R. The scale of repeat prescribing, *British Journal of General Practice*, 1996, 46: 649–653.

33 Opinion Leader Research. *Your health, your care, your say: Research report*, 2006: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127357

34 World Health Organization. *Adherence to Long-Term Therapies: Evidence for action*, 2003: www.who.int/chp/knowledge/publications/adherence_introduction.pdf

35 Haynes RB. *Interventions to help patients follow prescriptions for medications*, Cochrane Database of Systematic Reviews, 2001, issue 1.

36 RPSGB. *Long-term conditions: integrating community pharmacy*, 2006: www.rpsgb.org/pdfs/ltcondintegcommphsumm.pdf

asthma, diabetes and coronary heart disease. Pharmacists support people in taking medicines as intended and can monitor their effectiveness with the person and other members of the care team.

4.50 The Government therefore believes that support for people with LTCs should develop beyond what is currently offered within the community pharmacy contractual framework. At present, that support from all or most pharmacies can be summarised as providing healthy lifestyle advice, support for self care, conducting medicines use reviews and advising people on how to take their medicines to best effect.

4.51 An increased contribution can be made at all three levels of care for people with LTCs:

- **Supported self care – where people monitor their own condition but may seek help and advice from time to time from pharmacies as part of the healthcare team supporting them. Or carers may ask on behalf of the person they are helping to look after.** Actions include: general advice and tips on healthy living and wellbeing; counselling people in the appropriate use of medicines and helping them feel more in control of their lives through appropriate information; and supporting problem-solving and building self-confidence to deal with everyday health issues. They can also signpost to other local services and facilities for more specific support and information.
- **Disease management – supporting people on multiple, complex medicines regimes and their carers.** Actions include: detecting poor control of the medical condition; initiating action to avoid deterioration of the condition, such as suggesting a change in the medicines regimen; helping people to optimise their treatment, using supplementary or independent prescribing; and, where appropriate, referring people to another appropriate health or social care professional. Many pharmacies already provide – as part of a locally enhanced service – regular monitoring for people whose condition has stabilised and who need occasional checks and follow-ups. Examples of this include blood pressure checks, anticoagulation checks and support for people with diabetes.
- **Case management – working alongside others, especially case managers and community matrons, supporting high-risk patients, such as those with multiple co-morbidities, to help people who often have highly complex needs and multiple conditions.** Actions include: advising changes in treatment; picking up interactions between medicines and suggesting testing to determine the impact of medicines on the patient's medical condition; and helping to interpret results of blood tests, for example for anticoagulant monitoring.

CASE STUDY

COVENTRY WEIGHT MANAGEMENT PROJECT

The aims of the Coventry weight management project are to develop and pilot a pharmacy-based obesity service within a single PCT (Coventry Teaching PCT) and to assess the impact of this service. The project aims to provide an obesity management service for people over the age of 18 years, with a Body Mass Index (BMI) of $\geq 30\text{kg/m}^2$ and $\leq 38\text{kg/m}^2$, with at least one diagnosed or established risk factor. The risk factors included:

- hypertension;
- type 2 diabetes;
- hyperlipidaemia; and
- increased waist circumference – greater than 102cm (40 inches) for males and greater than 88cm (35 inches) for women.*

By the end of August 2007, 150 people had been recruited and a total of 470 follow-ups had been conducted.

The primary outcome for this study is change in BMI and waist circumference. People who had completed Follow Up 4 (FU4) were used for an interim quantitative assessment. At FU4 this group of people (n=69) had lost on average 0.618 of their BMI and an average 3.37cm of waist circumference. The average BMI at recruitment was 34.3kg/m^2 . Of the 150 people recruited, paired data is available for 68 people.

- Of these, 68% (n=46) have had a reduction in weight, 16% (n=11) have shown no change and 16% (n=11) have had a slight increase in BMI since recruitment.
- The average waist measurement overall at recruitment was 111cm. Of these people, 72% (n=49) have had a reduction in waist circumference, 4% (n=3) have shown no change and 24% (n=16) have had a slight increase in waist circumference since recruitment.

The PCT undertook an evaluation and found that the overall result for the pooled pharmacy data was strongly statistically significant ($P < 0.001$).

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*Asian men should be below 90cm (36 inches) and Asian women below 80cm (32 inches).

A support service for people newly prescribed medicines for an LTC

A recent study³⁷ by the European Society of Cardiology found a 40% higher rate of heart disease in those who gave up statins in the first two years of their being prescribed. In England about 3.5 million people take statins. Growth in statins prescriptions recently has been around 16% (2005/06-2006/07) and this year about 12% is forecast (2006/07-2007/08). Statins save an estimated 10,000 lives from vascular disease each year – representing (at 2003 estimates) no fewer than 77,000 quality-adjusted life-years, worth £2.3 billion.

With statins now available OTC, people at a moderate risk of heart disease have the choice of buying statins to take control of their own risk. For those prescribed statins to reduce a high risk or to manage their existing disease, not taking them as intended can have serious implications for their health and is also an ineffective use of NHS resources. Pharmacists can support people prescribed statins from the outset, providing helpful reminders about taking the daily dose (e.g. with simple compliance aids, mobile text messaging or electronic messaging), as well as advising on dose monitoring and any side effects for those people who experience them. There is also a role for pharmacist independent prescribers, who can adjust dosages as required.

4.52 A report in the *European Heart Journal* (see box) highlighted some of the persistent problems that can arise for people starting to take a medicine for the first time – a medicine they may need to take for the rest of their life. People can experience problems early on because they do not understand why they need to take the medicine, how it works or how to take it and what the long term benefits of taking it are. Their GP may have explained these things, but often people do not always take all this information on board, especially if they have just been told that they have a condition for life. Therefore, this important information needs to be reinforced. People may also experience unforeseen side effects or interactions with their other medicines. As was reported in a report on trends in national patient surveys by the Picker Institute Europe:³⁸ 'only 58% of primary care patients who were prescribed new medicines in 2006 said they were given enough information about side effects, down from 61% in previous surveys'. Unless this is addressed from the outset, people may not take the medicine as intended, leading to further complications and morbidity.

37 Fernie J et al. Adherence to evidence-based statin guidelines reduces the risk of hospitalizations for acute myocardial infarction, *European Heart Journal*, 2007, 28: 154–159.

38 Richards N and Coulter A. *Is the NHS becoming more patient-centred? Trends from the national surveys of NHS patients in England 2002-07*, Picker Institute Europe, September 2007: www.pickereurope.org/Filestore/Publications/Trends_2007_final.pdf

Research into newly prescribed medicine

Research conducted in 2004³⁹ examined 258 people aged over 75 who were beginning new medicines for a chronic condition (e.g. stroke, coronary heart disease, asthma, diabetes and rheumatoid arthritis).

Sixty-seven (30%) out of 226 people still taking their medicine at 10 days and 43 (25%) out of 171 people still taking their medicine at four weeks were non-adherent. Of 208 people still taking their medicine at 10 days, 138 (66%) reported at least one problem. A majority still taking their medicine expressed a substantial and sustained need for further information at 10 days and again at four weeks. Several people who were adherent or who reported no problems at 10 days were non-adherent or had problems at four weeks.

4.53 Put simply, the person fails to get the benefits they should right from the onset of treatment. At worst, the person suffers poorer health outcomes and increased morbidity, and the medicines are wasted.

4.54 As a first step in tackling this problem, the Government believes that pharmacy should offer more support to people in the early stages of taking a new course of medicines to treat an LTC. Existing professional and contractual requirements mean that appropriate information and advice should be

provided whenever a prescription for a new medicine is first presented. But just as important, there should be more structured follow-up to ensure that the person is not experiencing problems with their medicines. If so, further advice and support on how to resolve these or onward referral, as appropriate, should be available.

4.55 The presumption should be that all such people would receive this service automatically until such time as their new regime has stabilised and they feel they no longer require regular support from their pharmacy. The service should be available from the pharmacy on presentation of the first prescription. Pharmacists will want to consider innovative ways of communicating patient-sensitive information, depending on people's preferences, such as text messaging or email messaging.

4.56 **The Government believes more support is needed for people who are newly prescribed a medicine to treat a long term condition. The Government will therefore discuss with the PSNC and NHS Employers how such a support service may best be introduced within the community pharmacy contractual work.** The scoping work to be carried out by CfH outlined in paragraph 4.17 will need to take into account any data capture that may be needed to support clinical governance arrangements, audits and PCT monitoring of service provision. Prioritisation to stimulate further research to evaluate new services such as this will be an early task for the Expert

³⁹ Barber N et al. Patients' problems with new medication for chronic conditions, *Quality and Safety in Health Care*, 2004, 13: 172–175.

CASE STUDY

LUNG CANCER AWARENESS MONTH

Lung Cancer Awareness Month (LCAM) takes place in November each year. In 2006, the Department of Health convened the LCAM Working Group, bringing together stakeholders to work on a co-ordinated campaign to raise awareness of the symptoms of lung cancer among members of the public and health professionals.

The group is well supported by pharmacists, with representation from:

- the RPSGB;
- the PSNC;
- the National Pharmacy Association; and
- the CPPE.

LCAM activity continues to grow, with LCAM 2007 benefiting from tremendous support from the pharmacy profession, including:

- posters and information leaflets in all UK pharmacies;
- in-store publicity, e.g. pharmacy radio, special feature on Healthpoint;
- LCAM presentations at the Pharmacy Show and to a meeting of representatives of all RPSGB branches;
- visits by MPs to local pharmacies across the UK;
- Lloydspharmacy running a campaign in 1,605 of its pharmacies, including posters, leaflets and 'bag-stuffers' with every bottle of cough medicine, plus hosting an LCAM event at its flagship pharmacy in London;
- other pharmacies, both independents and multiples, hosting LCAM events; and
- LCAM features in all major pharmacy journals – including articles for continuing professional development.

Community pharmacists were at the forefront of the campaign and, in support of this, the UK Lung Cancer Coalition (UKLCC) produced a toolkit to assist pharmacists in inviting MPs to pharmacies throughout November. This highlighted how pharmacists can help improve awareness of the early signs and symptoms of lung cancer, as well as offering advice and support. The toolkit can be found at: www.uklcc.org.uk/parliamentary_activity.asp. It provides easy-to-use resources for arranging an MP photocall, including template invitations and press releases.

There are other examples of pharmacy awareness-raising campaigns, including: sun awareness, diabetes, blood pressure, osteoporosis and other local initiatives.

Contacts: for further details of pharmacy involvement in LCAM: Graham Phillips – graham.phillips@manorpharmacygroup.co.uk; Davan Eustace – Deustace@blueyonder.co.uk

Panel on Health Services Research in Pharmacy, outlined in Chapter 6.

Preventing and detecting cancers

4.57 Community pharmacy also has an important role in the early detection and prevention of some cancers. It already contributes to reducing the risk of lung and other cancers through stop smoking services. However, community pharmacists and their staff may see people with, for example, persistent coughs or abnormal bowel motions, since both of these may involve the regular purchase of medicines to relieve symptoms. While normally harmless, on some occasions these symptoms can signal a more serious underlying cause, such as lung, stomach or bowel cancer.

4.58 **The Government believes it important that effective systems are in place for the efficient referral of people with symptoms, which may be indicative of cancer, from the pharmacy to their GP. The Government will therefore ask NHS Employers, the RPSGB and the PSNC to explore how professional and contractual arrangements can best support this.**

The role of pharmacies in an influenza pandemic

4.59 Community pharmacy will play a critical role in responding to an influenza pandemic and should be fully integrated into the primary care response. Demand for information, prescribed and OTC medicines, and influenza-related medicines and advice is likely to be very high. Assuming that stock availability can be maintained, pharmacists will

be expected to ensure that people continue as far as possible to have uninterrupted access to the medicines they need. In addition, community pharmacists and their staff will play a key role in encouraging self care, so that people who are able to manage their own symptoms (from their own homes) can do so safely and effectively without placing an extra burden on the healthcare system. It will be important for all community pharmacies to develop robust response plans, and to work with their PCT from an early stage so that plans are co-ordinated and consistent with the approach taken across the PCT area.

4.60 For further information on the role of community pharmacy during a pandemic, see *Pandemic Influenza: Guidance for primary care trusts and primary care professionals on the provision of healthcare in a community setting in England*: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080757

4.61 In the event of a pandemic, the focus of hospital pharmacy services may need to change in order to adapt to different prevailing circumstances. An extension of medicines management services may be necessary to ensure continuity of acute care, to reduce routine demands on medical and nursing colleagues and to contribute to the support for specific groups of patients who would normally be treated in hospital. In all situations, hospital pharmacies will have a key role in doing everything possible to facilitate the best use of

available resources. This may be, for example, by ensuring appropriate use of patients' own medicines during their admission, advising other clinicians on decisions about medicine use, and facilitating timely discharge of patients with adequate supplies of medicines and encouraging appropriate self care. Medicines management during a pandemic may extend to therapeutic substitution. Pharmacists are well placed to advise on the selection of safe and effective alternatives to medicines that may not be readily available.

- 4.62 For further information on the role of hospital pharmacy during a pandemic, see *Pandemic Influenza: Guidance on preparing acute hospitals in England*: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080754

Clinical leadership

- 4.63 The Government believes that the initiatives set out in this White Paper will require strong, authoritative, clinical leadership at both local and national levels. Leadership that will galvanise the profession and providers along new clinical pathways and ensure a reinvigorated clinical focus remains at the forefront of delivery and service development in the coming years.
- 4.64 To support this, **The Government will appoint two new clinical leaders this year. These new leaders will work directly to the Chief Pharmaceutical Officer to champion the development of pharmaceutical services and to help implement the actions in this White Paper.**
- 4.65 One will focus on pharmaceutical service delivery in the community and in primary care; the other on delivery in hospital pharmacy.
- 4.66 A key aspect to both roles will, however, be to devise and implement effective joint strategies and mechanisms to promote better patient experience and pharmaceutical outcomes for people across the different healthcare sectors. They will focus on promoting and stimulating the delivery of service models which best meet the needs of people going into and coming out of hospital and other clinical settings. In addition, they will have an important role in shaping future models of care flowing from the primary and community care strategy.
- 4.67 They will also be responsible for supporting the development of local clinical champions, to identify and spread best practice across the country, helping to overcome any barriers to service redesign and seamless care delivery. More details of their roles and remit will be available when these posts are advertised later this year.

Attributes of a world-class pharmacy in future

Premises

Project a professional image and environment, while taking into account local needs and national standards.
Are open, welcoming and accessible.
Accommodate a safe, secure and private discussion area

Staff

Provide trusted, professional service.
Have a friendly, welcoming, competent and considerate approach.
Have up-to-date relevant knowledge.
Have good interpersonal skills to help elicit relevant information in a sensitive manner

Information resources

Easy access to a range of up-to-date, evidence-based information to enable safe, effective and efficient decision-making, care and service provision.
Pharmacy safely and securely handles all types of information needed to provide safe care

Centre for healthy living

A primary source of information and advice for healthy living and health improvement.
Pharmacy is integrated into public health initiatives, such as stopping smoking, weight management and sexual health services

Wide range of clinical services

Pharmacy provides services directly or provides space and suitable facilities for others, e.g. minor ailment treatment, support for people with LTCs, vascular risk assessment, health trainers, immunisation, dermatology clinics

Leadership

Pharmacy is recognised by public and other professionals as local community leader in medicines and broader health and social care matters, e.g. sustainable development

Integrated services

Integrated working with others in the local health and social care team, e.g. joint asthma clinic with practice nurse or consultant pharmacist, undertaking audit with local GPs of repeat prescription requests, medicines training for care home staff

5

Communications and relationships



CHAPTER SUMMARY

It is clear that the public has a high regard for pharmacy, yet there remains a need to raise awareness of the many and varied services and benefits offered by pharmacies and pharmacists. This chapter outlines proposals to develop a communications programme, to support the delivery of key messages to patients, the public, the NHS and other stakeholders and to improve awareness and understanding of the role of pharmacy in providing services. It also sets out the Government's plans to commission and develop further research into the extent and pattern of use of pharmacy services.

In addition, the Government has asked NHS Employers to establish a working group to promote closer working between GPs and pharmacists, through a shared understanding of how their respective clinical roles can help deliver more personalised and effective care for their patients.

Views of patients and consumers

- 5.1 Pharmacy is highly regarded by the public. A MORI survey carried out in 2003⁴⁰ showed that people use pharmacists as a health resource second only to GPs. The public has expressed considerable satisfaction with pharmacy services, saying they were 'accessible, friendly and expert'.⁴¹ There is evidence of pharmacists being used as a source of advice and guidance and, in some cases, for minor or routine tests as well as medicines supply.
- 5.2 Omnibus research undertaken for this White Paper in December 2007 and qualitative work in January 2008 provide an overview of the frequency and patterns of usage of community pharmacies. The management summary of this research is available on the Department of Health's website.⁴²
- 5.3 For example, pharmacies are mainly used to enable prescribed medicines to be dispensed and to purchase supplies of over-the-counter medicines, either for a regular or one-off condition. Around one in 10 people get health advice from their pharmacy but, so far, very few use a pharmacy to obtain urgent advice or to make use of other health services, such as regular monitoring or screening. The majority of people always visit the same pharmacy, with around a third of people using a variety of pharmacies but one most often.
- 5.4 The qualitative research showed that there was considerable interest in making greater use of pharmacists for advice, for the treatment of minor ailments and for routine testing. Greater availability of repeat prescribing and dispensing would be widely welcomed, with many eager to hear how pharmacy could do more.

40 Worcester, Prof RM. *Patient Choice*, MORI, 2003.

41 Opinion Leader Research. *Your health, your care, your say: Research report*, 2006, page 47: www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicyAndGuidance/DH_4127357

42 Community pharmacy use; market research report: www.dh.gov.uk

5.5 Since April 2005, communications activity has focused on raising awareness of, and clarifying, the new contractual framework for community pharmacy with pharmacists and other health professionals.

5.6 The world-class pharmacy of the future, and the breadth of services it can offer, now need to be more widely understood by patients and the public.

CASE STUDY

EMERGENCY HORMONAL CONTRACEPTION IN SOUTHWARK

Pharmacy provision of EHC has proved to be popular with the public, and community pharmacies are now the major providers of this service in Lambeth and Southwark. A tiered pharmacy service model has been developed within a local modernisation programme, with support from a range of stakeholders, including specialist clinicians. This model links a range of pharmacy-based sexual health services to the community pharmacy contractual framework. Further details are available at: www.mysexualhealth.org.uk/what_we_do/increasing_access

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Communications programme

5.7 Therefore, over the coming months, **the Government will plan a programme of communications that seeks to:**

- **highlight the breadth of services and skills available within pharmacies;**
- **illustrate the role that pharmacies can play in promoting good health;**

- **raise awareness and knowledge of the role that pharmacy can play in managing long term conditions (LTCs) and reducing health inequalities; and**
- **increase the use of pharmacy services among target audiences.**

5.8 The research described on page 71 has broadly scoped communications requirements among the general population. To develop a robust programme that supports measurable behaviour change, **the Government will map the target audiences for this communications programme**, with a particular focus on people with LTCs and those who are most affected by health inequalities.

5.9 **The Government will commission further qualitative research to develop a better understanding of the particular needs of these audiences.** This will generate insights among these audiences that allows identification of the most appropriate channels and messages to communicate, and in a way that unlocks pharmacy's potential to help.

5.10 The programme will determine how best to shape communications and to harness the contributions that Government, the NHS and pharmacy can all make, maximising the use of existing channels or developing new ones. It will also identify any communications risks and consider how these might most effectively be managed.

CASE STUDY**REVIEW OF NEEDLE EXCHANGE SERVICES**

Leeds Primary Care Trust (PCT) reviewed its needle exchange services in 2005 and found that they tended to be sporadic and poorly used by injecting drug misusers. The PCT asked service users for their views and found that the choice of equipment offered in standard needle exchange packs did not meet their needs. Service users also commented on poor staff understanding, lack of confidentiality, as well as lack of easily accessible pharmacies. Leeds PCT, in partnership with the local pharmaceutical committee, sought to overhaul the service, including renegotiating contractor payments.

The number of pharmacies offering needle exchange has now more than doubled and there has been a large increase in the number of clients. One new feature of the service is the 'what works' form, which lists, with illustrations, the pieces of injecting equipment and other paraphernalia available. Drug misusers just tick off what they want the pharmacist to supply and fill in some basic demographic information that allows the service to be audited.

This permits a bespoke service for each client that is both confidential and discreet.

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Fostering closer professional relationships between pharmacy and other healthcare professionals, notably GPs

5.11 Anne Galbraith's report concludes that professional relationships between pharmacists and GPs have not developed as expected. In particular, the report found that integrated care would require a need for closer professional co-operation, e.g. in developing a local indicator for repeat dispensing services and how the provision of the medicines use review (MUR) service could best reflect local priorities.

CASE STUDY**PHARMACIST AS PARTNER IN PRIMARY MEDICAL PRACTICE**

Karen Acott is a pharmacist partner at Wallingbrook Health Centre in Devon (which also houses a dispensary). She runs the dispensing business and meets the pharmaceutical industry representatives. She is also responsible for human resources and training and development of three accredited checking technicians. She runs migraine, epilepsy and chronic pain clinics. Karen also reviews the medicines and notes of patients recently discharged from hospital and talks through with them any alterations to doses, etc. She has recently become an independent prescriber and this will help her prescribe as necessary in her migraine, epilepsy and chronic pain clinics, as well as enabling her to prescribe anti-malarials.

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5.12 The All-Party Pharmacy Group report *The Future of Pharmacy* (2007) echoed these findings, noting that professional relationships were strained. The report attributed this to a range of factors, including misconceptions and suspicions about roles and communications, which were not as developed as they could be. The Group's report made a number of recommendations, including advocating greater PCT involvement in fostering more effective local professional working relationships.

5.13 Specific actions in relation to repeat dispensing and MURs are set out in Chapter 3. The Government believes that good working relationships between all healthcare professionals are essential to the delivery of personalised and effective patient services. This requires far greater collaboration and stronger communications between healthcare professionals than has perhaps been evidenced so far. As indicated in the case study on page 73, there are benefits where pharmacists are active partners in collaboration with GPs.

5.14 A clear strategic focus and direction is needed to support further change. To effect this, **the Government believes effective professional relationships are important for the future development of services. It has therefore asked NHS Employers on behalf of PCTs to convene and lead a working group of pharmacy, medical and public representatives to formulate a series of actions to promote more effective professional relationships.** These will include setting achievable and realistic goals, incentives and outcome measures for delivering services that ensure closer

co-operation and closer working between pharmacists and GPs. This will start with repeat dispensing and the Electronic Prescription Service. NHS Employers will shortly invite representatives of the Pharmaceutical Services Negotiating Committee and the General Practitioners' Committee of the British Medical Association to join them in this important work.

5.15 The Government expects this new evidence-based focus, in time, to stimulate service providers to think creatively about how they can work together more effectively to develop a closer understanding of their respective clinical roles and contribution to shared care plans for people with LTCs, to integrated care pathways, to shared information and to clinical networks.

CASE STUDY

WEIGHT MANAGEMENT ACROSS BOUNDARIES

The Royal Pharmaceutical Society of Great Britain is working with North West Strategic Health Authority and the PCTs in the North West on a joint leadership programme, Leading across boundaries, for GPs, commissioners, PCT senior managers and community pharmacists focused on tackling weight management.

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6

Research and innovation in practice



CHAPTER SUMMARY

This chapter looks at proposals to support research and innovative pharmacy practice, and to promote the development of a sound evidence base that underpins and demonstrates how pharmacy delivers effective, high quality, value-for-money services. The Chief Pharmaceutical Officer will convene an expert panel to advise on research priorities and feed these into the National Institute for Health Research prioritisation processes.

The chapter also identifies the need for pharmacy to be open to new ways of working, building on good progress in the use of new technologies and systems in hospital pharmacy and on the experience in community pharmacy of the roll-out of the Electronic Prescription Service (EPS) and other initiatives.

Health services research in pharmacy

- 6.1 Research into pharmaceutical services is a relatively new area. Its focus has largely been on the acceptability and uptake of services by the public and on perceptions of the profession and their job satisfaction. Measures to date have largely been expressed in terms of inputs and outputs, rather than in terms of service quality, outcomes and relative cost-effectiveness.
- 6.2 The Government commissioned an updated review of research literature in the areas of sexual health, obesity and weight management, bone health and falls prevention, coronary heart disease and diabetes, and immunisation for this White Paper, covering the period 2004–07. The management summary of this report has been published on the PharmacyHealthLink website.⁴³
- 6.3 This found that a substantial number of studies and their findings have strengthened the evidence base of effectiveness for community pharmacy-based services in stopping smoking, in coronary heart disease management and prevention, in diabetes testing and management, and in hypertension. Most of the studies were conducted abroad in settings that might vary from those in the UK, and therefore further research is required within the UK. Some evidence of effectiveness was found relating to osteoporosis risk assessment and weight management. These areas remain promising and should also be tested in pilot studies and further research.
- 6.4 A composite review of research literature covering the period 1991–2007 is now in preparation. This will be published later in 2008.
- 6.5 Over the last 20 years, a body of evidence has been building, from both within and outside the UK, which demonstrates the positive impact of hospital clinical pharmacy services on patient outcomes. Examples include reduction in adverse drug events when pharmacists are part of inpatient clinical

⁴³ Anderson C, Blenkinsopp A and Armstrong M. *The contribution of community pharmacy to improving the public's health: Literature review update 2004–7*. Available at: www.pharmacyhealthlink.org.uk

- teams⁴⁴ and studies that demonstrate the association between clinical pharmacy services and lower treatment costs and better patient outcomes.⁴⁵ In the UK, increased input by clinical pharmacists at each stage of the patient's hospital journey, from admission through to discharge, has been shown to decrease the length of hospital stay and lower readmission rates.⁴⁶
- 6.6 However, within community pharmacy, the journey towards the provision of clinical services is at an earlier stage.
- 6.7 Future commissioning decisions will need to be based on sound evidence of improved health outcomes. As yet, the evidence base underpinning the value for money and effectiveness of current pharmacy services on clinical outcomes is, at best, patchy. However, this of itself is not a reason to abandon them, but indicates a need to explore further the development of the evidence base, including research tools.
- 6.8 Moves towards the delivery of more clinical services by pharmacists, together with the likely impact of technology (e.g. automated dispensing, electronic prescribing and drug administration), offer the opportunity to improve information. This will provide evidence to demonstrate how effective pharmacy is in delivering satisfactory outcomes for patients and therefore to help refine commissioning in future.
- 6.9 The Government also believes a clearer culture of evaluation needs to be at the heart of pharmacy service development and provision, and service evaluation should be considered alongside the community pharmacy contractual framework and any new service developments initiated as projects.
- 6.10 Through the Best Research for Best Health initiative, the Government is aiming to create a health research system in which the NHS supports outstanding individuals across the full breadth of service settings, conducting research focused on the needs of patients and the public.
- 6.11 Therefore, the Government will explore how best to create a clearer framework for the evaluation of pharmacy services. This is likely to focus on six principal research domains:
- patient and public perceptions and satisfaction;
 - impact on care and outcomes (including clinical and cost-effectiveness, safety and people's understanding of their medicines);
 - quality of service provision;
 - value for money;
 - impact on workload and flow; and
 - pharmacy staff attitudes.

44 Kucukarslan SN et al. Pharmacists on rounding teams reduce preventable adverse drug reactions in hospital general medicine units, *Archives of Internal Medicine*, 2003, 163: 2014–2018.

45 Bond CA, Raehl CL and Franke T. *Interrelationships among mortality rates, drug costs, total cost of care, and length of stay in United States hospitals: summary and recommendations for clinical pharmacy services and staffing*, *Pharmacotherapy*, 2001, 21: 129–141.

46 Scullin C, Scott MG, Hogg A and McElnay JC. An innovative approach to integrated medicines management, *Journal of Evaluation in Clinical Practice*, 2007, 13: 781–788.

6.12 **To do this, the Chief Pharmaceutical Officer will convene an expert panel to advise on priorities for health service research in pharmacy and feed the output of this into the Government's National Institute for Health Research prioritisation processes.**

Research capacity

6.13 In the early 1990s, the Government recognised a need for health services research in the areas of medicines and pharmacy. Through a programme of funded studentships and fellowships for pharmacists, known as the Pharmacy Practice Research Enterprise Scheme, research capacity and expertise were developed in such disciplines as epidemiology, health economics, health and occupational psychology, medical sociology and public health. Many of the beneficiaries of this scheme now occupy senior academic posts in pharmacy practice in schools of pharmacy.

6.14 Over the last 10 years, both the Community Pharmacy Research Consortium – a partnership of pharmacy organisations – and the Pharmacy Practice Research Trust have provided targeted research and development funds to inform key aspects of pharmacy policy and practice.

6.15 Pharmacy practice academics, often in collaboration with medical and nursing colleagues, have made major contributions to the understanding of medication errors and their avoidance, use of medicines in care homes, patients' beliefs about their medicines and their medicine-taking behaviour.

6.16 A five-year longitudinal cohort study funded by the Pharmacy Practice Research Trust is providing contemporary insights into the career aspirations, choices and experiences of pharmacy students and newly qualified pharmacists. More targeted studies have informed service delivery and organisation through demonstrating the impact and feasibility of community pharmacy-based schemes to: stop smoking, manage minor ailments, undertake needle exchange, and provide emergency hormonal contraception.

6.17 Despite this contribution, the number of academic pharmacists has declined over the last 10 years, causing an imbalance between teaching commitments and the capacity to undertake meaningful research. As part of the commitment by the Chief Pharmaceutical Officer to convene an expert panel to advise on research priorities, consideration will be given to sustaining the research capacity related to pharmacy practice and medicines use.

Pharmacists' support for research and development in medicines, and pharmacovigilance

6.18 There has been limited utilisation of the pharmacy network and pharmacists' scientific training in developing and delivering clinical research. It is likely that, as pharmacists' clinical expertise further develops, there will be greater opportunity for pharmacists to undertake research of this nature.

6.19 Good Clinical Practice in Clinical trials demands rigour and detailed processes in designing, delivering and monitoring clinical trials of medicines (www.mhra.gov.uk/Howweregulate/Medicines/Inspectionandstandards/GoodClinicalPractice/index.htm).

6.20 Hospital pharmacists routinely support clinical trials and have responded positively to requirements of clinical trials legislation. Developments in pharmacists' clinical skills, together with supplementary and independent prescribing, mean that pharmacists could now be more involved in, monitor or lead clinical trials with licensed medicines. This would support professional development and innovation, uptake of new medicines, and improvement in care, for example by increasing the number of trials in cancer or determining the clinical effectiveness of medicines in practice.

6.21 In addition, pharmacists in all settings already contribute to pharmacovigilance schemes, such as the Yellow Card system for adverse drug reactions overseen by the Commission on Human Medicines and the Medicines and Healthcare products Regulatory Agency (MHRA). New ways of assessing a person's likelihood to be susceptible to adverse drug reactions or side effects are now feasible, drawing on new approaches such as pharmacogenetics.

6.22 Therefore, the Government will explore with the pharmaceutical industry and the profession how best to utilise the pharmacy network in promoting research and development and pharmacovigilance.

CASE STUDY

LONDON CANCER NEW DRUGS GROUP

The London Cancer New Drugs Group (LCNDG) comprises clinicians and network pharmacists nominated by, and representing, the cancer networks in London and Hertfordshire. Membership also includes commissioners and representatives of specialist pharmacy services, and the group is chaired by a clinician.

LCNDG has delegated responsibility to develop recommendations for the managed entry of new treatments in cancer across London and Hertfordshire. The value of the group stems from its ability to make recommendations on the use of new treatments, typically one year in advance of the National Institute for Health and Clinical Excellence (NICE). In nearly all cases, the view of the LCNDG has been in line with that taken by NICE.

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Supporting evidence-based use of medicines

6.23 As pharmacy continues its transformation to a clinical profession, it becomes even more important that all pharmacists, like other clinical professionals, have at their fingertips the clinical evidence they need to make good decisions. The National Electronic Library for Medicines, developed by pharmacists for pharmacists but used by a wide range of professionals, is now a central part of the NHS National Knowledge Service and is likely to form part of any future developments in knowledge provision. It does, however, remain important that any sources of clinical evidence about medicines fit coherently with other strategic aims.

- 6.24 **The Chief Pharmaceutical Officer and the NHS Chief Knowledge Officer will therefore work together to maintain an overview of the existing information sources on medicines and support future developments that fit the needs of both individual practitioners and the NHS.**

Innovation in practice

- 6.25 To deliver on pharmacy's clinical agenda means adopting new ways of working that range from the purchasing of products in ready-to-use form from commercial suppliers through to the potential outsourcing of different service elements.
- 6.26 Building on good progress with the automation of dispensing in hospital, which has been shown to improve productivity, improve waiting times and reduce errors,⁴⁷ and working collaboratively within the NHS and beyond, there is much that can be done to increase efficiency in the supply of medicines.
- 6.27 Technology has now developed to the extent that automated hubs for bulk storage and dispensing could control and supply medicines rapidly and accurately. For patients in hospital, the adoption of decentralised dispensing robots in clinical areas could improve care. This would include the ability of pharmacy staff to be permanently based in clinical settings, maximising their clinical input and impact, and improving multidisciplinary communication.

CASE STUDY

HEART OF ENGLAND NHS FOUNDATION TRUST – OUTPATIENT SERVICE

The Trust has outsourced to a commercial partner the logistics of outpatient (including A&E) dispensing and medicines delivery, to provide choice for specific groups of patients with complex pharmaceutical needs. Alliance Boots, together with the Trust, opened a 'Your Local Boots Pharmacy' in the new main entrance of the Birmingham Heartlands Hospital to dispense hospital outpatient prescriptions. UniChem provides the home delivery service for patients with HIV and cystic fibrosis.

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Auto-identification and data capture to support safe medicine supply

- 6.28 In February 2007, the Government published its strategic case for wider adoption of auto-identification and data capture (AIDC) technologies in healthcare. AIDC involves the use of bar codes, radiofrequency identification and other machine-readable codes to identify an item or process quickly and accurately. Though used for decades in other sectors of industry such as retail, its use in healthcare has been limited. There is evidence of real improvements to patient safety when coding systems are used to match patients to their care: reduction in medication errors and dispensing errors; reduced risk of wrong-site surgery; accurate track and

⁴⁷ Fitzpatrick R, Cooke P, Southall C et al. Evaluation of an automated dispensary system in a hospital pharmacy dispensary, *Pharmaceutical Journal*, 2005, 274: 763–765.

trace of surgical instruments, equipment and other devices; and much better record-keeping. Using coding to manage supplies and purchasing electronically can cut costs dramatically, as well as improve efficiency.

- 6.29 The case for coding is compelling, but all parties need to work to commonly agreed standards if the benefits are to be realised fully. The GS1 System is an integrated system of global standards that provide unique and accurate identification. **The Government is recommending that the GS1 System should be adopted throughout the healthcare system in England, for both products and coding systems used within healthcare settings, such as patient identification codes on wristbands.**

CASE STUDY

CENTRE FOR MEDICATION SAFETY AND SERVICE QUALITY

The centre is a joint initiative between the Pharmacy Department at Imperial College Healthcare NHS Trust and the School of Pharmacy, University of London. Its recent research⁴⁸ has demonstrated that closed-loop electronic prescribing, automated dispensing and bar code patient identification reduce prescribing and administration errors, and increase confirmation of patient identity before administration.

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NHS preparative services and medicines manufacturing

- 6.30 For other pharmacy services, such as aseptic preparation, a balance should be struck between the availability of facilities of the right standard for acute needs and the efficiencies of centralising or outsourcing, which should be predicated on the clinical rationalisation of product lines, service redesign and the freeing up of clinical resource.
- 6.31 NHS organisations will therefore need to work with the pharmaceutical industry to develop licensed ready-to-administer or ready-to-use medicines. Procurement from commercial suppliers of more injectable products in ready-to-use or ready-to-administer forms will enable preparation of high- or moderate-risk products to be migrated from clinical areas to pharmacy.
- 6.32 When patients have ongoing needs for complex therapies, there is a clear opportunity for hospital and community pharmacy to work together, to ensure that medicines and advice are provided conveniently and consistently. In some circumstances, the delivery of medicines directly to a patient's home by a homecare company may offer advantages from the patient's perspective and also address capacity issues. Where they are used, homecare services should be underpinned by robust clinical governance arrangements and should provide patient benefit. To help develop appropriate systems for this market, the NHS Purchasing and

⁴⁸ Dean Franklin B, O'Grady K, Donyai P et al. The impact of a closed-loop electronic prescribing and administration system on prescribing errors, administration errors and staff time: a before-and-after study, *Quality and Safety in Health Care*, 2007, 14: 279–284.

Supply Agency has convened a national committee and provides an e-library on its website: www.pasa.nhs.uk

6.33 Along with commercial 'specials' suppliers, hospital preparative services play a vital role in ensuring that people who need particular products or formulations have timely access to the medicines they require. The National Advisory Board for NHS Hospitals Medicines Manufacturing and Preparative Services has oversight and co-ordination of reconfiguring medicines manufacturing into a national collaborative service. It also advises healthcare organisations on medicines manufacture and the use of unlicensed medicinal products.

6.34 **The Government will ask the National Advisory Board for NHS Hospitals Medicines Manufacturing and Preparative Services to devise practical steps further to rationalise the range of products manufactured by the service to ensure capacity is available for the implementation of the NPSA's safe medication practice recommendations and preparation of products for which a need has been identified by risk assessment.**

Specialist pharmacy services

6.35 Specialist pharmacy services, which are those provided across many health organisations to ensure access to pharmaceutical expertise in a range of disciplines, have an important role to play in catalysing innovation and ensuring its uptake. Specialist pharmacy services (including quality assurance, medicines procurement, medicines

information and clinical, community health and technical pharmacy) support all commissioning processes and enable providers of NHS services to deliver high quality care. There is an important interface between specialist pharmacy services and pharmacy education and training in terms of workforce planning and development.

6.36 **The Government will explore the extent to which specialist pharmacy services are available and commissioned across England, and their contribution to the delivery of innovative, cost-effective and more convenient care for patients.**

Antimicrobial prescribing

6.37 *The Health Act 2006: Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, 2006) makes clear the requirement for all NHS bodies to have antimicrobial prescribing policies. Antimicrobial pharmacists have a major role to play in developing and implementing these policies, and in audit. By working with multidisciplinary teams, they should be able to promote good antimicrobial prescribing practice that will help to prevent outbreaks of *Clostridium difficile* and limit the emergence of antibiotic-resistant bacteria.

6.38 Investing in pharmacy teams has been identified by the Government as the means to enable pharmacists to work with medical microbiologists and infectious diseases specialists. Providers and commissioners have been encouraged to make this investment from the Payment by Results tariff uplift

CASE STUDY**CONSULTANT PHARMACIST – ANTI-INFECTIVES**

In January 2007, the Southampton University Hospitals NHS Trust appointed Dr Kieran Hand to the first consultant pharmacist post in the specialty of microbiology and infectious diseases. Kieran is chair of the UK Clinical Pharmacy Association's infection management group, is an editor of the *Journal of Antimicrobial Chemotherapy*, and sits on the Health Protection Agency programme board for healthcare-associated infection and antimicrobial resistance.

As a consultant pharmacist, Kieran has taken forward the Trust's antibiotic policy, worked with medical microbiology colleagues to develop an integrated website for infection, developed audit processes for antimicrobial prescribing, and made a significant contribution to the education and training of professional groups in primary and secondary care settings. He is also involved in a collaborative project to develop primary care prescribing guidelines that will support decisions to withhold antibiotic therapy in appropriate circumstances and promote the use of low-risk antibiotics in vulnerable patients at risk of *Clostridium difficile* (*C. difficile*) infection.

Kieran has first-hand experience of responding to an outbreak of *C. difficile*. The combined effort of the Trust's antimicrobial management team and infection control team, coupled with the introduction of narrow-spectrum antibiotic guidelines for pneumonia in November 2007, has seen the incidence of infection with *C. difficile* fall from a baseline of 50–60 cases per month to 10 cases in February 2008.

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for 2008/09. Establishing consultant antimicrobial pharmacist posts in provider organisations, or across health communities, can bring additional benefits in terms of the education of other health professionals and research.

Use of information technology in community pharmacy

6.39 Release 2 of EPS, where prescriptions can be transmitted electronically, introduces significant benefits for patients, prescribers and dispensers. Work is underway in 17 initial implementer primary care trusts (PCTs) to prepare for limited deployment of systems that have undergone appropriate safety testing.

6.40 After this limited initial deployment, and once a system supplier has received authority for wider deployment, any pharmacy will be able to purchase or upgrade to a compliant system and operate the service, regardless of whether they are sited in one of the named PCTs. However, GPs may only operate Release 2 where their PCT has been directed by the Secretary of State that electronic signatures may be used. Work is therefore beginning with strategic health authority chief information officers to consider how and when more PCTs are chosen to be able to use the service.

- 6.41 While only in the scoping stage, further work is exploring how to develop EPS, to enable pharmacists to use it for other services that may involve the supply of a medicine, such as through minor ailment schemes.
- 6.42 In addition, in being able to operate EPS, pharmacies will be equipped with the building blocks to be able to access other services in the National Programme for IT. For example, one PCT is already piloting the roll-out of NHS mail to community pharmacies and pharmacists.
- 6.43 The Summary Care Record (SCR) will give healthcare professionals treating a patient secure access to some patient-specific information. This will support the healthcare professional in providing the safest and most effective intervention for the patient.
- 6.44 However, it is important that mechanisms are in place to fully address concerns about patient consent and maintaining patient confidentiality. The NHS Care Record Guarantee has been drawn up and agreed by key parties as to what patients have a right to expect about how any information about them in the Care Record Service may be stored, used, shared and transmitted. However, there have been specific concerns about the use of the Care Record Service in community pharmacies, also often thought of as a retail setting.
- 6.45 Some PCTs are early adopters of the SCR and are considering issues of patient consent and confidentiality. **The Government will therefore undertake further work with an early adopter PCT to consider the benefits, governance and practical arrangements of community pharmacists having access to the SCR.** This work and experience will be used to inform a key programme to consider how community pharmacy's access to the Care Record Service might be achieved. This programme will include the Clinical Reference Panel, the National Advisory Group and Patient Advisory Group, together with professional and representative organisations.
- 6.46 Consideration will also be given to how community pharmacists may be able to utilise other services such as 'Choose and Book' as they offer more clinically orientated services.

7

The pharmacy profession



CHAPTER SUMMARY

In this chapter, the Government makes clear its conviction that, as health professionals, pharmacists remain a significant untapped resource for delivering accessible services to the people who need them most. As such, the approach to the regulation of pharmacists must be similar to that for other clinical professions – that is, in a way that safeguards patients and the public and supports the strategic development of high quality pharmacy practice. This chapter sets out:

- action to establish a new professional regulator, the General Pharmaceutical Council (GPhC);
- how the Government looks to the profession itself to develop strong professional leadership to support and sustain pharmacy at this critical time of change, including opportunities now available to pharmacists to become prescribers, to develop special interests in defined clinical areas or to practise as consultant pharmacists; and
- changes in education and training that will help to ensure that pharmacists have the clinical competencies to deliver the types of services needed in the future.

To support the deployment of pharmacists' clinical skills, the Government is taking forward legislative changes that promote the better use of the pharmacy workforce – pharmacists, pharmacy technicians and other pharmacy staff. The Government will begin discussions with representative bodies on professional standards for appliance contractors.

Introduction

7.1 While new developmental paths have opened up for the profession, this White Paper proposes much more. The Government is convinced that there remains a significant resource of untapped expertise and capacity that could be used to provide a broader range, and much greater volume, of accessible clinical services to people who need them.

7.2 With greater clinical responsibilities come greater expectations:

- expectations of safety;
- expectations of quality; and
- expectations of accountability.

For pharmacy to take its rightful place as a clinical profession, contributing much more to the care of the public and patients, regulation needs to be approached in a similar way to that of other clinical professions.

7.3 Most pharmacists see regulation as a means of discipline. While maintaining fitness to practise is a critical aspect of regulation and therefore patient safety, regulation is also a key driver for improving quality of care to patients and the public, and therefore how the profession develops its practice too. It is, for example, the regulator who decides standards of education and the competencies a pharmacy graduate must have before registering as a pharmacist. This clearly determines the

The pharmacy profession

In recent years, the pharmacy profession has developed radically, and pharmacy practice has entered a new era. Developments include:

- pharmacist independent prescribing (shortly to be extended to include prescribing controlled drugs);
- pharmacists with special interests (PhwSIs) – for example dermatology, diabetes, drug misuse and anticoagulant monitoring;
- consultant pharmacists – working mainly in hospitals but with the potential to extend into primary care – who have expertise in specialties such as paediatrics, mental health, older people, critical care, cancer, HIV, anti-infectives and medicines safety;
- pharmacists registered as defined specialists on the UK Public Health Register, including those in senior public health posts at consultant or equivalent level;
- community pharmacists developing local clinical services – for example in drug misuse or hypertension management; and
- pharmacy technicians delivering more services directly to people – for example, medicines reconciliation and medication counselling in hospital – and contributing to health improvement in community pharmacies.

shape of future pharmacy practice. It is, and will continue to be, the regulator who ultimately decides whether or not specialist or advanced practice should be registered. An early example of this is pharmacist prescribing. Therefore, professional regulation, while designed for public and patient safety, is also about the strategic development of high quality pharmacy practice.

- 7.4 Processes for the accreditation of services, and for recognising that individual practitioners possess the competencies to deliver those services (credentialing), do not necessarily involve the professional regulator. For example, local accreditation requirements can be specified for enhanced services under the community pharmacy contract.

CASE STUDY

HARMONISING ACCREDITATION FOR ENHANCED COMMUNITY PHARMACY SERVICES

In the North West, the Harmonisation of Accreditation Group (HAG) has found widespread support for its aim of promoting high quality provision by standardising training and accreditation requirements and seeking reciprocal acceptance by primary care trusts (PCTs) of HAG-accredited pharmacists for the provision of enhanced services.

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Reforms to the profession in the Health and Social Care Bill

- 7.5 For pharmacy, the Royal Pharmaceutical Society of Great Britain (RPSGB) is currently both the regulator for the pharmacy profession and the body responsible for leading the profession and ensuring the highest standards of professional practice. It also has an important role in registering and inspecting pharmacy premises.
- 7.6 The White Paper, *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century*,⁴⁹ signalled the intention to establish a new regulatory body for pharmacy, called the General Pharmaceutical Council (GPhC), and to transfer the existing regulatory functions of the RPSGB to the GPhC. While recognising that ultimately it was a matter for the pharmacy profession, the White Paper also said that strong clinical leadership in pharmacy is critical and suggested that pharmacy might best be served by a body akin to a Royal College.
- 7.7 Following the report of a short-term working party on professional regulation and leadership in pharmacy led by Lord Carter of Coles and published in 2007,⁵⁰ measures to achieve these goals are now contained in the Health and Social Care Bill before Parliament, which will establish the GPhC. This Bill sets

out landmark reforms to overhaul the regulation of all health professionals, including pharmacists and pharmacy technicians, to ensure patient, public and professional confidence in the health professionals' watchdogs, to improve patient safety and to ensure the fair treatment of health professionals. Together with the government response to the fifth report of the Shipman Inquiry, these reforms make the protection of patients and the public the first priority of all who are concerned with healthcare. The legislative proposals will sustain and enhance the high regard in which the public hold health professionals and ensure that good regulation does not get in the way of good patient care.

- 7.8 The Health and Social Care Bill will also establish the new Care Quality Commission (CQC). The Government is consulting on which health and social care services – including, for the first time, NHS providers – will be required to register with the new commission in order to provide services. As pharmacies are registered with the RPSGB (and, in the future, the GPhC), it is not anticipated that these services will also be required to register with the CQC. However, in time, pharmacies may expand their activities into new fields that might require them to register with the CQC.

49 Department of Health. *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century*, 2007: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_065946

50 Department of Health. *Report of the working party on professional regulation and leadership in pharmacy*, 2007: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_074660

7.9 Parliamentary time and process permitting, the intention is for the GPhC to be created in shadow form in summer 2009, starting with the appointment of the chair, and for the GPhC to be fully functional by January 2010. The Government hopes that the development of a professional leadership body, perhaps a Royal College, to give clear, unified and strong professional leadership to the pharmacy profession will occur in parallel, and its effective operational date will coincide with that of the GPhC. However, this is a matter for the pharmacy profession.

7.10 Ministers have established a Pharmacy Regulation and Leadership Oversight Group, chaired by Ken Jarrold CBE, to advise on the establishment of the GPhC.

Undergraduate education

7.11 In the past, the pharmacy undergraduate course was largely scientific in nature. It comprised a broad but comprehensive education centred on how medicines are developed and made into dosage forms and how they work. However, in more recent years, and particularly over the last decade, universities have responded to changes in educational requirements as the public and employers have demanded more clinical involvement from pharmacists.

7.12 Driven largely by pharmacy practice departments at schools of pharmacy and by pharmacy practitioners themselves, the undergraduate course has changed

to embrace more clinical content, but, rightly, has retained science at its heart. Indeed, pharmacists' scientific training has helped underpin research, development and innovation in drug discovery in the UK's pharmaceutical industry as well as helping to ensure that pharmacists on the high street can relate science to the clinical environment. This combination of scientific and clinical training has led to the rigorous, logical and safe approach to medicines use that typifies pharmacists.

7.13 Some 10 years ago, the course was extended from a three-year Bachelor's undergraduate degree to a four-year Master's degree, reflecting the growth of knowledge and the complexity of medicines and their use.

7.14 However, the bulk of a pharmacist's clinical training still takes place away from the undergraduate experience, as a separate one-year pre-registration period, typically in either a hospital or a community pharmacy. There is limited opportunity for undergraduate pharmacy students to develop throughout their education a professional, patient-focused, clinical approach to practice, which would complement their scientific training. Other clinical professions, such as medicine, are adopting a different line on undergraduate training, where small group learning from day one is stimulated by clinical cases designed to promote clinical reasoning. Doctors who learn in this way are better prepared for contemporary practice and more adept

at identifying professional development needs, without sacrificing the acquisition of knowledge.^{51,52,53} This approach is adopted to only a limited extent in pharmacy at present.

- 7.15 As the demand for healthcare rises, and the complexity of therapeutic interventions (including medicines) increases, the demand for pharmacists' specialist skills in patient-centred pharmaceutical healthcare will grow markedly.
- 7.16 Building on the work already done by the RPSGB, the Government believes it is time to ensure that future pharmacists have the clinical, professional and leadership competencies to deliver the services of the future. This can be achieved in part by increasing the clinical content of undergraduate training. However, good science lies at the heart of knowledgeable, inquisitive practitioners who also recognise their limitations and are keen to address them. In this way, rational, clinical decision-making is achieved.

7.17 Therefore **the Government, working with all relevant parties, including the profession, schools of pharmacy, the regulator, the Higher Education Funding Council for England, Universities UK and employers, will begin planning to ensure that there is:**

- **meaningful clinical context and experience throughout the undergraduate programme and determine whether this can be maximised by integrating the degree course with the pre-registration training year;**
- **an appropriate funding framework in place to support academia and clinical practice in delivering the new programme; and**
- **sufficient capacity in the academic workforce and an appropriate infrastructure in clinical practice to provide high quality education.**

7.18 The Government wishes to see pilots of this new approach in place by October 2010. It is important that such changes are evaluated on a longitudinal basis to ensure that they are delivering the expected benefits for the public and patients.

51 Jones A, McArdle PJ and O'Neill PA. Perceptions of how well graduates are prepared for the role of pre-registration house officer: A comparison of outcomes from a traditional and an integrated PBL curriculum, *Medical Education*, 2002, 36: 16–25.

52 Blake RL, Hosokawa MC and Riley SL. Student performances on Step 1 and Step 2 of the United States Medical Licensing Examination following implementation of a problem-based learning curriculum, *Academic Medicine*, 2000, 75: 66–70.

53 Enarson C and Cariaga-Lo L. Influence of curriculum type on student performance in the United States Medical Licensing Examination Step 1 and Step 2 exams: Problem-based learning vs. lecture-based curriculum, *Medical Education*, 2001, 35: 1050–1055.

CASE STUDY**JOINT PROGRAMMES BOARD FOR EAST AND SOUTH EAST ENGLAND**

The Joint Programmes Board (JPB) is a collaborative venture between eight schools of pharmacy and senior NHS pharmacy partners across the four strategic health authorities (SHAs) in East and South East England. The JPB has four goals:

- to establish a unified post-registration higher education portfolio across East and South East England;
- to establish an educational infrastructure to support the progression of pharmacist practitioners to consultant level;
- to widen access to structured post-registration education; and
- to be an exemplar for formalised, integrated work-based education and training systems.

The JPB received initial funding from the Higher Education Funding Council for England in the form of a Strategic Development Fund award to develop a blueprint for its programme and to evaluate the outputs. The JPB currently has 350 hospital pharmacists enrolled in the general pharmacy programme and has plans to expand the provision to primary care and community pharmacy and to support the development of advanced practice. The competencies that underpin these programmes are drawn from the General Level Framework (GLF) and the Advanced and Consultant Level Framework (ACLF) and assessment is based on a range of measures, including performance. Materials from the JPB are available at: www.postgraduatepharmacy.org

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Postgraduate education and continuing professional development

- 7.19 Driven largely by senior pharmacy practitioners who articulated the requirement for greater clinical development of pharmacists, the first MSc courses in clinical pharmacy were established at the University of London and the University of Manchester in 1980. These courses, and the other MSc and doctoral programmes that followed, have trained many of the hospital pharmacy leaders and leading-edge hospital practitioners we see today.
- 7.20 Recognising the need for more widely available clinical training, the NHS has looked to academia to create and provide postgraduate diploma programmes in clinical pharmacy to support the development of, largely, hospital pharmacists.
- 7.21 The Centre for Postgraduate Pharmacy Education (CPPE) has led the way in providing clinical training and supporting continuing professional development (CPD) for community pharmacists, but now also caters for pharmacy technicians and hospital pharmacists. A recent review led by the Chief Pharmaceutical

Officer, supported by an advisory group, and an independent evaluation by the University of Birmingham confirmed CPPE as a centre of excellence in what it does.

7.22 Many employers, particularly those in the NHS, have taken the initiative by constructing schemes that link professional development to career progression. As a result, and underpinned by Agenda for Change, support has emerged for a clinical career pathway for hospital pharmacists.

7.23 The Competency Development and Evaluation Group (CoDEG, www.codeg.org), based in South East England, has proposed such a model for pharmacist development, which recognises four distinct phases:

- undergraduate and pre-registration;
- general;
- advanced; and
- consultant-level practice.

7.24 The model is underpinned by two professional development frameworks; one designed to support practice at the general level (GLF) and the other at advanced and consultant level (ACLF). The GLF improves and sustains pharmacists' performance in hospital practice⁵⁴ and there is evidence for a similar impact in community pharmacy.⁵⁵ Through the JPB for East and South East England, the CoDEG development model and frameworks have been

embedded in programmes that support practitioner development in the workplace.

7.25 In *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century*, the Government set out proposals for the introduction of a new system of revalidation, whereby all health professionals will be required to demonstrate periodically that they continue to meet the standards expected by their patients and the public. This will require a rigorous approach to CPD to support pharmacists (and pharmacy technicians, as statutory registration is introduced) in keeping their knowledge, skills and abilities up to date.

7.26 It is a requirement of the RPSGB's Code of Ethics that pharmacists and pharmacy technicians undertake and maintain evidence of CPD relevant to their field of practice. All pharmacists and pharmacy technicians sign a declaration relating to their CPD when they apply to be retained on the registers each year.

7.27 Over the next two years, it will be important that pharmacists and pharmacy technicians develop their CPD portfolios so that they are prepared for the introduction of a statutory CPD scheme when the GPhC takes responsibility for pharmacy regulation in 2010. Transitional arrangements are being formulated that will allow CPD records created in the period before the

54 Antoniou S, Webb DG, McRobbie D et al. A controlled study of the general level framework: Results of the South of England competency study, *Pharmacy Education*, 2005, 5: 201–207.

55 Mills ER, Farmer D, Bates I et al. *The new General Level Framework: A mechanism to support primary care and community pharmacy practice*. Proceedings of the UK Clinical Pharmacy Association symposium, November 2006, 30–31.

introduction of a statutory requirement to form part of the assessment process from 2010 onwards.

- 7.28 The RPSGB has already introduced a system for recording CPD, based on a model of reflective practice, and is continuing to refine its systems for reviewing and providing feedback on CPD records. **The Government will look to the RPSGB to work with the profession, employers and education providers to support pharmacists and pharmacy technicians in the regular recording of CPD activity.**

Advancing the practice of pharmacy

- 7.29 Development of the pharmacy workforce to deliver high quality clinical services includes the introduction of pharmacist prescribing, consultant pharmacists and PhwSIs. To an extent, opportunities to take forward these roles are dependent on the optimal use of skill mix, which is made possible through the availability of suitable training and contemporary qualifications for pharmacy support staff.

Consultant pharmacists

- 7.30 Guidance on the development of approved consultant pharmacist posts was published in March 2005.⁵⁶ The role of the consultant pharmacist was first identified in *A Vision for Pharmacy in the New NHS* (DH, 2003) and offers an opportunity to make a tangible difference to people's care, building on the success of pharmacists in developing

clinical and other specialist roles. These are intended to be innovative new posts that will help improve people's care by promoting clinical excellence within the NHS and strengthening professional leadership. In the last few years, the original concept set out in *A Vision* has been expanded to include consultant pharmacists practising in primary care. This will be particularly important in taking forward service delivery that crosses traditional boundaries. There are now over 20 approved consultant posts, specialising in defined clinical areas, from cancer to infectious disease, and from paediatrics to care of older people and mental health.

- 7.31 Consultant pharmacist posts are approved by panels at SHA level and contain four main job elements: expert practice, research and evaluation, education and professional leadership. To ensure a rigorous and consistent approach, the competency requirements for appointment to approved consultant pharmacist posts are drawn from the ACLF and specified in the guidance on consultant pharmacist posts.

- 7.32 **The Government will look to SHAs to ensure that there are appropriate arrangements in place to consider applications from organisations that wish to establish consultant pharmacist posts.** The Government encourages employers to avoid use of the term 'consultant pharmacist' unless it applies to a post that has been approved through an SHA-level panel.

⁵⁶ DH. *Guidance for the Development of Consultant Pharmacist Posts*, 2005: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4107445

CASE STUDY**CONSULTANT PHARMACIST**

Steve Williamson became the first consultant pharmacist in North East England, and only the second consultant pharmacist in cancer services in the country, when he was appointed to a joint post between Northumbria Healthcare NHS Foundation Trust and the North of England Cancer Network. Steve provides professional leadership and support to fellow pharmacists working in cancer services in the North East. His key challenges are managing the entry of new cancer medicines, stimulating and co-ordinating cancer-related research and service development, and working with local universities on curriculum design and research opportunities. He is also developing links with community and primary care pharmacists to take forward the clinical management and supply of oral anti-cancer medicines in the community.

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Pharmacists with special interests

7.33 A national framework for PhwSIs was launched in September 2006. PhwSIs offer the potential for people to gain better access to more specialist services in convenient locations, as well as making good use of the skills available in community pharmacy. Pharmacists now have the opportunity to provide innovative new services for people with long term conditions (LTCs) and those, for example, who require monitoring and adjustment of their anticoagulant treatment, or services related to drug misuse and sexual

health. The PhwSI model fits best with community pharmacists and other primary care pharmacists, but it does not preclude hospital pharmacists providing services in locations that are closer to people's homes.

- 7.34 Competencies to support the accreditation process for PhwSIs, and to clarify their level of specialist practice, were included in the 2006 guidance on PhwSIs. These were adapted from the ACLF to provide a consistent approach to developing an advanced level of pharmacist practice in both community and hospital pharmacy.
- 7.35 In April 2007, a further suite of publications, on *Implementing care closer to home: Convenient quality care for patients* (DH, 2007), supported the commissioning and accreditation of PhwSIs and GPs with special interests (GPwSIs) and the services they may provide. Both PhwSIs and GPwSIs supplement their generalist competencies and experience with additional expertise in a particular field, while retaining an ongoing commitment to their core generalist role. By summer 2008, a series of specialty frameworks will be available to underpin the accreditation of practitioners with special interests (PwSIs). This work is being taken forward by the Royal College of General Practitioners with the involvement of the RPSGB.

CASE STUDY**ANTICOAGULATION MONITORING IN BRADFORD**

Bradford and Airedale Teaching PCT has been at the forefront of the development of PwSIs, with around 140 accredited GPwSIs. Currently, eight community pharmacists conduct anticoagulation clinics either within their own pharmacy or in a nearby GP practice. Patients initiated and stabilised on warfarin at the hospital anticoagulation clinic are referred to the community pharmacist-led clinics. The patient's international normalised ratio (INR) is checked and their warfarin dose adjusted, if necessary, with the aid of computer decision support software. A PwSI accreditation panel is already well established in Bradford and the PCT is now supporting these anticoagulation pharmacists through the same accreditation process to develop them to PhwSI level, with the assistance of Bradford Teaching Hospitals NHS Trust. The clinics are currently funded by the PCT but will soon be commissioned by the GP practices through practice-based commissioning (PBC). There is also opportunity for other pharmacists not currently providing the service in Bradford to provide anticoagulation services through PBC.

Bradford and Airedale Teaching PCT also has two pharmacists who work in pharmacies adjacent to local drug misuse services, and is considering the PhwSI in drug misuse as a model to develop their services.

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Pharmacist prescribing

- 7.36 Pharmacists began training to be supplementary prescribers in 2003 and over 900 pharmacists in England have now qualified to prescribe, in partnership with a doctor.
- 7.37 Independent prescribing by pharmacists was introduced in 2006. Over 300 pharmacist independent prescribers are now qualified and registered in England. They may prescribe any licensed medicine for any medical condition that they are competent to treat. In addition, changes to regulations will soon enable pharmacist prescribers to prescribe controlled drugs independently. Pharmacist independent prescribing and supplementary prescribing are important steps towards increasing people's access to medicines, making better use of pharmacists' skills and helping to improve patient care.

Regulating advanced and specialist practice

- 7.38 The regulation of these new roles is at present largely driven from within the NHS, through a range of processes including accreditation of services, accreditation of practitioners and mechanisms for the approval of posts. The exception is pharmacist prescribing, which is subject to statutory regulation by the RPSGB.
- 7.39 The Government wants to see the deployment of advanced practitioner pharmacists, including those who have chosen to specialise, to accelerate markedly. However, as this occurs, regulation needs to be put on a more consistent footing to ensure patient safety. **The Government expects that as**

CASE STUDY**PHARMACIST PRESCRIBER IN A GP PRACTICE**

Rachel Hall has been prescribing for about two years, working in a busy GP surgery. She runs either a morning or an afternoon clinic every day and deals with around 50 to 60 patients a week. They have a range of LTCs such as diabetes, hypertension, chronic obstructive pulmonary disease, asthma and chronic kidney disease. Other duties include authorising some repeat medicines, answering medicines-related telephone queries, and supporting the Quality and Outcomes Framework (QOF) and medicines management initiatives recommended by the PCT.

Rachel's role in the practice has enabled her to provide patients with services that are flexible and accessible. Her appointments are 20 minutes long and pre-bookable, providing more time than patients would normally have at a GP appointment. The reduction in GP workload means that they can target their time towards the patients with more complex medical needs. This is borne out by the excellent QOF results for the practice in 2006/07, when it achieved maximum points for all clinical areas.

The GPs in Bristol were quick to see the benefits of having a pharmacist in their team – who was initially funded by the PCT for four hours a week. Following her initial qualification as a supplementary prescriber, Rachel was asked to work full time for the practice for four days a week, funded by the practice itself.

GP Dr Carole Buckley said: 'Pharmacists are highly trained and skilled professionals with a lot to offer patients as part of the primary healthcare team. We have found Rachel to be a huge asset to the practice. She is popular with patients and staff and increases both access and choice to patients for management of their chronic diseases and ongoing prescribing. She also improves the medicines management systems at the surgery, taking repeat prescribing decisions away from the busy doctors, freeing them for more clinical work with patients. Making Rachel a full-time member of the team has been a very positive move for this practice.'

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part of its early development, the new GPhC will seek to regulate advanced and specialist practice in pharmacy.

Indeed, the opportunity to create a new regulator in pharmacy brings with it the future opportunity to regulate both undergraduate and postgraduate education and training of pharmacists. The Government expects the GPhC to take this opportunity in line with, for example, the principles established

for medical regulation in the future and the Government's response to Sir John Tooke's independent inquiry into modernising medical careers.

Pharmacy expertise in the pharmaceutical industry

7.40 Some pharmacists choose a career in the pharmaceutical industry. They make a major contribution to both the success of the UK pharmaceutical

industry and therefore the care of patients with modern medicines. Their input ranges from fundamental research in drug discovery and scientifically formulating medicines in a way that makes them effective in clinical practice, through to making sure that medicine manufacturing processes are safe and of the right quality, typically by taking on the statutory role of 'qualified person'. This is supported by university schools of pharmacy, some of which have the most highly rated research programmes in these areas.

- 7.41 This important contribution must not be lost as pharmacy takes on a more clinical role, particularly as it also supports 'translational research' through helping to get laboratory ideas into clinical practice. Therefore, **the Government is asking the RPSGB to identify the unique competencies based on knowledge, skills and values that should remain within the pharmacy profession as its transformation to a scientifically based clinical profession accelerates.**

Development of pharmacy technicians

- 7.42 Pharmacy support staff develop their skills and knowledge through vocational qualifications based on National Occupational Standards (NOS). In order to best support new clinical roles in pharmacy, the NOS underpinning the National Vocational Qualifications in pharmacy services at levels 2 and 3 were reviewed and updated in consultation with a wide range of interested parties and regulators in a Skills for Health project during 2006/07.
- 7.43 A second Skills for Health project is currently under way to build more contemporary qualifications at level 2, which will meet the training needs of dispensing and pharmacy assistants in a variety of settings, and at level 3 for pharmacy technicians. These new qualifications will be consistent with the Qualifications and Credit Framework.
- 7.44 **The Government will consider what further training may be required to enable pharmacy technicians to supervise certain aspects of the sale or supply of medicines as envisaged by the Health Act 2006.**
- 7.45 The development of pharmacy support staff is a key enabler in improving pharmaceutical healthcare and, to this end, the Government commissioned work from the National Institute for Mental Health in England on expanding the role of pharmacy technicians. This forms part of a range of initiatives on medicines management in mental health trusts, including an organisational self-assessment toolkit, guidance on service level agreements and leadership development (see www.newwaysofworking.org.uk/pharmacy.aspx). Although designed for mental health services, many of the principles and activities outlined for pharmacy technicians can be applied broadly in different healthcare settings.

CASE STUDY

EXTENDING THE CONTRIBUTION OF PHARMACY TECHNICIANS

At both Essex Rivers Healthcare NHS Trust and the Cambridge University Hospitals NHS Foundation Trust, pharmacy technicians who have completed a university-accredited, but work-based, certificate in medicines management are making an important contribution to patient care at ward level. Working in close liaison with clinical pharmacists, and as part of the multidisciplinary team in their own right, their patient care roles now include:

- compiling medication histories;
- medicines reconciliation;
- discharge planning;
- patient counselling; and
- medicines supply.

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At Shrewsbury and Telford Hospital NHS Trust, pharmacy technicians are key to achieving the goal of safer medication practice on admission. After completing a professional development certificate, pharmacy technicians practise in admission areas and deliver a similar range of roles to their colleagues in Essex and Cambridge.

The service involves prioritisation of patients' pharmaceutical needs and making appropriate referrals for pharmacist reviews. This is welcomed by the pharmacists and is in the process of being rolled out across the trust.

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Pharmacy workforce planning

7.46 In January 2003, the RPSGB established the Pharmacy Workforce Planning and Policy Advisory Group with support from UK Health Departments. The Group's report was published in spring 2007⁵⁷ and contained a model for planning the pharmacy workforce that highlights a gap between demand and supply for

pharmacists. This was based on a set of input data and assumptions about key indicators of supply of, and demand for, pharmacists, including external factors such as the European Working Time Directive.

57 Available at: www.rpsgb.org.uk/pdfs/futphwfreqexceprt.pdf

7.47 To address the demand for pharmacists identified in this report:

- the number of pharmacy students has increased, through the expansion of existing schools of pharmacy and the opening of new schools of pharmacy;
- the grant paid to community pharmacy contractors to train pre-registration pharmacists has increased;
- new technology has been adopted, including automation and the Electronic Prescription Service; and
- employers have sought to recruit appropriately from abroad.

7.48 As part of the NHS Next Stage Review, the Government is considering how workforce planning for all health professions can be strengthened. Pharmacy workforce planning will form part of these future arrangements.

Utilising the pharmacy workforce to best effect

7.49 In December 2004, the Government published a consultation paper on making better use of the pharmacy workforce which explored options for allowing greater flexibility in using the skills and experience of pharmacists and others working within pharmacy to deliver a wider range of services. There was a strong and clear response to consultation, with 75% of respondents seeking greater clarity on the personal control requirement in the Medicines Act 1968, and 80% wanting to see changes to the requirement on the pharmacist to supervise the preparation, sale and supply of medicines.

7.50 The Health Act 2006 introduces provisions relating to pharmacist supervision of the sale and supply of medicines from the pharmacy and replaces the 'personal control' requirement in the Medicines Act 1968 with a requirement that each registered pharmacy is to have a responsible pharmacist. The Act also introduces powers that, together with existing powers in the Medicines Act 1968, enable greater flexibility in relation to the pharmacist supervision requirements and particularly the requirement on the pharmacist to supervise individual dispensing transactions.

7.51 Recognising changes in modern pharmacy practice and improvements in the training and skills of pharmacy staff (such as pharmacy technicians), these powers will enable a pharmacist to permit registered and suitably trained pharmacy staff to supervise certain aspects of the dispensing and supply of medicines. This will help free up pharmacists to use their clinical skills to better effect and to improve the range of services available in the pharmacy. The changes in the pharmacist supervision requirements also provide opportunities for pharmacy staff to develop their skills.

7.52 There is no compromise on public safety. The pharmacist in charge of the pharmacy – the responsible pharmacist – has a duty to ensure that there is safe and effective working in the pharmacy and, in meeting that duty, must be satisfied that staff, including those who supervise certain aspects of the dispensing and supply of medicine, are competent to perform their roles.

7.53 Greater detail on these requirements will be set out in regulations. These are important and significant changes for pharmacy. Therefore, the Government is taking a phased approach to consultation on the content of the regulations. Following informal consultation in early 2007, the Government began the first stage in October 2007 with the issue of a consultation paper on the responsible pharmacist regulations. Pharmacy provided a strong response, with over 300 replies received.

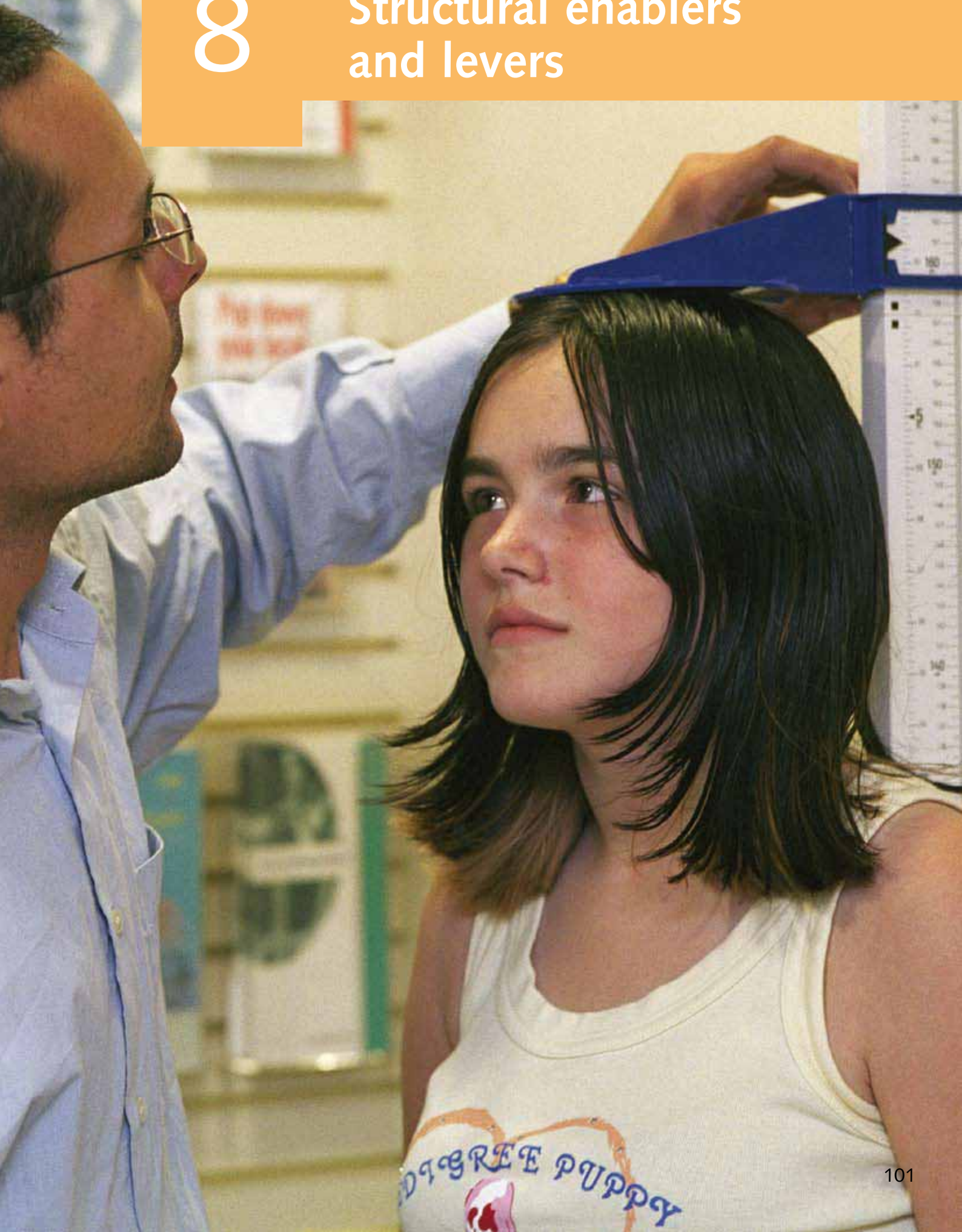
7.54 **The Government will publish a summary of the outcome of the consultation on the responsible pharmacist. Account will be taken of pharmacy views on the time needed to prepare for introduction of the responsible pharmacist regulations. The next stage will be consultation on the proposed content of regulations on the supervision requirements.**

Professional recognition for appliance contractors

7.55 Unlike pharmacists and doctors, appliance contractors have no professionally recognised body or association to which members are accountable for their professional conduct. While codes of conduct have been developed by representative organisations, as such they largely lie outside the professional and disciplinary requirements demanded of other health professions. **The Government will discuss with representatives of appliance contractors what further action may be needed so that their contractual requirements ensure service delivery is both professional and to high standards and quality.**

8

Structural enablers and levers



CHAPTER SUMMARY

The Government is inviting views on how, with others, it can support and help deliver this vision for pharmacy. This chapter puts forward a number of proposals for changing the current structure to enable and lever change. These include the Government's response to Anne Galbraith's review of the contractual arrangements for NHS pharmaceutical services, with a need to refocus commissioning away from dispensing services – important as these remain – and proposals for how high quality and innovative pharmaceutical services are rewarded. This chapter also sets out the Government's proposals to revise arrangements for new 100 hours per week pharmacies and its preferred option for reform, and considers the special position of market entry arrangements for dispensing doctors and appliance contractors. These will be subject to full consultation later in 2008.

Introduction

- 8.1 This chapter sets out a range of structural enablers and levers the Government believes are needed to secure the future provision of pharmacy services. The Government is inviting views on these proposals prior to a formal public consultation in summer 2008.

Review of market entry rules and contractual arrangements

- 8.2 For the last 20 years or so, whether or not a pharmaceutical contractor provides NHS services is largely determined by the regulatory system known as 'control of entry'. In broad terms, an application will only succeed if a primary care trust (PCT) considers it necessary or expedient to grant it in order to secure adequate provision of NHS pharmaceutical services locally. There are also certain complete exemptions to this test.
- 8.3 The Government reviewed the reformed arrangements introduced in 2005 and published the outcome in January 2007. The review found that, while

still early days, the reforms have had a modest, albeit uneven, impact. While access remained very good (99% of the population could get to a pharmacy within 20 minutes, including in deprived areas⁵⁸), the regulatory system is complex to administer. It is still largely driven by the providers, in that a provider decides whether or not to enter the market. However, the changes to the system have not improved business confidence. Contractors have invested their faith in the new contractual framework, but there is concern that they have yet to see the fruits of that commitment in terms of greater service commissioning by PCTs. In turn, PCTs believe that they have insufficient influence to commission services or to exercise control over where services are provided to meet the greatest needs. Such shortcomings are inconsistent with the thrust of NHS reforms and the desire to give PCTs more responsibility to secure effective commissioning of adequate services to address local priorities.

⁵⁸ Updated information for 2007 is reported in Chapter 1.

- 8.4 To meet these concerns, when publishing the outcome of the review into the reformed arrangements in January 2007, the Government launched a review of NHS pharmaceutical contractual arrangements, led by Anne Galbraith, former Chair of the Prescription Pricing Authority. This review also fulfilled a commitment given in *Our health, our care, our say* to develop pharmaceutical contractual arrangements in line with the wider ambitions of that White Paper.
- 8.5 Anne Galbraith's report, published alongside this White Paper, makes a number of recommendations to which this White Paper responds. A summary of Ann Galbraith's report in respect of contractual arrangements is set out in the box below.
- 8.6 In June 2007, the All-Party Pharmacy Group published the report of its inquiry into pharmacy services. This took a different approach. It found that progress with the new contractual framework had been patchy and called for more services to be determined at a national level. It suggested, in particular, that there should be more nationally agreed funding for advanced and essential services and consequently a move away from discretionary funding by PCTs for enhanced services. It also advocated six additional advanced services:
- managing people with stable long term conditions (LTCs);
 - sexual health, including chlamydia screening and advice;

Summary of Anne Galbraith's report in respect of contractual arrangements

- There is a need to strengthen PCTs' commissioning roles to stimulate competition and to ensure that future contractual arrangements are founded on the services to be provided and their quality, not simply on market entry.
- PCTs should undertake a more rigorous assessment of local pharmaceutical needs to provide an objective framework for future contractual arrangements and market entry, setting out the requirements for all potential providers to meet, but flexible enough to allow PCTs to contract for a minimum service to ensure prompt access to medicines and to the supply of appliances.
- PCTs should be able to terminate contractual rights for underperforming or poorly performing service providers. This will help address the currently limited means available to PCTs to open provision up to competition or to remove such provision where it is no longer needed or where providers fail to meet local needs.
- The report concludes that neither further moves to nationalised contracting arrangements nor simple deregulation would best meet these principles. However, it identifies two possible options – either complete devolution of contracting responsibilities to PCTs or the introduction of the concept of 'any willing provider' for the provision of essential services with more contestability for local enhanced clinical services.
- As a result, the complex 'control of entry' system would fall away.

- managing minor ailments;
- diabetes screening;
- obesity and weight management; and
- a broader range of diagnostic and screening services.

Commissioning for excellence in pharmacy

- 8.7 Many PCTs work hard at fostering a vibrant community pharmacy service with dedicated staff supporting the expansion of choice and services. However, that commitment is variable, leading to inconsistencies across the country. Generally, since Anne Galbraith completed her report, the commissioning capability and capacity of PCTs have been assessed as less mature in respect of primary care services generally.
- 8.8 The Government endorses, as part of the World Class Commissioning Programme, Anne Galbraith's recommendations to strengthen commissioning and that PCT local needs assessments are a valuable part of that process. The Government also considers that PCTs should have effective powers where contractors are underperforming or performing poorly.
- 8.9 The Government, however, concludes that commissioning development within PCTs is not yet at a stage where PCTs can be charged with full responsibility for contracting. A different approach is required while important developmental work to build commissioning systems and structures is under way.

The strategic commissioning direction – continuous service improvements through evidence-based commissioning using local needs assessments

Evidence-based clinical decision-making driving commissioning and delivery

- 8.10 There remain some significant areas where structures, systems and performance do not yet support the drive forward – for example, where the environment does not promote the right rewards for service providers or the right checks and balances for commissioners to ensure that services are meeting needs and are cost effective. The Government believes these areas to be particularly important if contractors are to invest in service improvement, confident that income streams offer greater security, while the NHS is confident that these services offer value for money and good health outcomes. Only in this way can the NHS align pharmacy as part of the fabric of patient-centred NHS services.
- 8.11 As medicines are the most common treatment intervention and most care pathways involve medicines, the Government recognises that early consideration of pharmaceutical, governance and logistical requirements relating to medicines are key to successful service redesign. Critical factors for ensuring that sufficient account is taken of medicines in the commissioning of services also include the competencies of those undertaking new roles, the support provided to patients and carers, and systems for the responsive handling of medicines issues under Payment by Results.

- 8.12 The Government believes that – in keeping with the services offered by the best pharmacies – commissioning in the future must foster a shift away from the dispensing service – important as this will always remain – to more clinically focused pharmaceutical services, as set out in this White Paper. Chapter 6 sets out areas where the Government believes there is a general need to improve the evidence base for pharmaceutical interventions. This will ensure that decisions based on clinical considerations and cost-effectiveness drive commissioning and delivery across care sectors, while also securing the promotion of health, wellbeing and independence for people.
- 8.13 Using this approach, rewards will, in time, be better directed at those pharmacies that fully embrace the new direction of change and that invest in staff and infrastructures to support high quality services. In pharmacy, commissioners have a readily available asset bank on which they can capitalise to help achieve this shift in focus.
- 8.14 Commissioners need to create the right environment – one that encourages innovative and imaginative solutions that better meet local needs, including providing more convenient access and greater choice of provider, at a time to suit the public. This can be particularly important in creating services for those people who do not normally access other NHS service provision, or who prefer a less formal health setting. In this way, pharmacy can provide services that help free up NHS capacity elsewhere –
- for example, enabling specialists to focus on more complex cases as care shifts from hospital to the community.
- 8.15 To realise this potential, the Government recognises that, over time, PCTs and practice-based commissioners need to encourage and consider a wider perspective on service commissioning and service delivery as well as promoting health. This includes commissioners recognising that pharmacy is a key and essential element in the delivery of clinical services and that pharmacies can offer opportunities that will help deliver commissioning plans that are responsive to local needs.
- 8.16 The Government considers that there is a need to meet a number of important preliminary and transitional milestones to achieve this longer-term strategic direction. These are:
- ensuring that commissioning meets local needs and links to practice-based commissioning (PBC);
 - revising arrangements for contracting for services;
 - revising payment mechanisms for such services; and
 - ensuring high quality and safety in the delivery of services.
- 8.17 Once these are in place, unnecessary market entry and exit barriers can be removed and can be replaced with criteria that place safety, quality and outcomes at the heart of delivery.

Ensuring that commissioning meets local needs and links to practice-based commissioning

8.18 PCTs and local authorities are now required to work together to produce a joint strategic needs assessment that identifies local needs. The principle is that, through local strategic partnerships, local area agreements and joint commissioning strategies, PCT, practice-based and local authority commissioners will secure improvements in health outcomes to meet identified needs, to reduce local inequalities and to deliver services that are designed around people and communities at best value for all.

8.19 Therefore, PCT pharmaceutical needs assessments (PNAs), first developed in 2004/05, should contribute to joint strategic needs assessments. Where integrated assessments lead to the identification of agreed priority actions to tackle and meet key national priorities (such as reductions in health inequalities, promotion of health, wellbeing and independence, and support for self care) as well as more local specific needs, these should be illustrated in the sustainable community strategy (SCS). As the overarching strategy for the area, the SCS will then inform negotiation of the local area agreement.

8.20 Feedback from the NHS and others indicates that, currently, there is considerable variation in the scope, depth and breadth of PNAs. Many PCTs have already reviewed their PNAs following mergers in October 2006, while others plan to do so. It is clear, however, that not all PCTs have yet

considered the need to either update or review their PNAs.

8.21 In the light of the new duties – and building on the support programme for world-class commissioning – **the Government therefore considers that the structure of and data requirements for PCT PNAs require further review and strengthening to ensure they are an effective and robust commissioning tool which supports PCT decisions.**

8.22 To help implement this work, **the Government has asked NHS Employers to establish a short-term working group to review these requirements and to devise an appropriate support programme for PCTs.**

Links to practice-based commissioning

8.23 Community pharmacists and PCTs have a long-established history of working together to identify innovative ways in which community pharmacists' skills and accessibility can be used to address local priorities. There are a number of best practice examples of innovative community pharmacy services that demonstrate how practice-based commissioners can look to a range of service opportunities to embed community pharmacy in their plans.

8.24 However, this is not a uniform experience. Consequently, PBC has registered to a limited extent with pharmacists. Unless steps are taken to broaden links with pharmacy, there is a risk that the benefit that community pharmacy can bring to reducing unplanned hospital admissions, reducing time to treatment, achieving cost-

effective health outcomes and improving quality could be lost.

8.25 The Government therefore advocates that commissioners should:

- involve community pharmacists in their health needs assessment activities;
- ensure that community pharmacists are included in local planning processes;
- understand and integrate the work of community pharmacists into care pathways for their patients and care plans for people with LTCs; and
- link with pharmacy stakeholders to understand where community pharmacy services can have the greatest impact in meeting the objectives for PBC.

8.26 Developing shared understanding is the responsibility of the PCT, which should use the Strategic Commissioning Tests (www.primarycarecontracting.nhs.uk/114.php) to bring the stakeholders together in a structured process to discuss and agree ways of working at a local level. Engaging clinicians and working in partnership with providers are both reflected in the 11 competencies for world-class commissioning against which PCTs will be judged. PCTs will also need to ensure that the priorities and plans of practice-based commissioners inform the reviews of their PNAs.

8.27 PBC continues to develop and grow locally, with implementation supported by the NHS Improvement Foundation's PBC development programme, which is funded by the Government. As part of the programme, events have been organised to encourage practice-based commissioners to involve pharmacy colleagues when considering redesigning care pathways or services. The Government is scoping the next phase of national support for implementing PBC in the context of the NHS Next Stage Review.

Revising arrangements for contracting for services

8.28 There are two elements to this: arrangements for essential services and arrangements for advanced and local enhanced services.

8.29 With regard to essential services, while PCT commissioning capacity builds, a move to direct local contracts held by PCTs is some way distant. However, in line with Anne Galbraith's recommendation, more use can be made of a readily available mechanism that enables national requirements for essential services to be tailored to more closely reflect local needs.

8.30 Local pharmaceutical services (LPS) arrangements permit pharmaceutical services to be delivered on the basis of locally negotiated contracts. Such contracts must include a dispensing service (to either all or some groups) and certain other terms of service (such as a complaints procedure and clinical governance). Beyond those required terms, the content of the contract and

the range of services to be provided under LPS arrangements are a matter for local negotiation. All services considered within this White Paper can be provided through LPS contracts, and indeed LPS is likely to be immediately useful, for example where national contractual framework arrangements might struggle to accommodate specific service configurations. Guidance on LPS is available at www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Communitypharmacy/Localpharmaceuticalservices/LPSPermanenceguidance/index.htm

8.31 So far, the provision of advanced and local enhanced services under the contractual framework suggests that some good progress has been made. However, given the extensive health challenges identified earlier, the pace of change is neither consistent nor sufficiently rapid. Pharmacy contractors and the All-Party Pharmacy Group in its report argued strongly for more services to be funded nationally and to be available from community pharmacies in all PCT areas. Their view is that, where left to PCTs alone, such services are not developing quickly or consistently enough as local enhanced services and there is an emerging risk of postcode provision. Therefore, more services should be available as either advanced or essential services.

8.32 With NHS Employers, the Government has looked at how to commission services better to meet the objectives of income security and value for money set out above. A number of factors were identified:

- There should be either a sufficient level of need for a particular service or a requirement for wide availability of the service across the country.
- Contractual structures should be capable of being applied to different kinds of service.
- There should be flexibility so that new services can be linked to and reflect PCTs' PNAs and can capture new kinds of services in the future.
- The new services will attract pharmacy interest and investment.
- This should not require extensive legislation and should conform to the direction set by the primary and community care strategy.

8.33 Taking these factors into account, as well as the desire to build momentum to underpin investment and shift the focus from dispensing to clinical services, it has been concluded that a further category of service is needed – directed enhanced services. This will provide a useful additional option alongside advanced services, which community pharmacies choose to provide, and local enhanced services, which PCTs commission according to local needs.

8.34 Directed enhanced services are where the Secretary of State issues Directions requiring PCTs to commission certain services. **The Government will use Directions in consultation with NHS Employers and PSNC to direct all PCTs that they have to commission certain services from pharmacy contractors according to the local needs they identify and subject to suitable accreditation requirements and service quality standards.**

8.35 This approach is most likely to be of use where there is a strong link with the use of medicines or where pharmacy provides a readily accessible location for people to access health improvement services. For example, this approach could be used for the proposed national minor ailment scheme or support for people newly prescribed a medicine for an LTC. Following discussions with NHS Employers and the PSNC, details of the evidence to support commissioning will be produced, as well as service criteria and specifications, with the intention that PCTs use this approach to commission services as soon as possible.

Revising payment mechanisms for such services

8.36 An important part of developing these new services will be to identify secure and appropriate funding streams. It is recognised that PCTs must be able to 'own' these new services. With different contracting options, funding may require different approaches depending on the types of services to be commissioned.

8.37 Within the community pharmacy contractual framework, the Government has concluded that there is a range of payment mechanisms that can be applied as appropriate:

- fees set nationally for services;
- fees set within a band range for services to give the PCT better control and reward those who deliver higher levels of service; and
- fees set locally for services.

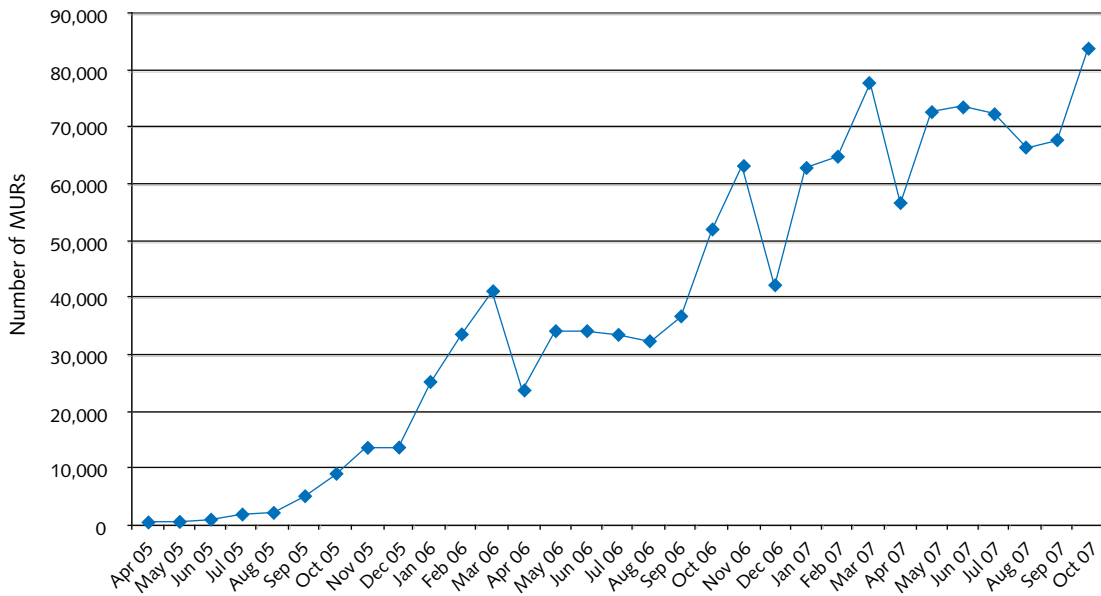
8.38 The Government is exploring the future development of tariffs for community-based health services, which would support greater transparency and consistency in commissioning arrangements and in supporting a broad provider base for community-based services. In future, the payments for some enhanced services could reflect these tariffs.

8.39 In the light of further discussions with the NHS and the PSNC, the Government will include future payment mechanisms as part of the fuller consultation in summer 2008.

Ensuring high quality and safety in the delivery of services

8.40 This White Paper has emphasised the increasing focus on the quality and safety of delivery. Good progress has already been made but there are three areas in which the Government considers that immediate improvements can be secured.

Number of medicines use reviews undertaken by community pharmacies each month



Source: Department of Health

8.41 These are:

- setting more robust standards for essential and advanced services and harmonising common accreditation standards for similar kinds of local enhanced services. This will reduce bureaucracy, ensure that pharmacists' skills are recognisable and accepted across PCT boundaries and reduce PCT administration time;
- introducing financial incentives and penalties. This is linked closely to the further discussions the Government will hold with the NHS and with the PSNC; and
- more effective sanctions to address poor performance.

8.42 Community pharmacies are commercial businesses as well as healthcare providers. In some areas, this has led to an over-emphasis on the **quantity** of services provided – such as the number of medicines use reviews (MURs) – rather than their **quality** and relevance to local health needs.

8.43 As the graph above illustrates, the attention of pharmacy contractors can be finance-driven – the number of MURs conducted was at its highest in the final month of the financial year. This can engender a sense that contractors focus on relatively simple outputs rather than on how they can deliver the benefits of better health to people. The Government believes that future contractual arrangements should encourage and reward pharmacy as clinical, not just retail, entrepreneurs.

8.44 At the same time, it is important to acknowledge the investment service providers have made. If the NHS is to make inroads into the significant health challenges that lie ahead, it is right that the focus for future investment should shift so as to better reward those contractors who are prepared to invest in improved facilities and who strive to improve the quality of services they offer – and can demonstrate that they do so.

- 8.45 Equally, public investment should not provide a permanent reward system for service providers who are prepared simply to deliver the bare minimum levels of service or whose focus is on patient throughput rather than patient satisfaction and not on the benefits of improved health outcomes within a service delivered to high quality standards. This is unacceptable when the taxpayer invests nearly £10 billion a year in pharmaceutical services overall.
- 8.46 **Therefore, the Government will work with the PSNC and NHS Employers to devise proposals to ensure that effective arrangements are in place to address unwarranted variations in standards and quality of service delivery.** This will include proposals for introducing adequate levers that will support effective action against contractors who fail to meet standards and that will encourage more than the bare minimum standards set for service delivery to be met.
- 8.47 **The Government will also work with the NHS and professional bodies to develop a set of pragmatic, easily measurable metrics or indicators that will serve to demonstrate the quality and outcomes of pharmacy service provision.**
- 8.48 These indicators could:
- form the basis of providing incentives for quality of service provision;
 - be utilised to help capture the performance of individual clinicians; and
 - be utilised to indicate where support may be needed to address poor performance.
- 8.49 As such, these indicators will need to be easily understandable, providing a basis for a continuously improving service that is offered fair rewards based on the quality standards met, in accordance with local needs. NHS Connecting for Health will be asked to consider how IT can support the capture and reporting of these data. Consideration will be given to publishing these data to help people choose the pharmaceutical services they want.
- Performance metrics in the Netherlands**

The Netherlands is introducing, following piloting of 120 indicators, a set of 44 performance indicators for community pharmacies as measures of pharmaceutical care. These indicators are grouped in clusters of information, comprising patient records, contraindications, documentation of allergy/non-tolerance, drug–drug interaction, dispensing, patient counselling and experience, compound medication and pharmacotherapy. When piloting these indicators, drug interactions proved a strong indicator of poor patient outcomes. Since January 2008, community pharmacies have used a web-based reporting system and form to record details of these indicators, which are available to the public to show the quality of services provided.

The Dutch Ministry of Health is exploring the development of a series of ‘chain’ indicators across health disciplines to measure patient care outcomes.
- 8.50 The emerging metrics and indicators from this work may also have relevance to the work of dispensing doctors.

8.51 The lack of defined quality markers in both the regulations and the Statement of Financial Entitlements (SFE) in relation to dispensing doctors might also contribute to differing standards and quality of service delivery. Just as in pharmacy, quality might be indicated in areas such as:

- service availability;
- additional advice for patients on the use of drugs/medicines;
- safe management of drugs/medicines;
- stock control and the availability of medicines at the point of dispensing;
- rational and cost-effective prescribing and dispensing (i.e. prescribing in a way that does not lead to wasteful dispensing);
- accuracy of dispensing;
- use of appropriately trained staff;
- collection of prescription charges; and
- services that focus on the promotion of health, wellbeing and independence for people.

8.52 A Dispensary Services Quality Scheme was introduced as part of the 2006/07 contract changes and is set out in the SFE. It introduces standards around governance, training and patient reviews. It is a voluntary scheme.

8.53 The Government will therefore ask NHS Employers to work with the General Practitioners' Committee of the British Medical Association and the Dispensing Doctors' Association to look at the development of further quality standards in dispensing practices and to examine any resource implications from this work.

Clinical audit – a vital tool

8.54 Clinical audit, at its best, can be a very effective service improvement tool. By reviewing whether actions match agreed standards, service providers can identify their own improvement needs; commissioners can access detailed information to support their commissioning duties; and patients can be provided with information to help them make informed choices about their care. Good clinical audit is carried out on a voluntary basis by clinicians who want to understand how effective their services are, and what they can do to ensure continuous improvement.

8.55 In 2006, the Chief Medical Officer's report *Good Doctors, Safer Patients* (DH, 2006) recognised that clinical audit has not yet lived up to this potential, and called for its reinvigoration. In February 2007, the White Paper *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century* set out plans to establish a National Clinical Audit Advisory Group (NCAAG) to drive the reinvigoration programme and provide a national focus for discussion and advice on matters relating to clinical audit.

8.56 The community pharmacy contractual framework currently requires a pharmacy to have clinical governance arrangements in place, including a clinical audit programme consisting of one pharmacy-based audit and one multidisciplinary audit a year. However, **the Government considers that the use of audits within the contractual framework needs to be strengthened and will work further with the NCAAG**

to explore how clinical audit, with all its potential as a service improvement tool, can be used more constructively to ensure that pharmacy services and systems are safe and effective.

Market entry for exempt pharmacies opening 100 hours per week

8.57 The introduction of new exempt categories of applications has opened up the pharmacy market as intended by the Government in its response to the 2003 Office of Fair Trading report. The Government completed a review of the reforms introduced in April 2005 and published its report in January 2007.⁵⁹

8.58 This showed that, despite earlier misgivings within the industry, the 100 hours per week exemption was by far the most popular. In 2005/06, it accounted for over two-thirds of all exempt applications, with 58% of these approved. However, an unanticipated outcome was the emergence of several 'copycat' exempt applications relating to the same area or PCT, where applicants would 'jockey for position' close to new developments such as large GP surgeries.

8.59 The Government's conclusion in 2006 was that patients and some NHS respondents reported that access had improved where 100 hours per week pharmacies opened, for example in under-provided or rural areas, with no evidence of an overall adverse impact on the network.

8.60 However, the NHS reported considerable problems with this exemption, which can be summarised as:

- a lack of PCT control over where such pharmacies are located;
- no match between the better access that a 100 hours per week pharmacy delivers and the need for such an improvement locally;
- clustering of 100 hours per week pharmacies close to each other or around income sources; and
- unbudgeted additional expenditure if thresholds for extra allowances are reached, at a cost to the PCT of some £25,000 per annum per 100 hours per week pharmacy.

8.61 These problems were echoed in Anne Galbraith's report, which set out: '[the] strongly-held views on the operation of the current system, particularly the impact of 100 hours pharmacies. Whilst we were told they have improved access in various areas, we were also made aware that they create uncertainty for contractors and impede PCTs' commissioning ability.'⁶⁰

8.62 Data for 2006/07 published by the NHS Information Centre⁶¹ showed that the 100 hours per week exemption was still by far the most popular. The exemption accounted for over four-fifths of all the exempt applications that PCTs decided. Of these over 80% were approved.

59 Department of Health. *Review of progress on reforms in England to the 'Control of Entry' system for NHS pharmaceutical contractors*, 2007: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063460

60 Galbraith A. *Review of NHS pharmaceutical contractual arrangements*, 2008: www.dh.gov.uk

61 NHS Information Centre. *General Pharmaceutical Services in England and Wales 1996–97 to 2005–06*, 2006: www.ic.nhs.uk/statistics-and-data-collections/primary-care/pharmacies/general-pharmaceutical-services-annual-bulletin-2005-06

8.63 Independent contractors and others have argued forcefully that they are subject to increased competition which affects their business certainty. The concerns of PCTs have remained, and such pharmacies hamper their efforts to plan strategically – and commission further clinical services – because of the costs arising from each new entrant. Therefore, while there are undoubted benefits in terms of improved access, there are also some significant drawbacks.

8.64 The Government has considered further what action may be appropriate in respect of 100 hours per week pharmacies and has identified four options on which it will seek further views in the full consultation to follow later in 2008:

- The first option would introduce a distance restriction on new 100 hours per week pharmacies of 1.6 km or 2 km. Both distance restrictions are used in the current regulations. This should lead to increased contestability for suitable sites and a better spread of 100 hours per week pharmacies across PCTs. It would prevent future clustering. At this stage, the Government would not apply these new measures to existing 100 hours per week pharmacies.
- The second option would impose a requirement on new applicants to justify the need for a new 100 hours per week pharmacy to the PCT. While still treated as an exemption to the main 'control of entry' test, the regulations would be amended to impose much tighter requirements for this exemption. This would give

better PCT control and probably more even distribution of such pharmacies, but it needs to be linked to robust and up-to-date assessments of local needs in order to validate PCT decisions.

- The third option would allow the exemption to continue but successful applicants would be contracted using LPS contract terms. LPS is a means of direct contracting between PCTs and the applicant and can be used to broaden service provision beyond traditional pharmacy services into areas such as outreach or training. This would give PCTs more control to avoid the fixed costs they currently incur from surplus provision. The benefits, however, depend on PCTs having developed more sophisticated commissioning and skills.
- The fourth option, which can be used on its own or in conjunction with the other three, would strengthen the requirements for the specific services a 100 hours per week pharmacy provides. For example, applications would be linked closely to the developments outlined in this White Paper on minor ailment schemes or for more services to be available during out-of-hours periods.

8.65 At this stage, the Government's preferred approach is to combine the first and fourth options – to introduce a new distance limit of 1.6 km or 2 km and to improve the service specifications and requirements for new 100 hours per week pharmacies. The services they provide, as well as meeting local needs, will then more closely match what the Government expects from all such pharmacies in the future, including

minor ailment schemes, better out-of-hours access to prescription medicines, including those for palliative care, urgent advice and the supply of emergency hormonal contraception. In this way, the policy on exemptions to market entry is aligned with the national priorities identified in the NHS Next Stage Review interim report and to be set out in the forthcoming primary and community care strategy, as well as demonstrating how access to a range of commonly needed out-of-hours services can be improved.

- 8.66 PCTs would negotiate with existing 100 hours per week pharmacies any necessary amendments to their current service provision.

Consent (market entry) for dispensing doctors

8.67 Given the Government's conclusion that commissioning development within PCTs is not yet at a stage where PCTs can be charged with full contractual responsibilities, there will remain a 'control of entry' regime. The Government believes that there are two principal concerns in relation to dispensing consent for doctors.

8.68 First, people's perceptions and expectations. The current regulatory system determines eligibility to receive dispensing services from a GP on the basis of the distance between the person's home and the nearest community pharmacy. This leads to the inequitable situation where, at the same GP practice, a patient who lives on one side of a road can receive convenient dispensing services from their surgery whereas a patient on the other side of

the road cannot. This test can also fail to identify the actual distance a person has to travel when going from home to the GP and on to the nearest pharmacy. If the surgery and the pharmacy are in opposite directions, the distance travelled can considerably exceed the 1.6 km stipulated in the regulations.

8.69 Second, the proximity of dispensing practices to community pharmacies. Some people who receive dispensing services from their GP surgery walk past a community pharmacy on their way to and from the surgery, particularly in market towns.

8.70 Both issues could be resolved by considering new 'control of entry' equivalent rules for dispensing practices. For example, instead of the current considerations that take into account the locality and the distance between the individual patient's address and the nearest pharmacy, there could be a single condition relating simply to the distance between the surgery and the nearest pharmacy. This might appear more logical, as the person will usually travel to the surgery to see the GP. If a prescription is provided, they are likely to have it dispensed during that same trip.

8.71 If a dispensing practice met the new single criteria, then dispensing to all the practice's patients would be allowed. This would be far more transparent for patients and would facilitate other changes such as allowing patients to buy over-the-counter medicines from their dispensing practices (this would be unmanageable where only a proportion of patients could receive dispensing services). However, no patient would be

forced to have their medicines dispensed by their practice (the choice to go elsewhere must reside with the patient).

8.72 Transitional rules would be required and these would need to consider the financial impact on the GP practice of losing the right to dispense as well as the impact on pharmacy provision. Practices meeting the new criteria could find that they dispense to more patients, but the counter position is that those who do not meet the conditions will have to accept that they will need to wind down their dispensing role. Provisions for the removal of dispensing consent already exist in the pharmaceutical regulations and could provide a model for such a phased approach.

8.73 Consideration would, as now, need to be given to patients with travel difficulties (for example the housebound), where there is no home delivery service available. PCTs might commission home delivery.

8.74 The Government considers that the current process has significant inconsistencies but is aware that the current market entry arrangements in rural areas reflect previous agreements between representative bodies of pharmacists and doctors. **Therefore, the Government proposes that any changes to dispensing doctor market entry arrangements should be part of a wider consultation on elements of the 'control of entry' system itself, as proposed here. The consultation will also consider whether current regulatory arrangements can be streamlined so that dispensing consent in future is sought under a single regulatory route.**

Market entry for appliance contractors

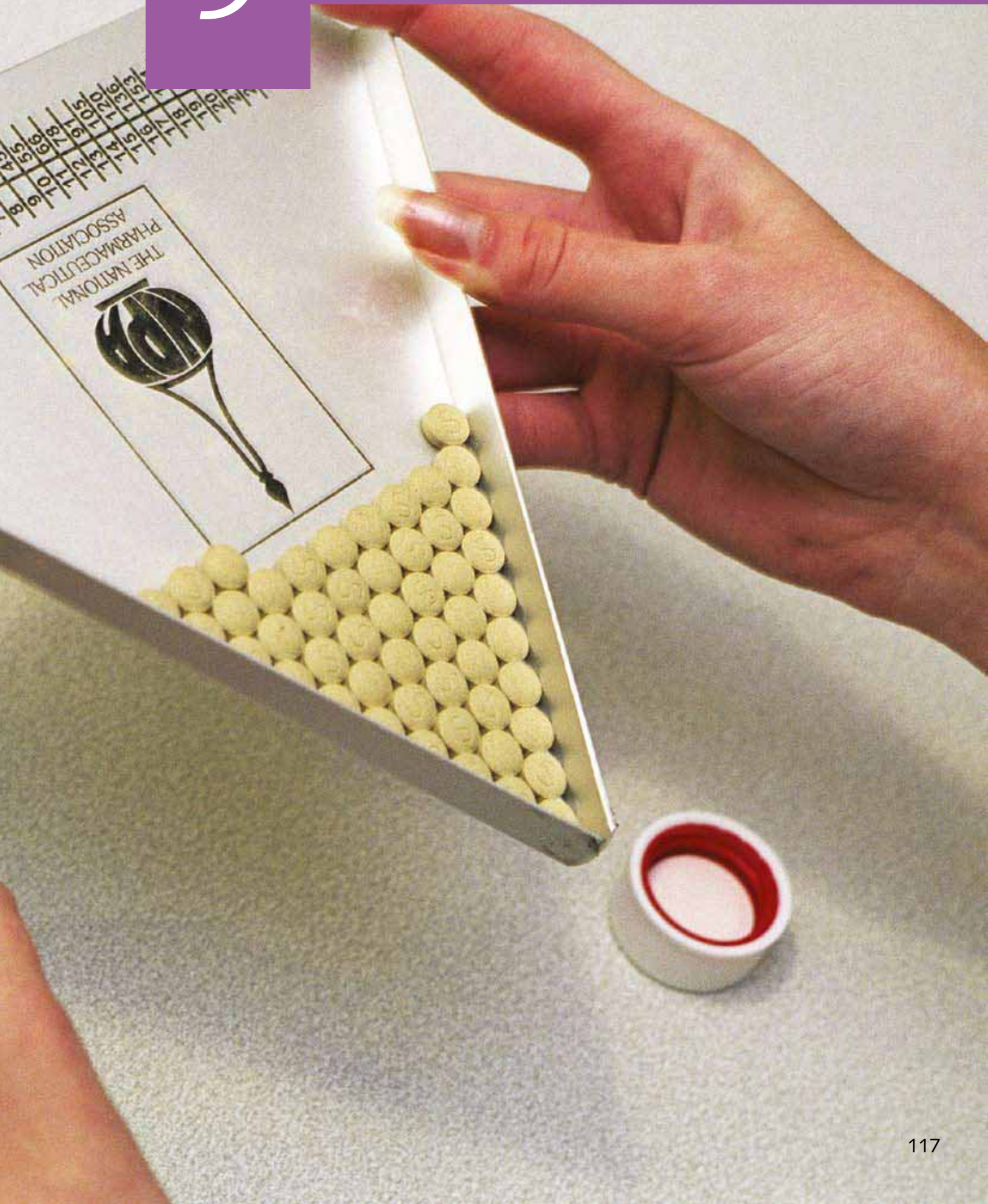
8.75 The 'control of entry' system applies to appliance contractors as it does to pharmacies. Anne Galbraith's report drew attention to problems new entrants face. The main concern is that the current system, even after reform, effectively freezes them out of the market. It is difficult for a contractor who supplies only appliances to be able to gain entry because of the nature of their business. Such contractors do not necessarily provide services to the local neighbourhood. They are more likely to provide them to a much wider catchment area and often nationwide, rather like internet-based pharmacy operations.

8.76 To overcome this, Anne Galbraith reported that specialist commissioning of appliance contractor services is one approach that had been suggested, where either the SHA or a lead PCT takes responsibility for applications that will have benefits for a number of PCTs – not just the PCT in which the premises are based. An alternative that can be considered is the introduction of the concept of 'any willing provider' to the market – but only provided such a potential contractor meets agreed minimum standards and conditions for supply.

8.77 **The Government will come forward with options for reform of market entry arrangements for appliance contractors which reflect their more specialist market, following discussions with their representatives.**

9

Conclusion



Conclusion

CHAPTER SUMMARY

This chapter sets out the Government's programme to support and deliver change, including further consultation on the detail of some proposals outlined in this White Paper, working in partnership with pharmacists and other health professionals, the public, and the NHS. An action plan at Annex 2 describes how the Government will monitor future progress on these commitments.

- 9.1 This White Paper describes the Government's programme for pharmacy in the years ahead. It rightly celebrates the enormous progress that has been made since publication of *A Vision for Pharmacy in the New NHS* in July 2003.
- 9.2 Since 2003, the NHS has also seen far-reaching changes. Building capacity and reforming NHS systems has been the priority. In future, the priority will shift to transforming services that are focused as much on prevention as cure, and patients being at the centre of NHS services, helping them to take better care of themselves, supported effectively by many health professionals to improve their health and wellbeing.
- 9.3 Pharmacy has followed a similar journey, with more capacity in terms of new pharmacies and system reform with a new contractual framework, reforms to market entry and new clinical directions for the profession, not least in terms of pharmacist prescribers, pharmacists with special interests, consultant pharmacists and pharmacists promoting health and wellbeing.
- 9.4 It is appropriate, therefore, that this White Paper should set out the changes the Government believes must be made so that pharmaceutical services themselves are transformed in the future.
- 9.5 Some of the key initiatives described earlier that will help deliver this transformation are:
- a strong drive to promote good health and prevent ill health by further enhancing pharmacy's contribution through initiatives such as:
 - stopping smoking;
 - reducing teenage pregnancy rates through access to emergency hormonal contraception and sexual health advice;
 - treating minor ailments promptly and effectively;
 - chlamydia screening and treatment; and
 - pharmacies being seen and used as community-based healthy living centres, which offer easily accessible and informal yet wholly professional advice and support, including support for self care;
 - new screening services for people at risk of vascular disease to be available from pharmacies in due course, and pharmacies to offer regular monitoring and check-up facilities for those people who have long

term conditions such as high blood pressure, diabetes and asthma;

- reinvigorated or new services that are focused on patients' needs, including:
 - a greater push to deliver repeat dispensing services across the country and quality medicines use reviews; and
 - support for people who are starting out on long term medicines courses where early support and interventions can make a big difference in terms of getting the best from their medicines and improving their health outcomes, and contributing to care plans for people with such conditions; and
- making significant changes to the structures underpinning delivery by enabling:
 - new directed enhanced services that encourage providers to invest;
 - a stronger focus on commissioning for quality that addresses local needs;
 - action to tackle poor performance; and
 - reforms to market entry for service providers and pharmacies open for 100 hours per week.
- provide a clear lead for people to help look after themselves, and ensure that there is timely and appropriate self care support for those who need it – particularly the increasing number of people with long term conditions;
- have a central role in contributing to integrated, fair and personalised health and social care partnerships with patients, addressing some of the key health inequalities still apparent in England; and
- make a significant contribution to achieving wider NHS goals for greater patient control, improved choice and local accountability, especially in terms of the patient journey from primary generalist care to secondary specialist care and back again.

9.6 The Government believes that this White Paper therefore presents a blueprint for action over the coming years for pharmaceutical services and contractors to:

- lead on the safer and more effective use of medicines;
- make a significant impact in promoting better health and wellbeing for all, as well as preventing ill health and supporting independence;

9.7 The Government recognises that much can be achieved by pharmacists now. However, the future will require developments in education and training that will equip pharmacists and pharmacy technicians for new clinical roles in patient care.

9.8 The action plan at Annex 2 summarises the commitments in this White Paper and sets out a challenging timetable and how the Government will now move forward to implement and deliver these commitments, in partnership with the public, pharmacy, other health professionals and the NHS. A further consultation document on key proposals set out here, including the structural changes proposed, will be published this summer after completion of the forthcoming primary and community care strategy.

Annex 1: Health challenges – how pharmacy can contribute

In addition to the usual services that pharmacies provide, including dispensing and advice on taking medicines, they may provide additional services and support to tackle some of the most pressing health challenges. These, and their likely benefits and outcomes, are set out in the table below.

Health challenge	Long term impact if not addressed	How pharmacy can contribute	Likely benefits and outcomes
<p>Healthy Weight Healthy Lives</p> <p>The current eating patterns of the average British adult substantially increase their risks of becoming obese and developing heart disease or cancer, with a third of vascular cases and a quarter of cancer deaths already thought to be diet-related.</p>	<p>By 2050, 60% of men and 50% of women are forecast to be obese.</p> <p>The health complications that can result – high blood pressure, diabetes – are among the most pressing problems faced.</p> <p>Improving diet could save 70,000 lives a year – or one in every 10 deaths.</p>	<ul style="list-style-type: none"> • Body Mass Index (BMI) and waist circumference measurements • Weight management clinics in the pharmacy or elsewhere • Prescribing or patient group directions (PGDs) to enable the supply of weight reduction medicines as part of an overall weight reduction strategy • Education, information and advice for all, including families with young children • Outreach work in the community • Exercise on prescription • Recommending the use of the NHS LifeCheck service and working with users' results in setting weight management goals • Vascular checks 	<ul style="list-style-type: none"> • A more health-literate population, aware of the effects of diet and physical activity on health • Increased awareness of the actions that can be taken to improve health • Improved access to a range of services aimed at improving diet and physical activity and reducing weight • Tailored information to help specific patient groups, e.g. children • Contribution to improving BMI scores, with the potential to improve health overall • Reduced risk of undetected complications • The public value community pharmacists as local leaders in health matters
<p>Smoking</p> <p>Smoking is set to decline and significant progress has been made in reducing how many people smoke. However, it is still the principal avoidable cause of premature death and ill health today.</p>	<p>Smoking causes 87,000 premature deaths each year in England – currently equivalent to one-fifth of all deaths</p>	<ul style="list-style-type: none"> • Opportunistic and brief advice/ interventions for stopping smoking • NHS stop smoking clinics, including in schools • Availability of over-the-counter products to support quitting • Community-based outreach • Supplementary prescribing of medicines that help people stop smoking • Availability of stop smoking medicines through PGDs 	<ul style="list-style-type: none"> • Successful quitters • Greater awareness of the range of options to support quitting • Potentially better health outcomes for people who quit • Health benefits due to the reduction in secondary smoke inhalation

Health challenge	Long term impact if not addressed	How pharmacy can contribute	Likely benefits and outcomes
<p>Sexual health</p> <p>Chlamydia is the most common sexually transmitted infection. Around 1 in 10 young people under the age of 25 are diagnosed with it each year.</p> <p>Accessibility of emergency hormonal contraception (EHC).</p> <p>Contraceptive support and advice to help reduce unintended pregnancies, especially teenage pregnancies.</p> <p>Safer sex messages and information on testing to help reduce HIV and sexually transmitted infections.</p>	<p>The risk of pelvic inflammatory disease, infertility and ectopic pregnancy will increase.</p> <p>Untreated infection will damage reproductive health.</p> <p>The cost to the NHS will be around £100 million a year (excluding in vitro fertilisation treatment costs).</p> <p>The number of unintended pregnancies will increase.</p>	<ul style="list-style-type: none"> • Promotion of condom use and access to free condoms at screening and treatment sites • Prescribing or PGDs to enable the supply of medicines related to sexual health • Availability of advice, EHC and other contraception in a secure and private environment • Doing an NHS teen LifeCheck • Raising awareness of HIV, chlamydia and other sexually transmitted infections, including HIV and the risks of re-infection • Providing, with the help of the National Chlamydia Screening Programme, an easy-to-use non-invasive test kit • Supplying the contraceptive pill 	<ul style="list-style-type: none"> • Increased awareness of sexual health and safer sexual practices • Greater understanding and availability of advice on contraception • A reduction in the rate of young people acquiring chlamydia and gonorrhoea and the number with long-standing chlamydia, and reducing the risks of infertility problems • Helping reduce teenage pregnancy rates • Younger people value pharmacies as a source of trusted advice and help

Health challenge	Long term impact if not addressed	How pharmacy can contribute	Likely benefits and outcomes
<p>Alcohol use</p> <p>Alcohol causes major health problems – up to 800,000 hospital admissions and 15,000 to 22,000 deaths in the UK in 2003 – as well as major social problems. Between 1991 and 2005, deaths directly attributed to alcohol almost doubled. More people die from alcohol-related causes than from breast cancer, cervical cancer and methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) infection combined.</p>	<p>Excessive alcohol consumption has insidious health complications because it can take a long time for life-threatening and life-lasting problems such as liver cirrhosis to become evident.</p> <p>For every £1 spent in treatment, the public sector saves £5 (UK Alcohol Treatment Trial Research Team 2005 – see Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT), <i>British Medical Journal</i>, September 2005).</p> <p>Further analysis within the Department of Health indicates that for every £1 spent on alcohol interventions, £1.70 is saved by the NHS.</p>	<ul style="list-style-type: none"> • Healthy lifestyle advice aimed at raising awareness of the harmful effects of excess alcohol • Brief interventions (such as screening, assessment, NHS LifeCheck) • Prescribing or PGDs to enable the supply of medicines related to reducing alcohol intake • Blood tests to detect levels of alcohol consumption and early risks of complications developing • Supervised monitoring of medicines to treat alcohol withdrawal 	<ul style="list-style-type: none"> • Enabling people to take the action they need to help themselves reduce risks and maintain healthier lifestyles • People manage their condition better • Increased awareness and identification of physical consequences and risk factors • Helping to reduce the incidence of alcohol-related conditions

Health challenge	Long term impact if not addressed	How pharmacy can contribute	Likely benefits and outcomes
<p>An ageing population</p> <p>By 2029, the number of 65–74-year-olds will have increased by just over 40%, and the number of 75–84-year-olds by 50%. The most dramatic increase will be in those who are over 85, with the numbers forecast to double.¹</p> <p>Three out of four people over 75 are prescribed medicines and 36% of older people are prescribed four or more medicines. Yet some estimates suggest that up to 50% of people do not take them as intended.</p>	<p>The greatest health costs arise in the final years of life. If healthy 75–84-year-olds become unhealthy 85-year-olds, this will increase the burden on the NHS.</p> <p>Around 10% of hospital admissions may result from older people not coping with or taking their medicines as intended.</p>	<ul style="list-style-type: none"> • Support for staying healthy and healthy lifestyle advice • Support for self-care • Signposting to social care • Aligning health and social care plans • Focused medication reviews for the most vulnerable, e.g. to prevent falls • Targeted pharmaceutical care through, for example, domiciliary visiting for those on complex medicine regimes, and multidisciplinary care and case management, including closer working with community matrons and case managers • A dispensing and delivery service for compliance aids 	<ul style="list-style-type: none"> • Reduced falls for older people, helping to reduce secondary care admissions • Better quality of health and increased independence for older people • Older people understand their medicines better, reducing the effects of the inappropriate use of multiple medicines • The health and social care aspects of the use of medicines are aligned

1 Office for National Statistics: www.statistics.gov.uk/downloads/theme_population/Population_Trends_131_web.pdf

Health challenge	Long term impact if not addressed	How pharmacy can contribute	Likely benefits and outcomes
<p>Long term conditions (LTCs)</p> <p>About two-thirds of medicines prescribed are for people with LTCs and 15 million people live with one or more of these conditions, such as asthma, heart disease or stroke.</p> <p>The prevalence of LTCs increases with age. By age 60, over half the population has at least one LTC.</p>	<p>The prevalence of LTCs is predicted to increase over the next 20 years by approximately 25% due to the effects of the ageing population.</p> <p>Those living with LTCs will be using services for longer. They will expect their medicines to be available promptly and to have confidence that early advice and support on medication is available before their condition causes more serious problems.</p> <p>Care services will face worsening pressures to support people at home and in the community.</p>	<ul style="list-style-type: none"> • Health campaigns aimed at improving awareness of the risks associated with certain LTCs • Improving medicines-related care for people with LTCs to reduce emergency admissions • Screening services within national guidelines following UK National Screening Committee recommendations to identify those at risk of developing, or who have already developed, a condition but are unaware of it – e.g. blood pressure and diabetes • Medication reviews and adherence programmes to improve medicine taking, tailored for particular conditions, including advice on new medicines, side effects, etc. • Monitoring with dedicated clinics using prescribing or PGDs to help control cholesterol for those on statins and blood pressure for those on antihypertensives • Signposting to social care information and aligning care plans • Prevention and early detection of some cancers 	<ul style="list-style-type: none"> • Increased awareness of risks encourages positive changes in behaviour, resulting in a reduced incidence of the condition in the long term • Earlier detection of diseases and better control of conditions can help reduce long term complications • Increased access to services and support for self care • Improved compliance with medicines and hence improved health outcomes

Health challenge	Long term impact if not addressed	How pharmacy can contribute	Likely benefits and outcomes
<p>Mental health</p> <p>A large number of people have mental health problems. For example, the 2001 Psychiatric Morbidity Survey published by the Office for National Statistics² suggested that one in six adults were assessed as having a neurotic disorder.</p> <p>According to the World Health Organization, by 2020 depression is expected to be the second most common cause of disability worldwide. It is the third most common reason for consultation in general practice, and occupies about a third of GPs' time.</p> <p>People with a severe mental health problem or learning disability have markedly poorer health outcomes than the rest of the population – e.g. on average people with schizophrenia die 10 years earlier.</p>	<p>Services users and carers will not receive the support they need to benefit from medicines.</p>	<ul style="list-style-type: none"> • Awareness and promotion of good mental health • Simple mechanisms to help people understand and take their medicines as intended • Liaison with GPs and community health teams • Instalment dispensing and supervised administration • Training for patients and carers about medicines • Involvement in evidence-based alternatives to medicines, e.g. information about/provision of computerised cognitive behavioural therapy and general information about talking therapies • Information about local support networks, mental health helplines, etc. • Involvement in outreach to minority communities • Identification of people who may show signs of depression and referring them on appropriately • Senior leadership on medicines issues and governance in mental health trusts and ensuring that appropriate service level agreements are in place with provider organisations³ 	<ul style="list-style-type: none"> • Better quality of life for people with better adherence to their medicines • People with mental health problems are better able to understand and manage their own condition • Readily available support in the community and/or closer to home • Improved access to drug therapy monitoring • Carers more supported in dealing with people taking medicines • Medicines policy issues in health systems that care for people with mental health problems are discussed and resolved at a senior level

² Office for National Statistics: www.statistics.gov.uk/products/p8258.asp

³ See: www.newwaysofworking.org.uk/pharmacy.aspx

Health challenge	Long term impact if not addressed	How pharmacy can contribute	Likely benefits and outcomes
<p>Healthcare-associated infections</p> <p><i>Clean, safe care</i>, published in January 2008,⁴ identified that healthcare-associated infections, on average, add 3 to 10 days to a patient's length of stay in hospital.</p> <p>It costs between £4,000 and £10,000 to treat a patient with an infection.</p>	<p>There will be a failure to achieve and sustain reductions in infections.</p>	<ul style="list-style-type: none"> • Senior specialist antimicrobial pharmacists, primary care trust pharmacists and microbiology/ infectious diseases/ infection control teams lead development, implementation and monitoring of antimicrobial guidelines across the health economy • Pharmacy-led 'switch' policies to convert patients from intravenous therapy to oral drug therapy at the earliest appropriate opportunity • Supporting the appropriate use of intravenous antibiotics at home • Community pharmacists and GPs work with hospital teams to align prescribing with agreed policy • Pharmacy in all settings is part of the public advice and campaign network to increase public awareness of antibiotic resistance and the rational approach to infection control matters regarding, for example, MRSA and <i>C.difficile</i> • Training junior doctors and nurses on rational antimicrobial prescribing, administration and use 	<ul style="list-style-type: none"> • A co-ordinated, rational and cost-effective approach to antimicrobial use • Reduced public demand for antibiotics in situations where they are ineffective, e.g. viral infections • Reduced volume of antibiotic prescribing and rational use will help limit the emergence and spread of resistant bacteria and help reduce <i>C.difficile</i> rates • Improved antimicrobial knowledge and skills in medical and nursing teams • Improved knowledge of the rational use of antibiotics by the public

4 Department of Health. *Clean, safe care: reducing infections and saving lives*, 2008: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081650

Health challenge	Long term impact if not addressed	How pharmacy can contribute	Likely benefits and outcomes
<p>Medication-related harm</p> <p>Errors can occur at any stage from prescribing and dispensing through to administration and monitoring. Harm can also occur in the absence of an error (an adverse drug reaction).</p> <p>Pirmohamed and colleagues (2004)⁵ estimated that, in England, 4.7% of all admissions were due to preventable harm from medicines.</p> <p>A systematic review in 2002⁶ concluded that between 3.5% and 7.3% of inpatients experience harm from medicines.</p>	<p>It is estimated that preventable harm from medicines could cost the NHS more than £750 million each year in England.</p>	<ul style="list-style-type: none"> • Chief pharmacists lead and promote safer medication practices • Community pharmacists work with GP and nurse prescribers on safe and rational prescribing • Training the whole trainee and qualified healthcare team on safe medicines use • Working with patients to help understanding of medicines • Medicines use reviews, clinical screening of prescriptions and identification of adverse drug events • Use of automation, auto-identification (bar-coding) and IT to provide opportunities for better medicines safety • Working every day with doctors, nurses, etc. to reduce dosage and administration errors • Ensuring that medicines are not omitted unnecessarily • Ensuring that medication allergies are clearly documented • Helping other professionals, e.g. those working with children, to calculate doses, safely administer medicines, etc. 	<ul style="list-style-type: none"> • Right medicine, right patient, right dose, at the right time • Reductions in preventable medicines-related morbidity and mortality • Fewer hospital admissions directly related to medication problems • Fewer dosage errors, omitted doses, etc. • New technologies reduce mis-selection and misidentification • Reduced length of stay and associated costs for hospital inpatients

5 Pirmohamed M et al. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients, *British Medical Journal*, 2004, 329: 15-19.

6 Wiffen P et al. *Adverse drug reactions in hospital patients*, 2002: www.ebandolier.com

Health challenge	Long term impact if not addressed	How pharmacy can contribute	Likely benefits and outcomes
<p>Drug misuse-related harm</p> <p>It is estimated that there are 332,000 problematic drug users (crack and heroin) in England.</p> <p>Among current injecting drug users, 42% are estimated to have contracted hepatitis C.⁷</p> <p>There is an increasing number of crack/cocaine users and steroid misusers.</p>	<p>Drug misuse results in harm to the individual and to the wider community.</p> <p>Rates of blood-borne viruses will rise.</p>	<ul style="list-style-type: none"> • Needle exchange services • Supervised administration of drug therapies • Wound management • Advice on safer injecting and harm reduction measures • Referral to other healthcare professionals as appropriate • Immunisation for and advice on blood-borne viruses • Information and signposting to treatment services • Support to clients to prevent them falling out of treatment • Use of independent/supplementary prescribing and PGDs, as appropriate • Wider and more flexible access through longer opening hours and weekend availability • Information and support on health issues, other than those that are specifically related to the client's addiction 	<ul style="list-style-type: none"> • Reduced risks to the individual user and wider social network – families, friends and communities • Reduction in health costs associated with wound infections and blood-borne viruses • Increases in the numbers of drug misusers in treatment • Reductions in the numbers in relapse • Support for increased retention in treatment • Improved communications between treatment providers participating in the clients' care plans

⁷ Health Protection Agency. *Shooting Up*, 2007: <http://194.74.226.162>

Health challenge	Long term impact if not addressed	How pharmacy can contribute	Likely benefits and outcomes
<p>Health and work</p> <p>Around 150 million working days were lost to sickness absence in 2006, at an estimated cost to the economy of £11.2 billion.⁸</p> <p>Common mental health problems, musculoskeletal disorders and cardio-respiratory disease account for about two-thirds of sickness absence, long term incapacity and early retirement.⁹</p> <p>There is strong evidence that work is generally good for physical and mental health and wellbeing. While temporary absence from work can be therapeutic, worklessness can be detrimental to health and wellbeing and lead to health inequalities.¹⁰</p>	<p>The annual economic costs of sickness absence and worklessness associated with working age ill health are estimated to be over £86 billion. If current trends continue, this is expected to rise to over £92 billion by 2025.¹¹</p> <p>For many people, short term sickness absence can progress to long term sickness absence and worklessness. Over 250,000 people move from work or a prolonged period of sickness absence to incapacity benefits each year.¹²</p> <p>The prevalence of psychiatric disorders among children whose parents have never worked is almost double that among children with parents in low-skilled posts and five times greater than that among children whose parents are in occupational professions.¹³</p>	<ul style="list-style-type: none"> • Raising awareness of the general benefits of work on health, e.g. through public health campaigns • Advice when handing out dispensed prescriptions or selling products, e.g. for back pain or depression • Supporting people in better self care, especially for common causes of sickness absence, e.g. back pain and stress • Outreach work with local employers, whose needs might vary depending on the nature of their business • Pharmacies may also wish to consider modelling themselves as healthy workplaces, perhaps even as local exemplars 	<ul style="list-style-type: none"> • Early intervention in sickness absence helps to prevent short term sickness absence from progressing to long term sickness absence, worklessness and poverty • Reduction in health costs associated with sickness absence • Reduction in the cost to the economy associated with sickness absence and worklessness • Better health outcomes for working-age people and their families, and improved prospects for children

8 Confederation of British Industry/AXA. *Attending to absence. Absence and labour turnover survey 2007*. Figures adjusted pro rata for England.

9 Waddell G and Burton KA. *Is Work Good for Your Health and Well-Being?*, 2006.

10 Waddell G and Burton KA. *Is Work Good for Your Health and Well-Being?*, 2006.

11 Black C. *Working for a healthier tomorrow*, 2008: www.workingforhealth.gov.uk/documents/working-for-a-healthier-tomorrow-tagged.pdf

12 Kemp PA and Davidson J. *Routes onto Incapacity Benefit: Findings from a survey of recent claimants*, 2007.

Figures adjusted pro rata for England: www.dwp.gov.uk/asd/asd5/rports2007-2008/rrep469.pdf

13 Office for National Statistics. *The health of children and young people*, 2001.

Annex 2: Action plan

Paragraph	Action	What to do	Timetable (start)	Timetable (end)
2.5	Application of world class commissioning competencies to the commissioning of pharmaceutical services	The Government will work with the NHS and relevant partners to identify how to apply the world class commissioning competencies to the commissioning of pharmaceutical services and how to support PCTs in developing their capability and capacity accordingly.		By April 2009
3.9	Medicines use reviews (MURs)	The Government believes it is necessary for MUR services to be prioritised to meet health needs and has asked NHS Employers to discuss with the PSNC a mechanism for delivering this and ensuring funding rewards health outcomes.	2008	Proposals by Dec 2008
3.17	Improving implementation of repeat dispensing	Part of the remit for the working group to be convened by NHS Employers, including pharmacy and medical representatives to develop professional working (see chapter 5), will be to identify and agree mechanisms that can support further incremental implementation of repeat dispensing.	Early opportunity	By April 2009
3.21	Research on extent and reasons why medicines are not used	The Government is commissioning research to establish the extent to which medicines are not used and to determine the varied and complex reasons why people do not take their medicines as intended. The outcome of this research, which will be available in 2009, will inform what future action needs to be taken to reduce waste.	Undertaken in 2008-09	Outcome available in 2009
3.26	Strengthening the commissioning of medicines adherence support	The Government considers further work is needed to strengthen the commissioning of services to support adherence to medicines and will therefore take forward, in partnership with interested parties, discussions on appropriate measures.	2008 onwards	
3.35	Extending the duration of medicines supplied in emergency	The Government will consider extending the provision of emergency supply to enable a 28-day supply to be made, subject to full consultation.	Early opportunity	Proposals by April 2009
3.39	Findings of Patient Drug Record Cards (PDRC) evaluation	The Government will consider the findings of the PDRC evaluation to determine what, if any, further action needs to be taken.	After summer 2008	
3.48	Availability of OTC medicines from GP dispensing practices	The Government believes there are sufficient grounds to reform arrangements for selling OTC medicines where the GP practice has consent to dispense. This needs to be linked to the broader reforms of dispensing by doctors in Chapter 8.	Consultation summer 2008	Subject to consultation

Paragraph	Action	What to do	Timetable (start)	Timetable (end)
3.59	Closer working between hospital and community pharmacies	The Government will ask the two new clinical leaders (outlined in chapter 4) to support NHS Employers and consider the optimal way in which services involving the transfer of care can best be commissioned within the current contractual framework.	Early opportunity	Proposals by April 2009
3.65	Development of local health community clinical pharmacy teams	The clinical leaders for hospital and community pharmacy (see chapter 4) will therefore be asked to devise appropriate mechanisms to support implementation in PCTs and to work with NHS Employers on appropriate commissioning arrangements.	Early opportunity	Ongoing
3.68	Pharmaceutical care for people with cancer	The Government expects PCTs to commission well-designed, safe services, that comply with the requirements of the Manual for Cancer Services and the NPSA Rapid Response Report on oral anti-cancer chemotherapy, to meet the needs of people with cancer who can benefit from receiving oral chemotherapy from their community pharmacy.	Ongoing	Ongoing
3.80	Safer medication practices	The Government considers that chief pharmacists of provider organisations, PCTs and other commissioners should have the lead role in ensuring that safe medication practices are embedded in patient care. This includes them: <ul style="list-style-type: none"> • working with patients, senior managers and other health professionals, including professional bodies, to identify, introduce and evaluate systems designed to reduce unintended hospital admissions related to medicines; and • working with other senior health professionals, senior managers and Safety Alert Broadcast System liaison officers to ensure that organisations respond to NPSA and other alerts efficiently and in good time, thereby reducing risk to patients. 	Ongoing	Ongoing
3.81	Safer medication practices	The Government has asked the NPSA to host an event later in 2008 to ensure that learning from best practice in the implementation of safety alerts informs future responses.		Summer 2008

Paragraph	Action	What to do	Timetable (start)	Timetable (end)
4.13	Support for pharmacy public health	The Public Health Leadership Forum for Pharmacy co-chaired by the Chief Pharmaceutical Officer and the Head of Public Health Workforce will identify a work programme for 2008-2010 to accelerate pharmacy's ongoing and expanding contribution to health, how it contributes to reducing health inequalities and with a particular focus on community leadership and sustainable development.	Spring 2008	Ongoing
4.17	Interventions and advice	The Government will ask NHS Connecting for Health to scope arrangements for electronically capturing information centrally about interventions made or advice given by pharmacists as part of the promotion of healthy lifestyles essential service.	Early opportunity	
4.20	Pharmacy staff as Health Trainers	The Government will invite pharmacy bodies and employers to consider and come forward with proposals on how they can support pharmacy staff to become health trainers, making appropriate links to the Skills for Health's National Occupational Standards for Health Trainers and the British Psychological Society's Health Trainer handbook.		Proposals by Dec 2008
4.25	Minor ailment schemes	The Government will examine with PSNC and NHS Employers how best minor ailments schemes can be incorporated within the community pharmacy contractual framework.	Early opportunity	Proposals by Spring 2009
4.31	Stop Smoking	The Government will ask NHS Employers to examine any further necessary steps to strengthen contractual arrangements so that stop smoking services provided in pharmacies show clear evidence of close partnership with local NHS Stop Smoking Services.	Early opportunity	Proposals by Spring 2009
4.34	Chlamydia screening	The Government will publish a national template later in 2008 to support PCTs' commissioning of chlamydia screening from community pharmacies as part of the National Chlamydia Screening Programme.		Autumn 2008
4.35	Access to contraception services	The Government will ask SHAs to ensure pharmacies are included within local schemes for contraceptive services. The Government will evaluate these schemes and publish findings to improve access to sexual health services generally and ensure robust standards are in place.	Ongoing Timetable to be determined	Ongoing

Paragraph	Action	What to do	Timetable (start)	Timetable (end)
4.37	Vascular checks	The Government has, therefore, announced a universal programme for vascular checks for everyone between the ages of 40 and 74.	In accordance with timetable for vascular programme	
4.40	Vascular risk assessment programme through pharmacies	As the vascular risk assessment programme develops, the Government will discuss with stakeholders including pharmacies what delivery arrangements best support implementation to ensure wide availability of this service as soon as possible.	In accordance with timetable for vascular programme	
4.41	Care of patients with diabetes – contribution of pharmacy	The National Clinical Director for Diabetes and Chief Pharmaceutical Officer are considering how best to maximise the safe and effective contribution of pharmacy, within a team environment, to the care of people with diabetes	Ongoing	Ongoing
4.56	Support to people in the early stages of taking a new course of medicines to treat a LTC.	The Government believes more support is needed for people who are newly prescribed a medicine to treat a long term condition. The Government will therefore discuss with the PSNC and NHS Employers how such a support service may best be introduced within the community pharmacy contractual framework.	Early opportunity	Proposals by Spring 2009
4.58	Early detection and prevention of some cancers	The Government believes it important that effective systems are in place for the efficient referral of people with symptoms, which may be indicative of cancer, from the pharmacy to their GP. The Government will therefore ask NHS Employers, the RPSGB and the PSNC to explore how professional and contractual arrangements can best support this.	Early opportunity	Proposals by Spring 2009
4.64	Two new pharmacist clinical leaders	The Government will appoint two new clinical leaders this year. These new leaders will work directly to the Chief Pharmaceutical Officer to champion the development of pharmaceutical services and to help implement the actions in this White Paper.	Mid 2008	Ongoing
5.7	Improving patient awareness and understanding of the roles and capabilities of pharmacy providers	The Government will plan a programme of communications that seeks to: <ul style="list-style-type: none"> highlight the breadth of services and skills available within pharmacies; illustrate the role pharmacies can play in promoting good health; raise awareness and knowledge of the role pharmacy can play in managing LTCs and reducing health inequalities; and increase the use of pharmacy services among target audiences. 	Early opportunity	Ongoing

Paragraph	Action	What to do	Timetable (start)	Timetable (end)
5.8	Mapping target audiences	The Government will map the target audiences for this communications programme.	Early opportunity	Preliminary map completed by Autumn 2008
5.9	Further research to inform communications programme	The Government will commission further qualitative research to develop a better understanding of the particular needs of these audiences.	Ongoing	Ongoing
5.14	Fostering closer professional relationships	The Government believes effective professional relationships are important for the future development of services. It has therefore asked NHS Employers on behalf of PCTs to convene and lead a working group of pharmacy, medical and public representatives to formulate a series of actions to promote more effective professional relationships.	Spring 2008	Ongoing
6.12	Clearer framework for the evaluation of pharmaceutical services	The Chief Pharmaceutical Officer will convene an expert panel to advise on priorities for health service research in pharmacy and feed the output of this into the Government's National Institute for Health Research prioritisation processes.	2008	Ongoing
6.22	Promoting research and development into pharmacy and pharmacovigilance	The Government will explore with the pharmaceutical industry and the profession how best to utilise the pharmacy network in promoting research and development and pharmacovigilance.	Linked to the NHS Next Stage Review	
6.24	Supporting evidence-based care	The Chief Pharmaceutical Officer and the NHS Chief Knowledge Officer will work together to maintain an overview of existing information sources on medicines and support future developments that fit the needs of both individual practitioners and the NHS.	Ongoing	
6.29	Auto-identification	The Government is recommending that the GS1 System should be adopted throughout the healthcare system in England, for both products and for coding systems used within healthcare settings, such as patient identification codes on wristbands.	Ongoing	
6.34	NHS preparative services and medicines manufacturing	The Government will ask the National Advisory Board for NHS Hospitals Medicines Manufacturing and Preparative Services to devise practical steps further to rationalise the range of products manufactured by the service to ensure capacity is available for the implementation of the NPSA's safe medication practice recommendations and preparation of products for which a need has been identified by risk assessment.	Spring 2008	Proposals by end 2008

Paragraph	Action	What to do	Timetable (start)	Timetable (end)
6.36	Specialist pharmacy services across England	The Government will explore the extent to which specialist pharmacy services are available and commissioned across England, and their contribution to the delivery of innovative, cost-effective and more convenient care for patients.	Spring 2008	Proposals by end 2008
6.45	Summary Care Record (SCR)	The Government will undertake further work with an early adopter PCT to consider the benefits, governance and practical arrangements of community pharmacists having access to the SCR.	2008	
7.17	Developing pharmacist undergraduate education	The Government, working with all relevant parties, including the profession, schools of pharmacy, the regulator, the Higher Education Funding Council for England (HEFCE), Universities UK and employers, will begin planning to ensure that there is: <ul style="list-style-type: none"> • meaningful clinical context and experience throughout the undergraduate programme and determine whether this can be maximised by integrating the degree course with the pre-registration training year; • an appropriate funding framework in place to support academia and clinical practice in delivering the new programme; and • sufficient capacity in the academic workforce and an appropriate infrastructure in clinical practice to provide high quality education. 		Pilots in place by October 2010
7.28	Continuing professional development	The Government will look to the RPSGB to work with the profession, employers and education providers to support pharmacists and pharmacy technicians in the regular recording of CPD activity.	Spring 2008	Ongoing
7.32	Appointment of consultant pharmacists	The Government will look to SHAs to ensure there are appropriate arrangements in place to consider applications from organisations that wish to establish consultant pharmacist posts.	Ongoing	Ongoing
7.39	Regulation of advanced and specialist practice in pharmacy	The Government expects that as part of its early development, the new GPhC will seek to regulate advanced and specialist practice in pharmacy.	2010	
7.41	Pharmacy expertise in the pharmaceutical industry	The Government is asking the RPSGB to identify the unique competencies based on knowledge, skills and values that should remain within the pharmacy profession as its transformation to a scientifically based clinical profession accelerates.	Spring 2008	By mid 2009

Paragraph	Action	What to do	Timetable (start)	Timetable (end)
7.44	Pharmacy technicians' development	The Government will consider what further training may be required to enable pharmacy technicians to supervise certain aspects of the sale or supply of medicines as envisaged by the Health Act 2006.	2008	2010
7.48	Workforce planning	As part of the NHS Next Stage Review, the Government is considering how workforce planning for all health professions can be strengthened. Pharmacy workforce planning will form part of these future arrangements.	Linked to NHS Next Stage Review	
7.54	Improving utilisation of pharmacy workforce	The Government will publish a summary of the outcome of the consultation on the responsible pharmacist. Account will be taken of pharmacy views on the time needed to prepare for introduction of the responsible pharmacist regulations. The next stage will be consultation on the proposed content of regulations on the supervision requirements.	Summary of consultation responses published Spring 2008. Regulations laid later in 2008 for commencement in 2009.	
7.55	Professional recognition for appliance contractors	The Government will discuss with representatives of appliance contractors what further action may be needed so that their contractual requirements ensure service delivery is both professional and to high standards and quality.	Early opportunity	For consultation later in 2008
8.21	Pharmaceutical Needs Assessments (PNAs)	The Government considers that the structure of and data requirements for PCT PNAs require further review and strengthening to ensure they are an effective and robust commissioning tool which supports PCT decisions.	Early opportunity	December 2008
8.22		The Government has asked NHS Employers to establish a short-term working group to review these requirements and to devise an appropriate support programme for PCTs.	Summer 2008	Autumn 2008
8.34	Introduction of directed enhanced services	The Government will use Directions in consultation with NHS Employers and PSNC to direct all PCTs that they have to commission certain services from pharmacy contractors according to the local needs they identify and subject to suitable accreditation requirements and service quality standards.	Spring 2008	Subject to negotiation
8.39	Future payment mechanisms	In the light of further discussions with the NHS and PSNC, the Government will include future payment mechanisms as part of full consultation later this summer,	Spring 2008	As part of consultation Summer 2008

Paragraph	Action	What to do	Timetable (start)	Timetable (end)
8.46	Ensuring high quality and safety in service delivery	The Government will work with the PSNC and NHS Employers to devise proposals to ensure effective arrangements are in place to address unwarranted variations in standards and quality of service delivery.	Early opportunity	Subject to negotiation
8.47	Development of metrics and indicators	The Government will work with the NHS and professional bodies to develop a set of pragmatic, easily measurable metrics or indicators which serve to demonstrate the quality and outcome of pharmacy service provision.	Summer 2008	Ongoing
8.56	Clinical audit of pharmacy services	The Government considers that the use of audits within the contractual framework needs to be strengthened and will work further with the NCAAG to explore how clinical audit, with all its potential as a service improvement tool, can be used more constructively to ensure pharmacy services and systems are safe and effective.	Ongoing	
8.64	100 hours per week pharmacies	The Government has considered further what action may be appropriate in respect of 100 hours per week pharmacies and has identified four options on which it will seek further views in the full consultation to follow later in 2008.	Already started	For consultation Summer 2008
8.74	Consent (market entry) for dispensing doctors	The Government proposes that any changes to dispensing doctor entry arrangements should be part of a wider consultation on elements of the "control of entry" system itself as proposed here. This consultation will also consider whether current regulatory arrangements can be streamlined so that dispensing consent in future is sought under a single regulatory route.		Summer 2008 as part of consultation
8.77	Market entry by appliance contractors	The Government will come forward with options for reform of market entry arrangements for appliance contractors which reflect their more specialist market, following discussions with their representatives.	Early opportunity	Summer 2008 as part of consultation

Glossary of terms

ACLF	Advanced and Consultant Level Framework
AIDC	Auto-identification and data capture
BMI	Body Mass Index
<i>C. difficile</i>	<i>Clostridium difficile</i>
CfH	NHS Connecting for Health
CoDEG	Competency Development and Evaluation Group
CPD	Continuing professional development
CPPE	Centre for Postgraduate Pharmacy Education
CQC	Care Quality Commission
EHC	Emergency hormonal contraception
EPS	Electronic Prescription Service
GLF	General Level Framework
GP	General practitioner
GPhC	General Pharmaceutical Council
GS1	A system of standards for an integrated approach to accurate identification using barcodes and other data carriers
GSL	General sale list (a category of medicine)
HAG	Harmonisation of Accreditation Group
IT	Information technology
JPB	Joint Programmes Board
LPS	Local pharmaceutical services (contract)
LTC	Long term condition
MHRA	Medicines and Healthcare products Regulatory Agency
MLE	Male life expectancy
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>
MUR	Medicines use review (a medicines use 'MOT')
NAO	National Audit Office
NCAAG	National Clinical Audit Advisory Group
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NOS	National Occupational Standards
NPSA	National Patient Safety Agency
OTC	Over-the-counter (medicines)
'P'	Pharmacy-only (a category of medicine)
PBC	Practice-based commissioning
PCT	Primary care trust
PDRC	Patient Drug Record Card

PGD	Patient group direction
PhwSI	Pharmacist with special interests
PNA	Pharmaceutical needs assessment
POM	Prescription-only medicine
PSNC	Pharmaceutical Services Negotiating Committee
PwSI	Practitioner with special interests
QOF	Quality and Outcomes Framework
RPSGB	Royal Pharmaceutical Society of Great Britain
SCR	Summary Care Record
SCS	Sustainable Community Strategy
SFE	Statement of Financial Entitlements
SHA	Strategic health authority
SNOMED	Systematised Nomenclature of Medicines

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