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

Dr Hamish Wilson and Professor Nick Barber

The Scottish Government
Riaghaltas na h-Alba

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

Contents **Page number**

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

Introduction

1. In October 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced a review of NHS Pharmaceutical Care of Patients in the Community. We were privileged to be invited to undertake that review. Our remit and terms of reference are detailed in Annex A.

2. We decided to approach our task by focusing primarily on the needs of patients and how pharmaceutical care can best contribute to the ambitions set out in the *Healthcare Quality Strategy for Scotland*[1] that is care which is person-centred, safe and effective. Our work has involved extensive discussions with a wide range of stakeholders, supported by a detailed online survey questionnaire to which we received over a hundred responses, many of them providing a wealth of information (see Annex B). We concluded our evidence gathering by convening a stakeholder conference at which we explored a range of issues which had emerged from our discussions and the questionnaire.

3. Although we heard a few concerns about the need for a review, there was general consensus that it was appropriate and timeous to give renewed consideration to what might be needed to optimise the role of pharmaceutical care in delivering the Scottish Government's 20:20 Vision of healthcare[2]. We were equally concerned to ensure that this built on the substantial progress which has been made since the publication in 2002 of *The Right Medicine*[3] and its subsequent implementation.

4. We have considered carefully the nature of our report. While much of what we heard was consistent in describing **what** was needed to build on what had already been achieved and to develop for the future, we recognised that there might be different approaches to **how** developments might best be delivered. We focus more on the "what" than the "how", although there are examples of the latter where we believe it is important to be more specific. While we have highlighted specific recommendations and propositions in bold text, we would wish the report to be read as a whole containing a co-ordinated approach for the future. The report is also not intended as a piece of academic research; it is, however, based on evidence, both published and from what we know, and what others have shown, to work. We recognise the (sometimes world) leading edge developments that have taken place in the range and quality of pharmacy services in Scotland and how those continue to evolve. We also acknowledge what we were told about current frustrations and impediments to progress but believe strongly that these can be overcome. There is now a

[1] The Healthcare Quality Strategy for NHSScotland, Scottish Government, May 2010.
[2] Achieving Sustainable Quality in Scotland's Healthcare: A 20:20 Vision 2011, Scottish Government, September 2011.
[3] The Right Medicine: A Strategy for Pharmaceutical Care in Scotland, Scottish Government, 2002.

unique opportunity to turn the ambitions of the public, patients and professionals into reality by creating a truly effective system of pharmaceutical care which will continue to make Scotland the envy of others.

Policy Context

5. Our review was commissioned and has been carried out in the context of Scottish Government policy. The ambition of the 20:20 Vision is that everyone will be able to live longer, healthier lives at home or in a homely setting, within a system of integrated health and social care, a focus on prevention and anticipatory care, and supported self management. And care will be delivered to the highest standards of quality and safety, with the person at the centre of all decisions. These three quality ambitions and the six quality outcomes described in the *Healthcare Quality Strategy* are fundamental to an effective system of pharmaceutical care.

6. In 2002, *The Right Medicine* set the agenda for modernising and strengthening the role of pharmacists to deliver improved services to the public and patients. It outlined ways in which improvements could be made to the public's health, to the access to and quality of care, and to the workforce and infrastructure support. This led to significant developments in community based pharmaceutical care, and in the role of pharmacists and pharmacies across Scotland. The current SNP administration's manifesto contains a commitment "to further enhance the role of pharmacists, building on the introduction of the Chronic Medication Service, and encourage even closer joint working between GPs, pharmacists and other community services …", building on what has already been achieved.

7. The recent consultation on proposals for better integration of adult health and social care[4], changing the way in which the NHS and Local Authorities work together and in partnership with the third and independent sectors, leading to a more seamless experience from the perspective of the service user and carer, adds a further dimension to the importance of pharmaceutical care in the community and the therapeutic partnerships needed to underpin that[5].

8. Over recent years, there has been a growing number of targeted initiatives related to the use of medicines, for example in the areas of decision support, reconciliation, administration, review and support. Medicines have also featured strongly in the patient safety, efficiency and productivity and e-health programmes. We welcome the recent impetus towards a more integrated and multi-professional approach to these initiatives; this is essential if we are to secure the most benefit for patients, harness the skills of all the professionals involved, and secure best value in the use of medicines. We recognise the financial pressures which face the NHS in Scotland, and consider that what

[4] Integration of Adult Health and Social Care in Scotland: Consultation on Proposals, Scottish Government, May 2012.
[5] Establishing Effective Therapeutic Partnerships - A generic framework to underpin the Chronic Medication Service element of the Community Pharmacy Contract, Scottish Government, December 2009.

we propose for the future of pharmaceutical care will have a direct and positive impact.

The Need for Change – Patients and Their Medicines

9. The changing demography of Scotland, the associated changes in morbidity and the continuing health inequalities set major challenges for pharmaceutical care in the future. The proportion of over 75s, who are the highest users of NHS services and for whom prescribing can be particularly complex, will increase by over 25% in the next 10 years, and the number of over 75s is likely to have increased by almost 60% in the next 20 years[6]. The pattern of disease will see a continuing shift towards long term conditions, with growing numbers of those with multi-morbidity, co-morbidity of physical and mental disorders, and resulting complex needs. In a recent Scottish study[7] an analysis of a database of the over one and three quarter million patients found that nearly a quarter were multimorbid (i.e. with two or more disorders), that onset of multi-morbidity occurred 10-15 years earlier in people living in the most deprived areas compared with the most affluent, and that the presence of a mental health disorder increased as the number of physical morbidities increased. The study illustrates the challenges to the traditional single-disease framework by which most health care has been configured and underlines the importance of generalist clinicians providing personalised, comprehensive and continuous care.

10. Medicines are the commonest form of treatment in the NHS. The total volume of prescription items dispensed in the community in Scotland in 2010/11 was 91.1 million items, with a total (net) cost of almost £1.14 billion[8]. However, medicines can harm as well as help. The sources of harm are adverse reactions to the medicines themselves, the errors made by healthcare professionals and carers, and failure by patients to adhere to the prescribed regime of treatment (non-adherence). These three sources of harm are often inter-related. These harms cause avoidable misery, unnecessary ill health, and sometimes death. These consequences also represent a significant drain on Scottish Government resources, such as increased hospital admissions, inappropriate escalation of treatment, increased waste and additional staff time. Studies have found that between 1.4% and 15.4% of hospital admissions were drug related and preventable; the commonest causes were prescribing and monitoring problems (53%) and non-adherence (33%)[9].

11. Non-adherence has been estimated to be responsible for 48% of asthma deaths, an 80% increased risk of death in diabetes and a 3.8-fold increased

[6] Achieving Sustainable Quality in Scotland's Healthcare: A 20:20 Vision 2011, Scottish Government, September 2011.

[7] Barnett K, Mercer SW, Norbury M, Watt G, et al, Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet 2012; 380: 37-43.

[8] NHS National Services Scotland:ISD, June 2011.

[9] Howard RL, Avery AJ et al, British Journal of Clinical Pharmacology, Vol 63, Issue 2, Feb 2007, 136-147.

risk of death following a heart attack[10]. Another manifestation of non-adherence is failure to collect prescriptions. Two small studies show that 2.9 - 5.2% of items prescribed were not dispensed[11], although they were conducted before prescriptions became free. Although one pound in every eight of NHS spending is on medicines, up to half of all the medicines prescribed are not used as the prescriber intended[12].

12. Waste medicines result predominantly from non-adherence, changes in prescribing and changes in the patient's condition. A study[13] of waste medicines in England in 2010 found that medicines worth in the order of around £300 million were wasted per year and about £150 million could be saved in cost effective ways. The proportionate equivalent for Scotland would be wastage of £30 million and savings of £15 million. The study concludes that 'the greatest social and economic returns are to be gained when reducing medicines waste can be effectively linked to improving care quality and health outcomes'.

13. Care homes residents have particularly high levels of co-morbidity and polypharmacy; seven out of ten residents receive some form of medication error each day (mostly a result of factors outside the control of the home). While many errors are of little or no clinical consequence this high prevalence results in adverse events and emergency admissions to hospital.[14]

14. A recent study for the GMC[15] suggests that around one in eight patients have prescribing or monitoring errors, involving around one in 20 of all prescription items. As is common with errors, the vast majority had no, or only a mild or moderate, effect. However, one in 550 items was associated with a serious error. Some factors that increased the probability of an error were the patient's age (<15, >64) and the number of items prescribed. Monitoring errors (failure to monitor for the adverse effects of certain medicines) tended to have more serious consequences than prescribing errors. The most frequent forms of prescribing error were 'incomplete information on the prescription' and 'dose/strength errors'; the most common

[10] Elliot R. Non adherence to medicines - not solved but solvable, J Health Serv Res Policy 2009, 14:58-61

[11] 1.Jones I, Britten N: Why do some patients not cash their prescriptions? *Br J Gen Pract* 1998, 48:903-905. 2.Beardon PHG, McGilchrist MM, McKendrick AD, McDevitt DG, MacDonald TM: Primary non-compliance with prescribed medication in primary care, *Br Med J* 1993, 307:846-848.

[12] Medicines adherence: Involving patients in discussions about prescribed medicines and supporting adherence, NICE clinical guidelines, January 2009.

[13] Evaluation of the scale, causes and costs of waste medicines, York Health Economics Consortium/School of Pharmacy, University of London, November 2010.

[14] 1.A Quest for Quality in Nursing Homes British Geriatrics Society, 2011. 2.Sunil M Shah et al, Quality of Prescribing in Care Homes and the Community in England and Wales, BJGP, May 2012. 3. Barber ND, Alldred DP, Raynor DK, Dickinson R et al. Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people. Quality and Safety in Health Care. 2009:341-6.

[15] Avery A, Barber N, Ghaleb M, Dean B et al, Investigating the prevalence and causes of prescribing errors in general practice: ThePRACtICe Study, A report for the GMC, 2012.

monitoring error was 'failure to request monitoring' (69%). In care homes[16] errors were more frequent; 39% of residents had one or more prescribing errors. Errors were prevalent everywhere; for every act (drug prescribed, or dispensed, or administered) there was an 8-10% chance of error. Monitoring errors, the errors most associated with harm, occurred in nearly 15% of relevant medicines.

15. Specific problems have been identified with the transfer of information at the primary/secondary care interface. A survey of GPs in Glasgow found that 58% were not satisfied with the information received from the hospital on patients' discharge therapy. In a medication record review study in England, no dose changes made in hospital and only 8% of new prescriptions started were highlighted in the discharge communication. Following discharge, 28% of the 87 drugs newly prescribed by the hospital were either not continued, or there was some discrepancy between the prescribing advice of the hospital and the subsequent prescription. For the medications that had been stopped by the hospitals, none was restarted by the practice within a month of hospital discharge. In Forth Valley, a medicines reconciliation project which tested the transferring of medication and care record history from and to community pharmacies as well as GPs found that in 35% of cases pharmacists stated that the data reduced the risk of inappropriate supply and in 10% of cases the information prevented a call to the hospital or GP.[17]

Pharmaceutical Care

16. Community pharmacists are generalists in their knowledge of medicines. Each pharmacy has a very mixed case load of patients for whom they provide professional care. Some twenty years ago it was estimated that a 'typical' pharmacy served, for example, up to 500 patients on antihypertensives, 150 asthmatics, 50 diabetics and 20 cancer patients – we would expect these figures to be higher now[18]. Their care should be delivered as 'pharmaceutical care', a philosophy which emphasises the pharmacist's responsibility for the outcome of the treatment, not just its supply. Pharmaceutical care is the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life. It involves cooperation with the patient, and other professionals, in designing, implementing and monitoring a therapeutic plan that will produce specific therapeutic outcomes for the patient.[19] This approach is a particularly effective way of (amongst other areas of care) managing long term conditions.

---

[16] Barber ND, Alldred DP, Raynor DK, Dickinson R, et al. Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people. Quality and Safety in Health Care. 2009:341-6.

[17] NHS Forth Valley Royal Hospital and Community Pharmacy Medicines Reconciliation Project – report unpublished.

[18] Pharmaceutical Care: The Future for Community Pharmacy-Report of the Joint Working Party on the future role of the community pharmacist services. Published by the Royal Pharmaceutical Society on behalf of the Department of Health and the pharmaceutical profession, March 1992.

[19] 1.Helper DD et al, Am J Pharm Educ 1989. 2.Hepler CD, Strand LM. March 1990. Opportunities and responsibilities in pharmaceutical care. American Journal of Hospital Pharmacy, Volume 47, pages 533-543.

17. Many of the problems associated with medicines and outlined in the previous section are addressed by this approach, including detecting prescribing and monitoring errors, involving patients in decision making, improving adherence and reducing waste. Pharmacists working with GP practices can significantly increase the quality of their prescribing[20]. To be effective pharmaceutical care requires good communication and shared understanding with patients and local prescribers. Additionally, the approach of being focussed on the outcome of interventions rather than the nature of them can be applied to self-care, and health promotion and prevention. In the case of self-care, the pharmacist will distinguish the complaints that require referral to a doctor and those that can be dealt with by self-medication, and provide appropriate advice and follow up. Targeted public health activities involving treatment and behaviour change, such as smoking cessation, are also a key part of pharmaceutical care. In Scotland, the main elements of the current Community Pharmacy contract – the Chronic Medication Service (CMS), the Minor Ailment Service (MAS) and the Public Health Service (PHS) – have underpinned this approach to pharmaceutical care.

18. But, importantly, to be most effective pharmaceutical care must be delivered within a framework of multi-disciplinary co-operation, which means that the pharmacist works in partnership with the GP, the nurse, the social care worker and any other professional involved to arrive at optimal treatment for the patient. And that therapeutic partnership also extends to the patient and any carers involved.

Changing Relationships

19. If we are to see the full benefits of pharmaceutical care, pharmacists in the community need to be seen by the public and fellow professionals as full members of the wider primary care team and a core part of the NHS. Community pharmacy is seen to act as a commercial enterprise with a focus on the supply function. Concerns about lack of continuity through changes in staff and use of locums get in the way of building continuing relationships. For the public, trust is a crucial factor in healthcare settings, and a recent study in the West of Scotland[21] demonstrated that participants' trust in pharmacists was less than it was for their GPs. The authors cited factors which reinforced trust and confidence in GPs such as registration, appointment systems, gatekeeper role, practice environments, and the nature of the interactions. They suggested that health systems had to change in a way that promotes trust in pharmacists, for example by increasing the quality and quantity of patient interactions with pharmacists and gaining GP support for extended pharmacy services. This is reinforced by a study of patient

[20] Avery AJ, Cantrill JA, Armstrong S, Cresswell K, et al, A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis, The Lancet, Volume 379, Issue 9823, Pages 1310 - 1319, 7 April 2012.

[21] Understanding public trust in services provided by community pharmacists relative to those provided by general practitioners: a qualitative study, Gidman W et al, BMJ Open 2012, Volume 2, Issue 3.

evaluation of a community pharmacy medicines management service which demonstrated that pharmacist intervention was associated with significant and positive changes in patient satisfaction, and that experiencing a community pharmacist–led service resulted in an attitudinal shift toward the pharmacist[22].

20. Thirty years ago there were tensions between pharmacists and doctors in the hospital setting; these have been resolved over time and we now have, generally, good team working, with important benefits for patient care. In the same way, the relationship between pharmacists in the community and fellow health and social care professionals needs to establish that parity of esteem as reflected in the recent joint statement by RCGP Scotland and RPS Scotland "Breaking down the barriers – how pharmacists and GPs can work together to improve patient care". This emphasises the complementary roles of pharmacists and GPs in patient care, the value of collaborative partnership, and the importance of professional learning together. It identifies a number of key areas of activity, e.g. managing long-term conditions, services to care homes, and supporting self-care and re-enablement, where improved working between the professions would bring benefits to patients. **We welcome this initiative and recommend that Scottish Government and NHS Scotland should use the opportunity of the policy changes already being implemented in community based care to work with these and the other professionals involved to reap the practical benefits of the proposals in the Statement. We also recommend that continuity and consistency of care, underpinned by patient registration, should be a key element in any future contractual arrangements for pharmaceutical care, to support the changing and positive role of the pharmacist in the community. We believe that Scottish Government should also take the opportunity of a move towards a more Scottish focused contract for general medical practice to reinforce joint working between the professions.**

Person Centred Care and Services

21. Person centred care and services fall into main three areas –

- care for patients with prescribed medicines
- diagnosis, treatment and advice for those requesting it
- public health services to change behaviour and promote healthy living

22. In our discussions, patients described what they wanted from their pharmacist and pharmacy in the community -

- continuity and consistency of professional input and care from an individual pharmacist
- easily understood information about their medicines adapted to the needs of the individual
- appropriate support and advice
- greater ownership of their own care
- accessible services

[22] Tinelli M, Bond C, Blenkinsopp A, et al, Patient evaluation of a community pharmacy medications management service, Ann Pharmacother 2007;41:1962–70.

- a suitable environment, which allowed privacy and confidentiality when required.

They also wanted to know that the relevant information needed to deliver high quality care would be shared between the professionals involved including when they used hospital services. Some form of patient held information (paper or electronic) about diagnoses, medication, allergies etc would be welcomed by many. They said that they would often ask a pharmacist questions about their medication which they were unwilling to ask of their GP. They also expected the overall system to be safe and error free, and that their pharmacist would act as the "guardian" of their medicines.

23. The arrangements already being put in place in Scotland for community pharmacy provide a good foundation to meet those needs. As indicated earlier, this could be reinforced by a stronger focus on the individual pharmacist and the personal and continuing relationship with patients and, where relevant, their carers. The term "named pharmacist" was used by many patients to describe that relationship, supported by a system of registration. This also means in some cases redefining the relationship between the pharmacy owner and the individual pharmacist to ensure that the latter has the freedom and is supported to exercise professional judgement for the benefit of patients. **This is a fundamental principle and we recommend that this should also be reflected in the future arrangements for pharmaceutical care in Scotland.**

24. Where medicines are prescribed, the supply of those medicines, important though it is, instead of being seen as the prime function of community pharmacy, becomes a trigger point for the establishment of a more meaningful clinical encounter between patient and pharmacist. This brings the opportunity for greater patient involvement in their own care and improved understanding of what the medicines are intended to achieve, how and when they should be taken, and how to resolve any concerns. In some circumstances the supply of a medicine can be separated from the provision of pharmaceutical care e.g. assessing risk factors in medication before treatment with medicines.

25. The professional relationship between pharmacist and GP also ensures a consistency of message and clinical regimen. This in turn leads to improved adherence, reduced waste and better patient outcomes. While this is most clearly demonstrated in relation to patients with chronic disease and multiple conditions, as exemplified by the development of CMS, it is also an important part of the service to acutely ill patients. Over 200,000 patients are now registered with CMS with numbers continuing to increase each month. A number of GP practices and community pharmacies are engaged in the Early Adopters phase of the serial prescribing and dispensing element of the service. **The focus now should be to build on the experience and lessons learnt from these Early Adopter sites whose pioneering work will help to embed and mainstream the serial prescribing and dispensing element of CMS so that the service can realise its full potential for patients.**

26. But the pharmacy and its professional staff also provide the focus for a wider range of services than just those related to prescription medicines. Readily accessible advice on self-care and appropriate treatment of common conditions is an important part of the role of the pharmacist in the community. This has been demonstrated by MAS, but there is a need for this role to be more widely understood by the public and by other professionals. **We recommend that Scottish Government should consider how the underlying principles might be extended more widely and suggest that this could usefully be taken forward under the umbrella of the joint initiatives supported by RCGP and RPS to ensure common standards and expectations of the two roles.**

27. The Public Health Service has also shown where specific targeted initiatives such as smoking cessation and EHC can have a direct and measurable impact on behaviour change and responsive care and treatment[23]. The pharmacy profession is keen to see further services included, but it is important that these are of high priority and evidence based, and that the time and resources committed provide value. A currently relevant example is in relation to alcohol misuse, where a review by Public Health Wales[24] found that community pharmacists trained in brief intervention techniques were able to screen for and provide advice to individuals who would benefit from reducing their alcohol consumption**. We recommend that the evidence for the contribution of pharmacists should be considered further within the Scotland wide strategy for tackling alcohol misuse.**

28. We recognise the major improvements to many pharmacy premises which have taken place over recent years, and the support provided by Scottish Government. We also welcome the approach by the General Pharmaceutical Council in its proposals for the standards of registered pharmacy premises, particularly the emphasis on safeguarding the health, safety and wellbeing of patients and the public, and on supporting professionalism which we see as consistent with the emphasis in this review. **We believe that an important part of the relationship with patients is to ensure that their privacy and confidentiality is safeguarded, and that pharmacy owners should actively consider how this can be achieved in their premises.** The design of premises can be an important factor in emphasising the nature of the professional services being delivered and the relationship with patients.

29. In all of these services, it is not just the pharmacist who is key to effective and efficient provision, but the whole pharmacy team, involving professionally registered technicians and counter assistants. We return to this in the section on workforce and education.

[23] Review of the Community Pharmacy Public Health Service for Smoking Cessation and Emergency Hormonal Contraception, Scottish Government, November 2011.
[24] The role of community pharmacy in reducing alcohol consumption in individuals drinking at hazardous or harmful levels: a rapid review of the evidence, National Public Health Service for Wales, August 2009.

Safe and Effective Services

30. Pharmacy is often described as a risk averse and rule bound profession, contrasted, for example, with the medical profession's approach to dealing with uncertainty. There is, however, strength in that complementarity, and the ability of pharmacists, for example, to detect errors in their scrutiny of prescriptions, to advise on interactions, and to assure the safe dispensing of medicines provides important protection to patients. But it is important that the pharmacist's contribution to safety is integrated with the wider health and social care system.

31. Access to and sharing of relevant clinical, including medication, information between professionals is fundamental to safe and effective care. This is particularly important where patients move from one care setting to another. And yet pharmacists in the community, unlike their counterparts in hospital, have generally not been included in the exchange of information, although they are regulated professionals bound by the same standards of confidentiality as other professions. **The full benefits to patient care will not be realised until pharmacists are part of the NHS system of sharing information,** and that in turn relies on the building of trust from patients and fellow professionals. It is only at this point that patients in the community will be able to benefit from the additional safety practices and clinical input that pharmacists deliver to patients in hospital.

32. **Within community based care, there is a significant opportunity for pharmacists to be full partners in the relevant parts of the Patient Safety in Primary Care Programme**. A shared agenda focusing on high risk medicines and high risk prescribing can demonstrate the complementary roles of the professions and the measurable benefits to patients. Inclusion of community pharmacy in medicines reconciliation, when patients enter and return from other care settings (hospital, care home etc), will provide more complete information for other professionals and additional safeguards and improved care for patients.

33. Within pharmacy in other parts of the UK, separate services for particular aspects of pharmaceutical care such as the reviews of medicines use and of new medicines have been established. While these have value in themselves, we support the approach in Scotland where they are part of a single, co-ordinated service for individual patients, building on the approach of CMS. This can be complemented by the use of risk prediction tools to target the identification of and support to those patients most at risk. This would also underline the importance of working with other care staff and the patients themselves to deliver mutually agreed outcomes.

34. For some services, e.g. drug misuse and end of life care, the development of particular expertise, including pharmacist prescribing, and networks of professional support, together with a multi-disciplinary and multi-agency approach, is essential. It is important that this specialist care is co-ordinated with mainstream provision, and relevant information exchanged. **These are also areas where a co-ordinated national approach to**

standards and specification of services would ensure equitable provision across the country, while recognising the specific needs of local areas.

35. In recent years pharmacists who have gained the appropriate qualification have been able to prescribe. However, in practice, little prescribing is done, because it needs to be part of a system in collaboration with others. **We believe that, given the increasing workload on GPs, working with prescribing pharmacists in a structured way could be mutually beneficial.** Pharmacists could reduce the calls on GPs by acting as an accessible, drop in triage centre with the ability to treat minor ailments (as has been shown in some of the Pharmore+ projects). Pharmacists could also work in agreed ways with patients to find the best formulation and medicine for them to improve patient experience and hence adherence. Any such developments would have to ensure they did not introduce a serious risk of moral hazard, in which the pharmacist would gain significant financial benefit from certain prescribing decisions. There may also be the opportunity to align more closely the training and future qualifications of doctors and pharmacists in prescribing to promote common standards across the professions, as happens already in some other countries.

Care Homes

36. We were specifically asked to consider the needs of residents in care homes and how these might best be met. As demonstrated in an earlier section of this review, on any one day seven out of ten residents in care homes will suffer at least one form of medication error[25], most of these being caused by the actions of doctors or pharmacists. The concerns about the variation in the quality of care generally and, in particular, of pharmaceutical care in some care homes have been well documented and the need to address these clearly demonstrated in the recent report by RPS Scotland[26] and in the RCGP Scotland and RPS Scotland Joint Statement[27]. The increasing dependency and multimorbidity of residents, many with dementia, requires high quality pharmaceutical care, to meet the clinical and hence medication needs of individual residents.

37. Fundamental to any improved and effective system of pharmaceutical care is a consistent clinical input from a suitably trained pharmacist, working in partnership with general medical practice, nursing, social work and care staff, and any other professionals involved, together with the care home owner. It is our view that the local NHS Board, in partnership with the local authority, should take responsibility for making this happen on behalf of the

[25] Barber ND, Alldred DP, Raynor DK, Dickinson R, et al. Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people. Quality and Safety in Health Care. 2009:341-6.
[26] Improving Pharmaceutical Care in Care Homes, Royal Pharmaceutical Society Scotland, March 2012.
[27] RCGP Scotland and RPS Scotland Joint Statement: Breaking down the barriers – how pharmacists and GPs can work together to improve patient care, RCGP Scotland and RPS Scotland, 2012.

care home residents, by entering into and monitoring contractual arrangements with pharmacists and general practitioners, and by arranging for the provision of specialist support (staff or services) where needed. While we recognise the principle of patient choice, there is substantial evidence from local examples (such as in Tayside) and clear support from our review work that the arrangements for each care home should be with one pharmacy team and, preferably, one general medical practice to ensure consistency of care and appropriate clinical governance.

38. We consider that the following principles should apply:

- pharmaceutical care and associated supply delivered through local not distant providers
- nationally agreed standards of service and contractual terms
- nationally agreed standards of documentation and recording systems
- integrated information exchange, including medicines reconciliation at admission, transfer and discharge
- all care providers having access to current medication details and to the sharing of other information appropriate to their particular responsibilities
- standards for the safe administration of medicines that meet the needs of individual residents
- encouragement of patients with the capacity to self care
- quality assured training and support for care home staff in medicines administration
- regular multi-disciplinary review of medication

39. The aim should, therefore, be to have a pharmaceutical care service which:

- is person centred
- improves quality of prescribing, monitoring and review of medication
- encourages accurate record keeping in homes
- reduces administration errors by carers
- supports patient self medication where appropriate
- improves adherence in self medicating patients
- addresses polypharmacy
- reduces inappropriate prescribing of psychoactive medication
- reduces high risk medicines
- reduces falls and hip fractures
- improves dementia care
- improves pain management
- improves palliative and end of life care

40. **The NHS Board should ensure that the supply of medicines complements the clinical service, and also monitor supply arrangements to ensure that they are cost effective and not subject to perverse incentives.** We support a move towards more original packs and away from MDS, unless assessed as required for an individual. **We also recommend that Scottish Government should consider whether it**

should debar the ownership of care homes by pharmacists or pharmacy bodies which are in contract to supply medicines or a clinical service to care homes and how it might also restrict ownership of pharmacies by care home proprietors.

41. A number of submissions to our review contained suggestions as to how a system such as that outlined above might work in practice, including the more integrated use of information technology. **We recommend that, as a matter of some urgency, Scottish Government should bring together all the relevant interested parties (including professional health and social care bodies, care home providers, Care Inspectorate, patient and carer representatives), and, building on the national reports and local experience, design and promote a coherent system of pharmaceutical care for care homes in Scotland.**

Care at Home

42. Many of the principles which relate to pharmaceutical care in care homes are also applicable to services for patients who require supported care at home. The situation can, however, be even more complex with a wide variety of formal or informal carers of varying capabilities, with the growing implications of Self Directed Support, and the issues arising from the operation of a number of recent pieces of legislation[28]. Direct supply of specialist items by homecare companies bypassing the mainstream services causes problems for pharmacists and GPs and the patient information they hold, and **we recommend that these arrangements should be reviewed by Scottish Government and NHS Boards.** We heard much about the considerable inconsistency both in the level and nature of services provided across Scotland. The multi-agency and multi-disciplinary challenges are precisely those which the current proposals on integration of health and social care are intended to address. As with care homes, the NHS Board in partnership with the local authority should be responsible for co-ordinating the local arrangements for pharmaceutical input.

43. We consider that the following principles should apply:

- nationally agreed service standards
- nationally agreed standards of documentation and recording systems
- clear definition of roles and responsibilities of all involved in giving care
- all care providers having access to current medication details and to the sharing of other information appropriate to their particular responsibilities
- single shared assessment and the use of MDS only where that is assessed as being appropriate for individual needs
- quality assured training, guidance and support for care staff (including informal carers) in medicines, safety issues, administration etc

[28] Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003, the Adult Support and Protection (Scotland) Act 2007, and the Protection of Vulnerable Groups (Scotland) Act 2007.

The aims should be as for those in care homes, but with a particular focus on re-ablement and the active involvement of family and paid carers. The use of such tools as SPARRA[29] can assist in identifying those at greatest risk and hence need for more intensive support. There is also the opportunity to use other members of the pharmacy team, as demonstrated in the Reshaping Care for Older People Programme, to contribute to the service provided. Advances in telehealth, including remote monitoring systems and prompts, can also support the input from professional staff.

44. We recognise the challenges for the NHS and its partners as the need for more extensive and specialised care is delivered in the community. This reinforces the need for professionals in the community to work effectively as part of a wider team involving those whose locus has traditionally been more hospital based, and with whom there has to be effective communication and exchange of information. Implementation of all the changes required to meet patient needs will inevitably take time, but we believe there is a widespread desire to move forward. **We recommend, therefore, that the practical evidence submitted to our review, together with local examples of good practice (e.g. in Highland) should be used as the basis of developing a national approach to which NHS Boards, Local Authorities, the Care Inspectorate and professional bodies are committed.**

National and Local Planning

45. The arrangements for NHS pharmaceutical services in Scotland are set out in primary and secondary legislation and in Directions. The core services for community pharmacy have been negotiated and specified nationally, along with the related funding envelope. Some nationally recognised pharmaceutical services such as those for drug misuse are arranged and funded locally, and, increasingly, NHS Boards have been entering into local arrangements for other services to meet local priorities and patient needs which they believe are appropriately provided by community pharmacy, e.g. palliative care, alcohol screening, out-of-hours services etc. In addition, Boards have engaged pharmacist prescribers to work with general practice in clinics for hypertension, respiratory disease, diabetes etc. We were given a very helpful summary of these locally arranged and funded services by the Primary Care Pharmacy Group.

46. We support having an appropriate balance between what is determined nationally, to ensure consistency of approach across Scotland, and what is arranged locally to meet specific needs. But we were struck by the duplication of effort across NHS Boards in the specification of a number of the services which they wished to secure locally and **we would recommend that, where possible, there should be a more co-ordinated approach organised through the professional groups.** This would also have the benefit of greater efficiency and consistency for patients wherever they live and for the pharmacy providers.

[29] Scottish Patients at Risk of Readmission and Admission.

47. A key role for NHS Boards is to administer, through their Pharmacy Practices Committee, the "control of entry" regulations which govern applications to join the local pharmaceutical list. While these regulations have played an important role in maintaining a network of pharmacies across Scotland, they are essentially reactive to applications made and, notwithstanding some recent changes, are not seen to be sufficiently responsive to local needs. The Smoking, Health and Social Care (Scotland) Act 2005 contains provisions for a more proactive approach whereby Boards would more systematically, and with appropriate consultation, review the local needs for pharmaceutical care and prepare and implement a pharmaceutical care services plan to meet these needs. **We recommend that these provisions should now be brought into effect as a key element in ensuring that pharmaceutical care services are available and readily accessible to the population of Scotland.** An important by-product of more systematic planning will be to ensure that the core and any additional pharmaceutical care services are properly integrated with the other community based services for which the Board is responsible.

48. A key element of local planning is ensuring equitable access to services. One of the hallmarks of community pharmacy has been its accessibility, providing a rapid and flexible response to public and patients. That needs to be maintained in the increasing focus on delivering a broader clinical service in addition to the dispensing of medicines. There are further opportunities for pharmacy premises to be seen as a wider community asset. Examples from the Pharmore+ programme[30] have demonstrated the potential for pharmacy to provide, and expand access to, a wider range of health and health improvement services. Some of the pilots included extended hours and prescribing of medicines, co-ordinated with other out-of-hours primary care provision. However, a significant challenge was engaging with and securing support from other professional groups. The pharmacy can also been used as a signposting agent, for example in referring patients on to the voluntary sector organisations that can provide additional expert support and information. **We recommend that NHS Boards could usefully learn from and adapt the models developed under this programme to meet local needs.**

49. In some rural areas where there is no community pharmacy the dispensing of medicines is carried out by general medical practices. Changes brought about by applications to open a pharmacy under the current "control of entry" system have caused significant concerns for local communities, and have, on occasions, undermined the professional partnership between pharmacists and GPs which the development of pharmaceutical care is intended to enhance. We take the view that the more proactive planning of services by NHS Boards needs to address these issues, and that, until that has taken place, no further changes should take place to the current disposition of services.

[30] Pharmore+ evaluation – unpublished.

50. **We recommend that the following principles might apply as part of the consultation with public and professional interests which should accompany the planning process –**

- GP services in rural areas should not be destabilised
- people should have access to pharmaceutical care and the associated input from pharmacists wherever they live, in addition to any dispensing service
- the establishment of a professional partnership between GPs and pharmacists
- the funding of GMS should be sufficient to provide an appropriate level of medical service, and not be dependent on payments for dispensing
- standards of dispensing and the payment arrangements (including drug cost reimbursement) should be the same for pharmacies and dispensing doctors
- appropriate notice needs to be given of any proposed change to service provision

Where the planning process results in the continued provision of dispensing by a medical practice, it would be for the NHS Board to make arrangements for a pharmaceutical care service to be provided to complement the medical dispensing service, by contracting with or employing a pharmacist or pharmacists. It would be important to have a clear understanding of the working relationships between the pharmacist and the medical practice, including the opportunity to use telehealth facilities.

Working Together

51. A number of pharmacists working in the community highlighted their professional isolation and a wish to work more closely with colleagues in the same discipline and with other professionals. **We recommend that NHS Boards to take the lead in creating professional networks and support for community based pharmacists, and to extend these to include the whole of the local pharmacy workforce.** A practical approach would be to focus on particular clinical areas such as polypharmacy in the elderly or the implementation of services such as CMS, building on the approaches which have already proved successful in areas such as end of life care and drug misuse. This would also have the advantage of creating an obvious bridge to the involvement of other professional groups.

52. The pharmacist in the community will be the member of a number of teams – the team within the pharmacy, the wider primary care team, and the network of pharmacists in area wherever they work. The role of these teams will change as the service needs and the locus of care change, from hospital to community, from GP practice to pharmacy and from professional to self care. In all of this the NHS Board has a key role to play in providing professional leadership and support. But the increasing pressures in the community and the need to provide pharmaceutical care to a larger number of dependent patients brings into sharp focus the sustainability of the traditional single handed pharmacist. **Just as medical practices and other some**

professional groups have sought ways to work together and provide a wider range of services, we recommend that a similar approach may be needed in pharmacy. Part of this may be to incentivise individual pharmacy practices working together, sharing support and premises, while at the same time preserving the accessibility so valued by the public. And, as has happened in hospital pharmacy, there is the opportunity to make greater and better use of pharmacy technicians in the community which will also help to free up a pharmacist's time.

53. A number of pharmacists working in the community are not based in community pharmacies. Some are working in GP premises, others in specific clinical areas, e.g. drug misuse, or in other settings such as care homes. Not all pharmaceutical care services have to have a community pharmacy as a base, and those which do have that base may still require the pharmacist or other team member to leave the pharmacy to work in other settings. **It is important that the most effective and efficient use is made of all the pharmacy professionals in an area, and the NHS Board needs to consider how that is best achieved in its own local circumstances.** Whatever the arrangements, the individual patient is key, and the communication and information exchange has to ensure that a co-ordinated pharmaceutical care service is provided.

Contracts and Funding

54. The main legislative arrangements which underpin the provision of pharmacy services in the community have been largely unchanged since the inception of the NHS. This has made the planning and implementation of the services which have been introduced in Scotland over the last ten years more complex than need be. The 2005 Act contains provisions which would allow for a more appropriate and flexible framework for the development and delivery of pharmaceutical care services. **We recommend that Scottish Government should also consider how these can be brought into effect in the context of the wider findings of this review and the developing policy landscape.** Future contract arrangements also need to be sufficiently flexible to take account of changing ways of providing care and increasingly complex therapies in the community.

55. Part of the framework for the future should relate to the listing arrangements. Currently, only pharmacies appear on the pharmaceutical list, with no identification of the individual pharmacists who provide the service. **We believe that the listing of individuals as well as organisations (which would be similar to what happens with other primary care contractor groups) is an important and positive element in underpinning the professional relationship with patients, and the clinical governance systems for which Boards are responsible.** It is also likely to be relevant to any future arrangements for revalidation for pharmacists. The practical implementation can draw on the experience gained with the listing of "performers" in other contractor professions.

56. The national funding arrangements which have accompanied the introduction of the new services over recent years have rightly sought to move the system from one which traditionally rewarded volume of dispensing to one which recognises the nature and quality of the professional service provided. But in so doing, the system has become somewhat complex, with a range of different types of payments included in "transition". **While not underestimating the challenge, we support the principle of a weighted capitation system based on registration supplemented by some activity measure to recognise acute dispensing.** It will be important to ensure that there are no perverse incentives and that the relevant probity measures are included. **We also believe that the payments for pharmaceutical care services to care homes (as described above) should be managed locally but within a nationally agreed framework.**

57. We recognise the benefits to both the NHS and the pharmacy contractors which have accrued from the jointly negotiated Efficient Purchasing and Prescribing Programme related to the purchasing of generic drugs for use in primary care in Scotland. It is important to ensure that the monitoring arrangements continue to deliver those benefits. Any alternative arrangement that might be considered would have to demonstrate greater savings.

58. We have not sought to establish in detail the impact on the use of resources of the proposals in this review. However, if effective measures are introduced then we would expect savings for the NHS and improved quality of life for patients. We would expect these to arise from reduced hospital admissions, from the consequences of fewer errors of all types, less polypharmacy, from increased appropriate adherence leading to better satisfaction with first line treatment, less escalation to more expensive treatment and less waste. We would also expect a shift in the use of time by pharmacists to allow them to spend more time with patients.

Information and Communication

59. Patients and their representatives consistently highlighted the importance of their pharmacist having access to the information needed to support the delivery of an effective service. They stressed that a pharmacist should be seen as a healthcare professional who, together with the rest of the pharmacy team, would be bound by the same code of confidentiality that applied elsewhere in the NHS. There is also a growing recognition in fellow professionals that sharing of relevant patient based information will enhance pharmaceutical care. The provision of role based access by pharmacists to the Emergency Care Summary (ECS) and to the developing Key Information Summary (KIS) needs to be part of the implementation of the eHealth Strategy. This also applies to the inclusion of pharmacy in the transfer of information and associated medicines reconciliation when a patient moves between service sectors. **We recommend that pharmacy should be seen as a key player and participant in these developments.**

60. Within the community pharmacy, **the development of the Pharmacy Care Record, which records the pharmaceutical care needs and**

provision for patients, should ensure that the information contained within it can be readily shared with other systems, and that other systems can feed information into it as appropriate. This will be an important contribution to the emerging proposals for a single, shared medication record that moves with the patient and is kept up to date by all those professionals with whom the patient has contact. Some patients will want to have ready access to and hold their own copy of that record, either in paper or electronic form, enhancing patient ownership of their own care.

61. The Patient Rights (Scotland) Act 2011 requires health care providers to ensure patients have the necessary information and support to participate as fully as possible in their health care, and that all reasonable steps are taken to provide that information and support in a form that is appropriate to the patient's needs. We welcome the Patient Access to Information on Medicines (PATIM) workstream, initiated within the *NHS inform* programme, which seeks to identify how information and approaches to communication could be improved to increase patient understanding of how to better manage their medicines in a safe and effective way. Health literacy is a key consideration when looking to provide information on medicines. For example, the NHSScotland Teach-back technique has been shown to be a useful tool to help check a patient's understanding of the information they have received. It is important, as recognised in PATIM, that other aspects including language, hearing and sight loss, learning disability, religion and belief are taken into account in tailoring medicines information to the needs of individuals.

Technology

62. Community pharmacy is already well placed to take advantage of the developments in IT, with connection to the NHS network, electronic transmission of prescriptions, electronic patient registration, and ongoing development of in-house systems. But, as stated above, it is important that this is all linked to the implementation of the overall eHealth strategy in Scotland. There is significant potential use of mobile devices and smart media to provide improved services to patients, e.g. for repeat prescriptions, and access to records and information, but it is important that those who cannot or choose not to access such solutions are not disadvantaged.

63. There is increasing use of new technologies to support people in their own homes, involving the health and social care sectors. NHS 24's Scottish Centre for Telehealth and Telecare (SCTT) is leading a programme of work as part of the DALLAS (Delivering Assisted Living at Scale) initiative to examine how quality of life can be improved and independent living supported for those with long term health and care issues. **We recommend that the implications for, and the potential to integrate with, pharmaceutical care need to be explored as part of this programme.** The growth of additional technologies to support the adherence of patients may also offer further opportunities for pharmaceutical care.

64. A number of community pharmacies have introduced robotic dispensing systems, which have the potential to offer significant gains in terms of safety.

As the range of barcoded products increases and as confidence in these systems grows, it should be possible for the pharmacist just to perform a clinical check of a prescription, rather than checking the finished product. This will free the pharmacist from the dispensary bench, and potentially the pharmacy, and liberate time. Further efficiencies may require a more substantial and nationally driven process, using the experience of countries such as the Netherlands, with pharmacies working together to support a network of robotic central filling, dispensing, and return of repeat prescriptions to local pharmacies. Such a system could reduce stockholdings and further free up staff time in individual pharmacies. **We recommend that Scottish Government should explore the potential with the profession, including the implications for capital investment.**

65. The technology associated with medicines themselves is changing, with the development of pharmacogenetics and the potential for more personalised drug therapies. This, coupled with the increasing use of more specialised medicines in the community, e.g. for chemotherapy, will required appropriate expertise and information to be available in community based pharmaceutical care.

Workforce and Education

66. Future workforce requirements are inextricably linked with the nature of the services that the NHS wishes to see delivered, and we are aware that work is currently underway to take forward a Workforce Development Plan for NHSScotland to support achievement of the 20:20 Vision. In relation to pharmacy, there is currently no central locus for national workforce planning in Scotland, and none of the "controls" which apply to some other clinical professions. Scotland cannot plan in isolation from developments elsewhere in the UK and in Europe, for example, the work being undertaken as part of the Modernising Pharmacy Careers (MPC) programme on education and training. And there has been a significant increase in the number of Schools of Pharmacy in England and Ireland, as well as increases in student intake in the two Scottish Schools. A practical result has been far greater availability of pharmacists to work in permanent posts, and a significantly reduced reliance on locums, bringing the opportunity for greater continuity of patient care.

67. We believe that the experience gained by NHS Education for Scotland (NES) in workforce planning for other clinical professions can usefully be applied to pharmacy, using data collection and trend analysis to lead to better supply and demand forecasting, and capacity planning. While the focus of our review is on community based pharmaceutical care, it is important that the pharmacy workforce of the future is seen as a more integrated whole, with greater flexibility and movement between sectors to take account of the changes in patient care and service delivery.

68. While the undergraduate course in the two Scottish Schools has seen an increase in the clinical and patient related context and content, there is a need for this to be further developed to ensure that graduates are suitably prepared to meet the evolving service and patient care needs of the future. It is

important that this encompasses all aspects of clinical care, community and hospital, but with a recognition of where the bulk of pharmaceutical care will be delivered. The opportunity should also be taken to continue to enhance the inter-disciplinary elements in undergraduate education, particularly with medicine, including greater co-operation between Pharmacy and Medical Schools. Learning together builds a strong foundation for more effective working together through greater understanding of and respect for each other's skills and expertise.

69. The Pre-Registration Pharmacist Scheme (PRPS), which is administered and funded by NES, has made good progress in achieving the objective of an appropriate period of cross-sectoral experience for graduates prior to registration, in line with the principles of the MPC proposals, albeit not within a formal integrated academic course. Whatever the final arrangements in Scotland for the five pre-registration years, the mismatch of graduate numbers and funded pre-registration places needs to be addressed. This should take into account the future workforce needs, and the nature of the funding support provided to those in that fifth year. If the PRPS were to continue and be seen as more integrated with the undergraduate course, there would seem to be logic in NES assuming for pharmacy the same role that they perform effectively for some other clinical professions i.e. becoming the employer of pre-registration trainees, quality assuring the training environments for educational purposes, ensuring the right balance of clinical (including inter-disciplinary) experience, and supporting and appraising the tutors.

70. A significant part of formal post graduate training, including the courses in Clinical Pharmacy and the Vocational Training Scheme, is currently focused on hospital based pharmacists, linking to potential career development. Just as there needs to be further work to continue to develop a structured Career Framework in hospital pharmacy, the opportunity should be taken to consider how such a Framework might apply in community pharmacy, based on clinical pharmacy practice, and recognising future CPD and revalidation requirements. This should also take account of the development of community based specialists and the inter-linking with the hospital based pharmacy services, with the increasing complexity of patient care ("hospital at home") in the community and the need for flexible professional input. The continuing benefits of inter-disciplinary learning (with medicine, nursing, social work etc) should be underpinned by more formal arrangements which provide protected learning time for community based pharmacists. This would support the practical implementation of, for example, the Patient Safety Programme in Primary Care, the delivery of services in Care Homes, and effective integration of health and social care for people with multiple needs in the community.

71. The development of pharmaceutical care in the community depends also on the skills and experience of the other members of the pharmacy team, the pharmacy technicians (now registered with GPhC), dispensing assistants and medicines counter assistants. There is a need to develop accredited training for pharmacy technicians in extended roles (e.g. checking of dispensed medicines, medicines review, patient counselling) linked more closely to the

education and training of pharmacists, and to ensure that the other pharmacy staff have the relevant skills to support the public health, self-care, and long-term medication needs of patients and their carers.

72. As with other clinical professions, the education and training system for pharmacists and other team members has to recognise the changing nature of NHS services and the opportunity for a more integrated workforce. **We recommend that there should be an early review of all aspects of pharmacy workforce and associated education and training, involving Scottish Government, NES, the Schools of Pharmacy, NHS Boards, and the professional groups to plan and take forward an integrated approach which meets the future service needs in Scotland.**

Delivering the Future

73. During the review we heard much about the inappropriateness and unsustainability of the traditional model of community pharmacy, described by many as a supply function in a commercial environment with increasing volumes of prescriptions, and pressures on time and resources. At the same time, all involved stressed the progress that had already been made in Scotland in moving towards a new model with pharmacists playing a key role in the healthcare system in optimising the use of and outcomes from medicines, supporting self care, and promoting health. The frustrations were largely about the speed of progress towards that model of pharmaceutical care with a particular desire to progress to full implementation of CMS. This review has sought to identify where and how that progress can be made, but with flexibility built in to recognise future uncertainties. A fundamental part of delivering the future will be for the NHS to establish a new relationship which emphasises the role and status of the individual pharmacist, the partnership with patients and other professionals, and the consequent implications for the pharmacy bodies which provide the environment and support for the delivery of the clinical services required.

74. We see key elements for the continued future direction being –

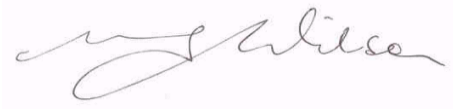
- a focus on professionalism and professional identity
- ownership by the pharmacy profession of its own value with a key clinical role to play in the NHS
- demonstration of the impact of that clinical contribution on patient outcomes and resource use
- a resulting changed perception by the public and fellow professionals
- heightening the profile and autonomy of the individual pharmacist while retaining the value of the pharmacy
- solidifying the relationship between patient and pharmacist and the wider team
- pharmacy owners supporting and empowering the individual pharmacists and not imposing inappropriate restraints or targets
- developing and using the skills of the whole pharmacy team

- development of therapeutic partnerships with patients, GPs and other professionals
- using the pharmacy as a community asset and a focus for information, support, referral and signposting
- promoting patient centred, safe and effective services as part of the wider primary and social care team
- proactive planning and co-operation at national and local level
- matching the reward system to the clinical services provided
- ensuring a safe and cost effective supply of medicines
- aligning the information systems to underpin integrated care
- using technology to improve service delivery and secure efficiencies
- designing education and training to meet the future professional and service needs

Implementation and Review

75. This report is submitted to Scottish Government as a contribution to their consideration of the continued development of NHS pharmaceutical care in the community and evolving approaches to wider healthcare delivery. It is a summary of our views on the way ahead and, on occasions, how to get there. We believe that what we propose should be seen as a co-ordinated programme and one which requires professional leadership. The submissions made to the review contained a wealth of material, much of it with valuable and practical proposals for delivery of specific aspects. We hope that Scottish Government will have the opportunity to use that in taking forward whatever follows from this review.

76. It is also important that any plan for future development has built into it measures for success and methods of monitoring and evaluation, so that there is a clear and demonstrable path for progress. The planning and delivery needs to involve all the stakeholders who gave so willingly and generously of their time and expertise in contributing to this review.



Dr Hamish Wilson
Review Lead

Professor Nick Barber
Professional Adviser and Support

ANNEX A

Remit and Terms of Reference

The Scottish Government is to undertake a review of the pharmaceutical care of patients in the community.

The review will focus on the needs of patients and the NHS; current arrangements for providing NHS Pharmaceutical Services across Scotland; their fitness for purpose; and sustainability into the future.

It will report key findings and conclusions and, in particular, will make recommendations on any changes that might be required to optimise the role of pharmaceutical care in the community to achieving the sustainable, high quality healthcare we are committed to through:

- the enhancement of the pharmacist's clinical role, and
- joint working between community and hospital based pharmacists, GPs and other healthcare clinicians and community services.

Terms of reference

In delivering NHS pharmaceutical care services in the community that are sustainable, of the highest quality, efficient and fit for the future a new and innovative approach is required in the form of a modern framework for ***NHS Pharmaceutical Care Services*** in Scotland to ensure:

1. A step shift away from a service regarded as "dispensing of prescriptions" to one where its main focus is providing ***NHS pharmaceutical care*** and an increased emphasis on providing direct care to patients;

2. Pharmaceutical care services are provided appropriately to reflect local need in the context of national priorities;

3. Pharmacists can contribute to improving patient care through delivering direct personalised pharmaceutical care services that are effective and efficient in partnership with other health and care professionals resulting in optimal therapy from care and medicines;
4. The specific pharmaceutical care service needs of residents in care homes and how best these should be met – an important part of the review will be to help inform service specification in this area and how best to achieve service delivery through clinical pharmacists;

5. Education, training and continued professional development remains relevant to providing modern NHS services;

6. Planning, designing and arrangements for the provision of NHS pharmaceutical care are fit for purpose to target national priorities, as well as focus service provision on the needs of patients and local populations;

7. Effective structures and processes are in place to deliver pharmaceutical care and direct care that best meet the needs of all the people and communities of Scotland and facilitates the professionalism of pharmacists;

8. The effective use of technology to improve efficiency, dispensing accuracy, communication and decision making, medicines adherence support, and hence to improve the quality of the service to patients.

9. Integrated working between primary care and hospital pharmacists and other clinicians.

10. The best possible use is made of available resources – particularly in relation to the efficiency of pharmaceutical care services and the pharmacists' contribution to efficient, safe and cost effective medicines use.

Process

In view of this, and building on the strengths of existing provision, the review will consider and take evidence on:

- How NHS pharmaceutical care can best contribute to the ambitions set out in the Healthcare Quality Strategy for Scotland (May 2010) - that is care that is person-centred, safe and effective to every patient every time - and the six high-level quality outcomes agreed by the Quality Alliance Board:

    - People have the best start in life and are enabled to live longer healthier lives;
    - People are supported to live well at home or in the community;
    - Everyone has a positive experience of healthcare;
    - All staff feel supported and engaged;
    - Healthcare is safe for every person, every time; and
    - Best possible use is made of available resources.

- the structures, processes, education and training that support the pharmaceutical care of patients in the community - including the planning, designing, and contracting arrangements - with the aim of using that capacity and capability to deliver further improvements in pharmaceutical care in our communities in the coming years.

Evidence will be gathered from a wide variety of stakeholders in Scotland from within the NHS, patient groups, the pharmaceutical and medical professions and their regulatory bodies, contractor representatives, educational bodies, and those working in social care and voluntary organisations.

The review will also take into consideration other forms of evidence, including research from within the UK and from abroad, as may be appropriate to supplement the evidence gathering process.

Output

The evidence gathered will be used to develop a report to be submitted to the Scottish Government's Chief Pharmaceutical Officer setting out key findings and conclusions, and to make recommendations on the future shape of NHS pharmaceutical care of patients in the community in Scotland.

Timescales

The main thrust of the review will commence early 2012 culminating in a final report by the Autumn 2012. Key milestones as currently planned include:

Milestone	**Timeline**
Agree Remit and Terms of Reference with Review Leads	November/December 2011
Share Agreed Remit and Terms of Reference together with details on evidence gathering	January 2012
Written evidence – issue survey questionnaire	March 2012
Conduct follow-up focus group and one-to-one discussion sessions based on review key themes and evidence gathered.	March to June 2012
Formulate conclusions and recommendations	July to August 2012
Submit final report to Scottish Government	October 2012

ANNEX B

Discussions were held with representatives from a number of stakeholders including:

Alliance Boots
Association of Directors of Social Work
BMA Scotland/SGPC
Care Inspectorate
Community Pharmacy Scotland
Company Chemist Association
General Pharmaceutical Council
Guild of Healthcare Pharmacists
Long Term Conditions Alliance Scotland
National Pharmacy Association
NHS National Education for Scotland
NHS Healthcare Improvement Scotland
NHS National Services Scotland
NHS Scotland Directors of Scotland
NHS Scotland Primary Care and Pharmacy Leads
Patients Association Scotland
Pharmacists' Defence Association
Robert Gordon University
Royal College of General Practitioners
Royal College of Nursing
Royal Pharmaceutical Society in Scotland
Unison
University of Strathclyde
Voluntary Health Scotland

Plus a number of individuals with an interest in specific aspects of the review.

Online survey questionnaire:

118 responses: 65 from representatives of organisations
53 from individuals – Pharmacists, pharmacy Managers/Owners, GPs, nurses, academics and members of the public.

Organisations responding:-

Aberdeenshire CHP
AlbaPharm Limited
Alliance Boots
Angus Council - Social Work and Health
Balmullo and Leuchers SODS (Save Our Dispensing Surgeries)
Boots Pharmacist Association

Borders Area Pharmacy Contractors' Committee
British Medical Association - Scottish General Practitioners' Committee
British Pharmaceutical Students' Association
Care Inspectorate
Community Pharmacy Scotland
Co-operative Pharmacy
Cordia Services LLP
Department of Public Health, NHS Lothian
Dispensing Doctors Association
Edinpharm
Fife Council Social Work Service
General Pharmaceutical Council
Grange Prestonfield Community Council
Guild of Healthcare Pharmacists
Largo Area Community Council
Lloydspharmacy
Lothian Pharmacy Contractors' Committee
Midlothian CHP
Moray Community Health and Social Care Partnership
National Pharmacy Association Scotland
NHS 24
NHS Borders
NHS Education for Scotland
NHS Fife
NHS Fife Strategic Pharmacy Group
NHS Forth Valley
NHS Forth Valley Area Pharmaceutical Committee
NHS Grampian
NHS Grampian Area Pharmaceutical Committee
NHS Greater Glasgow & Clyde
NHS Greater Glasgow and Clyde Area Pharmaceutical Committee
NHS Health Scotland
NHS Highland Area Pharmaceutical Committee
NHS Highland Community Pharmacy Services
NHS Lothian
NHS Scotland Directors of Pharmacy
NHS Shetland/NHS Orkney
NHS Tayside
NHS Tayside Area Pharmaceutical Committee
NHS Lanarkshire
North Lanarkshire Council
Pharmacists' Defence Association
Primary Care Pharmacy Group
Royal College of General Practitioners-Scotland
Royal College Of Nursing
Royal Pharmaceutical Society
Scottish National Acute Pharmacy Services Networking Group
Scottish Palliative Care Pharmacists' Association
Scottish Pharmaceutical Public Health Network
Scottish Prescribing Advisors Association

Scottish Specialist Pharmacists in Substance Misuse
South Lanarkshire Council
South Sector Glasgow CHP
Strathclyde Institute of Pharmacy & Biomedical Sciences
The Company Chemists' Association
The City of Edinburgh Council and its Multidisciplinary Partners
United Kingdom Clinical Pharmacy Association
West Dunbartonshire
West Lothian CHCP

Separate submissions were received from:

Association of Directors of Social Work
Long Term Conditions Alliance Scotland
NHS Healthcare Improvement Scotland

and from a number of organisations who had responded to the online survey questionnaire.

ISBN: 978-1-78256-816-2 (web only)

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Government by APS Group Scotland
DPPAS14610 (08/13)

Published by the Scottish Government, August 2013