ROYAL PHARMACEUTICAL SOCIETY England

Community Pharmacy in 2016/17 and beyond proposals

Royal Pharmaceutical Society response

We are the professional leadership body for pharmacists and this response reflects this role, as well as the potential impact of these proposals on patients and the public.

We recognise the need to consider efficiencies across the NHS in order to ensure the best use of NHS resources at this time of growing demand. We also realise that other sectors of the pharmacy profession are being asked to make efficiency savings[i]. The best contribution that pharmacists can make to NHS efficiencies is their role in medicines optimisation and prevention of ill health.

We would like assurance from Government that the overarching objective of these reforms centres on improving patient access to high quality care, advice and medicines from pharmacists including those working in community pharmacies.

If there is a mutual understanding between the profession and Government regarding this underpinning aim we believe there is much we can do to work together.

Executive Summary

1. We are concerned that the proposed cuts to the contract funding will have a negative impact on the health of the nation by reducing access to high quality pharmaceutical care delivered by community pharmacists.
2. All pharmacists are clinical pharmacists and community pharmacists make a variety of clinical interventions every hour of every day via the most accessible NHS service in the country.
3. All patients should have access to the unique clinical expertise of a pharmacist throughout the medicines supply process. New ways of delivering high quality pharmaceutical care that ensure this need to be explored bearing in mind that pharmacists should be wherever medicines touch patients.
4. New supply models must ensure appropriate clinical oversight, minimise waste and enable the delivery of safe, high quality medicines and advice to patients through the most appropriate channel.
5. This consultation should have been accompanied by an impact assessment as we are gravely concerned that the cuts will not necessarily deliver the desired efficiency savings and could be harmful to patients and the public.
6. There is a need for capacity within the system as the population grows and the number of people with multiple long term conditions increases. We are concerned that this

consultation has been formulated to solve an immediate problem without considering the future needs of patients.

7. This consultation proposes a 6% cut in funding but there is no clarity as to whether there will be further cuts to the global sum in future years, or indeed if there will be any fundamental changes to the contract itself, which could destabilise the sector and lead to uncertainty and a lack of investment for the future.
8. The purpose of the pharmacy profession is the safe and effective supply of medicines, while also ensuring that medicines are optimised for the individual and that patients are supported to get the best possible outcomes from their medicines. Additionally, pharmacy has a key role to play in improving the public's health as it is a point of contact for those who may not currently be ill but could benefit from a better understanding of factors that could impact on their future wellbeing.
9. The Royal Pharmaceutical Society welcomes the recognition of the clinical skills and expertise of pharmacists, the third largest healthcare profession in England, working in a variety of care settings. This is something we have advocated in our various campaigns on 'Shaping Pharmacy for the Future'[ii].
10. We welcome the new roles for pharmacists and we provide programmes of guidance, support and development, including access to high quality clinical training and expertise, to ensure every pharmacist across community, GP practice, care homes, hospital, prisons and urgent care is equipped with the clinical skills required to meet these changes ahead.

Principles of high quality care from community pharmacists

Below we set out eight principles, and outline descriptions, to drive high quality care from community pharmacists.

1. Part of a multidisciplinary team.

Multi - pharmacist pharmacies would become the norm. In some pharmacies, community pharmacists may work alongside many more practitioners as part of a highly networked wider virtual team. This wider team would include primary care professionals such as GPs, community nurses and, when appropriate, specialist input from hospital pharmacists and social care professionals. Many pharmacies will operate as local federations, sharing caseloads and referring patients. These arrangements would reflect the multi-specialty community provider outlined in the NHS Five Year Forward View (FYFV)[iii].

2. Intensive support for those with long term conditions and the frail elderly

Community pharmacist prescribers would routinely adjust, start, stop and change medicines as part of a holistic patient care plan and alongside other non-pharmaceutical interventions to improve care. Many community pharmacists may choose to specialise in supporting people with specific long term conditions (LTCs) or in supporting frail elderly patients with multi-morbidities. Patients could register with a pharmacy if they wished or have their care delivered through many pharmacies through shared care arrangements.

3. Focused on wellbeing and promoting good health

The pharmacy team, led by the pharmacist, would become a community resource for wellbeing and public health services including contraception, vaccinations for adults and children, the provision of stop smoking services and weight and alcohol reduction programmes.

4. Providing better access to effective treatments

Pharmacists will diagnose and treat minor illness, through the provision of NHS and individually funded treatments. Access to NHS prescription medicines and other clinically effective medicines through pharmacists would remain a defining feature of community pharmacy.

5. Open seven days

Pharmacies would be open to reflect a seven day NHS as a minimum, with many open evenings and some open 24 hours a day. The pattern of opening hours for each individual community pharmacy would be defined by the needs of the locality.

6. First contact urgent care

Every local health system (as referenced in the NHS planning guidance 2016/17-2022-21[iv]) would have access to a designated urgent care pharmacy that would offer early intervention for those with LTCs and treat minor illness and minor injuries. Community pharmacists with advanced urgent care skills would work alongside other urgent care practitioners to provide a first contact service that can refer to Accident and Emergency (A&E) E and out of hours (OOH) GPs as well as receive referrals from these services.

7. Digitally enabled

All community pharmacists would be able to read and write to integrated care records, and would be routinely aware of hospital discharge information to allow smooth transfer of patient care. Patients would be able to check medicines availability in real time online and contact pharmacists through Skype, phone as well as face to face.

8. Accessible

Community pharmacists would be more accessible in areas of high social deprivation or in "under doctored" areas.

RPS Concerns:

We cannot support the proposed 6% cut in funding to the community pharmacy contractual framework.

The lack of data or impact assessment provided alongside this consultation makes it extremely difficult to respond in detail as we have little evidence or supporting information to consider.

We are also disappointed in the extremely short timescales that have been set to respond and implement any decisions.

If the funding cuts proceed there should be an immediate change to the control of entry regulations to encourage mergers of pharmacies and to prevent new pharmacy premises from opening unless a local Pharmaceutical Needs Assessment (PNA) has identified a further need, for example, a new housing estate is being built and requires access to pharmaceutical services.

We understand that Department of Health (DH) have mapped out the geographical footprint of the community pharmacy network and that this shows areas with clusters of community pharmacy premises. However, as this data has not been made available to us we are unable to understand how the DH are determining viability or local need.

We also understand that DH consider there to be an overprovision in the order of 3,000 pharmacies[v]. It is unlikely that the reduced pharmacy numbers alone will result in sufficient savings to deliver the £170 million or that such structural change will occur before the proposed implementation date of 1st October 2016.

We have two major concerns. Firstly, that the reduction in payments will occur before any organised or orderly reduction in the number of pharmacies occurs. In this situation it is likely that all current owners of community pharmacies will respond to the reduction in income with actions to reduce costs. This will mean a reduction in staffing levels or opening hours and therefore potentially reduced access and a poorer quality service to patients and the public. This would also increase the workplace pressure felt by community pharmacy teams; we have grave concerns about the impact of the funding cuts on individual pharmacists and their teams and the impact on patient safety and care. The NHS more widely has experienced a number of high profile cases, for example Mid Staffordshire, where Trust Boards failed to give sufficient weight to delivery of clinical services because they were overly focused on finances. The RPS has received many communications from members concerned about their workload. This would suggest there is already an imbalance in the weighting, with many pharmacy owners focusing on delivery of supply with inadequate staffing levels to deliver quality clinical services. The proposed cuts are only likely to worsen this in the short term. Unhappy staff working with patients, with many regularly working additional hours above contract just to deliver the basics, are less likely to deliver the high quality clinical service that the DH is clearly aspiring to, something recognised within the Francis report[vi] and where action was taken in terms of staff 'friends & family test'.

Secondly, the increased volume of medicines supply, public health consultation and self-care support and enhanced service provision by the remaining pharmacies will require investment in staff skills, staffing levels and the physical capacity within the premises. This transition must be able to be well planned and enacted over a suitable timescale. Also, there should be mechanisms in place that would facilitate groups of pharmacies within the "clusters" to find local solutions to the high numbers of pharmacy premises which would ensure a continuity of service to their patients.

In order to mitigate against these concerns we would want to be reassured that an impact assessment and some modelling of the transition arrangements has been carried out with rigour and that this is reflected in the timelines used to implement any changes. We would want there to be some encouragement to adopt federation type arrangements that will align with the development of new care models and hence promote integration with wider primary care provision. We would be pleased to support and advise on these assessments and modelling, however we recognise that they may rest more appropriately with other pharmacy bodies.

The DH slide set[vii], which provides details of this consultation, clearly states (on page 13) that certain pharmacies will receive more NHS funds than others. We believe that the highest quality pharmaceutical care services should become the norm and so the principle of differential funding established in relation to the access scheme should also be applied to service quality. It will be very hard to deliver a top down method of differential payments that does not rely simply on prescription volume, as is stated on (page 12) the slide on discussion of the establishment payment. However it is important that quality is also recognised so that the degree to which a pharmacy supports its local community with self-care, public health, medicines optimisation and urgent care is recognised.

Continued increases in the proportion of older people and numbers of patients with LTCs with complex health needs requiring often large numbers of medicines will require greater input from pharmacy professionals. In addition, with the shift of care out of hospital settings and care being

increasingly delivered in patients' homes and communities as well as the development of new community-based integrated care services, greater capacity will be required from the pharmacy team. As outlined above the proposed 6% cut to the global sum will inevitably lead to cuts in staffing levels (particularly in smaller community pharmacies which have less flexibility in their business model i.e. they are more reliant on global sum income) and therefore developing the pharmacy workforce so it is flexible, adaptable and able to support new models of care, will be extremely challenging.

As a large number of community pharmacies are predicted to close, this could deter higher quality students from a career in community pharmacy and also reduce opportunities for pharmacy trainees to experience a community setting. Reduced staffing levels will also reduce training infrastructure and community pharmacies may decide, because of workload pressure not to take on trainees – not to mention the impact on morale of the existing pharmacy workforce and the potential for existing experienced pharmacists to leave the profession.

We are concerned to see that dispensing doctors are currently 'out of scope'. Surely the Government would like to see an equity of access and standards for the supply of medicines and if the new models of supply are deemed to be more effective and efficient then dispensing doctors should also have access to these models. Any co-located pharmacy and dispensing doctor practice should be examined as there is clearly duplication in service, costing the NHS significantly more.

We would like assurance from Government that the overarching objective of these reforms centres on improving patient access to high quality care, advice and medicines from pharmacists including those working in community pharmacies.

If there is a mutual understanding between the profession and Government regarding this underpinning aim we believe there is much we can do to work together.

Looking to the Future:

The RPS believes that pharmacists should be wherever medicines touch patients, whether this be in a community pharmacy, a hospital, a GP practice, a care home or an urgent care clinical hub. Pharmacists need to be included in all care pathways where patient care is delivered or wellbeing is supported. We also believe that these roles must deliver a cohesive service enabling improved use of medicines that integrates pharmacists working in the community into the delivery of primary care. Over the duration of the new contractual arrangements new models will emerge and evolve and where these impact positively on patient outcomes these will need to be supported to develop and be integrated into the mainstream. As recognised in the recently published Carter review, pharmacists need to focus on medicines optimisation as this is where significant efficiency savings can be made in the system[viii].

Clinical Care for those who need it most

There are many areas where pharmacists working in the community can be empowered by the NHS, local commissioners and their employers to deliver high quality clinical care. Improved access to care from community pharmacists would result in improved patient care, better use of medicines and reduced medicines waste. This is especially applicable to those who are most in need of the skills of pharmacists, for example patients with multimorbidities and the frail and elderly, especially those who live in care homes and domiciliary care settings.

The NHS is facing unprecedented demands now, due to ever increasing demographic challenges. Community pharmacists can help prevent ill health which will have impact in the medium and long term, however there are areas where community pharmacy could have an impact right now. We will describe these in detail later on in this submission.

Changing incentives for community pharmacy

The current reward package for community pharmacy drives down the prices of medicines through competition on price, it also incentivises efficiency through rewarding high volume activity. Currently there are few incentives that reward the quality of care, for example a connection between reward and clinical outcomes or patient reported outcomes. There are also areas where incentivising volume can be in conflict with clinical activity, particularly medicines optimisation where reducing the volume of medicines dispensed may be a desired outcome. Introducing quality metrics, increasing rewards for quality and outcomes will drive behaviour change and allow for better informed decision by patients and commissioners.

Cultural change in professionalism within a commercial environment

The current NHS structures require engagement and clinical leadership at a local as well as national level. Currently many community pharmacy organisations are organised as operational retail businesses with the vast majority of decision making taken at a national level. The changes we set out below will need to be matched by operational changes within these businesses to empower pharmacists to become engaged in local NHS decision making. The common theme of community pharmacy innovation is the recognition that individual clinical leadership is required, we would like to work with Government, NHS England and our colleagues across pharmacy to achieve this.

Underlining standards and good variation

We believe the public should be confident that there are fundamental professional standards across all community pharmacies. These standards need to continually evolve, for example the expectation to access medicine use reviews should in time become access to full clinical (level 3) medicine reviews. Alongside national fundamental standards good local variation in response to the needs of the local population must be funded properly and encouraged by local commissioners. Many community pharmacists as well as commissioners in some localities are frustrated by the limitations and constraints of the current contract.

There is uncertainty around the ability to commission services from pharmacy at a local level and some perceived barriers to co-commissioning of them. Currently, any pharmaceutical service designated by NHS England can only be commissioned by NHS England but there is a difference between a pharmaceutical service and commissioning services from community pharmacies at a local level. DH should provide greater clarity for local commissioners and providers about how to commission enhanced services and how to co-commission health services from community pharmacy.

Adding capacity and capability for the NHS now

We are all aware of the need for extra capacity as the population grows and the number of people living with multiple LTCs increases. The UK population is projected to increase by 4.4 million over the next decade, rising from 64.6 million in 2014 to 69.0 million at mid-2024. This increase, of 6.9% of the 2014 population, is equivalent to an average annual growth rate of 0.7% each year over the decade[ix]. 70% of total expenditure on health and care in England is associated with the treatment of the 30% of the population with one LTC or more, and the number of people in England with one or

more such condition, currently 15 million, is projected to increase to around 18 million by 2025[x]. The number of people with three or more LTCs is predicted to rise from 1.9 million in 2008 to 2.9 million in 2018[xi]. There needs to be flexibility within the system to cope with these changing demographics.

Community pharmacists are already relieving pressure on the system in terms of urgent and emergency care (see page 10). However, the creation of a robust network of urgent care pharmacies in the community could help further reduce such pressures.

Community pharmacists, working as part of a multidisciplinary team, in designated "urgent care pharmacies" would be able to deliver minor injury treatments as well as support for those with self-limiting urgent care needs. We have seen examples of this kind of service also support those with an acute exacerbation of a long term condition, preventing this from progressing to a level that requires acute hospital care. Development and training would be required alongside clearly defined standards and congruence with existing urgent care services. Defining and explaining clearly to the public the standards of care and services available would both improve capacity for the NHS and allow the public to make better informed decisions when accessing urgent care.

We are aware that Lloyds have introduced a 'First Care Clinic'[xii] at the frontline of an accident and emergency centre within a Manchester hospital. If this service could be replicated in the community, or at other A&E departments, this could ensure that only those people truly needing an emergency service were directed to A&E.

We believe that community pharmacists could undertake the management of patients with particular long term conditions (see page 11).

Community pharmacists play a significant role in the prevention of ill health which is a key element of the FYFV[xiii]. They are naturally the first point of contact for patients for advice on health and wellbeing (see page 12).

In the context of the changing healthcare needs, including public health, we are concerned that the ability of community pharmacists to add capacity and capability to the NHS may be put at risk.

Supporting and Developing the Workforce:

To deliver clinical pharmaceutical care in all care settings and support patients across the interfaces, the pharmacy workforce needs the appropriate support and development opportunities. All training should be developed to enable the pharmacy workforce to work across pathways and boundaries. In addition to the constant developments to the undergraduate programme, following registration all pharmacists should have access to the best quality clinical development opportunities guidance, support and expertise. The RPS has programmes in place to support every pharmacist from day-1 of registration through all stages of advancement, expertise and specialist practice as well as access to training, development and support for clinical workforce across sectors. As the enhanced role of pharmacists is developed and supported, training and education provision needs to be equal to other professionals working in similar environments e.g. if pharmacists in the community are providing urgent care as part of the 'urgent care pharmacies' they would need training that is developed in collaboration with the Royal College of Emergency Medicine.

Access and the Pharmacy Access Scheme:

We believe that good access to pharmaceutical care will be achieved when every patient can easily access a pharmacist's knowledge, expertise and support on medicines and their use as well as prevention of ill health in a timely and convenient way.

It is important that funding for community pharmacy is maintained at a sufficient level to ensure the quality of service provision to reward and retain pharmacies in the right place and offering high quality services that are required by the local population.

A study in 2014 showed that the majority of the population can access a community pharmacy within a 20 min walk and crucially, access is greater in areas of highest deprivation—a positive pharmacy care law[xiv]. This access to high quality pharmaceutical care must be maintained to ensure the increasing health needs of the population are met.

As discussed above, the proposed 6% reduction in funding is likely, in the first instance, to result in a reduced quality of service to patients and the public, ultimately leading to pharmacy closures. We are concerned that any closures would happen in an unplanned and ad hoc way which does not necessarily support patients where they most need care. We would like to see improved access to high quality clinical services and increased opportunities for face to face contact between patients and pharmacists in all care settings.

The current criteria that have been outlined for the Pharmacy Access Scheme focus on volume, cost deprivation and location. They do not attempt to take into account the quality of service provided by the pharmacy and this has to be a critical factor. Quality markers need to be developed based on current service provision, integration and innovation to ensure equity of access to high quality pharmaceutical care. Access for vulnerable patients and their carers, for whom travel may be difficult, is particularly important.

The development of quality markers may also highlight areas where there is insufficient pharmaceutical provision and so result in new pharmacies opening.

This access scheme also needs to strongly link with local Pharmaceutical Needs Assessments (PNAs) to ensure local requirements are taken into consideration. PNAs will need to be revisited following any local changes to pharmaceutical provision e.g. if one or more community pharmacies in the area close. There needs to be clarity with regard to the criteria used at a national level for the pharmacy access scheme and the requirements of the local population as determined in the PNA and Joint Strategic Needs Assessments (JSNAs).

Clarity is also required with regard to where the funding for this access scheme will come from; it is unclear whether this will be from the remaining global sum following the proposed 6% cut or from the monies taken as part of the cuts.

As mentioned in our opening statements, where there are potential pharmacy closures, it could be that pharmacists working in the community come together to form a network or federation that can then deliver services from the remaining pharmacies and this type of model should be encouraged. For example, LIPCO Healthcare, a federation of 63 independent community pharmacies in Leicester City, Leicestershire County and Rutland has successfully represented the members as a provider organisation to local commissioners.

There should be more pharmacies with a second or third pharmacist to deliver the clinical capacity required

The current community pharmacy network provides an accessible service where patients and members of the public can 'drop in' without an appointment and receive advice, medicines and reassurance from a healthcare professional. This service is often available seven days a week and we need to consider how this can be more functionally integrated into urgent and emergency care networks. In particular, the ability for patients to access an emergency supply of their repeat medicines is a valued service that we know can reduce the demand for urgent care providers in the NHS.

Community pharmacists deliver a range of public health services, crucially these support the prevention agenda, which is a core theme of the FYFV. The Healthy Living Pharmacy (HLP) model[xv] has demonstrated improvements in health and yet access to this great source of services and proactive health promotion that improve the public's health may be reduced, especially as there have also been cuts in the public health budget resulting in decommissioning of public health services from community pharmacies. We are concerned that these cumulative effects will deter further investment in public health practice by community pharmacists.

We note that there is little background material relating to this consultation. We would request that the DH makes public any assessment in relation to the Public Sector Equality Duty[xvi].

We are also aware that in one particular area clinical commissioning groups (CCGs) will be decommissioning all locally enhanced services delivered by community pharmacies from April this year. This effectively becomes a cumulative effect that reduces the sustainability of pharmacies who rely mainly on NHS dispensing income.

We strongly welcome the concept of improving access to pharmacists working across all care settings where patients touch medicines such as GP practices, care homes and domiciliary care, urgent care clinical hubs as well as the more traditional roles in community and hospital settings. These roles reflect the skills and expertise of pharmacists and improve patient care.

Integration and the Pharmacy Integration Fund (PhIF):

The purpose of the fund should be to ensure better access to high quality pharmacist expertise and knowledge across all care settings, and in particular primary care. Where a pharmaceutical service can be commissioned nationally then this should become part of the contract negotiations and the PhIF should not be used to develop the service. The PhIF should not be used where existing funds are available through existing sources, e.g. IT funding via the Health and Social Care Information Centre (HSCIC). Funds to support the work on the value proposition for community pharmacy to Public Health England (PHE) should not come out of the PhIF, and we would be interested to see more detail on this.

The PhIF should only be available for supporting change in pharmacy and its integration into health systems to benefit patients. We would expect bids for this fund to be led by pharmacists. The Executive Summary of the Carter Review[xvii] states that "clinical programmes designed to improve quality and efficiency across care pathways are coordinated under a single governance framework led by NHS Improvement to ensure that they align with the performance framework". Will this apply to PhIF and what are the implications? And, what would this mean for evaluation / performance management of the PhIF and its initiatives?

Like the methodology used for the development of the vanguard models, we would encourage the PhIF to be utilised to support local innovations and we would expect the criteria to include a system

wide approach to change. These would be led by a pharmacist but ensuring integration as a multidisciplinary team working on change together.

The NHS is facing enormous pressures. The RPS believes that under these current pressures, many of which are related to medicines, particularly in A&E settings and GP practices, now is the time to invest in pharmacists to save money and reduce pressures elsewhere in the NHS system.

We would like to see community pharmacists more fully integrated into local care models, particularly those models outlined in the FYFV, and supported to fully deliver the medicines optimisation agenda. Any changes to funding or the contract should result in improved patient care through better access to high quality pharmaceutical care, advice and access to medicines. There should be increased opportunities for face to face contact between patients and pharmacists in all care settings.

Any pharmacist delivering clinical care, in whatever care setting, would need access to the patient's record with the patient's consent. We consider that read and write access to the patient record is a basic pre-requisite. To truly deliver medicines optimisation it is essential that pharmacists working in a patient facing role have read and write access to the patient record.

NHS England is the organisation that has responsibility for all primary care contracts. We would suggest that NHS England has a responsibility to review these primary care contracts to ensure they are aligned and fully support integrated working between the professions to benefit patient care. We believe that major opportunities for efficiencies and better outcomes for patients will be lost if the GP and Pharmacy contracts continue to be disconnected.

We understand that the PhIF needs to be flexible as the NHS changes and adapts over time, and we are ideally placed to provide clinical leadership in this area due to our ongoing relationships with other Royal Colleges and patient representative organisations. We would like to work with Government and the NHS to determine the prioritisation process and how this can react to changes in the system as a whole, in particular it must encourage integration with the new models of care outlined in the FYFV.

Whilst NHS England have clarified the annual figures for the PhIF we propose that this is not set in stone and remains 'flexible' to adapt to the emerging models. We want to see the evaluation of services so that the adoption and spread of innovative services that are already being delivered by pharmacists working in the community will be accelerated through an evidence base. This would quickly demonstrate innovation that would result in viable, sustainable improvement in care for patients and the public.

The following areas should be supported by the PhIF, however, this is not a definitive list and other areas that emerge, reflecting patient need, must also be considered:

Improving urgent and emergency care through better use of pharmacists:

We have mentioned previously the need to integrate pharmacists into the delivery of urgent and emergency (U&E) care. Pharmacists working in the community provide a range of clinical services that reduce the pressure on A&E and GP practices and these include supply and advice around common ailments, supply of repeat urgent medicines and emergency hormonal contraception (EHC). When one of the first EHC services was introduced in London visits to A&E for EHC reduced by 52%[xviii]. RPS is happy to provide evaluated examples of all the services outlined above, all of which demonstrate the value of the service to both patients and the system.

It is essential that these services are recognised and referred into locally by the urgent clinical care hubs and so must be incorporated into the local Directory of Services (DOS). We envisage that the pharmacists employed to work within the urgent care clinical hubs will refer appropriate patients to their local community pharmacies for the services listed in the paragraph above as well as general medicines advice. This means that the workload within community pharmacies is likely to increase at a time when funding is being reduced and the ability of community pharmacists to continue to deliver such services is put at risk.

As outlined on page 3, we also propose the creation of a number of local 'urgent care pharmacies' in each locality commensurate with the geography outlined by place-based commissioning in the FYFV. Pharmacists working in the community would provide a high quality assessment and be an access point for urgent care. We are aware of advanced training in assessment and management of urgent cases being delivered for community pharmacists in the North West of England. This has resulted in reports of different referral patterns and confidence in managing cases; a full evaluation of this project is ongoing.

We are very keen to see community pharmacies used as a first contact point for urgent care that is functionally integrated into wider NHS provision. Reduction in opening hours and uncertainty about where premises might close within NHS commissioners and planners will make this more difficult to achieve.

Medicines optimisation within the community:

We want patients to expect to see pharmacists working in the community delivering an integrated service for patients with stable LTCs. This would include an annual medicines review as well as a review whenever a medicine is started, stopped or changed or when a patient moves between different care settings. The pharmacist would undertake appropriate monitoring and would make adjustments in treatment in light of the results and following a shared decision making discussion with the patient. The pharmacist, in discussion with the patient, would determine the most appropriate length of treatment depending on the patient's condition(s) and their needs. This would ensure that the length of treatment was determined by patient need and not cost savings. For a patient who is newly diagnosed and starting a new medicine, the pharmacist would spend time with the patient discussing the risks and benefits of the medicine in light of the condition and come to a shared decision with the patient about the medicine and it use. The pharmacist would either develop or add to the patient's care and support plan which would aim to optimise the patient's medicine for their condition(s) and improve their patient activation measures (PAMs). We are aware the Community Pharmacy Future II project is currently undertaking and evaluating such a model of care and that the Pharmaceutical Services Negotiating Committee (PSNC) is considering something that moves in this direction in its service development proposals[xix]. Such a service could require registration with a community pharmacy. Future negotiations and information flows should enable and support pharmacists working in the community to deliver this. The delivery of such a service would support the implementation of the medicines optimisation principles[xx] to ensure that patients were supported to get the most from the significant investments made in medicines.

We are aware of a number of examples where pharmacists working in the community are supporting the medicines optimisation agenda over and above their contractual requirements.

- Community pharmacists in the Isle of Wight are being commissioned to undertake a medicines review in the patient's own home once the patient has been discharged from

hospital which has resulted in a 37% reduction in patients leaving hospital being readmitted, and a 67.5% reduction in hospital bed days following discharge and the service.

- Newark and Sherwood CCG is testing new models of working and is commissioning community pharmacists who are independent prescribers to undertake sessions within their local GP practice. Early results show that pharmacists undertaking the complex medication reviews has saved over 300 direct contact GP hours. A similar model has been set up in London where they developed an outreach team of pharmacists from a community pharmacy provider, which work across London to support GPs on the day to day basis.
- A project in Leeds, "Making Time" is making sure people with learning disabilities get the best service they can from their community pharmacy. It is a flexible approach based on the patient's needs. So far 40 individuals are receiving the service and the feedback is positive from both service user and pharmacy teams. The commissioner has just approved the expansion of the service to another area of Leeds and the aim is to bring the number of people living with a learning disability receiving the service up to 100 individuals in the next few months.
- A service in Croydon CCG (Community Pharmacy Domiciliary Medicine Review Service) supports vulnerable, elderly patients. Community pharmacists are commissioned to visit vulnerable patients in their own homes and undertake a medicines review. The current model demonstrates that for every £1 invested in the provision of the service £7.45 is saved in relation to avoided emergency admissions. More detailed analysis from April 2013 to March 2014 shows an overall reduction of 18 emergency admissions episodes and 314 emergency admission beds days for patients who received the service with a cost avoidance of £106,132 and a reduction of 13 A&E attendances with a cost avoidance of £1,950.

Not only do such examples result in improved outcomes for patients they also relieve pressure on the NHS reducing unplanned hospital admissions and reducing medicines waste.

Prevention of ill health:

Pharmacists working in the community should be the first point of contact for health promotion and wellbeing advice as well as medicines supply and optimisation of medicines for individual patients. In order for this to be realised pharmacists working in the community need to become an integral part of primary care and be a natural part of care pathways.

We envisage pharmacists working in the community taking on a larger role in delivering the prevention agenda as they are ideally placed to provide public health interventions. Local Authorities (LAs) will want to tap into the potential of their community pharmacists to commission high quality services, which meet the needs of the local population. However some clarity around how this will be funded is needed. With two thirds of the adult population in England being obese, a third of the population in England drinking too much alcohol, and 1 in 5 of the adult population smoking there is much that pharmacists working in the community can do to support changes in lifestyle which will reduce the requirements for NHS care and support in future years. HLPs are increasingly being recognised by commissioners as having proven delivery of health promotional campaigns and health and wellbeing services; acceleration should be encouraged and supported by NHS England as well as Public Health England (PHE).

Pharmacists working in the community deliver flu vaccination services on a nationally commissioned basis. This service provision should be used to provide other vaccinations such as MMR, HPV, Hep B and pneumonia for patients and the public. Provision of travel vaccinations could also be considered. This provides greater choice, access and flexibility for patients and the public.

We agree with PSNC[xxi] that NHS England and PHE should work collaboratively to agree six national campaign topics each year. Each campaign could run for up to two months allowing PHE to deliver a consistent campaign message across the whole pharmacy network reaching millions of people at once.

Pharmacists working in different care settings:

We recognise and support the three examples of a new clinical infrastructure for the profession, in general practice, care homes and urgent care clinical hubs. This needs to sit alongside a robust pharmacy network within the community. Pharmacists working in care homes, GP practices and urgent clinical care hubs need to be able to refer to their colleagues in the community for ongoing care including medicines optimisation and lifestyle advice as well as for urgent medicines and support for self-care. We need to enhance the capacity of community pharmacists to work alongside colleagues in these settings and support them to embrace these roles themselves. There needs to be integration of pharmacy professionals in all of these different care settings.

Pharmacists working in and with GP practices:

We are pleased to see the adoption and support for clinical pharmacists in GP practices from NHS England. Alongside the Royal College of General Practitioners (RCGP) we would encourage the expansion of this model so that every GP practice has access to a practice pharmacists.

In November 2014 the RCGP published independent research by Deloitte[xxii] which estimated that savings of £447 million could be realised annually if there was increased spending on general practices. Community pharmacists can support the work of general practices to release these savings by diverting patients away from A&E, reducing the number of unnecessary ambulance call outs and by providing greater support in primary care to reduce the length of hospital stays for patients over 65.

Pharmacists working with and in care homes:

Pharmacists, as part of the multidisciplinary team, should have overall responsibility for medicines and their use in care homes. This will result in significant benefits to care home residents, care home providers and the NHS. This could be an important role for pharmacists and their teams within community pharmacy who currently manage the safe supply of medicines to care homes.

There are numerous examples where pharmacists are already undertaking a role in providing care to residents in care homes. A project undertaken in Northumbria demonstrated the benefit of pharmacist interventions in care homes. Using pharmacist prescribers employed by the local NHS Trust to carry out medicine reviews with residents and their families, the results showed that 1.7 medicines could be stopped for every resident reviewed. Net annualised savings of £184 per person could be achieved and, for every £1 invested in the intervention, £2.38 could be released from the medicines budget[xxiii].

Brighton and Hove CCG contracted an independent organisation to undertake medicine reviews for 2,000 care home residents working closely with all GP surgeries. The scheme was well received by GPs, care homes and residents. Medicines related savings were over £300K in a single year with about the same again estimated as savings from avoided hospital admissions.

Pharmacists working in urgent care clinical hubs:

There are a number of pharmacists currently working in either NHS 111 call centres or GP out of hour providers. As these two services come together into urgent care clinical hubs it is vital that

pharmacists are integrated as part of the service delivery. Pharmacists in these settings can support colleagues with medicine related queries and issues from both patients and the public and others working in the hubs. They can also signpost to the services delivered by their colleagues in community pharmacies.

Integrated Care 24 (IC24) has been employing pharmacists in some of its 111 services since March 2015. In a report submitted to NHSE as part of the 111 Pharmacy pilot it was noted that 63.4% of calls were closed with advice or advice to self-care or care via a community pharmacy. Pharmacists have been welcomed into the contact centre teams and also provide valuable clinical advice to the nurse and paramedic clinicians further supporting patient care. They are confident and efficient in dealing with pharmaceutical issues, allowing the other clinicians to spend their time on other clinical calls.

IC24 is also planning to expand its pharmacist workforce in the OOHs services providing telephone advice and repeat prescriptions following referral from 111. One pharmacist in the OOH service takes around 5 calls per hour on an 8 hour shift, mainly for repeat prescriptions, advising around medicines optimisation, medicines supply issues and other queries as required. These calls would normally be dealt with by a GP, thereby leaving them to deal with an additional 40 patients in a timely manner.

Care UK employ independent pharmacist prescribers and they are able to close 80—90% of calls (relating to repeat medication requests and medication advice) coming into the OOH providers.

New models of care

We think it is vital that the new models of care outlined in the FYFV consider the integration of pharmacists in a variety of care settings. As mentioned previously, we believe that pharmacists should be wherever a medicine and a patient touch so in relation to the new models of care they should be a fully integrated part of care delivery. We are aware that funding has been realised to support the new models of care and their adoption across the country will be encouraged. There should be opportunities for the PhIF to interface (not integrate and be lost) with the new models of care, as well as more opportunities for pharmacy to be realised within these new models specifically.

The NHS currently spends £15 billion on medicines[xxiv], 30-50% of which are not taken as prescribed. Pharmacists across all care settings can do much more to ensure there is shared decision making with patients about their medicines and that patients are supported to get the most from their medicines.

Integration should begin with integration across the pharmacy profession, using the clinical skills of pharmacists in the community, pharmacists in GP practices and pharmacists in the hospital to improve the transfer of care, outreach and medicines optimisation for all patients. Successful integration would ensure continuity of care for patients and a reduction in hospital readmissions and medicines waste. We are encouraged to see some hospitals now referring patients to their community pharmacist for ongoing support with their medicines. An initiative in Newcastle-upon Tyne refers hospital patients electronically to community pharmacies for post-discharge medicines reviews to avoid readmissions. This service has made almost 1,200 referrals in its first year and could expand further across North East England[xxv].

Lambeth and Southwark CCG are exploring the involvement of community pharmacists to support the ongoing care of patients who have been assessed and supported by an integrated care pharmacist. The aim of involving community pharmacists is to provide ongoing support for these

frail, elderly patients in line with an agreed care plan and ensuring the promotion around self-care and development of patient empowerment in a sustainable manner.

In the future we would expect more pharmacists to become independent prescribers, although barriers such as having to have a designated medical practitioner (DMP) and the training that is currently in place will need to be overcome, for example by using experienced pharmacist prescribers instead of DMPs and a competency based approach as in Alberta, Canada and looking at mechanisms to incorporate prescribing into the undergraduate and foundation years. This will mean that pharmacists working in all care settings will be able to deal with whole episodes of care, thereby taking additional pressure off other healthcare professionals within the system.

Enablers for the PhIF

The proposals outlined in this consultation are far reaching and if we truly want the profession to deliver more clinical services then the available funding needs to be adequate to deliver more value alongside creating the right environment and culture to enable this. There is a requirement for major change management from the pharmacy profession and this cannot be underestimated. Perhaps some of the initial PhIF, or other funds via HEE, NHS Leadership Academy, PHE or NHS England could be invested to provide practical support around this change management and leadership and other relevant enabling skills within the first year. This would be in addition to supporting the building of effective relationships between pharmacy and other health professions, and translation of what we know works from other initiatives to all health settings, faster and effectively. Learning from the Cater review[xxvi] also needs to be taken into account.

The PhIF needs to be flexible and adaptable to ensure pharmacists and the services they provide are fully integrated into new models of care within the system and that there is continuity within the models of integration. The PhIF will enable this but as pharmacists become more integrated into the system they should be able to access other funding sources such as transformation funds, funds for delivery of the FYFV models, better care funding etc more easily to help shape patient services.

In conclusion we would like to reiterate our willingness to use our wide breadth of expertise to help shape the PHIF and its use.

Access to medicines:

Pharmacy plays a vital role in the supply of medicines. There are a number of models and routes of medicines supply ranging from the traditional dispensing in both community and hospitals through to many new and emerging models as technology advances.

The supply of medicines provides a touchpoint with patients and enables an interaction to take place between the patient and the pharmacist potentially including an intervention either around medicines or lifestyle advice. Digitalising medicines supply and having more remote access to medicines may reduce this important interaction.

Regardless of the route of supply the RPS believes that medicines supply should be

1. safe & effective
2. person-centred
3. timely
4. equitable
5. mindful of waste

Provision of pharmaceutical care by a pharmacist should be embedded throughout any medicines supply process taking into account a clinical check[xxvii] and the principles and elements of medicines optimisation[xxviii].

The RPS believes that.

1. All patients should receive medicines which:
    - have been clinically reviewed by a pharmacist to ensure they are safe and appropriate for the patient
    - are supplied safely and securely in a timely manner via the most appropriate route for the patient
    - are labelled with clear information on how to take the medicine and any relevant warnings
    - have been stored and distributed appropriately.

2. All patients should be able to:
    - obtain information on the options available to them regarding how and where they receive their medicines.
    - order and receive their medicines in the most appropriate way for them
    - receive information and support in order to minimise waste
    - return unwanted medicines to a pharmacy for safe disposal.

3. At the time of supply of medicines all patients should be able to:
    - discuss their medicines with a pharmacist including having the opportunity to ask questions or raise concerns
    - access appropriate information with counselling and advice from a pharmacist via a route that is appropriate for them
    - receive written information and advice, in a format that is accessible and useful to them, on how to use and store their medicines and possible side effects
    - know when and how to seek further advice.

4. All patients with long term conditions should:
    - as a minimum be reviewed by a pharmacist at least once a year or whenever a medicine is started, stopped or changed and when a patient moves between different care settings
    - be able to request a review of their medicines by a pharmacist at any point in their treatment.

The number of prescription items is increasing annually by 2.5% but there are concerns about how the ever increasing prescription volumes can be processed safely and effectively if the number of community pharmacies and workforce is reduced. It is likely that due to the funding cuts, a number of community pharmacies will either close or reduce their staffing levels prior to the new methods of supply being available, causing an increase in workload across the community pharmacy sector.

We assume that centralised dispensing and hub and spoke models will be developed in line with Falsified Medicines Directive (FMD) requirements, that they will be enabled to support the electronic transfer of prescriptions as part of the Electronic Prescription Service (EPS) and that original pack dispensing (OPD) will be required to ensure efficient operation. We also assume that any changes

and revisions will be made in light of any changes to legislation in relation to responsible pharmacist and supervision legislation.

We are concerned that these new mechanisms of dispensing will reduce the communication between the pharmacist and the patient as we know there are a lot of unmeasured communications with patients about medicines issues and the ability to solve some of these issues may be lost. For example, when a patient is first prescribed a medicine, although they are often provided with information by the GP they are overwhelmed and being able to have a conversation with the pharmacist about the medicines is vital to ensuring that patients have the opportunity to discuss any concerns and queries.

There are also inherent risks with remote services operating at scale when the system breaks down, for example an online pharmacy had technical problems in December 2015. Patients are then reliant on local GPs and community pharmacies to step in and solve the supply problem. This assumes local capacity and this could be more difficult if some community pharmacies close. We need to also learn lessons from the implementation of EPS and repeat dispensing which have perhaps not performed to the level that was originally expected.

No data has been shared on which to base the assumption that centralised dispensing or hub and spoke models will create funding efficiencies in the systems. However, there may be potential to free up a community pharmacists' time to deliver more face to face patient services and improve the optimisation of medicines for individual patients, as this is where the real efficiencies to the system could be realised.

For any new systems that are introduced there needs to be an equality in the ability to utilise these new methods of supply. It is critical that any methods of supply maintain patient safety and ensure provision of high quality of pharmaceutical care.

Clarity is required as to where responsibility lies in relation to the supply of medicines i.e. who is accountable for what in relation to centralised dispensing or hub and spoke models. We would expect the General Pharmaceutical Council (GPhC) to have a position on this.

The policy direction in the consultation encourages patients to order their medication online. We have no problem if this system enables a patient to order from their GP with collection from a local community pharmacy. However this could lead to a change in people's behaviour. Are we promoting or encouraging more high risk behaviour by encouraging patients to obtain medicines online and the accompanying problems of online counterfeit medicines? Care also needs to be taken to avoid inequality of access e.g. for vulnerable patients who may be unable or incapable of accessing or using online services.

The RPS is committed to ensuring that pharmaceutical care is sustainable and has an environmental footprint that is measured. What is the effect of the proposals on the environment? The suggested new models of medicines supply such as click and collect or home delivery are likely to result in a growth in transport needs which we would want to be assessed through an environmental impact assessment.

Essential Enablers:

If these enablers are implemented then the resultant action will underpin and support the delivery of clinical services by pharmacists.

- Health Education England (HEE) must be mandated to provide additional resources for pharmacists to ensure the right support and enablers are in place to ensure the workforce can deliver this vision
- Student and pre-registration pharmacists should be given the opportunity to undertake practice within the care settings outlined in the consultation (GP practices, care homes and urgent care clinical hubs)
- The current funding for the education and training of pharmacists needs to be reprioritised to ensure it provides the skills and knowledge set required to deliver the vision we have outlined in this submission and as part of the RPS vision for the transforming the pharmacy workforce[xxix]
- All pharmacists need to have better access to prescribing rights alongside the opportunities, support and enablers to train and practice as an independent prescriber
- Mandate commissioners to commission pharmacists to deliver services that involve medicines and patients. This will mean that local commissioners (CCGs and local NHS England) will be given the explicit responsibility for the 'integration' agenda to involve pharmacists in the strategic planning currently underway to deliver the five year forward view. We are aware there are currently perceived barriers in relation to co-commissioning and these would need to be removed
- Develop drivers and levers that ensure where innovation is successful in one area it is supported and adopted universally to enable equity of access and reduction of variability
- Ensure the new models of care consider the local involvement of pharmacists in delivery of patient care as most aspects of patient care will involve a medicine. Investment in medicines is the largest intervention in the NHS with £15.5 billion being spent on medicines in 2014/15[xxx]
- Integration across the pharmacy profession needs to be supported by Government and all stakeholders and should also be a key element of the implementation of the Carter Review
- Any initiatives supported by the PhIF need to be viable, sustainable, scaleable and reproducible.

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About us

The Royal Pharmaceutical Society (RPS) is the professional body for every pharmacist in Great Britain. We are the only body that represents all sectors and specialisms of pharmacy in Great Britain.

The RPS leads and supports the development of the pharmacy profession to deliver excellence of care and service to patients and the public. This includes the advancement of science, practice, education and knowledge in pharmacy and the provision of professional standards and guidance to promote and deliver excellence. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

Its functions and services include:

Leadership, representation and advocacy: Ensuring the expertise of the pharmacist is heard by governments, the media and the public.

Professional development, education and support: helping pharmacists deliver excellent care and also to advance their careers through professional advancement, career advice and guidance on good practice.

Professional networking and publications: hosting and facilitating a series of communication channels to enable pharmacists to discuss areas of common interest, develop and learn.

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