The changing shape and role of pharmacy

-consolidation of expertise and resources

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Throughout the history of healthcare, from what one known as compounders to the modern-day pharmacists, all represented a valuable link between the doctors and the patients. There was a common phrase 'Ask the pharmacists', used then and it has returned back into the community.

There are huge technological advances facilitating improvement in quality of care. The NHS with its significant transformation would inevitably bring many new challenges for the primary care, requiring additions specialised support in the GP surgeries.

The NHS England's House of Care model includes many solutions involving changes in many working practices and developing multidisciplinary team approaches. In this context the modern pharmacists would need to be placed in a position for their proactive engagement to be more effective interfaces between specialist providers and the wider primary and community care teams.

A glance at the past development

The origin of access to many drugs goes back to many years when the European countries, including Briton developed apothecaries derived from Peppers, and other Spices. The traders of spices brought crude drugs and prepared medicines and sold to Grocers or Apothecaries. It evolved into a distinct occupational group in the thirteenth century. These practices were allowed under the law of Guild of Grocers until 1617 when the Society of Apothecaries was formed[1].

These apothecaries were both physicians and pharmacists, diagnosing and dispensing the medicines. Later by 1815 a new group had emerged and expanding to act as chemists and druggists to become manufacturers and packaging for the wholesale market. The Apothecaries Act of 1815 confirmed apothecaries as general practitioners and leaving others to retail selling and supply of medicines[1].

The modern pharmacy has its roots began with the foundation of the Pharmaceutical Society of Great Britain in 1841. Its membership jumped from 800 in 1841 to 2000 in 1842. By 1868, when it was made illegal for anyone to sell or dispensing or compounding medicines, or to use the title chemist and druggist or pharmacist, or dispensing chemist, unless formally registered to do so. Today in 2020, there are estimated 42,990 registered pharmacists and 19,311 registered pharmacy technicians in England.[2]

The word 'compounder' was well known in the colonial Britain. They were processing drug by mixing or altering ingredients to create a medication tailored to the needs of an individual patient. In other words, they were basically pharmacist but not allows to prescribe medication. This was done by the doctors. This relationship between the doctor, pharmacist and the patient were strengthened by 1880 when the House of Lords ruled that companies could not only use restricted titles but could sell poisons provided it were sold by a qualified person, confirming the pivotal role of pharmacist in the process.

In a landmark court decision in October 1920 the Court imposed restrictions that the Society did not have powers to regulate wage, hours of business, and the prices at which goods were sold, or to provide insurance or legal services.
By 1946, 24 million workers were covered by National Insurance. In July 1948 the National Health Service made the service available to everyone, raising the prescription numbers from 70 million in 1947 to 250 million in 1949. The counter sales started to had decline rapidly and more dispensing assistants were recruited. During 1950s and 60s, the numbers new drugs came into the market with the increase of tablets and capsules, the extemporaneous dispensing decreased. Prescriptions alone generated almost half of the income of the pharmacist.

In the early 1980s a new role for hospital and industrial pharmacists emerged. The community pharmacies reinvented itself with initiatives such as the National Pharmaceutical Association's 'Ask Your Pharmacist' Campaign.

The Nuffield Report in 2014 pointed towards the change for community pharmacy to shift away from dispensing and supply, and towards pharmacists as care-provers. It noted, "We believe that the pharmacy profession has a distinctive and indispensable contribution to make to health care that is capable of still further development'.

Pressures on the GP surgeries

There are demographic changes and more complex health needs, placing more demands in the primary care sector. It is also worrying that the number of GPs relative to the size of the population has been notably fallen since the 1960s.[3]

The North West London and the East of England would have lowest total number of GPs per 100,000 people. Also, lesser numbers of previously trained are likely to join the NHS.

The inconsistency in the immigration policy has nurtured a shortfall in recruiting enough from abroad. In recent years, more GPs have also sought early retirement, adding more pressure on the NHS.

The Royal Pharmaceutical Society (RPS) believes that primary care patients should have the benefit of a pharmacist's clinical expertise in the GP surgeries, like that is experienced by patients in hospital.
The Nuffield report (2015) suggested that 3.6 per cent of patients, most of them older and frail, took up more than a third of the bed capacity in England's hospitals in 2014. Most having competed their treatment could be discharged back into the community. However, due to shortages in arrangements in providing homes care or a placement in any care homes, many have no choice but to be remain in the hospital. The policy of unblocking beds occupancy, understandably, has become a necessity to prioritise urgent cases and to facilitate emergency admissions.

It falls upon the GPs to pickup the treads of care for those discharged from the hospital care, leaving the surgeries overwhelmed, originating from patient requests and prescribing and other follow up recommendations from other health professionals. It is important to bear the factors that and inappropriate polypharmacy in frail elderly people can be problematic. The face-to-face consultation time constraints and the demands on the GPs means that quality of care can be compromised.

It would be prudent to have practice pharmacist as a part of the team in the GP surgeries as part of processing the patient's clinical record with the appropriate medication.

This can also help reducing communication gaps and easy access to expert advice for patients making the system more user friendly. This can support patients by helping them in relation to any self-limiting minor ailment consultations and provide guidance to get the most from their medicines.

There have been previous calls by the Royal Pharmaceutical Society (RPS) and General Medical Council to have greater involvement of a pharmacist in medical practices.[4] However, in March 2015, both of these institutions accepted 'radical proposals' which were aimed at encouraging the pharmacists working in GP practices all over the country.

Prescribing pharmacists and access to medical record

The NHS Summary Care Record (SCR) is an electronic summary of key clinical information. Now this is being integrated to create central patient record systems for use by all healthcare professionals, but the focus is now on ensuring inter-operability between individual health record systems and across boundaries.

This is one of the significant changes in the primary care is the access to medical records of patients in the pharmacists in the community pharmacy setups. This would also be a game changer for the primary care where the community pharmacist resource was rather seen as stand-alone entity, but now using the NHS reference number, access to the medical record enables the 'prescribing pharmacist' to review medication or offer advice.

Savings on prescriptions:

Medicines are recognised as the single biggest intervention for the prevention and treatment of ill health. It costs the NHS approximately £14.4 billion (2013–2014). The World Health Organization estimated, the adherence among patients with chronic diseases averages only 50%. The cost of non-adherence has been reported to be over £300 million with a potential to save £500million in the UK.[2] One of the key roles for the clinical pharmacist independent prescriber would add value for medication reviews, moving the management of patients with multiple long-term conditions away from the doctors. There are other areas such as the blood tests, adjustment of therapies and issues relating to pain controls for acute sufferers, to ensure no one falls through the cracks in the service that should be a patient centric process.

Quality control

The Pharmacists can deliver safe, high quality, effective and efficient care to patients. Most physicians are familiar with consequences of errors in prescribing medicine. The PRACtICe study[5] has indicated the overall prevalence of prescribing and monitoring errors in general practice at 5%, coupled with the large numbers of unscheduled admissions caused by medicines, about 7%. The PINCER study evidenced the cost effectiveness and the value of the pharmacist.

An added benefit would be that the practice pharmacist could help in managing good practice guidance issued from the National Institute for Health and Care Excellence, and the Medicines and Healthcare Products Regulatory Agency.

The pharmacist independent prescriber role would also provide scope for medication review clinics, moving the management of patients with multiple long-term conditions away from the doctors, while providing effective support for patients.

As the technology is advances, the future pharmacists with specific training would provide expertise in the optimal use of medicines in multi-morbidity. The Centre for Workforce Development has predicted likelihood of having surplus of over 19,000 pharmacists in the UK. By 2040. Thus, deploying the skilled pooled of professional would a part of the solution. They could ideally complement the role of GPs and practice nurses and adding value to the range of knowledge available in GP surgeries to manage increasingly complex care. At least, their presence would help improve care across the interfaces between specialist providers and the wider primary and community care teams.

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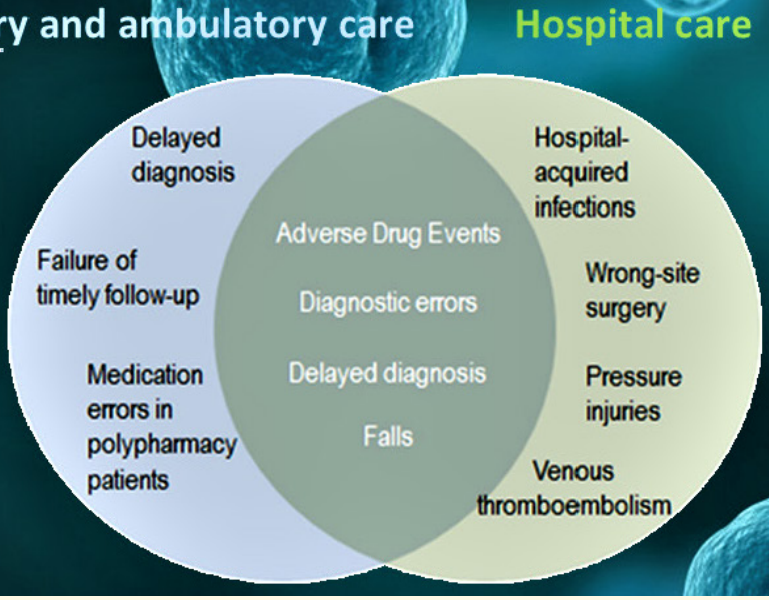
5. The need for good prescribing practice is well documented by the PRACtICe study.

Improve patient safety by eliminating adverse events in health care settings

It is estimated that every year more than 300,000 patients acquire a healthcare associated infection (HCAI, HAI or nosocominal infection)as a result of care with in the NHS.



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