

Pharmacy Practice Research Strategy

2007 - 2011

1 Background

- 1.1 Projects under the commissioned research programme under the 2002-2006 Research Strategy focussed on three key areas of workforce, education and ethics.

2 Progress and the 2002-2006 programmes

- 2.1 Commissioning under the 2002-2006 Strategy was completed by the Trustees in 2006 with the award of the final project – ‘*A national evaluation of the implementation of the new contractual framework for community pharmacy*’. Currently two projects are still ongoing; the 2006 graduate cohort study (due to complete in 2009) and the third ethics PhD (funded jointly with the AHRC)¹
- 2.2 The projects funded are summarised in Figure 1 and results have been used to inform, for example, the development of the revised RPSGB's Code of Ethics, reviews of the new contractual framework by Primary Care Organisations, regulatory impact assessments and an education policy review (Fit for the Future).
- 2.3 Projects commissioned under the 2002-2006 strategy, summarised below, were delivered on budget and on time - all reports have been delivered and peer reviewed, all have been published.

¹ Arts and Humanities Research Council

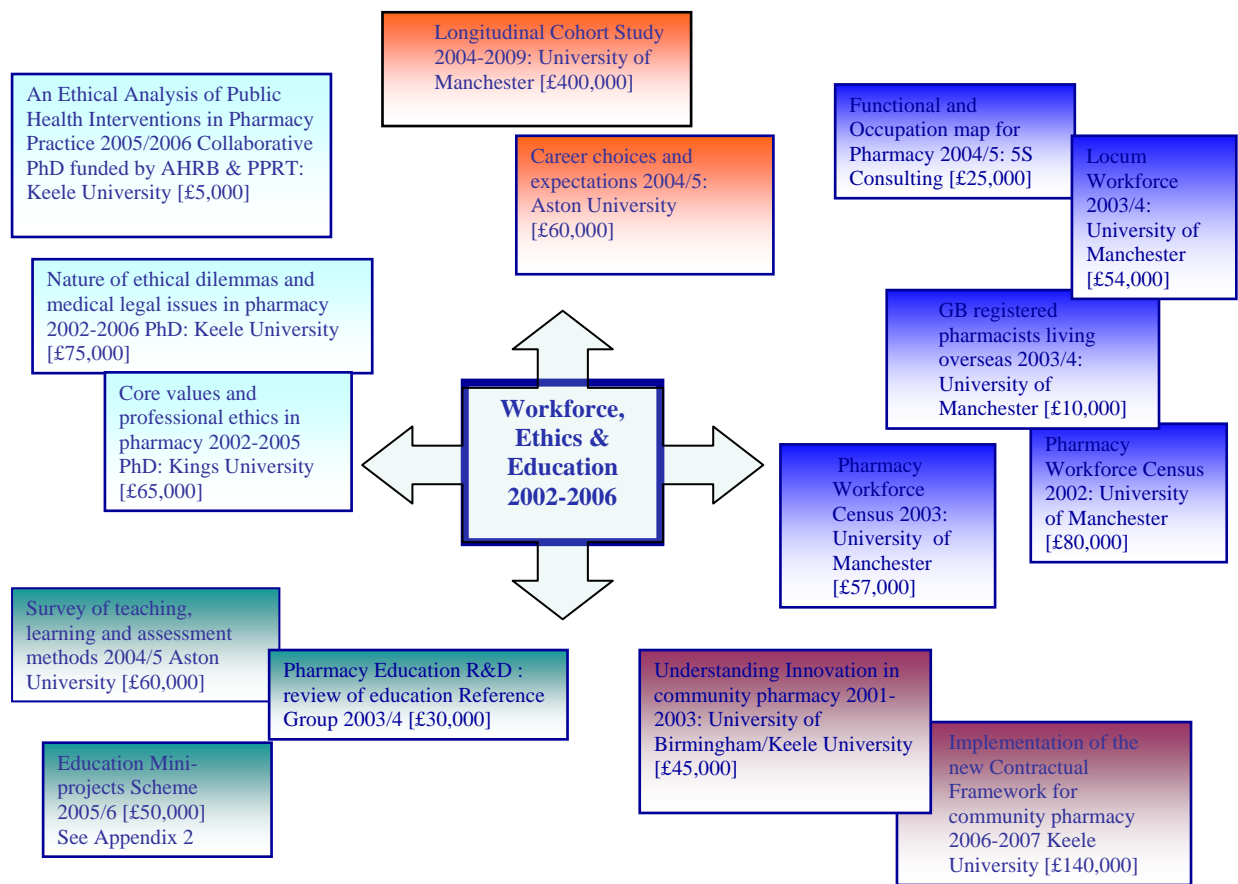


Figure 1.

3. The 2007 – 2011 research strategy & policy context

3.1 Since the 2002-2006 Strategy, many key policy documents, White Papers, inquiry reports and indeed pieces of legislation have been published. The 2007-2011 Strategy is heavily influenced by these changes in both policy and practice initiatives and by the outputs from published results from earlier supported research. In the interests of brevity the following summary references key Department of Health policy papers (it is recognised that there are equivalent policies in Scotland and Wales).

Overall, health policy² is aiming, over the next ten years, to make measurable progress in:

- promoting independence and well-being of individuals through better community health and social care and greater integration between local health and social care organisations;
- developing capacity through a wider range of service providers to secure value for money and improved access to community health and social care services;
- changing the way the whole system works by giving the public greater control over their local services and shifting health services from acute hospitals into local communities.

3.2 Health policy and medicines

In relation to medicines specifically, the focus of policy is likely to continue to be developing medicines management^{3,4} – defined by the Department of Health as including:

“the clinical, cost-effective and safe use of medicines to ensure that patients get the maximum benefit from the medicines they need, while at the same time minimising potential harm.”

It is expected that its policy relating to medicines management will be underpinned by the following values:

- Involving patients as partners in decisions about their medicines, supporting them to take their medicines effectively and enabling them to ask about their medicines.
- Promoting choice for patients in decisions about treatment, when and where treatment takes place, and the level of self-management of their condition.
- Recognising the role of families and carers in medicines management.

² Department of Health (2006). *Our health, our care, our say: a new direction for community services*.

³ Management of medicines: a resource to support implementation of wider aspects of medicines management in the NSF's for diabetes, renal services and long term conditions.

⁴ Similarly, in Scotland, Development of Pharmaceutical care – The Right Medicine. Pharmaceutical Care in Scotland, 2002.

- Encouraging partnership working between patients, professionals, managers and industry to improve the use of medicines.
- Encouraging different professionals to provide support to patients about their medicines and promoting lifestyle changes to achieve the best health outcomes.
- Recognising that medicines are only one component of treatment and care within the overall management of people with long-term conditions.
- Encouraging innovation in medicines management.
- Ensuring equity of access to medicines.
- Improving access to medicines information for patients, carers and families.

Given the size of the NHS prescribing budget (in 2004 it is estimated that the NHS spent £10.7 billion on NHS medicines⁵) and the investment made by the public in non-prescription medicines (the public spent £2,074 million on over-the-counter medicines in the UK in 2005⁶) and, more importantly, the rate of change over the last ten years (over the past decade, the annual number of prescription items per person in the UK has risen from 9 to more than 12⁷) and the extent of medication errors (serious errors in the use of prescribed medicines account for 20% of clinical negligence claims in the NHS) it is unlikely that the direction of policy travel in relation to medicines will change in the next 5-10 years.

3.3 Health policy and pharmacy

In addition to specific health policy relating to medicines and pharmacy's key role in delivering aspects of that policy, there is a linked but broader theme emerging and that is maximising pharmacy's contribution, especially in community pharmacy, to delivering broader health and wellbeing services which link to broader public health policy in relation to, for example, smoking cessation and sexual health.^{8,9}

There has been a plethora of legislative changes and policy consultations all aimed at developing the contribution made by pharmacists, technicians and the pharmacy infrastructure to delivering the wider policy objectives in relation to medicines and public health. These include changes to legislation to allow pharmacists to become supplementary and independent prescribers¹⁰; changes to the Medicines Act to create the role of the responsible pharmacist and to clarify the functions that a pharmacist must undertake in a community

⁵ Medicines for Health: Understanding the 2005 PPRS. Industry Briefing. The Association of British Pharmaceutical Industry, 2005.

⁶ OTC Market Growth 2005, PAGB – <http://www.pagb.co.uk/information/PDFs/2005marketfigures.pdf>

⁷ Medicines for Health: Understanding the 2005 PPRS. Industry Briefing. The Association of British Pharmaceutical Industry, 2005.

⁸ The Right Medicine: Pharmaceutical Care in Scotland, 2002.

⁹ Remedies for Success – a Strategy for Pharmacy in Wales, 2002.

¹⁰ Improving patient's access to medicines: a guide to implementing nurse and pharmacists independent prescribing within the NHS in England – July 2004.

pharmacy¹¹ and developing new career opportunities for pharmacists including Pharmacists with a Special Interest (PhWSI)¹² and consultant pharmacist posts¹³. Many of these are GB wide initiatives.

Indeed, the RPSGB's s60 Order reflects these developments in the role, functions and practice of pharmacists and the wider pharmacy workforce – the draft Order gives the RPSGB regulatory powers to set up a register of pharmacy technicians and regulate this new professional group; to enforce many of the educational best practice standards and to co-ordinate standard setting and enforcement across all aspects of pharmacy education including post-registration to underpin advanced and specialist practice. It also allows the introduction of a modern set of Fitness to Practise rules. This new set of powers and regulatory duties will allow the RPSGB to effectively regulate new areas of practice and to develop a fully operationalised set of both practice and education standards for both pharmacists and technicians.¹⁴

4. Research fit for purpose in 2011

The face of the profession is changing as a result of the significant changes seen in policy in the last 5 years – aspects of practice that were identified in Pharmacy in a New Age as aspirational are now enshrined in legislation (prescribing) and areas that were leading edge practice are part of mainstream services funded by the NHS (medicines usage reviews and self-care).

The role of technicians has developed across all sectors. Building on leading edge practice in hospitals many community pharmacists now work with a team of qualified, and soon to be registered professionals, whose practice and level of responsibility and autonomy has changed and will continue to change more rapidly as pharmacists take on additional clinical responsibility.

All of the changes mean that pharmacists are taking greater personal and professional responsibility for the clinical care of patients and the health and wellbeing of the public than at any time in the past. Across all areas of the NHS pharmacists are working as fully integrated members of the healthcare team – whilst this may still be on a sessional basis for community pharmacists it is a trend that will develop over the coming years. Professional competence has been re-defined – pharmacists are no longer the prescriber's backstop but frontline professionals in their own right. Their practice and professional judgment will be scrutinised and judged by other members of the team. The trust that colleagues put in the skills and knowledge of pharmacists and technicians must not be misplaced and the reliance that patients put on their judgment must be fully justified.

¹¹ Health Act 2006 and Health Bill information paper – Medicines and pharmacists making the best use of the pharmacy workforce
¹² Department of Health (2006). *Implementing care closer to home – providing convenient care for patients. A national framework for pharmacists with special interests*
¹³ Department of Health (2005). *Guidance for the development of consultant pharmacist posts*
¹⁴ Department of Health (2006). *Pharmacists and Pharmacy Technicians Order*

Aspects of practice that were nice to have, such as good consultation skills and meticulous record keeping are now crucial – from here on it matters if pharmacists forget to ask questions in a medication review; or in dispensing a repeat prescription; or misinterpret body language; or miss cues from patients about emerging problems.

Pharmacists may be the only healthcare professional the patient is seeing routinely so it matters if they miss something or handle a clinical situation poorly.

The research agenda for 2007-2011 must produce results that will underpin development and implementation of the new regulatory framework but also the leadership responsibilities which will require a greater emphasis on supporting pharmacists to develop their own practice in relation to patient consultations, implement the new standards, contribute effectively to the wider healthcare team and manage their own pharmacy teams.

There are three themes proposed for the 2007-2011 Research Strategy:

- Patients, medicines and professionalism in pharmacy;
- Patient safety and pharmacy practice; and,
- Social capital, health inequalities and pharmacy.

4.1 Patients, medicines and professionalism in pharmacy

There is growing evidence that for many, but perhaps not all, patients' greater involvement in decisions about their health and their treatments leads to better outcomes. This observation is leading to many initiatives including the expert patient programme and, in relation to medicines specifically, the work of Medicines Partnership. Work completed on mental health, heart failure and other chronic illness is beginning to shed light on what patients want and need to know about their health and their medicines. Work being conducted by Professor Theo Raynor and colleagues in Leeds is demonstrating how patients interpret information about the risk of side effects. Projects in this theme will explore what patients expect, need and want to know about their medicines (including adverse effects, risks and benefits). It explores issues of consent and will build on Professor Rob Horne's work on concordance presented at the 2006 British Pharmaceutical Conference.

Work in this theme will also explore what pharmacists and technicians expect, need and want in order to deliver patient centred professionalism.

We know from work completed in medicine and from interim results from the funded ethics PhDs, something of the nature of the skills, attitudes and values that pharmacists will need, but very little about how to teach and assess them. We understand a limited amount about the impact that the attitudes that teachers and mentors have on developing professionalism and no significant experience of using patients, real or simulated, in teaching and assessment; we need to develop validate and reliability test appropriate assessment methods for use at all levels of pharmacy education including in the future

revalidation and recertification. Projects in this area will inform development on all educational standards.

This work will build on the initial projects commissioned in relation to education and also ethics – it will produce results to underpin policy in relation to education and performance assessment and also in relation to the development of future operationalised standards of practice.

Work could also monitor patients' expectations and levels of trust as they experience greater levels of clinical care from pharmacists in different roles and settings as prescribers and clinical specialists. Comparison of data from such research with similar studies amongst patients and their doctors would prove to be a valuable exercise as both professions' roles converge in relation to prescribing¹⁵. Similarly, as the clinical risk of encounters with pharmacists increase, work to establish patient's expectations of how pharmacists work and are regulated collectively and individually will be pertinent – especially as the RPSGB's new Code of Ethics and Fitness to Practise systems bed down.

4.2 Patient safety and pharmacy practice

Initial studies relating to dispensing errors in community pharmacy¹⁶ and job satisfaction/stress¹⁷ indicate that more work in this area would be valuable as the new community pharmacy contract develops and pharmacists develop the responsible pharmacists roles and take additional clinical responsibility and change the ways in which traditional responsibilities are discharged by working with technicians and increasing use of technology in dispensing and medicines supply. Research in this theme will explore models of best practice in relation to managing part time and flexible workforces whilst delivering patient centred care which will support the RPSGB in its standard setting work, Continuing Professional Development and other systems established to support pharmacists to develop their own practice and that of other members of their own teams and the wider healthcare team.

The process of innovation in community has already been studied and implementation of the new contract is being evaluated – initiatives to develop formative assessments and supportive teaching and learning experiences, mentoring support and peer support groups will underpin development of the RPSGB's leadership function and complement its regulatory functions. Projects in this theme will be developed to look at the uptake and embedding in particular of pharmacogenetics technology in prescribing and medicines management practice¹⁸, ensuring that the profession continues to innovate across the next decade.

¹⁵ Askham & Chisholm (2006). Patient-centred medical professionalism; towards an agenda for research and action. The Picker Institute.

¹⁶ Ashcroft, D. et al. (2005). *Patient Safety in Community Pharmacy: Understanding Errors and Managing Risk*. Community Pharmacy Research Consortium, RPSGB.

¹⁷ Hassell, K. et al. 2006 *Pharmacy Workforce Census 2005: Main Findings*. RPSGB.

¹⁸ Martin, P. & Morrison, M. 2006 *Realising the Potential of Genomic Medicine*. Pharmacy Practice Research Trust, RPSGB.

4.3 Social capital, health inequalities and community pharmacy

In light of the Wanless Report's agenda, work has already been commissioned within the RPSGB to review health inequalities and the role of community pharmacists in tackling community development issues and building social capital. This together with the evaluation of the new contract will develop the foundation for further research to consider the emerging roles of pharmacists and their teams in public health.

While research is looking at public use of community pharmacy as a healthcare resource little is known about what community pharmacy provides in terms of general social and welfare advice. Research is needed to identify the benefits people derive from their local community pharmacy and how this potentially adds to the social capital of an area and plays into the wider community and neighbourhood development policies and the wider health, as opposed to healthcare, agenda.¹⁹

Research on pharmacy's role in neighbourhood regeneration and renewal is lacking²⁰ and therefore initial focus might usefully be directed at addressing specific questions in relation to pharmacy involvement with health development.

Since difficulties lie in the measuring and methodological aspects of the concept of social capital, future research to address this acknowledged difficulty would be a logical next step.

5. Progress with commissioning under the 2007- 2011 Research Strategy

5.1 The findings from the 2002-2006 programme and subsequent publications have identified further areas of research that informed the development of the 2007-2011 strategy. Furthermore, the profession and the wider policy context in which it operates has changed considerably over the last 5 years and these have influenced directions for research in areas such as patient choice, patient centred professionalism and interprofessional working and the role of pharmacy in the community and patient care pathways.

5.2 To take forward the 2007-2011 strategy, the PPRT held a stakeholders meeting to identify priorities within the three key areas. The results of this, areas of research identified through the previous published research and research emerging from among other professions, led to a designated programme for the first year of commissioning to take forward priority research areas. Two initial calls for proposals were issued in 2008:

- Professionalism in undergraduates and in early years of practice;

¹⁹ Social capital & health inequalities – discussion paper prepared for the Community Pharmacy Research Consortium

²⁰ Doyal, L. *et al.* (2005) *Pharmacy's contribution to tackling health inequalities*. RPSGB

- Collaborative practice for the care of patients with long term conditions or public health.

5.2.1 Professionalism

Titles of the professionalism projects commissioned are as follows:

- Manchester University - "Curriculum mapping of professionalism in undergraduate education".
- Swansea University - "Contextualising patient centred professionalism in pharmacy practice: consulting with patients, professionals and stakeholders".

5.2.2 The Trustees agreed to take forward these projects. These projects once brought together will provide a robust overview of professionalism from different perspectives. The projects were selected on the basis of the inclusion of patients in the research and for their ability to be compared and contrasted with findings from across other professions.

5.2.3 The results will inform educationalists, the new regulatory body and the new professional body in terms of helping to develop standards and competencies early in education and throughout early career pathways based directly on patient expectations. The mapping exercise embedded in the Manchester undergraduate study will provide a detailed profile of how professionalism (in all its forms and definitions) is currently taught and assessed at undergraduate level – critical baseline data on which to contextualise the findings from the other two studies.

5.2.4. Projects are due to start in September/October 2008 for completion within a 12 to 18 month period.

5.3 Multiprofessional Practice Grants

5.3.1 The same stakeholder meeting identified the following issues as being central to future development and commissioning of safe and effective pharmacy services; multi-professional working together with the assessment of patient benefit and value for money.

5.3.2 A grant was awarded to Denise Taylor and Jane Sutton from the University of Bath for the project '*Evaluating pharmacist provision of clozapine services*'.

5.3.3 The PPRT anticipates that this will at least go some way to providing empirical evidence in one important and under researched clinical area. The project is due to start in September/October 2008 for completion within a 21 to 22 month period.

5.4 Collaborative AHRC/ESRC PhD studentships

- 5.4.1 As part of its research capacity building, and in light of the pharmacist's extended clinical role and integration into mainstream healthcare, there is general agreement that there is an increasing need for pharmacy research to move from a largely science based professional model to one that incorporates social science and philosophy.
- 5.4.2 Under the remit of the 2002-2006 strategy, the value of an external perspective of pharmacy practice was demonstrated through the funded ethics PhDs undertaken by departments of philosophy and published by the PPRT. Therefore, in 2008 the PPRT incorporated within its research programme a collaborative partnership grant scheme. This scheme seeks to explore pharmacy practice in the wider context of, for example, law and ethics, social science, health economics, epidemiology and psychology. Four applications were short listed by the PPRT to be worked into full applications for submission to the ESRC (Economic and Social Research Council) and AHRC (Arts and Humanities Research Council). Project funding will be shared with the research councils and support PhD students in the 2009/10 academic year.

5.5 Social Capital/Community Cohesion

- 5.5.1 The Trustees have begun scoping this area of work and will consider commissioning in 2009/10.

6. Policy Update

- 6.1 The 2007-2011 Research Strategy (and the grants from PTECO) is due to be reviewed in 2009 as part of forward planning. Details of all projects, events and publications produced by the PPRT are available from the PPRT website: www.pprt.org.uk.
- 6.2 In April 2008 the government published a White Paper for pharmacy. This paper contained considerable aspirations for the future of pharmacy practice. However, the paper stated that the evidence to support the introduction of new services was at present inadequate. The PPRT undertook a full analysis of the implications for pharmacy practice research and for the PPRT and concluded that in light of the findings, the focus of the originally agreed strategic direction for research may have to be revisited.
- 6.3 The PPRT published its analysis and hosted a large scale stakeholder event in November 2008. The outcomes of the event will inform commissioning rounds in 2009.

Research Strategy for Pharmacy 2002-2009

Appendix 1.

