HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM Scottish NHS Directors of Pharmacy

1. Considering the Health and Sport Committee's report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities.

General comments

- Whilst the introduction of the new GP contract was welcomed there is a need to consider the role of primary care beyond the GP practice. Once clear about what the future role of primary care should be in terms of scope there is an opportunity to then design contractual frameworks across primary care contractors (GPs, Pharmacists, Dentists and Optometrists) to deliver that future role, making best use of every member of the wider primary care team. There is both the opportunity, and need, for greater integrated planning for primary care contractor services at the national level.

- In considering the future of primary care there is a need to pay particular attention to the interface with secondary care services, which are increasingly delivering longer term chronic treatments under specialist supervision, and to achieving continuity of care between in-hours and out-of-hours (OOH) services.

- The emphasis in public feedback on social prescribing and on the health service taking on social care exemplifies both the desire within the public to have effective integrated services but also the expanding medicalisation of health and well-being. It is reassuring that the public consider non drug options for care are legitimate and need more emphasis. However, there is a risk that if the NHS expands in these areas that it further cements medicalisation. Whilst very supportive of increased self-care and self-directed care there is a need to further consider how this is best achieved to enable patients to maximise their health and wellbeing.

- The public support for information sharing and adoption of technology should drive a shift from the overly cautious approach to information sharing that currently exists within the NHS to one that lives up to the expectations of patients. The NHS and other public bodies significantly lag behind private sector in terms of information sharing and adoption of technology. Public expectations include that a health professional treating them has access to accurate, up-to-date information, relevant to that health professional’s needs to care for the patient at the right time in an easily accessible way. This expectation of information sharing should drive what and how information is shared with in an information governance framework that facilitates sharing rather than making it more difficult. This does not in any way mean that the NHS should not respect the patient data it uses, but a shift from a ‘you can’t’ to a ‘let’s work out how’ approach would better serve patients and professionals when considering how data should be shared.
Pharmaceutical Care Services

- The wider Primary Care team if used effectively could help address the expressed desires from this work. From a pharmacy perspective, the increasing emphasis on pharmaceutical care roles outlined in ‘Achieving excellence in pharmaceutical care: a strategy for Scotland’ will require a contractual framework which rebalances the supply of medicines with the delivery of high quality pharmaceutical care interfaced with GP practices / Pharmacotherapy team activities and hospital care provision. That rebalancing might include the contractual segregation of supply and clinical pharmacy service provision even where those two roles are completed by the same pharmacy.

- The availability of pharmacy services without appointment at times when GP practices are closed provides an important route to unscheduled care services. Given the pressures on out of hours medical provision, and in order to support appropriate use of Accident and Emergency Services, there is a role for management of minor illness, common clinical conditions and urgent supply of medicines which has not been optimised to date.

- One example of future pharmaceutical care service provision that should be further explored and facilitated by any future contracting process would be for pharmacists to be contracted to provide Personal Pharmaceutical Care Services (PCS) to a registered caseload / list of patients. Such PCS would include:
  - Standardised, periodic, structured review of all medication and communication with other members of the health and social care team as necessary,
  - monitoring of individual patient responses to medication (including clinical examination and biochemical assessments) and amending that medication appropriately using independent prescriber rights where necessary,
  - counselling of patients in relation to the medicines they are using,
  - supporting the provision of medicines that offer the best benefit and risk to the patient and value to the local health economy,
  - promotion of self-care / management and responding to acute care provision for common clinical conditions,
  - maintenance of patient care at home or in a homely setting including support and interface with hospital at home type services,
  - arranging the supply of medication dispensing for their list of patients.

These services would be subject to patient registration in a similar way to GP practice registration.

Sharing information
• The Health & Sport Committee surveys of the public’s views indicate strong support for the sharing of information to support delivery of direct care and the greater use of technology, be it to book appointments, access results, receive reminders or for consultation by video.

• It is vital that a health professional treating a patient has access to accurate, up-to-date information, relevant to that health professional’s needs to care for the patient at the right time in an easily accessible way. That access must support the seamless and safe provision of care between clinical settings, health professionals and in hours and out-of-hours services. Significant improvement, supported by investment, is required to achieve this goal.

Use of technology

• The role of technology in the supply of medicines is advancing with dispensing robots becoming more common in community pharmacy and larger national chains continuing to develop ‘just in time’ systems of delivery of dispensed medicines to their pharmacies that have been assembled off site. Further, the innovative use of bar code technology could free time for patient care.

• This growing use of technology for the assembly of dispensed medicines is sadly not matched by improvements in technology that facilitates full pharmaceutical care. Work in Scottish Health Boards has shown how video technology can be used to:
  • facilitate rural consultations and medicines review,
  • provide remote access to medicines under the supervision of a distant pharmacy,
  • allow the transfer of information about the medicines that patients have received from a pharmacy to their hospital on admission so that a more accurate list of medicines can be constructed so that patients get the medicines they need,
  • allow the transfer of electronic discharge information to community pharmacies to ensure that patients receive the pharmaceutical support they need as they return home from a hospital stay,
  • provide community pharmacists with access to laboratory results that help them manage patient’s medication more safely or to help bring diagnostic services closer to the patient.

The challenge is that each of these remain localised approaches when the real scale of benefit will only be achieved if they adopted nationally. Given the mixture of individual pharmacist owners, small family run chains and large internationally owned multiples there is a need to drive the adoption of technology changes through the national contract with a greater emphasis on a core pharmaceutical care IT system. One option is that this is owned by the NHS and interfaced with other primary and secondary care information systems.
Provision of minor ailment and illness treatment, health advice and health protection activity e.g. vaccination, screening

- The provision of advice for minor ailments and the provision of treatment (either on the NHS or via purchase) has long been a bedrock of pharmacy service provision. Recent developments of the Pharmacy First approach demonstrate how community pharmacy can provide fast and easy access to health professional advice and treatment with prescription only medication for simple urinary tract infections and impetigo. The evidence for pharmacy’s contribution to care such as this was made several years ago and that evidence was high quality and robust.

- The Minor Ailment Service (MAS) should be expanded and future MAS needs to focus on the range of conditions that require the expertise of a health professional to diagnose and treat and the use of medicines that are restricted to prescription only status in the main. This would provide a clear delineation between the evidence based provision of minor ailment and illness treatment and the provision of other treatments and remedies that should fall within the realm of self-care. In this way the MAS would be more effective in moving minor ailment and illness activity away from the GP but would also provide a clear route of access in terms of formal NHS care provision versus self-care.

- There is a need to make community pharmacy premises a real locus of ‘on the high street’ health advice and lifestyle / behavioural support with appropriate training of staff / access to visiting staff and investment in resources. The emphasis on the GMS contract has perhaps dominated perspectives and limited consideration on the broader use of the whole primary care team. The alternative is to accept a limited role for pharmacy teams in those areas that have a direct link to a pharmaceutical e.g. smoking cessation. An enhanced role in this arena would fit well with the health protection functions being considered for community pharmacy such as routine and travel vaccination. It is important to note that any use of pharmacy premises for vaccination will require premises infrastructure upgrades and be designed in a way to utilise staff other than pharmacists and pharmacy technicians.

Premises Development

- In considering a new contract there is a need to review the current network of pharmacy provision and consider how the co-location of services wanted by the public is balanced with access to both medicines and health advice.

- There will be a need to consider the decoupling of supply of medicines and delivery of clinical pharmacy services and whether larger, multi-pharmacist pharmacies offer advantage over the more common single pharmacist model that is currently prevalent.
As part of that review there is a need to consider opportunities to repurpose pharmacy premises. Against a backdrop of extremely limited space within GP premises there is an opportunity, with appropriate financing, to repurpose current retail space within community pharmacies for NHS purposes. These spaces, upgraded to provide NHS standard consultation and treatment rooms, would provide the primary care team with added flexibility to provide care at the place and time that better meets patient’s expectations.

Pharmacotherapy Services

Pharmacotherapy services form a significant element of the new GP contract with an expectation that by 2021 Level 1 services will be in place to include:

- Authorising / actioning all acute prescribing requests
- Authorising / actioning all repeat prescribing requests
- Authorising / actioning hospital immediate discharge letters
- Medicines reconciliation
- Medicine safety reviews / recalls
- Monitoring high risk medicines
- Non clinical medication review
- Monitoring clinics
- Medication compliance reviews in the patient’s own home
- Medication management advice and reviews for care home patients

The commitment made within the GMS contract to delivery of Pharmacotherapy Services is significantly challenging. Key amongst those challenges are:

- ability to recruit the workforce required without destabilising other pharmacy services in the hospital or community pharmacy settings,
- training the large numbers of pharmacists and technicians that are likely to be required to deliver the service as aspiring to in the contract,
- providing the infrastructure needed to support effective service provision when even the availability of suitable clinical space within GP practices is a challenge,
- balancing the need for standardisation in systems and processes to allow an efficient pharmacotherapy service to be delivered against the independent contractor nature of General Practice,
- delineation of professional responsibility and accountability within a quality service with robust clinical governance,
- a need for more clarity around the roles of the whole primary care team, GPs, nurses, administrative staff and others in delivery of a pharmacotherapy service,
- resolving the current apparent mismatch between the funding earmarked for this service and the aspirations laid out in the GMS contract.
In developing and implementing Pharmacotherapy Services there is a need to:

- Develop a shared vision for how pharmacy teams can support both general practice and primary care in its wider sense. This vision needs to maximise the time that can be released within GP practices whilst being realistic about the workforce and service challenges that face us.
- Recognise that the Pharmacotherapy service will not operate effectively, safely and efficiently without integration and partnership with community pharmacy services.
- Reconsider the role of community pharmacy in the delivery of pharmacotherapy services in a partnership approach to care provision.
- Accelerate the scope and volume of prescriptions that are managed through the NHS serial repeat system (Managed Care and Review) in order to maximise the repeat prescriptions that can be appropriately managed by community pharmacy once the pharmacotherapy team have authorised them.
- Increase the contractual levers and incentives to drive the scale of change required both within community pharmacies, but also within General Practice.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

- **Workforce**: With the advent of pharmacotherapy services there is a significant mismatch between the numbers and skillsets needed to fulfil the commitments in the GMS contract and the graduates and newly qualified pharmacists produced in Scotland. For pharmacy technicians the situation is significantly worse where there is no established extra-numerary training pipeline i.e. all trainees are trained on the job and the numbers being produced via this route only produce enough to supply the historical model of service need rather than those additionally needed for pharmacotherapy services. Pharmacy technician training needs to meet the needs of all employers/students not just those in urban/central areas. This workforce issue applies to many professional groups including doctors, nurses and AHPs but as there is no workforce plan at national level for the number of pharmacy professionals needed there has been little work to address this capacity issue.
- **Technology**: There is a need to invest both in information sharing technology to support the types of care described in our response to Question 1 but also the automation of dispensing. Automation of dispensing provides an opportunity to release staff capacity to take on new roles but uptake in community pharmacy remains relatively slow.
- **Geography and flexibility**: There is a need to be more flexible with how premises are used and shared amongst practitioners. In rural areas small satellite general practices are under increasing pressure financially but patients place high value on having localised access to General Practice, even if it is at limited times of the week.
One solution would be incentivise the sharing of practices so that within a community pharmacy there was a consultation and treatment room, built and maintained to NHS standards, that GPs, district nurses, practice nurses, secondary care outreach clinicians could use to see local patients near to their homes. Clearly this space would need to be remunerated for but it would potentially provide a cost effective solution to bringing services nearer to patients homes whilst repurposing and professionalising the retail areas of community pharmacy.

- **Contract:** The current Pharmaceutical Care Services Arrangements will need significant change in order to provide a sustainable, incentivised, performance assured framework for community pharmacy services in the future. In preparing for that change there should be careful consideration of the potential benefit of segregating the supply elements of the contract from the clinical pharmacy / pharmaceutical care elements of the contract. There should also be a move to contracts with individual pharmacists rather than corporate entities bringing a stronger relationship of responsibility and accountability for service provision to those who are directly professionally regulated as individuals.

- **Integration:** There is a need to further integrate pharmaceutical care provision with primary care, secondary care and social care. The key to that integration is registration of patients with an individual pharmacist / pharmacy supplemented by a revised contractual framework and information sharing. The ability for others in the health service or social care to be able to identify the pharmacist or pharmacy responsible for pharmaceutical care provision for a patient via registration and the assurance such registration brings in terms of quality of care and data handling etc. will enable pharmaceutical care services to play a more effective role in patient care.

- **Data control:** A large majority of patients reported being happy for relevant health information/notes to be shared across the primary care team to help co-ordinate the best care for them. However, the current segregation of data control by contractor creates challenges in care delivery and measuring population health, health improvement and quality improvement of health service provision. There is a need to consider how NHS Scotland itself can increase its role in data stewardship in partnership with contractors to the benefit of all.

3. **How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?**

   The question perhaps should be what do we need to put in place to enable us to measure and monitor the effectiveness of multi-disciplinary teams and GP cluster working and support evaluation in terms of outcomes, prevention and health inequalities?

   The key will be an integrated health data set that allows measurement of both health gain and those outcomes important to patients. Most measurement at the moment is focussed on activity levels, time to treatment, and access to new treatments rather than whether health has been improved, bad outcomes avoided, lives extended, and people’s well-being
improved. The Digital Health Institute is a useful step in this direction but it needs to be recognised that use of technology and data analytics in the NHS lags behind most private enterprises who use that data to improve their business. This requires significant investment.

Further, the public survey indicated strong support for patient data to be shared between those providing direct care but less support for the health service as an organisation to have access to that data. To undertake the types of measurement that are meaningful, valid and reliable there will need to be organisational access to patient level data and appropriate investment in the analyst capacity and expert interpretation needed to make best use of that data. In doing so there is a need to resolve the concerns of the public with clear messaging about the benefit of such sharing but also commitments to anonymise the data where appropriate and guarantee confidentiality where it is not.