A Response to:

Review of NHS Pharmaceutical Care of Patients in the Community in Scotland

Dr Elspeth Weir

Head of Policy Development

May 2012

Background

On 17th October, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced a review of NHS Pharmaceutical Care of Patients in the Community.

The review authors have conducted evidence gathering in two formats:

1) Meeting key stakeholders and service users including patient groups
2) Requesting completion of an online survey questionnaire.

This document outlines Community Pharmacy Scotland's response to the online survey questionnaire. We expect in the coming weeks to have further meetings with the report authors.

Responses to the questionnaire were prepared and delivered within a five week timescale and were limited to a 4000 character window. The online questionnaire was split into eight sections loosely based on the NHS Quality Strategy headings:

Section 1: Person-centred NHS Pharmaceutical Care

Section 2: Safe NHS Pharmaceutical Care

Section 3: Effective/Clinically Effective NHS Pharmaceutical Care

Section 4: Technology

Section 5: Education and Training

Section 6: Use of Resources

Section 7: Access to NHS Pharmaceutical Care Services

Section 8: Other

Community Pharmacy Scotland decided to submit longer responses and further supporting evidence to questions 9, 18, 20 and 32. We have previously submitted evidence to the review on:

- A Vision for Community Pharmacy in Scotland – What next?
- The Vision – Response to the Consultation
- Feedback from a CPS Strategy Day in January 2012
- CPS Response to the PHS Review with proposed actions
- Hospital Discharge Service from NHS Wales
- CPS Care Home Proposals including new Service Specification
- CPS Minor Ailment Service Review and Proposals for Development
- CPS Framework for Healthy Living Pharmacy model
- CPS Proposals about Compliance Aids

Our response to each section is outlined on the following pages.

Section 1 Person Centred Care

Quality Ambition

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

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

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

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

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

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

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

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

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

Community Pharmacy Scotland Response

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

We feel currently that there is a lack of knowledge amongst patients as to what pharmaceutical care represents for them. The term does not necessarily capture public imagination or understanding. So the first improvement we would suggest is to raise awareness on what is currently happening in community pharmacies across Scotland. As part of this awareness raising, we propose it would be useful to explore using questionnaires current patients' needs and values of the pharmacy service. This will also allow patient understanding/satisfaction of pharmaceutical care services to be analysed and from this improvements could be planned based on the fundamental needs and desires of the patients themselves. We know that work has already been carried out in relation to patient experience of GP services as part of the *Better Together* programme and we should be looking to build on knowledge already gained in this process.

Within the community pharmacy setting pharmacy, contractors have made significant investment to ensure that patients are able to access pharmacies which offer services delivered by trained staff in a clean, safe and regulated environment. The new regulator for pharmacy is currently engaged in consultation on draft standards. As part of this process it has engaged with the public and it would be helpful to hear the views that the patients and the public have expressed.

Over the past ten years contractors have worked with the Scottish Government on the development of new services to meet patient need in terms of access, equality and support for long term conditions. It is noticeable these developments have been made in isolation from the public and patients. We are keen in the future to involve patients in further service development to ensure the services meet expectations and needs.

CPS believes that the introduction of patient registration with a community pharmacy of their choice, for the provision of the Chronic Medication Service (CMS), facilitates shared decision making and the building of relationships to explore needs and values. Due to the forthcoming change in demographics and the expected increase in dementia sufferers we need to be start engaging early with patients to ensure that their needs and values are identified, recorded and addressed in the long term.

CPS also believes that we need to think about how we ensure increased involvement of family and/or carers, due to social care integration with patients' pharmaceutical care, when appropriate. At the present time we do not have consent to share information when it would be in the best interests of the patient themselves (e.g. palliative care patient) or indeed the best interests of the family/carer. Within the care home setting community pharmacists currently do not even have the ability to gain consent to speak to patients' about their own medicines, or to provide services which are available to patients resident in the community. These consent issues need to be discussed and moved on to ensure we are able to do the best for patients.

Empowering patients with poor health literacy to allow them to become active in their own care is crucial.

Premises layout is also important when considering individual needs and in the last decade pharmacy contractors have come a long way to delivering premises fit for purpose. An appropriate clean, safe and regulated environment for the delivery of NHS pharmaceutical care which creates ease of access and delivers an efficient, professional service from a highly skilled pharmacy team is the gold standard.

We think the time has come for a relaunch of the Chronic Medication Service. We need to celebrate what has already happened, amend areas where problems have been identified, restate why this service is being provided and focus patients and pharmacists' minds on the rationale behind it. CMS is a major project and sufficient resource is needed to get the project embedded within a short time frame. Otherwise impetus will be lost.

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

We have already set out in our answer to Q1 a number of areas for improvement. Chief among them is the increased emphasis being placed on CMS and the interactions with patients and/or their carers which will develop.

CPS recognises we have a key role in helping patients, families and carers to make decisions about their medicines. We believe the issue of consent may pose barriers to effective partnership working and we are keen to recognise, evaluate and remove these barriers. The issues have particularly arisen in the care home setting where patient consent is more difficult to obtain.

To ensure continuity of care pharmacists working in community pharmacies must have relevant health information from other healthcare professionals (e.g. diagnosis, blood results, access to Emergency Care Summary), as this would avoid duplication of effort and make for a smoother patient experience. This flow of information would not all be one way to pharmacy but, as a pharmaceutical care picture was built up, this could be shared to the benefit of other relevant healthcare professionals involved in a patient's care.

As part of CMS a pharmacist should be able to decide, within their own expertise/competence, upon amending treatment to the benefit of the patient with their agreement. This would be part of the patient-pharmacist relationship and the picture could be built up as part of the patient registration to a pharmacy within CMS. Participation in CMS will change the focus from a dispensing service to a holistic care service for a patient.

In the future there will be more complex patients in community settings and this may mean more pharmaceutical care having to be delivered in a domiciliary setting where previously it would have been a care home/secondary care setting. The ways of working within the primary health care team and regulations will have to be adapted to allow community pharmacists to fully engage in this type of care. We also need to think about how information is accessed in an up to date and secure manner.

The Scottish Government drive to integrate Health and Social Care will mean that primary care health and social services will have to collaborate more effectively to deliver the optimum outcomes for their patients/service users. At the moment there are examples of positive partnership working between health and social care but this has to be replicated effectively across Health Boards and partnerships

and resources have to be managed to maximise patient/public outcomes for the recipients of the services.

As service delivery progresses CPS feels we need to build in the opportunity for pharmacists to participate in peer review activity and share learning experiences with a view to delivering a positive patient experience.

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

At the moment the professional responsibilities of both pharmacists and technicians mean they will make appropriate interventions when there is a query about the medicine which has been prescribed for a patient. The provision of CMS is at an early stage but it represents the start of the patient pharmaceutical care journey in relation to their use of the medicines which have been prescribed for them. Simple conversation and interaction over a period of time will enable formalised pharmaceutical care to take place in a way which can be evidenced and demonstrate the benefit for patients in improved outcomes and safety.

Support must be provided for patients through discussion on what they are taking, if it is in a formulation appropriate to their needs and any problems or issues can be identified and then addressed.

In order to address the issues which could arise, pharmaceutical care needs to improve in:

- The way information is recorded on the patient's PCR
- The development of PGDs to allow interventions to be made
- The utilisation of pharmacist's prescribing skills to allow appropriate intervention/management to occur
- The production of a personalised care plan and administration prompts in a patient centred way
- The sharing of information when a patient moves service provider due to relocation or when a patient moves from one health setting to another including secondary care (SIGN discharge guidelines).
- The introduction of support through use of technology initiatives

The ability to provide pharmaceutical care easily and reproducibly would be enhanced through standardisation of the way the patient's pharmacy care record (PCR) is populated. The use of drop down boxes underpinned by Read Coded interventions would make entry easier and help with the extraction of key areas for action and review to ensure care is provided quickly and monitored on an ongoing basis.

In order to ensure that pharmacists across Scotland are in a position to intervene in certain recognised situations to optimise patient benefit from medicines we would like to see greater use being made both of the facility for Patient Group Directives and of pharmacists' prescribing skills. The development of the PGD route should open up more scope for intervention and offer equity for patients and could be put in place relatively quickly. We will talk at Question (17) about the need for a prescribing strategy and the benefits that would bring. Patients can be provided with their personalised care plan including

where appropriate a Medicines Administration Record (MAR) chart to act as a prompt for taking medicine. We should be looking at ways to standardise the production of MAR charts and how these charts could be modified to meet specific patient need, e.g. in relation to literacy. We should wherever possible be finding ways to obviate the need for provision of a compliance aid.

We need to explore how information on a person's medicine regime can be reconciled across health care settings. To ensure the delivery of appropriate pharmaceutical care pharmacists have to be given access to appropriate parts of the patient healthcare record.

We could start to explore how technology could support an appropriate medicine taking regime – for example through use of a smart application or a text message to prompt patients to take their medicines or report side effects. For patients in remote and rural areas we could look at ways to link them to a pharmacy using telehealth so they don't have to physically attend the pharmacy for support or advice.

Pharmaceutical care needs to be developed to provide support to ensure optimum use of medicines by care home staff. For the future, as the plans to integrate health and social care are progressed, the support package for patients and/or their carers who are in the community must also be progressed to ensure patient safety and optimum medicine regimes.

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

The first thing we require is a willingness to embrace collaborative working. All parties must participate and realise each professional brings a useful skill set to the partnership.

We see a need to ensure alignment of the different independent contractor contracts including incentives to ensure each other's skills and expertise are maximised for the benefit of patients. In that respect we are disappointed that there has been a change to the way negotiations on the pharmacy contract have been side-lined from the negotiations for the other primary care contractors. With the need to reshape care we should be looking at how bundles of care should be delivered for patients and how that can be most effectively taken forward within each of the contracts. In that context it is unfortunate that the GP contract, alone amongst the contracts for independent providers, is not Scotland-specific.

As part of the changes to current practices we have to put in place a process of allowing greater access to relevant information for all parties involved in patient care. We also need to ensure information passed between health professionals wherever possible conforms to the working practices of each other. This will require design of appropriate information, electronically transferred with prioritisation of need for response, as part of this process.

We would welcome a move to achieve a different way of working in relation to patients resident in care homes. The recommendation from the Royal Pharmaceutical Society in its recent report for closer alignment between a GP, a community pharmacist and a care home is a good start point and we would support further discussion around that for all patients.

We would like to see the development of opportunities for small group working to explore how pharmaceutical care forms part of the overall provision of care for a patient and for greater sharing of information across the pharmacy workforce. We would like to move to a situation where pharmacists working across primary and secondary care, no matter their employer, were able to meet and discuss clinical issues e.g. at a NHS Board forum; this would help to build up a greater understanding of each other's role. To improve visibility on secondary specialists it would also benefit primary care to see a database of contact information prepared.

For pharmacists working in the community sector there are greater barriers to participation in such events. The NHS Boards should seek innovative ways to offer protected time for study in the same way that other professionals are given. We believe this training should be delivered jointly with other health professionals to promote closer working between all parts of primary care.

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

In our view continuity of care is best provided by the team working within the community pharmacy. Patients choose which pharmacy they access; we do not choose the patients. Within the current patient journey, episodes of care occur as supply is provided to patients. We believe that the link between supply and the delivery of care must be maintained to ensure patients have access to continuity of care; without that link we believe the risk to patient safety increases.

Different services will be provided by different people at different times according to the needs of the patient but the important factor is that the pharmacy has a holistic record of the services being provided for that patient. Every pharmacy contractor has an obligation to ensure that a patient receives continuity of care. Every pharmacist employed by a pharmacy has a professional responsibility to ensure patient care. Any other method of service delivery will result in an additional costly bureaucratic burden for a new service co-ordinator and issues about governance arrangements.

We need to pursue the registration of patients with a pharmacy for the provision of the chronic medication service. Information on the CMS care plan developed through recording episodes of care for that patient will be accessible by all pharmacists working within that pharmacy. Issues which have been identified will be documented and the steps being taken to ensure patient care will be known. After a period of time the outcomes delivered by CMS should be measured from the PCR and patient experience of the service fed back to allow analysis and further change if required.

In our view the roll out of the full CMS service including serial prescriptions will deliver opportunities for planned working to meet patient need and improve continuity of care.

We believe optimal delivery of pharmaceutical care services is best achieved through the development of national services. Due to local clinical priorities, we realise NHS Boards will want to deliver local services. We believe these should be underpinned by the use of national standard templates to ensure continuity of care being delivered by pharmacists working in different NHS Board areas. That would also ensure that the burden on the individual pharmacist was less if they were to work in more than one area.

We also need to look at the use of technology to ensure that continuity of care is available in the event that pharmaceutical care is being provided through a domiciliary visit or to a care home.

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

Community pharmacy contractors currently deliver a number of core pharmaceutical care services which all contribute to supporting self-care. The Minor Ailment Service offers access, for a subsection of the population, to advice and care for a minor and self-limiting condition. CPS would like to see an opening up of the service together with formulary changes as we feel that would bring benefits for patients and efficiencies for the NHS in general and we have set our proposals out in a paper *("Minor Ailment Service – A Review and Proposals for Redevelopment?")* previously submitted.

The take-up by the public of the current patient centred public health services continues to grow. Feedback in the recent Scottish Government review highlighted that patients appreciated the opportunity to receive care in their pharmacy. Community Pharmacy Scotland would welcome the opportunity to discuss how we could introduce a number of other public health services, e.g. a travel medicine service (or vaccination service), alcohol brief interventions or the counterweight programme which would support patients in their efforts to self-care when they have a long term condition and are looking to maximise the benefits from their medication regime. Patient feedback from a pilot in Greater Glasgow and Clyde, to deliver alcohol brief interventions, is that patients find the service which utilises scratch cards to be helpful, non-targeted and non-threatening. A number of patients have taken up the information for further support.

Community Pharmacy Scotland suggests that there is scope through working with patients in the Chronic Medication Service to increase respect and understanding for their medicines. The patient would be empowered to manage their own condition in the way which best suited them. This management would include patient identification of deterioration in their condition requiring intervention. We would also suggest that pharmaceutical care should develop through the availability of supporting information e.g. the availability of a mobile phone app or the ability to refer to other sources of support.

The availability of a pharmacist in every community pharmacy means that advice can be given when a patient wants to self-medicate. Abuse of OTC medicines can also be picked up.

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

The Living and Dying Well Action Plan recognises that currently over 55,000 people in Scotland die each year. Due to the anticipated population change, more patients will die at home or close to home. Across NHS Boards the Palliative Care pharmacy networks have developed, increasing access to medicines in a timely fashion. Audit Scotland recognised this system **was working well** and CPS believes this is due to the co-operative nature of working between contractors to support delivery of care to patients and carers at this difficult time. Further integration with OOH services and between professionals would enhance care, e.g. involvement of community pharmacists with the multidisciplinary meetings of the PHCT.

CPS believes community pharmacies should be able to respond to requests for medicines as quickly as possible and community pharmacy contractors need to be made aware more quickly of when a patient has been registered by a GP practice on their QOF Palliative Care Register. It would be beneficial if a link could be built between the entry on the QOF Palliative Care register and the patient's PCR.

Current practice also dictates that Community Pharmacy has no access to the electronic palliative care summary. We know the eHealth Strategy recommends that access to the emergency care summary should be made wider by 2014. We feel that access to the palliative care summary if it not already planned would improve continuity of care for patients.

From the clinical perspective CPS is keen to ensure that Pharmacists are able to make appropriate therapeutic interventions particularly in the OOH period to prevent hospital admission. This would require to be underpinned by better electronic records so that any pharmacist could provide safe and effective care. We welcome the recent changes to the controlled drug regulations to support independent prescribing by pharmacists.

NHS Forth Valley has previously piloted access to rescue treatment for COPD patients unable to access a GP appointment. Pharmacists using PGDs were able to supply antibiotics and steroids if appropriate to improve patient care. The system required GP sign off to allow patients to enter the scheme. We believe interventions like this if made early enough could reduce hospital admissions and slow progression down the illness trajectory observed. We believe that the PCR should be developed to support recording and dissemination of these interventions to GPs similar to the OOH summaries from NHS 24, thus allowing visibility for all.

The Gold Standards for Care recommend continued learning through various means. This training includes local and external teaching, significant event analysis and audit. We believe joint training with other members of the PHCT will support greater understanding of each other's skills and ensure standardisation of care occurs across an area served by the pharmacy.

The Living and Dying Well Action Plan recommends that NHS Boards and CHPs should take steps, including use of PGDs and Just in Case boxes where appropriate, to facilitate the use of anticipatory prescribing to enhance patient care and aid the prevention of unnecessary crises and unscheduled hospital admissions. These frameworks are currently only accessible to District Nursing Teams.

Now that GPs and District Nurses are less available at weekends it would seem logical to allow the Community Pharmacies to use the PGD framework available in Boards to support direct patient care. The building blocks to get there would be greater multidisciplinary working and appreciation of skills each healthcare professional can bring for patient care.

We believe that the PCR could be developed to support joint pathways of care between GP Practices and Pharmacies for these patients. GPs could authorise anticipatory prescribing on an individual patient basis so they allow Community Pharmacists as well as District Nurses to make changes to improve patient symptom control.

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

Community Pharmacy Scotland is of the view that the delivery of pharmaceutical care services through a registered community pharmacy does meet the needs of patients and communities. We know of no other evidence that another model works. Any change to the current model would carry colossal risk for patients and communities. The community pharmacy is a hub in the community and it offers access to

an independently regulated healthcare environment, which provides the NHS with the full range of pharmaceutical care services, regulated professional staff, knowledge, continuity of care, good governance arrangements and patient choice.

The provision of pharmaceutical care through a pharmacy means that the patient can access supply of their medicines and pharmaceutical care in the one setting and at the same time. The patient is not faced with unnecessary steps in their healthcare journey.

The pharmacy contractor has the opportunity to determine how services are delivered and in some instances may decide that services should be provided in a different setting, e.g. the patient's home, care homes or through a visit to another local setting to interact with members of the public who do not normally visit their pharmacy e.g. the provision of a smoking cessation clinic in a pub or at a football stadium.

The current arrangements where the funding of community pharmacy is made through a mixture of reimbursement for product supplied and a negotiated global sum are crucial to the survival of the pharmacy network. Radical changes to this model have the potential to create an environment of widespread disinvestment and loss of access to care for patients and the NHS.

Section 2: *Safe* NHS Pharmaceutical Care

Quality Ambition

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

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

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

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

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

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

Community Pharmacy Scotland Response

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

CPS takes the view that the main priority is the delivery of pharmaceutical care through one contractual framework focused on patient safety; this framework should encompass supply and pharmaceutical care for patients with definable reproducible outcomes to evidence avoidance of injury or harm.
Key pillars of this are:

1. Supporting provision of the right medicine at the right time in the right form
2. An improved focus on medicines deemed to carry a higher risk of harm or injury
3. Better handling of information when a patient crosses an interface between health professionals and setting
4. Improving Health literacy

Supporting Provision of the Right Medicine at the Right Time in the Right Form

The prime focus of community pharmacy is to ensure that the prescribing and dispensing of medicines for patients is carried out safely and effectively. During 2010/11 there were over 100 million dispensing episodes across Scotland. In March 2009, a cross sectional survey of all prescription interventions which occurred in one week was carried out across Scotland. This resulted in the logging of over 7200 interventions. These interventions ranged from the need for change to ensure the prescription was legal to, in over 70% of interventions, queries about the item prescribed. In 2010 the Chronic Medication Service (CMS) was implemented. The introduction of this system of personalised pharmaceutical care to patients with long term conditions is helping to support the development of a systematic approach to the provision of care.

CMS is currently in the early stages. Over 150,000 patients have been registered and an initial assessment to determine the priority to establish a care plan for them has also happened for the majority. The introduction of CMS has allowed community pharmacy to build upon the direct care which was already provided to patients in Scotland but if community pharmacy is truly to maximise the benefits for patients from medicines then other elements also need to be put into place. In this section we will comment upon the **safe** priorities but return to other aspects at the appropriate point.

It is not yet possible for all pharmacy contractors to deliver all elements of CMS for all patients as the serial dispensing element is currently only available at a number of early adopter sites. Community Pharmacy Scotland is disappointed that it has not been possible to implement roll out across Scotland more quickly. Feedback given to us by pharmacies which operate a managed repeat service which allows them to manage the prescription workflow and utilise better non-busy periods is that this has led to a reduction in the incidence of errors. NHS Scotland should be looking to provide the necessary resource to speed up the introduction of serial dispensing across Scotland.

It remains the case however that there are still too many hospital admissions which occur as the result of misadventures with medicines (information from 2004 (BMJ 2004: 329: 15-9) suggests a figure of 6.5% for unplanned hospital admissions. Many of these hospital admissions are for patients who are receiving a high risk medicine (BMJ 2011;342:d3514).

Medicines with a higher risk of causing injury or harm

Community pharmacy contractors and their staff now have access to the protocols for Lithium and Methotrexate which have been incorporated into the pharmaceutical care record (PCR) which is available to document pharmaceutical care given after a patient registers for CMS. A priority should be to build upon that initiative with the addition of more protocols for other high risk medicines.

Consideration should also be given to creating a national group which contains GPs and Pharmacists to deliver jointly agreed care protocols around evidenced areas of high risk prescribing that include clinical indicators to trigger action in instances when a potentially harmful combination has been prescribed, e.g. warfarin and aspirin or in instances where a product has not been prescribed e.g. prescribing of a NSAID without a PPI. This joint working group would be tasked with reducing harm from commonly prescribed medicines.

For these high risk medicines a priority must also be to allow pharmacists working within community pharmacies access to the results of blood monitoring to facilitate informed decisions. Pharmaceutical care cannot be practised in a vacuum. As part of that process national standards should be developed for drugs which require monitoring in order to ensure that everyone in the primary care team is aware of the actions required and the timescales e.g. ACE inhibitor initiation, when are bloods required for baseline review and annual review.

One way that this might be tackled is to look at introducing care bundles for conditions which cover interventions that apply to both primary and secondary care. The bundles will set out the role and responsibility that each healthcare professional/setting has to ultimately prevent harm from the initiated treatment. An example for warfarin could mean a community pharmacy focussing on the NPSA recommendations, GP practices could undertake differing enhanced services to those run by local acute hospital out-patient clinics, but together they are all reinforcing messages and working to reduce the potential for harm to result from warfarin treatment. Different interventions could be the responsibility of each healthcare member of the care pathway but by having agreement on responsibility, duplication of effort will be minimised, and each member's strengths utilised fully

Over time resource needs to be given to allow use of the information which has been built up in the PCR. The issues which have arisen should be explored, how they were resolved and the learning points and good practice shared.

Medicine Reconciliation/Data Sharing

A patient will be at risk of harm when they move from one setting for care to another due to the need for reconciliation of medicines in use. There are two key areas for improvement, the information held by the patient and the sharing of information. The PCR should be used to create a summary of the declared medicines currently being taken and a copy given to the patient for visibility to other health professionals when the patient moves setting. Secondly other health professionals have to post information including changes to a central repository which is accessible by all health professionals involved in that patient's care.

Innovative practice, as illustrated by a NHS Forth Valley pilot, around sharing of information between primary and secondary care using PCR has demonstrated a value and shown how existing systems can support such communication. The electronic information helps support ongoing safe medicine use upon admission to hospital and when the patient is returned to the community. This is achieved by the pharmacist using the information supplied to check either previously prescribed and not supplied medicines or to review medicines supplied to the patient previously. These types of intervention to improve medicines reconciliation are a cost-effective use of NHS resources and improve the patients NHS experience.

Improving Health Literacy

Health literacy has been defined as "the degree to which individuals have the capacity to obtain process and understand basic health information and services needed to make basic health decisions."

A further priority must be to improve patient literacy in relation to the taking of their medicines. A third of older adults in UK have difficulties reading and understanding basic health related written information. Poorer understanding is associated with higher mortality. The limited health literacy capabilities within this population have implications for the design and delivery of health related services for older adults in Scotland. *BMJ 2012;* 344 :e1602

One way to tackle this will be through the production of an individual care plan and a personalised MAR sheet which may include pictorial representation to underpin written information. For those patients who are no longer able to self-medicate the provision of information in an accessible form for their carers or the staff involved in the administration of medicine should also be a key priority.

Other tools which can be developed and delivered in community pharmacy to improve patient understanding of medicines include the "teach back" method (Schillinger D, Piette J, Grumbach K, et al. Closing the loop: physician communication with diabetic patients who have low health literacy. *Arch Intern Med.* 2003;163(1):83-90). This method has been shown to improve understanding of medicines by patients. We believe training in this method should be encouraged and recording implemented into pharmacy care record.

Pharmacist Training/Competence

In recent times concern has grown around the possibility of prosecution should a dispensing error occur. In order to prevent avoidable injury or harm for patients there is a need for an open culture to ensure that all health care professionals report and learn from mistakes. Changes to legislation are needed to support this culture. The regulatory body for pharmacy (GPhC) will also be acting shortly to bring forward new standards for the safe and effective practice of pharmacy.

The providers of pharmaceutical care must maintain their competence and be able to demonstrate that they have done so to ensure patient safety. In that context we see the need to monitor closely how the pharmacy regulator intends to proceed with the revalidation of pharmacy professionals.

The workforce within community pharmacy must also be given the opportunity to participate in events which highlight patient safety issues and any changes resulting from examination of these events. One

possibility there would be to look at ways to facilitate practice based learning for small groups - this could be something for NES and the territorial boards to consider jointly.
The idea of a focus on patient safety must be built into all educational courses.

Medicines Regulatory Issues

This is another area which is causing us concern in relation to our ability to provide safe pharmaceutical care. There are two elements to this. The first is an increase in the use of products out with the terms of the product licence. The second is the decision taken by the MHRA to allow continued use of products where the information contained in the Patient Information Leaflet is out of date. The rationale for that is that it ensures continued availability of product. In terms of patient care it is putting an additional burden on the community pharmacist rather than the MHRA taking steps to rectify the problem.

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

Pharmaceutical care services for patients in the community are delivered to a very large extent from within the community pharmacy. In terms of ease of access for the patient we would expect that environment will continue but in the future it is also likely that some services will be provided to a greater extent in the patient's home (not subject to regulation) or in a supported care / care home environment (subject to inspection by the Care Inspectorate). Whatever the environment it must inspire confidence for the patient.

Community pharmacy premises **must be registered** with the General Pharmaceutical Council (GPhC). The pharmacy regulator, the Council of which includes lay members, is the only regulator with statutory powers in relation to premises. It has national powers and should be responsive/flexible enough to adapt to changes in practice across Great Britain. The presence of an independent national regulator will help to ensure that cross boundary issues do not arise when a patient moves from one part of the country to another and that the interpretation of standards by Inspectors from different parts of the country are consistent.

GPhC is currently carrying out a consultation on modernising pharmacy regulation. It has set out how it intends to define the nature of pharmacy premises which it will register. Premises which do not meet that definition, e.g. the provision of service within a doctor's surgery will not be registered, and there is then an issue and a cost for NHS Boards in relation to the governance arrangements.

The draft standards which GPhC is currently consulting on through "Modernising Pharmacy Regulation" are comprehensive and cover far more than the layout or size of premises. The focus is on ensuring the health, safety and wellbeing of patients, the public and staff. Community Pharmacy Scotland will continue to engage with the regulator on the development of the new standards and on how compliance will be monitored.

There should be no need for NHS Boards to duplicate the authority of the regulator in relation to premises standards, particularly as pharmacy premises are also subject to the statutory requirements of Health and Safety and Environmental Health. The availability of the SG Scottish Planning Note (No 36)

produced by Health Facilities Ltd should be used as a benchmark when planning new premises and refits. Some NHS Boards have also produced useful templates which may be helpful when gauging whether premises are complying with GPhC standards.

Pharmacy premises have undergone a transformation over the last decade. Pharmacy contractors have invested heavily in their premises, supported to a modest extent by funding from the Scottish Government, and the provision of one if not two consultation rooms is now the norm. More than ever consultation rooms/quiet areas are being utilised to deliver private patient focused services such as the public health services, the chronic medication service and other local services (e.g. alcohol brief interventions). Other improvements have included the increased access to pharmacy premises for people with disabilities (e.g. visual, hearing, and physical).

The provision of pharmaceutical care services from a community pharmacy ensures that services are provided in a holistic manner by all members of the pharmacy team.

Members of that team also need to feel safe in the premises in which they operate and the risk in lone working for both patients and a member of the team must be considered if operating outwith the premises.

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

Community Pharmacy Scotland (CPS) welcomes the recent publication by RPS of its report *"Improving Pharmaceutical Care in Care Homes".* CPS had already looked into areas where service delivery could be enhanced (paper submitted) and there appears to be a number of areas of commonality between the two reports. CPS is keen that its members deliver the necessary clinical service, plus an efficient supply function and additional support for those involved with the provision of care to residents. We suggest that use of the full range of pharmaceutical care services such as MAS could deliver benefits to the NHS and patients.

Government officials have made it clear to us that the provision of CMS for care home residents is not an option. We would submit that CMS is the answer but a different format is needed which builds upon the elements already present within CMS. We consider SG should develop the PCR to ensure that residents in a care home are easily trackable and supported, using the risk assessment and care issue identification methodology currently available in CMS. That would help to ensure transferability of information when a patient moves from one health care setting to another. We would encourage for reasons of patient safety access to serial prescriptions for care home patients. Use of the e- underpinning would mean information on prescription status was constantly updated and therefore accurate.

The creation of a pharmaceutical care plan for residents of a care home should be a priority as these patients are likely to be frailer and at more risk of medicine harm than other patients. We also need to be given a framework for intervention to allow us to make suitable patient- centred changes. We would welcome the introduction of national guidelines for care homes to support efficient working practices in

managing repeat medicines, supply and administration. The sharing of information should also be a priority with greater alignment between the GP, the CP and the care home.

As a first step we support the idea of a more robust contract system which will remove the perceived opportunity of perverse incentives and a service level agreement between community pharmacy contractors, the care home providers and the NHS Boards. The current contract situation is volatile and acts against the introduction of long term improvements. The development of the new arrangements in Tayside for provision of services to the residents of care homes is helpful and we would welcome the opportunity to discuss with NHS Scotland how that might be incorporated into Scotland wide working. The Tayside arrangements have also demonstrated the benefits from involvement of pharmacy technicians in the roles identified.

CPS notes the recommendation in the RPS report on the non-provision of compliance aids for patients resident in care homes. As most products are now available in patient packs, the use of which could be supplemented with the production of national MAR sheets available in paper and electronically for care homes, we are in agreement with RPS that the continued provision of compliance aids should not be necessary. That will also release time to provide care. We would like to go further than the RPS recommendation and call on the Care Inspectorate to deliver an action plan for the cessation of the use of compliance aids in care homes.

We wish to see more effort put into collaborative working between the pharmacy contractor providing the clinical and supply services and other healthcare professionals who have more specialised knowledge, e.g. the psychiatric nurse attached to a home or a pharmacist from the secondary care service who has appropriate specialised knowledge for advice and support.

Community pharmacists who are providing a service for the residents of care homes have a responsibility to maintain their competence. As and when new training is provided the onus should be on the pharmacist to keep up to date.

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

Pharmaceutical care should be developed in a logical progression targeting areas where most benefit could be derived. Pharmacy contractors are building up their involvement with patients registered for CMS and a number of initiatives could be put in place to help with poor prescribing practices. NHS Scotland should be supporting changes to the PCR so that poor practice maybe identified, extracted and remedied.

We believe action in the following areas will build on the current activity. The community pharmacy network must be empowered to make meaningful interventions on behalf of patients who are receiving:

- a new medicine
- a high risk medicine
- a medication where misadventures are a possibility

- a prescribed medication where the benefits may have become questionable

New Medicine Support Tool

The introduction of NMIST will help pharmacists to support patients prescribed a medicine for the first time. The tool will allow stepwise assessment of whether the new medicine is appropriate with their other medicines or if a high risk combination has been introduced.

Research has shown that non-adherence due to problems with a newly prescribed medicine can be significant. Early intervention is expected to support continued use and better patient outcomes. Intervention may also recognise adverse reactions sooner and prevent unnecessary hospital admissions.

Identification of repeated problems with particular medicines must be collated, information shared widely and any necessary improvements identified built into IT systems. Recording interventions in the PCR will help to show where community pharmacy has a role. Work is needed to improve the interface between PMR and PCR, to ensure that up to date information is always available to viewers of the PCR.

An opportunity exists with NMIST to identify poor practice in relation to common classes of medicines. The pharmacist should identify and manage risks holistically with the patient.

Support for patients receiving a high risk medicine

Pharmaceutical care for patients receiving a high risk medicine needs development to ensure that the pharmacist has sufficient information to allow them to assess whether prescribing is appropriate. The parameters to trigger action should be set out within the PCR and a protocol agreed for sharing information with the prescriber. Areas of poor prescribing practice should be highlighted to a wider audience facilitating discussion and possible modification.

Support for patients who are taking a medicine where misadventures are a possibility

CPS suggests that work should take place with the Safety Programme in Primary Care to tackle the top 10 medicine misadventures which lead to hospital admission. A multidisciplinary group should be established and charged with developing a set of clinical indicators to identify potential problem areas. Using these clinical indicators the community pharmacy team and the PHCT could work together to reduce the incidence of such problems. A baseline for each intervention should be developed and changes over time monitored demonstrating improved patient safety.

Inappropriate Polypharmacy

SMC evaluates information for new products to determine their use within NHS Scotland. As patients live longer and medicines use becomes more complex, the time has come for the creation of another body to review the evidence for treatment combinations and offers guidelines to prescribers for optimum regimes depending upon the point of a patient in a pathway of care.

The new QIP Indicators in GMS include a focus on prescribing and GPs, in association with Boards, will identify 3 extra areas for prescribing improvement. We believe a focus on polypharmacy in the elderly which included input from community pharmacy would deliver benefits.

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

The registration of patients with their community pharmacy and the creation at the pharmacy by pharmacists of a pharmaceutical care plan for the patient will help to ensure better information is available. The patient and/or their carer (where consent has been given) should be provided with a copy of that information together with a copy of a medication chart increasing the likelihood that the information will be available to share elsewhere. The fact that the information is accessible within the community pharmacy by pharmacists working within that pharmacy also helps to secure continuity of care for the patient.

The care plan carries a pharmacist's name opening up the opportunity for interaction with a pharmacist or another healthcare professional in another setting. Over time we could look at ways to support the patient by making information available electronically, e.g. a smart card, a phone app or access online.

In Wales a new service has recently been introduced to provide support from community pharmacies to individuals discharged into the community. The idea behind the service is to improve the flow of medicines information. The individual can take their discharge letter to the community pharmacy where it can be used as part of a review process to ensure that any medication prescribed within the community remains appropriate. For Scottish patients who have a long term condition and who can register with their pharmacy for the Chronic Medication Service this type of information sharing would bring many benefits. (We can send in more detail on the service spec separately).

Community Pharmacy Scotland supports the position that discharge information should be timely, accurate and based on the draft SIGN guidelines on discharge information which are currently being reviewed and is out for consultation.

We have already put forward in our answer to Q9 the benefits of information sharing between the primary and acute settings as seen in the pilot currently underway in Forth Valley.

We also need to ensure that when a prescription is dispensed then that medicines information is updated automatically from the PMR system to the PCR. Community pharmacy contractors will be exploring ways to take greater ownership of the software development process by PMR companies and Scottish Government to ensure they are fit for purpose. The release of funding for the PMR companies should only be released once contractors have signed off that the system is fit for purpose.

We also believe that the GPs and emergency care summary should also have visibility on dispensed information for all prescriptions so that accurate information is available to support medicines reconciliation.

Section 3: Effective NHS Pharmaceutical Care

Quality Ambition

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

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

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

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

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

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

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

Community Pharmacy Scotland Response

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

NHS Boards should lead on the planning for the provision of pharmaceutical care services through the community pharmacy network. NHS Boards have the power to determine applications for inclusion in the pharmaceutical list. The delivery of PCS plans should be expedited ensuring synergy with Local Delivery Plans and HEAT targets to ensure pharmaceutical care is being targeted appropriately. NHS Boards should be monitoring delivery against their plan and taking steps to address areas of poor service delivery.

Pharmacy contractors should be responsible for providing an effective pharmaceutical care service within their NHS Board area. The aim throughout should be to ensure that patients are provided with a service meeting their identified needs and offering continuity of care. The contractor should determine the best way to make that happen.

The current distribution of community pharmacy contracts has been under scrutiny for some time. In the interim some pharmacies have closed or merged; the existing legislation offers no guarantee that another contract will not be granted subsequently. CPS is willing to participate in a network review which should factor in ways to promote co-operative working in terms of openings, closures and mergers. Closures and mergers should not adversely affect the public's ability to receive PCS close to their desired location of access, an important point in remote and rural areas of Scotland.

Currently there is little opportunity for pharmacies to enter into long term contracts to provide additional services. Apart from substance misuse services and advice to care homes there is little long term planning or dedicated funding around innovative services. The use of a LES in Tayside to develop new arrangements for services to care home residents offers a pointer to another way of working. For 2012/13 changes have been introduced to the SESP to enhance local autonomy with funding no longer restricted to general medical practice. CPS would like to see new pharmaceutical services developed using this funding but in a more focused way. We have collated information from the pharmacy contractor committee in each NHS Board. Initially there is a multiplicity of services but in reality the same service is being provided with a particular NHS Board spin to it. For pharmacists that makes it very difficult to ensure continuity across Boards and may lead to patient confusion if they try to access a service across a NHS board boundary.

As Scotland is a relatively small country this is a waste of resource. Different areas should be concentrating on different priorities in line with identified local or national need, e.g. care for COPD patients or structured interventions with the aim of reducing hospital admissions. The redesigned service should be supported for a reasonable period of time to allow service delivery against locally agreed measurable outcomes. If successful the service could then be rolled out nationwide as happened with MAS. We would recommend that a group be set up to establish service templates. CPS has already drafted a template for use by local committees in discussions with NHS Boards.

We also believe NHS Boards should be planning pharmacy public health services in their area to target action around health inequalities. For example community pharmacies could provide alcohol brief interventions, cancer awareness information and NHS health checks.

NHS Boards should also consider service development for patients living in remote and rural areas or for patients who are homeless and/or living in hostels. An outreach contract could be offered for service provision either by one contractor or though the network on a collaborative basis. Services offered could be on a sessional basis or through the use of modern technology, e.g. a video link to a pharmacy, and the provision of a vending machine for commonly used products for minor and self-limiting conditions.

Question 15.The NHS in Scotland is based on co-operation not competition. How can this be translated into effective and efficient NHS pharmaceutical care for patients in their communities?

CPS strongly suggests that competition actually offers many benefits for NHS Scotland. Pharmacy contractors have invested significantly in NHS service provision – as they have taken that financial risk they will compete to ensure that a return is achieved on that investment. Competition benefits patients and the NHS too because it means that:

- Premises and Staff standards are maintained to ensure patients continue to access the pharmacy
- Patients and the public receive a service which meets their needs in terms of access and availability of a healthcare professional including opening at weekends and after 6pm.
- It drives efficiencies and quality within the system
- Efficient purchasing of generic medicines has helped to maintain lower drug costs

Scottish Community pharmacies have co-operated over many years with NHS Scotland to develop innovative services required by patients. Individual pharmacies co-operate through:

- stock sharing at times of shortages to ensure patients' needs are met
- staff sharing between branches
- the design of rota opening arrangements to ensure patient access at times of particular need.
- sharing of information when patients access care out with their normal setting e.g. when a patient requires care when on holiday
- Pharmacy Champion Network

Community pharmacy contractors also co-operate in membership of buying groups. These groups help to drive efficiencies with drug purchasing costs for the NHS.

In the future it may beneficial for Health Boards and Pharmacy Contractors to co-operate on a local basis to tackle particular clinical or patients safety issues in a focussed manner. For example contractors could implement a safety measure around a particular prescribing issue such as Methotrexate 10mg usage or focus on the use of statins for a calendar quarter so that every patient in an area is targeted with the same care.

Pharmacy contractors currently engage in a number of public health activities within the Public Health Service, one of the core elements of the national contract. One of the components of the national service is PHS poster campaigns. Sometimes these national campaigns lack a specific focus for increased pharmacy input beyond displaying the poster. We believe this is a missed opportunity and would provide scope for increasing pharmacies role in promoting public health and co-operating to ensure consistent messages are pro-actively delivered to patients.

We also need to look at ways to co-operate with health care colleagues; recently we have engaged with our optometry colleagues to deliver shared care around eyes utilising the Minor Ailment Service. We believe this type of model could and should be delivered on a wider basis with other health care colleagues e.g. joint working on the availability of instant access to the GP for an appropriate referral.

Pharmacist independent prescribers now have access to the full range of medications and it is time to consider how to move to a model where the doctor diagnoses and the pharmacist prescribes. The patient would be provided with the prescription to take away but in order to ensure there was no conflict between the prescribing and dispensing functions, a pharmacist prescriber working within a pharmacy could consider how to work co-operatively with colleagues to deliver care for patients he or she does not dispense for.

Community pharmacy also needs to engage with the debate around making better use of the skills of the pharmacy team, in other words co-operating with other pharmacy professionals. In hospitals the dispensing service is carried out by technicians and care is provided by the pharmacist. That could be mimicked in community pharmacy were the legalisation to change and contractors had ensured that their staff had the necessary technical expertise to meet GPhC standards.

Community pharmacies could share equipment and stock to meet geographic and/or demographic need.

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

CPS is supportive of collaborative working to deliver some aspects of NHS pharmaceutical care. Examples include:

- Community pharmacies and specialist hospice pharmacists work together to provide end of life care through the palliative care network
- Community Pharmacies and secondary care communicating around medicines reconciliation and assessment of need for a compliance aid.

The growth of more complex patients in the community means we will need to look at ways of sourcing support from outside expertise to enhance pharmaceutical care. In the acute and the primary care sectors pharmacists have developed skills in specialised areas. It does not seem sensible that a specialised pharmacist is available in every pharmacy. Rather these specialised pharmacists should

form a resource which is available to all community pharmacies and these pharmacists should collaborate with their colleagues to increase the skill base across the whole pharmacy network. We see that as an on-going development with patients being able to access the clinical care which they need from their community pharmacy who in turn are able to receive support when required from outside specialists.

For example pharmacists working with their colleagues in the acute sector have provided care for patients with leukaemia (Imatinib) and we are starting to see care bundles being prepared to support patients in the community to receive their anti-TNF medications and clinical care.

We propose that more use should be made of the facilities available within community pharmacies. This will facilitate all pharmacists employed by a pharmacy having a chance to build up their expertise. This would improve continuity of care for patients.

Tensions currently exist between primary care pharmacists and the contractor pharmacist network due to a lack of collaborative working between these groups. It is perceived often that the primary care pharmacists seem to be less involved with the provision of pharmaceutical care and more with controlling GP prescribing budgets. In order to address that tension we need either to find a way to work collaboratively or we need to have a fundamental shift in the way funding for these primary care pharmacists is allocated.

CPS is keen to provide medicines management services on behalf of the NHS in Scotland in a collaborative fashion. We believe NHS Boards and pharmacy contractors across a Health Board area could agree areas for targeting during a financial year. Performance management would be used to ensure delivery of the required savings without the NHS employing pharmacists.

Given the need for more complex patient care in the community in future years we propose that it is time to look at reallocation of the Health Board funds allocated for medicines management to the community pharmacy global sum. Contractors would then be in a position to employ these pharmacists on a sessional basis if required and develop the more complex care services needed in a setting which offers continuity and access for the patient i.e. their community pharmacy.

In terms of individual pharmacists working collaboratively to provide pharmaceutical care in the community we can't see how they would be able to do this unless the NHS Board was providing them with a facility. That then opens up questions about:

- the status of these pharmacists – are they employed or are they contracting with the Board?
- the nature of the premises from which they are operating – it cannot be a pharmacy (regulated by GPhC) as they are not involved with sale or supply.

For either scenario the bureaucratic burden and the governance issues for the NHS Board will only increase.

Community pharmacy contractors could ask their employee pharmacists to work collaboratively and that might help to develop areas of expertise; pharmacists could not expect their employers to provide them with facilities to work in for which no payment was provided to the contractor.

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

The introduction of the Minor Ailment service and the unscheduled care arrangements mean that all community pharmacists are now able to provide a patient with a supply when there is a specific need. Patients have become more accustomed to the sight of pharmacists prescribing for them. The Minor Ailment Service could be modified to improve further the care available to patients at weekends and in other GP out of hours periods. For example, using a PGD, pharmacists could prescribe Trimethoprim for patients who have presented with an uncomplicated UTI. Such a scheme is currently being piloted by a number of pharmacies within Greater Glasgow and Clyde.

Development of a Prescribing Strategy

The way in which pharmacist prescribers are using their skills has developed in a piecemeal fashion. It is now time to develop a national strategy on how their skills should be used within the Chronic Medication Service. The time taken to develop and implement CMS has been detrimental to the progress of prescribing by pharmacists.

Pharmacy prescribing should be developed in line with key national priorities. e.g. polypharmacy review, for COPD/heart failure control to support reduction of hospital admissions, or in services for drug misusers such as reduction in use of benzodiazepines, other areas could be first port of call in the out of hours period by NHS 24

We should be encouraging NHS Boards working with their local committees to consider the use of community pharmacies and pharmacist prescribers whenever they look at extending or planning and commissioning new services.

There are other alternatives available for consideration:

Firstly we could to look at placing management of a specific condition into pharmacists' hands. The benefit from this is that the care could happen in the patient's community or close to their work rather than as often currently happens where the patient has to go to the GP surgery for a nurse-run clinic. That can be a problem particularly for the elderly in rural areas where there may be transport difficulties.

Secondly we could look at the establishment of a service where the GP would discharge a patient into the pharmacy's care and the pharmacy would act within set parameters. That would represent a development of the current supplementary prescriber arrangements. It could be developed to support such care and if certain aspects of the patient's condition e.g. blood pressure went outside agreed parameters then a referral back would be made.

For these developments to happen on a long term continuous basis we need a new dedicated funding stream and a realistic period set for monitoring activity of the agreed outcomes. We also need to look at the resourcing and training of pharmacist prescribers as funding for days in practice is currently unavailable and we propose increasing access to mentors from the pharmacy arena as well as general practice.

For all these activities community pharmacies must be given access as a minimum to the summary care record or to appropriate medical records to ensure that service is safely delivered by the pharmacy. Patients could also be provided with a card to summarise information on their current medication including OTC use.

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

The strength of Community Pharmacy in this client group is the regular daily contact with these patients, which allows us to build relationships and gain detailed knowledge of that person's life, associations and substance misuse habits.

We are often the first professional group to be able to interact with that patient when their drug taking behaviour changes or when social factors alter. We see these patients more often and for longer periods of time within 14 days of treatment than their GP's and Community Psychiatric Nurses (CPN's) see them in 1 year's worth of treatment.

CPS believes that the role of the pharmacist could be expanded in the area of drug misuse. We are particularly keen to expand our interactions with community addiction teams and prescribers to support service delivery. We are keen to start providing information through a care plan so that prescribers get a picture of how the patient has been during the previous prescription period. Recorded factors such as numbers of days presented, appearance of the patient and any concerns on social issues should be part of this care plan

Several key areas need to be considered for development under the banding of drug misuse:

1. Illicit Opiate Addiction
2. Recreational Drugs e.g. cocaine and cannabis
3. Alcohol
4. OTC and Prescription Drug Abuse
5. Steroid and Growth Hormone Abuse

1) Illicit Opiate Addiction

Pharmaceutical care services for the drug misuser in Scotland frequently come out of good practice in health boards e.g. methadone supervision in Greater Glasgow and Lothian. The use of pharmacy contractors to provide methadone supervision and needle exchange is identified in "The Orange Book" as good practice.

Most pharmacy contractors in Scotland now provide dispensing and supervision services for methadone and buprenorphine on a daily basis. Many Health Boards also use pharmacy as needle exchange locations for misusers.

The government published the Road to Recovery in the last parliament - this strategy is keen to move away from the current model of long term substitute prescribing and move towards abstinence in individuals.

The strategy still recognises the need for prescribing but is keen to move individuals away from long term prescribing and onto abstinence and a goal of active contribution in society. We do need to recognise though, despite the aspiration to have all patients drug free, that this may be unachievable in the short or medium term for patients without the use of maintenance therapy to promote stability and safety for children of this client group.

A review of the strategy indicates a place for pharmacy to provide enhanced care for patients. These enhancements include treatment, vaccination and care pathway enhancements. Currently some NHS Boards have started to deliver these developments but reproducibility nationally is patchy.

a) **Treatment**

Supplementary and Independent Prescribing

The strategy recognises the need to improve access to methadone and buprenorphine, it recognises pharmacy has an important role to offer using non-medical prescribing.

There are examples throughout the country of SP/ IP clinics working within this field, from Methadone clinics to Benzodiazepine reduction clinics. We must accept that not all pharmacies providing methadone services are willing to extend their roles, however there are a few in every Health Board area who are willing, and they must be encouraged and supported.

Supplementary and Independent Prescribing is a useful conduit to improve titration/reduction of patients currently on methadone. Pharmacy could have a key role in providing support to a caseload of stable patients who are currently reducing their methadone or are on a fixed dose with no hope of reducing in the short to medium term. Movement of these patients from CAT teams or GP care could improve access to service for more complex or unstable patients that require specialist support. We are keen in conjunction with addiction specialists to look at researching novel methods for detoxification in patients who wish to move on in their treatment pathway.

b) **Supervision Arrangements**

The SG strategy is keen to identify and support any patient who is keen to work. This indicates a need for either flexibility in supervision/dispensing arrangements or a change in current pharmacy opening times to support collection and supervision of methadone before or after work.

CPS is keen community pharmacists using their close relationships with patients be involved in looking for innovative support for patients to ensure medicine and patient safety.

c) Naltrexone

The strategy is also keen to move towards increasing the use of naltrexone. Contractors have a role to play here with supervision of naltrexone service and supporting relapse prevention.

d) Testing

The testing of drug misusers is extremely useful during periods of substitute prescribing. Clinicians being aware of the outcome of the result can improve the safety of substitute prescribing.

The outcome of a test can support increased titration of methadone or buprenorphine if required leading to improved stability of the patient. The use of oral swabs by community pharmacy could and should support other clinicians or the pharmacist prescribers to prescribe safely and appropriately for patients.

e) Prevention and Detection of Blood Borne Viruses

Community Pharmacy contractors could play a vital role in the support to misusers whom currently are not accessing services of addiction teams or GPs.

BBV Testing

The use of oral swabs or blood spots to test for BBV is crucial to prevent the spread of Hep C and HIV in Scotland. Drug misusers presenting to needle exchange services or for methadone supervision could be tested after being offered counselling.

Vaccination

Contractors should be able to offer Hepatitis vaccination to all drug misusers. Contractors are ideally placed to follow up patients who may have been lost to follow up from vaccination programmes offered by GP or addiction teams. This is due to clients being able to access services at any time and the requirement to collect their substitute prescription from the pharmacy. This may be especially useful for chaotic misusers who are unable or don't turn up for appointments at their GP.

f) Care Pathways

Community Pharmacy contractors are ideally placed to support care pathways of drug misusers. Contractors are the location most frequently attended by misusers.

Care-Planning - The strategy is keen to ensure drug misusers are provided with an individualised care plan. This plan is to be a holistic assessment of their needs and be reviewed regularly. The plan is to cover both treatment, rehabilitation and training or employment needs.

As previously identified it is key community pharmacists augment this careplan.

Social Work

Due to the regularity of visits by misusers and their families improved dialogue with social services is key to improving care and safety of clients.

Prison Service

Community Pharmacy contractors are ideally placed to support the prison services deliver enhanced transition arrangements for drug misusers. Currently release from prison can be fraught with difficulty and good communication between community pharmacy contractors and the prison service may help ensure the rehabilitated offender is able to access treatment close to home upon release.

Signposting

Supporting pharmacists to providing sign posting to other services would improve care of clients.

g) Overdose Treatment Provision – Naloxone

CPS is keen to be involved in the provision of Naloxone to patients and families at risk of overdose. This scheme has been nationally rolled out but repeat supplies are not currently available in very many community pharmacies despite them offering needle exchange.

2) Recreational Drugs

The treatment modalities for recreational drugs are different to those of opiates such as heroin. Substitute prescribing is not helpful for this client group and we need to deliver Cognitive Behavioural Therapy and holistic care to include social support to help patients.

Currently very few pharmacists are trained in this and it would require significant resource and commitment to reproduce this in every pharmacy.

However, being able to sign post patients who report a problem with recreational agents is a vital role pharmacy can complete. We need to ensure pharmacies are sighted to appropriate pathways to ensure patients are supported adequately.

3) Alcohol

CPS wants to provide brief intervention for patients using innovative tools such as scratch cards to identify patients most at risk of harm for alcohol. Once identified as a harmful drinker, we would provide a brief intervention which has been proven to reduce consumption. NHS Health Scotland have just published a report “Increasing capacity in alcohol screening and brief interventions: A role for community pharmacy?” which recognises we are able to play a role in this area.

We also need to provide more care to those who have been recognised as being addicted to alcohol. Prescriptions are being provided currently for some patients using agents such as acamprosate or disulfiram. We are keen to help provide a national service for disulfiram consumption which has been recognised by SIGN to work more effectively if supervised. This service would include breath testing to ensure concordance with treatment.

4) OTC, P and Prescription Medicine Abuse

We need to recognise that unfortunately we have a growing problem with addiction to prescribed and purchased medication. CPS notes that the DH has published two studies, which were conducted by the

National Addiction Centre and National Treatment Agency for Substance Misuse in England. These studies recognise that people can become dependent on tranquilisers, sleeping pills and opiate based painkillers, such as codeine, particularly if taken at high doses for prolonged periods. Long-term dependence on substances such as benzodiazepines has been identified as a particular issue..

The research findings also suggest:

- most prescribing falls within current guidelines;
- long-term prescribing increases the likelihood of dependency but this is not inevitable;
- over the last 19 years dispensing of benzodiazepines has decreased but there has been an increase in the prescribing of anxiolytic benzodiazepines and the sale and prescription of opioid painkillers;
- dependence may be overcome if individuals are supported to reduce gradually their medication;
- of the 32,510 people in drug treatment in England who reported problems with prescription or over-the-counter medicines only 3,735 were not also using illegal drugs

Using pharmaceutical care should be able to prompt prescribers/pharmacists to prevent more patients from becoming addicted to prescribed/purchased medicines. We need to use IT to help recognise overprovision and we propose an expert group should be created to look into this issue further.

5) Steroid and Growth Hormone Abuse

The Advisory Council on Misuse of Drugs reported in 2010 that the most comprehensive data on drug misuse for England and Wales estimated that in the 16-59 year old age group around 226,000 people admitted to "ever" having used anabolic steroids, with 50,000 users in the past year, and 19,000 in the past month (Hoare and Moon, 2010).

Community Pharmacy Scotland considers the Public Health Service could be used to flag this issue to the public at large. Supporting information on the issue should be made available via pharmacy especially needle exchanges that may see misusers most frequently.

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

Community Pharmacy Scotland takes the view that it should not be necessary to introduce changes, one example being the mooted pharmacist contracts to support professional focus and input. As professionals, pharmacist must take responsibility for their own actions and make the care of patients their first concern. Pharmacists must accept that the delivery of pharmaceutical services has changed and the way they worked previously is no longer sustainable. They must show a greater willingness to adapt.

There remains a need to look at amending the legislation which sets out the supervision requirements and the approach to dealing with dispensing errors. Work also needs to take place to create a culture where it is accepted practice for a pharmacist to have oversight of the dispensing process without the need for active participation in every event.

The slow progress towards implementation of CMS has been a source of frustration for pharmacists. Community Pharmacy Scotland proposes that more emphasis should now be placed on the introduction of peer review sessions. The Chronic Medication Service has now been operational, to a certain degree, for almost 2 years. It will be beneficial for practice to share examples of where pharmacist intervention has made a difference. Confidence would build if pharmacists could see that what they were doing was in line with other practitioners.

We should also consider how we resource a framework for protected learning time for pharmacy professionals. Pharmacy contractors have been supportive of meeting learning needs to date but it would be helpful to discuss with Government new methods to provide support. Other countries have models where health professionals meet together to review patient care. We would be supportive of a similar model in Scotland.

It is an unfortunate by product of the review that uncertainty has been created and the focus once again has drifted from the delivery of care services.

As implementation of the pharmacy contract moves on the system of remuneration has also started to change. Further negotiations will take place later this year. Changes in the way remuneration is delivered will factor through to how service delivery is prioritised.

Section 4: Technology

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

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

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

Community Pharmacy Scotland Response

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

Our analysis of the Pharmaceutical Care journey identified four key groups where IT development could improve the delivery of pharmaceutical care:

1. Patients
2. Pharmacies
3. GP/PHCT
4. Secondary Care

IT development for Patients

Currently the level of direct IT interaction between patients and community pharmacy on NHS care is at a low level. Any direct IT care is probably delivered using the internet with the patient self-selecting to search for information on their medicines or symptoms. CPS has identified the following areas where a direct interaction using IT could support patients:

a) Information Provision
b) Adherence Support
c) Supply Prompts
d) Sensory Support

a) Information Provision

Information provision could take place in a number of ways, for example through the use of telehealth facilities, through the provision of an e-Advice care Plan,or through Literacy Support. , **f**

CPS is keen that we ensure provision of care is maximised through many mediums. The development of **telehealth technology** such as internet video telephony e.g. Skype ® offers another medium in which pharmacy can interact with patients on a face to face basis without needing direct contact. We expect that more patients will be maintained at home in the coming years, some of whom may be housebound. CPS believes this patient group is frequently overlooked for care and using this technology it would be possible as part of any future package of care to provide support without the need for domiciliary visiting.

CPS also suggests that this medium may be particularly useful in remote and rural areas where access to direct pharmaceutical care services is limited due to rurality and the lack of access to a pharmacy. We do recognise this modality may not replace the benefit of direct face to face contact for all patients.

CPS believes that some patients readily use the internet as a source of information on medicines. Information on the internet is not always from trusted sources and CPS is keen to see if technology can underpin information production which could be sent to patients electronically. One way to do this would be through an **E-Advice Care Plan**

CPS notes the current specification for the Chronic Medication Service (CMS) stipulates that patients be given a pharmaceutical care plan once developed. We believe this document could be further developed and integrated with NHS Inform to ensure consistent health information is given to patients. Developments of the document could support embedding of links into the medicines section and for example lifestyle advice where this is required to be delivered as part of an identified care issue. The links could be directed at NHS Scotland trusted sources of advice to ensure patient safety.

CPS recognises this would need the use of patient's electronic mail addresses and this may cause concern around security. However, where the patient agrees, a development such as this will hopefully support improved understanding.

In terms of **Literacy Support** CPS notes the Scottish Survey of Adult literacy in 2009 recognised that around one-quarter of the Scottish population (26.7%) may face occasional challenges and constrained opportunities due to their literacy difficulties, but will generally cope with their day-to-day lives. CPS also recognises that the survey recognised that a key factor linked to lower literacy capabilities is poverty, with adults living in 15% of the most deprived areas in Scotland more likely to have literacy capabilities at the lower end of the scale.

CPS notes that patients from these deprived communities are more likely to be admitted to hospital with unplanned admissions than those from the most affluent. We are unsure how many of these admissions are as a result of medicine misadventure caused by literacy problems – for example has there been non adherence due to the complexity of a medicine regime or accidental over or under consumption leading to toxicity and/or ineffective medicine use.

However, we do know from evidence that 40-80% of the medical information patients receive is forgotten immediately (Kessels RP et al Patients' memory for medical information. *J R Soc Med.* May 2003;96(5):219-22) and nearly half of the information retained is incorrect (Anderson et al, Patient information recall in a rheumatology clinic. *Rheumatology.* 1979;18(1):18-22). Developments to support these issues include the Teach back method.

Teach-back is a way to confirm that you have explained to the patient what they need to know in a manner that the patient understands.

We are keen to see if using technology such as podcasts, or patient tailored videos perhaps utilising mobile phone technology can supplement the Teach Back Approach to improving adherence to medicines in all patients.

b) Adherence Support

We note from evidence that one of the main reasons that patients fail to achieve maximum benefits from their medicines is due to poor adherence. We believe information technology could provide underpinning support to patients through smartphone applications or text messaging. We note from evidence (Zurivac D et al (2012) Mobile Phone Text messaging: Tool for Malaria Control in Africa, PLoS Med 9 (2): e1001176) that text messaging has been used to improve concordance with medicine

regimes for Malaria treatment. We believe the NHS in Scotland should be looking to implement text messaging support strategies for patients which could be tailored using the pharmacy care record.

CPS also notes that text technology was associated with improved smoking cessation results over usual care (Free et al; Smoking cessation support delivered via mobile phone text messaging (txt2stop): a single-blind, randomised trial Lancet. 2011 June 30; 378(9785): 49–55).

The modality has been further developed by one pharmaceutical company who have prepared a smartphone application to support compliance with oral contraceptives. We believe the NHS in Scotland could further develop this concept to support patients and practitioners with an application which could provide medication prompts and also provide healthcare professionals with an accurate dispensed medicine history. The application could also contain the patients pharmaceutical care plan which would support sharing with secondary care and primary care colleagues across the interface.

c) Supply Prompts

Moving to serial prescriptions as part of the Chronic Medication Service provides pharmacy with greater visibility on patients ordering habits for medicines. Pharmacy will be in a much better position to ensure patients don't run out of repeat medicines and therefore reduce the reliance on the unscheduled care PGD. We believe this process could be underpinned with SMS technology so that patients are reminded to come to collect their medicines. If the patients don't collect their medicines within a predetermined period reminders could be sent or a personal call completed to find out how the patients is getting on. This process may help patients who stockpile medicines to reduce their stock levels therefore cutting waste.

d) Sensory Support

CPS recognises that the need for support for patients with a sensory impairment is likely to increase in the coming years. The previous premises audits carried out by community pharmacy contractors increased the use of hearing loops but we have to recognise more may need to be done to support those with hearing issues to access care.

CPS believes technology could and should be harnessed to provide support to patients with a sensory impairment. We look forward to working with other bodies to see what needs and could be done to help this patient group.

IT Development for Community Pharmacies

Community Pharmacy contractors were originally at the forefront of embracing the use of IT in the workplace. We believe that mantle has been superseded by other members of the primary healthcare team and we believe that we need to improve both our PMR and PCR offering to make pharmaceutical care a reality in day to day practice.

PMR systems have changed over the last 5 years to support contract development. All the systems available are now able to support service delivery. Whether individuals feel the systems deliver on their

behalf is a more moot point. During this time however, support to provide pharmaceutical care has not particularly moved on in PMR systems.

CPS would like to see PMR systems changing to prompt for care issue development. For example it would be helpful for the systems to prompt for the high risk medicine support tools currently available or that the patient is receiving the medicine for the first time. It would also be helpful for the PMR system to recognise under/over compliance with medication. This type of prompt would be helpful to support patient dialogue around appropriate use of medicines.

PMR systems need also to deliver on audit tools to hunt for care issues. Trying to hunt for patients currently being prescribed a medicine is not the same on every system. These means it is very difficult to hunt for patients over the age of 75 and on a NSAID for example. We believe PMR system suppliers are currently looking at their offerings and developing them further. We would encourage suppliers to engage with the contractor network to develop solutions.

The **Pharmacy Care Record** (PCR) is currently in its infancy for development but is supporting pharmacists to record our input to care of patients. CPS recognises investment will be required into the Pharmacy Care Record to make it the truly powerful tool it should be to improve patient care.

Currently the system is not in a format where data placed in the PCR can be extracted easily. Care issues are also not recorded in a systematic manner which would then allow a pharmacy to identify the most common issues they are finding with medicines. We believe moving the PCR to a system with Read-Coded standardised care issues will improve the understanding of where care can be improved and simplify recording. The Read Coding will also support reporting on level of issues and improved production of end of treatment care summaries as it will flag issues to which other members of the PHCT need to respond.

We currently operate a system where the PCR and PMR are not particularly integrated. There are benefits from this as the PCR is consistent from pharmacy to pharmacy and pharmacies receive the PCR updates on the same day. The lack of automatic synchronisation between PCR and PMR does however; make updating the PCR with PMR data more laborious than it needs to be. We would be keen to develop a system that allows for automatic updating when an item is dispensed to the patient. This information would improve medicines reconciliation across the interface and reduce the time it takes to update the PCR.

We also need to develop the PCR to accept single issue drop from a dialogue box in the PMR. This would save having to open care issues in the PCR when you may only want to record a short update on a patient. Not all patient notes need to be long but the picture developed over time will show holistic care.

We also need to look at the systems we use to record care. CPS believes that the current system of using desktop PCs is probably unsustainable. We need to consider the use of tablet PCs and other devices to record care episodes. We would be keen to input into any review of this area to ensure that any recommendations are fit for purpose.

The other area we need to look at in relation to community pharmacies is the use of bar codes and robotics in the Dispensing Process

The use of barcoding on prescriptions has delivered safety improvements in transcription of prescriptions. We believe the European directive on falsified medicines currently out for consultation is likely to mandate the use of barcodes in the dispensing process for patient packs. CPS recognises this is likely to add further safety improvements in the dispensing process.

We are keen that further review of the dispensing process is undertaken to ensure the error rate is minimised where possible. Any recognised improvements must be underpinned using technology to ensure they become business as usual.

We also note that some pharmacies have commenced the use of robotics to underpin the supply function. CPS believes widespread use of this technology needs to extensively piloted prior to greater use. This pilot would look at cost effectiveness and whether the resulting time savings increased the level of pharmaceutical care delivered. We do however, believe that any regulatory barrier, actual or perceived, to prevent a group of pharmacies from working together to co-operate on the use of a robot should be removed so that the development can be implemented if proven to be effective.

We would also like to see PMR systems adopt developments so that a pharmacy could label in the pharmacy and send to the offsite location for dispensing. This would improve the effectiveness of offsite dispensing as clinical checks could be made at the point of labelling rather than once the product has been prepared therefore minimising waste.

IT Developments for GP/PHCT

CPS believes the use of technology is key to improving the effectiveness of pharmaceutical care interventions with the primary healthcare team. Once the pharmacist working within the community pharmacy recognises an issue we need to make sure the intervention is communicated to the primary healthcare team in a pre-agreed fashion to ensure implementation of a required change.

Work flow in General Practice has changed dramatically since the inception of the new contract. Health Boards use e-referrals and GP teams now import all letters from secondary care directly into the patient's record rather than file them by hand. CPS recognises the need to ensure CMS interventions are sent to the primary healthcare team in a format which fits into their workflow and is easily responded to so that patients can be supported with the next steps. We believe that technology needs to underpin this process to ensure it is fit for purpose. We are looking to see what the lessons are learnt from the end of treatment care summary pilot currently underway to provide direction on this area.

The other area which may require technology development is care by NHS 24. CPS believes that due to telehealth NHS 24 is likely to become even further involved in patient care. We expect NHS 24 will start telephone prescribing for patients as part of this process in the unscheduled care period. PMR and PCR developments may need to include receiving information from this care modality to ensure support for patients.

IT developments for Secondary Care

As patients get frailer they are likely to require more short stays in secondary care. The length of stays is decreasing and the time of discharge due to the pressure on acute beds is likely to cause patients to be sent home in the unscheduled period.

CPS believes we need to use technology to ensure pharmacies are made aware of patients being discharged home. As part of this process each pharmacy should be sent a copy of the patients immediate discharge letter and a list of any care issues which early intervention may be required.

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

CPS believes that further access to patient's records is required to improve patient safety and the delivery of pharmaceutical care. We note the NHS eHealth strategy has recommended access to the emergency care summary.

CPS believes all health care professionals need to respect that the data held in a patient's records is the patient's information. On that basis the patient should be the one who chooses who should view what data and when. In future it is more likely patients will have access to their own information using IT rather than as currently where all members of the PHCT have their own individual records and don't share information.

CPS believes Pharmaceutical Care would be improved if we had access to:

- Diagnosis History
- Allergy to Medicine Information
- Blood Results
- Immediate Discharge Letters (IDLs)
- Secondary Care Pharmaceutical Care Plans
- Anticipatory Care Plans and SPARRA data
-

Currently we only have two data sources. The first is the prescription which has no information on the patient's diagnosis or reason for prescription. The second source of information is the patient's self-reported information; this may be inconsistent in quality.

A diagnosis history will focus any response to questions a patient may have on medicines. Drugs have varying uses e.g. beta-blockers: hypertension or secondary prevention. Information is contextualised depending on the indication. By having a diagnosis, appropriate information will be given to the patient.

We also currently fail to share accurate recorded drug allergy history between general practice and community pharmacy. It would be helpful if, when a patient has a recorded drug allergy, a message was sent to their community pharmacy to prevent further dispensing.

Access to blood results will improve patient safety. Pharmacists can back up GP systems ensuring medicine monitoring occurs appropriately and the results keep a patient safe (INR result in therapeutic range). Pharmacists can also make recommendations around medicines and efficacy (e.g. cholesterol result below 5mmol).

IDLs are key to ensure no medicines stopped in secondary care are supplied to patients. This is particularly important with serial prescriptions which may have been prepared in advance of the patient attending the pharmacy. Access to the IDL means waste could be reduced and appropriate clinical checks made on the new list of medicines. Use of the IDL will also allow reconciliation with medicines stored in the patient's house and may identify medicines missed by the secondary care team on admission.

We are aware secondary care teams will generally prepare a care plan as appropriate during admission. We feel it would be beneficial if this care plan followed the patient to the community.

CPS also notes the development of anticipatory care plans and the innovative use of SPARRA data by PHCT. We have had no input into this process but believe co-operative working with PHCT around medicine use and safety could add value to this process.

CPS believes data should also be shared by us with the PHCT. CPS believes we should share all dispensed information with prescribers. We currently share all CMS data from serial prescriptions but don't share data on AMS/MAS dispensing/supply - we believe this would help improve data flow within the PHCT.

We also need to integrate other non-medical prescribers into e-systems. This electronic support for prescribing would improve AMS usage with subsequent data visibility.

The other source of data we are currently preparing is the PCR within community pharmacy. CPS believes this information should be shared with both health professionals and patients electronically to support care.

To hold all the data we believe we need to use the PCR as the repository. Development of the PCR to become the prime source of communication and information transfer will be key in the future.

Section 5: Education and Training

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

Q22. What developments would you recommend for Pharmacists?

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

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

Community Pharmacy Scotland Response

Q22. What developments would you recommend for Pharmacists?

To start with we think greater emphasis should be placed on workforce planning and how many pharmacists should be educated and trained. We are likely to be entering a situation where it will become increasingly difficult for graduates to secure registration due to a shortage of training places.

We responded in 2011 to the consultation from the pharmacy regulator (GPhC) on the initial education and training standards for pharmacists. At that time we supported the move away from a focus on the inputs of the degree course to outputs. It's too soon to say with any confidence yet what the outcome of that switch in emphasis will be. We would be reluctant to see any more fundamental change being introduced while we are still in a period of transition.

Where we were looking to see change and development was in:

- The actual selection process
- A continuing focus on ensuring numeracy standards were met
- Ensuring language proficiency
- Ensuring good communication skills and in the areas of "holding difficult conversations"
- The way the curriculum was delivered and in particular a shift to delivering content in an integrated and progressive way would deliver skills which could then be taken out into the realities of life outside the university.
- The introduction of more clinical training delivered where possible in a multidisciplinary setting.

The other area we think needs to develop is in provision of support for pharmacists who act as tutors. NES has already started work with the pre-registration student tutors and that could maybe form a basis for developments elsewhere.

We have also responded to the Modernising Pharmacy careers consultation. We were not supportive of the proposal to introduce two six month training periods rather than the current pre-registration year. We have asked for more evidence on what the benefits would be and we think any change in that direction would require extensive discussion.

For ongoing development of the profession we have suggested at Q17 the development of a prescribing strategy. We believe this prescribing strategy should set the direction of travel for the progression of an individual within their personal development plan. Completion of PDPs should be integral to the CPD recording process and ultimately revalidation.

When revalidation is introduced there has to be transparency for the NHS that community pharmacists are fit for purpose. We are not keen for the NHS to introduce a duplicate system over that proposed by the GPhC. We need to look at innovative ways to ensure information is shared appropriately.

We also need to examine how a framework can be developed and resourced to ensure protected learning time is made available for the pharmacy team in line with that currently available to other health professionals.

Q.23 What developments would you recommend for technicians, assistants and support?

We feel the time has come for an overhaul of the training requirements for pharmacy technicians but before that we need to scope out what the role of pharmacy technician now is. The current training is not forward thinking and many elements covered are gradually disappearing from day to day practice. We also need to ensure that technicians are provided with:

- appropriate IT and database skills
- communication skills which will allow them to meet the challenges ahead as more patient-facing complex care is delivered in the community.
- Skills to adapt to future service development.

There is a need to ensure adequate resource is provided to facilitate the input needed by those who are providing training and assessing competence in the workplace.

We have been participating in the development of a training module for pharmacist assistants and we look forward to finding out the impact of that new course is and where further change is required.

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

We believe multi-disciplinary learning could be enhanced by synergistic use of the contractual frameworks. We believe multi-disciplinary working should start at undergraduate level and be maintained throughout everybody's career.

We would like to see NES build upon the good work it has started on multidisciplinary post-graduate education. We welcome a number of the innovative approaches it has adopted e.g. Web based e-learning and virtual rooms for education.

We suggest NES introduce small multidisciplinary group learning for particular topics.

As with all developments we have to consider how time and resource can be found to facilitate training.

Section 6: Use of Resources

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

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

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

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

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

Community Pharmacy Scotland response

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

CPS suggests that a narrow focus on cost effective prescribing may not always deliver cost effective treatment for patients. Considerable change has already occurred since the first Audit Scotland report in 1999, *"Supporting Prescribing in General Practice".* The use of generic medicines as first line treatment in many conditions is now the norm and the development of SMC to provide advice to prescribers on new drugs is recognised as world leading.

CPS recognises that the iterative holistic approach to care planning may well identify prescribing which is not cost effective.

This may be due to:

a) Non-Formulary Compliance

b) Branded Prescribing

c) Medication Review identifying issues of Inappropriate Prescribing

Community Pharmacists are currently unlikely to intervene at the point of dispensing or care around an issue of non-formulary compliance. The pharmacist's first responsibility at this point is to ensure the prescribed medicine is safe and clinically appropriate for the patient.

CPS notes increasing use of prompts such as Scriptswitch® by Health Boards is driving compliance to formulary in general practice prescribing and we see it as a logical step for PMR suppliers to provide similar prompts at the point of dispensing to remind pharmacists of the status. CPS believes if incentivisation were put in place for pharmacy contractors, similar to that in General Practice incentive schemes, pharmacies would be more likely to consider the need to consider the formulary item at the point of dispensing.

Branded prescribing has decreased across all Health Boards to ensure savings are in place once a patent expires. CPS notes the Department of Health failed to move on the introduction of generic substitution which was part of the last PPRS discussions. CPS is keen that regulations change in the UK to permit generic substitution. We believe this should be incentivised also to ensure maximum savings are delivered to the public purse.

CPS believes that over time CMS provision will become more involved in medication review and identification of inappropriate prescribing and supporting patients to get the best out of their medicines. This involvement may actually increase drug costs due to the selection of more effective treatments. This change however, has the potential to release secondary care savings due to the prevention of admission.

CPS has also proposed the introduction of a limited list of medicines for the Minor Ailment Service. This would support appropriate prescribing and possibly allow increased access to the service.

We are also waiting to see if pharmacy can play a role in monitoring new medicine usage when value based pricing becomes an actuality in the UK.

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

Community Pharmacy Scotland recognises that significant advances in medical and pharmaceutical care in the most recent generation have led us to the situation we are in now. We have increasing life expectancy and are now having to plan how service delivery will be bolstered to support our older patients in a climate of stagnant investment and increasing expectation of services. We need to recognise the work to date and celebrate the achievements in the care we provide as a primary health care team.

Community Pharmacy Scotland believes that in the future due to on-going pressure on acute beds it is likely that interventions currently carried out in secondary care that could be carried out in primary care should be carried out in primary care. As a consequence we see that the following could impact upon future pharmaceutical care.

a) Increased Care at Home e.g. IV antibiotics at home / chemotherapy at home
b) Virtual Wards and Step up/Step down care
c) Telehealth and Telecare
d) Anticipatory Care Provision
e) Homecare

We believe community pharmacy contractors close to the patient's home are ideally placed to support the PHCT in shifting the balance care agenda.

Potential developments in cancer treatments such as moving to the use of new oral agents will lead to a greater need for support for patients closer to home. This could lead to pharmacies being a location where cancer nurse specialists could safely provide care in partnership with community pharmacies for patients. We believe this model will be popular with patients as it saves having to visit secondary care for appointment as this can be expensive and time consuming when they feel unwell.

We also see down-streaming of care for conditions such as DVT and cellulitis leading to increased need for support from pharmacists for these conditions. Care would be protocol driven to ensure safety and lead to a reduction in the use of acute beds for these conditions.

The development of virtual wards and step up and step down care is also likely to increase the level of need for pharmacy input to patient care. We will also need to support improved communication links in this situation so care can be provided safely and effectively.

Telehealth and Telerate will also offer opportunities for pharmaceutical care. If GPs and their teams are able to monitor patients remotely they are likely to intervene at an earlier stage in patient care to prevent hospital admissions. Community Pharmacy Scotland is keen to explore where we can work with our social care colleagues and primary care colleagues so we can support telehealth and tableware adoption.

Community Pharmacy Scotland also recognises the work done in primary health care teams to support the introduction of anticipatory care planning. We believe the support to patients is critical to prevent or minimise hospital admissions. We would like to see the environment changing so that pharmacy is able to support the medicine intervention component of anticipatory care planning using CMS. This could include for example COPD acute intervention and support for Heart Failure by titration of ACE inhibitors and beta blockers.

The recent report on Homecare by the Department of Health (Homecare Medicines: Towards a Vision for the future) recognises problems with that setting of medicine delivery and support. Community Pharmacy Scotland believes that we are ideally placed to support care to patients using homecare medicines. We welcome pilots by NHS Boards in oral chemotherapy and anti-TNF provision for rheumatoid arthritis. We believe care protocols could be integrated into Pharmacy Care Record to improve patient safety with these agents. We welcome dialogue with patient groups on how to improve services on a national basis.

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

Community Pharmacy Scotland notes the work from the University of York and the then School of Pharmacy in London as being a useful place to start in identifying and remedying the root causes of medicines waste. The report into medicine waste recognised the following areas should be considered when tackling medicine waste. We recognise its outputs fit neatly into CMS and PHS:

a) **Targeted support for patients starting new therapy**

We have recently introduced the NMIST tool for PCR which aims to support adherence and identify side effects at an early stage of a medicine use. We believe widespread use of this tool may reduce inappropriate medicine wastage.

b) **Ensuring Medication and associated treatment regimens are effectively reviewed by doctors and pharmacists**

The care planning element of chronic medication service will feed in patient responses on their perception of their medicines and support improved reviews by all professionals in their care. We are keen patients engage proactively to get maximum benefit from their medicines

c) **Incentivising closer professional management of medicines at the point of dispensing**

We want to see CMS deliver an ability for pharmacists to minimise stockpiling of medicines. Intervention at the point of supply to ascertain the medicines are required should prevent over ordering.

We also believe that patient confidence in not having to order their medicines early due to availability of supply through serial prescriptions will minimise stockholding at home. We see the development of synchronisation of supplies at first dispensing of a serial prescription as a way of helping to reduce waste.

d) **Using 28 day prescribing interval routinely**

It may be useful to consider the use of 28 day dispensing intervals on serial scripts to reduce stockholding in patient's houses and therefore waste. We need to balance that perceived benefit against the workload generated for community pharmacy.

e) **Caring better for "treatment resistant" patients who may not be taking their medicines correctly**

Community Pharmacy Scotland is keen that as CMS grows we collate information from patients to identify those who may take their medicines correctly and those who may require more intervention. These interventions may be around encouraging regular adherence; this will require regular review to ensure treatment is now not causing harm. Time may also be spent with patients identifying and discussing medicines that patients won't take. We then in partnership with others need to prevent repeat dispensing of these items.

f) **Improved Communication across the Interface of primary and secondary care**

As identified elsewhere improved use of immediate discharge letter data transfer could contribute to reduced supplies of discontinued medicines.

g) **Improved public awareness on waste issues**

Community Pharmacy Scotland recognises increased levels of public awareness on the issues of waste medicines need to be delivered. These messages need to be succinct and tailored for the public.

We propose a national campaign using the PHS posters be considered in the next financial year.

Finally the introduction of a new system of care (CMS) gives rise to the opportunity for community pharmacy to take ownership of the repeat prescribing process from GPs.

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

The Government has previously acknowledged the pharmacy network is supported through two funding streams, reimbursement and remuneration. We have concerns that any shift away from this position would have grave consequences for the NHS and the pharmacy network in Scotland.

We are therefore pleased the NHS in Scotland has chosen to seek innovative ways of improving efficiency in purchase through the current pharmacy network. Through the Scottish system of setting a tariff for one year and monitoring retained purchase profit we believe the current mechanisms of EPPP (Efficient Purchasing and Prescribing Programme) sharing has delivered on behalf of NHS Boards and pharmacy contractors.

We also recognise that the patent cliff is starting to accelerate in the coming months with the expiry of Atorvastatin, Quetiapine and Olanzapine. These expiries will remove several drugs from the most costly prescribed drugs in Scotland and should deliver further efficiencies.

Community Pharmacy Scotland is disappointed that the current PPRS deal is being diluted by the increasing shift to a model where direct to pharmacy distribution models are the norm rather than unique. We believe this fundamental shift has ultimately cost the Government money due to the reduced discount being achieved on branded medicines.

We are aware the Department of Health has consulted upon value based pricing and look to see if that model will provide benefits over the current PPRS deal for Government.

We are also keen that a review of the cost effectiveness of supply through homecare is carried out. We believe there are risks not only in governance but also VAT consequentials for Boards.

We are keen to look at other methods for improving efficiency in discussion with SG. We have previously suggested alterations for flu vaccine prices to the SG and worked collaboratively on the introduction of category R. We welcome an open dialogue on the next steps to ensure NHS Boards and contractors continue to receive appropriate value and incentivisation.

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

The Right Medicine recognised the need to develop pharmacy teams to ensure pharmaceutical care is delivered. We have seen the introduction of regulated professional teams into pharmacies and the adoption of accredited checking technicians to support the dispensing process. We need to make sure any questions about responsibility for registered technicians and pharmacists are explained to all professionals involved. Pharmacists should maintain oversight of the dispensing process but focus more on the care of the patient rather than the actual assembly process. To this end it would be helpful if the issue of single dispensing errors was resolved.

Within the community pharmacy, the team of contractor, responsible pharmacist and support staff all have roles to play to ensure NHS pharmaceutical care is delivered safely and effectively. Separation of any element risks jeopardising the team ethos required to deliver continuity of pharmaceutical care.

Community Pharmacy Scotland recognises the good work support staff have put into place to support service delivery for public health services such as Smoking Cessation, Counterweight and Keep Well. Evidence (PHS review) from these schemes demonstrates high levels of satisfaction with the interventions made by the pharmacy team. This work needs to be extended so that support staff across the piece can access training on brief advice, motivational and behavioural change in health promotion and can champion delivery in these areas. Evidence from England suggests that Healthy Living Pharmacies are welcomed and appreciated by the public.

Once trained it should become second nature for support staff to intervene on issues of public health to users of pharmacy services. They can also help to ensure that there is delivery of continuity of care for patients accessing a pharmacy.

Community Pharmacy Scotland recognises that training and support should be provided for staff to complete certain administrative tasks on behalf of pharmacists. The new module for pharmacists' assistants will help to reinforce the support they can and the projection of a quality service. As we also need to be moving towards a situation which is as paper free as possible we should be looking to

develop the skills of support staff to manage that new role and recruit staff with skills other than those we have traditionally used.

Section 7: Access to NHS Pharmaceutical Services

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

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

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

The current network of community pharmacies offers extensive ready access to the full range of pharmaceutical care services. There are only a few rural pockets where patients cannot readily access a full pharmaceutical service. These should be identifiable from NHS Boards Pharmaceutical Care Plans. A robust system should be put in place to identify where turnover of GP dispensing reaches a level at which a pharmacy would be viable. We need avoid the situation where a GP practice had a dispensing turnover in excess of £1m and no Board recognised the need for change.

NHS Boards in the preparation of their pharmaceutical care services plan must be identifying where areas of difficulty for access occur. They need to be thinking about innovative solutions so their patients can access pharmaceutical care services. Funding may be required to deliver to service to these areas. Currently there is no dedicated support available for pharmacies which open in remote and rural areas. If we want to deliver pharmaceutical care services to all people then resource must be provided.

We are aware that a number of vending machines have been installed in pharmacies in the UK. The main use seems to be to replace a collection and delivery point thereby improving access to medicines. Without the addition of a video link it is difficult to see how care services could be provided and there will be a substantial cost attached to this option. The most effective way would seem to be to introduce an outreach contract for community pharmacies to provide pharmaceutical care services for the area on a sessional basis

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

We have recommended in Q30 the provision of an out reach contract for provision of pharmaceutical care services to patients in areas where a full time pharmacy would not be viable.

Section 8: Other

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

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

Before answering this question Community Pharmacy Scotland looked back to the principles agreed in 2003 to underpin the new community pharmacy contract (Part of our Q32 supplementary submission). We had worked jointly with SG on these since the publication of the commitment in *the Right Medicine* to: work with the profession to develop a new contract and system of remuneration for community pharmacists to provide incentives to further improve and deliver quality healthcare services. The principles remain relevant and tie in with many of the questions asked in this review.

Since 2003 considerable change has been effected. We are however only part-way through the process. In order to deliver high quality pharmaceutical care for patients in the community our view is that NHS Scotland can't afford to see that process derailed now by the introduction of further fundamental change. Instead we need to build on what has been achieved, continue to change where necessary and shift resource to make it happen. In our response to Q1 we talked about the lack of public awareness on pharmaceutical care services and think we should have a relaunch once the review has been completed.

We have developed a Vision for a comprehensive pharmaceutical care service for patients and it can be summed up as:

- Safe and effective supply of medicines
- Pharmaceutical Care including adherence support, medicine adjustment and waste reduction
- Lifestyle Management/Interventions
    - Interventions for people with long term conditions to help them live healthier lives and manage their condition
    - Interventions for those people who have not yet developed a condition but may be at risk (identified through health checks)
- Convenient access to public health services
    - smoking cessation
    - emergency hormonal contraception
    - flu vaccination
    - long term contraception
    - alcohol brief interventions
    - sexual health
    - travel health
    - incorporating LTCs support

These services would provide a total care service for long term conditions throughout the patient journey and increasingly complex medicine regimes. To facilitate the delivery of above technology will be required to support dispensing and care efficiency.

Services will be provided by generalist pharmacists, some of whom will develop more specialist skills, through independent prescribing status or other areas of study, and will be able to provide clinics across the pharmacies of their employers to enable provision of more complex services.

We have also produced a framework encompassing all the services and we have submitted it in our Q32 supplementary paper.

We have one other issue to raise. We do not think that the separation of community pharmacy from the other primary care services within Scottish Government has been helpful. We are disappointed that the focus appears to have switched to cost of medicines rather than the benefits which medicines bring for patients. Community Pharmacy Scotland strongly believes more would be achieved in collaboration and co-operation if community pharmacy was returned to the primary care directorate.