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**Target Paper**

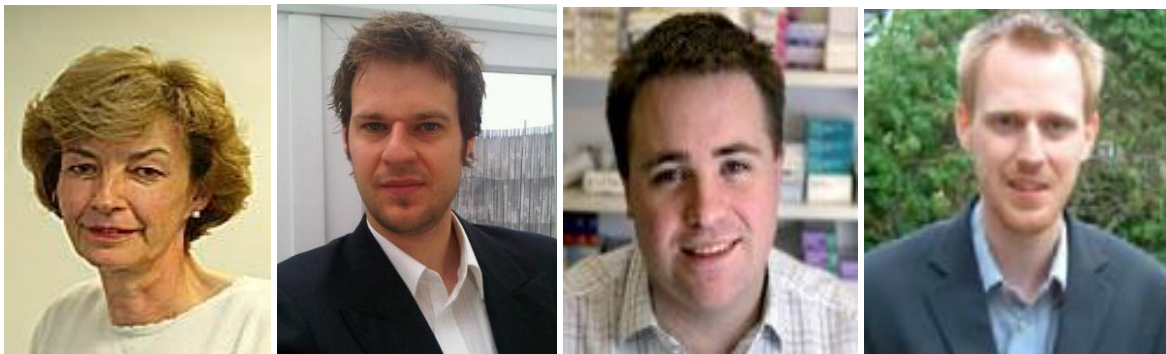


**Delivering Enhanced Pharmacy Services in a Modern NHS:  
Improving Outcomes in Public Health and Long-Term Conditions**

*The Bow Group Health Policy Committee  
(Ross Carroll, Michael Hewitson and Stuart Carroll)*

*with a foreword by Baroness Julia Cumberlege*

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### **Baroness Cumberlege**

Julia Cumberlege was raised to the peerage of Baroness Cumberlege of Newick in 1990. She has long-standing expertise in healthcare issues and served as Joint Parliamentary Under-Secretary from 1992-1997, and was Opposition spokesperson for health in 1997. In addition to a wealth of experience gained in senior health positions in public bodies, Baroness Cumberlege is Chair of the All Party Health Group, Vice-Chair of the All Party Maternity Group, and Vice-Chair of the All Party Pharmacy Group.

### **Ross Carroll**

Ross Carroll is a Public Policy and Government Affairs Manager. Ross is a qualified pharmacist and is a member of the Bow Group Health Policy Committee through which he has published policy papers on topics such as military healthcare. Ross has also published work on the development of the Northern Irish economy.

### **Mike Hewitson**

Mike Hewitson is a Community Pharmacy Contractor in West Dorset, and a member of the Bow Group Health Policy Committee. Mike has valuable expertise as a member of the Board of Management of the National Pharmacy Association, the Dorset Local Pharmaceutical Committee, the Healthcare Professionals Commissioning Network, and the Pharmacy Clinical Leadership Network. The opinions expressed in this document do not necessarily reflect any of these organisations.

### **Stuart Carroll**

Stuart Carroll is a Senior Health Economist and Policy Analyst, and the Chairman of the Bow Group Health Policy Committee. Stuart has authorship credits in a number of policy papers on topics including military healthcare, the National Institute for Health and Clinical Excellence (NICE) and the Quality and Outcomes Framework (QOF). Stuart is also a member of the Bow Group Council, where he serves as Treasurer.

# **FOREWORD**

## **Baroness Julia Cumberlege**

I am delighted that the Bow Group has undertaken this important research paper on the role of community pharmacy in the modern NHS. As Vice Chair of the Parliamentary All-Party Pharmacy Group (APPG), I have been closely involved in raising awareness about the value of community pharmacy and encouraging the Government to give the profession greater responsibility in NHS primary care and public health.

There is little doubt that the recognition of pharmacy's capability and expertise has really grown in recent years. Community pharmacy has so much to offer in the NHS, and can deliver real value as well as innovative solutions to the major challenges we now face.

Thanks in large part to the work of the APPG, all the main political parties understand this and agree that pharmacy must play a pivotal role in delivering extra frontline NHS services. What we need now is action.

One of the major benefits that pharmacy brings is the ability to operate in the heart of communities, providing healthcare to people who are often the hardest to reach but who need it the most. Community pharmacists are trained healthcare professionals and now offer a wide range of front line services that go above and beyond traditional medicine dispensing, whether this is vascular risk assessments or helping people manage serious and long term conditions such as diabetes. Equally exciting is pharmacy's potential in delivering changes to consumer behaviour. Public healthcare faces some grave challenges such as obesity, alcohol abuse and smoking related illness. Pharmacists are ideally placed to educate communities and make tangible progress in helping people lead healthier lives.

Just like the NHS as a whole, pharmacy faces a challenging economic and political environment, and it must adapt accordingly. While protected from cuts, the NHS and pharmacy will need to find ways of doing more for less. However the current climate should be viewed as a great opportunity for pharmacy, particularly if it can illustrate the long term cost benefits it can deliver. The Medicine Use Review (MUR) service for example can save the NHS huge amounts by educating patients with complex medicine regimes how to take their drugs properly, while the proposed First Prescription Service would provide much-needed support for patients with newly diagnosed long term conditions.

So what does the future hold for community pharmacy? While there has undoubtedly been real progress, particularly over recent years, I believe that the new Government needs to take faster action to capitalise fully on the profession's capability. Community pharmacy can tackle so many major challenges in healthcare, from the scandal of wasted medicines to the fight against sexually transmitted diseases. However there are barriers to progress that the

Government can remove with some simple and straightforward policy changes. I am concerned, for example, about patchy commissioning arrangements, and the Government must outline its new plans on how it intends to ensure that there is consistency in the commissioning of pharmacy services.

Over the coming months, the APPG will continue to communicate these concerns to policy makers, and work with Government on the issues that matter most to the profession. I feel hugely positive about the future of pharmacy, particularly if it can seize the initiative in the new look NHS. I hope that this report will play an important part in facilitating that progress.

**Baroness Cumberlege**

**31<sup>st</sup> August 2010**



The Bow Group (BG) was founded in February 1951 as an association of Conservative graduates, set up by a number of students who wanted to carry on discussing policy and ideas after they had left university. They were also concerned by the monopoly which socialist ideas had in intellectual university circles. It originally met at Bow, East London, from which it takes its name.

Geoffrey Howe, William Rees-Mogg and Norman St John Stevas were among those attending the first meeting. From the start, the Group attracted top-flight graduates and quickly drew the attention of a number of government ministers, notably Harold Macmillan. In the intervening time, Michael Howard, Norman Lamont and Peter Lilley have all held the BG chairmanship. Christopher Bland, the current Chairman of BT, was BG chairman in 1969. In the recent General Election five recent members of the BG Council were elected to the Commons.

Since its foundation the BG has been a great source of policy ideas, and many of its papers have had a direct influence on government policy and the life of the nation. Although it has no corporate view, it has at times been associated with views both of left and right - always within the broad beliefs of the Conservative Party. The BG has four clear objectives:

To contribute to the formation of Conservative Party policy

To publish members' work and policy committee research

To arrange meetings, debates and conferences

To stimulate and promote fresh thinking in the Conservative Party

**Recent publications include (all available at [www.bowgroup.org](http://www.bowgroup.org)):**

*'Equity and Excellence: Liberating the NHS' – Opportunities and Challenges*  
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*The Case for Energy Crops: How Developing Countries can Help Themselves & Boost UK Energy Security*  
Tony Lodge (BG Transport & Energy Committee) **July 2010**

*The Enterprise Nation? Developing Northern Ireland into an Enterprise Zone*  
Ross Carroll with a foreword by Lord Trimble (BG Economics Committee) **April 2010**

*The Quality and Outcomes Framework – What Type of Quality and Which Outcomes?*  
Gary Jones, Stuart Carroll & Jennifer White (BG Health Committee) **February 2010**

*The Right Track – Delivering the Conservatives' Vision for High Speed Rail*  
Tony Lodge with a foreword by Lord Heseltine (BG Transport & Energy Committee) **January 2010**

*"People Power: Reforming QUANGOs" – Is this Applicable to Health Agencies?*  
Stuart Carroll & Nick Hoile (BG Health Committee) including contributions from Sir Andrew Dillon, Dr. Richard Barker and Dr. Bill Moyes **November 2009**

*More for Less: Cutting Public Spending, Protecting Public Services*  
The Rt. Hon John Redwood MP & Carl Thomson (BG Economics Committee) **November 2009**

*Doing Veterans Justice: Conversations with the Forgotten Fighters*  
Ross Carroll, Stuart Carroll and Julien Rey (BG Health Committee) including contributions from Simon Weston OBE and Captain Surgeon Morgan O'Connell **June 2009**



**A Report by the Health Policy Committee of the Bow Group**

**(September 16<sup>th</sup> 2010)**

**Ross Carroll, Michael Hewitson and Stuart Carroll**

**Bow Group Health Policy Committee**

The Health Policy Committee is committed to researching and analysing the issues and challenges facing the NHS and wider healthcare sector as a result of Government policies. The Committee regularly meets to discuss new research projects and how it can support viable, sustainable and effective policies to improve the provision and delivery of healthcare services.

Chairman – Stuart Carroll

For more information about the Health Policy Committee, please contact Stuart Carroll on [health.policy@thebowgroup.org](mailto:health.policy@thebowgroup.org).

For more information about this paper, please contact Ross Carroll on: [rcarroll.health@gmail.com](mailto:rcarroll.health@gmail.com)

## **Technical Acronyms and Abbreviations**

ACTs	Accredited Checking Technicians
APPG	All Party Pharmacy Group
BMI	Body Mass Index
BMJ	British Medical Journal
CASH	Contraception and Sexual Health
C&D	Chemist and Druggist
CMS	Chronic Medication Service
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
DH	Department of Health
EHC	Emergency Hormonal Contraception
EPS	Electronic Prescription Service
EPSIF	Enhanced Pharmacy Service Innovation Fund
GP	General Practitioner
HAG	Harmonisation of Accreditation Group
HLP	Healthy Living Pharmacy
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LTC	Long-term conditions
MAS	Minor Ailments Scheme
MURs	Medicines Use Reviews
NAO	National Audit Office
NCSP	National Chlamydia Screening Programme

NICE	National Institute for Health and Clinical Excellence
NHS	National Health Service
NPAC	National Pharmacy Association Conference
NRP	Nicotine replacement therapy
NSCC	National Smoking Cessation Conference
QALY	Quality-adjusted life year
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
PBC	Practice Based Commissioning
PCT	Primary Care Trust
PSNC	Pharmaceutical Services Negotiating Committee
RPSGB	Royal Pharmaceutical Society of Great Britain
SHA	Strategic Health Authority
SLA	Service level agreement
WHO	World Health Organisation

## Executive Summary

- Despite the coalition Government's pledge to ring-fence the healthcare budget, the NHS is facing a sustained period of financial retrenchment and increased user demand. Against this backdrop – and the impact of the UK's parlous public finances – it is vital that all aspects of healthcare are examined to assess where increased value and quality can be delivered in a more cost-effective manner to foster improved patient outcomes.
- This research paper consulted a multitude of stakeholders to determine whether pharmacy – and specifically Enhanced Pharmacy Services – can play a role in improving health outcomes in public health and long-term conditions (LTCs).
- The conclusions drawn from our research suggest that Enhanced Pharmacy Services are an under-utilised resource that can deliver innovative, cost-effective services to patients in a highly accessible manner, whilst facilitating the NHS to achieve its Quality, Innovation, Productivity and Prevention (QIPP) objectives.
- For example, it is estimated that some 57 million GP consultations each year involve minor ailments, which could in most cases be dealt with at a pharmacy. The average cost of a pharmacy consultation (£17.75) relative to an average GP consultation (£32) is £14.25 less expensive. If all patients with minor ailments were to receive pharmacy consultations, then over £812 million could potentially be saved from the NHS budget. This equates to just over 4% of the Government's pledged £20 billion target for efficiency savings.
- Pharmacy Enhanced Services include smoking cessation, weight loss and sexual health programmes, and are therefore directly aligned with the Government's policy emphasis on public health and preventative healthcare. Furthermore, emergent Healthy Living Pharmacies (HLPs) have the potential to play a significant role in providing information to inform patients' health and lifestyle choices. 99% of the population can get to a pharmacy within 20 minutes by car and 96% can do so by walking or using public transport. Pharmacy therefore offers easy and equitable access for public health patients. Pharmacy Enhanced Services should therefore feature prominently in the new Public Health Service as a way to improve access and reduce health inequalities.
- It is reported that around 30-50% of patients do not take their medications correctly, whilst the cost of hospital admissions as a result of incorrect medicine usage could be up to nearly £200 million a year. This is a cost likely to increase as the population ages, and patients take more medications. Given the Government's policy that hospitals will be charged for patient readmissions occurring within 30 days of discharge, this paper recommends Medicine Use Reviews (MURs) should be conducted before and after planned hospital admissions for patients with LTCs to limit the effects of modifications to patients' medication regimens at the care interface.

- Despite some excellent outcomes from Pharmacy Enhanced Services in some areas of the country, commissioning of Enhanced Services is patchy and far from universal. There are numerous reasons for this, including poor measurement and capture of outcomes from Pharmacy Contractors; lack of understanding from commissioners; uncompetitive reimbursement rates for enhanced services; and a perception that GPs influence and preferences dominate local decisions.
- We recommend that sustained efforts are made to improve GP/pharmacists relationships where they are weak, and to further build upon relationships where they are strong. We suggest that local pharmacists have representation within local GP consortia and are represented on local Health and Wellbeing Boards to help optimise the local integration of patient care.
- The current Community Pharmacy funding mechanism encourages pharmacy contractors to obtain the best price for the medicines that they purchase for the NHS and in return contractors are allowed to retain some of these savings. Anything in excess of the agreed cap is returned to the Department of Health (DH). These are in essence additional windfall savings to the taxpayer and are generated through the hard work and diligence of pharmacy contractors. We recommend these savings are retained within pharmacy through the establishment of an “Enhanced Pharmacy Service innovation fund” – EPSIF. We propose that this fund should sit outside of the DH– free from political interference – and should serve to enable evidenced based commissioning of Pharmacy Enhanced Services to improve local health outcomes.
- Although there are important issues pertaining to practical implementation – such as a transient patient population – the concept of a pharmacy Quality and Outcomes Framework (QOF) is something that appears to be viewed as broadly workable and favourable by those submitting views to this paper. We recommend that the Government looks to develop a truly outcomes-based pharmacy QOF that complements – and where appropriate has confluence with – the existing GP QOF.
- The current economic climate and the UK’s parlous public finances throws up many important policy challenges across all Government departments. The NHS may be the Government’s foremost sacred cow, but this does not mean the NHS is somehow immune from unprecedented and costly healthcare challenges or is exempt from the Whitehall efficiency drive. It is from this perspective that fresh thinking, a new approach and programme of service reform are desperately needed.
- If the Government is to have a realistic chance of achieving its stated objectives – a genuinely patient-centric service; shifting care to the community setting; improving patient health outcomes and patient experiences; and facilitating a more economically affordable NHS – it is imperative the skills and expertise of all healthcare professionals are fully optimised and utilised. As this paper shows, in some areas pharmacy and pharmacists – as accessible frontline healthcare professionals – are making a valuable and telling contribution to achieving these objectives. We believe that by addressing the issues raised in this paper there is

significant scope for this contribution to be further enhanced across all parts of the country.

- For far too long, politicians on all sides have caricatured the NHS as being a service of “doctors and nurses”. A quick comb through major political speeches on the NHS since 1948 shows as much. Despite the excellent work undertaken by doctors and nurses, the reality is that the NHS is a multi-dimensional service spanning way beyond two medical professions. The wider skill mix of the NHS is far too frequently a background political thought. It is this thought process that has all too often pigeonholed policy thinking on how best to deliver frontline health services.
- In the “new era of politics” with a “new kind of Government”, it is essential the NHS takes advantage of the opportunity to better reach out to all healthcare professions and healthcare professionals. This will be to the benefit of patients and their health outcomes. It is from this perspective that pharmacists should be fully utilised and with it their skills, expertise and accessibility to help facilitate a better NHS.

## 1. Introduction

The aftermath of the credit crunch – and the ongoing squeeze on the UK’s heavily strained public finances – has affected the spending plans of all Government departments. The NHS is no different. Despite the Coalition Government’s pledge to ring-fence health spending, the NHS has been tasked with finding £20 billion of savings from 2011 to 2014. Moreover, the health service has become used to annual budgetary increases averaging 7% per year since 2000 meaning that ring-fencing the existing budget alone will feel like a budget cut across the health service. Even the NHS as the sacred cow of Government policy is not immune from the new “Age of Austerity”.

This new economic reality is brought sharply into focus when considering demographic pressures up to 2017, namely the UK’s aging population and increased public health challenges, are likely to cost the NHS an additional £1.1-1.4 billion per year.<sup>1</sup> Furthermore, the recent publication of the Government’s NHS White Paper, *‘Equity and Excellence: Liberating the NHS’*, has signaled wholesale changes to the NHS, with particular focus on greater patient engagement and improving patient health outcomes through the emphasising of quality and outcomes, and devolving commissioning responsibilities to local GPs.<sup>2</sup>

With the sharpened economic context in mind, it is vital that every area of healthcare delivery is scrutinised to assess and evaluate where improvements can be made and where the provision of healthcare to patients can be optimised. It is the purpose of this paper to research and review the role pharmacy – specifically Enhanced Pharmacy Services – can play in facilitating improved cost-effectiveness, patient involvement and health outcomes in the modern NHS.

## 2. The role of pharmacy

The role of pharmacy has evolved significantly throughout the last decade, and is set to evolve and expand further across the current Parliament and beyond. The traditional role of the pharmacist – stereotypically depicted as an individual attired in a white coat, stationed in the dispensary, and assiduously counting tablets to complete a patient’s prescription – has developed markedly in recent times.

Pharmacists study for four years, and then typically train in either the NHS or the community setting for a fifth year under professional supervision, before sitting a professional qualification and eventually being registered to practice. Throughout this half decade of studying, pharmacists learn an extensive amount about human biology, physiology and pharmacology, whilst developing expertise in medicines management and pharmacotherapy.

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<sup>1</sup> The Kings Fund and Institute for Fiscal Studies: How cold will it be? Prospects for NHS funding 2011 – 2017. July 2009.

<sup>2</sup> See S. Carroll S & G. Jones, “‘Equity and Excellence: Liberating the NHS’ – Opportunities and Challenges”, Bow Group Health Policy Committee’s response to the Government’s White Paper, August 2010.

However, as the population ages, and in turn the prevalence of LTCs and public health problems such as obesity, alcohol abuse and sexually transmitted diseases increases, the strain currently placed on general practice and the acute sector is set to appreciably intensify. It is from this perspective that policymakers will look to further utilise many of the key skills and expertise of pharmacists in order to alleviate this burden and optimise the delivery of improved patient health outcomes.

The last decade has witnessed an increase in the provision of what is known as “Enhanced Services” – services such as smoking cessation, anticoagulation monitoring, cholesterol checks and even prescribing itself. It is pharmacists who are now increasingly responsible for, and engaging with, this wide range of healthcare services previously considered to be outside of their clinical domain and professional remit. Moreover, it is very likely that the range of these services delivered by pharmacists will increase throughout the life-cycle of the current Parliament surpassing the 2010 General Election and beyond. However, the provision of Enhanced Services is currently patchy, with pockets of local “best practice”, but a lack of universal excellence across the country.

With the above challenges in mind, this paper is designed to explore and examine how pharmacy – with a specific focus on Enhanced Services – can help the Government combat the increase in costs associated with LTCs and achieve its stated public health aspirations for local healthcare delivery. Specifically, we analyse what Enhanced Services are currently being delivered and why these services are seemingly not being optimised more extensively throughout the healthcare system. We consider what incentives might be required to see Enhanced Services delivered more universally; what Enhanced Services should be delivered in the future; and what measurement and outcomes are needed, and if this could potentially lead to the development of a pharmacy Quality and Outcomes Framework (QOF).

### 3. Public health challenges

Many public health problems across the UK are now approaching crisis point, both in terms of health outcomes and cost to the economy. Some examples of this are illustrated below:

- Britain now has the **highest obesity rates in Europe**, with obesity responsible for increasing the prevalence of diseases such as diabetes, cancer and heart disease in patients.<sup>3</sup> The 2007 Foresight Report into Obesity projected that the costs to the NHS attributable to overweight and obesity would double to £10 billion per year by 2050, with costs to society and business at today’s prices estimated to reach **£49.9 billion per year**.<sup>4</sup>
- The UK has amongst the **worst rates of sexually transmitted infection**, although the cost of this to the NHS has not been calculated. According to data from the Office for National Statistics, 41,325 girls under 18 in England and Wales fell pregnant in 2008, while the number of pregnancies among under-16s was 7,577.

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<sup>3</sup> D. Haslam & W. James, Obesity, The Lancet, Volume 366, Issue 9492, Pages 1197-1209..

<sup>4</sup> ‘Tackling Obesity: Future Choices’, The Foresight Report, 2007.

- **Rising rates of alcohol abuse** have been witnessed over the last decade, and this is projected to cost society anything up to **£25.1 billion a year**<sup>5</sup>, with hospital admissions and deaths due to alcohol poisoning rising over the last decade.<sup>6</sup>
- However, **drug and alcohol abuse** charity Addiction have placed the cost of drug abuse at **£110 billion** from 1998 – 2008 in terms of health treatment costs and crime.<sup>7</sup>
- Despite continuous tax increases and legislation to ban smoking in public places, **smoking-related disease** continues to claim over **84,000 lives every year**.<sup>8</sup> The direct cost of this to the NHS alone is over **£5 billion**<sup>9</sup> – around 5% of the entire English NHS budget – and this is not considering the wider societal impact that 84,000 deaths a year brings to the economy.

It is clear that, collectively, the figures above represent a stark and unsustainable reality vis-à-vis the public health challenges that continue to undermine UK health outcomes. Furthermore, it is clear that as well as impacting the health care sector, if these challenges are not confronted, the health and productivity of the UK population will dramatically diminish adding productivity losses and inefficiency to an already beleaguered UK economy. Dame Carol Black – the Government Director for Health and Work – has estimated the cost of dealing with sickness among people of working-age at over £75 billion every year with the **loss to the wider economy at almost £130 billion**.<sup>10</sup> In times of economic boom, this figure would beg immediate action. In times of financial crisis and desperately needed economic growth, it is completely unsustainable.

#### 4. Long-term conditions (LTCs)

In addition to the aforementioned growing public health issues, another area that is going to impose additional pressures on health and societal resources are LTCs. This is in some way inter-related, as LTCs can include diabetes, heart disease or Chronic Obstructive Pulmonary Disease (COPD) that can be derived from poor public health outcomes, although other conditions, such as rheumatoid arthritis, Parkinson’s disease or asthma are more distinct from the public health agenda.

Roughly 15.4 million people in England live with a LTC,<sup>11</sup> equivalent to around one in three of the total population and therefore impacting a number of working age adults with a commensurate effect on the UK economy. Given the well-documented fact that the UK

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<sup>5</sup> ‘Tougher laws for drinks industry could be imminent’, DH press release, 22nd July 2008.

<sup>6</sup> NHS Information Centre, Statistics on Alcohol: England, 2009.

<sup>7</sup> Addiction, ‘Cost of the UK’s illegal drug problem’, 25 February 2008

<sup>8</sup> NHS smoking information card

[http://www.pharmacymeetspublichealth.org.uk/pdf/SMOKING\\_cards.pdf](http://www.pharmacymeetspublichealth.org.uk/pdf/SMOKING_cards.pdf), Accessed August 2010.

<sup>9</sup> BBC, Smoking disease costs NHS £5bn, 8<sup>th</sup> June 2009

<http://news.bbc.co.uk/1/hi/health/8086142.stm>, Accessed September 2010.

<sup>10</sup> Dame Carol Black, ‘Working for a healthier tomorrow’, 17<sup>th</sup> March 2008.

<sup>11</sup> Department of Health, ‘Long-term Conditions’,

<http://www.dh.gov.uk/en/Healthcare/Longtermconditions/index.htm>, Accessed September 2010.

population is ageing, it is estimated that the number of people in England with a long-term condition will rise by 23% over the next 25 years.<sup>12</sup>

Responding to the demographic pressures of an ageing population and increased public health challenges – with subsequent increased demand on the NHS – it is estimated to cost an additional £1.4 billion a year alone.<sup>13</sup> This is salient in wider economic terms, but is more acutely critical for the NHS when considering the DH's best estimate that treatment and care of those with LTCs accounts for 69% of the total health and social care spending in England. To put it another way, £7 in every £10 spent.<sup>12</sup>

Furthermore, patients with LTCs are intensive users of the most expensive healthcare services, with 5% of the patients occupying 60% of all hospital beds; 52% of all GP consultations; and 65% of all out patient appointments.<sup>14</sup> This is important as it is known that the proportion of the NHS budget spent in hospitals is significant, estimated to be anywhere from 60% to 76%.<sup>14,15</sup> Better management of these conditions will mean moving patients out of hospitals where appropriate, with treatment taking place in the community and nearer to their home. This has already informed the thinking of recent policy documents (See Figure 1)

A final related point is the challenge of achieving universal medicines adherence by patients, which is critical in patients with LTCs; many of whom are on a number of different medications. Reviews across different disease areas reports that between 30% and 50% of patients do not take or use their prescribed medicines as recommended by their prescriber, with the World Health Organisation (WHO) having identified several long-term, chronic conditions in which levels of medicines adherence in developed countries are a particular problem. These include asthma, depression, diabetes, epilepsy and hypertension.<sup>16</sup> Medicines supplied on prescription cost the NHS £8.1 billion in 2007–08. If as many as 50% of patients don't take their medicines as recommended, this could mean that £4 billion of medicines are not used correctly, with a sub-optimal patient outcomes and potentially needless – and costly – hospital admissions occurring as a direct consequence.

#### 4.1. Key recommendations

**★ Given pharmacists are medication experts and LTC prevalence is likely to increase in line with the aging population, pharmacy should have a greater role in treating LTCs, helping to optimise the use of medicines, reduce waste and monitor health goals.**

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<sup>12</sup> Technology Strategy Board. Driving Innovation. 'Managing Long-Term Conditions – Remote Monitoring', April 2009, [http://www.innovateuk.org/assets/pdf/competition-documents/briefs/sbri-longtermconditions\\_02.pdf](http://www.innovateuk.org/assets/pdf/competition-documents/briefs/sbri-longtermconditions_02.pdf). Accessed September 2010.

<sup>13</sup> The Kings Fund and Institute for Fiscal Studies: How cold will it be? Prospects for NHS funding 2011 – 2017. July 2009.

<sup>14</sup> Policy Exchange: Controlling Public Spending: The NHS in a tight period of public funding, 7<sup>th</sup> January 2010.

<sup>15</sup> Reform, 'Fewer Hospitals, More Competition', March 2010.

<sup>16</sup> NICE. Costing statement: Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence, <http://www.nice.org.uk/nicedia/pdf/CG76CostStatement.pdf>, Accessed September 2010.

★ Pharmacy should be integrated into care pathways for LTCs, utilising professional expertise where appropriate.

## 5. Does pharmacy have a role?

From the perspective of increased public health challenges and the entrenchment of LTCs, and given the austere economic outlook defined by tightened public spending, it is clear that all parts of the healthcare system must look to deliver more efficient, effective and innovative services to tackle these ongoing problems. Pharmacy is well placed to increase its contribution to these critical areas of public health and LTCs. This is something noted by the Conservative Party in its *Healthier Nation* pre-election Green Paper:

*“Pharmacies and their staff are a vital resource for healthcare and condition management; they are close to the communities they serve and well placed to provide information about medical conditions, lifestyle choices and medicines management; they are many people’s most frequent link to a knowledgeable health professional. There are some excellent examples of best practice that have been seen in some pharmacies, including offering cholesterol, Chlamydia and blood sugar tests or providing computer terminals to enable people to research and print information on their condition and how it can best be managed. A Conservative government would support proposals to develop pharmacist involvement in the area of preventive care such as health checks. Once accepted, these measures would be integrated into the Pharmacy Contract.”<sup>17</sup>*

The important role that pharmacy is likely to have in meeting future public health priorities can be further attested to by recent pronouncements from each of the three main political parties. **Mark Simmonds MP**, former Conservative Shadow Minister for Health with responsibility for pharmacy, has been noted as stating:

*“Pharmacists are well located in their communities, and many offer excellent additional services, such as quitting smoking clinics, weight management advice and medicines use reviews. Personally, I would like to see a greater role for pharmacists in providing this information and advice, as many people, particularly men, are reluctant to visit their doctor, but more willing to visit their local chemist to seek healthcare advice.”<sup>18</sup>*

Highlighting the fact that the Liberal Democrats also place an importance on pharmacy, **Norman Lamb MP**, the Liberal Democrats former spokesman on health, has stated:

*“The network of community pharmacies has a really important role to play in screening and awareness about a host of health issues like smoking and obesity. At the moment PCTs stand passively by as NHS money is diverted to other areas. Instead you could incentivise them to use the forces available, including pharmacies, to make it happen.”<sup>19</sup>*

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<sup>17</sup> Conservative Party. A Healthier Nation. Policy Green Paper No.12.

<sup>18</sup> Mark Simmonds MP, <http://www.marksimmonds.org/text.aspx?id=71>, Accessed September 2010.

<sup>19</sup> Chemist and Druggist, ‘Lib Dems: Star Role for Pharmacy in NHS Vision’, 8<sup>th</sup> April 2010, [http://www.chemistanddruggist.co.uk/c/portal/layout?p\\_1\\_id=259751&CMPI\\_SHARED\\_articleId=3911837&CMPI\\_SHARED\\_ImageArticleId=3911837&CMPI\\_SHARED\\_articleIdRelated=3911837&CMPI\\_SHARED\\_ToolsArticleId=3911837&CMPI\\_SHARED\\_CommentArticleId=3911837&articleTitle=Lib](http://www.chemistanddruggist.co.uk/c/portal/layout?p_1_id=259751&CMPI_SHARED_articleId=3911837&CMPI_SHARED_ImageArticleId=3911837&CMPI_SHARED_articleIdRelated=3911837&CMPI_SHARED_ToolsArticleId=3911837&CMPI_SHARED_CommentArticleId=3911837&articleTitle=Lib), Accessed September 2010.

**Mike O'Brien MP**, the last Labour Government minister with responsibility for pharmacy stated in a House of Commons debate in 2010:

*“Pharmacy has an important contribution to make to improving public health and reducing health inequalities. One of the themes in our 2008 White Paper ‘Pharmacy in England: building on strengths-delivering the future’ was to help people to self-care-to improve their health and well-being and to take better care of themselves. Work is progressing on a framework to transform into healthy living pharmacies, focusing on prevention as well as cure. We have also published a number of educational resources to help pharmacy staff deliver advice to members of the public on subjects including stopping smoking, weight management and physical activity.”<sup>20</sup>*

There would therefore appear to be a degree of cross-party support for building upon – and evolving – the role that pharmacy can play in improving health outcomes. Indeed, the newly appointed Under-Secretary State for Health **Earl Howe** addressed the All Party Pharmacy Group (APPG) in July 2010, stating that he would like to see pharmacy aid the improvement of health outcomes in public health and LTCs through innovative Enhanced Services and the pharmacist’s role as medicines management experts.

## 6. Recent policy direction

Whilst all the main political parties appear to expound the great importance of the role pharmacy must play to improve public health outcomes over the next decade, it is important that such statements are congruent with the wider direction of health policy for the NHS. This is critical for ensuring services are integrated to achieve optimal care and outcomes for patients. Indeed, **Earl Howe** mentioned at the APPG meeting that he does not want to see past work that is progressive go to waste, with the positive elements of the past pharmacy White Paper retained where it conflates with the Government’s new NHS White Paper.

Despite what some would see as capricious changes in policy over the last 13 years, the broad direction of travel from the previous Labour Government was to pursue a “patient-centric” health service that focuses on preventative measures and that recognised the concept of patient choice, with a concomitant drive to treat patients outside of the acute sector and in community care. This has recently come into sharper focus due to the parlous state of public finances and given that upwards of 76% of the NHS budget is spent in hospitals,<sup>21</sup> with subsequent decisions taken by clinicians accounting for 80% of overall hospital spending.<sup>22</sup> This contrasts with community services that account for just 10% of all healthcare purchased by the NHS in 2008/2009.<sup>23</sup>

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<sup>20</sup> Hansard, Mike O’Brien MP, 26<sup>th</sup> February 2010.

<sup>21</sup> Policy Exchange: Controlling Public Spending: The NHS in a tight period of public funding, 7<sup>th</sup> January 2010

<sup>22</sup> E. Bury et al (2007), “How service-line management can improve hospital performance”, Health International, Vol. 7, pp. 54-65.

<sup>23</sup> Audit Commission, ‘More for less: are productivity and efficiency improving the NHS?’, Health Briefing November 2009.

*'Equity and excellence: Liberating the NHS'* in some respects continues – and in other respects dramatically develops – the momentum towards a truly patient-centric NHS, devolving decision-making as close to the patient as possible, whilst providing mechanisms for patients to be at the heart of everything the NHS does. The White Paper also makes clear that pharmacists have a role to play in delivering the aspirations this policy document sets out, whilst highlighting that increased patient choice and patient involvement requires the patient, as part of this “deal”, to take a greater responsibility for their own care. Specifically, the White Paper states:

*“We are also clear that increasing patient choice is not a one-way street. In return for greater choice and control, patients should accept responsibility for the choices they make, concordance with treatment programmes and the implications for their lifestyle.”<sup>24</sup>*

It is here that pharmacy can potentially play a great role in informing patients about health and lifestyle decisions. This is not least the case given the great accessibility and convenience associated with a patient visiting a pharmacy (see page 20).

**Figure 1** (see next page) summarises the key policy papers from the last five years relating to pharmacy.

## **7. How *can* pharmacy contribute to improved public health outcomes?**

In a recent speech to the Faculty of Public Health conference, **Secretary of State for Health Andrew Lansley MP**, stated:

*“Public health efforts, which only try to control supply, will fail. We have to impact on demand. That means we have to change behaviour, and change people's relationships with each other and with drugs, alcohol, tobacco and food... that is why, contrary to the media reporting, I applauded Jamie Oliver's initiative on school dinners and when he went to Rotherham - because Jamie 'got it'. He got that it's not just about a witch hunt against saturated fats, salt and sugars. It's about creating a better understanding of, and relationship with, good food and diet. And even more, it's about self-confidence - it's about building self-esteem.”<sup>25</sup>*

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<sup>24</sup> Department of Health, 'Equity and Excellence: Liberating the NHS', July 2010.

<sup>25</sup> Andrew Lansley MP speech: 'A new approach to public health'.

[http://www.dh.gov.uk/en/MediaCentre/Speeches/DH\\_117280](http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_117280), Accessed September 2010.

## Figure 1: Recent Policy Direction for Pharmacy

> In 2006 **'Our health, our care, our say'**, supported local innovation and reform, whilst encouraging the use of new providers to move services to the community. It highlighted the need for service redesign so that "more care [is] undertaken outside hospitals and in the home." It also contained a chapter on "better access to community services" and within this predicated the expanded use of pharmacies and extended pharmacy services.

> In 2008 **Lord Darzi's Next Stage Review** set out a vision to improve quality of care for all, creating a more responsive "locally-led, patient-centred, clinically driven" service. It called for the further expansion of community services, moving caring closer to the home and the integration of primary and secondary care. In relation to Enhanced Services such as vascular health checks, it stated that "in particular, we believe that pharmacies have a key role to play as providers of prevention services."

> In 2010, the previous Labour Government's last White Paper, **'NHS 2010 - 2015: from good to great'** stated that "significant transformation in the way in which care is delivered" is to be pursued, with the development of care in the community expected to bring annual savings of £2.7 billion. In relation to pharmacy and its role, it stated: "Pharmacies are a crucial local partner, and are well-positioned to provide personalised health advice within local communities."

> The coalition Government published ***Equity and Excellence: Liberating the NHS*** in July 2010, with the overarching aim of devolving decision making as close to the patient as possible and focusing heavily on improving health outcomes. It also makes clear that patients will be required to take a greater responsibility for making informed health and lifestyle choices. Pharmacists, working with doctors and other health professionals, have an important and expanding role in optimising the use of medicines and in supporting better health, whilst pharmacy services will benefit from greater transparency in NHS pricing and payment for services.

In addition to these more general White Papers, there has been a handful of pharmacy specific policy documents published over the past decade. In particular, there are two key documents:

> In 2005, **'Choosing health through pharmacy: A programme for pharmaceutical public health 2005 – 2015'**, was published, aimed at "releasing the potential" of pharmacy with regards to public health. Some public health priorities for pharmacy were advocated, including: reducing smoking, heart disease, strokes and cancer; under 18 conception rate; tackling obesity in children; health inequalities; LTCs; suicide and undetermined risk and other interventions to improve health and reduce health inequalities.

> In 2008, **'Pharmacy in England: Building on Strength, Delivering the Future'** aimed to set out a vision for building on the strengths of pharmacy, using the sector's capacity and capability to deliver further improvements in pharmaceutical services over the "coming years" as part of an overall strategy to ensure safe, effective, fairer and more personalised patient care.

Despite the mass media coverage surrounding Lansley's comments concerning celebrity chef Jamie Oliver, more noteworthy was the Secretary of State's comments that achieving better public health outcomes involves a behavioral change in the consumer, driven by robust information and education, along with personal responsibility. This is the very essence of public health and the very essence of the policy challenge confronting the Government.

Pharmacies can aid this process in many ways, not least given they are highly accessible health outlets and can therefore target the "difficult to reach" patient groups in a way other health services have more difficulty in doing. Indeed, 99% of the population, even those living in the most deprived areas, can get to a pharmacy within 20 minutes by car and 96% can do so by walking or using public transport. In addition, pharmacy opening hours are often greater than those of GP surgeries. Therefore, stronger commissioning of appropriate services from community pharmacy can provide people choice of service provider and ensure that hard to reach groups – such as rural communities or the working age population – have easy access to primary care health professionals.

Accessibility of services is of course important but the primary concern of the NHS still has to be one of improved patient outcomes, and more details regarding the positive outcomes associated with local smoking cessation, obesity reduction or prevention of sexually transmitted diseases are highlighted in Section 11. In addition to outcomes, innovative and preventative service provision is critical as part of the QIPP agenda, designed to maximise quality in straitened times.

An example of this is the evolution of services provided by some pharmacies in Portsmouth has seen the development of "healthy living pharmacies". This concept – given pharmacy's ability to reach all parts of the population as described above – conflates with Mr. Lansley's vision about changing individuals understanding and behaviour based upon evidence based information and an understanding about how patients lead their lives. This concept also resonates with the Conservative's stated objective to unleash an "information revolution" across the NHS to health improve patient choice and drive up quality. In the arena of public health, pharmacies are well placed given their accessibility and the skills set of their staff to provide public health information and appropriate interventions to patients and the public as part of a "healthy living pharmacy" initiative.

There is also a compelling economic argument for commissioners to consider appropriate pharmacy services, as they are often simple and cost effective ways to help ensure world class standards for commissioning are achieved as quickly as possible. Furthermore, it is estimated that some 57 million GP consultations each year involve minor ailments, which could be dealt with at a pharmacy.<sup>26</sup> The average GP surgery consultation lasts 11.7 minutes and costs £32.<sup>27</sup> The same 11.7 minute consultation in pharmacy would cost £17.75.<sup>28</sup> If these patients could be moved to pharmacy then over £812 million could potentially be saved. This is a significant amount of money – approximately 4% of the £20 billion the NHS needs to save – that could be saved through a fairly simple policy change.

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<sup>26</sup> Joint paper submitted to the DH by the PSNC and the Proprietary Association of Great Britain, December 2007.

<sup>27</sup> Personal Social Services Research Unit, *Unit Costs of Health and Social Care 2008*, 23<sup>rd</sup> December 2008.

<sup>28</sup> Personal Social Services Research Unit, *Unit Costs of Health and Social Care 2008*, 23<sup>rd</sup> December 2008.

Pharmacy services in Finland have demonstrated impressive reductions in GP appointments (down 6.2 million/year and saving €300m/year) and emergency visits (750,000/year and saving around €70m/yr) simply by offering patients advice, improving adherence to prescribed medicines, and correcting prescribing errors.<sup>29</sup> In addition, findings presented to the 2010 International Pharmaceutical Federation conference in Lisbon showed that pharmacies had managed to reduce the number of prescriptions by 2.6 million/year and had prevented 123,000 nights in hospital – this alone saved the equivalent of €565 million (approximately £470 million).<sup>30</sup> Given the larger relative population size in the UK, potential savings could be much bigger if replicated in the UK.

## 8. The importance of long-term conditions (LTCs)

Many of the issues outlined in Section 7 equally apply to LTCs. However, one of the major issues with LTCs that is divergent from public health challenges pertains to the interface between care, be it primary and secondary care, or the interface between secondary care and the return home of a patient who may be on multiple medications, having seen numerous healthcare professionals throughout their care pathway. Here, pharmacy can help prevent medication errors, which may worsen patient outcomes and potentially cause costly and needless admissions to the acute sector. From a medicines perspective, this could therefore help to further integrate care.

**Bob Wilson, Associate Director of Pharmacy, Policy and Prescribing at Leicestershire County and Rutland Primary Care Trust (PCT)** commented: *“Pharmacy services are often cheaper and therefore better value for money than other contractors providing similar services. Under the ‘any willing provider’ principle (increasingly the case), this means that any provider including pharmacy can pitch on a more even footing. With regards to public health, look at Emergency Hormonal Contraception (EHC) as an example that has worked very well (ease of access and quality service has resulted in use by a large number of women.) When considering Long Term Conditions, medication errors can occur as patients move between healthcare sectors. Pharmacists have regular contact with patients on repeat medicines and therefore, medicines support services to reduce errors are key. Pharmacists could be paid to provide services which deliver elements of care pathways for LTCs as they have the knowledge and expertise, and often extended opening hours which provides the necessary patient support and extended access to that support.”*<sup>31</sup>

**Kevin Noble, Community Pharmacy Lead at Isle of Wight PCT** agreed: *“There are opportunities to commission effective medicines management services via community pharmacy, and such services could provide positive outcomes for the NHS. Services should be commissioned where pharmacy interventions demonstrate cost saving outcomes.”*<sup>32</sup>

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<sup>29</sup> The Association of Finnish Pharmacies. Annual Report, 2009.

<sup>30</sup> C. Chapman, ‘Pharmacies save £460m in advice, study finds’, Chemist & Druggist. 2<sup>nd</sup> February 2010.

<sup>31</sup> Personal communication, August 2010.

<sup>32</sup> Personal communication, August 2010.

## 9. Footfall in pharmacy

As discussed, a key benefit for policymakers and healthcare commissioners of community pharmacy based services is the ability to reach a large number of people; many of whom may not be accessible to other primary care services. **Figure 2** below gives an approximation of the number of pharmacy visits versus General Practice visits per year. Data is approximate due to the dynamic nature of the community pharmacy patient population.

**Figure 2: Pharmacy versus GP visits per year in the UK**

Location	Est. visits/day	Est. visits/year
Community Pharmacy - specific health advice	260,000	95 million
Community Pharmacy - prescriptions and other purchases	1,540,000	560 million
Community Pharmacy - all visits	1,800,000	655 million
General Practice	510,000	186 million

*Source: IDS UK Healthcare Marketing Brochure.*

As pharmacies are located in the heart of their communities, they have the potential to access difficult to reach patient groups such as minority ethnic and disadvantaged groups.<sup>33</sup> It is this demographic and throughput which makes pharmacy a crucial partner in addressing the key public health challenges for the 21<sup>st</sup> century.

## 10. What Enhanced Services do pharmacies currently deliver?

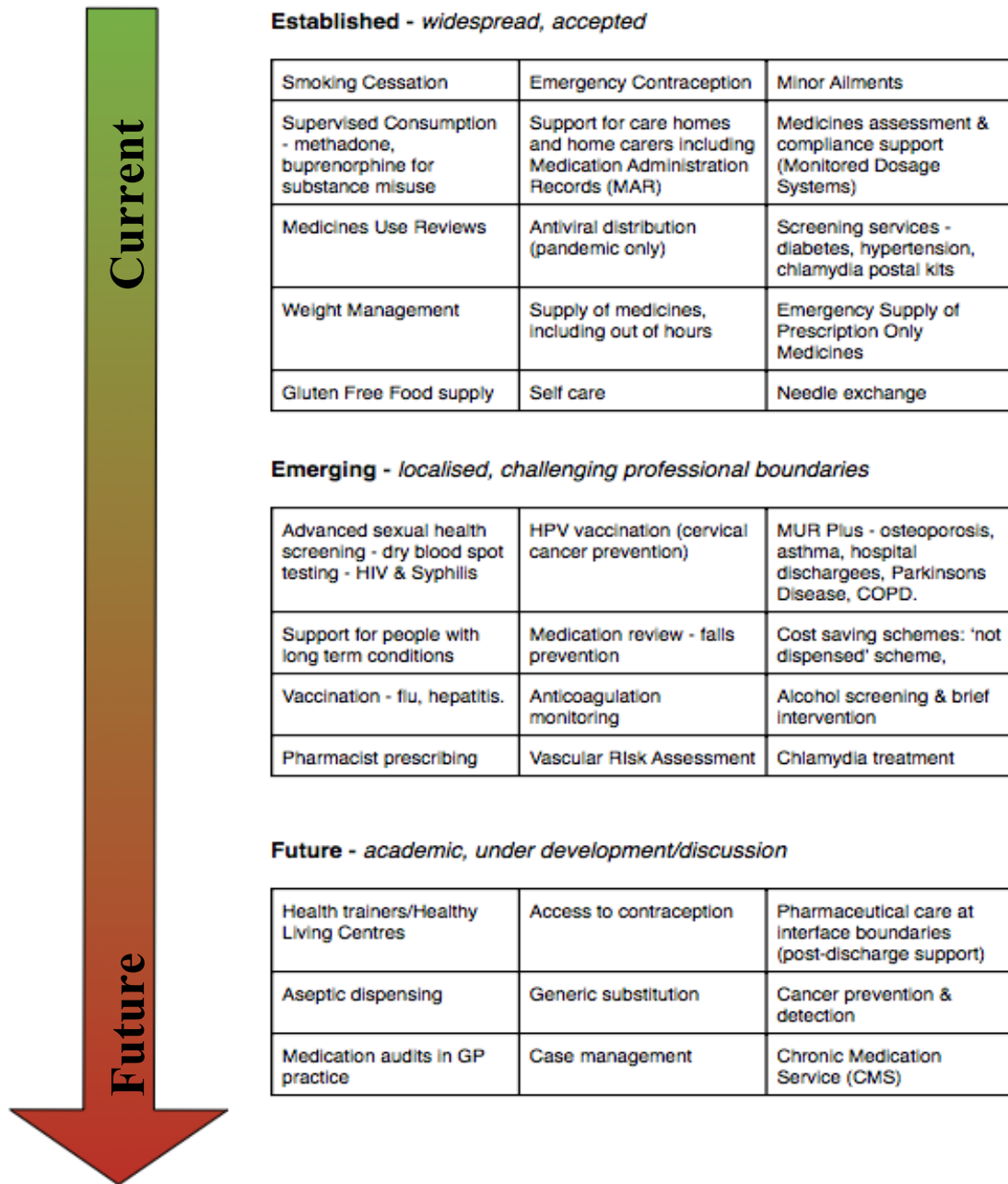
The 2005 Pharmacy Contract brought the opportunity for PCTs to commission Enhanced Services from pharmacies. Since that time, a number of new services have been designed to meet local health needs and the range of services on offer currently – with prospective future services – is outlined in **Figure 3**.

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<sup>33</sup> NICE, 'Smoking Cessation Services in Primary Care', February 2008

Figure 3: Development of Pharmaceutical Services

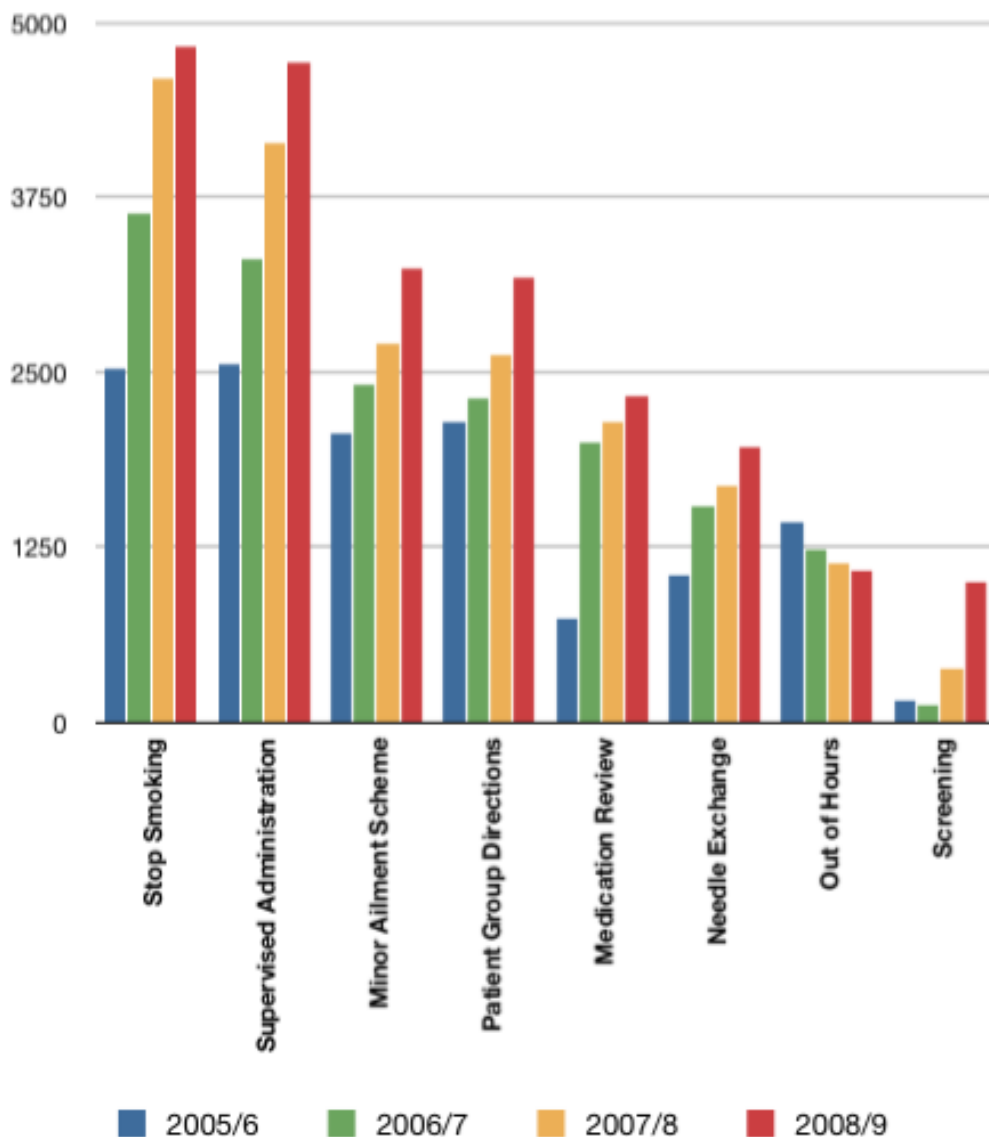
## Development of Pharmaceutical Services in the UK



Although many PCTs offer basic enhanced services such as emergency contraception schemes to reduce teenage pregnancies, the specifications, payments, paperwork and importantly qualifications for each service vary from PCT to PCT. **Figure 4** shows the numbers of pharmacies in contract for the most popular enhanced services.

**Figure 4: Number of pharmacies in contract for Enhanced Services. Source – General Pharmaceutical Services in England and Wales, NHS Information Centre, November 2009.**

**Number of Pharmacies in Contract for Enhanced Services in England 2005-2009**



*NB: Patient Group Directions includes supply of Emergency Contraception  
Medication Review excludes the MUR service*

It is therefore an important question to ponder as to how pharmacy can contribute to improving public health outcomes.

## 11. How *does* pharmacy contribute to improved public health outcomes?

Public health challenges for the NHS are stark: persuade patients to eat better and less; exercise more; drink less alcohol; and stop smoking. The four horsemen of the apocalypse together account for more than £9.4 billion in direct costs to the NHS each year.<sup>34</sup> However, studies have shown that even in these cash-strapped times, that investment in prevention initiatives is a sound business strategy (Figure 5).<sup>35</sup>

**Figure 5: Investment and potential saving for alcohol, smoking and obesity**

Behaviour	Investment	Potential Saving
Alcohol	£0.8 million	£3.3 million
Smoking	£0.3 million	£1.2 million
Obesity	£2.0 million	£2.2 million
Total	£3.1 million	£6.7 million

Pharmacy – in its unique position at the heart of our communities – is well placed to tackle each of these public health crises: providing convenient access, without an appointment to a highly qualified healthcare professional who sees people when they are well, not just when they are sick – and does so on average more times a year than they see their GP.

### 11.1. Key recommendations

★ Pharmacy delivered public health services should be included as part of the Government's new Public Health Service. As capacity in the provider arms of PCTs is reduced, accessible, cost-effective and outcomes orientated services, including pharmacy enhanced services, should be commissioned.

★ Investing in prevention is a sound, cost-containment and cost-effectiveness strategy. As a patient facing service pharmacy has a number of key attributes that fit well with promoting public health and preventative healthcare messages to a wider cross-section of society. Pharmacy should therefore be central to Government's public health and preventative healthcare strategy.

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<sup>34</sup> N. Plumridge, 'The Big Four', Health Services Journal, 17<sup>th</sup> June 2010.

## 11.2. Smoking cessation services

*“Community pharmacies serve local communities and have the potential to reach large numbers of people who use tobacco. They are able to meet the needs of minority ethnic and disadvantaged groups and those who may have difficulty accessing other community services”*

**National Institute for Health and Clinical Excellence (NICE), Smoking Cessation Services in Primary Care, February 2008.**

The use of nicotine replacement therapy (NRT) and smoking cessation techniques are now well known, with many patients visiting their pharmacy to commence such treatment. A recent example of this success was highlighted at the 2010 National Smoking Cessation Conference (NSCC), which heard about the benefits of a pharmacy led smoking cessation service in deprived areas of Glasgow. The service had helped more than 5,000 patients to quit smoking in 2009, with more than 75% of patients coming from the most socially deprived quartile.<sup>35</sup> The authors of the conference report drew the conclusion that the service improved smoking cessation outcomes and was highly acceptable to patients in socially deprived areas.<sup>36</sup>

A report from the University of York titled *‘Cost-effectiveness of brief intervention and referral for smoking cessation’* found that smoking cessation interventions made by GPs and nurses was cost-effective, generating Quality Adjusted Life Year (QALY)<sup>37</sup> gains at low costs, and that a mean cost saving of £448 per ex-smoker was estimated.<sup>38</sup> If these interventions were handled by pharmacists instead of GPs, thereby freeing up GP time, then taking the abovementioned Glasgow results, this would equate to savings of £2,240,000 in this area alone with vastly improved local health outcomes.

More than three quarters (77%) of PCTs in England have commissioned smoking cessation services from pharmacy. However, only 1 in 3 pharmacies were providing these services according to a report in the *Pharmaceutical Journal* shortly after the introduction of the current Community Pharmacy Contractual Framework.<sup>39</sup> A summary of recent research evidence for the National Public Health Service for Wales shows that pharmacy-based smoking cessation services are cost effective.<sup>40</sup>

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<sup>35</sup> C. Chapman, ‘Glasgow Boasts Record Smoking Cessation Year’, *Chemist & Druggist* 18<sup>th</sup> June 2010.

<sup>36</sup> A. Secoular, J. Doogan J & K Henderson, ‘The benefits of a pharmacy led enhanced smoking cessation service in deprived areas of Glasgow’, 2010 UK National Smoking Cessation Conference Abstract.

<sup>37</sup> The QALY is a health outcomes measure that seeks to capture the quality of life (morbidity) and quantity of life (mortality/survival) of a given intervention for a patient. It is used by NICE for the purposes of cost-effectiveness analyses to calculate the cost per QALY of a given intervention versus a comparator.

<sup>38</sup> University of York, ‘Cost-effectiveness of brief intervention and referral for smoking cessation’.

<sup>39</sup> Bradley F, Ashcroft D and Noyce P, ‘Commissioning services and the new community pharmacy contract: (3) Uptake of enhanced services’, *Pharmaceutical Journal*, 2006. 277: 224-226.

<sup>40</sup> E. Tyler, ‘Smoking cessation interventions by community pharmacy: a rapid review of the evidence’, National Public Health Service for Wales, 6<sup>th</sup> October 2010.

### 11.2.1. Key recommendations

★ **Directors of Public Health should strongly consider commissioning pharmacy based smoking cessation services against a national template, using benchmark pricing to ensure the quality of the service.**

## 11.3. Defusing the obesity “time-bomb”

Coventry has seen an innovative pharmacy led enhanced service commissioned, designed to tackle the rising obesity problem (see Section 3). The scheme provides an individualised service for patients with a body mass index of 30 to 35, with at least one diagnosed or established risk factor, such as hypertension, Type 2 diabetes, raised total cholesterol or waist circumference greater than 102cm for men and 88cm for women. Each patient is first assessed by the pharmacist, who takes the patient’s BMI, waist measurement, blood pressure and tests their blood glucose and cholesterol levels. Patients are then given a weight management programme diary, an appointment card and a weight loss advice booklet. They are set targets for a diet and exercise plan, aiming for a five per cent weight loss by the end of the programme. Patients are referred to their GP for any monitoring parameters that fall outside of the service protocol. They are then booked in for a series of 11 follow-up meetings with the pharmacist over the course of the next 12 months.

A total of ten pharmacies were selected to take part in this pilot despite over half of the pharmacies in Coventry expressing an interest, with each selected pharmacy having a target of 15 patients. The DH contributed two £7,500 sums to aid the development and implementation of this service.<sup>41</sup>

Describing the rationale behind the programme, **Laurence Tressler** – Deputy Head of Medicines Management and community pharmacy clinical governance facilitator at Coventry Teaching PCT – has stated: *“Looking at some of the data that are available, 10 per cent weight loss can reduce blood pressure by 10mmHg, fasting blood glucose by up to 50 per cent and total cholesterol by 10 per cent. There’s the possibility that some of these patients are going to require less medication for treating their conditions in the future.”*

An interim report on this pilot demonstrated an improvement in health outcomes. 68% of participants had lost weight, losing an average of 0.62 of their BMI. The average waist measurement of patients was 111cm at the start – 72% had reduced this by an average of 3.37cm each. Some 63 patients were referred to their GP for management of health conditions – 31% for hypertension, 18% for diabetes, 27% for obesity and 23% for heart conditions.

### 11.3.1. Key recommendations

★ **Directors of Public Health should consider pharmacy-based weight management services as part of the new Public Health Service.**

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<sup>41</sup> The Pharmaceutical Journal, ‘Obesity rises up the agenda in Coventry’, Vol. 278, 2007.

## 11.4 Health living pharmacies (HLPs)

The UK faces key public health challenges such as rising levels of obesity leading to increasing diagnoses of Type 2 Diabetes, excessive alcohol consumption and smoking. As briefly mentioned in section 7, the Healthy Living Pharmacy (HLP) concept emerged from the 2008 White Paper – *Pharmacy in England: Building on Strengths, Delivering the Future* – and sought to offer pharmacies as locations where patients could be given support and advice on how to lead a healthy lifestyle, and supporting people with LTCs.

In relation to the NHS White Paper, this is in line with the Secretary of State’s vision of more informed patients taking a greater degree of control over their care. NHS Portsmouth has recently published its Prospectus for the healthy living concept. The Prospectus sketches a tiered approach where more able providers are able to offer more involved interventions such as full clinical medication reviews or pharmacist prescribing<sup>42</sup>. The concept is about providing sustainable improvements to health in areas of high deprivation or pressing public health needs. **Mike Holden, Chief Officer of Hampshire and Isle of Wight Local Pharmaceutical Committee** commented on the six pharmacies to become the first HLPs in the country: “*NHS Portsmouth has insisted on this [HLP] being a sign of quality that the public can have confidence in, so patients can be assured these pharmacies really do offer healthy living*”<sup>43</sup>.

One key advantage of the HLP concept has been access to groups of patients who do not traditionally engage with General Practice. Figures from the Portsmouth pilot project showed that 30% of patients seen for a MUR had not seen their GP or practice nurse in the previous 12 months. Under GP Commissioning, patients who are not registered with a GP may become disenfranchised from healthcare spending. Whilst consortia will be responsible for commissioning for the unregistered, there is no evidence to suggest that consortia will be able to provide access for this group. HLPs could provide an alternative ‘any-willing provider’ model for the care of patients outside of the traditional General Practice model.

### 11.4.1. Key recommendations

★ **In the context of the UK’s ongoing public health challenges, the HLP concept should be expanded to help promote better public health information, and to aid prevention of illness and disease where possible.**

★ **HLPs could provide an accessible model for care of patients currently not registered with, or regularly accessing a GP or other primary care services; a significant and often forgotten sub-group in the UK population.**

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<sup>42</sup> NHS Portsmouth. December 2009. Healthy Living Pharmacy Prospectus.

<sup>43</sup> Pharmaceutical Journal, 2010. 284: 601. Portsmouth pharmacies first in England to be named Healthy Living Pharmacies.

## 11.5 Sexual health services

Pharmacy has become an increasingly important venue for community sexual health services, since the implementation of the Community Pharmacy Contractual Framework in 2005. Access to emergency contraception is a common enhanced pharmacy service as pharmacies are open in the evenings and at weekends, with no need to book an appointment. Pharmacies in Lambeth and Southwark have been involved in the Emergency Hormonal Contraception service since 2000, in a bid to tackle the 10,500 unintended pregnancies in the area (1998 figures).

In the first year of the service, it was found that 50% of women accessed the service at the weekend or on Mondays, when it can be difficult to obtain appointments at family planning clinics or GP<sup>44</sup>, a critical finding given that emergency contraception is most effective if taken within the first 24 hours after unprotected sex.

In an extension of this scheme, NHS Lambeth and Southwark recently launched a pilot programme to improve access to oral contraceptives through pharmacy. **Jo Holmes**, Head of Primary Care Delivery at NHS Southwark, said at the launch of the pilot: *“the pilot recognises that many young women already use community pharmacy to access emergency contraception. In Lambeth and Southwark there are over 8,000 consultations every year”*<sup>45</sup>. Pharmacies participating in the pilot are able to provide oral contraception which would normally only be available with a prescription, thus easing access to ongoing contraception. Both the Emergency and Regular Contraception services require the pharmacist to offer advice about sexually transmitted infections and to signpost to GP or specialist Contraception and Sexual Health (CASH) services where appropriate.

Another recent development in the role of pharmacy in sexual health services has been its participation in the National Chlamydia Screening Programme (NCSP). Pharmacies across the country are being commissioned to provide access to postal testing kits for young people in the NCSP target groups (15-24 year olds). Young women can visit pharmacies for a number of reasons, including buying makeup or to seek emergency contraception or buy pregnancy tests.<sup>46</sup> A pilot study, again in NHS Southwark revealed that 16% of patients tested in pharmacy would not have been screened in any other setting.<sup>47</sup>

Pharmacies on the Isle of Wight have become the first in the country to offer an innovative sexual health service, dried blood spot testing for Hepatitis B & C, HIV and syphilis. The free, confidential service has won several national awards including a Silver Medal at the 2010 Chief Medical Officer’s Public Health Awards<sup>48</sup>, and an industry C&D Award.

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<sup>44</sup> Royal Pharmaceutical Society of Great Britain. Pharmacy in Action: Case Study. Emergency hormonal contraception service.

<sup>45</sup> NHS Southwark. Press release 11/12/2009. Oral Contraception pilot launches in Southwark and Lambeth Pharmacies.

<sup>46</sup> National Chlamydia Screening Programme. Towards best practice for screening in community pharmacy. June 2009.

<sup>47</sup> National Chlamydia Screening Programme. Towards best practice for screening in community pharmacy. June 2009.

<sup>48</sup> Department of Health. Winners of the Chief Medical Officer’s Public Health Awards, 2010.

**National Aids Trust Chief Executive, Deborah Jack** commented on the service *“Having HIV tests conducted in local pharmacies will help make testing more routine”*<sup>49</sup>.

With more than half a million people in the UK estimated to be living with undiagnosed hepatitis B and C, the introduction of testing services in pharmacies could potentially save thousands of lives whilst providing value and cost-effectiveness for commissioners. Indeed, it was recently reported that last year, a viral hepatitis testing pilot project in 19 pharmacies across the nation found a hepatitis B or C positive patient in every six tests conducted. Across the pharmacies, a total of 234 tests were conducted, diagnosing 35 people with hepatitis C (15% of tests) and four people with hepatitis B (2% of tests). The proportion of hepatitis C-positive diagnoses was higher than those found in GP surgeries, where 4% of tests find positive hepatitis C patients and 2% of tests find hepatitis B patients according to the Hepatitis C Trust.<sup>50</sup>

The **Hepatitis C Trust** has also been calling for free testing to be introduced in pharmacies, with **Chief Executive Charles Gore** stating: *“It is a tragedy that increasing numbers of people with hepatitis B and C are dying, often from particularly unpleasant liver cancer which these viruses can cause. It is a tragedy because they have generally been living with the virus for years and could have been given treatment at any point, if only they had been diagnosed. So we desperately need new approaches to testing that will find the undiagnosed patients and this pilot study shows pharmacy testing could be just what is needed. If the pharmacy testing pilot is taken as a model and rolled out by PCTs and pharmacies nationally, we can stop people dying needlessly,”* he adds.

This is an example to highlight that, where conditions are correct, pharmacy is able to provide additional, patient centred enhanced services and offer support to other parts of the wider healthcare service.

### **11.5.1. Key recommendations**

★ **As part on the new Public Health Service, all pharmacies should offer a minimum of emergency hormonal contraception and Chlamydia screening.**

★ **Policymakers should consider whether access to ongoing contraception could, in the future, be offered more effectively through pharmacies.**

★ **Advanced sexual health services, such as testing and screening, should be commissioned in areas of need by Directors of Public Health. This would help to improve local delivery and improve patient health outcomes.**

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<sup>49</sup> J Richardson, ‘NHS Funds Pharmacy HIV Screening’, Chemist & Druggist, 10<sup>th</sup> December 2009.

<sup>50</sup> The Pharmaceutical Journal, ‘Pharmacy hepatitis tests “could save thousands of lives”’, 24<sup>th</sup> August 2010.

## 12. Optimising the use of medicines

Pharmacists are uniquely qualified and located health professionals who are able to apply their knowledge about the use of medicines to help patients to get the most from their prescribed medicines. **Jonathan Mason**, National Clinical Director for Pharmacy estimates that between 30 and 50% of all medicines prescribed for LTCs are not taken as intended (see section 4).<sup>51</sup> Although there are composite reasons for medicinal non-adherence, most notably environmental and behavioural factors, it is increasingly clear that pharmacy has a direct role in dealing with this persistent problem. This is particularly the case in terms of educating, supporting and explaining to patients the necessary particulars around given regimens and medicinal schedules, especially with LTCs. When this problem is added to estimates of medicines which are wasted ranging from £100m to £800m<sup>52</sup> and research showing that up to 5% of all hospital admissions are due to medicines related problems, it seems that more input is required from pharmacists.

### 12.1 Medicines use review

Pharmacies are funded to perform up to 400 MURs each year and can only perform one per patient in any 12 month period, unless they have specific concerns which would warrant an additional (intervention) MUR. The pharmacy will at the end of the review provide a copy of the paperwork for the patient and one to the GP. MURs are a good opportunity to address a patient's reasons for non-compliance and resolve them before they come to harm. Uptake of MURs by community pharmacies has increased year on year since their introduction, in 2009/10 1.7million MURs were conducted, by around 7,000 of the UK's 10,000 pharmacies.<sup>53</sup>

In an example of positive outcomes, a 2009 review of a targeted MUR project in Hampshire and Isle of Wight showed great potential benefits in the treatment of asthma. Pharmacies offered MURs to 965 asthmatic patients, 37% of the cohort were not compliant with their treatment, mainly due to problems with their inhaler device. Pharmacists were able to educate patients about the correct way to use their inhalers which resulted in 98% of patients agreeing or strongly agreeing that the pharmacist clearly explained how they could get the maximum benefit from their medicine. Interestingly, 30% of patients seen in the study had not been reviewed by their GP practice in the previous 12 months. More than half of GPs questioned about the study felt that the target MUR scheme would reduce their long-term workload.<sup>54</sup>

In addition, some hospital admissions are due to poor adherence with prescribed medicines in asthma, such as inhaled steroids<sup>55</sup>, and by promoting better patient management and

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<sup>51</sup> Pharmaceutical Journal, 4/3/2010. 284:239. Work smarter, not harder and make sure patients benefit more from their MURs. Mason J.

<sup>52</sup> National Audit Office, 2007. Prescribing Costs in Primary Care.

<sup>53</sup> Pharmaceutical Services Negotiating Committee. MUR Statistics 2009/10.

<sup>54</sup> J. Portlock, M. Holden & S. Patel, 'A community pharmacy asthma MUR project in Hampshire and the Isle of Wight', Pharmaceutical Journal, 2009. 282: 109-112.

<sup>55</sup> C. Livingstone, 'Onwards and upwards with target MURs', Pharmaceutical Journal, 2010. 284: 57-60.

adherence of medication, in this instance for asthma, there is potential for large cost savings by using pharmacists to prevent needless and costly hospital admissions.

The Care Quality Commission (CQC), the body that regulates the provision of health and adult social care in England, recently published a report about the need to improve the management of patient medicines after they have been discharged from hospital. One study detailed in the report found that almost a third of patients were readmitted to hospital within 2 weeks of discharge because they had reverted to pre-admission and therefore incorrect medicines due to a lack of communication between primary and secondary care.<sup>56</sup> The report highlights the importance of the MUR service for patient post-discharge. In some areas, PCTs are asking pharmacies to carry out pre-admission MURs and post-discharge MURs to highlight and discuss any changes.

The interlinking issues of medicines management post-discharge from hospital; the degree of clear, effective and joined up communication between primary and secondary care; the need to continually monitor a patient's medicinal requirements long-term; and the role of pharmacy in helping provide a workable and practical solution now confer extra importance for hospital and secondary care providers in England. The Government's recently stated policy that hospitals will not be reimbursed for patient readmissions within 30 days of discharge for related and therefore avoidable conditions changes the whole terms of reference regarding what hospitals must do to circumvent this punitive penalty.<sup>57</sup>

It has already been mentioned that between 30-50% of patients may not take their medications correctly. Research from 2001 showed that 3-4% of hospital admissions were as a result of avoidable, medicines related illnesses,<sup>58</sup> whilst 2006/2007 NHS reference costs indicated that approximately £16.4 billion was spent on hospital admissions (excluding critical care). The cost of admissions from not taking medicines correctly was therefore suggested to be up to £196 million in 2006/2007.<sup>59</sup> With an ageing population likely produce more "poly-pharmacy" patients – that is, patients on multiple medications and pharmaceutical interventions - this figure is likely to increase if policy in this area remains unfettered.

Although eliminating nosocomial infections will be the key, ensuring patients are not swiftly returning to hospital due to prescription and/or medicinal errors will be essential and offers immediate benefits on all sides. It is from this perspective that pharmacy can play a pivotal role in not only improving patient health outcomes and patient care but also in terms of saving hospitals money from reimbursement foregone due to basic prescribing oversights.

One note of caution is the continued need to translate innovations such as MURs into tangible outcomes. Senior Liberal Democrat **Norman Lamb MP** – former shadow health spokesman and current Chief Parliamentary and Political Advisor to the **Deputy Prime**

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<sup>56</sup> Care Quality Commission. October 2009. Managing patients' medicines after discharge from hospital.

<sup>57</sup> BBC, 'Hospitals to face financial penalties for readmissions', 8<sup>th</sup> June 2010, Accessed September 2010.

<sup>58</sup>J. Meyer, 'Concordance: and opportunity for partnership in medicine-taking' Nursing Times Research 6: 564–5, 2001.

<sup>59</sup> NICE. Costing statement: Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence, <http://www.nice.org.uk/nicemedia/pdf/CG76CostStatement.pdf>, Accessed September 2010.

**Minister Nick Clegg MP** told this paper: *“The role of pharmacists does have to be effectively co-ordinated. I was shocked when recently visiting a GP practice to be told that they great piles of forms with the results of Medicine Use Reviews which pile up and are never really used in any meaningful way – this looks dangerously like spending a lot of money heating the atmosphere to no real benefit. The principle of the Medicine Use Review is very good, but the results must be utilised to improve patient care.”*<sup>60</sup>

### **12.1.1. Key recommendations**

**★ MURs should become fully integrated into care pathways for LTCs.**

**★ Strong, communicative relationships with GPs should be fostered to ensure coordination and coherence of MUR usage in order to optimise outcomes for patients.**

**★ MURs should be considered as part of pre-planned and post-planned hospital admissions to reduce the risk of medicines related readmissions. This would help Trusts to avoid falling foul of the Government’s new policy penalising hospitals for readmissions for related conditions within 30 days of discharge.**

### **12.2 First prescription service**

During an average 7 minute GP appointment, there is a limited opportunity for the GP to discuss new medicine treatments in detail. For example, a newly diagnosed diabetic patient may have to absorb a large amount of information about their condition, appointment schedule and diagnostic tests before even considering the medicine(s) that they have been prescribed. When considering that the medicine may be the main tool for managing the condition, it may be surprising to lay people how little time is spent discussing treatment.

Adherence – the medical term for patients taking their prescribed medicines in the correct and appropriate way – is related to a patient’s own knowledge and beliefs about their illness; their motivation to manage their condition; and the confidence they have in their treatment.<sup>61</sup> NICE Clinical Guideline 76 specifically tackles the issue of adherence and suggests involving patients in decisions about their medicines, whilst identifying the need to tackle non-adherence. The consequences of non-adherence can be severe, adversely effecting patient outcomes, and increasing long term costs to the NHS.

As previously discussed, up to half of patients with LTCs do not use their medicines as intended.<sup>62</sup> The discontinuation rate for a new medicine prescribed for a patient with a LTC is 20% at month 2 and 60% at month 12.<sup>63</sup> Proof of concept research has shown that

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<sup>60</sup> Personal communication, August 2010.

<sup>61</sup> A Buxton, ‘Tackling the challenge of non-adherence’, PSNC conference, 2010.

<sup>62</sup> J. Mason, ‘Work smarter, not harder and make sure patients benefit more from their MURs’, *Pharmaceutical Journal*, 4<sup>th</sup> March 2010, 284: 239.

<sup>63</sup> A. Buxton, ‘Tackling the Challenge of Non-Adherence’, *Pharmaceutical Services Negotiating Committee*, Conference 2010.

pharmacists can positively impact on the discontinuation rate.<sup>64</sup> Subsequently, it has been proposed that a National ‘First Prescription Service’ be introduced as a more intensive intervention than the usual patient counselling which might happen when a patient collects a new medicine. It is likely that the service would take the form of a consultation with a pharmacist upon a patient with an LTC being prescribed a new medicine for their LTC and would also include some element of follow-up such as a second appointment or a telephone call, although no service specifications have yet been published. Impacting upon discontinuation rates for proprietary medicines would have large cost saving implications for the NHS and would help to tackle waste of medicines.

Research in Australia has shown that pharmacists can make a positive impact on improving compliance with prescribed medicines. PriceWaterhouseCoopers conducted the study on behalf of the Pharmacy Guild of Australia and was able to demonstrate statistically significant improvements in compliance at 3 and 6 months. The study was able to demonstrate for patients with heart failure \$1 spent on the compliance service saved \$14 in healthcare costs. In addition the study showed that patients who had a previous heart attack were more likely to die if they were non-compliant with their medication, therefore improving the use of medicines had beneficial clinical outcomes beyond controlling costs.<sup>65</sup>

### 12.2.1. Key recommendations

★ **A national First Prescription Service should be rolled out to tackle non-adherence and non-compliance with medicines prescribed for patients with LTCs.**

★ **Improvement in outcomes for patients accessing this proposed First Prescription Services should be monitored and, where demonstrable improvements are made, recurring funding from the DH should be made available.**

### 12.3 Medicines management services

There are many reasons for patients not using their medicines properly, ranging from forgetting to take them (unintentional non-compliance), to discontinuing the medicine deliberately due to their own beliefs. There are many options open to pharmacists to assist patients to take their medicines better, patient education is at least part of an answer. For some patients, more practical assistance is required. This could take the form of helping patients to access their medicines by using more appropriate containers; providing prescription collection/delivery services; it could mean the use of a multi-dose compliance aid filled by the pharmacy.

For some patients, the NHS repeat prescription system can be confusing as it is a multi-step process involving 1) submitting the request, 2) collecting the prescription, 3) getting it dispensed and 4) collecting the medicine. Pharmacies frequently receive requests from

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<sup>64</sup> N. Barber et al, ‘Patients’ problems with new medication for chronic conditions’, *Qual Saf Health Care*, 2004. 13: 172-175.

<sup>65</sup> A. Feyer et al, ‘National trial to test strategies to improve medication compliance in a community pharmacy setting – full report’, The Pharmacy Guild of Australia.

patients who have run out of their medicines because of delays in any stage in the process; they also receive requests from patients who are away from home and do not have their regular medicines. Under current regulations, the pharmacy can provide the patient with an emergency supply of up to 28 days treatment. However, they do so privately outside of the NHS. This can create an unnecessary barrier to access, particularly for patients on low or fixed incomes, for whom the medicine is just as vital.

In some cases, this can lead to the referral of the patient to their GP or for patients away from home can lead to ‘Temporary Registration’ with a GP, which costs the NHS in each instance. Since the launch of the Scottish Community Pharmacy Contract in 2005, pharmacies north of the border have been able to supply patients with emergency supplies at NHS expense, and can do so for longer periods of time: ‘The Unscheduled Care Service’.<sup>66</sup> This would cut down on workload for General Practice and improve availability of medicines to patients.

### 12.3.1. Key recommendations

★ **The merits of a national Unscheduled Care Service for England should be actively considered. A comprehensive review of the experience in Scotland should be undertaken to inform any such policy move in this direction.**

## 12.4 Prescribing support services to GP practices

Prescribing Support services encompass the provision of advice and support to GPs on the prescribing of medicines. This can include how medicines are prescribed or the cost effectiveness of different treatment options, expertise that Dr. Has Joshi of the Royal College of GPs suggests is value-added and welcomed as by GPs (see Section 13.4). Up to now, this service has largely been provided by PCTs and has neglected to include the community pharmacy contractors who effectively spend the prescribing budget. This has had the effect of leaving pharmacy contractors as voiceless stakeholders in the prescribing process – often perversely incentivised to spend NHS resources unnecessarily. *Equity and Excellence* sets a strategic aim of pharmacists working with doctors and other healthcare professionals to optimise the use of medicines.

A logical application of this aim could be the provision of prescribing support services to GP practices by the local pharmacy contractors who administer the same prescribing budget. This would provide a number of enhancements over the status quo which could be perpetuated under GP Commissioning by Contracting current PCT employees to provide the same service. **Figure 6** below highlights the potential advantages of pharmacy contractors becoming providers of prescribing support services.

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<sup>66</sup> Community Pharmacy Scotland. NHS Care Services: Unscheduled Care (CPUS). [http://www.communitypharmacyscotland.org.uk/nhs\\_care\\_services/unscheduled\\_care\\_cpus.asp](http://www.communitypharmacyscotland.org.uk/nhs_care_services/unscheduled_care_cpus.asp), Accessed August 2010.

## Figure 6: The advantages of pharmacy contractors becoming providers of prescribing support services

- Promote multi-disciplinary working between pharmacy and medicine, thus integrating care for patient.
- Demonstrate the value of pharmacists to GPs beyond ‘prescribing error detection’.
- Community Pharmacy Contractors could be incentivised to reduce waste of medicines and promote budgetary responsibility.
- Community Pharmacy Contractors have a number of additional cost control levers which they could use to ensure Consortia come in on budget for medicines, which aren’t open to non-contractors.
- Control of short-term ‘cost saving’ measures such as the use of branded generics which actually drive up the cost of all generic medicines to the NHS and can destabilise Contractors income.
- Empower community pharmacists to deliver consistent messages on the use of medicines.

### 12.4.1. Key recommendations

★ Prescribing support services should be opened up to pharmacy contractors to give pharmacists co-ownership of the prescribing budget. If cost-effective and an optimal arrangement, this could be achieved through the creation of pharmacy consortia.

★ The “any willing provider” concept should apply to prescribing support services, with commissioning of these services based upon quality, value and cost-effectiveness. Where willing and able to offer prescribing support services, pharmacy contractors should be considered equally along with any other willing provider. Employment of PCT staff should not automatically become the default position for commissioners, which would blunt competition.

## 13. What issues are preventing optimal delivery of enhanced services?

Pharmacies are predominantly NHS businesses with 90-95% of their turnover derived from NHS activities.<sup>67</sup> The vast majority of this funding is derived from the essential services component of the pharmacy contract, these are primarily based on volume dispensing fees, enhanced services comprise on average 1% of a community pharmacy’s turnover. Due to the extremely low value of enhanced service payments, it is often difficult for some pharmacies to reengineer their work processes away from the stereotypical dispensing function.

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<sup>67</sup> The Community Pharmacy – a guide for GPs and practice staff. April 2010. NHS Employers, British Medical Association and Pharmaceutical Services Negotiating Committee joint publication.

### 13.1 Commissioning/local rules

Enhanced services are commissioned by PCTs to address the health needs of local populations, making them a very flexible tool. As each PCT can operate its own Service Level Agreement (SLA) – which is the document defining how the service operates – it can mean that there are tremendous differences between the same services in neighbouring PCTs. The fractionation of requirements, including training and paperwork can make the operation of enhanced services onerous; particularly to large multiple pharmacy operators who may be providing a different emergency contraception service in every PCT, and may even be offering two different services from the same pharmacy at PCT boundaries. As each PCT has its own requirements for its services, locum pharmacists may have to undergo training in each area in which they work, which leads to unnecessary duplication of effort and to gaps in the service as the pharmacist may not be accredited in one area, but holds a perfectly valid qualification in a neighbouring area.

Increasingly, there is a move to harmonise enhanced service requirements across regions as it is recognised that service provision can be patchy. The North West Harmonisation of Accreditation Group (HAG) was a pioneering initiative which has sought to align the requirements of PCT enhanced services.<sup>68</sup> It is planned for this initiative to be rolled out across the UK. However, there is an alternative approach – National Enhanced Services, such as those employed by the GP Contract. Service specifications are set to national standards, reducing the need for individual organisations to expend time and effort defining the minutiae of a new service.

**Graham Phillips – a community pharmacy proprietor and member of the English Pharmacy Board** – told this paper: *“There are only so many services and ways of commissioning them. We do not need a different version in each PCT. There should be a nationally-agreed menu of services with audit and quality assurance built in and a payment structure nationally agreed.”*<sup>69</sup>

**Alliance Boots** tend to mirror the view expounded by Mr. Phillips in their commissioning submission to the Health Select Committee. Shared best practice in designing templates for services would reduce significant variations across PCTs and remove the possibility of developing 152 solutions for the same problem; something that could be exacerbated as we move toward GP consortia and local Directors of Public Health with direct responsibility for funding. This will also ensure that people accessing services are assured that this will be to the same standard and include the same things regardless of where they live. As soon as a successful service evaluation is produced for a model service, the service specification should be reviewed to produce a ‘best practice model’ and this should become the national template to enable high quality services to be spread efficiently fulfilling QIPP. This national template should be made available to local commissioners in a timely and planned way so that they do not unknowingly duplicate or waste resources. Standardisation of good and innovative services allows better focus on supporting delivery and on continuously improving quality.

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<sup>68</sup> Royal Pharmaceutical Society. English Board 18/7/2007. Harmonisation of Accreditation Group.

<sup>69</sup> Personal communication, August 2010.

Pharmacy Enhanced Service provision has been described in several sources as patchy.<sup>70,71</sup> **Bob Wilson** told this paper that the variable provision of pharmacy services is something he recognizes and is something that is a significant issue. Much discussion has followed to understand the reasons why commissioners in some areas commission more pharmacy local enhanced services than others. However, it must be recognised that the populations served by different commissioners have different needs and that options for service provision also vary. A number of reasons have been postulated.

### 13.2 Commissioner misunderstanding

Throughout the research of this paper, it has been apparent that there is a feeling across the pharmacy profession that PCT commissioners do not have an adequate understanding of pharmacy services and what value can be added through these. More generically, the **House of Commons Health Select Committee report** into commissioning commented that commissioning is still an Achilles heel within the NHS and that:

*“...weaknesses are due in large part to PCTs’ lack of skills, notably poor analysis of data, lack of clinical knowledge and the poor quality of much PCT management.”<sup>72</sup>*

**Kevin Noble** told this paper: *“We are lucky on the Isle of Wight because commissioners here have recognised the added value that integrating pharmacy can provide with many services i.e. improvements to access and facilitating access to otherwise hard to reach groups such as injecting drug users. In other areas there appears to be some ignorance in commissioning groups regarding what pharmacists can do when appropriately trained. An active LPC is therefore vital...you need somebody in the PCT actively driving things.”* However, one commissioner that submitted to this paper mentioned however that on occasion’s pharmacy providers have not always helped to endear themselves to commissioners, opining: *“In some areas, and in some cases, pharmacy services providers have not covered themselves in glory. They have pitched for services, had them commissioned and then not delivered meaning a minority has clouded the perception of pharmacy services in general.”<sup>73</sup>*

**Alliance Boots** also highlighted some issue around the commissioning process, important given their position as one of the major provider of pharmacy services in the UK. Alliance Boots suggested that to improve commissioning processes, there must be better dialogue with all stakeholders to design and agree outcomes before going to tender, with ongoing dialogue continuing when the service is implemented to amend and adapt activity according to local need.

It was also highlighted that, whilst the purchaser provider split has driven efficiencies across all health care settings since its introduction, it does suffer from the weakness that many on the purchasing side do not have expertise or experience of services provided in community pharmacy; something highlighted in the Health Select Committee report into commissioning.

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<sup>70</sup> PSNC Press Release, 21<sup>st</sup> September 2009.

<sup>71</sup> All Party Pharmacy Group AGM. 26<sup>th</sup> June 2007.

<sup>72</sup> House of Commons Health Select Committee. Commissioning. Fourth Report of Session 2009-2010. Volume I

<sup>73</sup> Personal communication, August 2010.

This may therefore impede the commissioning of pharmacy services in this setting. One method to overcome this could be to involve community pharmacist in the process, with every PCT having a board member with responsibility and accountability for pharmaceutical services. It was mentioned that the further devolution of commissioning to a GP level will exacerbate this situation.

### 13.3 GP influence

Many of the experts consulted throughout the research of this paper highlighted concerns around the preferences GPs receive when the commissioning of services are considered. Given that the Coalition Government has clearly stated its plan to implement a policy of GP commissioning, with local service redesign requiring the support of these GP commissioners, these concerns are unlikely to have been assuaged since the General Election.

When considering whether there are any “blockages” in the system that prohibit a more uniform and nationwide provision of pharmacy services, **Graham Phillips** told this paper: *“PCTs are blockers, as are GPs. PCTs simply lack the clinical and technical competencies and are dominated by the GPs. The fear is that this can lead to vested interests being realised. The Commissioning “playing field” is “vertically stacked” in favour of GPs, whilst the commissioning environment forces GPs to compete with community pharmacists. This is a nonsense. If we want to achieve patient-centred, multi-disciplinary care we must commission accordingly. The current “dog-eat-dog” commissioning scenario will never deliver partnerships in care. It entrenches “silo” behaviour leading to massive waste.”*<sup>74</sup>

One **commissioner** also highlighted issues involving GPs from his experience, stating: *“bids for local enhanced services have to go through PCT service planning boards and in this debate, GP concerns can be taken into account to a greater degree than others, and therefore pharmacy services can lose out.”*<sup>75</sup>

**Kevin Noble** also raised some concerns: *“I hope that when GP commissioning comes into being what we have achieved on the Island is recognised. I must admit that I do probably have slight concerns about this commissioning route and the future of services based outside of GP practice. There is the potential for a conflict of interest to arise and historically it has produced a lack of integrated services because the money has been detained by this particular group. The signs are not great from Practice Based Commissioning (PBC) where pharmacy had little involvement. There is a great opportunity for joint working to achieve integrated care rather than continuing to work in silos.”*<sup>76</sup>

A good example of where this joint, integrated working has been apparent is in the Isle of Wight, which as mentioned on page 30 and 32, is often held up as a cutting edge example for providing innovative, enhanced pharmacy services. On the Isle of Wight, the Local Pharmaceutical Committee (LPC) works with the Local Medicine Committee (LMC) to find opportunities for productive joint working, although Kevin Noble has acknowledged that an

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<sup>74</sup> Personal communication, August 2010.

<sup>75</sup> Personal communication, August 2010.

<sup>76</sup> Personal communication, August 2010.

active, energetic LPC that drives the agenda is vital to this. However, this is a rare case, and because of this the **Royal Pharmaceutical Society of Great Britain (RPSGB)** is currently reviewing submissions to its own enquiry on how to help GPs and pharmacists work together more effectively. The current consensus appears to be that there is a frustration amongst pharmacists, in that they are not commissioned more frequently to deliver such services, despite the fact that they wish to provide services of this kind. This frustration is further exacerbated by the very short tenure of some of these services.

The RPSGB told us that pharmacists fund the capital spend required to provide a pharmacy-led service, yet on many occasions this service is then stopped for reasons such as the PCT re-examining its policy, leaving the pharmacist with capital outlay and no source of recovery. Pharmacists do not expect security of tenure if the service provided is unsatisfactory but do require a length of tenure long enough to recover expenditure.

There is a perception amongst pharmacists that the commissioning bodies within PCTs are dominated by local GPs, with – in the majority of cases – no representation by pharmacists. It is also clear that there is a strong perception that GPs are far more likely to commission themselves or colleagues to provide a service. As it is unlikely that any one healthcare professional or provider can provide all the requirements of a care pathway, pharmacy needs to become better integrated into care pathways to ensure they can provide their relevant expertise at correct points along the pathway.

**Norman Lamb MP** told this paper: *“I do think that pharmacies need to be represented on the commissioning body to ensure that their potential is fully realised. If commissioning decisions are left to remote PCTs – or GPs alone - then there is a risk that the potential for pharmacy is not realised. Pharmacies should be involved in preventive healthcare. Their accessibility is widely recognised and pharmacists are trusted. I have argued the case for incentives to PCTs and to individuals to get involved in the whole agenda of prevention.”*<sup>77</sup>

The issues highlighted above involving barriers between GPs and pharmacists in certain areas seem highly inefficient, benefiting neither the GP nor the pharmacist. A more integrated primary care system would logically provide a more complementary skills mix that would ultimately benefit the patient. This assertion is backed up by research conducted by **The University of London (*Better Practices, Better Health*)**<sup>78</sup> which states:

*“...closer working between GPs (and other practice based professionals) and community pharmacists could contribute to both improving health outcomes and increasing the cost effectiveness of primary care. Counter-productive rivalries between community pharmacists and general medical practitioners would leave patient needs unmet and the professions involved vulnerable.”*

### **13.4 The GP’s perspective**

In the course of researching this paper, we also received comment from **Dr Has Joshi FRCGP, Vice-Chair of Council for the Royal College of General Practitioners (RCGP)**

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<sup>77</sup> Personal communication, August 2010.

<sup>78</sup> Better Practices, Better Health – University of London, May 2009.

to gauge how GPs view their relationship with pharmacy. Dr Joshi welcomed the concept of pharmacy providing further enhanced services, but suggested that the best way for this to proceed in practice was for joint working with GPs at a local level to ensure coherence in care, which would ultimately reduce issues at the GP/pharmacist interface and subsequently improve health outcomes. When considering what prevents further enhanced services being delivered by pharmacy, Dr. Joshi described a “corner shop mentality” on both sides, with pharmacies feeling the need to retain their independence whilst GPs had concerns about pharmacists taking services and possible income. Dr. Joshi therefore suggested that misconceptions could become pervasive in certain areas, whilst what is ultimately required is a drive for better, integrated communications resulting in effective working partnership. Dr. Joshi even suggested an innovative solution for the future, stating: *“An optimal solution could be to have shared premises where the sharing of best practice, patient experience, care pathways and so forth are fostered and encouraged, rather than “siloes” thinking. This would be an equal partnership, although the pharmacist would benefit as their value added would be much more apparent to the GP, therefore they would be listened to more in turn. Integrated care for patients is ultimately key.”*<sup>79</sup>

Commenting on GP/pharmacist relationships in general, Dr. Joshi stated: *“There are local variations – some areas work very well, others could be improved. A good example could be where pharmacists advise on cost-effectiveness and drug prescribing which GPs value as it is an area of expertise that aids the GP. Pharmacists prescribing helps too on things like minor ailments as it helps the GP workload.”*

## 12.5. Key recommendations

**★ Closer working relationships between GPs and pharmacists should be encouraged and practically implemented. The DH should look at ways to improve professional complementation and exchange of skill sets.**

**★ Local pharmacy contractors should have representation on the local health authority Health and Wellbeing Boards as proposed in the Government’s White Paper. Working alongside local Public Health Directors, GP consortia and other partners would help to ensure close integration across health and social care, and the promotion of health and wellbeing across local communities.**

## 13.5 Skills mix

As the pharmacist has to physically review every prescription item before it leaves the pharmacy, a large proportion of their day is spent in the dispensary, away from direct patient contact. Increasingly pharmacy support staff e.g. dispensing technicians, are being trained to take on advanced roles to free the pharmacist from the dispensary. Accredited Checking Technicians (ACTs) are able to perform a technical check on dispensed items to ensure that they comply with the prescription, this removes a time consuming activity from the pharmacist, allowing them to perform cognitive and clinical functions such as Medicines

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<sup>79</sup> Personal communication, August 2010.

Use Reviews.<sup>80</sup> The limitation with the new system is that it is more expensive as ACTs are paid more; and it only works in larger dispensing businesses as there is a requirement to have at least two technicians (one to dispense the prescription and one to check the prescription).

As part of the HLP project in Portsmouth, there has been investment in the role of Health Trainer Champions in pharmacies, which **Michael Holden** confirms is already showing outcome benefits in the effective delivery of public health services such as alcohol interventions, smoking cessation, weight management and general healthy lifestyle promotion.

Investing in the development of staff can be a double-edged sword in community pharmacy, as more highly skilled support staff are inevitably more attractive to rival employers, including the NHS. Salaries for newly qualified pharmacy technicians in hospital pharmacy are well in excess of most community pharmacy employers. **Figure 6** below gives a rough comparison of support staff salaries in primary and secondary care. This serves highlights an additional, financial challenge community pharmacies confront when attempting to develop local enhanced services.

**Figure 6: Support staff salaries in primary and secondary care**

Position, ( ) = NHS banding	NHS Salary Range	Approximate community employer salary
Pharmacy Support Worker (2)	£13,233 - £16,333	£11,000 - £13,000
Newly qualified technician (4)	£17,732 - £21,318	£15,000 - £18,000
Senior technician, ACT (5)	£20,710 - £26,839	£20,000 - £24,000

Source: NHS Pay Circular 2009/1. Salary bands for large pharmacy employers are commercially sensitive, bands are based on advertised positions in national pharmacy publications.

### 13.6 Business case/lead costs

Pharmacies are businesses as well as healthcare providers, as such it is important that services which are to be offered from their premises make sound business as well as healthcare sense. In some cases PCTs have restricted the uptake of enhanced services by making services uneconomical to run. For example, NHS Bournemouth and Poole, currently offers an emergency contraception service where the pharmacy is paid less for the Levonelle-1500 medicine than it costs to buy it.<sup>81</sup> In a large part, pharmacies are paid on a piecemeal basis for the services that they provide, which means in some areas that it is not

<sup>80</sup> Pharmaceutical Journal, 2002. Vol 269, p672. Costs and benefits come as technicians train for extended roles.

<sup>81</sup> Dorset Local Pharmaceutical Committee. [http://www.lpc-online.org.uk/bkpage/files/167/summary\\_enhanced%20services\\_sept\\_2009.pdf](http://www.lpc-online.org.uk/bkpage/files/167/summary_enhanced%20services_sept_2009.pdf), Accessed August 2010.

economically viable to run a service which is used by one or two patients per month and may bring the pharmacy less than £20/month in income. Local NHS enhanced services account for around 1% of total turnover<sup>82</sup>, GP enhanced services can account for up to 15% of practice turnover.<sup>83</sup> Therefore, the return on investment for up-skilling staff and investing in premises and infrastructure is not yet at levels which make it possible for some pharmacy contractors to make the necessary changes to their business processes.

A fairer mechanism for pharmacy contractors would be to remunerate a contractor's ability to offer the service on a consistent basis, rather than providing a piecemeal payment. For example, pharmacies could be given an annual retainer payment for demonstrating that they have been able to offer the service on at least 5 days out of 7 throughout the year. This mechanism would reward those Contractors who have invested to train and retain high quality staff, and are able to demonstrate that a minimum level of availability has been delivered. It would also provide businesses with a predictable and stable income from their clinical services, which is often not the case at present. Whilst costs for such a mechanism would inevitably be higher, for community pharmacy to realise its potential, contractors must be able to see that they are getting a return on their investment before they will migrate to a future based around clinical or cognitive services, piecemeal payments do not support businesses.

**Graham Phillips** concurred with this view, stating: *“For pharmacists to invest in their staff, their infrastructure, and training of staff they must have sustainable, realistic predictable resources. Pharmacies not meeting the quality agenda after a reasonable period for correction should not be paid for the service in question and ultimately should see this decommissioned.”*<sup>84</sup>

However, one PCT commissioner told us that the PSNC has a fundamental emphasis on driving up income and has no workable strategy that aligns pharmacy services to the PCT's agenda, exhibiting weak strategic planning. Clearly, pharmacy as a profession has to be able to demonstrate that it can add value in alignment with the PCT and wider NHS agenda, and moving forward, with the agenda of GP consortia and local Public Health Directors. Therefore, effective communication between representative bodies is required. **Kevin Noble** also sounded a note of caution, saying: *“nobody is going to commission more expensive services in these straitened times – pharmacy has to demonstrate its value, and this will have to be based on outcomes data, which pharmacy in general is not great at harnessing.”*

For pharmacy contractors to develop bids to run new NHS services is a very time consuming and complex process. Most bids for new services are developed by Local Pharmaceutical Committees (LPCs) which is the body which is recognised in statute as representing community pharmacy contractors. Many LPCs have become frustrated with bidding for new services as they can struggle to gain the necessary support from PCTs. Many have now put development work on hold in light of the tightening financial situation.

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<sup>82</sup> The community pharmacy - a guide for general practitioners and practice staff. April 2010. Joint publication: PSNC, BMA and NHS Employers.

<sup>83</sup> The GP practice - a guide for community pharmacists and pharmacy staff. April 2010. Joint publication: PSNC, BMA and NHS Employers.

<sup>84</sup> Personal communication, August 2010.

## 13. 7. IT Infrastructure

One criticism from pharmacy contractors for the failure of some enhanced services is that services are paper-based. PCTs have failed to invest in electronic submission and recording systems for pharmacy enhanced services, they are over-reliant on manual paper based systems. This has the effect of increasing bureaucratic burden for Contractors, and also for PCTs as they have to manually input data into their own management databases. The use of an electronic submission system would generate efficiency savings for the payer (Government) in the medium term and would enable better assessment of outcomes from pharmacy services. For Pharmacy Contractors the current system is problematic to administer, with payments delayed by up to three months, with little or no audit trail to ensure that payments have been accurately processed. At least one Pharmacy Contractor has initiated legal proceedings against their PCT because of inaccuracy and delays in enhanced service payments.<sup>85</sup>

The Scottish Community Pharmacy Contract has an IT development programme called ePharmacy.<sup>86</sup> The programme aims to ‘develop e-applications to underpin the future delivery of community pharmaceutical services and improve communications across the healthcare team’. To date the programme has yielded the electronic Minor Ailments Scheme (eMAS), and the new Chronic Medication Service (CMS)<sup>87</sup>, the basic infrastructure is in place for expansion of community pharmacy services in Scotland. Community Pharmacy Wales is also in the process of developing an IT infrastructure for community pharmacy in the Principality.

The development of IT infrastructure in England has somewhat stalled as PCTs seem to be unwilling to invest in such a project, nationally PSNC has not prioritised this stream of activity, at least in public. It would seem prudent to invest in IT infrastructure to underpin planned expansion of pharmacy services. Experience in Scotland and Wales has shown that it is possible to develop such a capability without incurring the sorts of delays or cost-overruns as the Electronic Prescription Service (EPS) has endured.

### 13.7.1. Key recommendations

**★ An IT infrastructure for the delivery of Enhanced Services, communication with other healthcare providers, and the capture of outcomes data should all be created. However, lessons from past, sub-optimal Government IT projects should be learned to ensure cost-effectiveness.**

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<sup>85</sup> Chemist & Druggist, ‘PCT taken to court over service payments’, 23<sup>rd</sup> June 2010, [http://www.chemistanddruggist.co.uk/c/portal/layout?p\\_1\\_id=259751&CMPI\\_SHARED\\_articleId=4173821&CMPI\\_SHARED\\_ImageArticleId=4173821&CMPI\\_SHARED\\_CommentArticleId=4173821&CMPI\\_SHARED\\_ToolsArticleId=4173821&CMPI\\_SHARED\\_articleIdRelated=4173821](http://www.chemistanddruggist.co.uk/c/portal/layout?p_1_id=259751&CMPI_SHARED_articleId=4173821&CMPI_SHARED_ImageArticleId=4173821&CMPI_SHARED_CommentArticleId=4173821&CMPI_SHARED_ToolsArticleId=4173821&CMPI_SHARED_articleIdRelated=4173821), Accessed September 2010.

<sup>86</sup> Community Pharmacy Scotland. NHS Care Services: Infrastructure. [http://www.communitypharmacyscotland.org.uk/nhs\\_care\\_services/infrastructure/epharmacy.asp](http://www.communitypharmacyscotland.org.uk/nhs_care_services/infrastructure/epharmacy.asp), Accessed August 2010.

<sup>87</sup> NHS Scotland, [http://www.communitypharmacy.scot.nhs.uk/core\\_services/cms.html](http://www.communitypharmacy.scot.nhs.uk/core_services/cms.html), Accessed August 2010.

★ All future Enhanced Services should be delivered electronically thereby reducing the environmental impact and duplication associated with paper-based systems.

### 13. 8 Service decommissioning

In the current financial climate there is increasing evidence that pharmacy services are being targeted for cuts by local PCTs. In some circumstances, where Contractors are poorly performing, there may be adequate justification for some rationalisation. In some areas Minor Ailments Schemes (MAS) have been cut, in others, smoking cessation services have been targeted. This would appear to be a false economy as patients are likely to simply move to more expensive GP services, whilst concurrently placing greater strain on the GP appointment system. **Sue Sharpe, Chief Executive of the Pharmaceutical Services Negotiating Committee (PSNC)** stressed that *“commissioners should see community pharmacy as a solution to ongoing budgetary pressures - scaling back pharmacy services as a response to cost-cutting pressures would be penny wise but pound foolish....pharmacists can manage minor ailments far more cost effectively than GPs”*<sup>88</sup>.

NHS Surrey has recently announced the decommissioning of its successful pharmacy smoking cessation service which had helped more than 300 people quit last year.<sup>89</sup> The same service, offered through GP surgeries has been retained. There is a perception in the pharmacy professional press that pharmacy services are at times unfairly targeted for cuts over GP services, in an op-ed piece, **Chemist & Druggist News Editor, Max Gosney** declared: *“A PCT will always cut a pharmacist-led smoking cessation service over an identical GP scheme”*<sup>90</sup>. A spokesman for the **National Pharmacy Association** commented: *“...the local NHS should not hastily cut back on valuable and proven front-line services. This has the effect of fracturing continuity of care and undermining NHS Contractors confidence to invest for the future”*.<sup>91</sup>

The smoking cessation service in Tameside and Glossop PCT is under threat for ‘exceeding its budget’ - in other words it had performed too well and had supplied more quitters than expected. **Ian Short, Secretary of Tameside and Glossop LPC** reiterated the feeling that pharmacy services are a ‘soft target’ for cuts. East Lancashire PCT has also scaled back its minor ailments service, which had ‘exceeded forecasts’<sup>92</sup> - it is a false economy to move the treatment of minor ailments back to General Practice. **Andy Murdock Director of Lloydspharmacy** responded *“if we are going to have greater efficiency in the NHS it would make sense to move treatment to the right place. In my view pharmacy is the best place [for minor ailments]. If you look at the cost of pharmacy, it is cheaper. If you’re increasing access, and doing it cheaper....its a false economy [for PCTs to cut services]”*<sup>93</sup>.

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<sup>88</sup> Pharmaceutical Journal, 21/7/2010. Pharmacy services are starting to be cut by PCTs. 285: 107

<sup>89</sup> C. Chapman, ‘Surrey PCT Scraps Pharmacy Smoking Cessation Service, Chemist & Druggist, 21<sup>st</sup> August 2010.

<sup>90</sup> M. Gosney, ‘Prepare to defend your services’, Chemist & Druggist. 19<sup>th</sup> August 2010.

<sup>91</sup> Pharmaceutical Journal, 21/7/2010. Pharmacy services are starting to be cut by PCTs. 285: 107

<sup>92</sup> C. Chapman, ‘More enhanced services axed as PCT cutbacks spread to the North’ Chemist & Druggist. 26<sup>th</sup> August 2010.

<sup>93</sup> C. Chapman, ‘More enhanced services axed as PCT cutbacks spread to the North’ Chemist & Druggist. 26<sup>th</sup> August 2010.

## 14. How can we incentivise pharmacy to provide more additional services?

Pharmacists are graduate professionals with new pharmacists requiring at least five years of undergraduate and vocational training. Pharmacists study the design, theory and use of medicines at great depth, yet they have been treated by Government merely as an intermediate step in the supply of medicines. This is reflected in the Community Pharmacy Contractual Framework, which largely still rewards pharmacists supply function. As independent contractors to the NHS, community pharmacists do not enjoy the same security of reward as NHS employed pharmacists, for example, they are not entitled to NHS pensions, sick pay or holiday; plus the financial risk in purchasing a business, the investment and development of that business are entirely at the risk of the pharmacist (or company in the case of large multiple chains), stock holding again is entirely at the financial risk of the Contractor and could be worth between £15-£75k per pharmacy – up to £1 billion nationally.

In an article published in the British Medical Journal (BMJ) earlier this year, Elizabeth Richardson and Professor Allyson Pollock of the Centre for International Public Health Policy questioned the rationale for pharmacy based services. In this article the authors cited “the absence of national data, central monitoring and research...means that the effectiveness, equity, efficiency, value for money and above the implications for access, safety and quality of patient care are not known”<sup>94</sup>.

The article was mixed in its review of Pharmacy Enhanced Services, saying that there is good evidence for smoking cessation and emergency contraception services, and early evidence to support MURs for asthma patients; while evidence for more complex clinical services such as screening and minor ailments requires more research. Despite being challenged by some<sup>95</sup>, this report does highlight that there are a number of issues which are hindering the effective delivery of enhanced services, in particular: lack of national data, central monitoring and research into outcomes. The recommendations which we have laid out below at least in part attempt to tackle some of these issues.

### 14.1 Payments for enhanced services

For pharmacy to deliver on its potential, we need new ways of rewarding pharmacists for the service that they provide, traditionally PCTs have used piecemeal payments for each item of service provided, e.g. £10 per Emergency Contraception Consultation. There are two problems with this model: 1) income is unpredictable, and to a large extent insignificant; and 2) contractors bear all of the financial risk. From a taxpayer perspective, piecemeal payments provide fantastic value, as the contractor is paid for exactly what is provided. However, under any new model which proposes that pharmacy should move towards spending more time delivering services we should review how other service professions charge for their time.

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<sup>94</sup> Richardson E and Pollock A. Community pharmacy: moving from dispensing to diagnosis and treatment. BMJ 2010; 340L c2298

<sup>95</sup> “Rapid response to this article” (Sewak N, Kerr N, Martin J), Richardson E and Pollock A. Community pharmacy: moving from dispensing to diagnosis and treatment. BMJ 2010; 340L c2298

General Practice has a complicated set of contractual arrangements, with payments for enhanced services are calculated in a variety of different ways depending on the type of service. One example is the payment of a fee per registered patient for the provision of a service (capitation), which to a large extent can ignore the actual size of the population using that service; Near Patient Testing services are often contracted in this way. The difficulty for pharmacies in using this model is that they do not have defined or registered populations. A solution to this problem could be the development of a registration model for all patients, or more realistically for certain high priority patient groups such as those not registered with a GP, or disease-specific populations such as those with LTCs.

The Community Pharmacy Contract in Scotland already uses a patient registration model for both its MAS and its CMS. Capitation payments would provide Contractors with stable, predictable payments for enhanced services and would allow the Government to ensure quality through the development of QOF metrics based on the defined population. It was recently reported that the uptake of MAS was higher in deprived areas, aiding the drive to combat health inequalities<sup>96</sup>; a key aim of the Secretary of State's White Paper.

The development of a registration model would also empower pharmacy contractors to develop services which reflect the profile of their list. For example, pharmacies with high prevalence of respiratory disease could focus their resources to identify, advise and support patients through their disease process. For commissioners of services, data from the pharmacy's list would allow micro-targeting of specialist services to ensure resources were wisely spent. The concept of a registered list for pharmacies would also allow the profession to break down some of the barriers which exist to closer working with other professionals such as GP or secondary care; often cited barriers are: GPs may not know which pharmacy a patient uses and may need patient consent to communicate with the pharmacy.

#### **14.1.1. Key recommendations**

**★ All Enhanced Services should be paid by electronic submission of monitoring documents to the relevant commissioning body. Data would be collated centrally and could be used to measure performance against quality metrics.**

**★ A capitation model should be adopted for patients with LTCs. This would allow fairer payment for the consistent delivery of Enhanced Services.**

#### **14.2 Commissioning and design of enhanced services**

The current commissioning environment for pharmacy services has led to patchy distribution and quality of services. For national pharmacy multiples, it is extremely difficult to standardise their approach to enhanced services when they could have more than 150 versions of a service which have to be delivered in slightly different ways. This has also led to uneven pricing, quality and continuity of the services being provided. The proposed NHS

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<sup>96</sup> The Pharmaceutical Journal, 21/28 August 2010, Vol 285, no. 7615/16

Commissioning Board has the potential to rectify this problem, standardising pricing, SLA and accreditation to allow a more consistent approach to enhanced services. It is vital that services are written to national standards to avoid the same mistakes in the future.

National service specifications would be a major advantage when it comes to developing an IT platform for enhanced service delivery and remuneration. It would also be a benefit in the collation of research evidence to support the value of pharmacy services as it would provide a cohort of data that would be comparable for the purposes of benchmarking. Commissioners responsible for local services could then choose to commission services in areas where there was a clear need, but the service they were commissioning would be to a nationally agreed standard.

Pharmacists are to a large extent, passive in the commissioning process, as decisions are generally made by PCTs. However, there are many pharmacists who care passionately about patients and services, but those professionals have until now found it difficult to make the breakthrough to getting a service commissioned. *'Equity and Excellence'* establishes the principle that professionals should be free to deliver services for patients without interference from bureaucrats. Quality metrics could be built into all national service specifications. Where a pharmacy has consistently performed well and met the quality criterion for a service, their performance should be rewarded.

The Secretary of State for Health, Andrew Lansley MP, confirmed during a television interview on the BBC's *Newsnight* programme, the GP Commissioning is about General Practice, rather than GP Commissioning.<sup>97</sup> It would be in consistent with that aim that pharmacists should be included by right in the GP commissioning consortia. This would avoid the disconnect that has occurred with Practice Based Commissioning (PBC), which is largely commissioning by GPs from GPs.

#### 14.2.1. Key recommendations

**★ Pharmacists – along with other appropriate healthcare professionals – should be involved in providing clinical evidence to GP commissioning consortia to ensure that GP commissioning encompasses the full range of clinical expertise, and evidence base, of all relevant frontline healthcare professionals. This would ensure locally integrated healthcare services and pathways of care for patients.**

**★ Enhanced Services should follow national template for service specification to avoid the multiplicity of service designs, accreditation standards, payments bands and mechanisms.**

#### 14.3 Funding innovation

Some of the development aspirations that have been identified during the research of this paper may seem over-ambitious given the current state of public finances. The issues associated with sub-optimal commissioning of pharmacy services have been highlighted in section 13. However, there is a clear need to advance the “invest to save” philosophy should

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<sup>97</sup> BBC Newsnight, 12<sup>th</sup> July 2010, Andrew Lansley MP.

the NHS be serious about improving patient health outcomes and putting the health service on a more sustainable and affordable financial footing. There is also a pressing need for the NHS to apply a true and proper definition of value and innovation promoting core principles at every available opportunity. The NHS cannot simply cut or save its way to a better and more successful future.

The current Community Pharmacy funding mechanism encourages contractors to obtain the best price for the medicines that they purchase for the NHS and in return contractors are allowed to retain some of these savings. Anything in excess of the agreed cap is returned to the DH. These are in essence additional windfall savings to the taxpayer and are generated through the hard work and diligence of pharmacy contractors. Based on the National Audit Office (NAO) analysis of the Community Pharmacy Contractual Framework, these savings amount to £1.6 billion since the launch of the Framework in 2005.<sup>98</sup>

Using the important principle of benefit sharing an agreement between the Treasury and the DH that identified health savings will be recycled into the NHS, an agreed percentage of these excess savings could be retained within pharmacy and be reinvested in patient care via the establishment of an “innovation fund” to support the development of IT infrastructure (section 13.7), new enhanced pharmacy services, and better integration with other healthcare providers. Consistent with the over-arching vision of the Government’s White Paper reforms and the Prime Minister’s personal desire to see greater localism, this would help to empower local healthcare professionals to deliver local services directly responsive to the needs of their patient population.

One practical way of operating this “enhanced pharmacy service innovation fund (EPS-IF)” would be to allow an expert professional body to draw on the fund to develop and commission new services and then roll them out with built in quality metrics which could manage and monitor service progress. These services would be subject to the Secretary of State’s four criteria for service redesign: 1) support of GP commissioners; 2) patient involvement; 3) clinical evidence base; and 4) improving health outcomes. If the service then proved to add value and improve outcomes, it could become part of recurring local public health or wider national funding, or the professional body that would administer the innovation fund could fund another short-term cycle through the innovation fund.

The fund would also be used to fund development of IT infrastructure, research evidence, premises and workforce. Development of new services would be in the hands of healthcare professionals and away from politicians and DH bureaucracy; something that speaks to the very soul of the Government’s White Paper, *‘Equity and Excellence’*.

### **14.3.1. Key recommendations**

**★ An innovation fund should be set up, outside of the DH, to aid the development of enhanced pharmacy services and to tackle barriers to service delivery that have been identified. The fund should be populated by channelling purchase profits beyond the agreed cap using quality metrics to evaluate progress. Careful thought and analysis**

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<sup>98</sup> National Audit Office, ‘The Community Pharmacy Contractual Framework and the Retained Medicine Margin’, 2010.

would be needed when considering the establishment and constitution of the professional expert body that would administer the innovation fund.

#### 14.4 Timetable for implementation of new services

The 2005 Pharmacy Contractual Framework aspired to transition pharmacy services from the supply of medicines to the provision of healthcare, that goal has to a large part been missed, as no new advanced services have been introduced. For pharmacies which have invested in improving their workforce, premises and clinical skills the lack of new services (and new funding) has undermined confidence to invest. Ian Facer, Chairman of the National Pharmacy Association told Chemist and Druggist magazine that he had invested in automation and the development of his staff, because the previous Government had indicated its intention to commission new services from pharmacy, but had failed to put any new money into the system.<sup>99</sup> Consistently pharmacy has received kind words from politicians of all parties, culminating in the 2008 White Paper, but these aspirations have remained fundamentally unfulfilled.

If pharmacy is going to transition itself away from supply, towards a service based remuneration package, which is tied to patient outcomes, there needs to be a stronger imperative for politicians and DH officials to deliver on their promises. To that end, any future contract should include a Contractual timetable for the rollout of new services, failure to do so would lead to lack of buy in from Contractors, and would be seen as too vague to give any confidence to change their business models.

##### 14.4.1. Key recommendations

★ **Under an Innovation Fund, contractors would be empowered to trial new services for their local populations without political interference from the centre from the DH, which would negate the need for such assurances.**

★ **Under current arrangements, the development of new services has been painfully slow. A continuation of this slow pace risk holding back the profession. If maintained, the status quo should be mandated to roll out new services at a specified rate.**

#### 14.5. Measurement and outcomes

Despite the potential for pharmacy to contribute to public health and LTC challenges, one area that pharmacy needs to improve on is capture of data and measurement of outcomes. Throughout the researching of this paper, it was clear that many good initiatives are taking place in pharmacy but that robust capture and measurement of outcomes is far from universal, which in turn often makes it difficult for commissioners to assess – and ultimately commission – the impact and value of a pharmacy service in a truly evidence based manner. This is something highlighted in the above-mentioned article by Richardson and Pollock.

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<sup>99</sup> Chemist & Druggist. Video: Zoe Smeaton talks to Ian Facer at the PSNC Conference, 16<sup>th</sup> March 2010.

## 15. Is a pharmacy QOF feasible?

An idea that could improve the provision, quality and range of enhanced pharmacy services – but that would ultimately be based on improved outcomes measurement - is a Quality and Outcomes Framework (QOF) for pharmacy. In a report published earlier this year, the Bow Group examined the QOF making a number of detailed recommendations to improve its operational functioning and advance its intended aims. One of these recommendations was to look more closely at how a pharmacy QOF could be implemented and made to work.<sup>100</sup>

The existing QOF for GPs was launched in April 2004 as a voluntary incentive scheme for GP practices in the UK rewarding doctors based on the quality of care delivered to patients, and was pitched as a means of delivering substantial financial rewards for high quality care. It was argued that by introducing this framework GPs would be provided with incentives to diagnose, treat, and record information for more patients than ever before. Whilst there has been some debate around the overall effectiveness of QOF, and whether it is truly geared towards outcomes and not process, it is generally agreed that QOF has played a role in the drive to improve standards of care. It is therefore logical to consider the extrapolation of this concept and the feasibility of importing its core principles into pharmacy.

However, a number of challenges exist before a nationwide QOF is likely to come to fruition. Firstly, the very attributes that make pharmacy such a compelling tool in combating the public health challenges and (Section 4) – namely its accessibility – is also one of the biggest barriers in developing a QOF. This is because, where patients tend to be registered with one GP, the population of patients utilising pharmacies is highly transient, creating a difficulty in continuity of care. A second challenge is the widely acknowledged failure in general terms of pharmacy to capture data from outcomes measurement.

However, these issues do not inherently preclude a pharmacy QOF as a concept. Indeed, in an example of highly innovative local service development, NHS Doncaster developed a local QOF for pharmacy, based on similar principles to those established for General Practice. In 2008/2009, this was carried out across 61 of the 66 Doncaster Pharmacies, increasing to 65 in 2009/2010. Similar to the GP QOF, the objective of this initiative is to improve the effectiveness of care, patient safety and experience and to encourage Primary Care Contractors to implement processes, practices and systems which go beyond the basic contractual expectations, and to deliver services that are underpinned by recognised “best practice”. Initially, a multidisciplinary team of assessors was successfully recruited and trained to conduct review visits with each participating contractor.

The purpose of this review visit was to assess current levels of quality and achievement, and to give advice on areas for improvement. Each year the QOF develops; thus at first, an indicator may have been to simply have a policy, then subsequently it may have been to demonstrate the implementation or delivery of that policy. The current indicators (see **Figure 7** for brief summary of indicators) have tried to make the indicators quantifiable by measuring specific numbers of records similar to the GP version.

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<sup>100</sup> G. Jones, S. Carroll & J. White, ‘The Quality and Outcomes Framework (QOF): What Quality and Which Outcomes?’, Bow Group Target Paper, February 2010.

## Figure 7: Doncaster QOF Indicators

- Staff trained in life support
- Quarterly review of patient complaints and suggestions
- Reporting significant events
- Internal audit including child protection
- Procedures on safeguarding vulnerable people
- Response to safety alert system
- Infection prevention and control policy
- Implementation of NPSA warfarin guidance →
- Implementation of NPSA opioid guidance → Demonstrate patient benefits
- Implementation of NPSA methotrexate guidance →
- Controlled drugs management
- Locum induction pack and SOP
- Development of support staff
- Fridge line products handling
- Annual staff appraisal
- Action plan for implementing NPSA midazolam, lithium and paraffin products
- MURs for poly-pharmacy patients and risk of falls
- BMI measurement
- Annual patient survey
- Prescription ordering service
- Identification and support for carers
- Proactive identification of those at risk of falls

It is understood that this is the first and only scheme of its kind, although the NHS Doncaster scheme has been supplied to a number of other Trusts and related organisations who are considering adopting a similar approach. The feedback from participants involved in this scheme has been excellent, with many suggesting that it led them to question whether their current activity is in the best interests of patients, leading to improved quality of services, whilst others highlighted how it yielded a closer and more constructive working relationship between pharmacies and the PCT, leading to better quality. These examples are areas that should be warmly welcomed by the Secretary of State and responsible Minister for pharmacy under the QIPP agenda.

## 15.1. Outcomes

As mentioned in Section 14.5, measurement and capture of data and outcomes has often been an area where pharmacy needs to demonstrate improvement. This patchy measurement of outcomes has been sighted as a casual factor in the reduced commissioning of pharmacy services in certain localities, and it is equally likely to impair a sustainable, long-term QOF truly focused on outcomes. Much of the debate surrounding the GP QOF has centred on whether it is truly outcomes focused or whether too much attention is paid to process and procedure.

Whilst the Doncaster QOF is in its infancy and as mentioned above, is a concept that will modify each year, any national pharmacy QOF must be constructed to focus on patient health outcomes at the earliest possible point. Initially pharmacies may need to focus on process to ensure critical procedures that will affect quality are in place, any QOF must soon move towards building upon these processes to provide for measurable and demonstrable improvement in patient outcomes.

## 15.2 Plausibility of a pharmacy QOF

A number of the experts consulted in the course of our research suggested that as a concept, a pharmacy QOF is desirable and broadly something that would be welcomed by the profession. **Kevin Noble** agreed that there was definite logic to a pharmacy QOF, whilst **Bob Wilson** told this paper: *“It is often harder to measure patient outcomes from pharmacy services, therefore the services and pharmacy expertise may be under-valued. However, there is not enough routine measurement, but in principle some kind of pharmacy QOF would be welcomed. It has clearly worked for GP services as money follows quality. The devil is in detail though, with a question around how you measure outcomes in pharmacy when there may be a number of other contributing factors.”*<sup>101</sup>

**Norman Lamb MP** stated: *“With regards to QOF and pharmacy, this may be worth considering. I have already mentioned the possibility of incentives for commissioners and for individuals. Incentives for professionals may also be worth experimenting with in pharmacy. We do, however, have to be careful of perverse consequences which sometimes flow from the use of such incentives.”* **The RPSGB** told us that a QOF is possible but that it must be integrated with the existing QOF for general practice, to enhance rather than challenge the work of other healthcare practitioners and to encourage collaborative ways of working. **Dr Has Joshi** stated: *“QOF is an issue. Pharmacists do some of the GP QOF work and don’t get paid. Pharmacists should have separate QOF – developed in consultation with GPs to ensure integrated care for patients – with separate funding stream for this. Outcomes should then be collected and shared with GPs to improve care. BP or cholesterol tests for e.g. are good but if outcomes not shared patient care in round suboptimal.”*<sup>102</sup>

It would appear that one of the most profound ways to influence behaviours within an acceptably short period of time in primary care is to incentivise all healthcare professionals

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<sup>101</sup> Personal communication, August 2010.

<sup>102</sup> Personal communication, August 2010.

to work more co-operatively. This in turn would then lead to the quality improvement in terms of health outcomes desired in public health and LTCs.

### 15.3 Key recommendations

**★ Although there are important issues pertaining to practical implementation – such as a transient patient population – the concept of a pharmacy QOF is something that appears to be viewed as broadly workable and favourable by those submitting views to this paper. The Government should look to develop a truly evidence based, outcomes orientated pharmacy QOF that complements – and where appropriate has confluence with – the existing GP QOF.**

## 16. Concluding thoughts

The current economic climate and the state of the UK's parlous public finances throws up many important policy challenges across all Government departments. Despite enjoying the status as the Government's foremost sacred cow, the NHS is confronting unprecedented challenges itself and it is by no means immune from the efficiency drive sweeping across Whitehall. It is from this perspective that fresh thinking, a new approach and a programme of service reform is no longer simply an option but rather a compulsory imperative. This is particularly the case when considering how healthcare services across the NHS are delivered to patients.

If the Government is to have a realistic chance of achieving its stated objectives of making the NHS genuinely patient-centric; shifting care to the community setting to improve patient experiences and patient health outcomes; and facilitate a more efficient, effective and affordable NHS it is imperative that the skills of all healthcare professionals are utilised and maximised across an increasingly pressurised healthcare service. This is not least the case when considering the Government's ambitious efficiency savings target of £20 billion. The new Whitehall buzz phrase of "more for less" slips nicely off the tongue, but working out how to do it is an all together different matter.

Indeed, the £20 billion target will only be hit through ramping up dynamic value, innovative thinking and increased productivity across every single part of the NHS. As this paper has shown, in some areas pharmacy and pharmacists – as accessible frontline healthcare professionals – are making a valuable and telling contribution in this regard. We believe that by addressing the issues raised in this paper there is significant scope for this contribution to be further enhanced across all parts of the country.

For far too long, politicians on all sides have caricatured the NHS as being a service of "doctors and nurses". A quick comb through major political speeches on the NHS from Health Secretaries, Prime Ministers, Chancellors, Cabinet Ministers and Governments over the last 20 years shows the political proclivity of politicians to peddle this two-dimensional platitude. Rosy rhetoric is one thing. The practical reality is usually something very different.

Indeed, despite the excellent work undertaken by doctors and nurses, the reality is that the NHS is a multi-dimensional service spanning way beyond two medical professions. It must be a source of continued frustration to pharmacists, occupational therapists, physiotherapists, health visitors, dieticians, midwives and all other professions alike that the skill mix of the NHS is far too frequently a background political thought. It is this thought process that has all too often pigeonholed policy thinking on how best to deliver frontline health services.

This narrow mindset is now no longer sustainable or indeed economically affordable. In the current Age of Austerity, it is now imperative that the public gets value for money and public expenditure is optimised. As we collectively strive to make the NHS the best healthcare service in the world, it is even more vital that the public receives good quality healthcare when they require it. Improved quality delivered in a more productive, innovative and cost-effective manner are the foundation stones of the Government's QIPP agenda. Medicines are tools: tools to help people to stay well, live comfortable lives, fight illness and disease, and to function with wellbeing and vitality. As with any tool, medicines have the potential to cause harm where used inappropriately or ineffectively, and this is particularly the case with LTCs that often results in "poly-pharmacy" patients.

Pharmacists are the foremost healthcare profession capable of preventing medicines related harm. Through better patient education – namely promoting prevention of ill health – and better identification of problems at an early stage with effective and timely interventions, pharmacists can demonstrate their true value to the NHS. Pharmacies are located in the heart of our communities and provide highly accessible, well-qualified healthcare professionals for the public to utilise. Pharmacists provide convenient access to good health and lifestyle advice for local communities, when they are well, not just when they are sick. The Government's admirable drive to control long-term demand on health services plays to the strengths of pharmacy, which can help prevent illness through the reduction of behaviours resulting in ill-health such as smoking, alcohol consumption and obesity. The new Public Health Service would be wise to draw upon the network of community pharmacies to access patients who are not seen by other healthcare providers and which could help reduce inequalities.

Peripheral speeches, agreeable White Papers, occasional rhetoric and promising platitudes about the value of pharmacists are no longer enough. The UK's economic situation won't allow it; the country's aging population cannot sustain it; and mounting public health challenges render it unwise to continually under-utilise the important skills and expertise of *all* other healthcare professionals. This necessitates action – not just any old action, but immediate action. It is true that pharmacy itself needs to change. Our research highlights an appetite within the profession for this to happen and for this to be embraced. However, it is critical that policy changes too. The barriers that we have identified to improving the use of pharmacy are surmountable – but only *if* action follows words.

It is our hope that in the "new era of politics" with a "new kind of Government", the NHS will embrace the opportunity to better reach out to all healthcare professions and healthcare professionals. This will be to the benefit of patients and their health outcomes. To this extent, it is time to better and more fully utilise the "men in the white coats". If the NHS fails to do so, it will not just be a missed opportunity that is dispensed. It will also be a failure to properly prescribe an innovative solution to help facilitate a better NHS.

## Acknowledgements

We would like to convey our deep gratitude and sincere thanks to the following experts and organisations without which this research piece would not have been possible:

1. **Mr. Annesley Abercorn** – Chairman of the Bow Group.
2. **Alliance Boots.**
3. **Baroness Julia Cumberlege** – House of Lords.
4. **Mr. Graham Godwin-Pearson** – Web Consultant to the Bow Group.
5. **Mr. Mike Holden** – Chief Officer of Hampshire and Isle of Wight Local Pharmaceutical Committee.
6. **Mr. Gary Jones** – Member of the Bow Group Health Policy Committee.
7. **Dr. Has Joshi** – Vice-Chair of Council for the Royal College of General Practitioners.
8. **Hon. Norman Lamb MP** – Chief Parliamentary and Political Adviser to the Deputy Prime Minister, Rt. Hon Nick Clegg MP.
9. **Mr. Mark Nicholson** – Research Secretary of the Bow Group.
10. **Mr Kevin Noble** – Community Pharmacy Lead at Isle of Wight PCT.
11. **Mr. Graham Phillips** – Community Pharmacy Proprietor, Senior Pharmacist and Member of the English Pharmacy Board.
12. **The Royal Pharmaceutical Society of Great Britain.**
13. **Hon. Mark Simmonds MP** – Member of Parliament for Boston and Skegness.
14. **Mr. Tony Lodge** – Chairman of the Bow Group Energy and Transport Committee.
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An extra special thanks to **Baroness Cumberlege** and **Gary Jones** for all their tremendous help and support throughout the researching, drafting and writing of this paper.

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