

MAKING IT BETTER...

A STRATEGY FOR PHARMACY IN THE COMMUNITY

A CONSULTATION PAPER

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1. Executive Summary

The Department is committed to continue to build a first class Health Service that meets the needs of patients and society at large promptly, conveniently and effectively. To do this we need to ensure we make best use of the skills and expertise of all the people who work in and for the HPSS. This consultative strategy outlines the way in which community pharmacy can develop to meet these needs.

It is predicated on the aim:

“to maintain, develop and support a stable pharmacy network to provide, in partnership with others, a quality and comprehensive pharmaceutical service assuring the safe and effective use of medicines, minimising barriers to provide equitable health and social care to all.”

Community pharmacies play an important role within the health service and in the community as a whole. Within each community, they are a valuable and readily accessible healthcare resource. It is known that 123,000 adults, both healthy and sick visit community pharmacies in Northern Ireland every day. This equates to more than 9% of the NI adult population. Many of these people are older people, vulnerable or socially disadvantaged¹.

Implicit in the term ‘Community

Pharmacy’, is a close identity with, and a commitment to, the local community.

Pharmacists working in this environment are distinctive in that they:

- Regularly come into contact with healthy people as well as the sick;
- Can be contacted without an appointment;
- Tend to be questioned by, and are perceived to be open to questioning by, the patient or client.

Societal needs and expectations continue to change and it is essential that the services we provide are modern and respond to such changing needs. This strategy sets a vision for community pharmacy where:

“Community pharmacy will offer an open door to the health service providing up-to-date, quality and focused care, based on individual and community need. The community pharmacist will be recognised as the medicines expert working as an integral part of the health and social care team, freely accessible to everyone.”

In order to achieve this vision, a number of themes have been identified and have been developed as chapters within this document.

Chapter 4 sets out the case for building

upon the community pharmacy as an open door for accessing public health. In *Investing for Health*, this role was recognised and has led on to the development of a pioneering community partnership approach through projects supported by the 'Building Community Pharmacy Partnership' initiative. The strategy calls on this work to be progressed as significant benefits have accrued using this approach.

In addition, a number of innovative pilots in Northern Ireland have demonstrated how various health promotion activities e.g. smoking cessation services can be provided within a community pharmacy setting. The strategy identifies further areas for development and outlines how a 'Health Promoting Pharmacy Scheme' could set such services within an accredited quality structure.

Community pharmacists already contribute to improving the use of medicines in primary care. Chapter 5, 'Improving the Use of Medicines' describes various medicines management services and ways to best utilise the community pharmacist's skills. These expand on the medicines management initiative that has been in operation in Northern Ireland for a number of years. 'The Managing your Medicines' scheme has provided a successful basis, and to build on this

success, improved referral mechanisms and the appointment of a regional facilitator have been recommended. Additional medicines management services such as pharmacist-managed medication review, prescribing support, repeat dispensing, limited pharmacist supply on the HPSS for common ailments and supplementary prescribing are also advocated.

Patients receive care from a number of sources and can receive such care at a variety of different locations e.g. at home, residential care, health centres, hospitals, etc. Problems, particularly with regard to transfer of information regarding medication, continue to occur as patients are transferred between different settings. These problems can crucially affect patient outcome. 'Promoting Seamless Care' (Chapter 6) outlines the need for an integrated, standardised medicines management framework for admission and discharge policies between primary, secondary, tertiary and community care, involving liaison between hospital and community pharmacists with improved electronic communications.

This last theme is further explored in Chapter 8 'Improving Access and Communication'. We need to apply more fully to the Health Service those information and communication

innovations that are part of modern life. This strategy makes specific provision to improve communication and information flows to help deliver community pharmacy services.

People who use our health services expect to experience the highest quality care delivered from confident, competent professional staff. The strategy outlines developments to augment the quality of community pharmacy services. Under the theme of 'Quality Improvement' (Chapter 7), the quality agenda is set out with the establishment of a clinical governance framework involving standard operating procedures, risk management, awards for high standards of practice, a continuous professional development (CPD) framework for all staff and the designation of specific research sites to innovate and develop pharmaceutical services in primary care.

To achieve the delivery of quality services, Chapter 9 'New Structures and Systems', makes recommendations to review the workforce needs, the community pharmacy contract and the regulations for contracting services. It recommends building on the successes of current structures and advocates enhancing these to provide a stable network of community pharmacies, which deliver excellence in the new services outlined.

This strategy builds on traditional roles and aspires to the future with a vision in which the service is an integral part of the health and social care team and the pharmacist's skills are used to the fullest possible extent.

2: Introduction

2.1 Community Pharmacies in Northern Ireland

Community pharmacies play an important role within the health service and in the community as a whole. In Northern Ireland there are currently 509 community pharmacies with Health Service contracts.

Within each community they are a valuable and readily accessible healthcare resource. The community pharmacy is essentially an 'open door' to the Health Service and is therefore in a prime position to deliver effective, well-targeted services to promote health and social well-being. This is supported by the following evidence:

- A recent independent survey found that approximately 123,000 people, both healthy and ill, visit pharmacies in NI every day. This equates to more than 9% of the NI adult population.¹ It is estimated that more than 91% of customers visit a community pharmacy every month.
- The same study demonstrated that people in social classes of greatest need use community pharmacy on a more regular basis than those in higher social classes, and;
- 83% of patients in NI currently use the same pharmacy routinely. This increases to 90% in patients over 65 years of age.

- A study undertaken in NI in 1990 showed that in 90% of approaches by a member of the public, a pharmacist was available for consultation within 1.5 minutes.²
- Ninety-three per cent of the resident population would welcome an extended pharmacy health promotion service.³

The evidence clearly shows that community pharmacy is exceptional in terms of accessibility, standards of service and dedicated customer patronage. It is a sustainable resource that provides a unique foundation for further development.

Implicit in the term 'Community Pharmacy', is a close identity with, and a commitment to, the local community. Community pharmacists have, by virtue of their financial investment in their premises and staff, made a commitment to their local community, and present a sustainable asset. Moreover, since professional pharmaceutical services operate within the context of a business, they have a very strong motivation to be customer and client-centred. Distinctively, unlike many other health professionals, pharmacists:

- Regularly come into contact with healthy people as well as the sick;

- Can be contacted without an appointment;
- Tend to be questioned by, and are perceived to be open to questioning by, the patient or client.

2.2 Community Pharmacy Services

Community pharmacy traditionally provides services in four core areas:

- **Treatment of common ailments.** Advising on responsible self-care, selling appropriate OTC treatment and referring to other members of the health care team if necessary.
- **Provision of prescribed medicines** for acute and long-term conditions. This also involves advising on correct use of the medicines or devices, helping patients to monitor the effects of treatment and working with the patient to ensure continuity of supplies.
- **Working with other health and social care professionals.** Advising others on technical and clinical aspects of medicines.
- **Health promotion and disease prevention.** Activities in this area include the direct provision of advice, access to information resources and the delivery of specialist services such as smoking cessation programmes.

The level at which some of these services are delivered depends on a number of

factors, including local needs, interests and available resources.

Many of the 123,000 adults who visit community pharmacies in Northern Ireland every day are older people, vulnerable or socially disadvantaged¹. Table 1 illustrates the spectrum of people who are regularly served by a single community pharmacy.

table 1: Who visits a pharmacy?

Your local pharmacy serves, on average⁴:

- 50 people with diabetes
- 150 people with asthma
- 500 people with hypertension
- 20 cancer patients
- 10 mental health patients
- 8 colostomy patients
- 50 pregnant women
- 750 older people
- 500 under fives
- 600 carers
- 50 patients recently discharged from hospital

2.3 Strategic vision

The Department is committed to continue to build a first class Health Service that meets the needs of patients and society in a prompt accessible way. To do this we need to ensure we make best use of the skills and expertise of all the people who work in and for the HPSS. This strategy outlines the way in which we hope community pharmacy can develop to meet these needs.

This strategy builds on traditional roles and

aspires to the future with a vision in which the service is an integral part of the health and social care team and the pharmacist's skills are used to the fullest possible extent.

Our vision is one where:

"Community pharmacy will offer an open door to the health service providing up-to-date, quality and focused care, based on individual and community need. The community pharmacist will be recognised as the medicines expert working as an integral part of the health and social care team, freely accessible to everyone."

Our Mission statement sets out the way in which we believe this vision will be achieved:

"Our aim is to maintain, develop and support a stable pharmacy network to provide, in partnership with others, a quality and comprehensive pharmaceutical service assuring the safe and effective use of medicines, minimising barriers to provide equitable health and social care to all."

3. Strategic Context

3.1 Introduction

Unlike other branches of the Health Service, community pharmacy has developed professional services within the framework of a commercial enterprise. Nevertheless, it has kept pace with the developments in healthcare and has built up a range of core services that form a critical element of the overall primary care health service. In doing so it has achieved a respected and trusted position in the community. In order to achieve full value from these services in future, additional resources will need to be committed. Consideration of the strategic context in which the services will operate lends further weight to arguments for developing and strengthening community pharmacy services.

Global Factors

3.2 Ageing population

The number of older people over 65 years of age will continue to increase as life expectancy increases. It has been estimated that the proportion of the population of pensionable age in Northern Ireland will rise by 27% by 2015⁵. This group consumes a larger proportion of medicines than other age groups with many individuals commonly receiving

three, four or more regular medicines⁶. As both the number of older people and the number of treatments for chronic and degenerative diseases increase, there will be an exponential increase in demands for patient education, therapy monitoring, prescribing advice and information for carers. Inevitably, this will have a major impact on community pharmacy services.

3.3 Technological advances

The growth in the use and application of computers, the Internet and mobile telephones in our daily lives will continue. There will be increasing use of electronics, computer technology and robotics in healthcare, following similar developments in other industries. The IT implementation plan for the Health Service has been set out.⁷ Electronic health records will be introduced and electronic prescribing will become the norm throughout the Health Service. It is already technically possible for prescriptions to be sent electronically and plans are well-advanced in the UK and beyond to have patients' medication records retained on secure internet sites so that they can be accessed by authorised personnel from remote sites. Telemedicine is advancing rapidly and some routine monitoring of patients is already being undertaken at a distance, with results sent electronically and clinical instructions relayed by telephone or email. Pharmacy, together with other health and

social care professions, needs to embrace these opportunities in order to further enhance the delivery of quality, accessible patient care.

In pharmacies it will soon be possible to link electronically-generated prescriptions with dispensing robots. Dispensing robots have already been installed in three hospitals in England and pilot schemes in Wales are scheduled to start in 2003. Computer technology will also be used to improve inventory control and to eliminate inefficiencies in the pharmaceutical supply chain. These technological advances will reduce or perhaps eliminate many routine tasks associated with medicines supply and allow more resources to be applied to the provision of advice and support for patients, carers and other health and social care professionals.

3.4 Changing public expectations

Public expectations of the healthcare system are changing as individuals become better informed. There is an expectation that all health and social care services will increasingly need to be available at times convenient to the public and that accurate information and advice will need to be made available to meet public demand.

Government policy encourages people to take greater responsibility for their own health, encouraging greater levels of self-

care and ultimately leading to the development of 'expert patients'.

Incorporated in this policy initiative is the drive to deregulate certain medicines from prescription-only (POM) to Pharmacy medicines (P), to make access to effective treatments easier for people. In principle this will lead to better health for all but it also imposes a requirement for good quality supportive information and guidance to ensure that information is interpreted accurately and all medicines, acquired from any source, are supplied and used safely and effectively. The ready availability of health care information via the internet has greatly expanded this challenge and it is likely that 'direct to consumer' (DTC) advertising of prescription medicines will further fuel the need for accurate information about the effectiveness, appropriateness and tolerability of medicinal products. Health and social care professionals, particularly community pharmacists, will be required to provide this level of support.

3.5 Public awareness of medical/medication errors

There is growing public awareness of adverse incidents occurring within the Health Service. Between 3% and 6% of patients are admitted to hospital as a result of adverse effects of medicines and this figure can reach almost 30% amongst older people⁸. Serious errors in the use of

prescribed medicines accounted for 20% of all clinical negligence litigation⁸. To date, most studies of medication errors have focused on those that occur in hospital and work is ongoing to reduce the potential risks in this area. Such work needs to be replicated in the primary care setting. Community pharmacists will be expected to play a central role in the development of risk-management strategies to contribute to the avoidance of medication-related adverse incidents.

3.6 Growth in the use of alternative/complementary medicines

The use of complementary medicines is widespread. It is partly driven by dissatisfaction with the results of conventional treatment and partly by the belief that 'natural' products are pure and free from adverse effects. The effectiveness of some complementary medicines and therapeutic approaches is recognised; for example, acupuncture has an established role in pain management and St John's Wort is effective in the treatment of mild depression. However, evidence of effectiveness is lacking for many other complementary approaches and some complementary medicines have significant interactions with prescribed medicines. The public's increasing interest in complementary approaches should not be dismissed, but rather supported and advised according to the best available

evidence of effectiveness.

Health Service Factors

3.7 Reorganisation of primary care

The Health and Social Services Act 2001 sets out the legislative framework for the establishment of Local Health and Social Care Groups (LHSCGs), which were formed in April 2002. Local commissioning based on community needs and priorities should lead to the delivery of appropriately targeted services by a fully integrated primary care team. Local service development and change will be dependent on effective communication, teamwork, negotiating skills and strategic awareness. All representatives on LHSCGs will have a key role to play in ensuring appropriate care provision for the local population. Pharmacist representatives will also need to ensure that any potential pharmaceutical contribution to service developments are considered. Pharmacist representatives will need to access and provide appropriate current evidence to inform service development. Equally important, they must ensure that information is disseminated effectively from LHSCGs to pharmacists within the locality and to other localities, to ensure pharmaceutical service development across NI adopts a well co-ordinated, flexible, cohesive approach.

3.8 The public health strategy

The Interdepartmental Strategy, *Investing for Health*⁹ outlines the framework for improving public health in Northern Ireland. The strategy highlights the evidence that the inequalities in health between the rich and poor are widening and has two overarching aims,

- To improve the health status of all our people, and
- To reduce inequalities in health

The implementation of *Investing for Health* will be dependent on partnership working at all levels. This will involve departments, all those in the wider health and social care family, the community and voluntary sector and the public. Future public health roles of the community pharmacy and community pharmacist are recognised within the strategy.

3.9 The Quality Agenda

The recent consultation document *Best Practice Best Care*¹⁰ outlined the quality framework for the HPSS. This led to The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003. The Order sets out the legislative framework for the establishment of a quality system for the Health and Personal Social Services. The new legislation imposes on HPSS bodies:

- A statutory duty of quality
- The requirement to have risk management systems
- Effective user involvement

It also outlines the development and role of the new Regulation and Improvement Authority (RIA) which will be responsible for monitoring the activities of HPSS bodies in relation to:

- Setting standards – improving services and practice;
- Delivering services – ensuring local accountability; and
- Improving monitoring and regulation of the services.

The proposals will have immediate implications for all health and social care professionals, including community pharmacists as independent contractors.

Clinical governance will continue to be a cornerstone of the Health Service. There will be an ongoing need for new and existing systems to demonstrate:

- Clear lines of responsibility and accountability;
- A comprehensive programme of quality improvement;
- Clear policies for managing risk;
- Education and training plans;
- Procedures in place to identify and remedy poor performance.

3.10 Public engagement and participation

Hitherto, the service provided by the HPSS has been based largely on decisions made by commissioners or health professionals on behalf of the public, based on health service priorities and delivered in ways

they believe to be in the public's best interest. However, this approach has been criticised as leading to a disempowered, disengaged and disinterested public and it has been accepted that this is not the most effective way to proceed. It is now understood that for the public to accept decisions, they must be involved in the decision making process and given the opportunity to influence.

A previous report¹¹ identified engagement with the public as a key factor in the future success for the NHS. In the future the public will undoubtedly become more involved in the organisation of health services in several areas including:

- The involvement of communities in the development of locally responsive, accessible services;
- The involvement of the public in deciding health and social care priorities;
- Individual health-determining behaviours, the use of services and the development of major programmes of self-care and disease management.

3.11 Implications of devolution

The provision of Health and Social Services is a devolved matter under the control of the NI administration. The Department (DHSSPS) is committed to the aims that make up the Programme for Government priority of *Working for a Healthier People*¹². They are to:

- Reduce preventable disease, ill-health and health inequalities
- Modernise and improve hospital and primary care services to ensure more timely and effective care and treatment for patients.
- Ensure that the environment supports healthy living;
- Enable those with disability, mental health difficulties chronic illness or terminal illness to achieve the highest standard of living and to be fully integrated with in society.

In addition, the Department has a commitment to develop North/South relations and to improve cross-border relations on health and public safety matters.

The future developments in community pharmacy will be set against this background.

3.12 Developments in pharmaceutical technology

The number and technical complexity of prescription medicines is likely to increase. This will be driven by:

- The development of more biotech medicines, including gene therapy
- The development of medicines to treat previously untreatable conditions

The growth of pharmacogenetics and pharmacogenomics will enable drug

selection on the basis of an individual's genetic make-up. These techniques enable, for example, the identification of individuals who cannot metabolise particular drugs well and are therefore highly susceptible to side effects. Vulnerable patients can then be given lower doses or alternative, safer treatment. All of these factors, together with future advances in drug technology, will increase the demand for expert pharmaceutical advice and information.

3.13 Continued pressure on HPSS budgets

There are around 24.3 million items dispensed annually (2001-2002) at a cost of £267 million¹³. In recent years prescribing costs have been rising at a rate greater than 10% per annum.¹³ The pressure to contain spending within available budgets will not diminish. Within the HPSS there will be increasing requirement for evidence of value-for-money and cost-effectiveness. In particular, limitation of prescribing budgets will continue. There will be a continuing demand for information about costs and consequences of drug treatment and community pharmacists, and others, will have a vital role to play in providing specialist advice and guidance to help inform rational drug use.

3.14 New roles in primary care

Government policy aims to create a more flexible, responsive HPSS workforce. Recent years have seen many changes to traditional professional boundaries for all those involved in the provision of health and social care. In pharmacy this has already led to some pharmacists working outside conventional community pharmacy, fulfilling new roles in primary care, for example, working in community health initiatives or in GP practices. Developments, including the extension of prescribing rights for pharmacists, nurses and others, will further encourage role diversification within primary care. This will improve access to care for many and allow professions to work together to meet the increasing demands in primary care, while ensuring the talents and skills of each are directed and used most effectively.

3.15 Extension of prescribing rights

The Crown Review¹⁴ recognised that pharmacists had the expert knowledge that would equip them to become skilled prescribers and paved the way for pharmacists to assume prescribing responsibilities. The Crown Review recommended that there should be two categories of pharmacist prescribers: **supplementary prescribers**, who will prescribe continuing treatment within the framework of a treatment plan agreed with

the patient's doctor, and **independent prescribers** who will be able to prescribe on their own authority. Clearly, these developments will make it easier for patients to access treatment and will also improve access to pharmaceutical advice. Some pharmacists will become supplementary prescribers within the next 12 months and the groundwork has been laid for some to become independent prescribers in due course. These developments could lead to major changes in the way in which community pharmacists organise their premises and activities.

Pharmacy Factors

3.16 Changes in the profile of community pharmacies

Increasing numbers of pharmacies are being amalgamated into large groups or chains. Although many pharmacies remain operated by their pharmacist owners, today a significant number of pharmacists working in the community are employees, rather than owners of the pharmacies in which they work. Furthermore, retailing has seen the arrival of the global competitor who can replicate success in cities and towns throughout the country. In community pharmacy the competitive pressures will continue to require efficiency, economic purchasing, value-

added deployment of staff and sound business decision-making. However, key to the success of a future community pharmacy business will be the provision of quality services, which are responsive and directed appropriately to meet local needs and demands.

3.17 Professional aspirations

Entrants to the profession of pharmacy have now completed a four-year degree course, encompassing pharmaceutical, clinical and behavioural sciences. They have also completed a one-year, practice-based pre-registration training. These pharmacists are highly trained in medicines technology and therapeutics and are likely to become frustrated and disillusioned if their working environment does not fully utilise these skills.

Pharmacists offer unique, accessible and valuable skills to the Health Service. It is in the public interest to ensure that pharmacists' expertise is applied fully.

4. Supporting Public Health

4.1 Introduction

Public health has been defined as¹⁵, *“The application of knowledge, skills and resources to the science and art of preventing disease, prolonging life, promoting, protecting and improving health for all through organised efforts of society.”*

Public health is concerned with improving the health status of the population and underpins all Health Service-related activities carried out by many different health and social care professionals. The recently published interdepartmental public health strategy, *“Investing for Health”*⁹ outlines the Government’s agenda for improving public health in Northern Ireland. This document identifies key determinants of ill-health as poverty, unemployment and income inadequacy. It also highlights education, access to health services and environmental factors such as water supplies, roads and housing as important factors. The most significant lifestyle factor is smoking.

Investing for Health has two overarching aims:

- to improve the health status of all our people, and
- to reduce inequalities in health

Seven key objectives are identified along with quantitative targets that will help to meet the overall aims. Several of these have particular relevance to community pharmacy services, for example:

- The promotion of mental health and emotional well-being at the individual and community levels
- Enabling people to make healthier choices, especially in relation to obesity and dental decay
- Reducing teenage pregnancy and improving sexual health
- Drug misuse
- Sensible use of alcohol and drugs

Investing for Health emphasises the future delivery of this far reaching strategy rests on partnerships, between departments, public health professionals, members of primary health and social care teams, the community and voluntary sector, local communities and others. The *“Building the Community-Pharmacy Partnership”* initiative is highlighted as an innovative example of partnership working with local communities and endorsed as a model for future service development. The public health roles for Health Service professionals are outlined, including both established roles and new and exciting future opportunities for the pharmacy profession.

"A core function of pharmacists at all levels is to prevent ill health and promote and protect public health.. This encompasses a vast range of activity, from the provision of health promotion advice to advised self care... to medicine management programmes.... Community pharmacies provide a unique forum for health development ... the opportunity to target people who would otherwise have little or no contact with health promotion messages....the position of the community pharmacy with its visibility, accessibility and loyal customer patronage renders it an ideal Health Promotion Centre

We will support and encourage community pharmacists to:

- work with local communities to develop services tailored to their particular needs;*
- develop health promoting pharmacies, including community outreach ...and offering the opportunity for other professions to provide their services there;*
- make optimal use of their specialised knowledge of medicines, leading to safer and more effective use...*
- participate in co-ordinated health promotion programmes ...*
- develop as a public health resource, by establishing a community-based indicator which records relevant self care data..*
- target the medicines education and advice needs of those who are most at risk from the adverse effects of medicationdirectly or through those who care for them;*

... Clearly there is much to gain by exploiting the opportunity that the community pharmacy-public interface presents, to offer health promotion in a care environment."

Taken from Investing for Health, DHSSPS, 2000

Community pharmacy encompasses a wide range of public health activity, this includes: lifestyle advice, early detection of disease, disease prevention, appropriate use of medicines and supporting local communities.

Until now public health initiatives for pharmacy have involved:

- The management of prescribed medicines and chronic conditions
- Treatment of common ailments
- Promotion of healthy lifestyle choices
- Provision of health advice.

While these activities embrace the core of many professional activities, they are often delivered in isolation from other members of the health and social care team and are generally provided in response to the needs of an individual, rather than on the basis of wider community needs. As part of the new public health system, pharmacists need to think more widely, to work more effectively in an integrated co-ordinated team, responding to individual needs while understanding the real health needs of the local population and developing ways of evaluating, improving and monitoring its care.

4.2 Developing community pharmacies as a public health resource

The “open door” of community pharmacy, offering direct access to professional skills provides the opportunity to use community pharmacies more effectively to enhance the health and social well-being of the population. Community pharmacists are unique in their position for interacting with healthy individuals.

Pharmacies generally have available a wide variety of healthcare and health maintenance products and pharmacists have many opportunities to provide one-to-one advice on many subjects. The future must harness the opportunities afforded both by community pharmacists and the community pharmacy, ensuring optimal use of the pharmacy environment alongside the skills and talents of the pharmacist and pharmacy support staff.

There has been extensive research into the contribution pharmacists make to health development. A systematic review of peer-reviewed publications demonstrated robust evidence of effectiveness of community pharmacy services in several key areas¹⁵:

- Smoking cessation
- Lipid management in the prevention of heart disease
- Supervised methadone administration
- Emergency hormonal contraception

- Immunisation
- Patient education and monitoring of diabetes

This has been further supported by a systematic review of the non-peer-reviewed UK research on the contribution of community pharmacists to public health¹⁶.

Health Promoting Pharmacies

The future development of community pharmacies as accredited “Health Promoting Pharmacies”, or wellness centres, designed to improve the health and well-being of their local population will be a key area for development. This will involve establishing a quality framework for both pharmacies and pharmacists involved in the delivery of an extended health promotion service. The service will involve the provision of:

- personal advice on health promotion, and disease prevention.
- advice on lifestyle management, including the role of complementary therapies
- advice on self-care for minor ailments
- referral to other health and social care professionals
- an extension to the community support structure with pharmacists signposting people to other relevant groups within the local community
- community-focused care

Pharmacies with an extended health promotion service may also provide a channel for access to other therapists and health professionals who help maintain health and well-being e.g. dieticians, podiatrists, physiotherapists, counsellors, and complementary therapists. This may involve direct access through sessions in the pharmacy premises or through signposting or referral mechanisms.

Action 4.2.1: *A “Health Promoting Pharmacy” accreditation scheme will be developed. HSS Boards will be asked to begin to establish a “Health Promoting Pharmacies Network”.*

Action 4.2.2: *HSS Boards, Trusts and the Health Promotion Agency for Northern Ireland, will be asked to ensure that future health promotion campaigns involve community pharmacies in a systematic, co-ordinated and innovative way to ensure that a consistent health message is given to the public.*

The development of community pharmacies as wellness centres, with an extended health promotion role, will provide the opportunity to build on existing successful initiatives such as smoking cessation services, immunisation campaigns, drug misuse services and falls prevention schemes.

Smoking cessation services

Research and development has positioned Northern Ireland at the forefront of pharmacy-based smoking cessation initiatives^{17,18}. This work resulted in a multidisciplinary training programme “*Smoking Challenge*”, that is now widely used throughout the UK.

The evidence supporting the use of nicotine replacement therapy (NRT) as an effective aid to help people give up smoking¹⁹ has further encouraged pharmacists develop effective cessation models to help people reinforce their desire to give up.

Spotlight on local innovation.....

Since the reclassification of NRT as a prescribable medicine, pharmacists in the Mid-Ulster area have extended their smoking cessation support role and developed a successful specialist pharmacy-based smoking cessation model involving support, advice and incorporating supply of NRT on prescription (issued by GP on request of pharmacist). The evaluation of the cessation service demonstrated that this model extended through a network of pharmacies in the locality, provided the service to 594 people, 56% of whom successfully managed to stop smoking and remain off four weeks after their quit date. This service, while pharmacist-led, has been developed in close co-operation with local GPs and is a good example of integrated working delivering real patient care benefits.

Action 4.2.3: *DHSSPS will facilitate the development of a regional evidence-based model for pharmacy-based smoking cessation services. All HSS Boards, Trusts and LHSCGs will be encouraged to adopt this as the pharmacy-based model.*

Immunisation

Increasing uptake of immunisation, both in adults and children, continues to be a priority for the DHSSPS. Community pharmacists have a longstanding role in the provision of information, advice and supply of adult vaccines, particularly in immunisation associated with travel. More recently they have expanded and developed their role in Influenza immunisation campaigns, exploiting their unique interface to relay key campaign messages to the public. However, the community pharmacy environment still remains an untapped resource. Many international models exist where pharmacies offer an extended immunisation service, either by running regionally co-ordinated, focused public awareness campaigns²⁰, or facilitating immunisation, allowing people to access immunisations directly in community pharmacies, by appropriately trained pharmacists, or other health professionals²⁰.

Spotlight on local innovation....

Northern Health and Social Services Board (NHSSB) 2001-2002 Influenza Immunisation Campaign provides an example of a successful integrated health promotion model. Here, a scheme was introduced to allow community pharmacists to identify patients at risk from flu, educate them on the benefits of immunisation and refer, where appropriate, to their GP. The scheme complemented the GP system by increasing the overall immunisation rate.

Action 4.2.4: *Work will be undertaken with key stakeholders to consider appropriate models to consolidate and extend the role of community pharmacists/community pharmacy in immunisation campaigns.*

Drug misuse services

Pharmacists in NI already provide a significant contribution in tackling drug misuse and abuse, working closely with community addiction teams. Services currently provided include, needle exchange, daily dispensing and community support. Again, a wealth of evidence exists demonstrating pharmacists' effectiveness in playing an extended role in the management of drug misuse and addiction and this will be a further area for future development.

Spotlight on local innovation....

Following a needs assessment, a pharmacy-

based needle exchange scheme was established in 7 community pharmacies in areas of demonstrated need across Northern Ireland. The scheme was drawn up using the experience of best practice from across the UK, and was set within a quality standards framework. A regional facilitator was employed by DHSSPS to co-ordinate the managed introduction of the service. This initiative has proved to be extremely effective and high levels of satisfaction have been reported by pharmacists, users of the scheme and others working in the area of addiction.

Action 4.2.5: *Further steps will be taken, in partnership with community drug and alcohol teams, to build on the success of needle exchange schemes to offer a wider range of drug misuse services.*

Falls prevention initiatives

Innovative schemes have been set up in the community, demonstrating how pharmacists can work effectively with others in the primary care team to help reduce the risk of medicine-related falls, particularly in older patients, through medication review, advice and referral. Evidence from these initiatives demonstrates clear patient care benefits.

Spotlight on local innovation....

Pharmacists demonstrated a key role as part of a recent multidisciplinary falls prevention

initiative set up in the SHSSB area. Patients were assessed by a practice nurse and referred to the pharmacist if they were taking six or more medicines for a medication review. The outcomes demonstrated that 52% of referrals assessed had actual or potential medicine associated problems and resulted in a medical intervention.

Action 4.2.6: *HSS Boards and Trusts will be encouraged to include a referral system to pharmacists for medication review as an integral part of future falls prevention initiatives.*

4.3 Health surveillance

Investing for Health proposes the further development of community pharmacies as a public health resource, by establishing a community-based indicator, which records relevant self-care data. Community pharmacists are often one of the first to detect a public health problem in a local community. This may be something simple such as an increasing incidence of head lice or chickenpox in an area, but there have also been occasions where the pharmacist has been one of the first to be alerted to a major public health concern e.g. in the recent outbreak of *Cryptosporidium* contamination of the water supply in the EHSSB area.

This will require further integration of the

community pharmacy into the public health system. Such a development will allow important public health messages to be relayed through the community to the public and from the community pharmacy to the wider public health surveillance team. This will help form part of an early warning system to identify outbreaks of communicable diseases or other public health concerns in the community.

Action 4.3: *Work will be undertaken in collaboration with other appropriate agencies to map out a model for health surveillance through community pharmacies.*

4.4 Waste management

Ensuring the safe, appropriate disposal of medicinal and clinical waste is an important public health protection activity. Community pharmacists' clinical activities serve to reduce medicines wastage particularly by encouraging rational prescribing and through regular medication review. However, excess unused medicines in our communities can lead to misuse, abuse and untoward effects. Pharmacists offer a waste management service to their local community, involving mainly medicinal and, to a lesser degree, clinical waste. Recent changes in regulations governing the disposal of medicinal and clinical

waste have increased the complexity of providing this service in community pharmacies.

Spotlight on local innovation...

Pharmacists in the NHSSB have recently been involved in a “Why Waste” campaign, focusing on increasing public awareness of the dangers of hoarding medicines and encouraging the public to bring unwanted medicines to their local community pharmacy. This campaign was extremely successful with significant quantities of unwanted medicine returned by the public. This forms a useful model for further development.

Action 4.4: *HSS Boards, Trusts and LHSCGs will be encouraged to develop evidence-based community pharmacist-managed DUMP campaigns to reduce the risk associated with medicines wastage in local communities.*

4.5 Mainstreaming the Building the Community–Pharmacy Partnership Initiative

*Building the Community-Pharmacy Partnership*²¹ is an important, innovative joint initiative developed and co-ordinated in partnership by the Community Development and Health Network (CDHN), a voluntary membership organisation committed to promoting and supporting action on health issues, and the Pharmaceutical Branch of the DHSSPS,

funded by Executive Programme Funds for 3 years.

The initiative was created in recognising the considerable potential for developing community pharmacies as a community health resource and realising the wealth of expertise, experience, knowledge and skills held by both community pharmacists and community organisations, that when combined, could be of immense benefit to the community and the Health Service.

The main aims of the ‘Building the Community Pharmacy Partnership’ (BCPP) project are, through a community development approach, to:

- establish stronger partnerships between local communities and community pharmacists to address local health needs; and to
- deliver, through the community pharmacy or pharmacist, appropriate, targeted health and social services in response to identified need

Projects meeting the key criteria of the initiative have been funded across Northern Ireland. Over £250,000 has been distributed to more than 40 initiatives. Projects are intrinsically partnership initiatives, some led by pharmacists and others by other community and voluntary agencies. They cover a wide range of issues with a number operating across a

locality, while others are based in small rural villages or urban housing estates. In relation to needs, some focus on the generic needs within a community while others focus on specific needs, such as sexual health, the needs of older people or carers. Many projects aim to bring appropriate health and social care services to people who are not able to visit the community pharmacy. These have often been developed as an outreach service whereby the pharmacist provides domiciliary care to older or housebound people, or provide specific services to local community groups, schools, hostels or other community organisations. The initiative is, therefore, particularly relevant to those disadvantaged and excluded from the mainstream of society.

A key challenge within the initiative is both to raise awareness within the community of the full range of services that pharmacists and pharmacies can offer and to raise awareness amongst pharmacists of the wealth of skills and expertise held within the community sector, so that new community-led services may be proposed that utilise the full complement of skills within a local area.

This initiative already provides many successful examples of how partnership working and a community needs-led approach can deliver real benefits to

pharmacists and their local communities. It will be an important model for the future delivery of public health pharmacy services.

Action 4.5.1: *Reports of the BCPP initiative will be collated in a single document and disseminated to LHSCGs, HSS Boards and Trusts, community pharmacists, and the community and voluntary sector as an example of good practice, to inform future commissioning and delivery of health and social care services.*

Action 4.5.2: *Following a full evaluation of the initiative, DHSSPS will work with key stakeholders to establish a suitable template identifying key criteria and quality standards for the future delivery of such initiatives and will undertake further work to identify a suitable method for mainstreaming the effective models.*

Action 4.5.3: *The Department will work with all key stakeholders to develop an assessment tool for determining the pharmaceutical and public health needs of local populations that can be met through community pharmacies.*

5. Improving the use of medicines

5.1 Introduction

Medicines play a central role in modern health care and represent the most common therapeutic intervention. At any one time:

- 20% of children will be taking one or more prescribed medicines;
- more than 40% of adults living in their own homes report taking prescribed medication;
- adults are taking on average 2.3 medicines each;
- one third of adults aged 75 years or more take four or more different prescribed medicines each²².

Yet surveys have shown that many patients cannot or do not take their medicines as prescribed. This gives rise to avoidable complications due to poor adherence, avoidable side effects and wastage of medicines.

- Unused medicines worth more than £90 million are returned to community pharmacies each year in the UK²², this equates to approximately £2 million in NI. Moreover, 11% of households have been found to have one or more medicine that is no longer being used;

- Research has shown that many patients do not take their medicines as intended. Between a quarter and a half of all older people patients do not take their medicines as prescribed, and, remarkably, it has been estimated that up to 80% of transplant rejections are attributable to non-adherence to medication regimes;
- Studies have estimated the proportions of hospital admissions due to medicine-related problems range from 6% to 30%²³.

Medicines management services offer a means to improve the way that medicines are used both by individual patients and by the HPSS. Medicines management embraces a range of activities designed to improve all aspects of the supply and use of medicines (table 2).

Table 2 Examples of medicines management services include:

- Prescribing support
- Prescription review
- Medication monitoring
- Repeat dispensing
- Pharmacist-led clinics e.g. for specific groups - patients with diabetes, asthma, heart disease
- Health promotion programmes
- Services to nursing and residential homes
- Domiciliary services
- Interface management - ensuring continuity of medicines' supply
- Patient education

Each of these services draws on the skills and expertise of the pharmacist working in the community to help make better use of medicines, through more cost-effective prescribing, more effective management of patients' medication after prescribing and improved communication at the interfaces.

5.2 Community pharmacy-based 'Managing your Medicines' scheme

The recent development of the "Managing your Medicines" scheme, for the first time offers community pharmacists in NI a real opportunity to use their specialist knowledge and expertise and, more importantly, provides a unique opportunity for them to spend dedicated time with people to improve their care.

This is a new service funded by the DHSSPS through the HSS Boards. In this scheme, eligible people who are taking multiple medicines, have a history of poor compliance or have recently been discharged from hospital, can have their complete medication history (prescribed, OTC and complementary medicines) reviewed by their local pharmacist. Patients may access the scheme either by self-referral or by referral from their GP or other care provider. The service was launched over the winter period 2000-2001, with an initial target of 20% of pharmacies actively providing the service (increased to 30% for 2002/03). The evidence suggests that the target will be met by the end of March 2003. The early adopters have shown a high level of commitment and have been positive about the service, both in terms of the improvements in patient care and the professional rewards.

Action 5.2.1: *DHSSPS will work with key stakeholders to extend and consolidate the existing Managing your Medicines scheme, building further collaboration across the primary care team.*

Action 5.2.2: *DHSSPS will work with key stakeholders to facilitate the development of a referral scheme to formalise patient referral from care providers to the community pharmacist for medicines management services*

Action 5.2.3: *A regional pharmacist facilitator will be appointed to oversee and co-ordinate the service throughout NI.*

5.3 Medication review and Prescribing Support in other settings

There have been a number of small scale schemes set up across NI involving pharmacists undertaking medication review in Nursing Homes. Each of the schemes has been successful and has demonstrated effectiveness in reducing the number of drugs taken by patients, identifying medicine-related problems and improving medication administration systems in the nursing homes. This has been highlighted as an example of best practice in the recent Community Care Review²⁴ and forms a key target area for future development.

Action 5.3.1: *HSS Boards, Trusts and LHSCGs will be asked to work with care home providers to encourage pharmacist-managed medication review.*

There are examples of high-quality, effective medication reviews being carried out by pharmacists based in GP practices^{25,26}. The practice-based model allows the pharmacist to work alongside the practice team. This means that possible solutions to medication-related problems can be discussed with other team members and implemented immediately, so that patients receive a smooth, co-ordinated service.

Developments in IT should help to drive this type of development. Provision of these types of services by community pharmacists will further strengthen local primary care teams.

A medication review service provided by community pharmacists is an important development, which can contribute to prescribing support services. Such services originated from concerns over primary care drug spend and have been provided by HSS Board personnel. These services have evolved over the years to address broader issues of quality in primary care prescribing. With the widening agenda for prescribing support and the increase in primary care prescribers, it will be necessary to engage community pharmacists as a resource to deliver prescribing support.

Action 5.3.2: *DHSSPS will work with HSS Boards to build on existing good practice by developing an appropriate model through which community pharmacists may provide prescribing support to GPs, nurse prescribers and other practitioners.*

5.4 Support for carers

Increasingly people in the community are relying on carers for support in many aspects of their lives, including managing their medicines. The need to provide support for patients and their carers in taking and administering medicines is now acknowledged. The perceived benefits of such support include optimisation of treatment, minimisation of adverse events and a reduction in medicine wastage. A project which involves pharmacists and carers working together to develop a training and information pack which addresses the needs of carers, particularly lay carers, on the use and administration of medicines is currently underway in Mid-Ulster funded through the *Building the Community-Pharmacy Partnership* initiative²¹.

5.5 Repeat dispensing

Repeat dispensing schemes can yield considerable benefits to patients and GPs. A pilot scheme has shown that there were both cost savings and greater patient, GP and pharmacist satisfaction²⁷.

Action 5.4: *DHSSPS will undertake to work with HSS Boards, Trusts and other key agencies to increase the support provided to carers to encourage the safe, effective administration and use of medicines.*

Spotlight on local innovation

DHSSPS recently funded a pilot study on repeat dispensing in NI. Patients taking long-term medication were given prescriptions by their GPs, which could be dispensed by their pharmacy in several installments. Each time a patient collected an installment, the pharmacist confirmed that a further supply was needed and that no problems were being experienced with the medicine. The results of this study demonstrated:

- Patients using the pharmacy-managed repeat dispensing scheme were twice as likely to be compliant at six months compared to control patients
- Cost-savings analysis in terms of non-dispensed medicines in the test group, estimated £62 per patient for 6 months or approximately £10 per patient per month
- A high level of GP, pharmacist and patient satisfaction.

Action 5.5: *DHSSPS will work with key stakeholders to commence the managed roll-out of repeat dispensing.*

5.6 Pharmacist supply on the NHS

It is now widely accepted that the role of pharmacists in helping people deal with

common ailments e.g. colds, flu, indigestion or hayfever, could be utilised more fully. Moreover, it is estimated that a significant proportion of consultations with GPs are for relatively common ailments. That is not to suggest that such consultations are unnecessary, however, there is no doubt that in many cases people might find a visit to their pharmacy a safe, satisfactory, and more convenient way of getting help. Furthermore, there are people who currently treat themselves without consulting a health professional, who might well benefit from and value advice given by pharmacists.

A number of UK-based pilot studies e.g. the *“Care in the Chemist Scheme”*²⁸ have reported the success of pharmacist supply on the NHS for common ailments. Pilot projects in Scotland have permitted community pharmacists to prescribe over the counter medicines as well as some prescription-only medicines on the NHS to patients who are normally exempt from prescription charges²⁹. The wealth of high quality evidence in support of pharmacists carrying out this role, has established this as an important area for future development. Pharmacists providing this service have provided a valuable contribution to health care by improving access to medicines and reducing GP workload for common ailments by up to 39%²⁸. These schemes have been

extremely well received by pharmacists, GPs and, most importantly, by the people using the service. The pilot studies were limited to a small number of conditions and medicines, and strict protocols were used to manage and monitor the service. None of the studies reported a significant rise in drug costs for the management of common ailments.

Spotlight on local innovation

Pharmaceutical Branch, DHSSPS recently commissioned work investigating the potential of pharmacist supply on the Health Service in NI. This identified and considered the relevant issues for the successful development and roll-out of such a service and proposed models for further consideration. In researching this area, the consultants carried out a large number of interviews with pharmacists, GPs, nurses, other health professionals, and members of the public. These included one-to-one interviews and large focus group sessions. The majority of the views expressed were extremely supportive of pharmacists taking on this role. This was true for all professional groups and members of the public interviewed. Particular issues that were identified as important included development of appropriate protocols, training, probity and remuneration.

Action 5.6: *DHSSPS will work with key stakeholders to develop and implement an evidence-based system to permit pharmacist supply on the HS for an agreed range of medicines used to treat common ailments.*

5.7 Supplementary prescribing by pharmacists

A common framework for supplementary prescribing is currently being developed. Supplementary prescribing, (previously known as dependent prescribing) will allow pharmacists to work closely with independent prescribers (usually a medical practitioner) and make changes to medicines within a pre-agreed patient care plan.

Due to additional changes in legislation required in Northern Ireland, it is likely that clinical pharmacists working within the hospital environment will be the first to be trained as supplementary prescribers. However, it is the intention that this will be an opportunity open to all pharmacists once the necessary changes to legislation have been effected. There would be a logical fit between certain extended services and supplementary prescribing. For example, pharmacists who already have demonstrable expertise in the management of, for example, asthma treatment, anticoagulation or hyperlipidaemia would be ideal candidates to take on supplementary prescribing for patients receiving these treatments. These developments will serve to enhance healthcare while strengthening pharmacy within the primary care team. By definition, any such developments in this area will be in partnership with local GPs.

Action 5.7: *DHSSPS will work with key stakeholders to implement a phased introduction of supplementary prescribing in pharmacy practice.*

5.8 Access to electronic health records (EHRs)

Access to EHRs will be essential if community pharmacists are to contribute effectively to patient care as members of the primary care healthcare team. This will have implications for IT resources and procedures to safeguard confidentiality. At present community pharmacies maintain patient medication records (PMRs) that contain details of medicines that have been prescribed and supplied. When, in future, EHRs are implemented, pharmacists will not only need to read them, but will also be required to record relevant data such as interventions and recommendations.

Action 5.8: *DHSSPS will work with key stakeholders to establish how the existing community pharmacy Patient Medication Records can be developed in preparation for a shared electronic health record to allow the routine recording of additional information, particularly clinical pharmacy interventions.*

6. Promoting Seamless Care

6.1 Introduction

It is generally accepted that the interfaces between organisations and professional groups are the points at which communication is most likely to break down. This occurs because of failure to understand different organisational cultures or systems. For example, miscommunications across the primary/secondary care interface have been numerous and many studies have shown how this has had a negative impact on patient care. It is an issue that is particularly important to the development of community pharmacy services. In order to work efficiently community pharmacies need to have links with pharmacies in secondary and tertiary care and also with other members of the primary health care team.

A feature common to most of these potential areas for development are that they involve much closer integration between pharmacists, GPs and other health professionals. Closer co-operation between members of primary health care teams, and between hospital and community pharmacies would benefit patients. Within this general field a number of key areas for attention have been identified.

6.2 Integrated primary/secondary care medicines management

There is an increased recognition that a dedicated interface role is necessary to achieve more pro-active liaison between all the relevant practitioners in primary and secondary care and so improve understanding, promote seamless care for patients and reduce risk. Pharmacists have already been appointed as a result of concerns identified with the increased use of more specialised drugs in the community setting.

Spotlight on local innovation

The benefits of a hospital-based community services liaison pharmacist were demonstrated recently by a pilot study based in Antrim Area Hospital. This found 61% of patients had an incomplete medication history on admission, 21% of patients who brought their own drugs were not dealt with appropriately and 33% of discharged patients had medication-related problems. The study also found that a Trust-based community liaison pharmacist produced benefits in terms of patient medication management, reduced readmission rates (by 2.4%) and reduced wastage of patients' own drugs.

The "Integrated Medicines Management" initiative is a major initiative currently being implemented in United Hospitals Trust, funded by the Executive Programme Funds. This involves a dedicated clinical pharmacy service at all parts of the patient

care journey from admission to discharge. It also seeks to provide a more seamless approach to pharmaceutical care across the primary/secondary care interface and to promote consistency of treatment across the two domains. A further feature of this project is improved medicines procurement systems and minimisation of wastage. Preliminary results show that this project has been able to deliver timely reviews of medication, individually-tailored patient education, and efficient transfer of information to GPs and community pharmacists. As a result, the initiative has raised the overall quality of care and made it easier for community pharmacists and GPs to provide ongoing care. A key element of the work has been the collecting of information on prescribed medicines from community pharmacists to inform hospital admission histories.

Action 6.2: *DHSSPS will work with HSS Boards and Trusts to encourage the introduction of an integrated, standardised medicines management framework for admission and discharge policies between primary, secondary, tertiary and community care, involving liaison between hospital and community pharmacists*

6.3 Harmonisation of product supply

An additional element of the “Integrated Medicines Management” initiative is the

harmonisation of product supply. Within the initiative, it has been agreed between primary and secondary care agencies that specific brands of commonly-used products will be used. The advantage for patients is that there is no change in the appearance of the medication as they move between primary and secondary care.

Action 6.3: *DHSSPS will work with key stakeholders to highlight the benefits of harmonisation of product supply and encourage the implementation of such schemes more widely.*

6.4 Specialist medicines issues

Specialist medicines, such as erythropoietin, methotrexate, cyclosporin, require more intensive monitoring than many other treatments in order to ensure that the patient is receiving a large enough dose to achieve the desired effects but is not experiencing serious side effects. These products have often been the subjects of shared care arrangements. The community pharmacist has a logical place in the management of specialist medicines therapy and in order to function effectively, needs to be fully aware of the treatment plan.

Action 6.4: *DHSSPS will work with HSS Boards and Trusts to ensure that future shared care arrangements for specialist medicines explicitly involve the community pharmacist. In addition, joint training of GPs, community pharmacists and others as appropriate, will be offered in relation to specialist medicines use.*

6.5 Interface between pharmacists and other health and social care professionals

Clearly, if the primary care team is to function most effectively in the patient's interests, it is important that members of the team have a good understanding of each other's responsibilities and constraints and have effective channels of communication. In this context, the relationship between community pharmacists and GPs is one of the most critical. This will become even more critical when pharmacists become supplementary prescribers, and eventually, independent prescribers.

Action 6.5.1: *DHSSPS will work to ensure that contractual agreements with independent contractors promote maximum collaboration to benefit patient care.*

As professional boundaries are increasingly blurred, more opportunity exists for joint education and training which in itself will contribute to

collaborative working. To this end, we wish to build on the developments in multidisciplinary training mediated through the Northern Ireland Centre for Postgraduate Pharmaceutical Education and Training (NICPPET).

Action 6.5.2: *DHSSPS will work with NICPPET and other education providers to encourage joint training programmes for pharmacists, GPs, nurses and others.*

6.6 Developing clinical pharmacy networks

Patient care may be significantly enhanced by the development of networks of hospital and community pharmacists working with other health and social care professionals e.g. in care of older people, palliative care. Such networks would be able to share expertise in such a way as to offer co-ordinated, seamless care to patients.

Spotlight on local innovation

Hospital and community pharmacists in the SHSSB have together developed a network of community pharmacies which provide an enhanced palliative care service. These pharmacies work closely with GP out-of-hours co-operatives ensuring patients have access to a full range of appropriate palliative care medicines at all times. Pharmacists and GPs in the area have undertaken additional training to support the delivery of the service. This network is now active and is regularly used by the public.

Action 6.6: *DHSSPS will support and encourage HSS Boards, Trusts and LHSCGs to build on current practice and extend the primary-secondary care clinical pharmacy network by developing further programmes of specialist care.*

6.7 Information technology issues and communication strategy

Information technology issues are fundamental to many of the proposed developments in community pharmacy, one example being the Electronic Prescribing Eligibility System outlined in paragraph 9.3. The improved communication opportunities that should result from the implementation

of the HPSS ICT strategy⁷ will need to be fully exploited. Community pharmacists need to be able to communicate electronically with professional colleagues at all levels and need to have access to electronic health records. This will include electronic links with tertiary care facilities and community care services.

Action 6.7: *DHSSPS will work with key stakeholders to encourage work to be initiated to link community pharmacists electronically to each other and to other members of the health and social care team, including medical practices and hospitals, through a secure email or internet facility.*

7. Quality improvement

7.1 Introduction

The pharmacy profession in Northern Ireland is highly regulated and recent evidence suggests a high level of public support for the quality of services already provided by pharmacists¹. Notwithstanding this, and in light of current government policy, there is a need for the profession, as with all healthcare professions, to ensure continuous quality improvement in the services it provides to the public. Pharmacy is currently regulated at three levels; the legal framework, the professional framework and the contractual framework. These three levels are not discrete but are interlinked.

7.2 The Legal framework

The legal framework within which pharmacy is practised is defined by the Medicines Act 1968 and the Misuse of Drugs Act 1971 and the Regulations stemming from these Acts. In Northern Ireland there are two Inspectors warranted under this legislation, who visit registered pharmacies to ensure compliance with the standards required under the Acts and their Regulations. The Inspectorate is concerned both with inspection and enforcement in order to ensure that safe and effective pharmacy services are available to the public.

7.3 The Professional framework

The pharmacy profession is regulated by the Pharmacy (Northern Ireland) Order 1976 and this establishes the Pharmaceutical Society of Northern Ireland (PSNI) and provides its mandate as the regulatory body for the profession. Under the Order, PSNI maintains a register of pharmacists who are permitted to practice pharmacy and take supervision of a pharmacy. It also holds a register of premises from which medicines may be sold and prescriptions dispensed.

PSNI sets out the educational requirements that must be satisfied to gain entry to the pharmaceutical register. Pharmacy students must now undertake a four-year degree course at an accredited School of Pharmacy. In Northern Ireland, PSNI undertakes this accreditation jointly with the Royal Pharmaceutical Society of GB on a five yearly basis. Students with a degree (MPharm) are required to complete a one-year period of pre-registration training under the mentorship of a tutor pharmacist.

Registered pharmacists have a professional obligation to engage in continuing professional development (CPD) activities in order to maintain their professional competency. Currently the profession is preparing to make CPD mandatory for pharmacists by 2004.

The Pharmacy Order also establishes the Statutory Committee (SC) under the chairmanship of a barrister. This committee has the right to remove the name of a pharmacist, and where appropriate a pharmacy, from the registers, where that pharmacist has been shown to be in breach of the law or the Code of Ethics or the premises is of a poor standard.

PSNI publishes a Code of Ethics with extensive guidance governing the practice of pharmacy for its members.

The Health Act 1999 brings PSNI under the remit of the Council for the Regulation of Health Professions. This body will require professions with self-regulation responsibilities, to come into line with government requirements on standards of professional practice in a modern Health Service. The Health and Personal Social Services (NI) Act 2001 provides an additional opportunity for the pharmaceutical profession in Northern Ireland to develop its regulatory framework in line with other regions of the UK.

Action 7.3: *DHSSPS will work with the PSNI to ensure the development and implementation of a professional self-regulatory framework sufficient to support a quality pharmaceutical service, including the introduction of mandatory continuing professional development for its members.*

7.4 The Contractual framework

Pharmacies, which have a dispensing contract with their respective HSS Board are permitted to dispense, on behalf of the HPSS, prescriptions issued by GPs, Dentists and suitably qualified nurses. These pharmacies are bound by a Terms of Service contract as defined in the HPSS (NI) Order 1972 and its various Regulations. Currently the terms of service relate mainly to the dispensing of HPSS prescriptions with some additional services including keeping Patient Medication Records and the display of health promotion leaflets.

It is recognised that the current remuneration system for community pharmacies has created a perverse incentive by rewarding high volumes of dispensing, but not rewarding high-quality patient care services. It is now time to consider the application of alternative systems of remuneration in community pharmacy services, linked to terms of service that are quality, rather than volume based. Indeed *Best Practice – Best Care*¹⁰ indicated that the quality of services provided by independent contractors should be secured through contractual arrangements. Changes should be designed to help ensure that the emphasis in community pharmacy continues to shift from products to patients, and from working in isolation to operating more fully

as part of the primary care team. This is discussed more fully in section 9.2.

7.5 Responding to the Clinical and Social Care Governance Agenda

Within the chapter on Strategic Context, reference was made to the demands of the overall quality agenda. Community pharmacy needs to respond to these demands in terms of improving standards of safety, quality and efficacy. This is likely to mean the further development of Standard Operating Procedures (SOPs) for the delivery of the growing range of pharmaceutical services and will contribute to consistent standards of practice across the province. We would expect the HPSS and the PSNI to work closely together in order that such SOPs become a requirement of the Society's Professional Codes of Practice.

Action 7.5: *DHSSPS will work with key stakeholders in developing the clinical and social care governance framework for community pharmacy and this will include standard operating procedures for all common tasks and services.*

7.6 Medicines risk management

A pharmacist-led, dedicated "Medicines Risk Management" (MRM) initiative has been set up in secondary care in Northern Ireland, funded through the Executive

Programme Funds. The work falls into two main areas (a) the development of the risk management process, involving identification, analysis, evaluation and implementation of measures to reduce medicine-related risks, and (b) the development of good practice policies. So far, relatively little attention has been paid to medication errors in primary care, although this is the area where most medicines are prescribed, dispensed and used. There is an urgent need for the development of a formal medicines risk management system in the primary care setting, analogous to that which has been set up in secondary care. Such a system would involve community pharmacists in the processes of monitoring and reporting incidents but would almost certainly need additional staffing resources to facilitate and co-ordinate the overall scheme.

Action 7.6: *DHSSPS will work with key stakeholders to develop and implement a Medicines Risk Management initiative to extend the MRM process in primary care and to ensure dissemination of best practice.*

7.7 Rewards for high quality service

It has been demonstrated in other regions that rewarding the successful attainment of a high standard of practice, encourages pharmacists to improve the quality of their services and/or premises³⁰. This will be

formalised locally through the award of Charter Marks for services developed with, and valued by, the public.

This may include an accreditation scheme for specific patient-care services e.g. care for people with diabetes, asthma, skin disorders or for specific additional activities e.g. health promotion. Accreditation will indicate that the pharmacist had undertaken additional training in the topic and has the required facilities on site to provide a specialist level of service to the public.

Action 7.7: *DHSSPS will work with key stakeholders to investigate the feasibility of a system of Charter Marks for high standards of practice. This will include appropriate studies to find out which aspects of services or activities are most valued by the public.*

7.8 Education and training

The need for mandatory CPD has already been mentioned at 7.3. Under Article 44 of the Health and Personal Social Services (Northern Ireland) Order 1972, the DHSSPS has authority to provide training for pharmacists providing or intending to provide their services in the HPSS. The Department has exercised its authority by entering into a formal agreement with The Queen's University of Belfast for the provision of post-graduate pharmaceutical

education and training delivered through NICPPET at the School of Pharmacy. The terms of agreement with the University specify that the Chief Pharmaceutical Officer, DHSSPS will commission an annual programme of postgraduate education and training to be provided by the Centre.

The work of NICPPET is recognised by the Department as being a crucial element in providing CPD opportunities for pharmacists to underpin their pharmaceutical care and medicines' management services. During 2001/02 over 800 hours of continuing education opportunity were provided by NICPPET through its direct and distance learning programmes.

This Strategy has identified a number of areas in which community pharmacists will need additional training and the Department will look to the Centre as a key provider for this requirement.

Action 7.8: *Through the Commission for Pharmacy Postgraduate Education and Training, DHSSPS will enable NICPPET to continue to provide for the ongoing training and development needs relative to the provision of HPSS pharmaceutical services.*

7.9 Research and development

The widespread acknowledgement of the

value of evidence-based practice underlines the importance of Research and Development (R&D) in underpinning service developments in healthcare.

Following a request from the Northern Ireland Research and Development Office in 1997, a Working Group was established with the remit, "To prepare a Business Plan for Pharmacy Practice Research allied to the pharmaceutical and associated dimensions of the delivery and development of HPSS services". A five-year business plan was produced in response.

The Working Group identified Pharmacy Practice Research (PPR) as an integral part of the HPSS agenda. In this respect it recognised the considerable strength of pharmacy derived from its fundamental scientific base, the application of that science to therapeutic settings, as well as the historical contribution of pharmaceutical research to health service development. Critical to the PPR Business Plan were the issues of infrastructure, personal development, research priorities, multidisciplinary collaboration, dissemination, resource allocation, research partnerships and cultural change.

In its response to this business plan, the R&D Office has acknowledged the importance of high quality pharmacy

practice research and the need for seed funding to boost the research enterprise in NI. To this end they have recruited a pharmacy practice research and development co-ordinator and are reviewing the infrastructural support required for successful practice research studies.

In order to launch a successful practice research network in community pharmacy, some additional resources will be needed. One route would be the establishment of Research Fellowships in community pharmacy practice. Such a scheme could provide the additional flexibility required to have a researcher intimately involved with the day-to-day practice of community pharmacy without compromising the viability of the business.

Action 7.9: *DHSSPS will continue to work with the Research and Development Office to encourage primary care pharmacy practice research, in particular by recommending the identification of a number of designated community pharmacy research sites adequately resourced to support the research enterprise.*

7.10 Improving community pharmacy premises

Among the priorities for the HPSS is a commitment for modern health facilities in

local communities. In order to support the extended professional role of the pharmacist, improvements in community pharmacy premises will be encouraged. This will allow greater privacy for patients in community pharmacies by increasing consultation areas, as well as providing models of how community pharmacies might look in the future.

Raising the profile of community pharmacy will mean addressing the concerns of people who cannot access pharmacy services because of mobility problems or

other disabilities. Pharmacists, along with other healthcare professionals, should be encouraged to ensure that all premises have better access for people with disabilities, in line with the Disability Discrimination Act 1995.

Action 7.10: *DHSSPS will help support improvements in pharmacy premises to ensure a high standard of care provision, within a professional environment.*

8. Improving access and communication

8.1 Introduction

The DHSSPS Corporate Plan 2002/03 – 2004/05, outlines the specific objective to *'Promote social inclusion and ensure greater equity of access to health and social services'*. It is therefore incumbent upon the Department to seek more equitable access to services including the full range of pharmaceutical services. As many of the issues are around access and communication, suggested actions will have to be taken forward in conjunction with work advocated under the following chapter which outlines new structures and systems.

8.2 Access to pharmaceutical services

Access to pharmacies by the general population in Northern Ireland is excellent. The current distribution is one pharmacy to three thousand people, a ratio only surpassed by France in the European Union.

However, there has been some anecdotal evidence to suggest that under the current regulatory framework there is variability of access to some types of pharmaceutical services. In addition, the Department has carried out some preliminary work, which has identified the need to consider improving access to pharmaceutical services in specific communities.

Pharmaceutical services have been extending beyond the traditional roles. With such changes, the pharmacy profession has responded with imagination and dynamism to embrace new ways of working. However, within such a rapidly evolving field, there has been variation in the provision of new and extended services. The placement of pharmacies in response to need is critical to the further development of community pharmacy services, because it will be impossible to realise fully the benefits of extended services and improved quality without first improving access to the services.

Action 8.2: *DHSSPS will work with HSS Boards and other stakeholders to develop ways to ensure equitable access to the full range of pharmaceutical services.*

8.3 Extended opening hours

Access to dispensing services is generally good, however, the current system does not deliver full access in the evenings, at weekends or on public holidays that is uniformly as good as patients want. Furthermore, some people may have difficulty in finding out how to get a prescription dispensed urgently outside normal hours.

To improve out-of-hours access to community pharmacy services, the NHSSB,

in 2000, introduced a community pharmacist on-call service, to provide 24-hour emergency cover throughout the Northern Board area. However, this service, for a number of valid reasons, was not used sufficiently by the local population to warrant ongoing funding and was withdrawn in 2001. Late opening (e.g. until 10.00 pm) may provide a service that is better matched to the community's needs.

In the Southern Health and Social Services Board, a pilot project is underway to evaluate innovative ways of providing pharmaceutical services outside of normal business hours. The pilot project involves community pharmacists working collaboratively in out of hours Co-op centres. This could provide a useful model for future service development. In addition, the issue of out of hours provision needs to be considered in the light of possible changes to the General Medical Services contract.

Action 8.3: *DHSSPS will ask HSS Boards, Trusts and LHSCGs to undertake further work to determine the public's needs and expectations for out-of-hours pharmacy services and to propose ways in which these might be met.*

8.4 Community pharmacy outreach services

In order to provide effective patient-centred care, clinical community pharmacy services need to be delivered directly to patients who are often outside the pharmacy environment. This may involve visiting patients at home, in residential or nursing homes or in other community-based settings (e.g. care homes, homeless shelters, schools). This is further discussed in section 4.5.

Action 8.4: *DHSSPS will encourage HSS Boards, Trusts and LHSCGs to build on the evidence provided by the Building the Community-Pharmacy Partnership Initiative to consider pharmacy outreach schemes as an option in their development of community based services.*

8.5 Specialist community pharmacy clinics

Effective monitoring helps to control long-term chronic conditions and pharmacists can provide the link between treatment and monitoring. In other parts of the UK, it is now becoming common for pharmacists to run clinics for anticoagulant therapy, asthma, diabetes and coronary heart disease^{15,16}. This means that patients with poor symptom control or inappropriate therapy can be identified and appropriate action taken as early as possible. As a

result, dosages of medicines can be adjusted within agreed limits without patients having to visit their GP. This would complement the developments in supplementary prescribing.

Action 8.5: *DHSSPS will encourage HSS Boards, Trusts and LHSCGs to work with key stakeholders locally to develop evidence-based specialist clinics in community pharmacies, handle on-going monitoring and treatment of specific conditions, complementing other services provided locally.*

8.6 Referral systems in primary care

Community pharmacists are often the first point of contact a person has with the Health Service. One key function of pharmacists could be to act as an information resource to direct people to

the appropriate service provider in their locality. This may take the form of a referral to their GP or other health care professional on presentation of symptoms, or alternatively, a referral to a community support or advisory service. There would be advantages in a formal referral system. Depending on the situation, this may involve a formal referral letter detailing the reasons for referral, a formal electronic communication or simply making an appointment for the person. This augments the previous action (5.2.2) which focuses specifically on medication review.

Action 8.6: *DHSSPS will ask HSS Boards, Trusts and LHSCGs to develop community pharmacies as a local signposting resource to direct people to a range of care providers, including community support and complementary therapy options.*

9. New structures and systems

9.1 Introduction

A number of new structures and systems will be needed to support the developments proposed in chapters 4-8. These will hinge around the implementation of new technology and the development of new job profiles and career structures for pharmacists and for pharmacy support staff. Central to much of this is the new pharmacy contract. Regardless of the timetable for the new contract, this Strategy identifies a number of critical areas in which a new approach will be required to enable the services and activities described in earlier chapters to develop fully.

9.2 Remuneration and Regulation

Reference has already been made to the emphasis on volume in the current contract as opposed to quality and the need to develop a remuneration system that shifts the focus from product to patient. Many pharmacies already offer services in excess of the minimum required, or invest in improving the quality of what they can offer patients. Under the current system, this investment is not always recognised, where it does not lead to additional dispensing volume. Indeed, in some cases the professionalism of pharmacists may even lead to a loss of business, where they identify and act on unnecessary prescriptions.

Alongside the need to ensure that pharmacy services are quality driven, there will also be a need to work with the profession to ensure that people have the right access to pharmaceutical services. The current regulatory system for granting a community pharmacy Health Service contract was introduced in 1987. This system has ensured that there is a stable network of community pharmacies to provide services to our population. A recent Office of Fair Trading Report recommended deregulation of this system across the UK. However, Minister, having considered the matter concluded that *“simple and complete deregulation, as set out in the OFT report, is not a realistic option and is not, therefore, the way forward for Northern Ireland.”* However, he also made clear that in negotiating a new contract there needed to be consideration of how the existing regulatory arrangements could be improved to take account of changing health policies.

Action 9.2: *DHSSPS will work with the Pharmaceutical Contractors Committee and other stakeholders to develop and implement a new contract for pharmaceutical services, which will ensure that quality is rewarded and that there is accessibility to these quality services for all our population. In so doing, consideration will be given to improvements to the present regulatory system for pharmacies.*

9.3 Electronic prescribing and IT

Northern Ireland has embarked, through an “Invest to Save” initiative, on setting up an Electronic Prescription and Eligibility System (EPES) pilot project involving an integrated primary and secondary care IT network where each patient has a unique identification number. This project serves to emphasise the importance of a good IT infrastructure and electronic links between all members of the health care team. Such a system will have a huge impact on the work of community pharmacists and patient care and will facilitate the development of many of the proposals discussed in this report.

Action 9.3: *DHSSPS will continue to work with key stakeholders to progress the EPES project.*

9.4 Automated dispensing

Automated dispensing has been developed over recent years as a means to augment accurate, responsive and safe dispensing systems. The full benefits are realised when it is combined with electronic prescribing. Automated and semi-automated systems are now used in a number of other European countries (e.g. Sweden, The Netherlands) and experience from these sites shows that the automated systems liberate time for pharmacists to spend on patient-focused activities. In addition, automated dispensing systems improve inventory control and space

utilisation in the dispensary. If community pharmacists are to develop fully their roles as members of the primary care team then it will be essential to have systems that ensure that dispensing of medicines is fast, accurate and safe and does not take up a disproportionate amount of pharmacists’ time.

Action 9.4: *DHSSPS will encourage HSS Boards and Trusts to pilot the use of an automated dispensing system to determine the impact on pharmacist time, provision of additional services and economic viability.*

9.5 Workforce Issues

A suitably qualified, skilled, competent and sufficient workforce is the cornerstone of the sustained delivery of effective, high quality pharmaceutical services. The Department is committed to making the best use of the skills and expertise of the people who work in and for the HPSS. This strategy recognises a number of critical workforce issues.

The DHSSPS will work with the profession, the School of Pharmacy and Colleges of Further Education to ensure that there are sufficient registered pharmacists and qualified technicians for the needs of the HPSS. This will include reviewing the skill mix requirements in hospital and community pharmacy and examining how to utilise fully the skills of pharmacy technicians, dispensers and assistants.

Action 9.5.1: *DHSSPS will continue to work with the Profession, the School of Pharmacy and Colleges of Further Education to ensure that there are sufficient registered pharmacists and qualified pharmacy technicians for the needs of the HPSS.*

Role of employee pharmacists

With the increasing numbers of pharmacies owned by multiples, employee pharmacists now form the majority of the community pharmacy workforce. This is obviously a vital group of pharmacists as it is this group, in the main, which is responsible for delivering community pharmacy services on the ground and, in particular, for delivering extended services. It is essential that employee pharmacists are valued and are recognised as occupying an important position and having a valuable contribution to make within a modern community pharmacy service.

Action 9.5.2: *DHSSPS will encourage HSS Boards and LHSCGs to develop mechanisms to reward pharmacists/community pharmacy businesses for the activities that the community needs or values most. This should include the creation of an incentive for employee pharmacists involved in service delivery.*

Second pharmacists

The range and complexity of the tasks envisaged for the community pharmacist as a member of the primary health care team are such that it is unlikely that a single-handed pharmacist could perform them all satisfactorily. One of the key benefits of the community pharmacy service is the fact that a pharmacist is available without an appointment at any time (during opening hours). In the further development of community pharmacy services, it will be important that this feature is not lost as additional services are developed. It will be important for community pharmacies to have an appropriate skill mix and number of pharmacists in order to be able to offer services of the required standard. In some cases this may require the appointment of a second pharmacist. It may also be possible for groups of community pharmacies to work together in order to recruit, share and deploy additional staff resources. In this respect the profession is encouraged to explore innovative ways of collaborative working.

Role of pharmacy support staff

As demands for pharmacists' clinical expertise increase and as automation and technology are developed to help with the dispensing function, it will be important to ensure an appropriate skill mix.

This means giving proper consideration to the roles of pharmacists, pharmacy technicians and other pharmacy support staff and using their skills in the best possible way. In recent years some pharmacy technicians in hospital have been given the training and authority to check dispensed items (although the process remains the responsibility of the pharmacist in charge). A similar process could operate in community pharmacy and would liberate pharmacist time for patients care activities. Pharmacy technicians in community pharmacies may require some additional training in order to take on this role.

Action 9.5.3: *DHSSPS will encourage community pharmacists to delegate routine tasks to suitably-trained pharmacy technicians.*

9.6 Membership of LHSCG Boards

Community pharmacists have seats on the boards of the recently constituted LHSCGs. This provides an excellent platform from which to fully integrate community pharmacy into the primary health and social care team and to explain how effective community pharmacy services can help LHSCGs to meet their goals.

Action 9.6: *DHSSPS will ask HSS Boards to prepare a resource pack of briefing material for community pharmacist members of LHSCGs. The pack should contain information about the scope and effectiveness of community pharmacy services to demonstrate how and where community pharmacy can contribute best as part of the primary health and social care team and local community.*

9.7 Pharmacy Locality Groups

Community pharmacists located within the boundaries of each LHSCGs have, over the last two years, come together to form Pharmacy Locality Groups. The emergence of such groups is a good example of collaborative working within the profession and has contributed to the infrastructure supporting the work of the new LHSCGs.

Since being established, locality groups have demonstrated many examples of successful joint working. A number have been funded through the *Building the Community-Pharmacy Partnership* initiative to undertake an assessment of local community need and to develop networks with other key agencies in the area. For many pharmacists, working within locality groups is a challenging and rewarding experience. It embraces a new way of working, shifting the emphasis from

competition to collaboration in order to improve health and social care provision in the local area. This is a welcome development and one to be encouraged to support the local commissioning of health and social care services.

Action 9.7: *DHSSPS will work with HSS Boards to determine a possible model for formal recognition of Pharmacy Locality Groups, taking account of existing representative and advisory structures.*

10. Conclusion

Primary care services closely affect the whole population. In the DHSSPS consultation document Building the Way Forward in Primary Care³¹, it is advocated that ensuring the right structures are in place and the right policies are pursued are central to achieving the Executive's strategic priorities.

This paper sets out proposals for new arrangements in the provision of community pharmacy services and is

intended to set a clear direction for the development of policies and structures over the medium term. The overall aim is to improve the quality of services for people. The Department wishes all those with an interest in such matters to be given the opportunity to contribute to the development of policy in this important area. It will welcome comments on the issues raised in this paper and is committed to ensuring that all such comments be carefully considered before final policy decisions are taken.

Annex 1 Summary of Action Points

Number

Action

4.2.1

A "Health Promoting Pharmacy" accreditation scheme will be developed. HSS Boards will be asked to begin to establish a "Health Promoting Pharmacies Network".

4.2.2

HSS Boards, Trusts and the Health Promotion Agency for Northern Ireland, will be asked to ensure that future health promotion campaigns involve community pharmacies in a systematic, co-ordinated and innovative way to ensure that a consistent health message is given.

4.2.3

DHSSPS will facilitate the development of a regional evidence-based model for pharmacy-based smoking cessation services. All HSS Boards, Trusts and LHSCGs will be encouraged to adopt this as the pharmacy-based model.

4.2.4

Work will be undertaken with key stakeholders to consider appropriate models to consolidate and extend the role of community pharmacists/community pharmacy in immunisation campaigns.

Number	Action
4.2.5	Further steps will be taken, in partnership with community drug and alcohol teams, to build on the success of needle exchange schemes to offer a wider range of drug misuse services.
4.2.6	HSS Boards and Trusts will be encouraged to include a referral system to pharmacists for medication review as an integral part of future falls prevention initiatives.
4.3.	Work will be undertaken in collaboration with other appropriate agencies to map out a model for health surveillance through community pharmacies.
4.4	HSS Boards, Trusts and LHSCGs will be encouraged to develop evidence-based community pharmacist-managed DUMP campaigns to reduce the risk associated with medicines wastage in local communities.
4.5.1	Reports of the BCPP initiative will be collated in a single document and disseminated to LHSCGs, HSS Boards and Trusts, community pharmacists, and the community and voluntary sector as an example of good practice, to inform future commissioning and delivery of health and social care services.
4.5.2	Following a full evaluation of the initiative, DHSSPS will work with key stakeholders to establish a suitable template identifying key criteria and quality standards for the future delivery of such initiatives and will undertake further work to identify a suitable method for mainstreaming the effective models.
4.5.3	DHSSPS will work with all key stakeholders to develop an assessment tool for determining the public health needs of local populations that can be met through community pharmacies .
5.2.1	DHSSPS will work with key stakeholders to extend and consolidate the existing Managing your Medicines scheme.

Number	Action
5.2.2	DHSSPS will work with key stakeholders to facilitate the development of a referral scheme to formalise patient referral from care providers to the community pharmacist for medicines management services.
5.2.3	A regional pharmacist facilitator will be appointed to oversee and co-ordinate the service ("Managing your Medicines" Scheme) throughout NI.
5.3.1	HSS Boards, Trusts and LHSCGs will be asked to work with care home providers to encourage pharmacist-managed medication review.
5.3.2	DHSSPS will work with HSS Boards to build on existing good practice by developing an appropriate model through which community pharmacists may provide prescribing support to GPs, nurse prescribers and other practitioners.
5.4	DHSSPS will undertake to work with HSS Boards, Trusts and other key agencies to increase the support provided to carers to encourage the safe, effective administration and use of medicines.
5.5	DHSSPS will work with key stakeholders to commence the managed roll-out of repeat dispensing.
5.6	DHSSPS will work with key stakeholders to develop and implement an evidence-based system to permit pharmacist supply on the HS for an agreed range of medicines used to treat common ailments.
5.7	DHSSPS will work with key stakeholders to implement a phased introduction of supplementary prescribing in pharmacy practice.
5.8	DHSSPS will work with key stakeholders to establish how the existing community pharmacy Patient Medication Records can be developed in preparation for a shared electronic health record to allow the routine recording of additional information, particularly clinical pharmacy interventions.

Number**Action**

6.2

DHSSPS will work with HSS Boards and Trusts to encourage the introduction of an integrated, standardised medicines management framework for admission and discharge policies between primary, secondary, tertiary and community care, involving liaison between hospital and community pharmacists.

6.3

DHSSPS will work with key stakeholders to highlight the benefits of harmonisation of product supply and encourage the implementation of such schemes more widely.

6.4

DHSSPS will work with HSS Boards and Trusts to ensure future shared care arrangements for specialist drugs explicitly involve the community pharmacist. In addition, joint training of GPs, community pharmacists and others as appropriate, will be offered in relation to specialist medicines use.

6.5.1

DHSSPS will work to ensure that contractual agreements with independent contractors promote maximum collaboration to benefit patient care.

6.5.2

DHSSPS will work with NICPPET and other education providers to encourage joint training programmes for pharmacists, GPs, nurses and others.

6.6

DHSSPS will support and encourage HSS Boards, Trusts and LHSCGs to build on current practice and extend the primary-secondary care clinical pharmacy network by developing further programmes of specialist care.

6.7

DHSSPS will work with key stakeholders to encourage work to be initiated to link community pharmacists electronically to each other and to other members of the health and social care team, including medical practices and hospitals, through a secure email or internet facility.

Number	Action
7.3	DHSSPS will work with the PSNI to ensure the development and implementation of a professional self-regulatory framework sufficient to support a quality pharmaceutical service, including the introduction of mandatory continuing professional development for its members.
7.5.	DHSSPS will work with key stakeholders in developing the clinical governance framework for community pharmacy and this will include standard operating procedures for all common tasks and services
7.6	DHSSPS will work with key stakeholders to develop and implement a Medicines Risk Management initiative to extend the MRM process in primary care and to ensure dissemination of best practice.
7.7	DHSSPS will work with key stakeholders to investigate the feasibility of a system of Charter Marks for high standards of practice. This will include appropriate studies to find out which services or activities are most valued by the public .
7.8	Through the Commission for Pharmacy Postgraduate Education and Training, DHSSPS will enable NICPPET to continue to provide for the ongoing training and development needs relative to the provision of HPSS pharmaceutical services.
7.9	DHSSPS will continue to work with the Research and Development Office to encourage primary care pharmacy practice research, in particular by recommending the identification of a number of designated community pharmacy research sites adequately resourced to support the research enterprise.
7.10	DHSSPS will help support improvements in pharmacy premises to ensure a high standard of care provision, within a professional environment.

Number	Action
8.2	DHSSPS will work with HSS Boards and other stakeholders to develop ways to ensure equitable access to the full range of pharmaceutical services.
8.3	DHSSPS will ask HSS Boards, Trusts and LHSCGs to undertake further work to determine the public's needs and expectations for out-of-hours pharmacy services and to propose ways in which these might be met.
8.4	DHSSPS will encourage HSS Boards, Trusts and LHSCGs to build on the evidence provided by the Building the Community-Pharmacy Partnership Initiative to consider pharmacy outreach schemes as an option in their development of community based services.
8.5	DHSSPS will encourage HSS Boards, Trusts and LHSCGs to work with key stakeholders locally to develop evidence based specialist clinics in community pharmacies, handle on-going monitoring and treatment of specific conditions, complementing other services provided locally.
8.6	DHSSPS will ask HSS Boards, Trusts and LHSCGs to develop community pharmacies as a local signposting resource to direct people to a range of care providers, including community support and complementary therapy options.
9.2.	DHSSPS will work with the Pharmaceutical Contractors Committee and other stakeholders to develop and implement a new contract for pharmaceutical services, which will ensure that quality is rewarded and that there is accessibility to these quality services for all our population. In so doing, consideration will be given to improvements to the present regulatory system for pharmacies.
9.3	DHSSPS will continue to work with key stakeholders to progress the EPES project.

Number	Action
9.4	DHSSPS will encourage HSS Boards and Trusts to pilot the use of an automated dispensing system to determine the impact on pharmacist time, provision of additional services and economic viability.
9.5.1	DHSSPS will continue to work with the Profession, the School of Pharmacy and Colleges of Further Education to ensure that there are sufficient registered pharmacists and qualified pharmacy technicians for the needs of the Health Service.
9.5.2	DHSSPS will encourage HSS Boards and LHSCGs to develop mechanisms to reward pharmacists/community pharmacy businesses for the activities that the community needs or values most. This should include the creation of an incentive for employee pharmacists involved in service delivery.
9.5.3	DHSSPS will encourage community pharmacists to delegate routine tasks to suitably-trained pharmacy technicians.
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9.7	DHSSPS will work with HSS Boards to determine a possible model for formal recognition of Pharmacy Locality Groups, taking account of existing representative and advisory structures.

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Notes

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