Cited submissions

http: www.rpharms.com/futuremodels

Submissions cited in the final report of the RPS Future Models of Care Commission.

Royal Pharmaceutical Society (2013)

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Commission on
Future Models of Care
Delivered through pharmacy

1. Name

Barbara Jesson

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of organisation?

Croydon Clinical Commissioning Group

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

The Local Authority, through reablement funds, have supported the commissioning of community pharmacists, trained and supported by primary care pharmacists, to deliver domiciliary MURs

8. What was it that impressed you about this pharmacy model of care?

the co-operation between different organisations. The acceptance of our evaluation system - ie adapted RIO scoring to show how each intervention may have avoided a hospital admission- this helped to maintain the funding stream over 2 further years

9. What benefits does it offer patients and the wider healthcare system?

Improved medicines safety for people in their own homes and avoided hospital admissions leading to savings

10. What helped the development of this model of care?

A system that had been developed previously which could demonstrate the benefit of the service. Close monitoring of quality and speaking to a pharmacist who was missing opportunities or producing poor MURs (we asked to have these sent in anonymously)

11. What hindered the development of this model of care?

We have to keep prompting them when activity falls especially through the summer months

12. Where can we find out more?

Croydon CCG Pharmacy Team- Victoria Williams or Barbara Jesson email first name. last name@croydonpct.nhs.uk

13. Do you have any other examples of new or innovative models of care to share with us?

Yes

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

Dispensing service for care homes- aimed at providing good quality information over and above what is usually provided including an MUR with resident and carer/nurse

15. What was it that impressed you about this pharmacy model of care?

The use of pharmacists knowledge not just as a route of supply

16. What benefits does it offer patients and the wider healthcare system?

better understanding of medicine use by care staff. All medicines including externals will be fully labelled. Thought will be given to the timings of medicines relevant to the individual Good quality MARs

17. What helped the development of this model of care?

Primary Care pharmacists visiting the care homes with GPs to conduct medication reviews and realising that the standard of dispensing and MAR charts provided were often less than helpful

18. What hindered the development of this model of care?

getting the multiples on board

19. Where can we find out more?

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21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Variable standard of delivery keeping up the interest and activity levels

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Helping the pharmacists to learn to delegate effectively Supporting them to achieve an ethos of continuous improvement (Faculty??) Confidence of commissioners in community pharmacy

23. Are there any existing services that you think could be better provided through pharmacy?

Sexual health services - for most areas this is based purely on activity not on information, signposting, avoidance of STI setc

24. Are there any services that pharmacy currently doesn't offer but you think it should?

Childhood vaccinations

5.Do you have any links to resources that you feel would be helpful to the commission?

Sorry but I do not have time to complete as IT is going down shortly!

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

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Yes

5. Are you responding on behalf of an organisation or as an individual?

Individual

6. If you are responding as an individual are you:

Pharmacist

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

MOAPARS-locally commissioned LPS for frail and vulnerable people to keep them in their own homes

8. What was it that impressed you about this pharmacy model of care?

Using LPS has allowed the use of the multidisciplinary team in community pharmacy, using pharmacy technician skills to do domiciliary care, and using drivers to monitor high risk patients. This is linked in with our CCG devevloping frailty pathway and is receiving referrals from social care, hospitals for discharged patients and GPs.

9. What benefits does it offer patients and the wider healthcare system?

Supports people to stay in their own homes, provides active input to manage medication issues for patients who are unable to normally access pharmacy services, and is preventing hospital admission and re-admission.

10. What helped the development of this model of care?

Integrated commissioning and joint working. Opportunities through transition to obtain funding to commission this service. LPS has allowed us to use the basic funding for pharmacy services to develop a much more innovative service and move away from an item of service payment to a holistic service-starting to develop a practice approach to provision of pharmaceutical care.

11. What hindered the development of this model of care?

Resources to drive this forward,lack of development of community pharmacy staff, lack of experience of using pharmacy technicians as autonomous practitioners working within the wider team.

12. Where can we find out more?

From me..and I will send you in more information. I did apply to pharmaceutical care awards but we were not shortlised.

13. Do you have any other examples of new or innovative models of care to share with us?

Yes

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

Community pharmacy based pain management clinic, using a community module of SystmOne GP clinical system to allow full access to GP patients medical records (with their consent) from the pharmacy, and using the skills of a prescribing pharmacist.

15. What was it that impressed you about this pharmacy model of care?

Provision of clinical pharmacy services from a community pharmacy-supporting the development of autonomous practice by a pharmacist-true pharmaceutical care as visioned by Heppler and Strand. Patient outcomes have been good, local GP was pleased and received positive support but unfortunately not yet formally commissioned!

16. What benefits does it offer patients and the wider healthcare system?

Opportunity for pharmacist to manage a case load of patients with long term conditions, where medication is a key element of care. Well accepted by patients. Using SystmOne for clinical records theoretically would allow all pharmacists commissioned by a CCG to use the same community model, accessing this on a standard pharmacy computer (this is a web-based service) so small set up costs (now the module is built) from various locations-hopefully community pharmacies across the CCG. Peripatetic services to provide care closer to home. Easily developed so that patieints with other conditions e.g. Asthma, COPD, CVD, Heart Failure, Parkinson, to be managed in a similar manner. Using a specialist pharmacist as a consultant, using consulting rooms in pharmacies to deliver these clinical services, or opportunity for community pharmacists n their own pharmacies to set up these services. No need to leave the pharmacy to access notes etc, and then patients see pharmacist as independent professional in their own right.

17. What helped the development of this model of care?

QIPP, a very keen pharmacist who pushed this for 2 years before we got the pilot going.

18. What hindered the development of this model of care?

Lack of on-going funding and due to the type of patients being referred not able to show savings by avoidiing hospital outpatient appointments. Moving forward procurement models may hinder this in that lead providers will be appointed who with then commission support-so unless written clearly into the service requirement providers may not think to commission pharmacists int he pathway.

19. Where can we find out more?

From me...I can send you a full report...Chris Rose, is in the final of this years C&D awards.

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Community pharmacists failure to deliver on the currently commissioned local enhanced services like smoking cessation, sexual health, -the current pharmacy contract which does not encourage time spent on clinical services as remuneration is still too attached to dispensing items and making a pofit on the drugs. Lack of clinical knowledge and skills of community pharmacists-some display very poor clinical knowledge-it is a real disadvantage to newly qualified community pharmacists that they do not have a better mentoring arrangement, or work more in teams to encourage learning and devleopment. Hopefully the new LPNs will help. However many pharmacists are so disillusioned that is makes it difficult. The new NHS structure is certainly not helping the delivery of services either since budgets are now split and opportunities to use existing community pharmacy budgets innnovatively is not there--since in CCGs dedicated community pharmacy budgets are low/not there now that most of the funding has gone to either NHSE or local authorities. Local authority funding is at risk since local authorities have many more pressures on them, and may choose to fund road safety schemes or child support rather than community pharmacy services.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Pharmacists need to get more savvy, take a greater interest in commissioning arrangements, get involved -yes this does mean coming out to evening meetings (my LPF meeting are so appallingly attended!) so that they can learn what is going on, network and input to discussions.

23. Are there any existing services that you think could be better provided through pharmacy?

Management of patients with long term conditions. We need to focus on those areas which GPs do not have the staff to support e.g. patients with parkinson's disease; mental health issues, links with substance misuse-domiciliary services-proper medicines use reviews and clinical reviews-but also a much greater focus on public health and deliver of public health services and messages. No one else is providing active public health services consistantly as no one is really interested in this. And yet community pharmacy is so well placed to provide this. I know several excellent community pharmacists who are sound clinically, have good relationships with their local GPs, and well respected by patients. But they are few and far between. The profession needs to recognise that consistancy of staff and delivery of services is required-but changing pharmacists on a daily basis, constantly using locums, part-time staff does not allow relationships to develop. We must work out a way to develop pharmacy practices-thus providing peer support.

24. Are there any services that pharmacy currently doesn't offer but you think it should?

Phlebotomy services-only provided in odd places-

25.Do you have any links to resources that you feel would be helpful to the commission?

No

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

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Yes

5. Are you responding on behalf of an organisation or as an individual?

Individual

6. Are you a?

Pharmacist

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Our research team was interested in gaining an understanding of the benefits to patients, health professionals, the organisation and the wider NHS sector of the inclusion of a pharmacist run medication management clinic service within an outpatient clinical service, led by a consultant gynaecologist and supported by a wide multi-disciplinary team, including junior doctors, nurses (specialist level and clinic), counsellor, and with direct access to linked secondary care services. The resulted in a PhD research program using action research methodology to identify patient and NHS service outcomes.

8. What was it that impressed you about this pharmacy model of care?

1. Benefits to patients with utilisation of US Minnesota pharmaceutical care model for delivery of an optimised medication management clinical service. SOP underpins practice to ensure risk free service for patients. 2. Benefits for primary care teams, including support for service development, audit and research, teaching and training and academic role development. 3. Ongoing development of this

pharmacist role with work undertaken within a national and policy context. 4. Identifying competencies for this pharmacist role that match the DH ratified RPS consultant pharmacist competencies, with understanding of NHS workforce and infra-structure support required to further optimise NHS patient care delivery 5. Support for community pharmacist clinical role development

9. What benefits does it offer patients and the wider healthcare system?

1. Face to face consultation with patients to provide level 2 clinical medication review. The pharmaceutical care model ensures assessment of 'all' patients medications with review to consider appropriate indication, efficacy, safety, compliance and concordance issues and for cost effectiveness 2. Support for primary care patient care delivery with management plan agreed by pharmacist and patient, copied to GP and any secondary care service providers. 3. The pharmacist role has developed to provide audit and teaching and training for primary care health professionals; and has developed with formalised deanery ratified teaching for trainee GPs as one example

10. What helped the development of this model of care?

Research team asking the question - what benefit does a pharmacist bring if role established within an MDT that provides an outpatient clinical service to patients referred to secondary care for a specialist opinion [thereby targeting high risk or complex patient cases with need for medication management support]

11. What hindered the development of this model of care?

Time lag between research findings and getting this into actual practice Funding for service and role development Interesting to note wider acceptance and support for service and role development versus slightly slower acceptance by organisation NHS changes and financial crisis

12. Where can we find out more?

Have published and presented regarding this service development. Would be happy to email in references on request

13. Do you have any other examples of new or innovative models of care to share with us?

Yes

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

Working with the NW London Diabetes Research Network and GP colleagues to develop protocol to include - transfer of a validated secondary care, MDT supported, medication management clinical (MMC) service to primary care CCG Network - to agree patient outcomes that will be assessed for high risk diabetic patients that would be reviewed within primary care, MDT supported, MMC service - to log patient journey from primary care MMC service to community pharmacy and back to the primary care service to inform service development for optimised patient care.

15. What was it that impressed you about this pharmacy model of care?

Interest from GP leads and support for service development and protocol. Please note that this work is still at development stage.

16. What benefits does it offer patients and the wider healthcare system?

Utilisation of pharmacy resource for NHS care delivery within primary care setting Gaining an understanding of infra-structure needs for pharmacy to help deliver a cost effective service Pharmaceutical care support for high risk diabetic patients Ideas generated for further needed research, eg. Need to develop and validate training program for community pharmacists, to be used to support young adolescent diabetics in the transition phase from childhood to adulthood. Identified as a group of high risk patients who become future heavy burden for NHS and social care services.

17. What helped the development of this model of care?

Work in progress but essentially based on development of a validated secondary care medication management clinical service model, establishment of pharmacist consultant role, interest in innovative cost effective NHS service development and interest from CCG GP leads to support more active pharmacy involvement for primary care NHS patient care delivery

18. What hindered the development of this model of care?

Work in progress - we are looking at developing protocol for research funding stream - NIHR Research for Patient Benefit. To inform this submission, we would like to undertake two pilot projects and are waiting to hear from the Diabetes Research Network with regards to funding support.

19. Where can we find out more?

I am happy to provide more information on request

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Need for workforce development, especially for MDT and inter-professional working [these facets were important and helped progress with service development at our hospital] Poor Infra-structure support for NHS pharmacy services

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

1. The work that this commission is undertaking is crucial to support future models of care to be delivered though pharmacy 2. It would be good to engage some CCG GP lead champions

23. Are there any existing services that you think could be better provided through pharmacy?

Medication Management - Level 2 clinical medication reviews undertaken with a specialist service, with formalised link to inform and support patient care provided by community pharmacy providing 'enhanced service' MURs.

24. Are there any services that pharmacy currently doesn't offer but you think it should?

Any patient journey which involves medication taking should have pharmaceutical care support, provided within a formalised supported NHS infra-structure.

25.Do you have any links to resources that you feel would be helpful to the commission?
26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

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Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of Organisation?

Guys & St Thomas NHS Foundation Trust

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

The Rehabilitation teams (which include the Rapid Response Team, Supported Discharge Team and Lambeth Integrated Enablement Team (LIET) Reablement) are part of a wider program to avoid hospital admissions. They facilitate earlier effective discharge from hospital by providing the extra support needed at home and deliver services consistent with an enablement approach to enhance and promote independence. The service consists of a multi-disciplinary team who provide intensive, short term rehabilitation and support to help clients regain and/or maintain their independent living. A pharmacist was recruited to undertake domiciliary medication reviews for patients with the highest medicines related risks as well as to equip clinicians and non-clinicians to optimise the use of medicines as part of routine care. The pharmacist aims to optimise medicines, improve adherence and reduce polypharmacy by taking the lead to identify, resolve and co-ordinate any aspects relating to medicines use whilst a client is on the team caseload. The service aims to improve patient outcomes, reduce medicine related risks and hospital admissions as well as improve patients' understanding of their medicines. The Home Ward

pharmacist received regular clinical supervision and support from a Consultant Pharmacist for older people

8. What was it that impressed you about this pharmacy model of care?

The Rehabilitation Teams pharmacist is seen as a readily available expert on medicines and provides education to the team on clinical, safety and practical aspects of the use of medicines. The pharmacist has been able to resolve specific issues between health and social care that previously hindered medicines optimisation for individual patients. The pharmacist interacts with a wide range of healthcare professionals across Primary and Secondary Care organisations and is therefore able to facilitate changes more readily through this network of contacts.

9. What benefits does it offer patients and the wider healthcare system?

Benefits to patients The patients that are under the care of the Rehabilitation Teams now have rapid access to a medicines review in their own home by a Pharmacist based in the community if this is deemed to be necessary. Benefits to the wider healthcare system: Since in post, the Rehabilitation Teams Pharmacist has managed to raise the awareness of the importance of considering medicines management patient needs when reviewing patients and staff are now aware of where help can be accessed. The staff working within these teams are now more aware of legislation and guidelines relating to medicines and are also in the process of receiving training and sign off to use Medicines Administration Record (MAR) charts in patients' own homes. All relevant members of staff within the rehabilitation teams have now received training and are in the process of being assessed to check competency to administer and safely handle medicines.

10. What helped the development of this model of care?

A history of successful working with a Consultant Pharmacist to develop a pathway for supporting older people with medicines across health and social care as well as piloting training for nursing and non clinical staff on the safe administration of medicines in domiciliary care highlighted the need to have a dedicated pharmacist for the team. Funding was agreed to test this model. Easily accessible senior professional support has been vital to deal with situations commonly encountered when dealing with vulnerable complex older patients particularly where there is uncertainty or paucity in the evidence base. . It has also been necessary in order to unblock the professional and organisational barriers encountered as part of working within multidisciplinary team across organisations in different boroughs.

11. What hindered the development of this model of care?

The role of the Rehabilitation Team Pharmacist is new. The lack of experience of having a readily available pharmacist within the team meant that initially the team members had difficulties envisioning what benefits if any a pharmacist could bring to the management of their patients. The pharmacist is expected to cover a large geographical area (Lambeth and Southwark). This means that travelling times are great and therefore there is reduced flexibility to respond to urgent referrals.

12. Where can we find out more?

Please contact: Celia Osuagwu, Rehabilition Team Support Pharmacist via Celia.Osuagwu@gstt.nhs.uk OR Lelly Oboh, Consultant Pharmacist (Care of Older People) via Lelly.Oboh@lambethpct.nhs.uk

13. Do you have any other examples of new or innovative models of care to share with us?

Yes

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

The Home Ward service is part of a wider program to reduce hospital admissions and facilitate early discharge. It provides integrated case management of individuals with complex needs and a range of interventions in an individual's home that offer an alternative to hospital admission. The service is aimed at adults most at risk of being admitted to hospital (usually vulnerable older people), and care is coordinated by the Home Ward matron with intensive support from a range of health professionals. A pharmacist was recruited to develop and deliver a clinical pharmacy service as well as optimise the use of medicines in the Home Ward. There are two main aspects of the Home Ward pharmacist's role: • Direct patient care: This involves medicines reconciliation and undertaking domiciliary medication reviews for patients with the highest pharmaceutical needs. A referral form was developed to enable the GPs and District nurses to identify and refer patients who were deemed to be at the highest risk of medicines related morbidity and/or hospital readmission who require pharmacy input. The pharmacist screens the referral forms to enable the prioritisation of workload and patients are visited at home. The pharmacist then undertakes a holistic medication review that considers various aspects of the individual's condition and circumstances. A care plan is then jointly agreed with the patient and the pharmacist makes recommendations to various health and social care practitioners to optimise the use of medicines. The pharmacist is able to carry out simple practical interventions to support the patient to take their medicines as prescribed. the pharmacist also received referrals from the locality community multidisciplinary team (CDMT) • Medicines management leadership: The Home Ward pharmacist provides expert advice and support on all aspects of prescribing and medicines handling (e.g. procurement, prescribing, medicines reconciliation, administration, storage, record keeping) within the Home Ward service to ensure that the use of medicines is optimised and meets safety, statutory and governance requirements. In addition to this, there is also the collating and analysis of prescribing data which enables the monitoring and improvement of clinical and cost effectiveness. Another important aspect of this role involves nurturing partnerships and facilitating collaborative working between multidisciplinary teams especially during the transfer of care. Identifying and providing support to meet medicines management training needs for clinical and non-clinical staff to reduce medicines related adverse incidents and improve outcomes is also a crucial aspect of the Home Ward pharmacist role. The Home Ward pharmacist received regular clinical supervision and support from a Consultant Pharmacist for older people and had access to Consultant Geriatrician advice.

15. What was it that impressed you about this pharmacy model of care?

The role of the Home Ward pharmacist extends beyond ensuring that medicines are optimised whilst the patients are within the Home Ward service. In order to be successful, the pharmacist is required to work closely with District Nursing Teams, Hospital Pharmacists, GPs, Consultants, Social Workers, Domiciliary Care Providers, as well as the patients and their relatives to ensure that seamless care is provided (i.e. the right drug is prescribed and then taken in a safe and effective manner to produce the desired outcomes.) The pharmacist is considered to be the expert on medicines and provides education to the team, as well as to individual GPs / non medical prescribers on clinical and cost effective prescribing.

16. What benefits does it offer patients and the wider healthcare system?

Benefits to patients Patients are most vulnerable and at higher risk of medicines related errors at the point of transfer of care between services or settings. Many errors are picked up by the Home Ward pharmacist and potentially adverse events averted e.g. wrong dosage, omitted drugs, inappropriate prescribing, duplication of therapy, non adherence etc. There are many examples of individual patient benefits: • Better access to medicines through liaison with local community pharmacies. • Improved

adherence (particularly with inhalers). • Resolution of conflicts between health and social care to facilitate safe administration of medicines. • Liaison with GPs to discontinue long term prescribed medicines that are no longer indicated. • Monitoring to improve therapeutic effects and reduce adverse effects of prescribed medicines. • Supporting and empowering patients to self administer medicines. Analysis of 30 patients who had their medicines reviewed identified 170 medicines related problems, 17 (10%) of which were classified as extreme risk using the NPSA risk matrix. Local healthcare system Working with the Specialist and Consultant Pharmacists and the Medical Consultant for Infectious Diseases (amongst others), the Home Ward Pharmacist led the development of an intravenous antibiotics guideline fit for purpose for the types of patients presenting to the Home Ward service. Previously there was confusion as to which guideline should be followed by the Home Ward service as patients are mainly admitted from two different trusts and Clinical Commissioning Groups. The Home Ward pharmacist also developed a process to improve access to medicines, as well as implemented a medicines reconciliation and recording system which has reduced delays, as well as prescribing and administration errors. The Home Ward Pharmacist has also reduced drug waste through tighter stock control and monitoring of prescribing data.

17. What helped the development of this model of care?

The Consultant Pharmacist involvement at the very early stages of commissioning and development of the service specification and operational policy was crucial to the development the pharmacist's role. Key aspects to ensure that medicines use is optimised at various stages in the care pathway was flagged up to the governance group. The issues were addressed through via a medicines work stream and highlighted the need to recruit a dedicated and integrated pharmacist post (6 months) within the team. High visibility of the Home Ward pharmacist and the provision of easy access to expert medicines advice and support within the team has led to the post being made permanent. Easily accessible senior professional support has been vital to deal with situations commonly encountered when dealing with vulnerable complex older patients particularly where there is uncertainty or paucity in the evidence base. It has also been necessary in order to unblock the professional and organisational barriers encountered as part of working within multidisciplinary team across organisations in different boroughs.

18. What hindered the development of this model of care?

The geographical area served by the Home Ward Service (Lambeth and Southwark) has proved to be a challenge to be covered effectively by one pharmacist.

19. Where can we find out more?

Please contact: Celia Osuagwu, Home Ward Pharmacist via Celia.Osuagwu@gstt.nhs.uk OR Lelly Oboh, Consultant Pharmacist (Care of Older People) via Lelly.Oboh@lambethpct.nhs.uk

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

I think that there is a general lack of insight into what skills different types of pharmacists possess. This means that there can be circumstances where we could provide a timely solution to an issue, but are unable to do so as we are not informed of the issue until it has progressed to a certain level.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

As pharmacists are now working more closely with teams and individuals who historically have not had

pharmacy liaison in the past (particularly in the community), attitudes are slowly changing about the contribution that pharmacists can make to holistic patient care.

23. Are there any existing services that you think could be better provided through pharmacy?

24. Are there any services that pharmacy currently doesn't offer but you think it should?

Medicines related training aimed at patients with long term conditions and / or their relatives.

25.Do you have any links to resources that you feel would be helpful to the commission?

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of Organisation?

North West London Hospitals Trust (1) and Medicines Use and Safety Team, East and South East England Specialist Pharmacy Services (2)

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

This NWLH (organisation 1) trust service was designed to support transfer of care between hospital and community, following the RPS work in July 2011 link. Continuity of care for stroke patients from secondary to primary care is provided by other disciplines such as occupational therapists, physiotherapists, speech and language therapists and dietitians, but there has not been a formal community pharmacy referral system until the NMS arrived. We proposed that the introduction of NMS was an opportunity to formalise referrals of newly discharged patients to community pharmacists and we chose the hyperacute stroke unit (HASU) at Northwick Park Hospital, London, as our pilot site. Antiplatelet agents are included in the NMS. The variety of patients treated include those who have been previously well and who have never taken a regular medicine for prevention of a long-term condition (as opposed to medicines for symptomatic relief of ailments). Others will already be taking some medicines and will be started on a number of new ones. Patients from both of these groups can be at high risk of readmission from a preventable medication-related event. Pharmacists working on the stroke unit consulted patients around discharge and highlighted the NMS service. Consent was obtained to contact

their regular community pharmacist by telephone and pass on relevant details. Community pharmacists agreed to telephone patients about one week after discharge to follow up care, signpost where required and offer NMS service in person in the pharmacy or by telephone. Consent forms were posted to patients/ brought with medicines delivery and returned to the pharmacy for telephone service.

8. What was it that impressed you about this pharmacy model of care?

It was simple, easy to implement and the activity could be incorporated into the ward pharmacists daily work. In addition, it fostered improving relationships and referrals between hospital and community pharmacists. Finally, it gave patients continuity of care around medicines which is of paramount importance in supporting adherence and medicines optimisation in the longer term, particularly where patients have a long term treatment which are prophylactic and are not treating symptoms

9. What benefits does it offer patients and the wider healthcare system?

. Continuity of care for stroke patients from secondary to primary care is provided by other disciplines such as occupational therapists, physiotherapists, speech and language therapists and dietitians, but there has not been a formal community pharmacy referral system until the NMS arrived. This system includes the pharmacist in the multidisciplinary care of stroke patients for long term support

10. What helped the development of this model of care?

Good relationships with community pharmacists, willingness from the team to work differently

11. What hindered the development of this model of care?

Only demonstrated in stroke patients, needs to be tried with general medical and surgical patients

12. Where can we find out more?

The Pharmaceutical Journal 2013;290:178 and email nina.barnett@nhs.net

13. Do you have any other examples of new or innovative models of care to share with us?

Yes

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

The aim of the service from the MUS team and E&SE England specialist pharmacy services (organisation 2) is to raise awareness among pharmacists of the benefits of a health coaching approach in improving medicines adherence. This has been delivered in London, accessible to nhs staff working in East and South East England and also delivered in Leeds, accessible to NHS staff in Yorkshire. It has been delivered by various pharmacists and led by myself, Nina Barnett, in london and by Chris Acomb in Leeds. Background: Having trained as a health coach (nina barnett) through the London Deanery multidisciplinary programme, I was keen to adapt the generic multidisciplinary training to be focussed on medicines adherence interventions.I created a methodology for short consultations (less than ten minutes) for pharmacists to use working with patients in a NMS, MUR,intermediate care, care home or hospital ward setting. This was known as the ‘four e’s’ and is based on a health coaching approach to medicines adherence. This work has further developed through the adherence workstream in East and South East England Specialist Pharmacy Services. We created and delivered of a staff development day in Sept 2012 which explored the need for change in consultation methods in pharmacy and described the

benefits of both a health coaching and cognitive behavioural therapy approach to medicines adherence support for patients. We worked with a patient from the expert patient programme, who also presented, to deliver the day. Following this learning event, we received a number of emails asking for access to training courses for pharmacists. A further development day was then run in April 2013 in Yorkshire, with a number of examples from practitioners of key issues in patient consultations and good practice sharing. We are now developing a resource for pharmacists and plan future awareness raising days to encourage localities to obtain funding for bespoke training for pharmacists in this model of care.

15. What was it that impressed you about this pharmacy model of care?

It addresses the medicines optimisation from the patient's perspective, supporting patients towards best health, reducing waste and maximising return on health investment for the NHS.

16. What benefits does it offer patients and the wider healthcare system?

Medicines adherence support using a coaching approach helps patient to take responsibility for their own health,

17. What helped the development of this model of care?

Willingness to consider new ways of working, national imperative, other intiatives such as the london gp deanery multidisciplinary health coaching training (ran from march 2012-march 2013), East of England health coaching training for clinicians (multidisciplinary – currently running), other models including co-creating health (health foundation), training for healthy living champions in community pharmacy and raising community pharmacists' awareness of the benefit of new ways of working through conferences etc.

18. What hindered the development of this model of care?

Time to deliver courses (attendance) Cost of health coaching courses, equity of delivery and access across primary and secondary care.

19. Where can we find out more?

Nina.barnett@nhs.net (Health coaching) and I have contacts for CBT, current East of England health coaching progammes and yorkshire lead for adherence

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Staff shortages leading to lack of development of services. lack of awareness of need for new models of care and how these can be integrated into real every day practice (people are overwhelmed with the workload they have)

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Integration of community pharmacists into wider health care system through referrals, payment by service not volume, skills development around consultation skills to allow pharmacist to engage in patients wider agenda for signposting and feel confident to manage psychological elements of adherence as well as practical ones (which they already do well).

23. Are there any existing services that you think could be better provided through pharmacy?

adherence support clinics, ward based self referral medicines optimisation clinics for patients

24. Are there any services that pharmacy currently doesn't offer but you think it should?

adherence support clinics, ward based self referral medicines optimisation clinics for patients

25.Do you have any links to resources that you feel would be helpful to the commission?

http://www.pjonline.com/clinical-pharmacist/look_on_the_bright_side

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

1. Name

Nina Barnett

2. Would you like to remain anonymous?

No

3. Email Address

nina.barnett@nhs.net

4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of Organisation?

Medicines use and safety team, East and South East England Specialist Pharmacy Services

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

In response to the national call to action around reducing inappropriate use of antipsychotic medicines in patients with dementia, we created a half day training programme and associated resource for secondary care pharmacists. The learning event included a lecture from a specialist mental health pharmacist about managing the condition, information from a specialist dementia nurse on how to interact and support patients with dementia and workshops with case studies. This was developed into an electronic resource, with a presentation and speaker notes, case studies and answers, tools and a document with links to key websites and documents to support reducing inappropirate use of these medicines in patients who have dementia. A resource for community pharmacists was also created and delivered at the pharmacy show in 2012, which included practical suggestions for community pharmacists who wish to support this initiative within the constraints of their role. This was very well received.

8. What was it that impressed you about this pharmacy model of care?

It was simple and cost effective to deliver and addressed the national agenda in an ongoing and sustainable way. We provided courses twice a year from Nov 2011 according to demand. The secondary care suite of resources has been used by individual trusts. the community resource is being used by LPFS

9. What benefits does it offer patients and the wider healthcare system?

Raising awareness of the problems with inappropriate use of these drugs and working collaboratively with health professionals, social care, families and carers to optimise patient outcomes

10. What helped the development of this model of care?

The network set up in East and South East England specialist pharmacy services including access to experts.

11. What hindered the development of this model of care?

time to attend, support back at base to roll out

12. Where can we find out more?

nina.barnett@nhs.net

13. Do you have any other examples of new or innovative models of care to share with us?

Yes

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

This service was designed to support generalist pharmacists working in secondary care who are responsible for patients post stroke. The Hyperacute stroke pharmacists group collaborated to deliver a half day learning event on management of stroke from acute presentation to long term care, focussing on medicines related issues. Content from this event was summarised in an online resource.We are continuing to develop our support for community pharmacists through delivering and evening event which focusses on antiplatelets and new anticoagulants post stroke and adherence support

15. What was it that impressed you about this pharmacy model of care?

It was simple to deliver and disseminate and focussed on patient group with long term health and medicines needs

16. What benefits does it offer patients and the wider healthcare system?

improving patient outcomes from stroke

17. What helped the development of this model of care?

collaborative network of expert pharmcists, network of secondary care pharmacists

18. What hindered the development of this model of care?

nina.barnett@nhs.net

19. Where can we find out more?

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

23. Are there any existing services that you think could be better provided through pharmacy?

24. Are there any services that pharmacy currently doesn't offer but you think it should?25.Do you have any links to resources that you feel would be helpful to the commission?

http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Meds-use-and-safety/Service-deliv-and-devel/CPS-redesign/Stroke-Therapeutics--a-resource-for-secondary-care-pharmacists-Vs1/?query=stroke&rank=61

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

1. Name

Nina Barnett

2. Would you like to remain anonymous?

No

3. Email Address

nina.barnett@nhs.net

4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of Organisation?

north west london hospitals nhs trust - pharmacy dept

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

The medicines support service aims to reduce preventable medicines related readmission to hospital through identifying and managing patients at risk of medicines related problems, aged 18 and over. The service is delivered by clinical pharmacists with a special interest in older people. Medication contributes to 5-8% of hospital admission and readmissions, of which almost half are preventable. There are financial and clinical incentives to develop and deliver a robust integrated medicines management services that contributes to optimization of use of medicines, reduction of waste and minimisation of preventable medicines-related problems leading to readmission. Our initial review of the service, from march 2010 to April 2011, looked at results from our medicines management pharmacists, who worked on two wards with inpatients identified by the pharmacy team as at risk of preventable medicines related readmission. Of the 276 patients referred, 147 were identified as high risk and received intensive medicines support and follow up post discharge to reduce risk of a medicines related readmission. Intervention included medicines reconciliation and reuse of patients own drugs (where this had not already occurred) clinical medication review and medicines use review with patients, carers and family, discharge liaison including community pharmacists, GPs, district nurses and care staff and documentation of recommendations

which were passed to the next sector of care. Both medicines adherence and cross-sector medicines communication issues were common reasons for referral. Of the 147 high risk patients referred, 17 patients were readmitted within 30 days of discharge and none with a preventable medicines related cause. If these data are applied to NWLH annual readmissions, the service has a potential for a net saving of £4.4 million pa to the NWLHT/local health economy. Rollout requires patient identification on admission using a validated tool, integration of the pharmacy team into the readmissions prevention service and development of robust referral pathways Cross-sector medicines-related communication and follow up with health and social care after discharge is key to success. Development of the service has included integration of services with readmissions teams, establishment of post discharge follow up telephone support and upskilling multidisciplinary team members with methods of identifying patients to allow referral. We also now refer patients to community pharmacists for NMS and MUR as appropriate

8. What was it that impressed you about this pharmacy model of care?

This model of care can be carried out by any clinical pharmacist and the tool used, PREVENT, is an evidence based guide to risk factors which can be evaluated by pharmacist as to whether the risk factors are already managed and/or are modifiable by pharmaceutical input. This model also encourages safe transfer of care, passes information to community pharmacists to take over care post discharge and uses adherence support techniques from health coaching to support patients with self care, raising their awareness of issues and increasing their responsibility for managing them

9. What benefits does it offer patients and the wider healthcare system?

Improves self care, supports good communication with the clinical and social care team. We have now established an email and telephone contact service for patients to access our medicines support pharmacist post discharge. Adherence support to optimise medicines related care for patients,. reduce waste.

10. What helped the development of this model of care?

Existing service on care of older people wards which was originally run by the PCT, handed over to the trust in 2007/8. Relationship with primary care was established. Care of older people consultant pharmacist available to lead the work, having links with multidisciplinary team in primary and secondary care. Supportive Chief pharmacist in PCT and Hospital.

11. What hindered the development of this model of care?

increased pressure on ward activities in the hospital meaning we have less time for this service. Ubiquitous use of multicompartment compliance aids where other support is needed

12. Where can we find out more?

nina.barnett@nhs.net

13. Do you have any other examples of new or innovative models of care to share with us?

Yes

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

Integrated care pilot - care home pharmacist service which aims to reduce inappopropriate readmission and admission from care homes to hospital. It will be delivered in care homes in harrow that have high admission rates by a care home pharmacist, lead nurse and mental health nurse and is funded for one year by outer NW london integrated care pilot. Pharmacists will provide medication review before the service user is admitted to the home and liaising with the care home, GP, nurses and family, support anticipatory care planning to ensure agreed actions around acute and chronic care. The pharmacist will also provide medication review and continuity of care if the patient leaves the care home for a hospital admission, ensuring good transfer of care at every change of care location. Results will be analysed in terms of reduced inappropriate admissions with subgroup of medication related admissions and use of Anticipatory care plans to reduce admissions.

15. What was it that impressed you about this pharmacy model of care?

This work builds on the lessons from the CHUMS report which highlighted issues with medicines in care homes and will support the reduction of inappropriate use of antipsychotics for patients with dementia

16. What benefits does it offer patients and the wider healthcare system?

This ensures that we provide medicines optimisation for care home patients in a continuing way and promotes appropriate use of the wider health care system

17. What helped the development of this model of care?

Funding from integrated care pilot for one year project, good relationships between drs, nurses, pharmacist, social services, primary and secondary care to get this off the ground. Clinician enthusiasm and expertise.

18. What hindered the development of this model of care?

Getting business cases together and going through required processes to recruit,

19. Where can we find out more?

nina.barnett@nhs.net

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

23. Are there any existing services that you think could be better provided through pharmacy?

24. Are there any services that pharmacy currently doesn't offer but you think it should?25.Do you have any links to resources that you feel would be helpful to the commission?

http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS025CHUMS-FinalReportwithappendices.pdf

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

1. **Name**

Parag Oza, on behalf of the Community Pharmacy future project team

2. Would you like to remain anonymous?

No

3. Email Address

Parag.oza@boots.co.uk

4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

If you are responding as an individual are you:

Healthcare professional

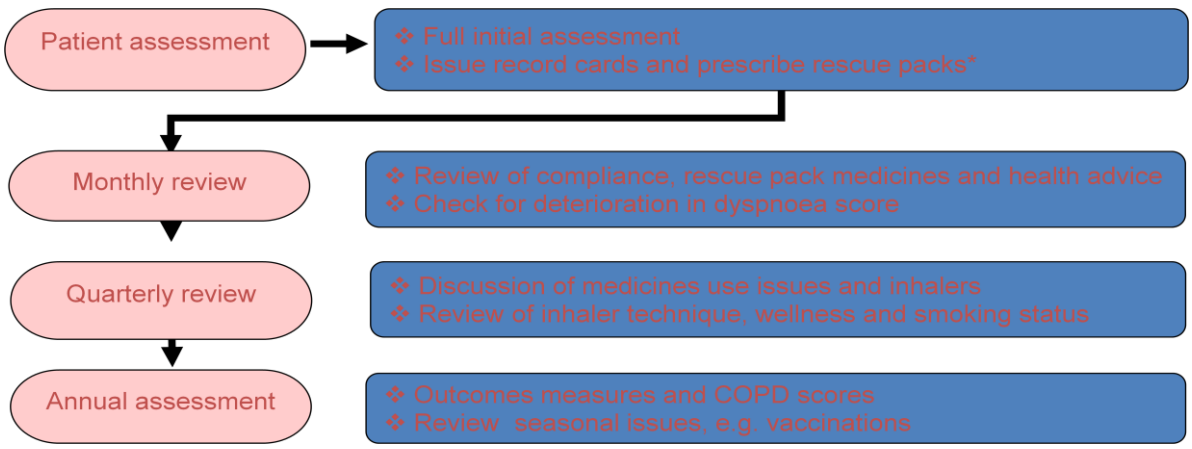
7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

As part of the Community Pharmacy Future project, patients with COPD in the Wirral have been supported through their long term condition with a service delivered by their community pharmacist. The service is being run through 39 pharmacies with representation from the large multiples (Boots UK, The Co-operative Pharmacy, Lloyds pharmacy, Rowlands Pharmacy), independent pharmacy and supermarket pharmacies.
The service aims to give patients and carers practical support for getting the best outcomes from their COPD medicines, and also help them in ways that improve their quality of life and health outcomes.

Providing this service allows pharmacists to:
Make clinical interventions related to medicines to improve medicines optimisation
Make onward referrals where appropriate to fellow healthcare professionals
Provide public health interventions that improve health and wellbeing

Deliver services within agreed national frameworks
Collect outcomes data that can be compared locally and nationally
Help patients to be able to look after themselves

Patients undergo an initial assessment once they have joined the service. This involves a COPD test (COPD Assessment Test) and dyspnoea score. Public health advice and information on lung health, diet, exercise and lifestyle are provided and interventions such as smoking cessation signposted where appropriate. Patients' symptoms and adherence with medication are monitored regularly to improve medicine optimisation and inhaler technique is checked to ensure they are receiving maximum benefit.. This typically happens when patients come into the pharmacy for their prescriptions. A patient held personal record card is provided and this is checked and updated. Targeted medicines use reviews are provided as part of the service and the provision of a rescue pack for rapid intervention is provided if necessary. Patients undertake an annual health assessment with measurement of outcomes and patient satisfaction, alongside appropriate seasonal interventions, for example flu vaccinations.



8. What was it that impressed you about this pharmacy model of care?

This service has been modelled on a template developed to be used for other long term conditions. After an initial consultation with the pharmacist, regular long-term support is provided and the follow-up consultations are used to reinforce messages, detect problems as they start to develop, review any changes proposed and improve medicines optimisation. After the consultations the pharmacist contacts the patient's GP and/or other primary care professionals if necessary. The model is tailored to the needs of patients.

The need for a robust evaluation and the collation of outcomes by pharmacy teams forms an integral part of the service. To this end, IMS health have been appointed as health economists supporting the service evaluation and independent qualitative research is being conducted on patients and pharmacists with additional qualitative surveys with GPs

9. What benefits does it offer patients and the wider healthcare system?

The model of care has been designed to make the case for change in relation to the role that pharmacy can play in the delivery of care for patients with COPD.

The service is complimentary to interventions made by GPs, nurses and other healthcare professionals, and are delivered to patients, in pharmacies, at the point of prescription collection. Pharmacy teams use opportunities for health interventions, and do not require appointments to be made. Patients benefit from additional healthcare professional support, particularly those who have difficulty attending clinics regularly. Patients' GPs are kept informed of the interventions and of any relevant clinical information relating to their patient.

Patients have reported they are already experiencing benefits from the service, even though the full evaluation period is not complete. Some of the benefits reported include a greater understanding of their condition, reassurance, emotional support and a greater professional regard for pharmacists. Patients have gained great value from the interventions and have reported a great satisfaction for the service

The work has enhanced the reputation of pharmacy as a whole among key external stakeholders. The work has been recognised as an example of good practice and innovation. It has proven pharmacy's ability to deliver challenging new services against ambitious timetables

10. What helped the development of this model of care?

The model of care has been developed as a result of a unique collaboration between teams at the four largest pharmacy companies. The four companies (Boots UK, The Co-operative Pharmacy, Lloyds pharmacy and Rowlands Pharmacy) have jointly recognised the need for robust health economic data to underpin new services whilst delivering exemplary patient care. This resource has been complemented by representatives from the independent pharmacy sector. The Community Pharmacy Future (CPF) project has been established to share expertise and build on individual strengths from various organisations.

The development of the model of care has been enhanced by an extensive amount of external engagement with key individuals in the healthcare system. Input has been sought from a wide range of clinical leads at the department of health. Local and national stakeholders have input into the development of the project, paving the way for future service developments. Other key people from the Department of Health Pharmacy Team, NHS National Clinical Directors, Leaders of NHS organisations, NHS medicines management teams, QIPP leads, Local medical and pharmaceutical committees and external bodies such as the British Lung Foundation have all supported in the development of the service

11. What hindered the development of this model of care?

None that have not been overcome although we would say a robust programme of GP, patient and healthcare professional engagement is key to the success of the delivery of a model of care from pharmacy

12. Where can we find out more?

Contact the CPF team at Parag.oza@boots.co.uk

13. Do you have any other examples of new or innovative models of care to share with us?

yes

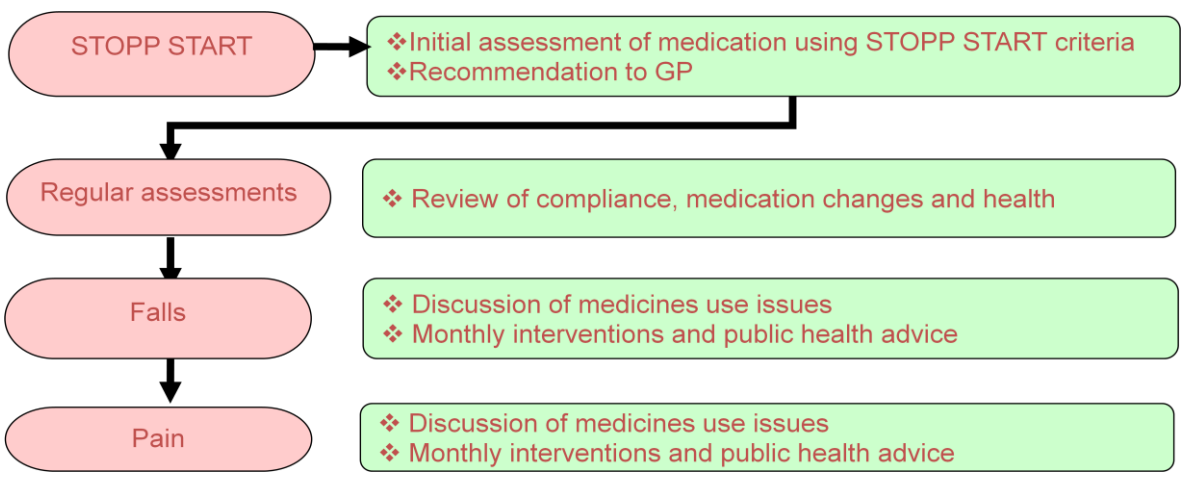
14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

As part of the Community Pharmacy Future project, patients in the Wigan area have been supported through their long term condition with a Four or More medicines service delivered by their community pharmacist. The service is being run through 39 pharmacies with representation from the large multiples (Boots UK, The Co-operative Pharmacy, Lloyds pharmacy, Rowlands Pharmacy), independent pharmacy and supermarket pharmacies.

The service aims to give patients and carers practical support for getting the best outcomes from medicines for long-term conditions and also help them in ways that improve health outcomes.

Providing these services will allow pharmacists to:
Make clinical interventions related to medicines and adherence to improve medicines optimisation
Make onward referrals where appropriate to fellow healthcare professionals
Provide public health interventions that improve health and wellbeing
Deliver services within agreed national frameworks
Collect outcomes data that can be compared locally and nationally
Help patients to be able to look after themselves

The service is based on a review of medication using evidence-based STOPP START criteria (potential inappropriate prescribing rules). Following an initial assessment, review of the medication and contact with a GP, recommendations are made on a patient's medication. Pharmacists undertake targeted reviews for risks of medication-related falls and pain management with the patient where appropriate. Sign posting and referral to social care on these elements happen were appropriate. Medicines optimisation forms an integral part of the service. There is regular monitoring of symptoms and adherence with repeat prescription management. Regular brief advice and information on health, diet, exercise and lifestyle is also provided when patients come into the pharmacy to collect their prescriptions. Reviews of progress are regular and public health interventions occur throughout. Targeted medicines use reviews focusing on medication adherence, and an annual health assessment with measurement of outcomes and patient satisfaction are part of the service together with seasonally appropriate interventions. Pharmacists work very closely with patients' GPs to ensure that they are kept fully informed of any discussions and recommendations.



*STOPP = Screening Tool of Older People's potentially inappropriate Prescribing

START = Screening Tool to Alert doctors to Right (appropriate, indicated) Treatments

15. What was it that impressed you about this pharmacy model of care?

This service has been modelled on a template developed to be used for other long term conditions. After an initial consultation with the pharmacist, regular long-term support is provided and the follow-up consultations are used to reinforce messages, detect problems as they start to develop, review any changes proposed and improve medicines optimisation. After the consultations the pharmacist contacts the patient's GP and/or other primary care professionals if necessary. The model is tailored to the needs of patients.

The need for a robust evaluation and the collation of outcomes by pharmacy teams forms an integral part of the service. To this end, IMS health have been appointed as health economists supporting the service

evaluation and independent qualitative research is being conducted on patients and pharmacists with additional qualitative surveys with GPs

16. What benefits does it offer patients and the wider healthcare system?

The model of care has been designed to make the case for change in relation to the role that pharmacy can play in the delivery of care for patients on four or more medicines.

The service is complimentary to interventions made by GPs, nurses and other healthcare professionals, and are delivered to patients, in pharmacies, at the point of prescription collection. Pharmacy teams use opportunities for health interventions, and do not require appointments to be made. Patients benefit from additional healthcare professional support, particularly those who have difficulty attending clinics regularly. Patients' GPs are kept informed of the interventions and of any relevant clinical information relating to their patient.

Patients have reported they are already experiencing benefits from the service, even though the full evaluation period is not complete. Some of the benefits reported include a greater understanding of their condition, reassurance, emotional support and a greater professional regard for pharmacists. Patients have gained great value from the interventions and have reported a great satisfaction for the service

The work has enhanced the reputation of pharmacy as a whole among key external stakeholders. The work has been recognised as an example of good practice and innovation. It has proven pharmacy's ability to deliver challenging new services against ambitious timetables

17. What helped the development of this model of care?

The model of care has been developed as a result of a unique collaboration between teams at the four largest pharmacy companies. The four companies (Boots UK, The Co-operative Pharmacy, Lloyds pharmacy and Rowlands Pharmacy) have jointly recognised the need for robust health economic data to underpin new services whilst delivering exemplary patient care. This resource has been complemented by representatives from the independent pharmacy sector. The Community Pharmacy Future (CPF) project has been established to share expertise and build on individual strengths from various organisations.

The development of the model of care has been enhanced by an extensive amount of external engagement with key individuals in the healthcare system. Input has been sought from a wide range of clinical leads at the department of health. Local and national stakeholders have input into the development of the project, paving the way for future service developments. Other key people from the Department of Health Pharmacy Team, NHS National Clinical Directors, Leaders of NHS organisations, NHS medicines management teams, QIPP leads, Local medical and pharmaceutical committees and external bodies such as the British Lung Foundation have all supported in the development of the service

18. What hindered the development of this model of care?

None that have not been overcome although we would say a robust programme of GP, patient and healthcare professional engagement is key to the success of the delivery of a model of care from pharmacy

19. Where can we find out more?

Contact the CPF team at Parag.oza@boots.co.uk

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

The current commissioning landscape has changed dramatically and pharmacy is keen to deliver services using standardised templates across the whole of England to a consistently high standard. We believe current local commissioning will hinder the development of scalable models of care and challenge the identification of best practice. A duplication of effort may in addition lead to inefficiencies

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

By harnessing the energy and effort that might have gone into separate service design we believe new models of care can be developed and delivered efficiently, with exceptional speed and quality and at significant scale. The standardised approach that we have used has driven quality. Pharmacy's value to the NHS and patient's quality of life has been evidenced. We believe a rapid exploration of possible interventions in the development of services and subsequent speed with implementation of these services in the way we have done, will help the development of new models of care.

23. Are there any existing services that you think could be better provided through pharmacy?

A full set of services based on the optimisation of their medicines designed to help patients with their long term conditions using similar models to the CPF models where public health advice and sign posting are integral to the service delivery

24. Are there any services that pharmacy currently doesn't offer but you think it should?

25.Do you have any links to resources that you feel would be helpful to the commission?

26. Can we thank you publicly for your submission?

27. Can we make your response public?

yes

1. Name

Rena Amin

2. Would you like to remain anonymous?

No

3. Email Address

rena.amin@nhs.net

4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Individual

6. If you are responding as an individual are you:

Pharmacist

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Practice employed independent pharmacists contributing to the optimisation agenda, improving patient safety and management of Long term conditions.The service is delivered in a GP practice, twice a week since 2004, and is essentially aimed at patients with long term conditions such as CVD, Hypertension and Respiratory. It was delivered by an independent pharmacist prescriber.

8. What was it that impressed you about this pharmacy model of care?

Patients care can be maximised right from diagnosis and on-going care. Preventative assessments are also undertaken so as to prevent hospital admissions or worsen the burden of disease. Structured annual and follow up reviews consistently improved concordance and also reduced pharmaceutical wastage, improved the adherance to formulary choices, an opportunity for patients to have this "one stop" clinic to have a full assessment of all their medications incl OTC and prescribed. Hospital discharge letters were also reviewed and updated by a competent HC profession (independent prescribing pharmacist) and this timely input supported the practice in having a robust repeat prescribing, repeat dispensing, electronic prescribing models implemented to its fullest.

9. What benefits does it offer patients and the wider healthcare system?

As mentioned above, the benefits to patients are multipronged. Better understanding of their condition, improved concordance, reduced hospital admission, timely intervention if their condition deteriorated or relapsed, appropriate referral to other agencies when needed.The benefits to wider HC system are improved use of medicines so reduction in wastage, budgetary control, fewer admissions both to emergency and A&E.

10. What helped the development of this model of care?

Self directed by the pharmacist delivering the care but having the full support and faith of the practice team in her abilities. The outcomes of this work in itself over the years have been a testament to her integral role in general practice. The pharmacist has also then stepped up to become a managing partner subsequently so shows that the contribution made by her has been accepted by the team and sees it as a valuable partner in improving clinical, business, IT and Information governance in general practice

11. What hindered the development of this model of care?

If a robust business model is planned, communication is set up with all stakeholders, then there will be no barriers.

12. Where can we find out more?

Contact the email given above please

13. Do you have any other examples of new or innovative models of care to share with us?

Yes

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

There are other examples of joint posts for practice based independent pharmacist prescribers around anticoagulations, heart failure and hypertension in one CCG alone (NHS Greenwich Clinical Commissioning Group)

15. What was it that impressed you about this pharmacy model of care?

The model is about empowering commissioners, sharing good practice and also leading by example

16. What benefits does it offer patients and the wider healthcare system?

as mentioned before

17. What helped the development of this model of care?

gaps in service provision and need to improve medicines management in primary care

18. What hindered the development of this model of care?

IT sometimes hinders as pharmacists cannot easily get access to the full RA card authorisation

19. Where can we find out more?

rena.amin@nhs.net

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Budget access and lack of understanding what pharmacist independent prescribers bring to the general practice, some over lapping roles, and they can be more expensive to employ compared to nurse independent prescriber

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Once the model and the benefits are shown and established, it is really self marketing model

23. Are there any existing services that you think could be better provided through pharmacy?

24. Are there any services that pharmacy currently doesn't offer but you think it should?

Yes

25.Do you have any links to resources that you feel would be helpful to the commission?

Yes

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

1. Name

Sara Dilks

2. Would you like to remain anonymous?

No

3. Email Address

sara.dilks@nhs.net

4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of organisation?

Northern Devon Healthcare NHS Trust

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Northern Devon Heathcare NHS Trust is providing a domiciliary medicines optimisation service to adult patients in Exeter and Holsworthy. The aim of the service is to reduce medicine-related hospital admissions and improve patients' use of their medicines and their understanding of why they are taking their medicines. A specialist pharmacist or pharmacy technician visits the patient at home and undertakes a clinical medication review to optimise their medicines as well as reconciling medicines, providing individual medicines information charts, assessing adherence, suggesting medicines management solutions, educating and counselling patients and demonstrating inhaler techniques. The Pharmacy team then liaise with other health and social care professionals involved in the patients' care as part of a multidisciplinary Complex Care Team. Interventions are then fed back to the patient's GP and a follow up visit or telephone call arranged to follow up any interventions. Patients are also signposted to other appropriate health, social care and volunteer organisations as appropriate. Patients most likely to benefit

include those starting on new medicines or those who have had significant changes to their medicines in hospital; or patients who want additional support with adherence.

8. What was it that impressed you about this pharmacy model of care?

The service has been developed since 2006 and is now embedded in the multidisciplinary complex care teams, linking both Health and social care. The team is comprised of both pharmacists and accredited technicians to achieve a suitable skill mix of staff.

9. What benefits does it offer patients and the wider healthcare system?

It offers vulnerable and complex patients access to medicines optimisation in their home environment, and aims to keep them at home.

10. What helped the development of this model of care?

Health and social care integration in Exeter and the development of multidisciplinary Complex Care Teams where a Pharmacist was seen as an essential team member.

11. What hindered the development of this model of care?

Initial reservations about the cost of a pharmacist in the complex care teams and would a pharmacist be cost effective as part of the teams.

12. Where can we find out more?

Hospital Pharmacist Journal article April 2008 Vol 15 p.135-137 "Managing patient's at home- as a domiciliary pharmacist" by Sara Dilks and Ian Nash

13. Do you have any other examples of new or innovative models of care to share with us?
14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?
15. What was it that impressed you about this pharmacy model of care?
16. What benefits does it offer patients and the wider healthcare system?
17. What helped the development of this model of care?
18. What hindered the development of this model of care?
19. Where can we find out more?
21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Lack of networking across new and evolving models, shareing of best practice needs to be encouraged acorss the country. there are little pockets of prople all developing similar services whilst having to start from scratch with processes, documentation and re-inventing the wheel.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Networking opportunities and a wider publicity of new models being used across the country.

23. Are there any existing services that you think could be better provided through pharmacy?

Discharge of complex and vulmerable patients from secondary care to primary care should also be managed by a pharmacy lead service.

24. Are there any services that pharmacy currently doesn't offer but you think it should?

Managing complex and vulnerable patients being discharged from secondary care to their homes and follow up in the community.

25.Do you have any links to resources that you feel would be helpful to the commission?

http://www.northdevonhealth.nhs.uk/2013/04/help-with-your-medicines/

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of organisation?

Faculty of Sexual and Reproductive Healthcare

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Pharmacy provision of emergency contraceptive pills and ongoing supplies of COC/POP usually on patient group directions or via non-medical prescribing, and treatments for chlamydia linked to chlamydia screening programme via training provided locally by doctors working to National service standards such as those produced by FSRH.

8. What was it that impressed you about this pharmacy model of care?

Speedy access at increased hours particularly in rural areas where community sexual and reproductive health clinics may not be open daily.

9. What benefits does it offer patients and the wider healthcare system?

Opportunities for safer sex messages and signposting to ongoing services such as GPs and clinics.

10. What helped the development of this model of care?

Good liaison between trainers in clinics and local pharmacists and links to commissioners regarding training in safeguarding issues.

11. What hindered the development of this model of care?

12. Where can we find out more?

Parker C., Duggan C. Developing a pharmacist-led medicines management service for mental health patients. British Journal of Clinical Pharmacy. 2011: 3; 182-4.

13. Do you have any other examples of new or innovative models of care to share with us?

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

15. What was it that impressed you about this pharmacy model of care?

16. What benefits does it offer patients and the wider healthcare system?

17. What helped the development of this model of care?

18. What hindered the development of this model of care?

19. Where can we find out more?

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Funding issues eg patchy availability of free pregnancy testing and provision of free condoms unless commissioned as part of LES for sexual health.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Early discussions with other professional bodies who can help in training.

23. Are there any existing services that you think could be better provided through pharmacy?

24. Are there any services that pharmacy currently doesn't offer but you think it should?

As above, free condoms via distribution schemes and free pregnancy testing. Better linkages with local sexual health services for speedy access when patients present out of patient group direction.

25.Do you have any links to resources that you feel would be helpful to the commission?

www.fsrh.org

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

1. Name

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of Organisation?

Central & North West London NHS Foundation Trust

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

In mental health services of Central and North West London NHS Foundation Trust a pharmacist led Medicines Management Review Service has been developed to enable members of the community mental health team to refer inidividual community based patients with specific medicines related concerns to a specialist mental health pharmacist for advice, review and prescribing.

8. What was it that impressed you about this pharmacy model of care?

This process has reduced the number of steps in the process for a patient. Previously the patient may have seen a Dr and raised concerns about medicines, the doctors may then have asked a pharmacist for advice, and then acted on that advice at a later patient appointment. This process coudl take several weeks. Now if a doctor has concerns or questions about a patients' treatment plan they simply refer the patient to see the pharmacist who sees the patients within 2 weeks of referall, reviews the scenario, makes a new treatment plan, and prescribes for the patient as necessary, before referring the patient back to the doctor.

9. What benefits does it offer patients and the wider healthcare system?

It means quicker access to a medicine review for patients. It means that patients have direct access themsleves to a specialist mental health pharmacist - rather than in the previous model, this access was restricted to via other professionals only.

10. What helped the development of this model of care?

the pharmacist running the service successfully qualified as a Non-medical prescriber. And later the CD regulations chaged such that she can now also prescribe conrolled drugs as needed (usually schedule 4 psychotropics).

11. What hindered the development of this model of care?

The aim is to develop this model in other similar areas of our service. Flexibility of suitability qualified staff and those intersted in becoming non-medical prescribers has delay this plan.

12. Where can we find out more?

Parker C., Duggan C. Developing a pharmacist-led medicines management service for mental health patients. British Journal of Clinical Pharmacy. 2011: 3; 182-4.

13. Do you have any other examples of new or innovative models of care to share with us?
14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?
15. What was it that impressed you about this pharmacy model of care?
16. What benefits does it offer patients and the wider healthcare system?
17. What helped the development of this model of care?
18. What hindered the development of this model of care?
19. Where can we find out more?
21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Some significant difficulties with interfacing of certain IT systmes, specifically care records between primary and secondary care, leading to very labour intensive and cumbersome process when trying to deliver care to individual patients. And specifically the lack of official link or co-ordination to a primary care pharmacy. All patients shoudl be registered with GPs so there is a clearly iedentified service to communicate with in that respect, but there is no method of identifying a patients' specific community pharmacy, so communication is poor/ad hoc. If all patients were registered with a single pharmacy for prescribed medicines - as they are with a GP - this owuld assist signifiantly with communication and so continiuty of service.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Greater liaison, better communication and shared goals between primary and secondary care. Support (project support, funding/advice. guidance etc) from the RPS to lead the way on such developments.

23. Are there any existing services that you think could be better provided through pharmacy?

Within in mental health services we need to invest significnatly more time (and effort) into optimising patients' use of medicines when they are in the community, as these are usually chronic (relapsing and remitting) illnesses.

24. Are there any services that pharmacy currently doesn't offer but you think it should?

Establish routine medicine optimisation reviews with a pharmacist for all patients prescribed medicines, either within primary care, or as a minimum within speciliast services.

25.Do you have any links to resources that you feel would be helpful to the commission?

http://www.cmhp.org.uk/

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

1. Name

David Ogden

2. Would you like to remain anonymous?

No

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david.ogden@stgeorges.nhs.uk

4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of organisation:

St George's Healthcare NHS Trust

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Aim: To improve access to antiretroviral medication, optimise medication and improve efficiency of prescribing in clinic Patient group: HIV positive individuals, starting or established on treatment attending a London HIV clinic Treatment & Care delivered by a non-medical prescribing pharmacist

8. What was it that impressed you about this pharmacy model of care?

Usual models of care involve a medical prescriber who assesses the patient and prescribes antiretroviral treatments. A separate appointment is needed for adherence support with a pharmacist. In this model, assessment, prescribing and adherence support can be provided in one consultation by an experienced non-medical prescribing pharmacist.

9. What benefits does it offer patients and the wider healthcare system?

Improved access to medicines when there is no doctor in clinic. Enables the patient to have regular access to medicines optimisation during follow-up with a pharmacist as part of the MDT in follow-up.

10. What helped the development of this model of care?

Support from the Consultant and Nurses in clinic as well as pharmacy management in secondary care.

11. What hindered the development of this model of care?

Cautious adoption by clinic, however there is data being published from myself and other NMP Pharmacist in the specialty in EJHP which should demonstrate that clinicians can be confident that follow-up can be supported safely and effectively by a non-medical prescribing pharmacist in clinic.

12. Where can we find out more?

Contact me at St George's Healthcare NHS Trust

13. Do you have any other examples of new or innovative models of care to share with us?

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

15. What was it that impressed you about this pharmacy model of care?

16. What benefits does it offer patients and the wider healthcare system?

17. What helped the development of this model of care?

18. What hindered the development of this model of care?

19. Where can we find out more?

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Having too many rotational staff who cannot work effectively in a specific role long enough to demonstrate their effectiveness as part of a MDT.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

We do need to invest in staff, through training, qualification appropriately to develop services. Selecting those staff who have vision and abilities to lead is important too.

23. Are there any existing services that you think could be better provided through pharmacy?

Repeat prescribing for chronic long-term conditions needs to be looked at. The traditional model of contact the GP every 28 days for a repeat is not giving the patient benefit, leads to poorer adherence and could be better managed by pharmacy.

24. Are there any services that pharmacy currently doesn't offer but you think it should?

HIV testing. I believe there are some pharmacies offering this now, however it is imperative that we diagnose this condition early and destigmatise this infection.

25.Do you have any links to resources that you feel would be helpful to the commission?

http://www.biomedcentral.com/content/pdf/1472-6963-13-192.pdf

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

1. Name

Joanne Bartlett

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of Organisation?

John Taylor Hospice Social Enterprise CIC

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Our team provides a clinical pharmacy service at end of life for patients in their preferred place of care. This is primarily at home. The aim is to provide services which include symptom control in complex patients or environments, support of other healthcare professionals involved in end of life care (GPs DNs Macmillan nurses, AHPs, Consultants). We have a team of 3 pharmacists and 1 pharmacy technician. We are part of a wider specialist multidisciplinary team which consists also of physiotherapists, OTs, dietitians and social workers. We primarily visit patients at home, we also conduct joint visits with macmillan nurses, specialist AHPs and GPs. Two members of our team are prescribers and prescribe both on FP10s and on syringe driver directives at end of life. With the macmillan nurses we advise and visit particularly in patients with organ failure, multiple co-morbidities or when standard treatment options have failed. To do this role we also required advanced communication skills as we have to deal directly with patients and families facing end of life.

8. What was it that impressed you about this pharmacy model of care?

The integration of professionals to prove complete care for the patient. The hands on delivery of the service.

9. What benefits does it offer patients and the wider healthcare system?

Expert advice and support for patients, carers and professionals (generalists and specialists). Delivery of care in preferred place of care including nursing and residential homes and community hospital wards. Enables patients to stay in their preffered place of care when possible. Opportunity to liaise with secondary care in super specialist MDTs.

10. What helped the development of this model of care?

Working with other AHPs and looking at their models of care. Advanced communication skills training. Supportive organisation and a commissioner with vision.

11. What hindered the development of this model of care?

Lack of understanding of the clinical pharmacists role. Lack of self promotion.

12. Where can we find out more?

louise.seager@nhs.net

13. Do you have any other examples of new or innovative models of care to share with us?

No

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Lack of promotion by ourselves and leaders in the field. Poor coordination.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

23. Are there any existing services that you think could be better provided through pharmacy?

24. Are there any services that pharmacy currently doesn't offer but you think it should?

5.Do you have any links to resources that you feel would be helpful to the commission?

www.pcpn.org.uk

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

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Marianne Price

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Individual

6. Are you a?

Healthcare professional

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

For the past 4 years pharmacists have been employed by Northamptonshire PCT to undertake medication reviews for care home residents and offer advice around medication management to care home staff

8. What was it that impressed you about this pharmacy model of care?

It has developed into a streamlined multidisciplinary team approach that includes the resident in the review process where possible

9. What benefits does it offer patients and the wider healthcare system?

Residents can make informed decisions about the medication they are prescribed , care staff knowledge is boosted , GPs are helped with their medication review targets . Overall this leads to cost effective prescribing for this population

10. What helped the development of this model of care?

The publication of the CHUMs study and Banerjee report and the backing of the commissioning group from the beginning of the project

11. What hindered the development of this model of care?

Reorganisation of the NHS

12. Where can we find out more?

Prescribing team at Nene Clinical Commissioning Group

13. Do you have any other examples of new or innovative models of care to share with us?
14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?
15. What was it that impressed you about this pharmacy model of care?
16. What benefits does it offer patients and the wider healthcare system?
17. What helped the development of this model of care?
18. What hindered the development of this model of care?
19. Where can we find out more?
21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

The public perception that pharmacists can only be found in local chemist shops " sticking labels onto medication boxes "

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

The appreciation by commissioners that pharmacists are the experts on medication and can offer advice on cost effective prescribing

23. Are there any existing services that you think could be better provided through pharmacy?
24. Are there any services that pharmacy currently doesn't offer but you think it should?
25.Do you have any links to resources that you feel would be helpful to the commission?
26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

1. Name

Petra Brown

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No

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Individual

6. Are you a?

Healthcare professional

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Pharmacists stopping as required medication for behavioural disturbance to protect patients getting above bnf maximum doses of antipsychotics. It was designed using a standard procedure and senior mental health pharmacists. They assess patients needs and stop medication to reduce risk of prolonged and high dose medication.

8. What was it that impressed you about this pharmacy model of care?

It reduced antipsychotic poly pharmacy and high dose prescribing to under 3%. Well below the national average.

9. What benefits does it offer patients and the wider healthcare system?

Reduces harm. Improved safety. Example that shows systems can be improved.

10. What helped the development of this model of care?

Good pharmacy team, good reputation of team, close working with medical and nursing staff, lots of audit and team discussion.

11. What hindered the development of this model of care?

Concern that nurses would be left trying to manage a difficult or aggressive patient with no prn medication available.

12. Where can we find out more?

Petra brown, Manchester mental health and social care trust

13. Do you have any other examples of new or innovative models of care to share with us?

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

Pharmacist in an adult ADHD clinic.

15. What was it that impressed you about this pharmacy model of care?

Pharmacist involved in a new field of medicines use.

16. What benefits does it offer patients and the wider healthcare system?

Ensure correct prescribing of novel medicines. Allows research into how they work. Makes sure pharmacist involved at point where patient seen.

17. What helped the development of this model of care?

Trust. Commissioners Consultant.

18. What hindered the development of this model of care?

Funding

19. Where can we find out more?

Petra brown. 07813783165. Manchester mental health.

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

How pharmacy is seen. As a shop not healthcare professional. How some pharmacists act. Making profit over care. The big multiples and lots of shopping deals. Little, messy community pharmacies with little health information.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Pharmacists being able to use professional position more flexibly to make decisions. Good quality pharmacy stores. More health promotion. More support for Ltc.

23. Are there any existing services that you think could be better provided through pharmacy?

General healthcare services. Giving some depot injections. Prescribing rolled out. Cpd of other gps.

24. Are there any services that pharmacy currently doesn't offer but you think it should?

Giving depots or vaccines. Monitoring mental health compliance incl community treatment orders. Monitoring side effects esp long term ones in mental health.

25.Do you have any links to resources that you feel would be helpful to the commission?

Www.mhsc.nhs.uk

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Individual

6. Are you a?

Healthcare professional

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

To optimise pharmaceutical therapy in care homes within Hounslow PCT, a care home pharmacist was recruited on a 0.6 to 0.8 WTE basis for one year to undertake clinical medication reviews with patients. Partnership working included the patient's GP and, where appropriate, secondary care, local community pharmacists and the local authority. The care home pharmacist agreed interventions with the patients GP and a follow-up visit was undertaken as appropriate. In addition this supported the development and delivery of Quality, Innovation, Productivity and Prevention (QIPP) initiatives in care homes.

8. What was it that impressed you about this pharmacy model of care?

The cost effective and quality outcomes that were achieved are namely: • Cost effective outcomes: o Annualised savings of £162,578 from a review of 334 patients. o £16,002 estimated savings for rationalising inappropriate use of dressings in two of the nursing homes. o Estimated cost of hospital avoidance is £51,282- £234,498 based on the RIO scoring method developed by Croydon PCT. • CCG

agreed to fund the role of care home pharmacist for an additional 3 years fixed term. • A GP LES was commissioned for the local authority funded residential home due to medicines management and clinical risks identified. • Local Authority care home service specifications to be amended to reflect the recommendation from the care home medication reviews outcome o Routine minimum training for nurses in nursing home o Medicines reconciliation and review for new residents or on discharge from hospital with timeline by pharmacist/GP or nurse o Local Authority to review monitoring standards for care homes.

9. What benefits does it offer patients and the wider healthcare system?

Benefits to patients • Reduce risk due to poly pharmacy and poor documentation on Medication Administration Record Charts • Utilise medicines more effectively for improved outcomes. • Support End of Life Care. • Support implementation of the NPSA's Medicines Alerts and MHRA drug safety alerts • Reduce the risk of inappropriate hospital admissions and support planned discharge thereby improving the effectiveness of care delivered in a primary care setting • Reduce medication errors in care home residents. Benefit to the wider health care system • Deliver net value savings by waste reduction interventions. • Support additional capacity to provide quality medicines management initiatives within care homes. • Support good practice across Outer North West London. • Support the Care Homes' Use of Medicines Study (CHUMS) published in October 20091. • Partnership working with other healthcare professionals. • Partnership working and better engagement with the Local Authority • Influence service redesign/ specifications e.g. community stoma care nurses, in reach specialist services in care homes • Target top 10 prescribing areas by utilising the work undertaken by East and South East England Specialist Pharmacy Services in relation to implementing QIPP in medicines management in Care Homes.(July 2011) • Support National priorities o NSF for Older People published in 2001. Specifically, standard 2, Person Centred Care. o Government's 2008 white paper 'Pharmacy in England: Building on Strengths - delivering the future'. o Compliance with the 16 regulations (out of the 28) that come within Part 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

10. What helped the development of this model of care?

• CHUMS-Care Home Use of Medicines Study report (October 2009)1 raised significant issues in care homes that additional support could improve care, reduce risks and improve cost effectiveness. • Hounslow PCT Medicines management team wrote a business case to demonstrate that this service will deliver value for money especially based on the following background • Limited medicines management support solely to care homes. • Higher Cost per ASTRO Prescribing Units2 (Cost/APU) for GP practices with care home patients leading to pressure on their prescribing budgets. Key drivers being specials, dressings and oral nutritional supplements. • Most effective method to support care homes and GP practices manage patients with complex medication needs. • Support delivery of QIPP in care homes. Reference 1. Care Homes' Use of Medicines Study (CHUMS) published in October 2009 accessed at http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS025CHUMS-FinalReportwithappendices.pdf 2. ASTRO Prescribing Units: This is obtained from epact.net and is a sophisticated weighting system that takes into account age, sex and temporary resident status and incorporating a greater number of age bands .This is available for cost and gives a realistic denominator when comparing the cost of prescribing between practices.

11. What hindered the development of this model of care?

• Convincing the PCT Clinical Executive Board that this will deliver clinical and cost effectives outcomes as GPs were already undertaking medication review as part of the QOF. • Identify and agree the initial funding for this service

12. Where can we find out more?

: Unoma Okoli., unoma.okoli@nhs.net Tel no: 01895488285 and

13. Do you have any other examples of new or innovative models of care to share with us?

no

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Funding is always a limitation

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Do not know really

23. Are there any existing services that you think could be better provided through pharmacy?

24. Are there any services that pharmacy currently doesn't offer but you think it should?

25.Do you have any links to resources that you feel would be helpful to the commission?

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

North West England Submission to Pharmacy Future Models of Care Commission

This submission to the English Pharmacy Board's Commission on future models of care delivered through pharmacy is the output of an interactive half day meeting held in Manchester on 1 May 2013. This report is a summary of the range of views expressed by those present at the workshop; listed at the end of this report. Those present included patients, doctors, health researchers and nurses as well as pharmacists working in a range of different sectors of pharmacy.

The workshop first heard about a range of different services currently delivered through pharmacy. This was followed by round table discussions about what might help and what might hinder the development of pharmacy services. Finally the workshop groups considered what the pharmacy services of the future might look like.

1. SERVICES DELIVERED THROUGH PHARMACY

Six separate pharmacy services were profiled in ten minute sessions to give those attending a taste of pharmacy across the healthcare sector.

1 – Healthy Living Pharmacies

Presented by Nigel Hughes, Community Pharmacy West Yorkshire

The Healthy Living Pharmacy concept was developed to build on the quality and effectiveness of community pharmacy services. A Healthy Living Pharmacy delivers a broad range of commissioned services to a high quality and consistently.

Each HLP has to provide a minimum of two 'enhanced' services, for example emergency contraception, stop smoking, weight loss.

Outcomes include better patient experience and more accessible services delivered through high street pharmacies. . People avoiding seeing their GP for issues that their pharmacist could help with and crucially intervening with helping people who say they wouldn't have done anything to improve their health

2 – Community Pharmacy Future Programme

Presented by Kath Gulson, Boots and Jane Devenish, Co-operative

The programme has been set up by four large pharmacy companies, Boots, LLoydspharmacy, Co-operative pharmacy and Rowlands. It aims to improve quality of care and provide long term support for patients with COPD, and people using four or more medicines. Patients are asked whether they would

like to get involved initially forsix months. For patients over 65 and using four or more medicines, the service aims are to: reduce unnecessary hospital admissions; minimise harm to patients through errors; and reduce medicines wastage. The consultation with the patient uses a process called Stop/Start to look at whether medication should be stopped or new medicines added (for example to protect against adverse effects of other medicines the patient may be taking.

When pharmacists speak to the patients they are asking: are patients using their medicine correctly?; are they at risk of falls? ; is their pain fully relieved? ; is there any advice or reinforcement that could be given on lifestyle choices and habits?

After the consultation the pharmacist contacts the patients GP and/or other primary care professionals if necessary.

For patients with COPD, pharmacists speak to patients on a monthly basis and focus on:

- the correct use of inhalers to deliver medicine; whether the patient requires an emergency rescue pack;
- teaching the patient to use lung exercise;
- giving and reinforcing public health advice –for example, no smoking, awareness of winter flu immunisations.

A key aim in the COPD programme is to encourage confidence in condition self-management

3 – Rheumatology Clinic, University Hospitals South Manchester

Presented by Dawn Bell, University Hospital of South Manchester NHS Foundation Trust

Since Jaunary 2013 a Pharmacist led Rheumatoid Arthritis Clinic provides support for patients starting on disease modifying antirheumatic drugs (DMARDs). This links to guidance from the National Institute for Health and Care Excellence (NICE) about the importance of managing early diagnosis well.

The service aim is to develop a relationship with the patient over time, discussing the benefits and risks of treatment, drug interactions and healthy lifestyle interventions on, for example, smoking and alcohol. Patients have a hot line to call and can access written information to support their medicines use. Consultants refer patients to the pharmacist (via email) if they are unsure about which treatment would best suit the patient. The pharmacist chooses the appropriate medicine(s) and uses a checklist to ensure that they councel the patient comprehensively.

4 – Refer to Pharmacy at East Lancashire Hospital NHS Trust

Presented by Alastair Gray, East Lancashire Hospitals NHS Trust

At risk patients are referred from hospital to community pharmacy for post-discharge pharmaceutical follow up (New Medicines Service, Discharge Medicines Review for people in Care Homes, and complex regimens), or referred to the local domiciliary medicines services. The service is due to go live in July 2013. Its aims are to improve adherence, improve health outcomes, reduce waste and reduce the chance of readmission to hospital.

How it works:

- Pharmacist or technician will make a bedside referral on tablet PC (wi-fi technology)

- Consent patient – language barrier solutions planned (both audio and written)
- Draw down patient demographics from scan of wristband (or by inputting hospital number)
- Referrer contact details automatically included
- Drop down referral options for speed (there will also be space for free text for other information)
- Find-a-pharmacy: from verbal, POD, Google maps (if unable to locate a pharmacy the process will terminate here)
- Referral parked until discharge
- Referral reminder sent to patient by text &/or e-mail the next working day (if patient agrees to receive them)
- Community Pharmacy prompt sent to log in to system
- Referrals manager option in community pharmacy
- Administrator overview – monitor for lack of community pharmacy acknowledgements; hospital referral patterns (pharmacist and ward) (if pharmacist does not log on to receive referrals administrator will give another prompt – it is acknowledged that this involves behaviour changes for pharmacists – it is anticipated pharmacies will receive between 1 and 2 referrals per day initially – hospital will look at patterns of referral and encourage all pharmacists and technicians to refer on discharge)
- Audit and Research tool (it is hoped that this tool will be used to identify a drop in readmissions for those patients who have taken up the referral to the community pharmacist against those who haven't had the intervention – in America a similar system resulted in a drop in re-admissions between 5 and 7%)

5 – Medicines Optimisation in an integrated health and social care model

Presented by Helen Liddle, Head of Medicines Management, Leeds South and East CCG

This project is working with care homes to expand Medicines Use Reviews for patients who are at high risk of being readmitted to hospital. The project task force is made up of multidisciplinary teams from social care, district nursing, practice-based pharmacy. Patients at risk of readmission are identified through a predictive risk profile. The predictor creates a list of patients to review on a 3 – 6 month basis.

Pharmacists are notified that an intervention will take place. There is a very structured process involved using a check list and a thorough review, that looks at the way patients use medicines, not just what medicines the patient uses. The pharmacist looks at information provided by the team, and gives recommendations. They become tasks. Tasks done, then checked that they have been done. The service will have a bolt on where patients are phoned and alerted ahead of time, to check up on their medicines. This won't be directive, just gentle research, questions. Showing that you care.

As an example: a recent patient was on 35 medicines. The pharmacist intervened by reviewing use of inhalers and insulin device, removing unnecessary medicines, the patient was on too many drugs and using them incorrectly. The pharmacist simplified the patient's routine. Reduced waste, reduced admissions, reduced cost on system.

6 – Christies Foundation Trust Cancer Service

Presented by Rob Duncomb, Director of Pharmacy, The Christie NHS Foundation Trust

Christies see 40,000 patents a year from a wide geographical area. Boots have a contract to supply medicines to Christie's patients so that all dispensing is done by specially trained Boots pharmacists. The

Christies pharmacy team concentrate on more clinical roles such as running patient clinics, ward rounds, patient counselling and adherence support etc.

With the Boots link up there is also scope to develop more customer focused services like, quicker turnaround times on site but also store pick up for patients who prefer not to wait for their medicines. Currently from ten designated Boots stores around Manchester but this could be rolled up further. Boots stores will also soon offer routine phlebotomy services for patients who need blood tests before their chemotherapy.

Bigger picture, the link up with community pharmacy is a way of starting to demystify cancer. Cancer can be a long term condition if detected early enough. Community pharmacists see more people than almost any other healthcare professional and could play a much more significant role in helping patients with cancer. For example, by having those difficult conversations that might help people get an earlier diagnosis. Christies is linking up with the school of pharmacy in Manchester to train students to identify when to and how to have those conversations. Community pharmacy could also contribute by helping patients to optimise their medications during the treatment phase. Many patients with cancer have other long term conditions for which they may be taking several medicines. Adding in complicated chemotherapy regimens means that patients may need extra support from their pharmacists to enable them to take their medicines as intended.

2. What might hinder the development of pharmacy services?

Each table discussed potential barriers to the development of pharmacy services. For the purpose of the report we have grouped the discussions into broad themes below, where there was repetition of the same or similar ideas we have only included this once.

The NHS (re)organisation:

There was a feeling that we have *"*lost networks" and " don't know who does what" with " lots of gaps in knowledge" and "no organisational memory"

The continuous change was not giving anything time to bed in and there was concern that the new system may be fragmented.

The sense of the inherent tension between responding to local need and having a national service was considered to be difficult to reconcile and it was difficult to see how good local initiatives could be scaled up.

There were some conflicts in incentives for example community pharmacists need to increase prescriptions dispensed for business – GPs need to reduce prescriptions to save money.

Primary and secondary care incentives are not well aligned. There is a risk that CCGs will not see it as a priority to move care out of hospitals, because it's not them who has to deal with long-term consequences. Money in different budget and can't be transferred.

In hospital pharmacy the barrier may be that commissioners are unaware of the value of the service. There may be poor relationships with commissioners or those that influence service development or changes. Who pays for the hospital service in the future?

Pharmacists generally aren't involved in commissioning of services and there is a poor evidence base for pharmacist interventions impacting patient outcomes.

From a point of view within the NHS, it can be hard to see a willingness to try new ideas involving pharmacy. The continuous call for evidence can stymie innovation.

Pharmacy could be a victim of a "glass ceiling" where there was little discussion of pharmacy by strategic NHS managers. It was presumed that some of this thinking of using pharmacy in a better way goes on, but there is not much evidence of the thinking being translated into action on the ground. Pharmacists need to be represented on strategic programme boards such as for LTCs, Urgent

Care –and on clinical senates to have a greater influence on strategic service redesign and care pathway development.

***The profession*:**

Pharmacists lack confidence and find it difficult to deal with uncertainty – they are black and white – the rest of the NHS doesn't think like that.

Consultation skills and ability to have "difficult conversations" on topics such as weight loss, excess drinking and sexual health are not sufficiently developed within the profession and the "skill mix" in pharmacy doesn't help practitioners flourish.

The lone practitioner model in community pharmacy, there is no sharing of knowledge or peer review or peer support available on site - are pharmacists the last "sole practitioners"? Pharmacists in community pharmacies are still predominantly involved in the technical role of dispensing and there is poor intra professional relationship between local hospital and community pharmacists.

Local authorities, with their new public health responsibilities lack the financial resources and the power to drive change. And not all pharmacists have the skills to do public involvement work in particular specialised medical fields.

***Public and others perception of pharmacy*:**

Pharmacists are not visible in pharmacies, always out the back, always have a barrier (the counter) between the person and the healthcare professional. Patients have limited expectation of community pharmacy "they just dispense" is commonly what the public perceived about pharmacists.

Medicines Use Reviews (MURs)and the New Medicines Service are still seen by some as duplicating the service they get from GP Practice or maybe a nurse and the quality of some new services such as the MUR has not been consistent.

Pharmacy is not seen as part of NHS by other professions or the public and patients aren't sure of how innovative pharmacy services relate to other services. Ie, blood pressure checked in pharmacy: people think they still need to go to their GP to do that, why would they bother doing it at pharmacy?

Pharmacies are not a private place. That lack of privacy makes people reluctant to discuss their medical histories, conversely the "non medical" environment meant some people feel more at ease.

The younger generation trust Google – they Google their conditions and their medication – don't have the culture of trust in pharmacists and other professionals that maybe older generations do.

***Systems, rules and tradition*:**

The housebound or those in care homes who never see a pharmacist – they can't get an MUR.

Children are not allowed to have an MUR.

The profession is scared by the threat of remote supervision which may reduce the need for pharmacists in pharmacies.

Competing pressures on individual pharmacists - new services vs increasing prescription numbers pharmacists are trying to do this with the same model and same number of pharmacies.

No consistent professional leadership. Employers, especially large employers, the NHS and patients and the public all have different priorities and pull pharmacists in different directions.

GP and Pharmacists' records do not always match. Transfer of care is reliant on good information coming in to help with planning and discharge, something we still haven't got.

High staff turnover – it takes time to build relationships between GP's, and pharmacists, because people move around so much the trust required for relationships between GPs and pharmacists does not develop.

3. What might to help develop pharmacy services

Pharmacies located in the heart of communities:

Large pharmacy chains can do things at scale over a wide geography which could have a big impact in a relatively short time.

The public trust pharmacists and based in part on the inherent knowledge pharmacists have about medicines. There is also a growing awareness that pharmacists can take on other roles. Pharmacists have contact with patients and carer so much more than other health care professionals (HCPs) that mean pharmacists can "make every contact count". This is particularly important with regards to carers who are often not seen by other HCP's.

Community pharmacy opening times and the extent and diversity of their locations are very good compared with other NHS services. Pharmacies employ local people working in local communities – which is a resource that could be could be harnessed for health improvement.

Smoking, obesity, alcohol and other lifestyle factors, pharmacists could intervene early to encourage healthier lifestyles. The fact that children and young people come into pharmacies gives the profession an opportunity to build long term relationships around good medicine taking as well as wellbeing more generally

The Francis report was is a way of refocusing everyone's attention on the patient, it helpfully brought up the question of quality and safety making people receptive to change and working on a different system. This coupled with strong evidence base that there are significant problems with medicines use gives a "moral imperative" for change.

A clear outcomes framework is needed to give guidance to map out services interventions and for everyone to link to.

The dispensing of medicines is extremely efficient and cost effective in relation to other countries.

The economic and political and social environment and the New NHS:

The demands on the NHS are growing which should be an opportunity for pharmacy with new roles needed given more demand from an older population with more complex long term conditions.

The growing use of IT should be an enabler. The summary care record has helped, but it's only a start.

A new pharmacy contract which rewards medicines optimization has the potential to produce cost savings and improve patient outcomes.

It is seen to be a good time to be "selling" services that reduce hospital admissions.

And that a reduction in costs may make services provided by pharmacists more affordable for the NHS some felt we had more influencers and advocates at a national and local level.

There have been calls to integrate pharmacists into teams and have pharmacists working on the same site as a GP improving prescribing and reducing errors and well as providing direct patient services to improve safety and quality.

Some felt that "hospital is the expensive bit of the NHA", and that there could be savings made on expensive medicines, pharmacy could contribute to a situation where waste could be cut.

There were thoughts that pharmacists may do some of the follow up for patients already especially when it is for information only with no follow up of a NMS or an MUR, this should be seen as a benefit to the NHS and captured as an intervention.

4. What might future pharmacy services look like?

Greater Adherence To Essential Standards

Some felt there needed to be a "zero tolerance to breach of essential standards". For example, most pharmacies operate a "minimum stock holding" to avoid tying up cash in stock which means patients will not be always be able to get full supply of medicines. This should not be acceptable. Avoidable error levels are far too high in prescribing and dispensing. Many patients, especially the most vulnerable, don't have the option of getting advice on medicines. We should not tolerate these standards in the future.

Improved Systems

It was noted that PSNC is compiling evidence of initiatives and schemes that have worked well, and that havent worked well, so that we dont have to reinvent the wheel. It focusses on community pharmacy, but will be a useful resource. It was suggested that there should be a change to the "look" of pharmacies to more professional image "more like Europe". It was suggested that health care professionals should map skills/expertise, and refer patients to others if they need expert advice. Access to discharge letter would empowers pharmacist – currently pharmacists do not get sight of the discharge letter. This went along with a feeling that community pharmacists could then be better in primary care team with nurses and GPs.

It was hoped that in the future we would make use of "telemedicines" for housebound patients or have peripatetic pharmacist. The delivery model for medicines for people with long term conditions should become the norm not the exception. Pharmacists should have the ability to offer online signposting to "real time" services which themselves may be enabled by technology or available offline. An example was offered: in Germany, telemonitoring is used as a two-way process. In the future, pharmacists could communicate with patients like this.

Finally, the payment system requires reworking and it was noted that it should be constantly monitored for opportunities to improve it. This led to an idea to present a financial benefits model to incentivise patients to change and to lean on their pharmacists, and a need for a systematised way to do this.

Training, Education and Development

It was agreed that there needed to be greater cross professional training at all levels including a basic understanding of each other's roles. Relationships, information sharing: are pharmacists making relationships with other professionals in the care pathway was noted to be important. Networking with new groups and colleagues from different care areas should be a priority in the future. LPNs have a role to play, former medicines management sits here. This is the forum that can spread out practice quickly

and effectively. They all talk to each other. You should be able to drop a model into one of them and it will spread out across other areas.

Concern about the oversupply of pharmacists was raised, along with greater competition. A proposed solution was that pharmacists are judged on care and compassion for patients. The “did you walk past the bed with the patient in need?” test was suggested. Personalisation of services was also brought up. It was suggested that there is a need to try to do things in a way that’s less regimented. We need to communicate with patients more and more effectively. Let the patient direct you and tell you what they want to deal with.

The return of altruism not avarice as main motivation to become a pharmacist was hoped for. Specialisms in pharmacy was proposed. Specialist pharmacists coming out of hospital to work in care homes, and for specialist generalist pharmacists in the community to manage co-morbid patients who are taking many medicines. It was noted that professional recognition might help to produce and encourage specialization. The need to fill gaps in pharmacy knowledge was noted. It was suggested that a restructure of the pharmacy degree might produce people who provide services that are needed.

<u>New Models</u>

Where new models already exist, it was suggested that pharmacists ‘tag onto existing new models of care’ rather than reinventing the wheel. Where funding is required, it was suggested that one could find little levers within CCGs to act as carrot and sticks.

It was suggested that in the future, the need for high street premises for dispensing would disappear and the role be replaced by something akin to a “medicines life coach”. This would accompany a total shift from a focus on medicines to a focus on population, public’s health, which would result in more multidisciplinary teams in the community. Imagine the power of a nurse and pharmacist working together being able to offer a minor injuries and minor ailments service.

It was expected that in the future personalised medicines and genetic profiling would be in the remit of a pharmacist - who is going to do this in the future if not the pharmacist? In future, services should be targeted to specific populations e.g. alcohol and student.

It was suggested that this could start by considering differentiated offers for pharmacy. Let’s not make all pharmacies all things to all men. Let’s admit that there are fundamental differences between the offer from a supermarket and perhaps a pharmacy in a GP centre. Then, get each to play to its strength - end the one size fits all contract for NHS pharmacy services. Perhaps a differentiated but national offer would allow choice for patients and stop fitting square pegs in round holes

Finally, it was noted that more discretionary products could come off prescription as a way to save money spent helping people with lifestyle-related conditions. But these include some aids for lifestyle change, like dietary aids etc.

Participant List

Elizabeth	Allen	Trustee	British Association of Skin Camouflage
Jan	Basey	Joint lead	Greater Manchester LPF
Dawn	Bell		University Hospital of South Manchester NHS Foundation Trust

Dianne	Bell	Senior Medicines Management Pharmacist	Central Manchester Foundation Trust
Petra	Brown	Chief Pharmacist	
Helen	Burgess	Prescribing Lead,	Ladybarn Group Practice,
Lynne	Calvert	Manager for Health Improvement & Neighbourhoods	Wigan Bourough Council
Phil	Conley	Health Improvement Programme Manager (Alcohol & Drugs)	Public Health England
Chris	Cutts		Centre for Pharmacy Postgraduate Education
Jane	Devenish	Clinical Service Development Lead	The Co-operative Pharmacy
Rob	Duncombe	Director of Pharmacy	The Christie NHS Foundation Trust
Peter	Elton	Director of public health	Bury Council
Rebecca	Elvey	Research Associate	The University of Manchester, School of Pharmacy and Pharmaceutical Sciences
Mo	Emmerson		Arthritis Care
Alistair	Gray	Clinical Services Lead Pharmacist	East Lancashire Hospitals NHS Trust
Nicola	Grey	Director	Green Line Consulting Limited in Manchester
Kath	Gulson	Healthcare Development Manager	Boots
Devina	Halsall	Pharmacist	
David	Hamilton	Staff Governor for the Christie.	The Christie NHS Foundation Trust
Amir	Hamman	CCG board member with lead rsponsibility for Long Term Conditions, Information Management & Technology and Patient Engagement / Empowerment	Tameside & Glossop CCG
Nigel	Hughes		Community Pharmacy West Yorkshire
David	Hume		Diabetes Voices
Carianne	Hunt		
Raj	Kumar	Director	Clinical Leaders Network
David	Lee		Epilepsy Society
Amy	Lepiorz	Quality and QIPP Manager- Optometry and Pharmacy	Greater Manchester Area Team NHS England
Helen	Liddell	Head of Medicines Management	Leeds South and East CCG
Kay	Marshall		University of Manchester, School of Pharmacy

Fin	McCaul	Community pharmacist	Prestwich Pharmacy
Anne	McCrystal		Manchester Mental Health and Social Care Trust
Ivor	Nathan [Dr]		Lay rep NICE
Nicky	Patel	CLN member	
Bruce	Prentice	Secretary	Ashton Leigh and Wigan LPC
Liz	Stafford	National Clinical Liaison Manager	Rowlands Pharmacy
Emma	Street	Lead nurse - medicines management	Manchester Mental Health and Social Care Trust
Rosemary	Wheeler	Team Manager, Intermediate Care	Stockport FT

1. Name

2020Health

2. Would you like to remain anonymous?

No

3. Email Address

4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of organisation?

2020Health

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

One of the clear conclusions that we came to following the completion of the Challenge is that community pharmacies are a significantly under used resource. The Wells Family Challenge provided a highly informative picture of health literacy. People do not understand the links between the food they are eating, exercise and illness. Many were unaware of the unseen dangers to their health. For those who discovered that their BMI, blood pressure or cholesterol was high, it was a surprise, as they generally felt fit. The pharmacist imparted educational value and in so doing provided much more than a service treating coughs and colds and alleviating pressure on GPs to treat minor illnesses; they can actually help prevent illness, a function that the GP surgery is currently unable to fulfil due to competing demands.

Easily accessible local resources, such as community pharmacies, appear to be an efficient and effective means by which to provide information on making healthy lifestyle choices, nutrition counselling and dietary advice. As part of the company's commitment to healthy eating, Sainsbury's had provided nutrition training for their pharmacists which clearly had an impact on how the pharmacists were able to assist the families. On average 59 percent of family members said that by the end of the Challenge that

their understanding of health issues, such as blood pressure, cholesterol, BMI, fat content and heart disease, was better.

Consequently there is scope for Pharmacy to innovate and develop new approaches of care which include the following:

a) **Taking on responsibility for provision of services from primary care.** In particular, providing monitoring services for cholesterol, blood pressure and weight management, all factors associated with increasing the risk of cardiovascular disease (CVD) and which were found to be in demand by the families. Helping to make these services more easily available, coupled with raising health literacy levels of these issues, indicate the increasing role for pharmacists to help the NHS make savings in terms of the overall cost of treating CVD. Cholesterol testing and other CVD related assessments could be undertaken by pharmacists on a much wider scale, as not all pharmacists currently offer these services. Algorithms would need to be in place so that once results are interpreted by the pharmacists, correct and appropriate action could then be taken.

b) **Community pharmacy advice programmes which could support and complement the work of GPs and their practices and other NHS services**. The family members' accounts indicated that the pharmacists provided them with a valuable opportunity to talk through information with a healthcare professional, leading to improved levels of follow through on the advice given.

   Families were also largely unaware of the knowledge base of the pharmacist and what they could do. The most common perception of the pharmacist was as someone who just dispensed prescriptions. Once the families were aware of what pharmacists could do it did change the way they would use a pharmacist and meant that the pharmacist would be the first point of call for advice on minor ailments. It was noted that the hours of access were better than for GPs. One family recalled an occasion during the course of the year when one of the children developed a skin rash. Due to the relationship which had been formed with the pharmacist, the mother rang the pharmacist who recommended the mother and child call into the pharmacy when they were next in the store. A subsequent short 2 minute consultation, during which the pharmacist was able to offer advice and some medication, resulted in the rash quickly clearing up. The family felt this route had significantly saved time in comparison to arranging to see their GP. This demonstrates the potential of establishing a more extensive and widely available advice programme through Pharmacy.

c) **Management of long term conditions and medicine usage**. With appropriate training and support, pharmacy can help provide assistance and support to those who suffer with long term conditions. An effective mentor relationship was seen to be established between family members and their pharmacists that aided progress (see section B below). In the case of one individual who is asthmatic, having the opportunity to talk through with the pharmacist how to properly use her inhaler significantly improved the management of her asthma. Likewise, those women who either had just given birth or became pregnant during the course of the Challenge benefited from the opportunity to talk through with the pharmacist what medication they could or could not take during and after pregnancy. These examples demonstrate the value of the counselling pharmacists are able to offer alongside the well established MUR currently undertaken.

d) **Free tests**. The early signs of disease start much younger than many understand and fully appreciate. If they are detected earlier, there is a greater chance to change habits and prevent the serious effects of prolonged poor lifestyle choices, ultimately saving GP time and potentially alleviating pressure on NHS services. Pharmacy could assist with this through not only emphasising the importance of health checks but also offering free, regular health checks offered to people at 25 years of age and then every five years. This challenges the idea that some signs of poor health do not materialise until you are older and would enable education to improve health and decision making.

8. What was it that impressed you about this pharmacy model of care?

What has emerged from the Wells Family Challenge is the difference made by talking through common health issues (such as the common cold) with a pharmacist. On the face of it 90 per cent of the families felt that the advice offered by pharmacists was already well known to them. What made the crucial difference was that the pharmacist became to be regarded as mentors who provided support and education, which allowed some daily health issues to be addressed and understood more clearly. The perception held by many of the families was that GPs were extremely busy with very demanding workloads. In contrast, pharmacists were considered to have the time available to talk through issues with individuals in a less busy environment.

9. What benefits does it offer patients and the wider healthcare system?

There is the scope for Pharmacy to develop effective services which benefit patients and healthcare system by:

- **Adopting a holistic approach**. Across the board, the pharmacists involved in the Challenge placed a strong emphasis on developing a holistic approach to their relationship in order to yield results. It was not just about weight loss and using weight as the only metric, but also monitoring and tracking body shape changes, reduction in blood pressure and so forth. The importance of trust was found to be significant in making progress and building good relationships with the families. The majority of pharmacists also stressed the important of emphasising a slow pace of change to families as opposed to seeing rapid changes in a short space of time. Consequently there is a case to be made for Pharmacy not to merely provide an extensive list of services but rather become known as a provider of healthcare which can treat the whole person for the long term, supported by the provision of a range of services.
- **Provision of accessible and convenient 'out of hours' service.** Being able to visit a pharmacist in the local supermarket at the same time as doing the weekly food shop was often cited as a key advantage by the families. This indicates that centrally located and regularly frequented community pharmacies, can benefit patients by not only filling knowledge gaps in information on making healthy lifestyle choices, nutrition counselling and dietary advice, but also mentor and coach them as they seek to implement that knowledge in their daily routines.

10. What helped the development of this model of care?

There are a number of levers which could establish new models of care through Pharmacy:

- **Technology.** App based technology (software which can be run on the internet, on your computer, on your phone or other electronic device) offers tangible ways in which to engage and empower the patient in their own management of care. In a similar way, this technology could help the

pharmacist in tracking and monitoring the health of patients with metrics such as cholesterol and blood glucose recording. Regular appointments with the pharmacist could allow app data to be checked, tracked and discussed with the pharmacist. Likewise, some app based solution may simply focus on the pharmacist running the app as they carry out regular tests and checks on the patient during appointment times. Data generated through these checks could be shared and exchanged with the patient's GP.

- **Partnership between pharmacists and nurses.** Clearly there is a distinction in the role and skills set nurses and pharmacists possess. Nevertheless, the synergy which could be generated by seeing the two professionals work together and compliment one another could be maximised in order to help relieve pressure of GP surgeries. Tests which require the skill of a nurse to carry out could be offered in a pharmacy setting, with the educational support and mentor role provided by the pharmacist who would be able to advise and plan a strategy based on the outcomes of the tests.
- **Reward system.** From The Wells Family Challenge it was apparent that when pharmacists were given the opportunity to use and develop their skills there were extremely keen to do. A sense of empowerment was also felt by many pharmacists who commented on how the Challenge had made them think about taking the initiative to introduce promotions. The Challenge made them think about how they undertook the Medicines Use Review (MUR) and helped them to think about broader health matters other than the MUR. A reward system could be introduced in order to promote and foster a long term culture of innovation in Pharmacy which incentivizes pharmacists to develop new ideas and approaches to health care.

11. What hindered the development of this model of care?

Prejudice and suspicion

From talking with pharmacists it is clear there is a perception that other healthcare professionals are cautious in their willingness to collaborate and work with pharmacists. This appears to be because of prejudice and other healthcare professionals believing that pharmacists are inferior to them as well as viewing private pharmacists, in particular, with suspicion that they want to make money by directing patients away from other primary care services and the NHS. Moving forward, the relationship between Pharmacy and other healthcare services needs to be improved so it is about complimenting as opposed to competing.

Weaknesses in the pharmacist's skill set

In terms of additional skills and training which the pharmacists felt that they need during the Wells Family Challenge, a reoccurring request was for further training in motivational skills in order to keep customers inspired and pursuing goals even when there was little change taking place in real time. The Challenge evidenced the uniqueness and value of the relationship between patient and pharmacist. Thus if this relationship is taken as a unique attribute to Pharmacy then training in motivational skills would only serve to strengthen this relationship.

Time restraints

Due to the small sample size for the Wells Family Challenge, it was relatively easy to implement the service provided by the pharmacists but it did present challenges in terms of time management towards the start of the Challenge. Scaling up a similar programme would require that consideration be given to

the necessary allocation of time and resources for similar programmes to succeed as the role of the pharmacist is clearly augmented and developed.

12. Where can we find out more?

Please contact 2020Health

Commission on
Future Models of Care
Delivered through pharmacy

1. Name

Lloyds Pharmacy

2. Would you like to remain anonymous?

No

3. Email Address

sam.fisher@celesio.co.uk

4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. If you are responding as an individual are you:

Healthcare professional

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Many patients with asthma accept symptoms as a normal part of living with the condition and many are unaware of the steps they can take to gain better control. While primary care makes considerable effort to manage these patients, the Lloydspharmacy Asthma Medicines Support Service (AMSS) explores the role for community pharmacists in improving patient care.

AMSS aims to identify patients who are experiencing difficulties with controlling their asthma. The service combines the use of a short series of questions, the Asthma Control Test (ACT), with a focused medicines use review.

The service highlighted a number of issues with patient asthma control and allowed the pharmacists to identify ways in which they could help improve patient care.

8. What was it that impressed you about this pharmacy model of care?

Findings show that a patient's ACT score significantly improves following a MUR. Thus MURs are a positive intervention to improve the control of asthma and are well accepted by this patient group.

This service demonstrates how the community pharmacist can make a direct and meaningful contribution to the management of patients with asthma utilising the services introduced as part of the pharmacy contract.

9. What benefits does it offer patients and the wider healthcare system?

Of those patients reviewed:

- 96% experienced day time symptoms of asthma
- 56% were using their reliever inhaler too frequently
- 41% were forgetting to use their preventer inhaler
- 52% required further patient education
- 22% needed help with inhaler technique
- 38% were identified as having poor control due to therapeutic inefficiency
- 26% were referred to their GP practice of whom
- 42% were prescribed add-on therapy
- 14% had a change in therapy
- 14% had there inhaler type altered
- 30% received changes to their directions

Patients were followed up to reassess asthma control using the ACT. Patients whose asthma was:

- 'Well controlled' increased from 5% to 9%
- 'Reasonably controlled' increased from 36% to 46%
- 'Not controlled' decreased from 59% to 45%

10. What helped the development of this model of care?

From a Lloydspharmacy perspective, we have a dedicated service development team working collaboratively across internal departments with each department providing pivotal support in developing the service. The development of this model of care was further supported by collaborative working with established charity partners such as Asthma UK.

This service demonstrates how pharmacy can make a direct and meaningful contribution to the management of patients with asthma, and has utilised the advanced service element of the pharmacy contract as a platform for delivery. This is also supported by the additional tools available to support the management of asthma, such as the ACT questionnaire and the Incheck dial.

11. What hindered the development of this model of care?

There were no specific issues that hindered development of this model of care.

12. Where can we find out more?

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13. Do you have any other examples of new or innovative models of care to share with us?

No

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

23. Are there any existing services that you think could be better provided through pharmacy?

24. Are there any services that pharmacy currently doesn't offer but you think it should?

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

NHS Confederation response to Royal Pharmaceutical Society Commission on future models of care delivered through pharmacy

The NHS Confederation believes the role and the opportunity that community pharmacy can play in improving and maintaining the nation's health has historically been undervalued. We therefore welcome, and are pleased to respond to, the call for evidence from the Royal Pharmaceutical Society's Commission on Future Models of Care.

Though we do not directly represent community pharmacy providers, our members see them as key partners in improving the services they commission and provide, with a crucial role to play in improving quality, efficiency and sustainability of the system as a whole.

Our response draws heavily on our learning from chairing a task group on the future commissioning of community pharmacy, as part of the Pharmacy and Public Health Forum chaired by Professor Richard Parish. It makes recommendations on the future role of pharmacy in relation to public health, and the actions that would enable and support this.

The future role of pharmacy

The NHS has historically undervalued the role that community pharmacy can play in improving and maintaining the public's health. Community pharmacists sit right at the heart of our communities, and are trusted, professional partners in supporting individual, family and community health. Effective community pharmacy services enable shared decision-making between service users and professionals and contribute to health improvement. We believe they have a significant and increased role to play in ensuring we have a sustainable healthcare system and that the NHS is able to survive and thrive over the coming decades.

However this will require a rethink about the place of community pharmacy in the health and care delivery system, and a repositioning of its role alongside primary medical care. It will also require greater imagination and awareness on the part of both commissioners (NHS England, clinical commissioning groups (CCGs) and local authorities) and providers regarding its potential to provide more accessible and effective provision of public health services.

An enhanced role for community pharmacy as a supplier of public health services should run alongside and not detract from its important existing roles in supplying medicines and optimising medicines use, and should be properly resourced. We believe that additional investment in community pharmacy would be strategically and financially beneficial to the NHS and local government by improving primary and secondary prevention of disease, access and patient empowerment and satisfaction.

It will also be important that community pharmacy's role in public health is integrated with that of the whole system. This means coordination between different commissioners and providers in order to avoid fragmentation and improve efficiency, including strong information flows between providers and commissioners of public health services. There should be a clear signposting system as well as formal referral mechanisms to and from community pharmacy services to other health professionals and health and wellbeing services.

In addition, in order to meet the needs of the growing number of people with long term conditions, the NHS will need to do more to support and enable people to play a greater role in managing their own conditions. Community pharmacies could potentially make a significant contribution to this. They are not only a source of advice and support from health professionals but can also be a place where some interventions integral to the management of many long term conditions (for example, medicine use reviews) can happen in a way that is convenient for patients and cost effective for the NHS. They therefore have a crucial role to play in a sustainable NHS.

Supporting and enabling change

If we are to exploit these opportunities for community pharmacy to play a greater role, it will be essential to align pharmacy providers' income and incentives to the future strategy for health (including public health) and care. Our recommendations cover three key areas:

- A coherent approach to commissioning community pharmacy
- A facilitating and engaging approach to community pharmacy providers, including incentives for new models of delivery
- Concerted public engagement and awareness raising

1. A coherent approach to commissioning community pharmacy

It will be vital to ensure the approaches of national and local commissioners are aligned. The community pharmacy contractual framework will need to fit with general and personal medical service contracts that promote common outcomes, and offer appropriate incentives and remuneration. CCGs and Commissioning Support Units (CSUs) will need to be cognisant of the role of community pharmacy as they develop plans and pathways for community and hospital services. A single, combined outcomes framework across all health, public health and care services would assist alignment.

There are opportunities for local authorities to commission community pharmacy as a key element of their health improvement strategies, based on their Joint Strategic Needs Assessments (JSNA) and the priorities agreed in the Joint Health and Wellbeing Strategy (JHWS). The Pharmaceutical Needs Assessment, linked to the JSNA, should be the basis on which commissioners and providers build their understanding of the contribution of community pharmacies and support their development as providers of public health services appropriate to local circumstances.

Community pharmacies often work across different commissioner boundaries and therefore value consistent service specifications and systems. To develop an enhanced evidence base regarding the potential contribution of community pharmacy there is also a need to collate data from different areas.

However, it will be important to ensure the need for consistency and efficiency, where the evidence base supports it, is balanced with the necessity for local authorities, health and wellbeing boards (HWBs) and CCGs to innovate and customise their approaches to address local circumstances.

2. A facilitating and engaging approach to community pharmacy providers, including incentives for new models of delivery.

We believe there is an opportunity to create incentives for the roll-out and evolution of innovative services, such as the Healthy Living Pharmacy model informed by the evaluation of the pathfinder work programme.

We would also like to see community pharmacies tackling the social determinants of health as well as improving health through primary prevention services and delivering treatment and secondary prevention services. We believe there is further untapped potential for them to do so, drawing on examples from areas including Wigan, where community pharmacies have been used innovatively to help address two key public health challenges in the area: fuel poverty and supporting people at risk of domestic abuse.

We would like to see commissioners recognising and encouraging this potential. In support of this, we would like national bodies to work together to make available best practice and examples of innovative service design. This could include key recommendations for effective commissioning from community pharmacy, illustrative model service specifications, guidance on appropriate tariffs for different services, and case studies to demonstrate the value of community pharmacy's role in the public health, health and care system.

Learning from the past suggests that short term and small scale commissioning of services from pharmacy providers has limited their ability to invest in service development and training. In order for innovation to be encouraged, more substantial contracts are needed.

3. Concerted public engagement and awareness raising. This would aim to stimulate access and utilisation of community pharmacy to drive understanding of the value and services provided by community pharmacy within the public and across the health and care system.

Patients and the public should be involved in decisions about the commissioning of public health services from community pharmacy and other providers. It will be important for commissioners to understand what patients and the public need and want. The public should be offered choice of access to such services based on where and how they wish to access them rather than where providers have historically delivered them. In addition, patients and the public will need to be able to understand what services are available from community pharmacies and how to access these.

The NHS Confederation represents all organisations that commission and provide NHS services. It is the only membership body to bring together and speak on behalf of the whole NHS.

Bridget Coleman
Whittington Hospital
Submission to Models of Care Commission

So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Reablement service
The reablement services are unusually funded from a joint budget between healthcare and social care and I think there is going to be a lot more joined up working between healthcare and social care in the future. Reablement delivers a package of care to patients on leaving hospital, intermediate care. This service is about 15 months old but it's been fully funded since April. A short pilot was funded to begin with but we felt we needed to go on beyond that to demonstrate the value of pharmacists within that team so we took a risk and funded it for the remainder of the pilot. It was successful and on the strength of the evaluation data that we submitted, they have agreed to now fund it for another year.

The aim of the service and who is involved in delivering it
The aim of the care is to promote independence and to prevent readmissions into hospital. It's delivered primarily by physiotherapists and occupational therapists but following success from pilot, we now have a pharmacist working within that team and the pharmacist attends twice weekly multidisciplinary team meetings (MDTs) in the Islington borough and from that they pick up referrals and then go and visit those patients post discharge in their own homes.

Where the service is delivered
It's almost a medicine use review with the patient but in their own home to pick up any problems or difficulties post discharge.

Which patient group it is aimed at
Predominantly the elderly patients but it is mostly patients who have been referred through reablement services but we are starting to accept referrals directly from social services, something called the access team and also from community matrons.

What was it that impressed you about this pharmacy model of care?
It has demonstrated there is a real need for it because we feel patients come into hospital, we think we do a fantastic job with them pharmacy wise but once they go home it's just off you go. However, it's always been in that follow up and what is a concern for many of us is what patients actually do with their medicines once they get home and how they reconcile medicines they've been given here with what they may have at home and if any confusion arises. So first there is a need which is what we thought was there which we've demonstrated is there and secondly the results of the evaluation has shown what a real impact a pharmacist can have with working within this service and that's very satisfying.

What benefits does it offer patients and the wider healthcare system?

To patients it's hopefully enabling them to take their medicines in the manner that they should be through a discussion and negotiation with them, it will identify any problems with existing medication with a view to changing that medication with the agreement of the patients' clinicians. What it also done is that the pharmacist has tackled problems which aren't pharmacy related because you pick up other things when you go into people's homes and it's very difficult to ignore them. So it's liaising with social services about various aids and things that haven't been done through social care which are picked up as well. So in a nutshell hopefully it's making life better for patients directly through enhancing their pharmaceutical care. For the wider health community, what we have done is a very preliminary analysis of readmissions within 30 days, and very few of these patients were readmitted and these are at risk patients. We can't say that this intervention stopped readmissions but it is very promising so for the wider healthcare community hopefully it will play a part preventing readmissions.

What helped the development of this model of care?

Having enthusiastic individuals who are prepared to take risks and innovate. It included pharmacists to get it off the ground at the beginning but also you need engagement by those who hold money and we did take a risk financially but that risk paid off. It's often the case of having to prove something is of benefit or potentially of benefit before you get the money to do it so it's having people prepared to do that.

What hindered the development of this model of care?

The main hindrance at the beginning was getting referrals really and in making the reablement people and others out there aware that this service was in existence. Since attending the twice weekly MDT meetings that hasn't become a problem but we've still got a bit of work to do in increasing awareness amongst others that this service is there. One of the other barriers is patients simply not wanting the visit and you have to respect that choice.

Musculoskeletal chronic pain service (MSK)

We have a pharmacist working within the musculoskeletal chronic pain service called MSK. The team is a physiotherapist-led team in primary care so it's an example of not only working out in primary care but also working within a multidisciplinary setting and lone working and taking on cases as well. When patients present to the service they're assessed and the lead physiotherapist decides whether any interventions will be of benefit to them. So it could be a pharmacist, physiotherapist or psychologist, any of those interventions and then an appointment would be scheduled with the pharmacist. This pharmacist will go through their pain control and make recommendations to change if necessary. At the moment those recommendations are made via the GP but this pharmacist is an independent prescriber so she is going to be starting to prescribe for all these patients directly. At the moment there is just one pharmacist involved but, they want to increase that. We have done one evaluation which looked at the types of interventions made and what the other members of the team felt about the service which was very positive. At the moment we have an MSc student looking at what patients think of this service.

The aim of the service

The aim is to control and improve the chronic pain management of these patients.

Where the service is delivered

Out in primary care.

Which patient group it is aimed at

Those with chronic pain, musculoskeletal but that will be non-cancer pain. These patients are often a lot of drugs due to multi-factorial pain so there is quite a scope for pharmacists to make an impact.

Who is involved in delivering it

A pharmacist, physiotherapists and a psychologist. There is also a medic within that team because any recommendations that the pharmacist makes goes via the patients' GP and they will be their primary clinician. So it's quite a small team of about five members.

What was it that impressed you about this pharmacy model of care?

The impact that pharmacists can have and also how pharmacists can work very effectively within a multidisciplinary setting.

What benefits does it offer patients and the wider healthcare system?

Hopefully, improved pain control which leads to improved quality of life and which ultimately will reduce the health burden on the health system because patients will pitching up with their GP less often.

What helped the development of this model of care?

Again it's commitment and it's enthusiasm, its people willing to do it. This wasn't something we were officially funded to do, we just did it and we just found somebody who had capacity to do it and it's more of a quality measure than anything else.

What hindered the development of this model of care?

It hasn't hindered but it threatened it. There was some resistance from the nurse specialists involved in the acute pain service because they felt that this pharmacist was muscling in on their territory. Professionally they felt threatened, we dealt with it so it was never actually a real threat but I think if it hadn't been handled in the correct way it could have been. Once they heard that our pharmacists were doing this they sort of felt that perhaps they would be in a better position to do it.

Pharmacist conducting MURs through SHINE

We had a pharmacist who was conducting MURs for vulnerable patients in Islington. This came about through an initiative run by Islington Council this time called SHINE which stands for the seasonal health interventions network. It centres around what is called affordable warmth and again the idea is to keep patients out of hospital and if they are warm in their own homes then that plays a part but there was a recognition that there are other measures that can be taken to keep patients out of hospital. One of those was how patients manage their medicines at home. One of our pharmacists has been accepting referrals from SHINE to conduct MURs with patients and that's mostly over the phone or patients come in over here to do it. There was a first service that we developed after becoming an ICO and we did it for free without any funding because we thought if we do it well it can be a template for other services and that's exactly the way it worked out. We use the principles that we used to develop that service for subsequence services and the way we evaluate these services.

The aim of the service

The aim is to help residents that are referred to the service to manage their medicines better and identify any problems with them.

Where the service is delivered

It's always been delivered from here so this isn't one that's delivered in primary care but a lot of its done over the phone or sometimes patients come.

Which patient group it is aimed at

Predominately elderly people, its vulnerable Islington residents but it tends to be the elderly.

Who is involved in delivering it

It's just one individual pharmacist but the referral number aren't huge and she does that, she imbeds that into her some of her other roles and referrals come from SHINE itself, the initiative network.

What was is that impressed you about this pharmacy model of care?

It's the same principles as before is its helping people with their medicines which is what it should be about but I think what it's shown is that there are other agencies that we can work with to identify people who need this assistance. I never would have dreamed that we could work with the Council to do

this and it's just shown me that sometimes we need to think outside the box and be a bit more creative.

What benefits does it offer patients and the wider healthcare system?

As before really if you get patients to manage their medicines better it can reduce the burden on healthcare services and social services as well.

What helped the development of this model of care?

Enthusiasm and it's just being willing to take a punt and try new things out really.

What hindered the development of this model of care?

Nothing, I think if we were to continue and increase this, I mean at the moment the numbers are very, very few and we can do with resisting resources, but if those numbers were to increase we would have to get funding. So the funding would be a potential hindrance.

Pharmacist seconded to the respiratory team

We've had a pharmacist who was seconded to the respiratory team. He has just finished that period of secondment and he was working with with the ICO and he has been working largely with the community respiratory service looking at oxygen in the community which is a completely unknown zone and looking at the use of misuse of home oxygen and from that we have a specialist respiratory post funded who is going to work across primary and secondary care which again is this working across the interface.

The aim of the service

For the secondment it was to look at how a home oxygen order form (HOOF) prescription (I think this is what was said) is prescribed in the community and how it is used by patients because it's use wasn't always evidence based and it was looking at whether patients were using ambulatory oxygen when they should be using their concentrators at home as that increases cost. So it's looking at both quality of care and appropriateness of care but also on cost of oxygen.

Where the service is delivered

That was delivered in patients' homes.

Which patient group it is aimed at

It was all those on home oxygen so that's going to be largely patients with COPD but there were some patients with cluster headaches too.

Who is involved in delivering it

The pharmacist was the one going in and looking at the home use but he was working with the community respiratory team which is nurses and some physiotherapists as well. So again its multidisciplinary working and of course our consultant here as well. So the new post will be multidisciplinary working as well as the respiratory team here are very collaborative.

What was is that impressed you about this pharmacy model of care?

The pharmacists were willing to have a go and do it because none of us here know a great deal about oxygen. It was a very steep learning curve for him and he was quite a junior pharmacist but he was very willing to take it on and the results hopefully will have patient impact in that oxygen will be used in a more evidence based manner and it should reduce cost and also the fact that we got a post out of it which nowadays is really good news and it's a permanent post as well.

What benefits does it offer patients and the wider healthcare system?

Hopefully improvements in outcome if they are using their oxygen in a more evidence based way, to the community hopefully reductions in cost as well if the right oxygen is used in the right place they are not over relying on the ambulatory care oxygen.

What helped the development of this model of care?

I think again we are down to enthusiasm which is great but also I think in this particular case it's the collaborative nature of the respiratory team and they actually approached us to help with this.

What hindered the development of this model of care?

Nothing, I don't think anything did in this case.

Integrated care pilot

One of our pharmacists has been working within the integrated care pilot, she's worked in North East Haringey on that pilot and now she's working in Islington as well.

The aim of the service

So the idea is to keep patients out of hospital and to deliver care much of the same way as it would be in hospital but in patients' homes. The pharmacist was actually the project lead for North East Haringey and she's also the pharmacist for the 2 pilots and she participates in the teleconferences too.

Where the service is delivered

This service is looking at caring for patients in their own homes rather than bringing them into hospital so that the GP is the lead clinician and the care is coordinated by the various individuals as it would be in the hospital but in the community setting but through teleconferencing.

Which patient group it is aimed at

Again its vulnerable patients who are at risk of readmission.

Who is involved in delivering it

One pharmacist but there are members of the multidisciplinary team so again it's an example of multidisciplinary working so there are consultants from the North Middlesex Hospital, there are GPs, physiotherapists, community matrons to name just a few but again it's an example of very much multidisciplinary working. They are all out in the community.

What was is that impressed you about this pharmacy model of care?

I think getting it off the ground in the first place, it's very challenging because quite rightly there has always been a very strong feeling that this needs to be GP led because they are the main care givers for patients in the community and if it wasn't GP led you didn't have the full support of GPs and a road to nowhere.

What benefits does it offer patients and the wider healthcare system?

What helped the development of this model of care?

What hindered the development of this model of care?

Anticoagulation monitoring service

That is something that has been going on for many years that I am developing and that I manage.

The aim of the service

The aim of the service is to effectively manage patients who are on oral anticoagulation.

Where the service is delivered

It is delivered within primary care as well.

Which patient group it is aimed at

Those on oral anticoagulants.

Who is involved in delivering it

Our clinical lead is a consultant cardiologist but there is direct management with clinical services which I think is unusual in pharmacy. It's not only that but it's what we call distributed service so we have one nurse specialist which I think is important to have because of the different skill mix but apart from her it's all pharmacy led. So we have the clinics here, traditional clinics in secondary care hospital but we are also commissioned from Barnet PCT to provide clinics in primary care so we have pharmacists going out every day to sites in Barnet to deliver clinics there and we also have outreach clinics from here in addition to that. We also provide an accredited training and accreditation program for anticoagulation practitioners across NCL as well.

What was is that impressed you about this pharmacy model of care?

Pharmacists can deliver care which has traditionally been delivered by doctors and can effectively manage this group of patients.

What benefits does it offer patients and the wider healthcare system?

Pharmacists have been doing this in other places for a while but we have taken it a step further and we're delivering out in primary care and it's a lot more challenging to deliver these sorts of services outside of the comfort of hospital where we have direct access to clinicians if things go wrong. We've also developed models of care where community pharmacists are delivering these services as well. We have an independent pharmacy in Islington which is being evaluated and published on that and also we have a Boots branch in Wood Green and also some pharmacies in Enfield, GP practices as well.

What helped the development of this model of care?

Being properly funded has helped, being commissioned to provide services, and having the support and collaborative nature of the lead commission as well. He has got a very strong vision as to where the service should go and the service should always innovate and that's been very rewarding, very inspirational.

What hindered the development of this model of care?

I think there is constant need to ensure staff are trained and accredited and re-accredited to a certain level to ensure safety of the service so that's been the main challenge but we have managed to do that but the training, but the training commitment is quite high because we do need to have high standards because it's to do with a dangerous drug but I wouldn't say it's a hindrance, it's more of a challenge but no there have been no other hindrances.

District nurse service

We've had a pharmacy technician working with district nurses administering medication. That was a six month pilot as a result of which they have got some permanent posts funded from it and that evaluation has been published. This service started last winter, so very recently.

The aim of the service

It was really to see if the pharmacist could work within a district nursing service and administer medication. The reason the DN's wanted to do it was to see if they added what they called value to the service so if it was cheaper really to have a technician doing it compared to a DN doing it. The result of the evaluation was that the technician did add value and that there was scope of adding further value.

Where the service is delivered

This service involves visiting patients in their own homes. Our pharmacy technician spent most of her time administering insulin but basically she was just administering medication.

Which patient group it is aimed at

It's largely housebound patients who need distinct nursing or who need extra assistance administering or prompting medication.

Who is involved in delivering it

Not pharmacists, just a pharmacy technician but I went out with her and managed her from here but she was also managed from the DN service by DN's.

What was is that impressed you about this pharmacy model of care?

I think it's a new direction for technicians to take and it's a role that demonstrated what a technician could undertake and it was a successful pilot in that in resulted in there being permanent positions for technicians within a DN service.

What benefits does it offer patients and the wider healthcare system?

I think in terms of patients it's the same benefits as a DN going in would give them with assistance with their medication, a regular face coming in everyday which is important to some people. In terms of the

healthcare system it's probably financial in that it's been demonstrated that the technician worker in the team adds value to the team by freeing up DN time to do other tasks.

What helped the development of this model of care?

The pharmacy technicians were more familiar with medication so they could do it more efficiently.

What hindered the development of this model of care?

Lack of enthusiasm this time from the pharmacy technicians. It's interesting there is a reluctance by some to take on a these new roles because it's not what they signed up for. I think fundamentally it was not really wanting to work outside the four walls of the hospital.

In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Lack of funding is the obvious one. We are lucky that we have had some very committed let's go for it individuals but there is, I can understand it, it's not a criticism there is a reluctance amongst some individuals to spread their wings and work in primary care. I can understand that it's not what they signed up for, they signed up for hospital pharmacy, got a hospital technician job and suddenly they've been asked to do something different. So it's not really a criticism and I do have a lot of sympathy but I think at the same time we have to acknowledge that it's a changing world, it's a changed organisation, patients spend most of their time out of hospital and that's where maybe we need to concentrate more on in delivering pharmaceutical care.

In general what might help or is currently helping the development of new models of care delivered through pharmacy?

I think we have some senior members of staff who are very committed to it and enthusiasm is a huge factor and we've got some really good staff here who are receptive to that and are willing to take on these new roles and they really give it their best. They take it on with enthusiasm and they are willing to push the boundaries. You really do need that, but I think you do need people who have got vision and can examine services in a critical way to see how we can better deliver them just because this is how it's done doesn't mean it's the best way as it is a changing world.

Are there any existing services that you think could be better provided through pharmacy?

I'm very, very pro MDT working and I don't think we should work in a silo we should be part a multidisciplinary team, I don't think its right to have it purely as a pharmacy service, it should be pharmacy making significant input into an existing team. I really think that is the way to go. We've had approaches from rheumatology, that's one, and we are starting to do some work with them because there is a lot around controlling the use of high cost drugs in rheumatology, a lot of monitoring of blood parameters also. So rheumatology is one area we don't have but we are starting to make inroads there. We do have surgery specialist pharmacists and perhaps we could have more input in pre-assessment clinics. That's probably one area. We have most other areas covered and pharmacists are in nearly all specialities. Rheumatology is the big one to get off the ground. So that's where building up good relationships in hospital really helps as well.

Are there any services that pharmacy currently doesn't offer but you think it should?

We could do more for medicines optimisation but we would be treading on the toes of our community colleagues doing that but arguably I think we could do it well. I think what would be nice to see although I don't know how possible this is, is more collaborative working between hospital and community pharmacists. I think the lines of communication aren't always the best but I'm sure there is scope there for joint working. Not only integrating care across direct clinical services but also asking our community colleagues. There is probably a lot of scope there.

I think it's the joint working between community and hospital pharmacists with the involvement of the patients GP whether they is any scope. I don't know how you would operate it; it's not very joined up. I think part of the problem, I know you can't be good old-fashioned talking communication but IT systems don't talk to each other for one so trying to exchange information so be hindering. That's a great thing to strive for. You just need need engagement by all and it's how to encourage engagement.

Commission on
Future Models of Care
Delivered through pharmacy

1. Name

David Green

2. Would you like to remain anonymous?

No

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Individual

6. Are you a?

Healthcare professional

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Pharmacist prescriber running respiratory care clinics from GP surgeries. Patient satisfaction is high and numbers likely to increase with appropriate funding. Prescribing changes are accepted and prescribing costs controlled.

8. What was it that impressed you about this pharmacy model of care?

Good use of a community pharmacist prescriber. Frees up GP time as well as better patient satisfaction.

9. What benefits does it offer patients and the wider healthcare system?

Easy access to prescriber supporting long term management. Potential to reduce hospital admissions and improve quality of life.

10. What helped the development of this model of care?

Good inter professional working and acknowledgement of benefits to allow funding.

11. What hindered the development of this model of care?

professional reluctance amongst some doctors

12. Where can we find out more?

contact me to be put in contact with prescriber

13. Do you have any other examples of new or innovative models of care to share with us?
14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?
15. What was it that impressed you about this pharmacy model of care?
16. What benefits does it offer patients and the wider healthcare system?
17. What helped the development of this model of care?
18. What hindered the development of this model of care?
19. Where can we find out more?
21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

too much focus on dispensing service fees for major multiples

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Better understanding of pharmacist input to manage patients and their medicines rather than dispensing without added value from the pharmacist. We need to focus pharmacists on the higher need patients with proper pharmaceutical care rather than paying for the numbers game e.g. MURs that allow poor value for money delivery.

23. Are there any existing services that you think could be better provided through pharmacy?

Care homes services should be managed properly with clinical input into the homes rather than just dispensing using MDS providfed as a loss leader. Home care support for carers in patients homes needs to be properly structured.

24. Are there any services that pharmacy currently doesn't offer but you think it should?

More NHS vaccination clinics. Better use of pharmacists as trainers in all areas Better use of prescribers in pharmacies with drop in clinics as well as in Health care premises

25.Do you have any links to resources that you feel would be helpful to the commission?

http://www.networks.nhs.uk/acl_users/credentials_cookie_auth/require_login?came_from=http%3A//www.networks.nhs.uk/nhs-networks/primary-and-community-care-pharmacy-network

26. Can we thank you publicly for your submission?
Yes

27. Can we make your response public?
Yes

Commission on
Future Models of Care
Delivered through pharmacy

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No

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of Organisation

Calderdale and Huddersfield NHS foundation Trust

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

This service was a 'virtual ward' with the aim of reducing readmissions to hospital (within 30 days of discharge) for patients assessed at high risk of readmission. Risk was assessed using a screening tool developed locally, incorporating LACE. Patients were assessed prior to discharge from an acute hospital trust, patient group >60 years of age, medical patients, discharged to own home or residential care, with no existing community support. Multidisciplinary team involving community matrons, hospital screening nurses, falls and demential practitioners, pharmacists and pharmacy technicians. Patients were followed up in their own home or by telephone by nominated case manager. Patients who scored highly on medication questions (ie polypharmacy, high risk medicines, changes to medication in hospital, compliance issues) were allocated to pharmacy.

8. What was it that impressed you about this pharmacy model of care?

Multidisciplinary model - innovative practice. this had not been tried before in the UK. The model was based on a similar model from Toronto. Holistic approach to supporting patients following discharge.

9. What benefits does it offer patients and the wider healthcare system?

Helps to support patients post discharge from hospital, initially to reduce readmissions, but also helps to maintain independence and ensure that patients get the best from their meds (medicines optimisation).

10. What helped the development of this model of care?

Support from within the hospital for pharmacy involvement. Recognition that medicines are a key factor in readmission. financial penalties to the organisation if patients readmitted within 30 days.

11. What hindered the development of this model of care?

Developing model. Pharmacy staff unaccustomed to visiting patients in a domiciliary setting. IT issues - initially access to system one. No electronic patient record in the hospital - took time to locate notes etc following discharge

12. Where can we find out more?

Can contact me or another member of the team. Fiona.smith1@cht.nhs.uk

13. Do you have any other examples of new or innovative models of care to share with us?

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

15. What was it that impressed you about this pharmacy model of care?

16. What benefits does it offer patients and the wider healthcare system?

17. What helped the development of this model of care?

18. What hindered the development of this model of care?

19. Where can we find out more?

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

constant change and reorganisation in the NHS. IT - compatability, access issues, not as well developed in secondary care.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

23. Are there any existing services that you think could be better provided through pharmacy?

24. Are there any services that pharmacy currently doesn't offer but you think it should?

25.Do you have any links to resources that you feel would be helpful to the commission?

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

1. Name

Chris Hetherington

2. Would you like to remain anonymous?

No

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Individual

6. Are you a?

Healthcare professional

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Substance misuse services via community pharmacy in Swindon. The aim is to improve access to prescribing services for substance misusers in Swindon. The service is delivered from a retail health centre pharmacy Services include emergency FP10MDA scripts, client detox using lofexidine/buprenorphine, shared care services (including prescribing methadone/buprenorphine)using pharmacy premises Service delivered by independent prescribing pharmacist in house working with local drug worker from local drug agency , also working with local GPs

8. What was it that impressed you about this pharmacy model of care?

Ease and speed of access, safety net for whole of drug treatment in Swindon, v positive client feedback

9. What benefits does it offer patients and the wider healthcare system?

As above....joined up service rather than fragmented service offerred/not offered by local GPs

10. What helped the development of this model of care?

Good links with local drug treatment agency and good links with local GPs

11. What hindered the development of this model of care?

Not been done before, agreeing payment, apathy

12. Where can we find out more?

Contact C Hetherington MRPharmS 01793 616280

13. Do you have any other examples of new or innovative models of care to share with us?

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

15. What was it that impressed you about this pharmacy model of care?

16. What benefits does it offer patients and the wider healthcare system?

17. What helped the development of this model of care?

18. What hindered the development of this model of care?

19. Where can we find out more?

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Apathy.money, lack of vision, pharmacy workoad is horrendous

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Proper payment and recognition

23. Are there any existing services that you think could be better provided through pharmacy?

Shared Care

24. Are there any services that pharmacy currently doesn't offer but you think it should?

25.Do you have any links to resources that you feel would be helpful to the commission?

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

1. Name

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of Organisation

City Health Care Partnership CIC

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

City Health Care Partnership CIC was commissioned to provide a pharmacy support service to care homes. The aims of the service were to ensure patients received a clinical medication review and optimisation of their medicines. This was provided by our care home pharmacist who liaised with the patient's GP, supplying community pharmacy and other healthcare professional involved in the patients care. A care home pharmacy technician provided support to the care home staff to ensure safe handling and administration of medicines in the care home setting. The technician also worked with the homes to reduce the amount of waste medicine.

8. What was it that impressed you about this pharmacy model of care?

The care home pharmacist and technician were able to provide dedicated support to the care homes to ensure medication standards were met, medication errors reduced and service-user safety improved. Other issues were also identified within care homes, for example patients on oral nutritional supplements

were not being screened correctly using MUST and had no nutritional care plans in place. The pharmacy support team then liasied with community dietetic service and arranged training for the care home staff.

9. What benefits does it offer patients and the wider healthcare system?

The care home team have built good working relationships with care home managers and staff, GPs, community pharmacies, CQC, older people's pharmacist in the acute trust and the community nursing teams that deliver care in residential homes to ensure that all agencies involved in patient care can work together for the benefit of the patient. This ensures more integrated working, improved relations and a reduction in waste medications

10. What helped the development of this model of care?

CHUMs report and the DoH alert in 2010 highlighted the need for PCTs to review the safety of local prescribing, dispesning, administration and monitoring arrangements in the provision of medciation to older people in care homes. Winning the SID award

11. What hindered the development of this model of care?

Some care homes would have patients registered with several GPs, quite time consuming for the pharmacist to visit with all GPs to discuss patients medication.

12. Where can we find out more?

emma.baggaley@chcphull.nhs.uk

13. Do you have any other examples of new or innovative models of care to share with us?

yes

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

A multidisclpilanry team of social and healthcare staff provide an intermediate care unit for patients who require reablement before they can return to their own home. In September 2012, funding was secured for a pharmacist and pharmacy technician to join the MDT to; Problem solve with medication issues on admission and throughout care Optimise medicines Assess and support for self-medication Plan for discharge Reduce the number of care calls on discharge for social services staff

15. What was it that impressed you about this pharmacy model of care?

Pharmacist and technician have fully integrated into the MDT. Not only are significant clinical interventions being made but also a reduction in social service calls to patients to help with medication has been reduced and some patients are able to continue managing medicines independently.

16. What benefits does it offer patients and the wider healthcare system?

Medicine errors are identifed on admission, so improving patient safety Patients now have the opportunity to discuss thier medicines with the pharmacy team prior to discharge, more patients have remained self medicating and independent with their medication. The pharmacy team have implemented the use of discharge letters to the patients GP and liaise with the GP regarding any change to the paitents medication whilst with intermediate care.

17. What helped the development of this model of care?

A weekly MDT meeting take place to aid with discharge planning for the patients.

18. What hindered the development of this model of care?

Different medication policies in use by the social teams and health teams.

19. Where can we find out more?

emma.baggaley@chcphull.nhs.uk

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Locally any new initiatives are only funded for 6-12 months and this is proving problematic for recrutiment of staff on a permanent basis.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

23. Are there any existing services that you think could be better provided through pharmacy?

24. Are there any services that pharmacy currently doesn't offer but you think it should?

25.Do you have any links to resources that you feel would be helpful to the commission?

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public? Yes

1. Name

Mike Hedley

2. Would you like to remain anonymous?

No

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of Organisation

NHS England Surrey and Sussex Team

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Joint project with community pharmacies and Eastbourne DGH pharmacy team for NMS for patients that are discharged on "new" medicines.Patients would be referred to community pharmacies (of patients choice) via electronic means using Sonar Informatics Web based platform. It is aimed at all patients who are discharged from hospital who have been initiated on a new medicine from the specific list. It involved input from pharmacy medicines management team in the hospital completing an online referral form using the Sonar Informatics system which sends a message to the patients chosen community pharmacy. The community pharmacy are then able to view discharge information and be able to contact the patient to initiate the NMS.

8. What was it that impressed you about this pharmacy model of care?

This effectively ensures that the patient's care seemlessly continues once discharged from hospital, with support from the community pharmacy, which in the past rarely happened resulting in the patient being re admitted into hospital at a later date.

9. What benefits does it offer patients and the wider healthcare system?

The patients health will generally improve if they take their prescribed medication as intended, thus preventing further admissions into hospital. This has obvious cost savings to the NHS

10. What helped the development of this model of care?

The Sonar Informatics system that was widely used by pharmacies in the area and the desire of the systems owner (a pharmacist) to improve this area of care

11. What hindered the development of this model of care?

Engagement by hospital pharmacy teams and the lack of knowledge relating to community pharmacy systems

12. Where can we find out more?

Contact Pritpal Thind, Sonar Informatics pritpal.thind@sonarinformatics.com

13. Do you have any other examples of new or innovative models of care to share with us?

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

15. What was it that impressed you about this pharmacy model of care?

16. What benefits does it offer patients and the wider healthcare system?

17. What helped the development of this model of care?

18. What hindered the development of this model of care?

19. Where can we find out more?

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

The ability of pharmacists to manage theirs and their teams time effectively, and also their ability to utilise the full potential of their teams

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

I think that the roll out of healthy living pharmacy models will be a great help, as this will teach pharmacies to better utilise their teams, and as a result will be better placed to engage with their customers / patients and thus provide improved levels of care. It is essential that all pharmacists learn that they cannot do everything single handed.

23. Are there any existing services that you think could be better provided through pharmacy?

Other than the traditional pharmacy services, the teaching of behaviour change processes and brief interventions to all staff, will perhaps enable the existing services to deliver what was first envisaged. Too

many services fail as pharmacies are or were often not proactive in their approach and thus were unable to "sign" up candidates for a given service.

24. Are there any services that pharmacy currently doesn't offer but you think it should?

There are several that are not universally available due to financial restrictions, for example I feel there should be a national minor ailments service, as this could reduce pressure on GP and A&E services

25.Do you have any links to resources that you feel would be helpful to the commission?

www.firstpct.org/

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation

6. Name of Organisation

Central and North West London NHS Foundation Trust

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Aim was to deliver a new purpose built clozapine clinic with point of care testing on site and an improved patient experience. The service was aimed at a chort of patients in Brent taking the aytipcal antipsychotic clozapine usually with a diagnosis of treatment resistant schizophrenia.

8. What was it that impressed you about this pharmacy model of care?

Involved multi-disciplinary group involved in the design and roll out of the service including nurses, consultants, managers, pharmacist and pharmacy technicians. Patients and carers views were obtained. Pre-dispensing of clozapine has made the process much leaner and it has reduced the level of complainst over medicines not being ready on time. satisfaction is high with the service with all professional groups.

9. What benefits does it offer patients and the wider healthcare system?

One visit to clinic. Patients and carers appreciate only having to make one visit to have their blood tests and collect their medication. Abnormal blood results are available at once and a treatment plan can be arranged with the patient at once and is not delayed traying to find the patient in the community. Clinic located away from main inpatient mental health site so reduces stigma associated with the environment of the previous clinic.

10. What helped the development of this model of care?

Extensive MDT involvement and locally driven by steering group to roll out. Industry support from Teva over the development, training and specifiation for the use of point of care testing.

11. What hindered the development of this model of care?

Funding gaps over the new service requiring an increase in staff costs.

12. Where can we find out more?

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13. Do you have any other examples of new or innovative models of care to share with us?
14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?
15. What was it that impressed you about this pharmacy model of care?
16. What benefits does it offer patients and the wider healthcare system?
17. What helped the development of this model of care?
18. What hindered the development of this model of care?
19. Where can we find out more?
21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Cost improvement programmes where up-front investment is needed to make longer term savings.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Better integration of pharmacists into management structures of directorates or in this trust service lines. Enhanced clinical leadership.

23. Are there any existing services that you think could be better provided through pharmacy?
24. Are there any services that pharmacy currently doesn't offer but you think it should?
25.Do you have any links to resources that you feel would be helpful to the commission?
26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?
Yes

Commission on
Future Models of Care
Delivered through pharmacy

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation Leeds Teaching Hosp NHS Trust

6. Name of organisation?

Leeds Teaching Hosp NHS Trust

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

• The IMPACT project aimed to enhance assessment of post-discharge needs for patients on the acute older people admission wards, to support effective teaching of patients/ carers, to signpost patients for post-discharge follow up and to enhance effective communication between healthcare professionals at transition of care •Of the project group 25% of IMPACT patients had an identified clinical action and 59% had a medicines support action post discharge. The 30 day re-admission rate for patients in the IMPACT project was 17% compared to 20% for all patients on the older people admission wards. • The IMPACT project has resulted in improved medicines support for older patients, reduced 30 day re-admissions by 3% and improved communication across the interface with healthcare professionals in primary care

8. What was it that impressed you about this pharmacy model of care?

The project showed a reduced re-admission rate for the project group. The patient benefits were improved education, improved clinical support, improved medicine support and signposting to services within primary care.

9. What benefits does it offer patients and the wider healthcare system?

From the project there was improved communication and relationships at the interface with greater knowledge of differing roles. The project also highlighted both pathway and clinical issues for future project work and resolution.

10. What helped the development of this model of care?

Project was part of the Clinical Value and Prescribing initiative which had buy in from all strategic stakeholders in Leeds.

11. What hindered the development of this model of care?

1. Difficult to follow up outcomes for patients once in primary care 2.This project was funded through transformation monies however there has been difficulty in progressing funding through the CCG for future roll out. 3. Leeds has moved from one PCT to 3 CCGs requiring whole city agreement.

12. Where can we find out more?

Submitted abstract to RPS or contact Heather Smith Consultant Pharmacist or Una Laverty Project Lead

13. Do you have any other examples of new or innovative models of care to share with us?

No

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?
15. What was it that impressed you about this pharmacy model of care?
16. What benefits does it offer patients and the wider healthcare system?
17. What helped the development of this model of care?
18. What hindered the development of this model of care?
19. Where can we find out more?

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

NHS management changes, IT limitations and access.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

As a result of the IMPACT project future models have been suggested. We are presently working up a model which will see hospital clinical pharmacist working with practice pharmacists to undertake Level 3 Medication review while in hospital. This collabrative working ensures high risk patients receive pharmacy lead Level 3 medication review. This reduces duplication of effort and ensures a quality review as part of QOF.

23. Are there any existing services that you think could be better provided through pharmacy?
24. Are there any services that pharmacy currently doesn't offer but you think it should?

Domicillary MURs

25.Do you have any links to resources that you feel would be helpful to the commission?

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

1. Name

Mr Jayesh Shah

2. Would you like to remain anonymous?

No

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jayesh75@gmail.com

4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Individual

6. Are you a?

Pharmacist

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Undertaking medication optimisation for patients in care homes on behalf of GPs. Reviews undertaken at GP surgeries using clinical systems, and then with carer and patient at care home. Success of implementation as number of preagreed criteria with GPs giving pharmacist power to change medication on clinical system. This project was by iRx Solutions and commissioned by Brighton and Hove CCG for 1542 residents

8. What was it that impressed you about this pharmacy model of care?

The process of implementation due to pre agreement ensured 95% of recommendations taken forward. Sustainable change due to education provided. Risk of harm from medicines measured pre and post pharmacy intervention.

9. What benefits does it offer patients and the wider healthcare system?

Financial savings. (£350,000 for these patients) Improved patient care Reduced polypharmacy

10. What helped the development of this model of care?

Previous experience in care home medication review

11. What hindered the development of this model of care?

GP Board meeting and red tape

12. Where can we find out more?

https://www.dropbox.com/s/ik95pwmrjf2hfao/iRx%20Solutions%20Care%20Home%20Poster_REV.pdf

13. Do you have any other examples of new or innovative models of care to share with us?

Yes

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?

Use of independet prescribers for delivering specific clinics to improve patient care. Example in final question of depression and anxiety, but other areas include statins, over active bladder, dermatology, erectile dysfunction etc

15. What was it that impressed you about this pharmacy model of care?

The focus on improving patient care

16. What benefits does it offer patients and the wider healthcare system?

Cost savings, improved education, better medicines adherence.

17. What helped the development of this model of care?

Pharmaceutical industry

18. What hindered the development of this model of care?

GP practices accepting service. PCT thinking it is a conflict of interest and therefore delaying service

19. Where can we find out more?

https://www.dropbox.com/s/4y95zdzr693v6gl/Depression%20and%20Anxiety%20-%20Project%20outline%20v6.pdf

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

GP and CCG. Financial payment for service. Dedicated time.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Pharmaceutical industry

23. Are there any existing services that you think could be better provided through pharmacy?

Hospital discharge services and communication with primary care. Alcohol dependence. Be mindful and basic IAPT services. GP Medication Reviews.

24. Are there any services that pharmacy currently doesn't offer but you think it should?

Alcohol dependence. Be mindful and basic IAPT services. Erectile dysfunction clinics.

25.Do you have any links to resources that you feel would be helpful to the commission?

https://www.dropbox.com/s/08m1xu623kqfoou/How_to_write_a_Business_Case_NMP_Vs1_June12_MB.pdf
https://www.dropbox.com/s/hqfrbnul3qhr2pl/iRx%20Solutions%20Brighton%20Care%20Homes.pptx
https://www.dropbox.com/s/bbhc7lydp5fazze/iRx%20Solutions%20W%20Sussex%20PCT.pptx
https://www.dropbox.com/s/g8cfyjacq8u1coy/3%20-%20Jayesh%20Shah%20article%20on%20Care%20Homes%20Project%20-%20Pharmceutical%20Journal%2C%20September%202011.pdf
https://dl-web.dropbox.com/get/iRx%20Solutions%20Care%20Homes%20Clinical%20%26%20Pharmaceutical%20Information%20or%20Resources/Pharmaceutical/Prevention%20of%20Disease/redbook8.pdf?w=AAA-8WEX-gBr3b17odp2I0_-u0HEu2hFqke7n9jEDFC6sA
https://www.dropbox.com/s/dxeftyebs00jx3i/ACB_Scoring_List_040412.pdf
https://www.dropbox.com/s/jl7pqbs3m53q6qc/2012%20Beers%20Criteria%20for%20Stopping%20Drugs%20in%20the%20Elderly.pdf
www.sabp.nhs.uk/moodhive
https://www.dropbox.com/s/ik95pwmrjf2hfao/iRx%20Solutions%20Care%20Home%20Poster_REV.pdf
https://www.dropbox.com/s/zmp24kej5ke9wn1/Angina%20-%20Executive%20summary.pdf

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

1. Name

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

Organisation. Central & North West London NHS Foundation Trust

6. Name of organisation?

Central & North West London NHS Foundation Trust

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Newly formed Psychiatric Liaison teams at Hillingdon Hospital and North West London Hospitals Trust included a specialist mental health pharmacist working within the team to advise and promote optimal use of medicines to treat and manage mental health disorders, both newly diagnosed or pre-existing. This service is delivered to inpatients (including A+E) and some outpatient clinics as appropriate at the acute hospital, with mainly older adults being seen by the pharmacist due to polypharmacy and medical complexity. The pharmacist was initially only included in a 3 month pilot, but the role has now continued for over 18 months.

8. What was it that impressed you about this pharmacy model of care?

It provides specialist medicines advice and support to the medical and psychiatric liaison teams in a timely manner, supporting clinicians through complex cases. By working within the team, rather than visiting the team, the pharmacist is able to proactively identify those patients likely to require his input

instead of relying of a referral via a psychiatric liaison nurse. Despite only seeing a select group of patients, the liaison pharmacist influences prescribing through education of the medical teams on best practice, pharmacology and drug selection.

9. What benefits does it offer patients and the wider healthcare system?

Psychiatric Liaison teams (such as RAID in Birmingham) have shown that for every £1 extra spent on psychiatric liaison teams a conservative saving of £3 in the wider health economy is seen due to patients being placed in their own homes and reducing readmissions. The team on which this figure is based do not include pharmacists. The addition of the pharmacist in the liaison team at Hillingdon Hospital has been shown to reduce the overall spend on psychotropic medicines (by three care of the elderly consultants who regularly refer to the psychiatric liaison team) by over 50% based on figures produced over a 3 month period before and after the formation of the liaison team with a pharmacist. Antipsychotic prescribing was reduced (possibly an effect of a national drive to reduce this in the elderly) and an increase in antidepressant use was seen (possibly due to a local unmet need). Patient receiving pharmaceutical care from the mental health pharmacist benefit from safe, effective and appropriate use of psychotropic medicines managed by a specialist rather than a general/non-mental health specialist. Dose changes to medicines, such as increasing suboptimal antidepressant doses, or switching medicines can be managed before discharge reducing the burden on the GP to assess and alter therapy where they may not have full expertise. Patients can be counselled fully on the use of their psychotropic medicines facilitated concordance and adherence as advised by NICE and vital in the speciality of mental health. The liaison pharmacist also regularly teaches and trains ward-based and pharmacy staff on aspects of medicines use within mental health to improve the quality of pharmaceutical care that patients with mental health disorders receive whilst in an acute hospital.

10. What helped the development of this model of care?

Although this role is unusual nationally and considered ‘non-essential’, the availability of funding was the primary reason for being able to develop this care model. A proactive pharmacy team within CNWL was able to identify the potential benefits to the service and to the patients by releasing an experienced pharmacist from other clinical commitments. 'No Health Without Mental Health' showed the importance of integrating mental health care into the physical health care environment. Pharmacists are well-placed to provide this holistic model of care due to the use of medicines both treating and potentially causing some psychiatric symptoms.

11. What hindered the development of this model of care?

There have been challenges in integrating the liaison team into the acute hospital, but in terms of the pharmacist within the team there have been relatively few. Being an unusual role nationally, few staff had worked closely with a pharmacist prior to the team’s inception and encouraging the staff to refer to the pharmacist’s expertise was initially difficult. However, as time continued, the liaison staff (nurses, OT and doctors) and medical teams regularly seek his opinion and advice. Liaison staff have become more confident in giving advice about medicines but also recognise their limitations and where specialist information is required. Agreements on where the usual ward pharmacist’s work stopped and the liaison pharmacist’s work began needed agreement, but close communication with the acute pharmacy team is vital where there is joint working. The variable work load of the liaison team and the variable number of patients referred to the pharmacist is difficult to ensure that staff time is used optimally, although the pharmacist is able to contribute to liaison team and directorate medicines management activities as required.

12. Where can we find out more?

You can contact myself. An article on the psychiatric liaison service has been published in the Health Service Journal although this does not include the specific role of the liaison pharmacist. Article available at http://www.hsj.co.uk/resource-centre/best-practice/qipp-resources/liaison-psychiatry-can-bridge-the-gap/5051771.article

13. Do you have any other examples of new or innovative models of care to share with us?

No

14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?
15. What was it that impressed you about this pharmacy model of care?

16. What benefits does it offer patients and the wider healthcare system?

17. What helped the development of this model of care?

18. What hindered the development of this model of care?

19. Where can we find out more?

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Lack of service funding and low retention of staff across all sectors of health care. Being able to innovate where there is little or absent evidence that a new model of care will provide good value for money.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

The reduced levels of funding require innovative practice to produce a higher quality service for less financial outlay. Pharmacists are able to utilise their diverse skill-set to improve quality and safety of health care interventions and prescribing.

23. Are there any existing services that you think could be better provided through pharmacy?

24. Are there any services that pharmacy currently doesn't offer but you think it should?
25.Do you have any links to resources that you feel would be helpful to the commission?

26. Can we thank you publicly for your submission?

Yes

27. Can we make your response public?

Yes

Commission on
Future Models of Care
Delivered through pharmacy

1. Name

2. Would you like to remain anonymous?

Yes

3. Email Address

4. If we need to, would you be happy for the Commission to contact you for more information?

5. Are you responding on behalf of an organisation or as an individual?

6. Are you a?

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

medicines optimisation review service for frail elderly patients in care homes. Pharmacists and dietician undertaking individual medication reviews and nutritional review. Consultation with care home staff and individual GPs. Referral on to in reach psychiatric team where appropriate with a view to reducing antipsychotic prescribing. Referrals to falls prevention team where appropriate. Aim: reduce use of unnecessary medicines. Review of risk/benefit rates in elderly population. Reduce use of unnecessary nutritional supps. Reduce hospital admissions. Improve quality of life for individuals.

8. What was it that impressed you about this pharmacy model of care?

21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Lack of agreement on responsibility for funding new services. IT systems incompatibility.

Commission on
Future Models of Care
Delivered through pharmacy

1. Name

Karena Mulcock

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4. If we need to, would you be happy for the Commission to contact you for more information?

Yes

5. Are you responding on behalf of an organisation or as an individual?

6. Name of Organisation

7. So, could you tell us about any new or innovative services involving pharmacy that have impressed you in the last two or three years?

Cluster Pharmacist to provide patient focussed pharmaceutical care direct to patients at home and in local community hospitals managed by Northern Devon Healthcare NHS Trust.These posts are aimed at supporting people with their medicines in their individual care setting to enable them to get the best use of their medicines.tThe link with the community hospitals enables supportive discharge and reconciliation of medicines at all interfaces including admission,discharge and return to primary care. T also allows efficient medication review and. Support for adherence to ensure patients receive safe and effective medication.

8. What was it that impressed you about this pharmacy model of care?

This model crosses interfaces and is patient focussed. Examples include enabling a planned discharge home of a patient on warfarin requiring help with adherence rather than needing care home accommodation due to compliance problems

9. What benefits does it offer patients and the wider healthcare system?

Benefits include reduced hospitals stays and readmissions to hospitals. Pharmacists can also signpost to other local services both pharmaceutical an via other healthcare professionals. Pharmacists are also able to be part of the multidisciplinary teams locally and support other staff with pharmaceutical issues such as medicines information and risk assessments for administration of injectable medicines

10. What helped the development of this model of care?

Multidisciplinary working with other healthcare professionals Support for the role by local managers who see the benefit of interventions by pharmacist in relation to medicines . Skill mixing has also been introduced to include pharmacy technicians .

11. What hindered the development of this model of care?

Organisational change and requirements to cut costs from local teams. A lack of medicines Management and medicines optimisation support and requirement from Commissioners in designing new services and delivery models

12. Where can we find out more?

Karena Mulcock Lead Pharmacist Medicines Management Team Eastern Area Northern Devon Health care Trust Unit 1 Exeter International Office Park Exeter Devon EX52HL 01392 356963

13. Do you have any other examples of new or innovative models of care to share with us?
14. Could you tell us about these new or innovative services involving pharmacy that have impressed you in the last two or three years?
15. What was it that impressed you about this pharmacy model of care?
16. What benefits does it offer patients and the wider healthcare system?
17. What helped the development of this model of care?
18. What hindered the development of this model of care?
19. Where can we find out more?
21. In general what do you think is hindering the development and integration of new models of care delivered through pharmacy?

Organisational change and lack of Medicines Management and pharmacy input at commissioning levels ie patient care pathways developed without medicines management. medicines are only thought of at the last moment and then only about supply rather than governance and optimisation and patient support.

22. In general what might help or is currently helping the development of new models of care delivered through pharmacy?

Support via social care and health models ensuring that social care also understand the requirement or medicines optimisation

23. Are there any existing services that you think could be better provided through pharmacy?

24. Are there any services that pharmacy currently doesn't offer but you think it should?
25.Do you have any links to resources that you feel would be helpful to the commission?

26. Can we thank you publicly for your submission?
Yes
27. Can we make your response public? Yes

UCL SCHOOL OF PHARMACY

ACT on Asthma Programme

A Service Evaluation of a Collaboration between Rowlands Pharmacy and GSK

Dr James Davies, Dr. Jennifer Gill and Prof David Taylor.

Executive Summary

- Asthma is a chronic inflammatory disease of the airways that afflicts 4.3 million adults in the UK, costing the NHS in the region of a billion pounds per annum to treat. The average community pharmacy in the UK supports about 400 asthmatic patients in the use of their inhaled medicines. Community pharmacy has a key role to play in helping patients use and understand their medications in asthma therapy.
- A support programme for asthmatic patients was developed and implemented by Rowlands pharmacy in association with GSK and rolled out across 419 pharmacies in England, Wales and Scotland. The intervention was designed to support people with asthma in the use of their medications. This collaborative programme between GSK and Rowlands pharmacy recorded patients' Asthma Control Test scores prior to, and following intervention, which resulted in a significant improvement in patients' Asthma Control Test scores.
- Initial markers of asthma control were recorded in 3737 asthmatic patients (58% female, aged between 16 and 92) who presented in participating pharmacies with a prescription for an inhaled therapy. These were recorded using an in-house electronic capture form. Prior to intervention, 4.4% of patients were well controlled, 28.1% were reasonably well controlled and 67.6% had poor control.
- Of these 3737, 1445 patients had a repeat Asthma Control Test score recorded between 6 and 16 weeks after the initial intervention. There was a statistically significant improvement in asthma control test scores, with 982 (68.0%) participants showing an improvement in their ACT scores, while 264 (18.3%) showed no change in their score. A quarter of the patients (n=372) with a reported Asthma Control Test (ACT) score less than 20 (considered to be an indication of poor asthmatic control), prior to intervention, had a subsequent increase in their ACT score to over 20 (indicative of reasonable asthma control) following the intervention.
- The evidence presented here suggests that this service has improved asthma control and has demonstrated that pharmacists and their pharmacy teams can be a significant help to patients in the use of their asthma medicines.

gsk GlaxoSmithKline

rowlands pharmacy
a company of the PHOENIX group

Introduction

Asthma is a chronic inflammatory disease of the airways that affects over four million adults in the UK (Asthma UK, 2012). The prevalence of asthma has increased in most developed countries since the 1970s (Anderson, 2005). In the region of a billion pounds is spent by the NHS each year on its treatment (Asthma UK, 2012).

Current UK asthma guidelines emphasize the importance of assessing and enhancing adherence to asthma treatment (SIGN and BTS, 2011). Yet patients with chronic conditions like asthma are estimated to take between a third and one half of their medications effectively (NICE, 2009). Medication adherence rates in asthma patients have consistently been shown to be only 30-40% (Bozek and Jarzab, 2010; Latry et al., 2008). Even in well-monitored clinical settings levels of 70% are obtained (Hess et al., 2006).

It has been widely reported that for asthmatic patients non-adherence results in poor asthma outcomes (Lasmar et al., 2009). Significant numbers of patients continue to experience suboptimal asthma control that places severe limits on their daily life and puts them at risk of asthma-related morbidity and mortality. Non-adherence aggravates airway inflammation and may result in an increase in exacerbations, subsequent healthcare utilization (Williams et al., 2004; Bender and Rand, 2004) and even death. It has been estimated that 75% of hospital admissions for asthma are avoidable and that 90% of deaths from asthma are potentially preventable (Asthma UK, 2012).

Education on optimal medication use is part of the strategy used to improve asthma control. However detecting and then addressing poor adherence and supporting patients in the use of their prescribed medications remains a challenge in current clinical practice. Specifically, in asthma treatment non-adherence of prescribed medicines and improper inhaler techniques have been reported. The causes of medication non-adherence are complex, but observational studies suggest that failure to elicit and address patients' individual circumstances and goals or preferences regarding their regimen may contribute to treatment non-adherence (Osterberg and Blaschke, 2005).

In the National Health Service asthma control is primarily delivered via general practice surgeries and hospital outpatient appointments. However, community pharmacists should be able to make a useful contribution to the management of this chronic condition due to their knowledge of medication and their frequency of contact with asthmatic patients. The average community pharmacy supports the care of an estimated 400 patients with asthma (Murphy, 2013).

Pharmacists have previously been shown to support patients by addressing concerns about side effects, through the provision of information and training about asthma medications and by facilitating the proper use of inhaled devices (Horne, 2006; Cochrane et al., 2000). As acknowledged by the Bow Group Health policy committee (Carroll et al., 2010), "*there is potential for large cost savings by using pharmacists to prevent needless and costly hospital admissions*".

The use of community pharmacy as a resource for supporting asthmatic patients has continued to develop in the UK. In 2011 the national contractual framework for pharmacies in England implemented a targeted MUR system, whereby pharmacists were encouraged to offer at least half of their Medicines Use Reviews (See Box 1) to specific patient groups, including people with asthma.

In Scotland, the community pharmacy agreement also acknowledges the role that pharmacies can play in supporting patients with chronic conditions. The Chronic Medication Service (CMS) was part of a concerted strategy established between Community Pharmacy Scotland and the health department to develop a service that supports patients in the use of their medications (CMS – See Box 2).

Against this background, Rowlands Pharmacy, a large UK based pharmacy chain, working in collaboration with GSK developed and implemented a national community pharmacist led asthma support service for asthmatic patients. This service aimed to improve the health and optimise the use of medicines in a cohort of patients with asthma.

It was hoped that by taking measures to educate asthmatic patients regarding their medication, and by supporting the effective and appropriate use of medicines, better asthmatic control could be achieved and patient quality of life improved.

This brief UCL School of Pharmacy report provides an evaluation of the collaborative programme that was developed between Rowlands Pharmacy and GSK. It initially describes the details of the intervention, before presenting the study results and an analysis of the data set captured electronically by the participating pharmacists. The report then describes the findings from a series of qualitative interviews with a sample of pharmacists involved in the programme and concludes by discussing the implications of these results for future national policy.

Intervention Design

The role of pharmacists in supporting patients with asthma is widely documented (Portlock et al., 2009). Rowlands pharmacy, in collaboration with GSK, developed an asthma intervention programme that aimed to improve the management of this chronic condition and support long term medication adherence. The intervention was designed in two phases (see Figure 1 below).

Inclusion Criteria

Patients aged over 16 years, with a repeat prescription for any inhaled asthmatic device, including non-GSK products, were eligible for the intervention. Staff were trained to discuss with each patient the difference between asthma and COPD. Patients with COPD were excluded from this intervention.

Box 1- Medicines Use Reviews (MUR)

The Medicines Use Review (MUR), implemented through the English 2005 pharmacy contractual framework, is a documented, face-to-face consultation between a patient and a community pharmacist that takes place in a pharmacy consultation room. The aim of this advanced service is to improve a patient's knowledge, adherence and use of medicines by ascertaining their understanding and experience of medicines taking (Pharmaceutical Services Negotiating Committee, 2012a).

During this documented consultation the pharmacist may identify ineffectual or poor medicines use, side effects, and/ or therapeutic drug interactions, which should be resolved through discussion with the patient. Where applicable, documented feedback, highlighting any medication related problems is supplied to the patient's GP on an approved form.

Beyond clinical governance requirements, any community pharmacy in England and Wales can offer this service as long as the pharmacist wishing to provide the service has completed a nationally accredited training programme. In addition the premises should have a private consultation area deemed fit for purpose by the contracting local primary care organization.

Contractors can claim reimbursement (currently £28 per MUR) from the NHS, subject to a maximum of 400 MURs per pharmacy per year. This can provide an additional £11,200 in income per annum. Recent data shows that nearly nine out of every ten community pharmacies in England have provided and been paid for providing an MUR (The NHS Information Centre, 2012), with a peak of 263,740 MURs completed in England during October 2012. This is equivalent to about 23 MURs per pharmacy each month. (Pharmaceutical Services Negotiating Committee, 2012b).

Phase 1 – Intervention

Patients presenting with prescriptions for asthma medications were invited to complete the Asthma Control Test™ (Schatz et al., 2006).[1] Completion of this tool provided pharmacists with an opportunity to further engage with their patients and to discuss their asthma medications. The entire pharmacy team (including pharmacists, dispensers and counter staff) were provided with training (described below) such that all staff could be responsible for making initial contact with the patients to describe the service.

Intervention

Those patients that met the inclusion criteria for the intervention following the ACT assessment were offered the opportunity to have a targeted MUR in England and Wales, or CMS consultation in Scotland.

1 Asthma Control Test is a trademark of QualityMetric Incorporated© 2002, by QualityMetric Incorporated.

Box 2- Chronic Medication Service (CMS)

The Chronic Medication Service (CMS) is a scheme allowing patients in Scotland with long-term conditions to register with a local community pharmacy of their choice for the provision of pharmaceutical care. The delivery of care is formed under a shared agreement between the patient, community pharmacist and General Practitioner (GP).

Introduced as part of contractual negotiations in 2010, the service builds on the principles outlined in Better Health, Better Care (The Scottish Government, 2007) by improving access to NHS services and promoting collaborative working between community pharmacists and GPs. The service aims to formalize the role of pharmacists in the management of long term conditions.

CMS operates in three stages:

- Stage 1: *Registration* – This involves the registration of patients with chronic condition(s) at a local community pharmacy of their choice.
- Stage 2: *Planning and Profiling* – This stage involves the application of a generic pharmaceutical care planning framework to individual patients. Pharmacists will assess the registered patients and identify and prioritise their needs, in order to target those most in need of support. A pharmaceutical care plan is then formulated.
- Stage 3: *Shared Care* – The pharmacy takes over responsibility for the supply of medications in collaboration with the GP. The GP produces a 24 or 48 week serial prescription for the patient which is dispensed at appropriate time intervals. Pharmacists support patients in the use of their medicines during this period. The pharmacist will host regular consultations with the patient to discuss the management of the medicines and appliances to ensure that they are optimized.

This service is thought to have a more holistic remit than the MUR service, delivering a full pharmaceutical care assessment. It also includes the use of serial prescriptions to allow repeat prescribing of long term medication and electronic communication and data storage, facilitating the transfer of information between GP and pharmacist (Blenkinsopp et al., 2012).

During the consultation pharmacists verified the patient's inhaler technique through the use of the In-Check DIAL (Alliance Tech Medical, Granburg, TX (Fiato et al., 2007). Pharmacists supported and counselled the patient on the most effective methods to ensure that they were taking their medication correctly. In addition patients with asthma were provided with advice on when to use their inhalers, and provided with the opportunity to discuss any concerns that they may have had with their medications.

Box 3 – Asthma Control Test

The Asthma Control Test (ACT) is a patient–administered questionnaire used for assessing asthma control. This was initially developed to support asthmatic patients under the routine care of an asthma specialist (Nathan et al., 2004). But recent studies have found that the ACT is reliable, valid and responsive to changes in asthma control over time in patients naïve to asthma specialty care and therefore can be applied in the community and non-specialist settings (Schatz et al., 2006). Although there is no gold standard for asthma control measurement, the ACT has been shown to correlate with the views of asthma specialists (ibid).

The instrument is simple and consists of five items that assess asthma symptoms (daytime and nocturnal), use of rescue medications, and the effect of asthma on daily function. Each item includes five response options corresponding to a 5-point rating scale. Responses for each of the five items are summed to yield a score that ranges from 5 (indicating poor asthma control) to 25 (complete asthma control).

It has been shown that the ACT questionnaire is suitable for the periodic monitoring of patients with asthma and has been shown to be responsive to changes in asthma control over time. Schatz and colleagues suggest that '*repeatedly administered to the individual patient over time, the ACT might be useful in gauging the success of therapeutic interventions and in identifying deterioration in asthma control, and therefore could be considered a useful tool in clinical research, as well as in clinical practice' (p555).*

Assessments of the ACT's screening accuracy for poorly controlled asthma suggests that patients with an ACT score of 19 or less might be experiencing control problems. Scores of 15 or less are particularly of concern because they predict asthma that is poorly controlled or not controlled at all. The ultimate goal of any intervention is to help patients achieve a consistent score of 25.

Phase 2 – Follow up

Patients were either contacted directly by phone, or approached when presenting with their repeat prescription for an asthma inhaler device to have the follow up consultation after a planned interval of 56 days. During follow up the ACT test was repeated for comparison purposes.

A period of 56 days was chosen because evidence suggests that medication changes in asthma take between 4-6 weeks to take effect and become stabilized followed by a further four week stabilisation period before the ACT test can detect any changes due to the new medication regimen. However, pragmatically the follow up ACT questions were completed between 6 -16 weeks after intervention.

Pilot

A 12 week pilot phase commenced in January 2011. Twenty-two Rowlands pharmacy branches across Liverpool and Greater Manchester were trained to deliver the intervention. Patients presenting with an eligible prescription for asthma medication were identified and invited to have an ACT assessment in addition to an MUR. Preliminary analysis of the pilot data suggested that 82% of patients from the pilot study showed improved asthma control. This positive signal was used for a more widespread adoption of the service across the Rowlands Estate.

Service Delivery and Roll Out

Rowlands pharmacy currently comprises 510 branches. Of these staff at 419 (82%) branches were trained to provide the asthma intervention service. Full service roll out to the whole estate was not achieved due to the initial exclusion of several branches located in Wales. (These pharmacies were already involved in a Community Pharmacy multidisciplinary audit, where participation for these pharmacists in both services may have skewed the data). Further exclusions were applied to those pharmacies where there was not an adequate consultation room for service delivery.

In addition, some local primary care commissioners had commissioned Rowlands pharmacy to provide medicines optimisation services for patients with asthma. Branches that already offer a commissioned asthma support service were excluded to prevent bias. This resulted in pharmacies in Scotland, England and Wales being included in this evaluation.

Training

Rowlands' ten service facilitators were trained in the background and delivery of the asthma initiative by the National Pharmacy Advisor from GSK and members of the Rowlands Commercial Services Team. This training took place in August 2011. The service facilitators led the training for branches and were responsible for delivering face to face training with all members of the pharmacy teams (both branch staff and pharmacists) within their areas. Logistically removing the whole pharmacy team for external training was not feasible and therefore training was conducted in branch. Each facilitator had responsibility for two geographic areas or regions equating to approximately 40 – 60 branches. Service roll-out was gradual from October 2011 onwards, with the majority of training completed by January 2012.

The training was designed to be flexible and to meet the needs of the pharmacists and the staff within each pharmacy. In some cases where staff needed support this necessitated half a day of in house training, for others, such as pharmacists that had previously been involved in respiratory interventions, this required only half an hour. This focussed approach provided the opportunity for personal support and allowed all staff to ask questions in a safe environment.

Data Recording

Electronic Data capture for the initiative was ongoing from September 2011 until September 2012 through the Rowlands internal patient support platform to allow for central analysis and interrogation. Data relating to the dates of the ACT scores, the basic patient demographics and Medicines Use Reviews were recorded within this platform.

Figure 1 – Asthma Intervention Process

PRESENTATION
Patient presents with prescription for inhaled asthma medications

↓

Asthma Control Test 1 - ACT1
Pharmacy staff invite the patient to complete an Asthma Control Test Score

↓

CONSULTATION / INTERVENTION
Pharmacist provides a consultation (MUR or CMS if applicable)

↓

CONTACT
Patient contacted for follow up appointment by pharmacy staff

↓

Asthma Control Test 2 - ACT2
Patient returns to pharmacy for follow up consultation and Asthma Control Test

Consent and Ethical Considerations

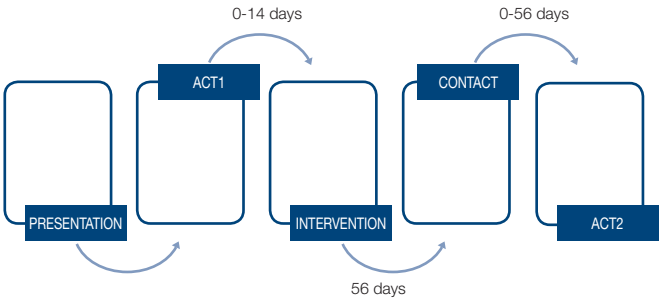
Patients completed two signed consent forms, one for participation in the intervention, and one for the MUR (or CMS). Patients consented to non-patient identifiable characteristics being supplied to third parties for the purposes of research and service evaluation. During training staff members were given a briefing on the consent process to ensure that patients provided fully informed written consent.

This service evaluation team presented their approach to UCL Ethics committee which deemed this to be a service evaluation and therefore did not require formal research approval.

Timescales

Data were collected at various time points throughout the process. As a pragmatic service implementation there was flexibility in the system to allow for intervention appointments to be made within two weeks of completing the first ACT. Patients were contacted approximately 2 months later to arrange a follow up ACT intervention. These were then completed within the next month. The total process could therefore last between 56 and 98 days (as shown in Figure 2).

Figure 2 – Timescales



Evaluation Approach

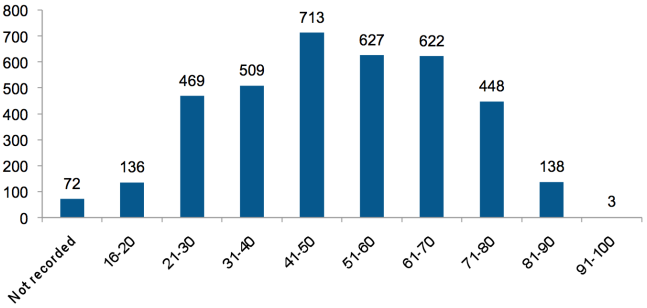
The evaluation team performed analysis on the available data from the electronic database supplied by Rowlands Pharmacy. After cleaning to remove obvious typographical errors, the data was analysed using SPSS v21 and Microsoft Excel through an exploratory approach.

In addition the service evaluation appraisal team conducted telephone interviews with a sample of pharmacists across the estate.

Results

Between January 2011 and September 2012, 3737 patients entered the service and completed the Asthma Control Test. 58% (n=2181) of the patient were female. Where age was reported (n=3665, 98.07%) it ranged from between 16 and 92 (mean 50.77, SD 17.91) as shown in figure 3 below.

Figure 3 – Age Range



All of these patients had an intervention with the pharmacist. In most cases the intervention was carried out on the same day as the first Asthma Control test score (93.87%, n=3509). 54 patients (1.4%) had the interventions within 7 days. 16 (0.43%) of interventions were between 7 and 21 days after their ACT1 score.

In most cases this intervention also constituted a medicines use review, (or formed part of the Chronic Medication Service in Scotland). In 119 cases an MUR consultation date prior to the first ACT score was

reported. This may be as a result of data entry issues, but does suggest that these patients were not given an NHS funded consultation (MUR or CMS) as part of this service. This may have been because the patient failed to meet the nationally set criteria required for an MUR consultation. For example, one such reason is that the patient had already received an MUR in the preceding 12 months. However, while these patients may not have met the national eligibility criteria for MURs or CMS, they still received an asthma intervention. The difference in these cases was that the pharmacies did not receive NHS funding for the intervention with these patients.

The remainder of interventions (n=39, 1.04%) were documented as being completed 21 days after the recording of the ACT1 score (range 26- 365). These may have been due to delayed data completion or data that was entered inaccurately.

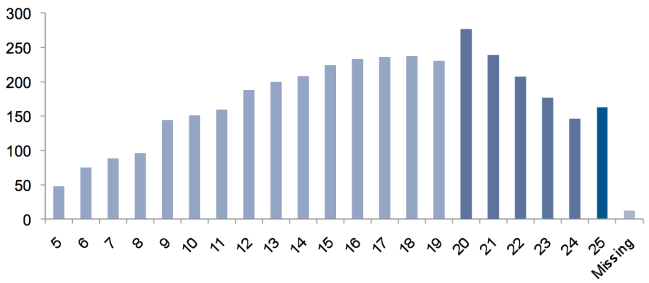
ACT1 Scores

3725 patients (99.7%) had an eligible ACT1 score reported. The minimum score for the ACT is 5. In 12 (0.3%) cases the scores recorded were below 5, suggesting an input error.

Asthma control test scores of 25 indicate that asthma has been under total control for the last 4 weeks. Scores between 20-24, suggest that asthma has been well controlled over the last four weeks. Those with scores below 20 are deemed to be 'off target', with their asthma uncontrolled during the past four weeks.

The eligible scores for the patients reported here are shown in figure 4 below. 163 patients (4.38%) were totally controlled, 1045 (28.05%) were reasonably well controlled and 2517 (67.57%) had poor control.

Figure 4 – ACT1 Scores



Uncontrolled – Well Controlled – Total Control

ACT2 Scores

1779 (47.60%) patients had a valid ACT2 score recorded (between 5 and 25). Four of these patients had an invalid ACT1 score. The loss of 1958 patients to follow up is discussed later in this report.

The period between intervention and the ACT2 date ranged between 0 days and 256 days. Those ACT scores recorded less than 42 days (6 weeks) after intervention were excluded (n=128) as were those where scores were reported 112 days (16 weeks) after the intervention (n=202). This left 1445 patients (38.78%) with follow up data within the service protocol. The ACT2 scores for the patients are shown in figure 5.

Statistical Analysis

All of the analysis from this point forward refers to the 1445 patients with both ACT1 and ACT2 scores. Age was reported by 98.0% of patients (n=1416, range 16-92) and the mean age was 51.3. Over half of those in this evaluation (57%, n=823) were female.

Comparison with the demographic profiles of all the patients that completed only ACT1 and those that completed ACT1 and ACT2 reveals no significant differences (Mean age: 50.78 vs 51.28, % Female: 58.4% vs 57%)

Table 1 – Asthma Control Scores at follow up

	ACT1 (%)	ACT2 (%)
Uncontrolled (<20)	947 (65.5)	605 (41.9)
Well Controlled (20-24)	422 (29.2)	694 (48.0)
Total Control (25)	76 (5.3)	149 (10.1)
	1445 (100)	1445 (100)

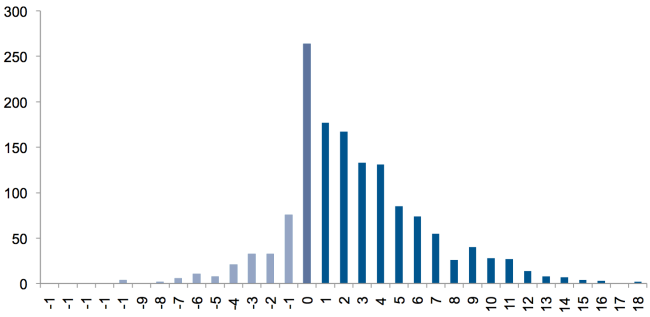
Changes in ACT Scores

Comparisons were made for those 1445 patients that had both a valid ACT1 and ACT2 score. The mean result shows an improvement of 2.61 (SD 4.014) points on the ACT scale (Median = 2). A paired t-test indicated that this improvement was statistically significant ($p<0.001$) [ACT1 mean 16.45 (SD 5.35, SEM 0.141, ACT2 Score 19.05 (SD 4.79, SEM 0.126]. However, in spite of this significant increase in ACT scores, the mean score at ACT2, though improved, by definition still fell into the category of 'uncontrolled'.

Further analysis of the data suggests that the improvement in ACT1 and ACT2 score holds true in both genders. [Male (n=622) ACT1 = 16.78 (SD 5.119, 0.205), 19.36 (SD 4.552, 0.183), Female (n=823) ACT1 = 16.19 (SD 5.507, 0.192), 18.80 (SD 4.949, 0.173)]

One patient showed an improvement of 18 points. However at the other end of the scale, one patient showed a decrease in asthma control of 19 points. The distribution of points is shown in figure 5 below.

Figure 5 – Changes in ACT scores



No Improvement – No Change – Improvement

Asthma Control

982 (68.0%) participants showed improvement in their ACT scores, 264 (18.3%) showed no change in their score, and for 199 patients (13.8%) their scores suggested worsening control. For the patients 264 that showed no change, the majority had either total control (n=52, 19.7%) or were well controlled (118, 44%).

Scores of less than 20 are considered uncontrolled. As such the number of patients showing a change above or below this level is important. 372 patients (25.74%) had an ACT1 score below 20 that improved to a score above 20 in ACT2. 30 (2.07%) patients had a score above 20 at ACT1 that dropped to below 20 in ACT2.

In the 199 patients (13.8%) that had a decrease in score between ACT1 and ACT2. 48% of them continued to be well controlled (a score between 20 and 24). The remaining 128 patients (64.3%) were uncontrolled as shown in table 2. The qualitative analysis provides insight into the actions taken with these patients.

Table 2 – Scores for Patients showing decreased control

	ACT1 (%)	ACT2 (%)
Uncontrolled (<20)	98 (49.2)	128 (64.3)
Well Controlled (20-24)	77 (38.7)	71 (48.0)
Total Control (25)	24 (12.1)	0 (0.0)
	199 (100)	199 (100)

Age and Gender Analysis

The improvement in score was observed across both age and gender. The only group that failed to show a statistically significant improvement in score were females aged over 80, as shown in table 3.

Table 3 – Comparison by Age and Gender

		Mean ACT1 (SD)	Mean ACT2 (SD)	Difference	P
Female	Under 21 (n=36)	15.17 (5.27)	18.06 (5.07)	2.89	<0.001
	21 -30 (n=96)	15.59 (4.83)	19.16 (4.34)	3.56	<0.001
	31-40 (n=110)	15.85 (5.45)	18.48 (4.95)	2.63	<0.001
	41-50 (n=169)	15.69 (5.62)	18.81 (5.23)	3.12	<0.001
	51-60 (n=137)	15.88 (5.53)	18.61 (4.95)	2.73	<0.001
	61-70 (n=136)	16.42 (5.52)	18.78 (5.17)	2.36	<0.001
	71-80 (n=99)	17.78 (5.56)	19.21 (4.52)	1.43	0.002
	Over 80 (n=33)	17.70 (6.28)	18.48 (5.82)	0.79	0.099
	Missing (n=7)				
Male	Under 21 (n=21)	16.48 (4.97)	18.95 (4.20)	2.48	0.001
	21 -30 (n=60)	17.12 (4.17)	20.30 (3.76)	3.18	<0.001
	31-40 (n=96)	17.51 (4.63)	19.96 (4.25)	2.45	<0.001
	41-50 (n=108)	16.02 (5.28)	18.72 (4.68)	2.70	<0.001
	51-60 (n=111)	16.39 (5.11)	19.64 (4.01)	3.25	<0.001
	61-70 (n=94)	16.62 (5.71)	18.38 (5.41)	1.77	<0.001
	71-80 (n=81)	16.93 (4.92)	18.99 (5.20)	2.06	<0.001
	Over 80 (n= 29)	16.90 (6.00)	20.17 (3.45)	3.28	<0.001
	Missing (n=22)				

Geographic Differences

Significant improvements in ACT scores were not observed across all of the geographical areas.

Table 4 – Geographic Variation by Area

Area	Mean ACT1 (SD)	Mean ACT2 (SD)	Difference	P
1 (n=22)	17.77 (6.62)	18.59 (6.55)	0.82	0.315
2 (n=27)	14.33 (4.54)	17.63 (4.48)	3.30	<0.001*
3 (n=27)	12.89 (5.40)	17.19 (4.42)	4.30	<0.001*
4 (n=29)	18.21 (5.07)	21.69 (4.15)	3.48	0.001*
5 (n=61)	13.85 (4.40)	18.72 (4.44)	4.87	<0.001*
6 (n=60)	14.82 (4.37)	16.93 (4.28)	2.12	<0.001*
7 (n=25)	13.84 (4.60)	15.96 (5.04)	2.12	0.014*
8 (n=71)	16.75 (4.67)	18.92 (4.12)	2.17	<0.001*
9 (n=95)	16.69 (5.48)	20.28 (4.49)	3.59	<0.001*
10 (n=247)	18.04 (5.10)	19.59 (4.79)	1.55	<0.001*
11 (n=61)	14.38 (5.26)	19.03 (4.24)	4.66	<0.001*
12 (n=90)	17.13 (4.93)	19.19 (4.31)	2.06	<0.001*
13 (n=11)	14.82 (3.92)	21.64 (2.38)	6.82	<0.001*
14 (n=24)	15.33 (5.04)	20.42 (4.62)	5.08	<0.001*
15 (n=261)	16.44 (5.22)	18.77 (5.09)	2.33	<0.001*
16 (n=12)	18.25 (6.17)	20.67 (3.47)	2.41	0.061
17 (n=33)	14.21 (4.23)	17.52 (4.23)	3.30	<0.001*
18 (n=117)	15.37 (4.95)	19.42 (3.90)	4.05	<0.001*
19 (n=109)	17.95 (6.74)	18.25 (6.13)	0.29	0.485
20 (n=63)	17.70 (4.84)	20.46 (4.07)	2.76	<0.001*

*Significant at the 0.05 level.

Three areas failed to show a significant improvement in ACT2 scores, these being areas 1, 16 and 19. Further qualitative evaluation explored the possible reason for this.

Data on number of interventions carried out in each of the devolved administrations is described in table 4 below and shows a similar level of improvement across the estate.

Table 5 – Devolved Administrations

	Mean ACT1 (SD)	Mean ACT2 (SD)
England (n=888)	16.03 (5.36)	19.05 (4.64)
Scotland (n=508)	17.22 (5.22)	19.17 (4.96)
Wales (n=49)	15.88 (5.77)	18.06 (5.47)

Qualitative Analysis

Brief telephone interviews were conducted with pharmacists from a range of pharmacies across the Rowlands estate to aid the interpretation of quantitative data.

Overview

Across the board the pharmacists were extremely positive about the service and felt that it provided them with an opportunity to talk to patients about their medications resulting in a noticeable benefit. The pharmacists reported that the training and associated skills increased their confidence and assisted them in the delivery of other services, particularly Medicines Use Reviews (MURs) for those in England.

Patient Recruitment

The pharmacists believed that the ACT scoring system was easy for patients to complete, as observed elsewhere (Nathan et al., 2004). Often patients were happy to complete the form, provided to them by the counter staff, while their prescriptions were being dispensed. Those pharmacies that had success with recruitment found that engagement of the staff and the team was vital to making the initial contact with the service users.

> *"All staff saw the benefit of providing the service; however [they] didn't always get positive responses from all customers who were approached"*

Some pharmacists suggested that staff had to explain the benefits to encourage patients to have the intervention. This finding is in line with previous research which suggested that patients were being selected and persuaded by the pharmacy staff to have MURs (Latif et al., 2011). Indeed, Latif et al found that a patient's main reason for accepting the offer of an MUR was simply because they had been asked or because they felt obligated to help the pharmacist (Latif et al., 2010).

While in general terms the literature suggests that patients are not strongly motivated by self interest or the prospect of personal benefit to have an MUR, in this case the pharmacists interviewed for this evaluation felt that many patients recognized the benefits of the service. As such it would appear that this service may have helped to change patient perceptions of pharmacy services and of MURs.

Recruitment was not always straightforward. It was reported that some patients believed the service was not appropriate for delivery in a pharmacy, and preferred to see their nurse or doctor at their GP practice. This perception has been reported in other studies of MURs, where patient uptake has been perceived as a barrier to MUR implementation (e.g. Elvey et al., 2006; Hall et al., 2006). This may be a manifestation of patient expectations of their experience in a community pharmacy setting. Visual aids such as posters and information about services may help to change perceptions towards seeing community pharmacy as a clinical service provider.

One area of interest reported by the pharmacists surveyed here was the lack of patients' knowledge of pharmacy services. This has been described elsewhere; in a randomly selected national survey of community pharmacies in England and Wales nearly half believed that poor recruitment to MURs was due to a lack of patient knowledge of the service (Ewen et al., 2006; Thomas et al., 2007).

In a few of the interviews the pharmacists suggested that patients often lacked the time to have an MUR. The academic literature however suggests that patients decline MURs for more complex reasons than simply time factors (Urban et al., 2008).

One of the recruitment challenges in this intervention related to the presentation and ineligibility of COPD patients. While the identification of an inhaler on a prescription was relatively straightforward, establishing the clinical condition was often a challenge. In many cases the patients were unaware of their diagnosis, either because they had not been told, or more often because a firm diagnosis had not been made (in the adult population differentiation between asthma and COPD symptoms can be difficult). In some cases the inhaled therapies on the prescription were indicative of asthma, but this relied on the pharmacist being able to make the differentiation (as opposed to the counter staff).

Intervention

Once recruited, patients were invited for the intervention (as an MUR in Wales and England, or CMS in Scotland). The targeted approach to MURs, enacted in October 2011, encourages pharmacists to offer at least half of their Medicines Use Reviews to specific patient groups, including people with asthma. The pharmacists interviewed felt that the ACT scoring system acted as a further facilitator to identify patients in this group.

> *"Helpful and useful addition. I found it to be very very helpful in recruiting for respiratory MURs"*

The benefit of helping to increase advanced services was raised by several of the pharmacists interviewed. As described above, CMS in Scotland and advanced services in England and Wales (See Boxes 1 and 2) form a core part of the pharmacy contractual framework and are integral to providing patient support and improving medicines use. In keeping with this the pharmacists were positive about the service and its effect on patient outcomes.

> *"[The] majority of patients understood the service and saw a direct benefit from the consultations"*

The aspects of the intervention that led to the improvements seen in the majority of the patients' ACT scores are described below. The approach and benefits that the patients received were varied across the estate.

Inspiratory Flow

One of the key tools provided to the pharmacists was the ability to check inspiratory flow using the In-Check DIAL. The pharmacists felt that although other healthcare practitioners may have often advised patients on good technique in respect to timing and posture with pressurised metered dose inhalers (pMDIs), they felt that patients were frequently unaware that a slow steady inspiratory effort is required for pMDIs.

> *"The tools were really good, the In-Check DIAL acted as a good visual aid to engage customers with"*

It was regularly reported that many patients were using the MDIs with too much inspiratory force, causing ineffectual deposition of medication in the mouth. Research has shown that this is a common problem for asthmatic patients, and that without a spacer device a large proportion of the drug is deposited in the mouth and oropharynx (Hirst et al., 2001).

Inhaler Type

In some cases it was apparent that pMDI devices were inappropriate for the patients. The intervention facilitated the transfer of recommendations to the general practitioner or asthma nurse in the local surgery for alterations to therapy. In a few instances this resulted in a prescription for a spacer device. For others, the type of device needed to be addressed. It was reported in some instances that Dry Powder Inhalers, which require a fast and forceful inspiratory effort, had been prescribed to patients that were unable to achieve sufficient flow rates, a common problem reported elsewhere (Roy et al., 2011).

Demonstration of Technique

The pharmacists helped to reinforce both good inhaler technique as well as recommending proper inhaler hygiene. Efficient use of pMDIs requires coordination between simultaneous inhalation and device actuation, a slow and continuous inspiratory flow rate during inhalation followed by a breath hold (Ernst, 1998). The pharmacists described several common mistakes (Van Beerendonk et al., 1998) that patients had with the use of their inhalers, such as a failure to exhale fully before inhalation of the medication, actuating the pMDI before or at the end of inhalation, or while breath-holding. All of these have been described in previous UK studies (Crompton et al., 2006).

> *"In my experience patients can see an instant benefit. There is a certain public perception about how you are supposed to use your inhaler that is not always accurate. Nearly every patient on a salbutamol inhaler was taking it incorrectly – patients were therefore generally grateful that someone was taking the time to check"*

As one pharmacist reported, many of the patients had not had the opportunity to demonstrate their technique in front of a health care professional. It was reported by others that the local general practitioners were "*too stretched with time*" to be able to undertake inhaler technique reviews, and therefore this pharmacy review service was seen as a useful intervention for these patients.

A Refresher

For several patients education on the use of the inhaler had last been provided when they were first diagnosed with the condition, which in one case was reported to be over a decade ago. They had since received no input on how to use their inhalers and developed bad habits. This pharmacist-led intervention offered a refresher for these patients. The pharmacists explained that changing patient behaviour when poor technique had been used for an extended period of time was challenging. In some cases, the effects of the changes in inhaler technique were profound, and accounted for an improvement of over 10 points in ACT scores for two patients.

Medication Regimen Education

It was commonly reported by the pharmacists than many of the patients were relying on their reliever therapy excessively whilst at the same time being non adherent to preventer therapy. The pharmacists offered further explanation as to the differences between the inhalers and the rationale for their respective use.

Pharmacists in several of the pharmacies reported that the large improvements in ACT scores had invariably been achieved by shifting patients away from the overuse of reliever therapy to using their preventative therapies regularly instead.

> *"Patients generally didn't fully understand or appreciate a proper regimen for their inhalers. Although they attended asthma nurses they didn't have a full understanding of how to take their medicines and therefore really appreciated someone in the pharmacy taking the time to talk to them and explain things properly to them"*

This intervention appears to be in line with other studies that have shown that education programmes can improve compliance and inhalation technique (Cochrane et al., 2000).

Poor Performers

A proportion of the patients had lower ACT scores following the intervention. Quantitate data on the objective cause of ACT2 reductions was not recorded in this evaluation. However, the reasons for lower scores were explored with the pharmacists. Often environmental factors such as the weather, or increased pollen counts were a contributing factor. Most often it appeared that ACT scores were reduced because of acute respiratory infections, either mild coughs and colds or more serious bacterial upper respiratory tract infection (URTI). In one case a middle aged man whose asthma had been well controlled subsequently suffered a considerable decrease in ACT score as a result of an URTI.

The pharmacists described the difficulties associated with determining the differences between COPD and asthma. In the poor performer group in particular, these patients were often more typical of a COPD profile. As such they still benefited from the advice in relation to inhaler technique and respiratory delivery of medications, but were at an increased risk of COPD exacerbations, and should probably not have been included in this service.

Action taken on poor performers

The interviews explored the actions taken by the pharmacists in those situations where patients had a reduction in ACT score following the intervention. The responses were variable across the sample, and generally rested upon the professional decision of the pharmacist as to the most appropriate course of action.

In most cases, where the cause of decreased score was evident to the pharmacist, such as an URTI, the patients

were advised to return once the infection had cleared for a re-test. In others, where the cause was less clear, the patients were offered further advice, counselling and support, and on occasion advised to return to their GP. While the ACT score is supposed to reflect asthma control over the previous month, many of the pharmacists felt that the immediate respiratory tract infection influenced patients' responses and resulted in poor outcomes.

In most cases records of the appointments and poor scores were often made in the Patient Medication Record (PMR) system so that the patient could be consulted again, and a further follow-up carried out on the next presentation of their prescription. This system tended to work best for those pharmacies with a higher number of repeat patients.

In a number of branches the ACT2 score may not always have been completed by the pharmacist. Because the initiative was designed to include the whole pharmacy team in delivery, in some cases the ACT2 was undertaken by dispensing staff, whose knowledge and training are reduced compared to the pharmacist. It is unclear as to the actions that the staff may have implemented upon receiving a poor ACT2 score due to the nature of the interviews conducted for this evaluation. However, each branch should have had a locally agreed protocol for referral with their team in advance of delegating task based on the professional judgement of the responsible pharmacist. It would appear that in some cases these protocols could be strengthened.

Follow Up

53% of the patients that had an ACT1 score recorded failed to have a second ACT2 consultation. The possible reasons for this limited follow up were explored in the qualitative element of the research as part of this service evaluation.

In some cases, patients with a score over 20 were not invited for follow up as they were deemed to be well controlled. The pharmacists reported that some of the patients felt the follow up was a burden when they had good scores, and did not want to repeat the same form. The pharmacists therefore adopted a personalisation approach whereby those who did well at ACT1 were not chased for follow up, with efforts focused on those patients performing poorly. Despite this, the electronic data does not confirm that this was routine practice across the estate–many of those failing to return for follow up had ACT scores below 20. Despite the significant shifts in scores from ACT1 to ACT2, the majority of patients, though improved, failed to reach scores defined as representing asthma control (>20). A possible conclusion may be that patients and HCPs including pharmacists accept that some symptoms are inevitable.

Getting patients to return for a follow up consultation was regarded as a challenge. In those branches that were in city centre locations the passing trade is often quite fleeting, and therefore it was reported that getting in contact with the patients for follow up was difficult. Whereas in more suburban locations the pharmacists were able to approach patients when they returned to collect their medication after two months. Accurate records helped to improve follow up rates. In one branch, where locums were generally used, some of the patients were lost to follow up due to inadequate reporting and recording systems within the pharmacy's PMR system.

Across the estate the pharmacists reported challenges associated with keeping appointments on both the pharmacist's and the patient's side. It was reported that patients often failed to attend when appointment systems had been trialled. Initial acceptance of an MUR followed by failure to attend a subsequent appointment is a common occurrence in community pharmacy (Blenkinsopp et al., 2007), possibly because patients expect a fast accessible service, rather than an appointment system.

However, appointments allow pharmacists to regulate their work but reflect a more formal approach to accessing pharmacists' advice (encouraging the view that pharmacists' time is more valuable than patients' (McDonald et al., 2010b)). In turn this changes the public perception of pharmacists as an accessible healthcare provider. Those pharmacists that operated a more flexible approach moving away from appointment systems appeared to be more effective in getting more patients to follow-up.

A further tactic to increase response was to carry out the follow up ACT2 by phone.

For MURs in general it has been suggested that improving patients' understanding of the service could be a key facilitator to future service delivery (Rosenbloom et al., 2005; Bassi and Wood, 2009; Davies and Pugsley, 2006). The logic of this argument would appear to hold true in the targeted intervention being offered here.

Perceived Benefits of the Service beyond ACT Score

The pharmacists interviewed were quick to point towards the benefits of the intervention beyond those immediately recorded by the ACT score. While there were discussions about the organisational and operational benefits of the service, such as increased confidence, skills as well as financial benefits from increasing the number of MURs, the majority of the benefits highlighted tended to focus on patient care.

One example of this was the case of a patient that had developed oral thrush through poor inhaler technique. The supportive counselling and effective OTC medication provided, not only cured the thrush but also helped improve the patient's adherence to their preventer therapy, thereby reducing further outbreaks. Potentially this contributed to better asthma control through more appropriate use of their preventer inhaler.

The service helped to improve pharmacists' relationships with their patients. One of the pharmacists interviewed in a socially and economically deprived area commented

on how important she felt the service was for the local community. She believed the service had directly led to a notable difference in the health and well-being of several of her patients. However, this represents one pharmacist's view and further validation is needed to confirm if this has been the case.

Those interviewed for this evaluation also revealed that the service had in some cases helped strengthen links with other healthcare professionals in primary care. One example is the improved links that were built by a Rowlands branch with the local asthma clinic that was being run by a PCT independent pharmacist prescriber. The Rowlands team were able to quickly pass recommendations to the PCT pharmacist. As a result this branch achieved a mean improvement of 4.25 in ACT scores, with one patient improving by 17 points.

Time

Management of time in community pharmacy settings has been reported as a challenge during the implementation of community pharmacy services. The service reported here was no exception to time management issues. Many pharmacists recognised that time was a factor in the delivery of the service. As one pharmacists commented "*It is difficult, because I don't know what I am coming back to*".

Such pressures are understandable when the mean reported time to complete the intervention was in the region of 15-20 minutes. (The national evaluation of MUR suggested that on average 22 minutes is spent with the patient (Blenkinsopp et al., 2007)). Many asthmatic patients have a number of other medications and therefore service delivery may take even longer, with one MUR reported to have lasted in excess of 45 minutes. In some cases the pharmacists used appointment systems to help manage their time.

One pharmacist believed that the initial ACT score should only be offered if the pharmacist was in a position to be able to offer an MUR.

> *"If I don't have the time to follow them up immediately, then if is probably wrong to offer them the ACT at all, I don't want someone to have a bad score and then not be able to follow them up at all".*

However, others disagreed with this approach and adopted a range of strategies such as asking the patient to return the following day, when it was too busy for an MUR to be completed.

It appears that those pharmacists that adequately delegated tasks were better able to handle the challenges associated with managing the time spent between the dispensary areas and the consultation room. Delegation such as this is one of the foundations captured within the design of this project and also a key feature of the 'healthy living' pharmacy concept, developed by NHS Portsmouth and the local pharmaceutical committee. Rowlands pharmacy has developed their own in-house "Elite Service Pharmacy" Kite Mark accreditation scheme as part of a healthy living initiative that operates under this model and is beginning to be rolled out across its branches. It aims to use pharmacies to promote good health and provide proactive health advice. In contrast to previous pharmacy innovation, 'advice' is not only provided by the pharmacist, but by the whole pharmacy team.

The initiative was promoted to branches as a means of using all members of the team to help in the recruitment process for advanced services and to ensure that the patient was getting the very best from each pharmacist consultation. It appears that in some cases there has been reluctance from the pharmacist to delegate to other members of the team. However, the qualitative interviews suggest that the pharmacists appreciate that a greater use of other members of the pharmacy team is a possible solution to the time challenge. The pharmacists believed that for task delegation to be effective the staff would need to have several opportunities to shadow the pharmacists and for both the pharmacist and the staff member to become comfortable with the assignment of aspects of the service to non-pharmacist staff.

Individual Motivation

One factor, while difficult to quantify in the qualitative interviews conducted, was the individual practitioner motivation to deliver the service. This element of practice has been reported in national studies of MUR implementation (Elvey et al., 2006). The vast majority of pharmacists interviewed welcomed the intention to move away from dispensing towards other cognitive based roles. Indeed, MURs and service delivery are seen as an opportunity through which the profession can evolve (Ewen et al., 2006; Latif and Boardman, 2007; Hughes et al., 2009) and enhance its relationship with patients (Cowley et al., 2010).

The continuity of the service was affected in a minority of branches that were operating with locums. In general the majority of the branches had permanent staff, and this aided effective follow up. The branch staff reported that factors of familiarity, such as working with staff who were strangers and unfamiliar settings, procedures, policies and equipment were felt to limit the delivery of the service by locums. This has been observed elsewhere (McDonald et al., 2010a), and suggests that individual professional priorities can influence the extent to which advanced services are provided. In turn, these priorities are influenced by all of the other factors outlined above.

Discussion

Rowlands pharmacy in collaboration with GSK implemented an ambitious asthma intervention programme across 419 community pharmacies. The overall results from this evaluation show a positive effect on asthma control as a result of a pharmacist intervention and are consistent with other community pharmacy based studies in asthma management (Armour et al., 2007; Barbanel et al., 2003; Mangiapane et al., 2005; Saini et al., 2004; Schulz et al., 2001; Hämmerlein et al., 2011; Weinberger et al., 2002; Weinberger et al., 2001).

The findings from this evaluation suggest that collaboration and partnership between the pharmaceutical industry and community pharmacy can produce an improvement in patient outcomes. Previous academic studies of community pharmacy interventions have focussed on small scale interventions. The intervention described here was operationalised across a wide range of pharmacies each functioning with different business models. Despite the variability across the estate, the overall outcome has been positive in terms of patients' outcomes and pharmacists' feedback.

The service was not designed to capture improvements in peak flow, asthma severity, drug utilisation, quality of life or asthma knowledge. However improvement in all of these have been observed in other community pharmacy based asthma intervention studies. It would seem reasonable to assume that the educational elements of this intervention have contributed to a positive impact across these markers. Indeed, beyond the ACT score, the pharmacists' intervention aimed to provide patients with a deeper insight into their disease and drug therapy.

There are particular difficulties in delivering self-management advice for asthma in primary care because of the milder nature of patient's symptoms compared to secondary care and the acceptability to patients of interventions. *A priori,* it seemed likely that in the main those patients with uncontrolled asthma (ACT<20) would benefit most from the intervention because a six month randomised control trial carried out in 66 community pharmacies in Germany found that patients with uncontrolled asthma at baseline had significantly increased ACT scores at 6 months whereas those that were controlled did not (Mehuys et al., 2008). Yet this evaluation suggests that patients across the board have benefited from this intervention provided by Rowlands pharmacists.

Several studies have shown that adherence to chronic asthma therapy is low, mainly with respect to inhaled corticosteroids (Horne, 2006). In this evaluation, the pharmacists reported that many of the improvements in ACT scores were as a result of encouraging patients to use steroid inhalers regularly and changing beliefs about medicines. The present findings stress the importance of patient education about the necessity of inhaled corticosteroids. Indeed, studies have shown that regular use of inhaled corticosteroids reduces asthma related hospitalisations and death (Edmonds et al., 2012).

Poor inhaler technique is associated with poor asthma control. Correct inhaler use is essential to ensure that medicines arrive in the lower airways, but is often overlooked. The pharmacists in this study frequently reported that patients do not use their devices correctly. They have shown that community pharmacists could play an important role in this area, by supporting patients in the use of their inhalers and regularly checking the technique during the course of treatment. It is however, worth stressing that this pharmacist intervention is not meant to replace formal asthma education but rather act as a complement to it.

As described in previous studies, the ACT is an excellent tool to rapidly (Mehuys et al., 2006) and accurately (Schatz et al., 2006) measure the asthma control of patients in a community pharmacy setting. In the case of this evaluation it has been a valuable tool, that has demonstrated that a pharmacist based intervention can have a positive impact on patients' asthmatic control, and a likely benefit on their medication use.

Methodological Limitations

From a research perspective, this was a service evaluation, and therefore does not meet the standards of a rigorous, randomised controlled trial design. In the ideal world a control group would be used to demonstrate the effects of the intervention. However, the results strongly suggest that there was an improvement in the asthma control of patients as a result of this intervention. It is highly likely that this community pharmacy based intervention was the cause of this improvement. One should not lose sight of the large sample size of nearly 1,500 patients, and the consistency of findings with other studies that adds weight to the benefits of the service that this evaluation describes.

Research into other services suggests that consumers often do not expect advice from pharmacists on health topics although satisfaction is high (Eades et al., 2011). These consumer expectations may have been reflected in the loss of over 50% of the patients to the follow up appointments seen here. This evaluation suggests that changing patient perceptions of community pharmacy as a place for healthcare service will be key to the continuity of follow up. There are opportunities for the community pharmacy profession to engage the public and promote community pharmacy as an active provider of services such as the one described here.

Patients in this evaluation may not be fully representative of the overall general population of asthmatic patients since they participated in the follow up ACT2 score, although the study did show a cross section of patients in terms of sex and age across the sample.

The use of an electronic data collection form facilitated analysis of this data. The data collection for the quantitative element of this evaluation was performed by the person who also delivered the intervention. However, on occasion there were erroneous data that required re-processing before analysis. Rowlands pharmacy has done a lot to ensure IT access across the estate, for example by having computers in all their consultation rooms. However, the data recorded here suggests that more could be done to improve the capability of the staff in accessing the systems. Relaying the importance of accurate data capture and the provision of training in software systems to the team could help to enhance the quality and depth of the data captured.

The sustainability of the benefits beyond two months was not assessed. However, other pharmaceutical care studies have shown effects can be sustained over a 12 month period (Mangiapane et al., 2005; Schulz et al., 2001). It is suggested here that the effects of this intervention are likely to last in excess of two months.

Conclusions

The pragmatic intervention developed in partnership between GSK and Rowlands pharmacy was based on the foundations of medicines optimisation, and used research principles to carry out post hoc analysis that has demonstrated the effectiveness of community pharmacies as a venue for the management of asthma.

The findings presented here were taken from a wide range of pharmacies across the Rowlands estate and suggest the feasibility of this approach across a variety of business models. They show that this brief simple pragmatic intervention could be delivered in any community pharmacy with a private consultation area once the pharmacist has completed basic training in asthma management, which argues for the generalisability of these results.

In the UK, community pharmacy continues to be described in policy as an underutilised resource, and this evaluation suggests that pharmacists could be used to greater effect in chronic disease management. Community pharmacists are in a unique position to make a useful contribution to chronic disease management due to their accessibility, expertise on medication and their frequent contacts with patients collecting repeat medication.

As described above the need for patient-focussed care is an essential part of the future strategy to improve asthma control in primary care. The results presented here add further weight to the argument that community pharmacists can be a key partner in the delivery of that strategy.

References

Anderson, H.R. 2005: Prevalence of asthma. *BMJ* 330: 1037-1038.

Armour, C., Bosnic-Anticevich, S., Brillant, M., et al. 2007: Pharmacy Asthma Care Program (PACP) improves outcomes for patients in the community. *Thorax* 62: 496-592.

Asthma UK. 2012: Asthma facts and FAQs. Available at http://www.asthma.org.uk/asthma-facts-and-statistics, Asthma UK, London. Accessed March 2013.

Barbanel, D., Eldridge, S. and Griffiths, C. 2003: Can a self-management programme delivered by a community pharmacist improve asthma control? A randomised trial. *Thorax* 58: 851-854.

Bassi, M. and Wood, K. 2009: Medicines use reviews: time for a new name? *International Journal of Pharmacy Practice* 17: B5-B6.

Bender, B.G. and Rand, C. 2004: Medication non-adherence and asthma treatment cost. *Current Opinion in Allergy and Clinical Immunology* 4: 191-195.

Blenkinsopp, A., Bond, C. and Raynor, D.K. 2012: Medication reviews. *British Journal of Clinical Pharmacology* 74: 573-580.

Blenkinsopp, A., Celino, G., Bond, C., et al. 2007: Community pharmacists' experience of providing medicines use reviews: findings from the national evaluation of the community pharmacy contractual framework. *International Journal of Pharmacy Practice* 15: B45-46.

Bozek, A. and Jarzab, J. 2010: Adherence to Asthma Therapy in Elderly Patients. *Journal of Asthma* 47: 162-165.

Carroll, R., Hewitson, M., Carroll, S., et al. 2010: *Delivering Enhanced Serivces in a Modern NHS: Imporving Outcomes in Public Health and Long-Term Conditions,* London: The Bow Group.

Cochrane, M.G., Bala, M.V., Downs, K.E., et al. 2000: Inhaled corticosteroids for asthma therapy: patient compliance, devices, and inhalation technique. *Chest* 117: 542-550.

Cowley, J., Gidman, W.K., McGregor, L., et al. 2010: Exploring community pharmacists' experience and opinions of Medication review services in England, Wales and Scotland. *International Journal of Pharmacy Practice* 18: 88-89.

Crompton, G.K., Barnes, P.J., Broeders, M., et al. 2006: The need to improve inhalation technique in Europe: A report from the Aerosol Drug Management Improvement Team. *Respiratory Medicine* 100: 1479-1494.

Davies, M. and Pugsley, L. 2006: Medication use review (MUR) assessment: do accredited pharmacists feel competent and confident to perform MURs? *International Journal of Pharmacy Practice* 14: B59-60.

Eades, C., Ferguson, J. and O'Carroll, R. 2011: Public health in community pharmacy: A systematic review of pharmacist and consumer views. *BMC Public Health* 11: 582.

Edmonds, M., Milan, S., Camargo Jr, C., et al. 2012: Early use of inhaled corticosteroids in the emergency department treatment of acute asthma. Cochrane Database of Systematic Reviews 12: pp113.

Elvey, R., Bradley, F., D, A., et al. 2006: Implementing medication usage reviews through the new community pharmacy contract: key drivers and barriers. *International Journal of Pharmacy Practice* 14: B32-B33.

Ernst, P. 1998: Inhaled drug delivery: A practical guide to prescribing inhaler devices. *Canadian Respiratory Journal* 5: 180-183.

Ewen, D., Ingram, M. and MacAdam, A. 2006: The uptake and perceptions of the medicines use review service by community pharmacists in England and Wales. *International Journal of Pharmacy Practice* 14: B61-62.

Fiato, K., Iwamoto, G., Harkins, M., et al. 2007: Monitoring flow rates and retention of inhalation techniques using the in-check dial device in adult asthmatics. *Journal of Asthma* 44: 209-212.

Hall, J., Smith, I. and Adams, A. 2006: Why are pharmacists not doing MURs? *Health Services Research and Pharmacy Practice Conference,.* Bath, April 3-4, 2006.

Hämmerlein, A., Müller, U. and Schulz, M. 2011: Pharmacist-led intervention study to improve inhalation technique in asthma and COPD patients. *Journal of Evaluation in Clinical Practice* 17: 61-70.

Hess, L.M., Raebel, M.A., Conner, D.A., et al. 2006: Measurement of Adherence in Pharmacy Administrative Databases: A Proposal for Standard Definitions and Preferred Measures. *The Annals of Pharmacotherapy* 40: 1280-1288.

Hirst, P.H., Pitcairn, G.R., Richards, J.C., et al. 2001: Deposition and pharmacokinetics of an HFA formulation of triamcinolone acetonide delivered by pressurized metered dose inhaler. *Journal of Aerosol Medicine: Deposition, Clearance, and Effects in the Lung* 14: 155-165.

Horne, R. 2006: Compliance, Adherence, and Concordance*Implications for Asthma Treatment. *CHEST Journal* 130: 65S-72S.

Hughes, M., Eifion, E., John, D., et al. 2009: Medicines Use reviews and language choice: an exploratory choice. *International Journal of Pharmacy Practice* 17: A41.

Lasmar, L., Camargos, P., Champs, N.S., et al. 2009: Adherence rate to inhaled corticosteroids and their impact on asthma control. *Allergy* 64: 784-789.

Latif, A. and Boardman, H. 2007: Pharmacist's Attitudes and factors affecting the number of medicines use reviews (MURs) performed. *International Journal of Pharmacy Practice* 15: A4.

Latif, A., Boardman, H. and Pollock, K. 2011: Reasons involved in selecting patients for a Medicines Use Review (MUR): exploring pharmacist and staff choices. *International Journal of Pharmacy Practice* 19: 31-32.

Latif, A., Pollock, K. and Boardman, H. 2010: Why do patients accept or decline the invitation for a Medicines Use review? *International Journal of Pharmacy Practice* 18: 21.

Latry, P., Pinet, M., Labat, A., et al. 2008: Adherence to anti-inflammatory treatment for asthma in clinical practice in France. *Clinical Therapeutics* 30, Part 1: 1058-1068.

Mangiapane, S., Schulz, M., Mühlig, S., et al. 2005: Community Pharmacy-Based Pharmaceutical Care for Asthma Patients. *The Annals of Pharmacotherapy* 39: 1817-1822.

McDonald, R., Cheraghi-Sohi, S., Sanders, C., et al. 2010a: Professional status in a changing world: The case of medicines use reviews in English community pharmacy. *Social Science & Medicine* 71: 451-458.

McDonald, R., Cheraghi-Sohi, S., Tickle, M., et al. 2010b: *The impact of incentives on the behaviour and performance of primary care professionals: Report for the National Institute for Health Research Service Delivery and Organisation programme SDO Project (08/1618/158),* London: Queen's Printer and Controller of HMSO 2010.

Mehuys, E., Van Bortel, L., Annemans, L., et al. 2006: Medication use and disease control of asthmatic patients in Flanders: A cross-sectional community pharmacy study. *Respiratory Medicine* 100: 1407-1414.

Mehuys, E., Van Bortel, L., De Bolle, L., et al. 2008: Effectiveness of pharmacist intervention for asthma control improvement. *European Respiratory Journal* 31: 790-799.

Murphy, A. 2013: SIMPLE approach to Asthma Management - NHS Leicester City. Available at: http://www.tin.nhs.uk/innovation-nhs-east-midlands/innovation-in-practice/regional-innovation-fund-projects-2009-10/simple-approach-to-asthma-management/. [Accessed February 2013]

Nathan, R.A., Sorkness, C.A., Kosinski, M., et al. 2004: Development of the asthma control test: A survey for assessing asthma control. *The Journal of allergy and clinical immunology* 113: 59-65.

NICE. 2009: Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence (CG67) In: National Institutie for Health and Clinical Excellence (ed).Available at: http://www.nice.org.uk/CG76

Osterberg, L. and Blaschke, T. 2005: Adherence to Medication. *New England Journal of Medicine* 353: 487-497.

Pharmaceutical Services Negotiating Committee. 2012a: *Medicines Use Review and Prescription Intervention service: Service Specification,* London.

Pharmaceutical Services Negotiating Committee. 2012b: *MUR Statistics*. Available at: http://www.psnc.org.uk/pages/mur_statistics.html.

Portlock, J., Holden, M. and Patel, S. 2009: A community pharmacy asthma MUR project in Hampshire and the Isle of Wight. *Pharmaceutical Journal* 282: 109-112.

Rosenbloom, E., Taylor, K. and Harding, G. 2005: The attitudes of service providers and users towards medicines reviews to support the single assessment process for older people. *International Journal of Pharmacy Practice* 13: R43.

Roy, A., Battle, K., Lurslurchachai, L., et al. 2011: Inhaler device, administration technique, and adherence to inhaled corticosteroids in patients with asthma. *Prim Care Respir J* 20: 148-154.

Saini, B., Krass, I. and Armour, C. 2004: Development, Implementation, and Evaluation of a Community Pharmacy–Based Asthma Care Model. *The Annals of Pharmacotherapy* 38: 1954-1960.

Schatz, M., Sorkness, C.A., Li, J.T., et al. 2006: Asthma Control Test: Reliability, validity, and responsiveness in patients not previously followed by asthma specialists. *The Journal of allergy and clinical immunology* 117: 549-556.

Schulz, M., Verheyen, F., Muhlig, S., et al. 2001: Pharmaceutical care services for asthma patients: a controlled intervention study. *J Clin Pharmacol* 41: 668-676.

SIGN and BTS. 2011: British guideline on the management of asthma: a national clinical guideline. Scottish Intercollegiate Guidelines Network and British Thoracic Society. *www.sign.ac.uk*.

The NHS Information Centre. 2012: General Pharmaceutical Services in England 2002-03 to 2011-12. In: The Health and Social Care Information Centre Department of Health (ed). London: Department of Health.

The Scottish Government. 2007: *Better Health, Better Care: Action Plan. http://www.scotland.gov.uk/Resource/Doc/206458/0054871.pdf,* Edinburgh.

Thomas, R., John, D., Roberts, D., et al. 2007: Barriers and facilitators to the delivery of medicines use review (MUR) services in community pharmacies in Wales. *International Journal of Pharmacy Practice* 15: A8-A9.

Urban, R., Rivers, P. and Morgan, J. 2008: Perceptions of medicines use reviews—the views of community pharmacists within a West Yorkshire primary care trust. *The Pharmaceutical Journal* 281: 303-305.

Van Beerendonk, I., Mesters, I., Mudde, A.N., et al. 1998: Assessment of the inhalation technique in outpatients with asthma or chronic obstructive pulmonary disease using a metered-dose inhaler or dry powder device. *Journal of Asthma* 35: 273-279.

Weinberger, M., Murray, M.D., Marrero, D.G., et al. 2001: Pharmaceutical care program for patients with reactive airways disease. *American Journal of Health-System Pharmacy (USA)* 58: 791-796.

Weinberger, M., Murray, M.D., Marrero, D.G., et al. 2002: Effectiveness of pharmacist care for patients with reactive airways disease: A randomized controlled trial. *JAMA* 288: 1594-1602.

Williams, L.K., Pladevall, M., Xi, H., et al. 2004: Relationship between adherence to inhaled corticosteroids and poor outcomes among adults with asthma. *Journal of Allergy and Clinical Immunology* 114: 1288-1293.

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Funding

GSK provided training materials and funded a collaborative programme with Rowlands pharmacy.

This report was researched and produced with funding provided by GlaxoSmithKline. Personal accountability for the objectivity and quality of the report lies with Dr. James Davies and Professor David Taylor of the University College London School of Pharmacy. The interpretations offered in this publication are those of the authors.

Acknowledgements

We would like to acknowledge the help and assistance of Nicky Grudy and Eilidh Campbell at Rowlands pharmacy for their assistance in the evaluation, and the pharmacists that gave their time to be interviewed as part of this evaluation.

We would also like to thank Andy Ibberson, Martin Crisp and Stephen Pemberton from GlaxoSmithKline and Dr James Parker, Medical Consultant to GSK, for their insights into this evaluation.

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