NATIONAL PHARMACY ASSOCIATION

# Maximising medicines optimisation through community pharmacy

Conclusions and recommendations from an NPA expert roundtable 27th Feb 2024

## Support for this roundtable

This meeting has been sponsored by CSL Seqirus; CSL Seqirus has had no input into the agenda, content or organisation of this meeting.

# Contents

# Foreword

Medicines optimisation entered the clinical lexicon in May 2013 when the Royal Pharmaceutical Society published a report outlining the principles behind the approach. The term has been attributed to former Chief Pharmacy Officer Keith Ridge.

The report's publication prompted a step change from the previous 'medicines management' approach of the 1990s, which aimed to achieve the greatest possible efficiency and effectiveness in the utilisation of medicines.

The concept of enabling the best outcomes for patients from their medicines is nothing new. The earliest legislation in England relating to medicines management was introduced in 1540. Later, the Apothecaries Act of 1791 provided regulations to ensure the quality of medicines.

However, medicines optimisation is a more holistic, progressive and systemised approach, as it encourages patients to take greater ownership of their treatment, while also looking to improve lifestyle measures and incorporate non-medical therapies.

Medicines optimisation should now form part of the wider concept of 'value based healthcare'. Its value for patients relates to being part of the whole cycle of care, not just a single intervention. This is positive for both patients and delivery costs.

It also aligns with NHS Right Care, introduced in 2009 to expose and tackle unwarranted variation, and improve outcomes for patients while securing value.

In this NHS, quality without efficiency is unsustainable, just as efficiency without quality is unthinkable.

This report aims to help accelerate this approach to care and add value to the existing dialogue about medicines optimisation.

The collective wisdom of participants in this round table discussion, which I am proud to have been invited to chair, has been captured to inform colleagues in all clinical disciplines.

I hope this report will provide a refreshed view and promote further development and implementation of optimisation in the deployment and utilisation of medicines in the NHS.

**Professor James Kingsland OBE, Primary Care Physician,**
**Clinical Professor School of Medicine, University of Central Lancashire**

# Summary recommendations

1 Medicines optimisation should happen – and be funded – at every medicines interface.

2 Community pharmacy must be better recognised as part of primary care within the family of the NHS.

3 Community pharmacist clinical leads at system level must be empowered and supported to use their medicines optimisation skills for maximum patient benefit.

4 Community-pharmacy based medicines optimisation services should be scaled up – and funded – to reach their full potential.

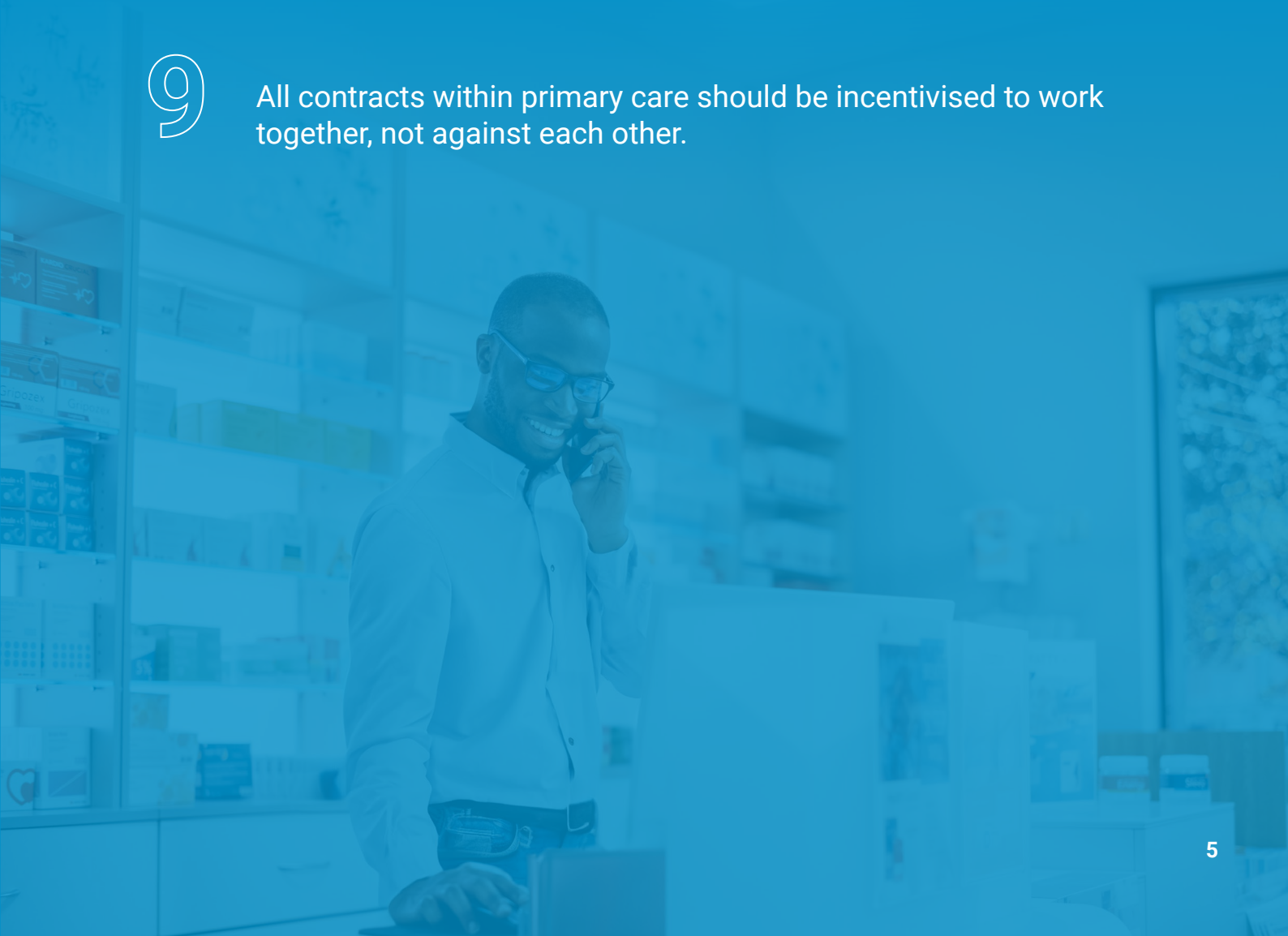
5 More evidence should be collected to show the effectiveness of community pharmacy services. We must also ask the right questions of the data.

6 Make better use of prescribers already working within community pharmacy, and apply lessons from pilots, such as IP pathfinders.

7 Pharmacists should be allowed to use their skills to help address medicines shortages through, for example, substitutions.

8 Primary care meetings must be scheduled at a time when all relevant stakeholders are available.

9 All contracts within primary care should be incentivised to work together, not against each other.



# Gathering collective insight

On 27th February 2024 the National Pharmacy Association (NPA) organised a roundtable at the Royal Society of Medicine to explore the direction of travel for the role of community pharmacy in optimising medicines.

The roundtable, chaired by Professor James Kingsland OBE, brought together healthcare leaders from the NHS, community pharmacy and other healthcare professions across the UK. Those present examined patient needs and existing models, as well as the challenges and opportunities for community pharmacy and medicines optimisation.

They also explored and shared insights around the value of, and need for, community pharmacy enabled medicines optimisation; intelligence on existing schemes at home and abroad; and the barriers faced in deploying a comprehensive new service pathway.

This report highlights the key points from the discussion, including proposed action points and recommendations to assist the development of strategic policy and practice thinking. The aim is to support those charged with influencing the next iteration of national community pharmacy contracts.

Next steps – the NPA will:

- Share the report with national and local health system leaders
- Use the report to raise awareness of the opportunities for community pharmacy to have a greater role in medicines optimisation among those developing the future contract
- Promote the report to community pharmacists and pharmacy contractors to help them scope a wider role for medicines optimisation in their own practice

# The Context

Medicines are the single biggest intervention made by the healthcare system, and their use continues to rise each year.

In the last decade, the number of medicines dispensed in community pharmacy in England each year has increased by 17%, reaching 1.18 billion in 2022/23. This comes at a cost of £10.4 billion – an 8% increase from £9.69 billion in 2021/22[1]. Total spending on medicines is the second highest cost to the NHS (after staff) and covers nearly 10% of all healthcare spending[2].

However, research suggests between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended[3]. At a time when NHS resources are stretched, ensuring the best use of these medicines is essential for both individual patients and the taxpayer.

Medicines optimisation considers:

- Systems for managing and improving patient safety
- Support for patients when they move care settings
- Medicines reconciliation, and medication review – ensuring people get the right choice of medicines, at the right time – are part of the decision-making process

Importantly, medicines optimisation is shown to improve adherence and tackle suboptimal prescribing, demonstrating its cost effectiveness[4].

Recent commissioning of the Discharge Medicines Service (DMS) has formalised pharmacy's role with patients moving settings and in medicines reconciliation.

As part of this process, pharmacies can review prescriptions following discharge from hospital, identifying errors, or supporting patients with changes. Evidence suggests DMS has the potential to remove the need for more than 29,000 readmissions to hospital every year[5].

Pharmacies have long supported patients with medicines reconciliation, ensuring they have the correct medication. Each year pharmacies support nearly three million patients with newly prescribed medicines[6].

The final part of medicines optimisation – medicines review – can improve care, through a patient's understanding and use of medications, as well as changing the medicines themselves[7].

Community pharmacy is ideally placed to meet all the facets of medicines optimisation, yet there is currently no contracted medicines review service through community pharmacy.

Although NHS England commissioned structured medication reviews (SMRs) from primary care networks (PCNs) from October 2020 (with PCNs required to identify patients who would benefit from these reviews), medicine review remains the missing strand of medicines optimisation in community pharmacy.

This is despite audits included in the Pharmacy Quality Scheme showing the immense impact community pharmacy has on patient safety. A 2022 medicines safety audit led to clinical advice being provided 385,000 times, identifying 90,000 patients needing additional care[8].

## Recommendations

- Convenient access is one of community pharmacy's key characteristics, so the NHS should support pharmacies to develop a significantly enhanced role in patient care
- Linking a commissioned medicines review service to other activities and services provided in community pharmacy would create an opportunity to offer this vital care in a different way – not least because, unlike general practice, community pharmacy gives patients and customers repeated touch points (such as repeat prescription collection) throughout the year
- Medicines optimisation, prevention, same day urgent care and long-term conditions should all be in scope for service development, informed policy-making and sufficient public investment over the coming years

# Setting the scene

The NPA has long championed the idea that community pharmacy should be a 'front door' to the NHS and the NHS Long Term Plan[9]. We aspire to a future where community pharmacy is an integral part of the NHS and delivers clinical services as a full healthcare partner.

Community pharmacy already plays a significant public health role in the major conditions cited in the Long Term Plan, including cardiovascular disease, diabetes, respiratory disease and mental health.

Meanwhile, last year's 'Fuller stock take'[10] into the work of the NHS at a local level pointed to opportunities for community pharmacy in prevention, mental health and cancer referrals. It also encouraged integrated care systems to develop a "single system-wide approach to managing integrated urgent care to guarantee same-day care for patients".

In February, NHS England's National Director for Primary Care and Community Services, Dr Amanda Doyle, told delegates at the NHS Confederation's Primary Care Conference 2024 that community pharmacy represents a "huge untapped pool of clinical capability". Dr Doyle said the fact that by 2026 all newly qualified pharmacists will be independent prescribers is "a game-changer for general practice as well as community pharmacy".

"We really see community pharmacy as a big part of the future of clinical service provision," she added[11].

As patients' expectations about how health services should be accessed and delivered continue to evolve, community pharmacies remain a vitally accessible bridge between online and in-person healthcare interactions. The NHS app gives patients access to their patient records, allows prescription ordering, and the opportunity to choose the pharmacy they want to collect from, but face-to-face care remains the preferred mode for many people. So, it remains important to offer patients a choice about how to access pharmacy support.

Part 1

# The needs of patients and commissioners

The roundtable discussion began with delegates exploring the needs of patients and commissioners around improving medication management in the NHS. The conversation highlighted the challenges of medicine supply issues and siloed working, as well the need for clear communication with patients and making every contact count.

## Patient expectation

When patients go to a pharmacy, they expect to receive high-quality service. They also expect to be seen in a timely manner without being 'ping-ponged' between services, and order a prescription with the expectation the medication will be at the pharmacy a few days later. But they don't always understand the medication ordering process, and some do not have the relevant IT skills to do it themselves via the NHS app. Often patients also need help to better understand medicines.

A commissioned walk-in medicines review service would give patients convenient access to the experts in medicines, where they need it.

Case study

### Helping patients in the right place, at the right time

A patient in his 80s with a prosthetic leg came into the pharmacy complaining of feeling unwell and asking for hayfever medicine. The pharmacist knew the patient had a history of heart failure. Noting that he was out of breath, the pharmacist was concerned that the patient's heart failure had deteriorated markedly and called NHS 111, after which the patient was admitted to hospital.

## Medicines shortages

Medicines supply has been compromised in the last year – both nationally and internationally. Brexit has exacerbated this and led some manufacturers to remove the UK from supply chains. A downward push in prices, the dominance of ingredient and formulation manufacturing operations in China and India creating a market with fewer different suppliers, and pressure on profitability, have also had an impact[12].

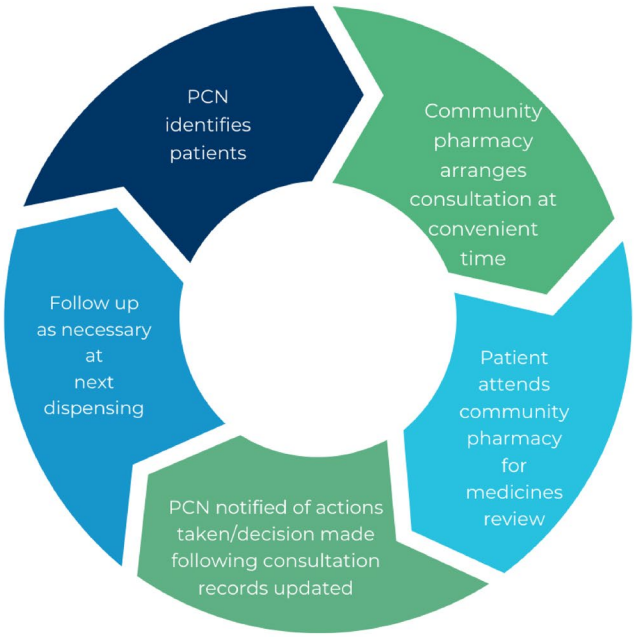
This has led to issues with patient satisfaction, treatment and safety. Delegates spoke of medicines shortages leading to diabetic patients being hospitalised, noting this type of unplanned care is extremely expensive and can be avoided by having the necessary medication available.

## More than medicines supply

While most people use community pharmacy for the supply of medicines, there are many opportunities for pharmacists and their teams to further develop pharmaceutical care in the community.

As health and wellbeing hubs, pharmacies already play a significant role in keeping people well, in addition to treating people when they are poorly.

By focusing on the accessibility of community pharmacy and designing the service to maximise continuity of care, patients can feel engaged in their care. Patients will have several opportunities to ask questions or follow up with decisions made, increasing the likelihood of successful changes to medicine. Previous pilots have shown that repeated, small contacts with patients can dramatically improve medicines adherence. Please see the schematic outlining this concept below.



The most recent example of opening up more clinical pathways in community pharmacy is England's Pharmacy First scheme. Launched on 31st January 2024, Pharmacy First gives patients access to prescription-only medicines, including antibiotics and antivirals where clinically appropriate, to treat seven common health conditions. People can get treatment by walking into the pharmacy or contacting them virtually, with GP receptionists (known as 'care navigators'), NHS 111 and providers of emergency care also able to direct patients into the pharmacy as part of an integrated team.

Roundtable delegates stressed a role for community pharmacy leaders to look at population health needs and encourage NHS England to support the development of further local services, as "one size doesn't fit all".

## Building partnerships

For many years healthcare professionals have recognised the importance of not working in isolation from their clinical colleagues, for the benefit of patient care and their professional development and career satisfaction.

Integrated care boards (ICBs) took over responsibility for commissioning pharmaceutical, general ophthalmic services and dentistry (POD) on 1st April 2023 as part of a range of commissioning reforms initiated by the Health and Social Care Act 2022, which many healthcare leaders hoped would unify previously siloed sectors of primary care.

Joined-up commissioning is a key tool in developing local systems, and roundtable delegates expressed the continued will to build partnerships with other health partners including their POD colleagues.

Pharmacy First provides a great opportunity for this, although care navigators in some GP practices are yet to be trained on the Pharmacy First referral pathway and this is hampering patient access to the service.

## Patient engagement

People don't take their medicines because they choose not to, but rather because they don't understand what the medicine is for, and how and why they need to take it. Pharmacists also say patients often can't identify the medicines they take unless the box is being held up in front of them.

This important observation shows the need to translate very technical information into something patients can understand, not least to avoid the problem of wasting medicines. Estimates suggest pharmaceutical waste in England totals around £300 million per year, including some £90 million worth of unused prescription medicines retained in people's homes at any one time[13].

Roundtable delegates suggested 'language empathy' to make sure patients understand, as well as always asking if they want to take the medicine they are being prescribed or recommended.

## Making every contact count

Community pharmacies are embedded within the communities they serve, with teams recruited from the places they work and strong relationships with local patients.

This makes community pharmacies the only places that can truly maximise the opportunities presented by the Make Every Contact Count (MECC) approach. For example, when handing over the medicines to the patient, to make sure they understand what they have been given or why they need to take it.

A commissioned medicines optimisation service from community pharmacy would include an MECC intervention when medicines are given out, mitigating the risk of medicines wastage and minimising the need for people to go to hospital due to medication issues.

> "Medicines optimisation is being misunderstood in the system. It's not about prescription switches, it's patient-centred care being given direct to the patient at that point of care in the service."

## Medicines optimisation

Medicines waste is a significant issue – £300 million in primary care alone, about half of which is avoidable[14].

With just under 1.2 billion items dispensed annually in England, ways to reduce the cost of medicines need to go hand-in-hand with medicines optimisation.

Estimates from the National Institute of Health & Care Excellence (NICE) suggests between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended[15].

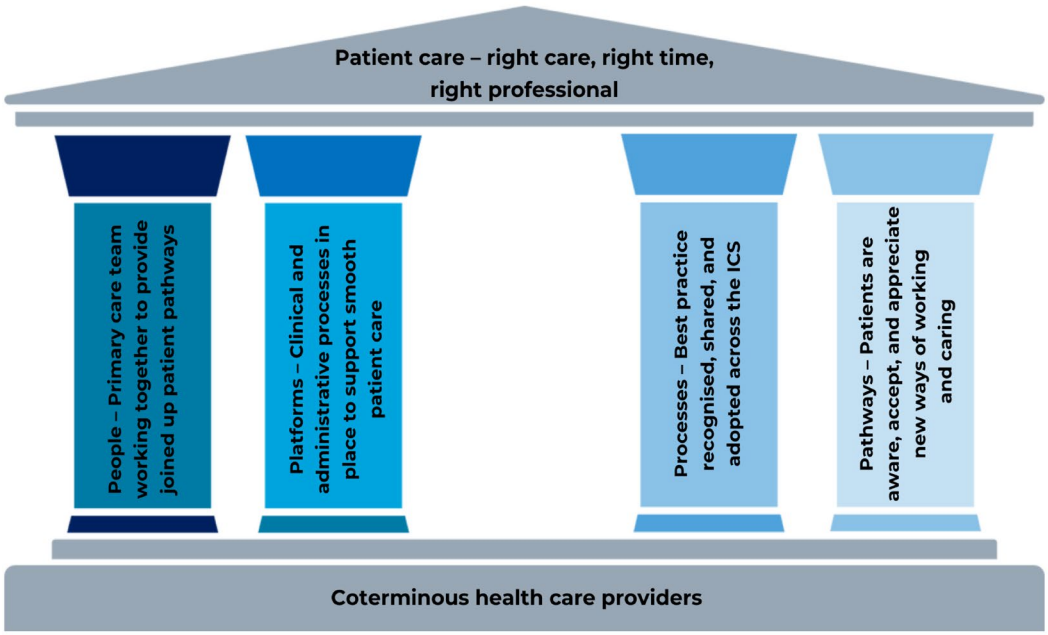
NHS England data shows up to 8% of all unplanned hospital admissions are due to medication issues, a figure which rises to 17% in the over 65s age group[16].

One-third of people over 75 years of age now take at least six medicines[17], with those taking 10 or more medicines 300% more likely to be admitted to hospital[18].

In addition, adverse effects of medicines account for 16.5% of hospital admissions[29].

Community pharmacy is an ideal location to support patients with multiple medications, and offers an efficient and accessible route to improve medicine adherence and quality of life. Crucially, new developments in digital technology, such as GP Connect, allow interventions to be shared with other clinicians[20].

The infographic below highlights the four key pillars of practice necessary to enable integrated patient care effectively and collaboratively.



Commissioning a medicines optimisation service in community pharmacy offers patient-centred care that isn't commissioned anywhere else, to reduce the injudicious use of medicines and help patients safely use their medicines – giving commissioners good clinical and financial outcomes.

## Why commission from community pharmacy?

General practice has long led on medicines optimisation, recently supplemented by expanding their teams (through PCNs) to incorporate a wide range of professions. However, general practice is under pressure like never before. A recent report set out a stark future where more than a quarter of practices may close because of workload pressures[21] – yet community pharmacy offers unparalleled community-based access and reach. Over 89% of the population can access a community pharmacy within a 20-minute walk[22] and many pharmacies have extended weekend and evening opening hours.

Commissioning care through pharmacy naturally targets those who need it most. Healthcare generally suffers from the 'inverse care law' – where access is reduced in places where it is needed most. However, community pharmacy is an exception, with 99.8% of people living in the most deprived areas within walking distance of a pharmacy[23].

Patients in deprived communities have additional barriers to healthcare, either through a lack of private transport, inflexible working conditions or additional caring commitments. The location of community pharmacy, coupled with easy access (no appointment required and extended opening hours), means many of these barriers are overcome.

Part 2

# Sharing what's good, and how to scale it

NICE published its quality standards in medicines optimisation in 2016[24]. Since then there have been many examples from around the world of initiatives optimising medication use to improve healthcare outcomes. These include New Zealand and Canada investing in pharmacist-led clinics, and the US promoting personalised medicine.

## Medicines optimisation in Scotland

The Medicines, Care and Review Service (MCR) is a core service in Scotland's community pharmacies. Any patient who has a long-term condition and is registered with a GP practice in Scotland can register with the community pharmacy of their choice for the MCR service.

Community pharmacy teams deliver both structured and opportunistic interventions to help people get the very best out of their prescribed medication, as well as minimising harm caused by medicines. The key intervention within the MCR service is the pharmaceutical care planning process. Pharmacists populate a patient profile for each person registered under MCR and undertake a care needs assessment for them within three months of registration.

This gives the pharmacist a more rounded view of the patient's health and allows them to identify those who have sub-optimal therapeutic management, side effects, or poor compliance. Patients can then be prioritised for further pharmaceutical care planning based on the identified care needs.

Individual care issues can be created within the patient profile and managed using a reports function on the patient care record (PCR) allowing for robust follow-up and closure of identified issues. There are also specific tools within the PCR to support pharmacists to deliver structured supportive interventions for newly prescribed medicines and therapies which are considered high-risk (including methotrexate, lithium, and warfarin).

To facilitate communication with other healthcare professionals and care services, the PCR has a function that allows the generation of an SBAR. This is a standardised method of conveying information about the care of a patient in a clear and concise way, giving an overview of the presenting situation, relevant background information and an assessment and recommendation as to what action (if any) needs to be taken.

As yet, the pharmacist independent prescriber service in Scotland doesn't include a medicines optimisation element. But pharmacy leaders would like to see the role expanded to do so, and are keeping an eye on England's IP Pathfinder sites for additional insights. They also support the aim of medicines optimisation becoming embedded in the workflow of pharmacies, rather than an extra service that busy pharmacies need to add in.

## Medicines optimisation in Wales

In 2022 the new pharmacy contract in Wales refocused a lot of pharmacy services into those which supported unscheduled care, such as emergency supply, which took the emphasis off other services that had a medicines optimisation element.

However, Wales does have an inhaler prescribing service, a COPD service in one health board, and the Discharge Medicines Service, which has reduced the risk of readmission for patients.

A retrospective cohort study, published in the BMJ in 2020, evaluated the association of the discharge medicines review (DMR) community pharmacy service with hospital readmissions through linking national health data sets from all hospitals and 703 community pharmacies across Wales. Of the 1,923 patients meeting the referral criteria for a community pharmacy DMR over a 13-month period (February 2017–April 2018), the provision of DMR was found to be the most significant attributing factor in reducing the likelihood of 90-day readmission[25].

Wales also has a third strand to its IP service which allows health boards to commission when there is a local need, with one example being a successful pain management service run by two IPs.

Pharmacy leaders in Wales acknowledge the importance of medicines optimisation, and are proposing a short-life working group across all systems and sectors to address the topic, with the aim of having something in place by 2025/26.

## Service developments outside the UK

Pharmacy systems and organisations around the world are facing similar problems to those here in the UK, including a lack of funding to deal with growing workloads, a shortage of pharmacists, and medicines supply problems – all of which play a role in the progress and development of services.

As in the UK, the understanding of the potential for new and expanded pharmacy services has increased as a result of the role community pharmacies played during the pandemic. A lot of what is new in world pharmacy first emerges in the UK – because we have a progressive attitude towards regulation and a managed system with a focus on outcomes and cost effectiveness. Here are some examples from pharmacy colleagues across the globe:

In recent times the greatest expansion of the role of community pharmacy has come in vaccination – in the US, New Zealand and Canada pharmacies are now the main provider of vaccines – and in urgent care.

Prescribing rights are a key tool to support medicines optimisation and exist, to some extent, in New Zealand, Canada, UK and the US.

Pharmacists in Spain and many US states have the ability to order and interpret lab tests.

Many community pharmacies in the Netherlands offer pharmacogenomic testing services to patients to determine how their body metabolises and responds to specific medications. Pharmacogenomic data is used to assess a patient's current medication regimen, identify potential drug-gene interactions, and suggest adjustments or alternative medications to optimise therapeutic outcomes. Research conducted in 2021 found that following testing 18% of the clinical samples were recommended to avoid certain medication (based on their current medicines use), and 14% to have their dose adjusted[26].

Pharmacists in Australia offer a range of reviews including home medicines, residential medication management and medicines use, and are currently seeking prescribing rights and the right to administer medicines. In the Queensland Community Pharmacy Advanced Scope Of Practice Pilot there is autonomous prescribing for GORD, impetigo, psoriasis, contraception and weight management, and chronic disease management for diabetes, hypertension, dyslipidaemia, asthma and COPD. The pilot features structured prescribing as part of a chronic disease management programme.

Portugal has programmes for medication adherence and medicines reconciliation. Prescriptions for common conditions are now issued for 12 months and pharmacies are empowered to manage supply and the condition. A deprescribing pilot is also underway in Portugal.

In Ireland, from September 2024, pharmacists will be allowed to extend prescriptions for prescriptions written on or after 1st March up to a maximum of 12 months for patients if they feel it is safe and appropriate to do so. This change enhances patient convenience, alleviates healthcare strain, and acknowledges pharmacists' expertise[27].

In the US, a 2023 Virginia Commonwealth University study found that pharmacists prescribing interventions for hypertension would save $10,000 per person over a 30-year time period. There are also examples of asthma management, lipid testing and management, and COPD management.

In Canada the Alberta Clinical Trial in Optimising Hypertension was conducted from 2009 to 2013[28]. Pharmacist follow-ups occurred every four weeks until BP was at goal for two consecutive visits followed by 12-week intervals for the remainder of the 24-week study duration. The pharmacist intervention achieved a significant reduction in SBP at six months compared with the active control group (−18.3 mm Hg vs −11.8 mm Hg, respectively; P < .001).

Pharmacists in Alberta are also funded to adapt prescriptions, to prescribe and manage on-going therapy.

Nova Scotia is currently trialling pharmacy primary care clinics in areas with the highest numbers of people without a family doctor. These provide treatment for strep throat, UTIs, chronic disease management for diabetes, asthma and COPD, vaccines and prescription renewals for all medicines.

Ontario now allows pharmacists to administer a wide range of substances via injection and inhalation, including anticoagulants, anti-Parkinson medications, HRT, monoclonal antibodies and Vitamin B12 shots.

Spain has a new service to promote adherence rates for patients on immunosuppressive therapies following solid organ transplants.

## Funding for scaling up

These examples show that pharmacy involvement in a wider range of public health initiatives creates multiple benefits for patients and the system, but funding is the sticking point.

Protecting public health involves long-term interventions that often don't show immediate material benefits. But, if – for example – mental health, women's health/sexual health and long-term conditions services were properly funded public health initiatives then primary care would see fewer patients through the door.

There are lots of areas where funding services in community pharmacy could improve public health and provide greater efficiency for the NHS. For example, while the aim of Pharmacy First is to encourage better public health prevention and improve patients' knowledge of their medication and condition, funding medicines optimisation in community pharmacy could help build a much bigger picture of the value base in the NHS – which is about much more than saving money.

## IT and connectivity

IT to enable community pharmacy to provide services often feels like an afterthought and, coupled with a lack of 'write' access into patient records, the inconsistency in digital connectivity for pharmacy is a barrier.

Funding for connectivity between community pharmacy and the rest of primary care would make a huge difference to patients – and to medicines optimisation – as well as improving trust and communications between community pharmacy and other primary care providers.

## ARRS and the workforce crisis

The NHS is experiencing an unprecedented workforce crisis, from which community pharmacy is not immune.

The Additional Roles Reimbursement Scheme (ARRS)[29] was introduced in England in 2019 with the aim of recruiting 26,000 additional staff into PCNs – a target it had met by May 2023. The latest Primary Care Workforce data for England, published by NHS Digital, gathered data from 1,248 PCNs and found in December 2023 there were 6,874 full-time equivalent pharmacists working in general practices and PCNs. This is a 24.5% increase from 5,522 in December 2022[30].

While ARRS has been very successful at increasing the number of pharmacists recruited into PCNs, Community Pharmacy England (CPE) Chief Executive, Janet Morrison, warned last year that the policy is "exacerbating pharmacy workforce problems", leaving many pharmacies understaffed and forced to close their doors temporarily to patients.

## Evidence and evaluations

A lack of evaluation of many of the services community pharmacy undertakes makes it hard to collate evidence to prove the return on investment for commissioners.

Medicines use reviews (MURs) are a good example of this. MURs were not a structured review and pharmacists had to record each intervention, which many found took longer than the consultation itself. Commissioners never saw these details, which pharmacists feel is part of what led to their demise.

> "One of our pharmacies is contracted under the Local Pharmaceutical Services provision, and within that has an adherence service which includes a domiciliary service. Addressing intentional non-adherence is our holy grail and we know that, especially with elderly patients, a key person to influence are the adult children of elderly patients. What they need is information about their parent's medicines, and that can make a huge impact on adherence. However, this service has been commissioned for 10 years and we have to write a huge annual report on it but we know no one looks at it. What we desperately need are people actually analysing the data, because there is plenty of evidence but it's not being looked at."

There are some areas where service progress is being followed and evaluated. The IP Pathfinder service will be evaluated by the University of Manchester, while another university is looking at Pharmacy First, and the DMS in England has a number of sets of peer reviewed evidence.

Optimising StruCtured medicAtion Reviews (OSCAR) is a National Applied Research Collaboration project funded by the National Institute for Health Research, and sponsored by the University of Oxford, looking at pharmacist interventions[31].

The study aims to understand how SMRs for patients with multiple long-term conditions are being conducted in England, what the challenges are, and how to best optimise them in future. The researchers are surveying pharmacists conducting SMRs across England, and will observe what happens in a sample of these reviews with a diverse group of patients from different GP surgeries. In addition, de-identified routinely-collected data about past SMRs will be collected from a national primary care database called Oxford Royal College of GPs Clinical Informatics Digital Hub. This information will include the characteristics of patients who have had a structured medication review, and any adjustments made to their medicines as a result (such as any medicines stopped or changed). The researchers say this research will generate new knowledge about how SMRs are conducted and experienced by pharmacists and patients, and what happens as a consequence of these reviews, with the findings ultimately fed back to PCNs to help improve equity, quality and effectiveness.

Roundtable delegates felt there is room for more evidence-gathering like this, suggesting that community pharmacy and system leaders need to work closer with academics to generate that evidence.

## Medicines optimisation as a way of understanding supply and demand

If we want to shape demand we first have to understand it, and medicines optimisation in community pharmacy can help us do this.

Community pharmacy is the ultimate walk-in centre and the relationship pharmacists have with patients is unique. Every time the pharmacist shows a patient their medicines it is a chance to open up a conversation about what they are taking and why. Pharmacists commonly report the pharmacy is the only healthcare setting where people are completely honest about how they are taking – or not taking – their medicines. These interventions are vital, as they encourage patients to take ownership of their treatment and further build a relationship with their local pharmacist as the expert in medicines.

Part 3

# Challenges and solutions to medicines optimisation in community pharmacy in England

Challenge: there is a lack of community pharmacy-based research showing the benefits of better medicines use, but credible evidence and structured approaches are necessary to support care pathway changes.

> *"A community is people who care in the good times and the bad, and that is what pharmacy is all about. Your community pharmacist knows the local families, their lifestyles, the vulnerable families, the demographic of the locality, and this is bespoke and niche to each pharmacy, so empowering local community pharmacies to treat their local populations could make them the biggest asset the NHS has. We are already making those impacts but we have just never been paid for it. I call us a 'ghost profession': people – and commissioners – don't think of community pharmacy as primary care, but the patient's journey starts with their interaction with the community pharmacist. We have saved the NHS so much money but that data is not recorded, so how do we capture that information? If we can recognise what's already been done we will expand exponentially on what we can do."*

Solution: build on existing evidence that community pharmacy has proved its worth and ability to scale when challenged to increase its clinical role. For example:

- DMS avoided 8,393 readmissions in its first year alone[33]
- In 2023, 2.8 million consultations were delivered in community pharmacies as part of the New Medicine Service[34]
- Around 3,000 consultations were delivered through England's new Pharmacy First service within its first three days[35]

Challenge: other healthcare professionals must work together with pharmacy to enhance services through collaboration and leadership.

*"Stop pitting us against GPs. Our commissioners need to see us as very different entities that can work together. The contract has to stop incentivising us against each other so that we can communicate and collaborate."*

Successful outcomes can be achieved through engaging with colleagues and building trust, but pharmacists must take responsibility for representing their views in settings where they are not being expressed.

Solution: GP and PCN pharmacists collaborate really well and community pharmacy doesn't need to duplicate their work, so options such as domiciliary care could be a new avenue of collaboration.

*"We were running a COVID-19 vaccination clinic 12 hours a day and had to find the workforce and volunteers to help. Within hours of setting it up our local GPs were pushing back that we were taking their work, but when we joined their weekly call they saw we were working together. In three months we went from being the villains to being the trainers, explaining to the PCN how we were doing this."*

The growing area of pharmacogenomics is another area where pharmacists can use their skills as the experts in medicines. Genotyping patients before starting therapy can help pharmacists and healthcare providers make more informed decisions about drug selection and dosage. This prevents side effects and improves the effectiveness of medicines, and is considered essential for the safe use of some drugs.

Challenge: patients can't get value from their medicines unless they actually have them, and the effort and cost for pharmacists to get hold of medicines when they are in shortage is huge.

Solution: if pharmacists can substitute, for example, a 20mg shortage for 2x10mg that would be beneficial, alongside getting into the patient record to make the substitution known to the patient's GP.

Challenge: ARRS has proven successful but some community pharmacy business owners feel it has contributed to their recruitment challenges.

*"I don't think the NHS really understands what independent businesses need funding for. Community pharmacy contractual services are very rigid and structured, so we need to take the essence of ARRS – which is doing something that is good – and facilitate that in community pharmacy."*

Solution: a nationally defined 'one workforce agenda' enabling a pharmacy professional to work in any part of the system, so the power of pharmacy delivery can be seen at every part of the system. Hybrid ARRS roles would enable pharmacists to work in community pharmacy, and encourage more integrated work across primary care. However, while there are examples of pharmacists working across roles locally which are part funded by general practice and community pharmacy, it is hard to mix and match like this on a national scale, as ARRS is currently funded by the GP contract.

Challenge: a lack of integrated IT and access to patient records creates a barrier to joined-up patient care. In addition, it's only when we pharmacists carry out interventions in great numbers that they build credibility with primary care colleagues, but this data needs to be recorded and shared.

Solution: every patient intervention should be able to be put into the GP record at every part of the system – including in community pharmacy. Systems need to work for everyone, rather than requiring the repeated input of information.

IP Pathfinder sites are already showing examples where pharmacists are getting access to GP systems to do SMRs, and Pharmacy First utilises GP Connect, which is a massive step forward in getting pharmacy access to records and will transform the potential for medicines optimisation.

Challenge: funding does not always appear to be properly addressed in the development of new services. In order to run a successful medicines optimisation service, pharmacists need to consider staffing needs and whether they need to employ a second pharmacist, if their consultation rooms are fit for the process, and where supervision fits into the process.

*"Medicines optimisation should happen – and be funded – at every interface of medicines. Revolutionising the term 'primary care' to include pharmacy is the way to do this."*

Solution: we need to change the narrative about medicines being a cost to being a value in the system. We know community pharmacy interventions can deliver value. As mentioned above, NMS has a huge wealth of evidence and so does DMS, so pharmacy leaders need to show others in the system this value.

In addition, every ICB needs a community pharmacy collaborative lead, but funding for these ended in March, and half of the roles will be cut. We need these to continue to exist.

*"When you change care you have to change the payment mechanism that supports it, and then that changes institutions."*

Challenge: patient awareness of the purpose and need for medicines optimisation and their willingness to engage with the process remains a challenge, as (regardless of the clinician) patients rarely value medicine reviews[32].

Solution: people don't think 'today I want to get my medicines optimised', so pharmacists need to make clear what medicines optimisation is. An entry point for this conversation with patients could be around electronic repeat dispensing, and synchronised medicines (ordering all the medication they have on repeat at the same time rather than irregular times throughout the month). Both create value for patients and are a win-win for pharmacy. A further bonus for the patient is the accessibility of community pharmacies, allowing them to access the service, without appointment, in a location close to their home.

Part 4

# The way ahead – connectivity of care

There is no denying there is considerable room for improvement across the health system in terms of patient safety, efficacy, post discharge reconciliation and waste reduction.

Some 16.5% of hospital admissions are due to adverse drug reactions and many more people are hospitalised because they aren't taking their medicines for a long-term medical condition properly[36], yet the Integrating NHS Pharmacy and Medicines Optimisation programme and Regional Medicines Optimisation Committees are not thoroughly engaged with community pharmacy.

More can be imagined and enabled to improve medicines safety right across the care pathway.

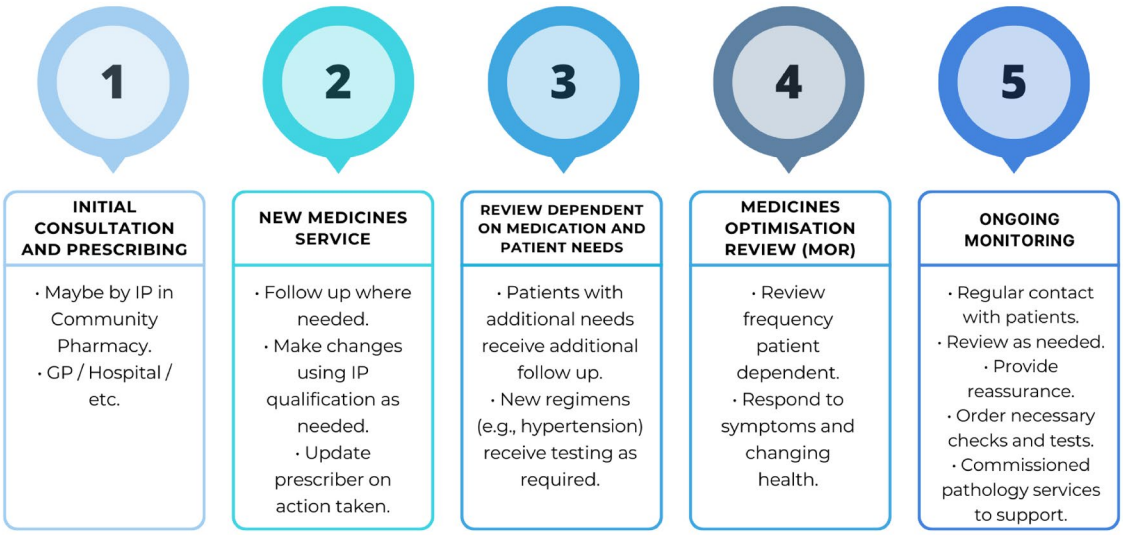
For example, locating SMRs principally in GP practices means the opportunity has so far been missed to mobilise the community pharmacy network in this space, so there should be a community pharmacy-based SMR offer with wraparound interventions enabled by independent prescribing. The community pharmacist would not only have full access to patient records, but also be able to send off for specific clinical indicators such as blood tests – enabling them to titrate medication as required.

Community pharmacy's provision of one billion NHS prescriptions in England annually is core to the primary care pharmaceutical supply chain. With the ramping up of independent prescribing and with the appropriate governance safeguards in place, community pharmacists will have the ability to undertake a full prescription management role.

Introducing medicines optimisation reviews offers a new pharmaceutical care pathway where patients expect and receive support tailored to their needs.

And while community pharmacy provision of medicines optimisation services in a variety of nursing, residential and supported domiciliary care settings is already widespread, there is potential for universal practice development to be explored here, and the opportunity to drive this aspect of pharmaceutical care across the network. For example, the medicines adherence service in Northern Ireland illustrates a new and sensible way to fix a pressing issue in England's pharmacy network.

The five-stage model shared below describes the sequence of pharmaceutical care interventions that could be applied to the patient journey around their medicines.




## Enablers to success

As accessible medicines experts, community pharmacists should be the go-to healthcare professionals for optimising the use of medicines. When coupled with independent prescribing, this offers a route to reducing NHS expenditure, reducing pharmacy workloads, and improving patient outcomes. Over time these reviews can link into a reformed repeat dispensing system. This will increase the efficiency of repeat prescription management, reducing the workload of pharmacy and GP teams.

Medicines optimisation reviews offer a new pharmaceutical care pathway where patients expect and receive tailored support that flexes to their needs. For instance, deterioration in a patient's health could prompt additional reviews that align with existing work with patient groups by other providers. This will require professionals in different locations to work together in a new way.

Using the connectivity of care offered by community pharmacy is an opportunity to support patients in their understanding and use of medicines. By stitching the opportunity of community pharmacy care into a patient's care pathway, new gateways for intervention are opened to provide an efficiency of service, effectiveness of outcomes, and high quality care.

## Key insights

- Primary care is a style of practice and a continuum of care where every sector works at its full potential
- Community pharmacies are not competing with general practice, we are providing pharmaceutical care
- Community pharmacy contractors need to be involved in the patient care journey within ICBs/ICSs
- Community pharmacy bucks the 'inverse care law' by accessing a higher volume of patients, with longer opening hours, in more deprived areas
- Supervision changes will free up pharmacists to have more time for patient interventions
- Avoiding complexity or duplication of interventions can make a strong service
- Community pharmacy can harness the power of offering older people medicines reviews, to support and manage medication with the person to take ownership of their medicines and health
- Community pharmacy interventions can make proven savings to the £9 billion primary care drugs budget, since estimates suggest there is £90 million worth of unused prescription medicines in people's homes at any one time[37]
- As there is no sign of an overarching primary care contract any time soon, find the win-wins where community pharmacy provides a service and general practice can also receive a payment from a secondary lever

# Conclusion

Previous experience shows community pharmacy is an ideal location to support patients prescribed multiple medications. The traditional barriers raised when realising the fullest deployment of medicines optimisation in community pharmacy are surmountable. Indeed, with national policy progress in play, especially with the IP Pathfinding, we are shaping the new ways of working required already.

Community pharmacists are increasingly becoming independent prescribers able to identify and make changes to a patient's medication. The pathfinder work currently underway is setting out funding pathways to allow prescriptions to be created, coupled with a national system for generating electronic prescriptions. In addition, Pharmacy First is already highlighting the relationship between the supply of medicines and medicines optimisation. GP Connect provides pharmacy teams with the information needed to identify patients, safely make changes to medication, and update records with intervention details that can be shared with other clinicians.

But, more can be done.

Medicines optimisation isn't a single intervention, it's a whole pathway of care that could lead to the transformation of delivering pharmacy services.

An adequately funded medicines optimisation service in a community pharmacy setting could, during the remainder of this decade, develop much further as a clinical care and safe medicines supply service. This will cost-effectively benefit patients, the public and the NHS.

**Professor James Kingsland OBE**

# Attendees and sponsors

## Attendees

Chair – Professor James Kingsland OBE, Primary Care Physician, Clinical Professor School of Medicine, University of Central Lancashire

NPA Board Members

- Olivier Picard, Pharmacy Owner, CPE Committee Member
- Sukhi Basra, Pharmacy Owner
- Sanjay Ganvir, Director and Superintendent, Green Light Pharmacy Group

NPA Executive Team

- Gareth Jones, Director of External and Corporate Affairs
- Helga Mangion, Policy Manager
- Michael Lennox, Integration Lead

CPE Committee, Independent Regional Rep, Sian Retallick

CPE Committee, Independent Regional Representative, Sami Hanna

CEO Community Pharmacy Scotland, Matt Barclay

Community Pharmacy Wales Director of Contractor Services, Judy Misra

CCA – Head of Policy, Nick Thayer

Boots The Chemists – Alister Huong, Head of Healthcare Service Partnerships

DHSC – Stefan Politowicz, Senior Pharmacist, Pharmacy Team

NHSE – Wasim Baqir, Senior Pharmacist, Pharmacy Integration Programme

RPS – James Davies, Director for England

Chief Pharmacist Frimley ICS and PPP Chair on Pharmacy, Yousaf Ahmad

# References


1. NHS Business Services Authority (2023) *Prescription Cost Analysis – England 2022/23*. Available at: https://media.nhsbsa.nhs.uk/news/nhs-publishes-report-on-prescription-costs-in-england.
2. Kings Fund (2023) *The NHS budget and how it has changed.* Available at: https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-budget-nutshell.
3. National Institute for Health and Care Excellence (2015) *Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes.* Available at: https://www.nice.org.uk/guidance/ng5/chapter/introduction.
4. Faria, et al. (2014) *Economics of Medicines Optimisation: Report for the Department of Health Policy Research Unit in Economic Evaluation of Health and Care Interventions.* Available at: https://pure.york.ac.uk/portal/en/publications/economics-of-medicines-optimisation-report-for-the-department-of-.
5. Thayer, N., Mackridge, A.J., White, S. (2023) 'Predicting the potential value of the new discharge medicines service in England'. *Journal of Pharmaceutical Health Services Research*, 14(3), pp. 248-255. Available at: https://academic.oup.com/jphsr/article/14/3/248/7123523.
6. NHS Business Services Authority (2024) *Dispensing contractors' data. CCA calculations are based on current proportions of hypertension case finding patients provided with ambulatory blood pressure monitoring.* Available at: https://www.nhsbsa.nhs.uk/prescription-data/dispensing-data/dispensing-contractors-data.
7. Royal Pharmaceutical Society (2024) *Medication Review: Quick Reference Guide.* Available at: https://www.rpharms.com/resources/pharmacy-guides/medication-review.
8. Health Services Journal (2023) *HSJ Patient Safety Awards 2023: Patient Safety Team of the Year.* Available at: https://www.hsj.co.uk/patient-safety-awards/hsj-patient-safety-awards-2023-patient-safety-team-of-the-year/7035534.article.
9. *The NHS Long Term Plan* (2019) Available at: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/.
10. Fuller, C. (2022) *Next steps for integrating primary care: Fuller stocktake report.* Available at: https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/.
11. The Pharmacist (2024) *Clinical service is the future for community pharmacy, says NHS director.* Available at: https://www.thepharmacist.co.uk/news/clinical-service-is-the-future-for-community-pharmacy-says-nhs-director/.
12. Nuffield Trust (2024) *Patients face "new normal" of medicines shortages as UK hampered by supply issues and impact of EU exit*.

Available at: https://www.nuffieldtrust.org.uk/news-item/patients-face-new-normal-of-medicines-shortages-as-uk-hampered-by-supply-issues-and-impact-of-eu-exit.

13. Community Pharmacy England (2016) *PSNC Briefing 054/16: Medicines Wastage and Prescription Duration.* Available at: https://cpe.org.uk/wp-content/uploads/2013/04/PSNC-Briefing-054.16-Medicines-Wastage-and-Prescription-Duration.pdf.
14. NHS England (2014) *NHS England launches medicines optimisation prototype dashboard.* Available at: https://www.england.nhs.uk/2014/06/mo-dash/.
15. National Institute for Health and Care Excellence (2015) *Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes.* Available at: https://www.nice.org.uk/guidance/ng5/resources/medicines-optimisation-the-safe-and-effective-use-of-medicines-to-enable-the-best-possible-outcomes-pdf-51041805253.
16. NHS England (2014)
17. NHS (2015) *Prescriptions Dispensed in the Community - Statistics for England, 2004-2014.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/prescriptions-dispensed-in-the-community/prescriptions-dispensed-in-the-community-statistics-for-england-2004-2014.
18. Payne, et al. (2014) 'Is polypharmacy always hazardous? A retrospective cohort analysis linked to electronic health records from primary and secondary care', *British Journal of Clinical Pharmacology*; 77(6), pp.1073-1082. Available at: https://pubmed.ncbi.nlm.nih.gov/24428591/.
19. University of Liverpool (2022) *Study highlights rising tide in adverse drug reactions.* Available at: https://news.liverpool.ac.uk/2022/07/05/study-highlights-rising-tide-in-adverse-drug-reactions/.
20. Twigg, et al. (2015) 'The four or more medicines (FOMM) support service: results from an evaluation of a new community pharmacy service aimed at over-65s', *International Journal of Pharmacy Practice*, 23(6), pp.407-414. Available at: https://pubmed.ncbi.nlm.nih.gov/25847545/.
21. Royal College of General Practitioners (2023) *A quarter of GP practices could close because of workload pressures, warns Royal College of GPs.* Available at: https://www.rcgp.org.uk/News/Fit-for-the-Future-GP-Pressures-Report.
22. Todd, et al. (2014) 'The positive pharmacy care law: an area-level analysis of the relationship between community pharmacy distribution, urbanity and social deprivation in England', *BMJ Open*, 4(8). Available at: https://bmjopen.bmj.com/content/4/8/e005764.
23. Todd, et al. (2014)
24. National Institute for Health and Care Excellence (2016) *Medicines optimisation.* Available at: https://www.nice.org.uk/guidance/qs120.
25. Mantzourani, et al. (2020) 'Exploring the association of the discharge medicines review with patient hospital readmissions through national routine data linkage in Wales: a retrospective cohort,' *BMJ Open*, 10(2). Available at: https://bmjopen.bmj.com/content/bmjopen/10/2/e033551.full.pdf.

26. World Pharmacy Council (2023) *Sector Analysis Report 2023: Showcasing the best of community pharmacy from around the world.* Available at: https://d2s3n99uw51hng.cloudfront.net/static/2023%20WPC%20Sector%20Analysis%20Report%20-%20Public%20Version.pdf.
27. Government of Ireland (2024) *Minister for Health secures government approval to further expand the role of pharmacists.* Available at: https://www.gov.ie/en/press-release/b5d9f-minister-for-health-secures-government-approval-to-further-expand-the-role-of-pharmacists/.
28. Dixon, et al. (2023) 'Cost-Effectiveness of Pharmacist Prescribing for Managing Hypertension in the United States' *JAMA Network Open*, 6(11). Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2811317#zoi231202r10.
29. NHS England (2019) *Expanding our workforce, Additional Roles Reimbursement Scheme.* Available at: https://www.england.nhs.uk/gp/expanding-our-workforce/#clinical-pharmacists.
30. NHS Digital (2024) *Primary care workforce data.* Available at: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Ffiles.digital.nhs.uk%2FF8%2FC82374%2FPrimary%2520Care%2520Workforce%252C%2520England%2520-%2520FTE%2520Nurses%252C%2520DPC%2520and%2520Admin%252C%2520December%25202023.xlsx&wdOrigin=BROWSELINK.
31. National Institute for Health Research (2024) *Optimising StruCtured medicAtion Reviews (OSCAR): A mixed methods process evaluation with integrated real-time observational cohort study.* Available at: https://www.phc.ox.ac.uk/research/groups-and-centres/hypertension/optimising-structured-medication-reviews-oscar-a-mixed-methods-process-evaluation-with-integrated-real-time-observational-cohort-study.
32. McCahon, et al. (2022) 'Patient perceptions and experiences of medication review: qualitative study in general practice', *BMC Primary Care*, 23(1). Available at: https://pubmed.ncbi.nlm.nih.gov/36418986/.
33. Thayer, N., Mackridge, A.J., White, S. (2023) 'Predicting the potential value of the new discharge medicines service in England', *Journal of Pharmaceutical Health Research*, 14(3), pp. 248-255. Available at: https://academic.oup.com/jphsr/article/14/3/248/7123523.
34. NHS England (2023) *Annual Report & Accounts.* Available at: https://assets.publishing.service.gov.uk/media/65b145be160765001118f82c/nhs-england-annual-report-and-accounts-2022-to-2023-print.pdf.
35. Community Pharmacy England (2024) *3,000 Pharmacy First appointments carried out in first 3 days.* Available at: https://cpe.org.uk/our-news/3000-pharmacy-first-appointments-carried-out-in-first-3-days/.
36. University of Liverpool (2022) *Study highlights rising tide in adverse drug reactions.* Available at: https://news.liverpool.ac.uk/2022/07/05/study-highlights-rising-tide-in-adverse-drug-reactions/.
37. Community Pharmacy England Policy Briefing (2016) *PSNC Briefing 054/16: Medicines Wastage and Prescription Duration.* Available at: https://cpe.org.uk/wp-content/uploads/2013/04/PSNC-Briefing-054.16-Medicines-Wastage-and-Prescription-Duration.pdf.

# Let’s start a conversation

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