

English Pharmacy Board 6 February 2008

PUBLIC BUSINESS

NHS Next Stage Review

Purpose

To advise the Board of the work being undertaken to influence the NHS Next Stage Review.

Strategic objective domains

- An organisation that consistently performs as a regulator, professional representative leader and publisher

Action required

To note the work carried out to date.

1. Background

The Board's working group to study the implications of Lord Darzi's *NHS Next Stage Review* met on 14 November 2007. The minutes of the meeting are attached at Appendix 1.

2. Progress

Since that meeting a letter has been sent to all the Regional Clinical Review Leads (Appendix 2), a letter to Lord Darzi (Appendix 3) and an event on Engagement with Pharmacy has been arranged for 27 February 2008 at the Society, with a further event in Manchester. Details of these are attached at Appendix 4.

3. Risk Implications

There are no risk implications.

4. Resource Implications

All resources need to be balanced against the budget available to the English Pharmacy Board.

Martyn Schofield
Deputy Head of Corporate Secretariat

ENGLISH PHARMACY BOARD NHS NEXT STAGE REVIEW WORKING GROUP

Minutes of the meeting held Wednesday 14 November 2007 at 1 Lambeth High Street, London SE1

Present

Chairman Paul Bennett

Brian Curwain Lindsey Gilpin
Rachael Lemon Gail Thomas

In Attendance

David Pruce Director of Practice & Quality Improvement

Martyn Schofield Deputy Head of Corporate Secretariat

Heidi Wright Head of Practice

07/01 Apologies for absence

David Mottram and David Miller.

07/02 Declaration of interests

07/03 Response to the interim report of the NHS Next Stage Review

The Chairman advised that he had been invited to join a reference group on the NHS Next Stage Review by Keith Ridge, Chief Pharmacist for England. This meant that the Board had clear way to directly get their view of the proposals heard. The group were advised that a joint letter to Lord Darzi had been signed by the President and the Chairman of the English Pharmacy Board. The contents of the letter had emphasized where in healthcare pharmacy could have input.

The consultation process for the review was moving forward rapidly and 72 regional groups had been established, each of which would be studying 8 areas of 'patient pathways'.

In a general discussion about the particular areas where pharmacy could play an important role in healthcare the following points were made:

- Pharmacists could play a large role in assisting patients with long term conditions. The pharmacist would in all likelihood be the only person a patient would see consistently, as rotas for doctors and nurses changed.
- The public health role of pharmacists could assist in reducing the workload for GPs. At present 40% of all appointments to GPs were regarding minor ailments. In response to this point Heidi Wright advised that she would gather evidence for the current role

pharmacists played in the care of patients with long term conditions such as asthma and diabetes.

- Pharmacies opening hours were often longer than those of GP surgeries thereby making a pharmacist more accessible to those who could not get to a GP during current opening hours.
- 745 million prescription items had been dispensed by community pharmacists in England and Wales in 2006 to 2007.

Action Points:

- Produce an aide-memoire of the paper for LPCs and Branches to use as a reference that detailed the key points.
- Find out who was active in the consultation and encourage pharmacists to become involved.
- Work to ensure pharmaceutical representation on the regional groups.
- Emphasize the 'value for money' aspect of utilising the skills of pharmacists, especially if pharmacists had access to patient records.
- Put together case studies where pharmacy was successfully involved in service redesign and where results of patient benefits, cost-effectiveness etc could be demonstrated.
- Write to the chairs of the 72 groups making a case for a pharmacist to be appointed to the group and let people know we are doing this so they have someone ready to attend the group – via Branches and LPCs

07/04 Any other business

There was no other business.

The Chairman thanked members for attending and closed the meeting.



**Royal
Pharmaceutical
Society**
of Great Britain

English Pharmacy Board

Regional Clinical Review Leads

16 January 2008

Dear Regional Lead

NHS NEXT STAGE REVIEW

We know that regional groups are finalising their reports on the eight areas of care set out in Lord Darzi's interim report on the NHS Next Stage Review.

Where pharmacists are included in regional groups, we greatly welcome this but we are also disappointed that, in a number of regions, pharmacists have found it difficult to contribute or have only become involved peripherally in this important work. As health professionals, pharmacists have the specific expertise to play a key role in identifying medicines needs in these care groups and, in particular, the safe and effective use of medicines. We believe this to be an essential part of delivering safe, effective and personalised care for patients.

Therefore, we are concerned that regional reports in each of the eight care areas recognise and include the integral part that pharmacy plays in clinical care pathways. We are aware that this work is well advanced. However, we strongly recommend that if groups have yet to discuss and address fully pharmacy's contribution in developing a vision for first class care that you now ask the chairs to take the opportunity to review their draft report to ensure that it does so. For our part, we are very happy to facilitate and support pharmacy engagement in your region in helping to finalise these reports.

Yours sincerely

Andy Murdock
Pharmacy Member, Advisory Board on Primary and Community Care Strategy

Paul Bennett
Chair, English Pharmacy Board

Sue Sharpe
Chief Executive, Pharmaceutical
Services Negotiating Committee

Vanessa Eggerdon
Association of Pharmacy Technicians

Ann Jacklin
Chair, Association of Teaching Hospital
Pharmacists

1 Lambeth High Street, London SE1 7JN
Head Office Telephone: 020 7735 9141 Facsimile: 020 7735 7629 www.rpsgb.org
Jeremy Holmes MA Chief Executive and Registrar
Patron: Her Majesty The Queen

Prof Lord Darzi of Denham KBE
Parliamentary Under Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 0AA

Appendix 3

22nd January 2008

MR HEMANT PATEL FRPHARMS
Telephone: 020 7572 2203
Facsimile: 020 7572 2500
e-mail: president@rpsgb.org

Dear Lord Darzi

Royal Pharmaceutical Society of Great Britain's submission of policy ideas to the NHS Next Stage Review

We are writing in response to your invitation to submit policy ideas to the NHS Next Stage Review and to Mark Britnell's call for policy ideas specifically on innovation. This letter follows on from our letter to you of 17th October 2007 which highlighted the contribution pharmacy can make to improving early detection, prevention and treatment of a wide range of health problems; improving access to healthcare; providing personalised care tailored to the needs of individuals; reducing the cost and improving the quality of prescribing decisions; and using NHS resources more effectively.

The Royal Pharmaceutical Society of Great Britain (RPSGB) is the regulatory and professional body for pharmacy. In our role as the professional development organisation, leadership body and regulator, we are working to ensure that the public benefits from safe, high-quality pharmaceutical services that meet their needs. Our vision is to make Great Britain the safest place in the world to take medicines.

The contribution of pharmacy

We think pharmacy can make an important contribution to the next stage of NHS reform because:

- Community pharmacies are in accessible locations and usually offer more convenient opening hours than GPs' surgeries. There are over 12,000 community pharmacies in GB. 79% of people live within 1 km of a pharmacy and 99% can reach a pharmacy within 20 minutes.
- Pharmacy can do far more than just shift services to a different location or deliver them more cheaply: it can redesign services and re-package combinations of services differently to meet patients' needs and preferences e.g. by providing expert advice, therapeutic monitoring and screening tests at a convenient time for the service user. This would help to meet the government's goal of extending screening for common diseases.
- The pharmacy workforce has the flexibility to create and spread innovative services (e.g. an increasing number of pharmacists are combining part-time professional roles in community pharmacy, PCTs and/or HEIs).
- Community pharmacies are businesses: they have the structural and cultural flexibility to roll out significant changes very rapidly (e.g. by 2006 the new community pharmacy contract had led to three-quarters of pharmacies installing private consultation areas¹,

making a whole range of new clinical services possible. By December 2006 about 500,000 medicines-use reviews had been conductedⁱⁱ).

Key changes required

Three changes that could make the greatest positive impact are:

1. Improving access and targeting: services should be organised so that patients can access pharmacists' expertise when and where they need it.
2. Increasing integration through better commissioning: PCTs should create a genuinely level playing field among all providers including pharmacy, but at the same time incentivise the integration of services along care pathways.
3. Fostering and spreading innovation in pharmacy services: we see this as key to achieving significant improvements in health outcomes.

Access and targeting

- Services should be organised so that patients can access pharmacists' expertise when and where they need it. For instance, NHS consultant pharmacists have the highest levels of clinical expertise but they are normally based in hospitals: that means that patients with multiple long-term conditions do not benefit from their expertise unless they happen to be admitted to hospital, but many patients with complex conditions who are not admitted to hospital could benefit from this expertise. In the future, services should be organised and delivered to meet patients' clinical needs (as in Figure 1 below) rather than according to sectoral and organisational boundaries.

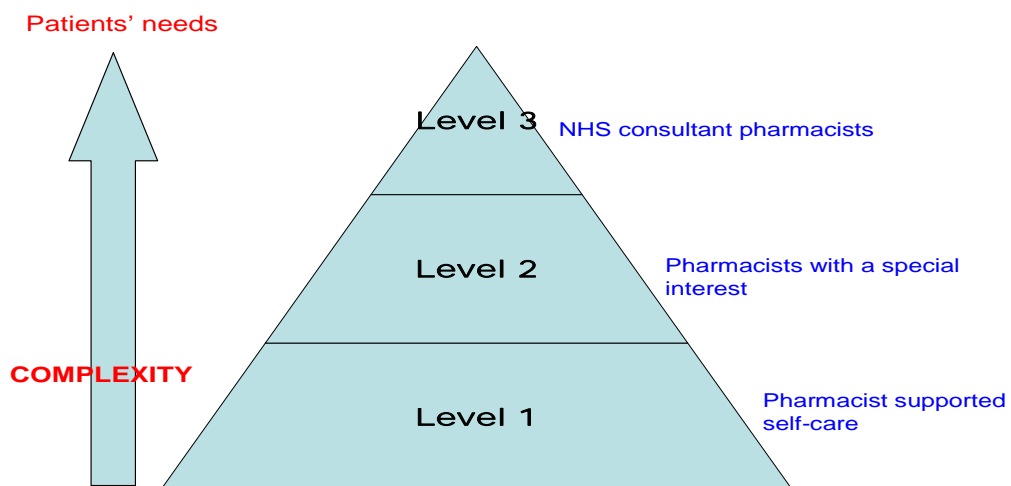


Figure 1: Matching pharmacists' expertise to the complexity of patients' needs

- Community pharmacists can make a particular contribution to the care of patients with long-term conditions which are not well controlled.ⁱⁱⁱ
- The financial and regulatory framework for community pharmacy must ensure that the existing network is preserved and in some cases expanded so as to ensure good access for all. This will be particularly important where GP practices are amalgamated into a smaller number of centres/polyclinics.

- New developments such as non-medical prescribing and pharmacists with a special interest allow for more differentiated targeting of community pharmacists' skills to particular types of patient need. All community pharmacists can offer supported self-care to patients whose condition is simple and well controlled, while pharmacists with a special interest (e.g. in diabetes) could offer comprehensive therapy management (see Figure 2 below).^{iv}

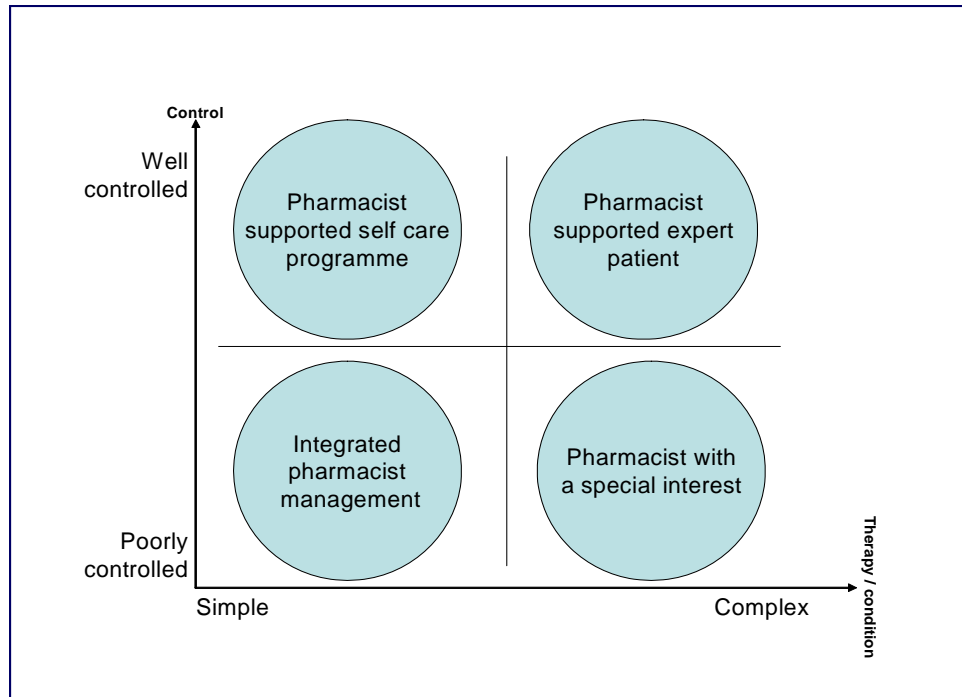


Figure 2: Targeting community pharmacy input to the management of long-term conditions

Integration

Pharmacy services are likely to have greater benefits for patients if they are integrated with other services. But patients cannot benefit from enhanced pharmacy services at all unless they are commissioned. The best outcomes may be achieved by requiring commissioners to create a level playing field among providers, while also incentivising collaboration between them.^v

Integration

- The pharmacist must be accepted as a full member of the local health team if their skills are to be effectively deployed. The Society has piloted a leadership development programme – Leading Across Boundaries – which has helped pharmacists to successfully integrate their services with those of other professions.
- Pharmacy services such as medicines use review (MUR) need to be integrated with GP care to benefit patients fully.^{vi}
- GP practices should be incentivised to employ a sessional pharmacist to work on prescribing quality and cost-effectiveness.

Information sharing

- Pharmacist access to the diagnosis or indication for prescribed medicines, laboratory test results and medication history for specified patients would improve the value and safety of pharmacy interventions.
- Until shared electronic records are implemented, patient-held shared records could be used as an interim measure.

Competition policy and strategy

- Greater clarity is needed about the government's current and future intentions regarding the role of competition and alternative service providers in delivering NHS services.

Commissioning

- We welcome the government's objective to improve the quality of commissioning.
- Commissioners should think more creatively about alternative solutions to the health needs of their populations.
- Commissioners may be reluctant to challenge the status quo of health service provision and unaware of the full range of local providers they could be making use of. They should be required to systematically and comprehensively map these providers and services including pharmacy services.^{vii}
- Practice-based commissioning is likely to entrench the dominance of GPs in primary care provision and disincentivise them from collaborating with pharmacy. We believe that significant reforms are needed to create greater integration and a level playing field among providers.^{viii}
- New commissioning models are needed to incentivise collaboration between GPs, pharmacists and other practitioners.

Innovation

We see fostering and spreading innovation as key to achieving a significant step change in how the NHS uses its resources and to securing markedly better health outcomes. We view innovation as encompassing both products (e.g. drug treatments and medical devices) and processes (e.g. clinical care, integrated inter-professional services, communication and information sharing). Commissioners of health services need high quality data about population health needs and the likely impact of different innovations on them to make effective investment decisions. For instance, innovations enabling early detection, prevention, cure or symptom alleviation of the common chronic conditions which account for the majority of ill-health and healthcare spending should be prioritised because they can make the biggest impact on life expectancy, quality of life and healthcare costs.^{ix}

Innovations are of interest to commissioners once they have demonstrated scalability (to create confidence that they do not just depend on a single enthusiast, and are capable of being delivered reliably at a certain volume) and cost-effectiveness. We have published evidence about pharmacy services for long-term conditions that meet these criteria.^x

Other changes required

Professional leadership

- Professional leadership is key: if practitioners cannot see a future for themselves in new service models, they are likely to slow down implementation through passive (or active) resistance. We would encourage more interaction between Local Medical Committees and Local Pharmaceutical Committees with the support of both SHAs and PCTs.

Improving quality and cost effectiveness

- Pharmacists have already demonstrated that they can both reduce the costs and improve the quality of prescribing decisions and thereby can help realise savings (for instance, potential annual savings of £227 million from switching to generic statins and three other commonly-prescribed drugs^{xi}). At the same time, better prescribing can reduce the number of adverse drug reactions which lead to emergency hospital admissions (the last Comprehensive Spending Review identified a reduction in emergency admissions through better care for those with long term conditions as a way of achieving substantial savings).

Workforce

- Pharmacists themselves must adapt their working practices to free up time for new roles to develop.
- Pharmacy education and training must be appropriate to these new roles – a requirement that the RPSGB is delivering through a major review, *Fit for the future*. We have already identified that the clinical content of training needs to be strengthened and properly funded.

Outcome measurement

- The impact of services for long-term conditions should be more rigorously monitored (there has been an over-emphasis on measuring processes rather than outcomes).

Safety

- A greater focus on patient safety is needed. Pharmacists can make an important contribution to improving safety at all stages of the medicines pathway.

Patient and public involvement

- Involving patients and the public from an early stage in the design of services can help ensure they are well targeted and meet patients' needs.

Pharmacists can make a valuable contribution in many areas and we stand ready to facilitate their involvement.

Yours sincerely

Hemant Patel
President
RPSGB

Paul Bennett
Chairman
English Pharmacy Board

Cc Mark Britnell
Director General of Commissioning and Service Management, Department of Health

ⁱ Blenkinsopp A, Bond C, Celino G, Inch J & Gray N (2007). *National evaluation of the new community pharmacy contract*. Pharmacy Practice Research Trust (confidential data, currently unpublished). The executive summary is available at <http://www.rpsgb.org/pdfs/pharmcontracteval.pdf>

ⁱⁱ National Audit Office (2007). *Prescribing costs in primary care. Executive summary* p. 6 para. 13. http://www.nao.org.uk/publications/nao_reports/06-07/0607454es.pdf

ⁱⁱⁱ <http://www.rpsgb.org/pdfs/ltcondintegcommphrept1.pdf>

^{iv} <http://www.rpsgb.org/pdfs/ltcondintegcommphrept1.pdf>

^v 'Wrong sort of competition' in NHS. Financial Times, 8th January 2008

^{vi} Blenkinsopp A, Bond C, Celino G, Inch J & Gray N (2007). *National evaluation of the new community pharmacy contract*. Pharmacy Practice Research Trust (confidential data, currently unpublished). The executive summary is available at <http://www.rpsgb.org/pdfs/pharmcontracteval.pdf>

^{vii} <http://www.rpsgb.org/pdfs/hpfeffectcommisreport.pdf>

^{viii} <http://www.rpsgb.org/pdfs/hpfeffectcommissexecbrief.pdf>

^{ix} Porter ME & Teisberg EO (2006). *Redefining health care: creating value-based competition on results*. Harvard Business School Press, pp. 140-143

^x <http://www.rpsgb.org/pdfs/ltcondintegcommphrept1.pdf>

^{xi} National Audit Office (2007). *Prescribing costs in primary care. Full report*, p 14 para. 2.17 http://www.nao.org.uk/publications/nao_reports/06-07/0607454.pdf

**Pharmacy Engagement Event
Minutes from meeting held at DH, Thursday 10th January 2008**

Present:

Keith Ridge, Mary Grafton, Angus Wrixon, Hemant Patel, Jeremy Holmes, Paul Bennett, Andy Murdock, Eileen Neilson.

Date of Events:

- 27th February in London.
- Manchester date TBC but should be no later than the following Tuesday.

Venue:

- It was agreed that this should ideally at the RPSGB.

Actions:

- RPSGB to confirm availability of venue
- Angus Wrixon to liaise with Deborah Oliver re making practical arrangements (using NHS PCC Event Team resource)

Attendees:

- Lord Darzi to attend the London event and film an intro for the Manchester event
- Invitation should come from the Review Team
- Important that initial invitation to reserve the date should go out w/c 14th January
- All parties to start collating potential attendees but some Chief Execs, Senior DH directors (eg Mark Britnell) and wider stakeholders should all be represented

Objectives / Themes / Outcomes:

- All agreed it is vital to generate real engagement as well as have practical outcomes from the event
- Senior figures outside the pharmacy arena should be invited – as should anyone who has an interest in making a contribution towards developing a clinical pathway
- Event should be positioned as an integrated, primary care event rather than purely pharmacy-led
- Potential morning theme was proposed for discussion and outcome – namely to take three of the eight clinical pathways to establish where pharmacy could make a major contribution and influence.
- Proposed that attendees split into 3 groups and take one pathway each.

- Proposed that groups would be facilitated by RPSGB and members of the English Board
- Potential afternoon session might be for delegates to establish the connections between primary and secondary care as they relate to pharmacy
- Proposed a plenary board is also incorporated into the event

Action:

All present to suggest candidate pathways for discussion

Other Actions and next meeting:

- All present agreed to become the Steering Group for the Events
- Angus Wrixon to liaise with Deborah Oliver – Comms Lead at RPSGB and other Comms Leads as stakeholders are identified
- Next meeting at 4.30pm on Monday 14th January at Skipton House or by teleconference to discuss draft programme and themes – and follow up on all action points above.