ROYAL PHARMACEUTICAL SOCIETY

Towards a future vision for general practice
Royal Pharmaceutical Society response

What kind of service should general practice provide to patients in the future?
We are aware that population needs are changing with more people living longer but also more patients with multiple conditions, meaning that many people are now on multiple medicines.

General practice is one of many access points for patients within primary care, other access points include community pharmacies, opticians and dental practices, so services in the future need to ensure better collaboration between all primary care providers. The range of healthcare professionals working in primary care should be able to refer patients across primary care and into secondary care such as community pharmacist referrals to pharmacists in GP practices and to other primary care professionals such as podiatrists e.g. for diabetes related foot care.

The sharing of information about the patient and the care they are receiving is critical so patient information flows amongst primary, and secondary care providers, needs to happen. Digital services need to be interoperable so that patient information can be accessed in one place and patients can authorise a variety of healthcare professionals to have access to their information.

In the future there will be more digital services where appropriate such as video / Skype consultations where you can see the patient but they don't have to travel. These will need to work alongside face to face consultations for those people who need or want this option. In addition, the ability to send prescriptions electronically is already available but there should be better uptake of this service amongst GP colleagues with currently only 63% of prescriptions being prescribed electronically (August 2018). In addition, EPS enables a GP to authorise a group of prescriptions for up to 12 months. Again, the use of EPS for repeat prescribing should be further encouraged as it supports the seamless flow of information about prescription needs for patients and reduces administrative time within a practice.

Some GP practice teams already include practice pharmacists who can review medicines, especially for those patients who have multiple conditions, we would see this service expanding in the future and also strengthening the links between practice and community pharmacists in some areas.
It would be beneficial to patients if they could have longer consultation times with the relevant member of the GP practice team, particularly as they may have multiple conditions, or may also want to discuss mental health issues. These consultations need to person-centred and not limited to just one issue.

How should this health drive improvements in health outcomes?
Sharing of information so everyone who is providing care to a person knows what has happened previously and can act on it will improve the care a person receives. It also reduces the number of times people have to repeat the same information.

GP practices and other primary care providers need to learn from each other to reduce variation. There should be better use and sharing of population data (e.g. NHS Right Care) and informatics to inform care provision.

GP practice teams need to work more collaboratively with other healthcare colleagues such as community pharmacists to ensure better integration across care pathways for patients.

How should the role of the GP develop in future?
The GP needs to continue to be the expert medical generalist with a focus on diagnosis. The GP practice needs to continue to co-ordinate care for their patients. Due to workload pressure this co-ordinator role will not necessarily be undertaken by the GP but by another member of the team such as a care navigator. The GP is one of several access points into the NHS so there needs to be more collaborative working between all primary care providers, and also better working with secondary care.

Services need to focus around the patient and the GP practice is one of the many services the patient can use. Community pharmacy should be promoted as the first place to go for minor illness with the ability to refer a person to their GP if the person's concern is deemed to be more serious. In Wales, where there is a national Common Ailments service, many surgeries advise patients to visit a pharmacy first. If we are to reduce pressures on GPs then serious consideration needs to be given to designing a national service for England, expanding on the good work that is happening in the North East and being rolled out to other parts of England. Community pharmacies should also be seen as health and wellbeing centres as they can provide advice on healthy living.

What are the barriers and enablers to achieving this?
Competition between health care professions working in primary care is currently exacerbated by competitive contracts. An enabler to change this could be the introduction of primary care network contracts or integrated care provider contracts, bringing together a variety of providers across a locality.

There needs to be a culture change amongst professionals but also amongst patients and the public to enable truly integrated care to happen.

IT systems need to be interoperable and contain accurate and timely information so information can be exchanged between healthcare professionals, with patient consent. Currently many systems are not interoperable, so clinical standards are essential to support this.

How should the wider practice team develop in future?
Every GP practice should include a practice pharmacist as part of their team and a senior pharmacist should be employed within each GP federation to coordinate and support their activities.

There should be better joint working with pharmacists working in the community who generally see patients in between their GP visits, who can provide extra support for patients taking long-term medicines and who can undertake prevention and minor illness activity. In the future, community pharmacists will be providing more support for people with long-term conditions in

terms of supported self-management as well as the current role they undertake around supporting self-care.

What are the key barriers and enablers to achieving this?
Currently providers often have a competitive approach. All providers need to work collaboratively to achieve agreed joint outcomes in a locality.

How should general practice relate to the wider health care system in future?
General practice should not see itself as the only place for a person to go in the primary care setting as it is one of a number of options for patients. Therefore the GP practice needs to become better at sharing the information they hold on patients with other healthcare providers, with the patient's consent.

General practice needs to be open to a variety of different models developing in the future and become involved in the development of these models.

The vision for general practice needs to align with the vision of other professions working in primary care. In terms of pharmacy we see pharmacists integrated into a variety of settings in primary care such as GP practices, care homes, Integrated Urgent Care Clinical Assessment Services as well as community pharmacies, and there is a need for seamless care across all of these settings.

What are the key barriers and enablers to achieve this?
In the past the NHS at a national level has focused mainly on secondary care and the majority of the funding has gone into this sector too. In the future the national focus must be on primary care and funding allocated accordingly.

There needs to be more of a focus on prevention to prevent or delay people needing to call on the NHS. GPs, along with other primary care providers, need to realise this and incorporate prevention strategies into their way of working – or work with other primary care providers to deliver preventative care.

There needs to be national strategies that deliver integrated care across healthcare professionals and care settings.

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Chair, English Pharmacy Board

About us

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

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

Its functions and services include:

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

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

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

EXAMPLE 1: Community pharmacies support medication monitoring in children and young people with attention deficit/hyperactivity disorder (ADHD)

Children and young people who are prescribed medicines for ADHD and related conditions need regular monitoring of key metrics (height, weight, blood pressure and pulse). For many families, a clinic appointment for physical screening means missing school unnecessarily and a parent missing work.

A Sussex Partnership NHS Foundation Trust led project enabled families to select a community pharmacy to provide the physical monitoring of key metrics with the results available to their clinicians via a secure website.

Community pharmacies were able to offer appointments locally at more convenient times. This meant that increased numbers of patients have engaged with medication monitoring, and received improved quality of care closer to home. It is also estimated that around 40% of the child and adolescent mental health services team resource was released for other activities.
www.health.org.uk/programmes/innovating-improvement/projects/developing-community-pharmacies-support-medication

EXAMPLE 2: Physical health checks in community pharmacies

Patients with a diagnosis for psychotic illness have been receiving physical health checks in community pharmacies through a collaboration between North East London Local Pharmaceutical Committee (NEL LPC), North East London NHS FT and University College London, with support from Public Health London Borough of Barking and Dagenham and the London Mental Health Strategic Clinical Network.

Funded by a Health Foundation Innovation Award, patients known to the Barking and Dagenham Community Recovery Team, were offered physical health checks at a local participating community pharmacy. This included ECG, blood pressure, cholesterol and glucose testing with results available on the same day. Pharmacists spent up to an hour coaching patients and empowering them to self-manage their physical health.

From September 2016 to January 2018, 180 patients were offered health checks with 140 (78%) taking up the offer. Of all attendees 70% had all five cardiometabolic risk factors monitored which is significantly better than standard care in Barking and Dagenham, where only 36% of patients had all five risk factors monitored and higher than the NHS England national averages for inpatient and community settings.

psnc.org.uk/services-commissioning/locally-commissioned-services/service-case-study-community-pharmacies-tackle-inequalities-for-patients-with-psychosis/

EXAMPLE 3 Widening access to pharmacist expertise: Pharmacists in liaison psychiatry teams

In order to overcome the divide between mental and physical health, liaison psychiatry services aim to treat people with psychiatric illness and a comorbidity/physical illness in an acute hospital. Liaison psychiatry teams are fully integrated into acute hospitals and available within working hours and out-of-hours. A liaison psychiatry review should provide clear and concise documented plans in the acute hospital notes at the time of assessment; incorporating a management plan including medicines or therapeutic intervention.

Within Northumberland Tyne and Wear there are five Psychiatric Liaison Teams (PLTs) covering 17 sites. The Sunderland Royal Hospital Liaison Team has a pharmacist as a member of the team. The PLT pharmacist provides a link between disciplines within healthcare settings and provides medical and pharmaceutical advice to nursing staff and patients without requiring direct consultant contact. This reduces medical involvement where possible, focuses resources appropriately and saves money. The PLT pharmacist is also an extra resource to acute trust inpatient pharmacy teams when necessary.

In 2017/18 the PLT pharmacist worked for 96 days, received 149 referrals comprising of 137 individuals, and undertook 362 patient-facing medication reviews. Medication changes were made in 94 individuals with 51 including de-prescribing advice. The psychiatric liaison team and acute trust pharmacists were asked for feedback via survey and 95% of respondents considered the service to be good or excellent.

EXAMPLE 4: Prevention of type 2 diabetes in community pharmacies:
Participating patients underwent an assessment using a validated questionnaire to determine their 10-year risk of developing type 2 diabetes within Boots pharmacies. Patients were given appropriate lifestyle advice or referred to their general practitioner if necessary.

Key findings: In total, 21,302 risk assessments were performed. Nearly one-third (29%) of 3427 risk assessments analysed yielded a result of moderate or high chance of developing the condition. Nearly one-third (29.1%) of assessments yielded a result of a moderate or high chance of developing the condition, with 60.4% being conducted on people considered overweight or obese. Community pharmacies can identify a significant number of patients at risk of developing type 2 diabetes in the next 10 years.
http://onlinelibrary.wiley.com/doi/10.1111/ijpp.12139/full

EXAMPLE 5: Screening in community pharmacy
Green Light Pharmacy has a long-standing collaboration with local third-sector bodies and neighbourhood organisations linked to the local authority's Health and Wellbeing Board. The overall project is funded by the Big Lottery and a key delivery stream is focussed on addressing health inequalities that exist between the local population and the rest of the population (of the borough/city/country).

The current service has been branded as WellFair to link it to other services that are available via social prescribing, including healthy walks and patient-led health talks. During the 1 and a half years that this project has been running, Green Light Pharmacy has screened 695 people. Of this

136 people were eligible and consented to having a fuller health check as a follow-up to the screening, looking at vascular health, mental health, cancer screening, and dental/optical health access. This doesn't exclude people with existing health conditions as it is a useful way of re-engaging people with health and social care services.

Around 90% of those receiving full screening were referred to NHS follow-up to address health issues that were identified, primarily related to vascular health but also mental health.
http://www.westeustonpartnership.co.uk/wellfair/

EXAMPLE 6: Early detection of atrial fibrillation (AF) in community pharmacies

As part of one of the NHSE Innovation Test Bed, North East London Care City worked with local pharmacies, to trial early testing of AF using a KardiaMobile handheld mobile device from AliveCor. It spots AF in 30 seconds. Those with an abnormal result receive rapid referral to a One Stop AF clinic where a patient will undergo minimally invasive diagnostic tests and meet with an Arrhythmia Nurse to discuss the result and, if appropriate, receive treatment. The whole process takes 2-3 weeks, compared to a national average of 12 weeks at present.

Professionals and patients not only got to experience the use of a novel piece of technology but they experienced first-hand the benefits and challenges of integrating a digital innovation into a clinical pathway. Over the course of the 6 month pilot, 672 people were screened across 21 pharmacies in Waltham Forest. Of those screened, 110 were referred for specialist review, 74 were triaged out by an Arrhythmia Nurse and 30 patients attended the clinic. Of these 30, 23 had possible AF and 2 had known AF.

https://www.youtube.com/watch?v=k4xxNNx9dfY

Another project, led by a team at the Royal Brompton and Harefield NHS Foundation Trust, is looking at how the detection and treatment of atrial fibrillation (AF) can be improved via 'enhanced' medicines use reviews in community pharmacies. Community pharmacists currently provide medicines use reviews to patients and are ideally situated to facilitate the diagnosis of AF.

Ten community pharmacists will carry out detailed medicines reviews for patients with risk factors for developing AF, for example high blood pressure or diabetes and, in patients with existing AF, they will check that they are receiving optimised treatment and are taking anticoagulants. As part of the consultation, the pharmacists will use a portable electrocardiography (ECG) device, called an AliveCor monitor, to detect AF. Patients who are found to have undiagnosed AF, are not appropriately anticoagulated, have poor heart rate control, or have high symptom burden, will be referred to the Arrhythmia Care Team at Harefield Hospital, where they will be reviewed and offered individualised treatment.
http://www.health.org.uk/programmes/innovating-improvement/projects/enhanced-medicines-use-reviews-improve-detection-and

In a different study, pharmacists in six pharmacies in Kent undertook atrial fibrillation screening from October 2014 to January 2015. Of 594 patients screened, nine were identified as at risk of

having AF and were referred to their GP. The service also identified 109 patients with undiagnosed hypertension, 176 patients with a Body Mass Index of more than 30, 131 with an Audit-C score of more than 5 and 59 smokers. Pharmacists provided 413 interventions in 326 patients aimed at weight reduction (239), alcohol consumption (123) and smoking cessation (51).
http://www.heartrhythmalliance.org/files/files/afa/for-clinicians/Twigg_2016.pdf

EXAMPLE 7: Pharmacists supporting patients with dementia
Pharmacists are ideally placed to recognise any deterioration or decline in mental health and recognise early signs and symptoms of LTCs such as dementia or cancer. The final package for community pharmacy in 2016/17 and beyond introduces a quality payment system and one of the quality criteria is that 80% of all pharmacy staff working in patient facing roles are trained dementia friends.

The majority of community pharmacists England are now dementia friends and Manchester have recently published a framework to ensure all the community pharmacists in the area are dementia friendly environments
http://psnc.org.uk/bolton-lpc/bolton-ccg-information/dementia-friendly-pharmacy-framework/

EXAMPLE 8: Supporting patients to get the most from their medicines
Aimed at patients aged over 65 years taking four or more medicines:

- High users of NHS resources who may not be getting optimal benefits from medicines
- Poor adherence can lead to worsening of the condition
- Adherence is more problematical with multiple medicines
- Older people are more susceptible to adverse drug reactions.
- 620 patients recruited by 25 pharmacies across Wigan in four months across all socio-demographic areas.

Patients saw benefits from pharmacist interventions which improved their understanding of their medicines and addressed specific issues they were having.

After six months, patients had:

- Significant increase in medicines adherence
- Significant reduction in medical and self-treated falls
- Significant increase in patient quality of life.

Patients reported a general improvement in health. Pharmacy teams picked up on a range of issues, not all medicines related. Patients were more satisfied with the management of their condition, a key NHS objective. Quality of life was improved in small but significant ways, such as advising on the correct length of walking sticks and how medicines could fit in with home and social life.

Based on the findings from the FOMM Service, it is estimated that if the service was delivered from 11,100 pharmacies in England to 954,600 patients then the NHS would see annual benefits of:

- £35.57m in reduced medicines costs and hospital admissions as a result of STOPP / START recommendations
- £33.87m in reduced hospital costs due to reduction in falls that result in fractures.

- 17,200 QALYs
- Benefits as a result of improved medicines adherence, pain, and falls that do not require secondary care treatment have not been quantified

http://www.communitypharmacyfuture.org.uk/

EXAMPLE 9: Supporting patients with asthma

In collaboration with other health professionals, community pharmacists were given extra training to deliver structured asthma reviews including reviewing inhaler technique.13 pharmacists carried out reviews in Leicester city centre on 165 patients with follow-up appointments at 3 and 6 months:

- 42% of patients had not had an asthma review at their GP practice in the last 12 months
- 56% had not had their inhaler technique checked in the last year

Using the validated Asthma Control Test (ACT) the results showed most improvement in those patients who had not had an asthma review from their GP in the last 12 months; showing patients receiving significant clinical and quality of life improvement. It is known that people only take their medicines as prescribed 50% of the time which leads to poor outcomes and wasted resources. The study found considerable improvement in patients' compliance with their medicines, resulting in better overall asthma control. The study demonstrated a 32% decrease in GP appointments and a 40% reduction in hospital admissions. The authors concluded that to improve patient outcomes and thus decrease hospital admissions, pharmacist asthma reviews should be targeted at patients who have not had a review from the GP recently, capitalising on the accessibility and approachability of the community pharmacist.
http://www.pharmaceutical-journal.com/news-and-analysis/features/make-asthma-simple-for-your-patients/11138140.article

EXAMPLE 10: Digital Minor Illness Referral Service (DMIRS)

This digital minor illness referral project enables NHS 111 to refer patients with minor illnesses - such as sore throats, coughs, colds, tummy troubles, teething, and aches and pains - to a local community pharmacy.

The initial project ran from 4 December 2017 to 31 March 2018 across Durham, Darlington, Tees, Northumberland and Tyne and Wear where the North East Ambulance Service NHS Foundation Trust (NEAS) is the NHS 111 provider. It was extended to 30 September 2018 and is now further extended to 31 March 2019.

Over 8,500 patients in the North East have been referred into the service for advice from a pharmacist and over 80% of patients are 'very satisfied' with the service. Only 11% of those patients seen have been referred to a GP for an urgent in hours appointment. The initiative is being piloted in other areas to help reduce pressure on GP care and A&E departments and deliver better access to care, closer to home, and with a self care emphasis.

Previously, less than 1% of NHS 111 referrals were to a community pharmacy - calls were referred to other primary care locations such as general practices (in and out of hours), walk-in centres or, in some cases, A&E. These appointments can restrict access and reduce the time GPs have to focus on patients with greater clinical need.

https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/dispensing-contractors-information/digital-minor

EXAMPLE 11: Virtual clinics for atrial fibrillation

In Lambeth 47 GP practices were involved in an AF virtual clinic. This involved 2 specialist anticoagulation pharmacists reviewing the all patients within the practice who had been identified as having AF but were not currently anticoagulated. Of the 1,340 patients reviewed across the practices 1,292 were anticoagulated preventing an additional 45 strokes per annum.