May 2018

Wider than Medicines

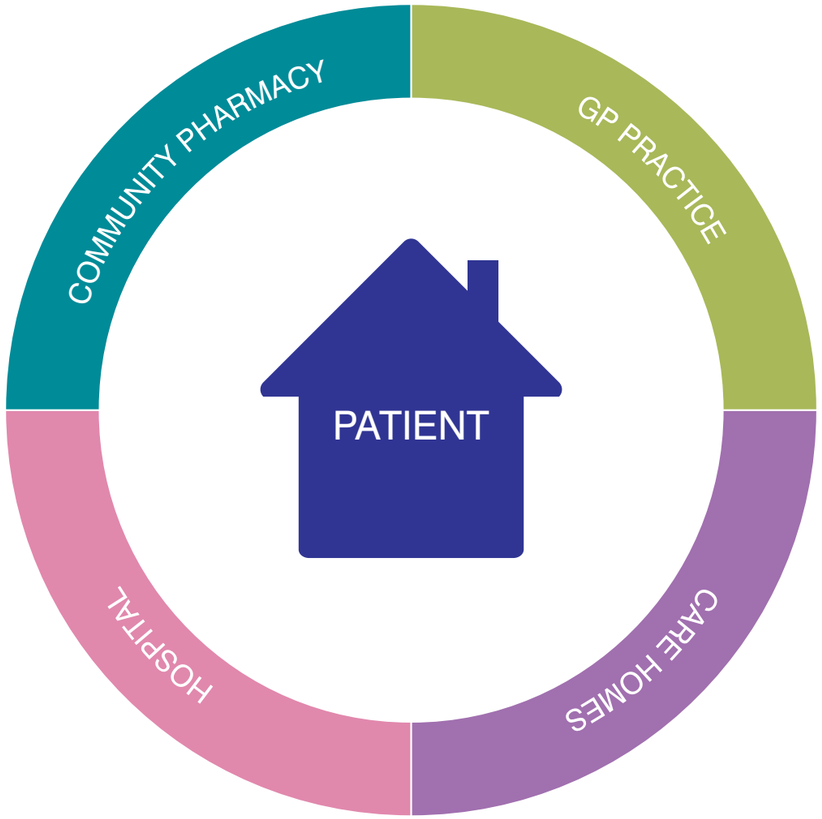
A Pharmacy perspective on creating an integrated health system

Road Map 2

| representing **your** interests |

pda
the pharmacists' defence association

Pharmacy in the evolving health system



Putting the patients at the centre of a community of practice

Wider than medicines

Today, medicines are the most common clinical intervention made by doctors and the cost of medicines represents around 13.5% of the entire NHS budget. After salaries, this is the second largest NHS budget item.

When medicines are used correctly, they can alleviate the symptoms of chronic conditions and can successfully treat acute conditions. However, when they are not used correctly or are not managed properly, or if prescribed in the wrong combinations they can fail to alleviate symptoms or cure patients and, in many situations, they can actually cause harm placing an unnecessary burden upon the NHS.

Research has shown (DH policy research programme) that each year £750 million of medicines are not taken as required and they are unlikely to be working properly or at all because of this poor compliance. Additionally, a further £300 million of medicines are simply wasted each year (York and London waste report); perhaps because they are unnecessary. Worse still, around 7% of hospital beds are occupied by patients who have been harmed by their medicines due to Adverse Drug Reactions (NICE). In many instances, this occurs even though they have been taking their medicines in accordance with their prescriber's intentions.

All of this points to a powerful conclusion; **The use of medicines in society is so important, that it deserves much more attention than hitherto has been the case.** It is time for the system to be dramatically improved so that much more attention can be paid to helping patients use and manage their medicines effectively and safely; this is a discipline called Pharmaceutical Care. Many pharmacists are working hard, but they have not been allowed to work smart. As the experts in medicines, their deployment across large parts of the healthcare system has thus far been hampered by a lack of focus upon these unique skills and a lack of collaborative working opportunities especially with colleagues in other sectors. In turn, this leads to other members of the healthcare team working sub optimally, because they too are involved in matters which could more effectively be undertaken by pharmacists. Pharmacists' interventions should be much wider than the current focus on provision of medicines. Equally as important, the skills of pharmacists in the area of pharmaceutical care are truly unique and whilst the prospect of using pharmacists' clinical skills to try and plug holes in the current GP shortage crisis may look attractive, this approach serves to prop up a system that begs to be substantially overhauled because it fails to concentrate the use of healthcare professionals upon the areas in which they could drive the greatest benefits. For pharmacists, this focus largely does not take advantage of the significant and powerful opportunities of pharmaceutical care.

As decision makers shape the future of health and social care systems there is the need for a wider, bolder and more comprehensive joined-up strategy; one which takes a fully integrated approach and one which also ensures that pharmacy adds the most benefit to the care and safety of patients via a focus upon the effective and safe use of medicines, whichever part of the primary or secondary care system they find themselves in. Pharmaceutical care, if integrated properly across the whole of the healthcare system through the creation of a joined-up community of pharmacy practice would lead to improved outcomes, improved medicines safety and better patient journeys. The whole pharmacy system should be enabled to support such a programme as this will benefit patients, healthcare professionals and ultimately, the taxpayer.

This PDA policy paper, broadens out considerably, the strategic proposals that were put by the PDA in 2012 (Road Map 1), it considers the tactical measures that can be taken and the joined-up thinking that needs to occur to achieve these broader strategic aims. With this initiative, the PDA seeks to engage with policy makers, pharmacists, other healthcare professions and wider stakeholders so that together we can produce a unified and cohesive proposal for the future of pharmacy services in the NHS.

Mark Koziol
Chairman
The Pharmacists' Defence Association

Working smarter

Currently, Pharmacists are working in a variety of settings across communities; in the traditional community pharmacy, in GP surgeries, in hospitals, in care and residential homes, in primary care organisations and other places. They are not only dispensing medicines, but also providing services, care and advice. They are increasingly developing new roles designed to alleviate the pressure on GPs.

Repeat prescriptions account for 80% of all prescriptions issued by GP surgeries and many of them will be for Long-Term Conditions (LTC). It often remains the case that GPs having made the initial diagnosis remain involved in reviewing patients' medication periodically. This added workload reduces the ability of GPs to be able to handle urgent presentations and this unnecessarily drives patients to A&E departments in order to secure urgent care, creating further pressure on hospitals. This is just one example of how silo working places unnecessary burdens upon the NHS and leads to a poor patient journey; there are many such examples.

The patient journey is at its best when the various members of the healthcare team are able to focus upon their unique professional skills. In the case of GPs, this is diagnosing patients; for hospital staff this is providing specialist treatment, and for pharmacists, this is the safe and effective use of medicines and specifically in the provision of pharmaceutical care. This can only occur if it is done within a managed and coordinated framework.

By focusing on interventions throughout the patient care journey, we can eliminate some of the silo working in the system. Through the creation of a community of practice we can ensure that pharmacists, doctors and others across all sectors can apply their unique skills collaboratively, so that they can achieve joint objectives in a much more efficient and joined up way. This proposal seeks to explore what contribution pharmacists as experts in medicines in particular can best make in this new joined up community of practice.

Community Pharmacists – a focus upon population health management and pharmacovigilance

The community pharmacist until now has been ensconced in the dispensary and involved in the labour-intensive assembly of medicines as part of the dispensing process and typically has therefore been largely unavailable to engage in the more time demanding and structured clinical role of pharmaceutical care delivery.

Emerging from the dispensary, a more 'patient facing pharmacist' would be able to identify the patient's medicines needs as they present at the pharmacy and make that all important clinical check of the prescription as is the current role. Additionally, this pharmacist could also use the incoming prescription as an opportunity to develop a much more comprehensive clinical relationship with the patient.

Using the Summary Care Record (and eventually the full patient records) the 'patient facing pharmacist' would seek to make important clinical interventions. These could, and should, be driven by a population health management programme and opportunistic pharmacovigilance. Examples may include:

- The pharmacist changing the antibiotic that appears on a presented prescription because it falls outside of local antimicrobial stewardship guidelines.
- Identifying and stopping short-term drugs which have been issued as repeat prescriptions in error and could cause harm.
- Instigating blood result monitoring where this was missing, this could lead to the changing of dosages of prescribed medicines, where results necessitated this.

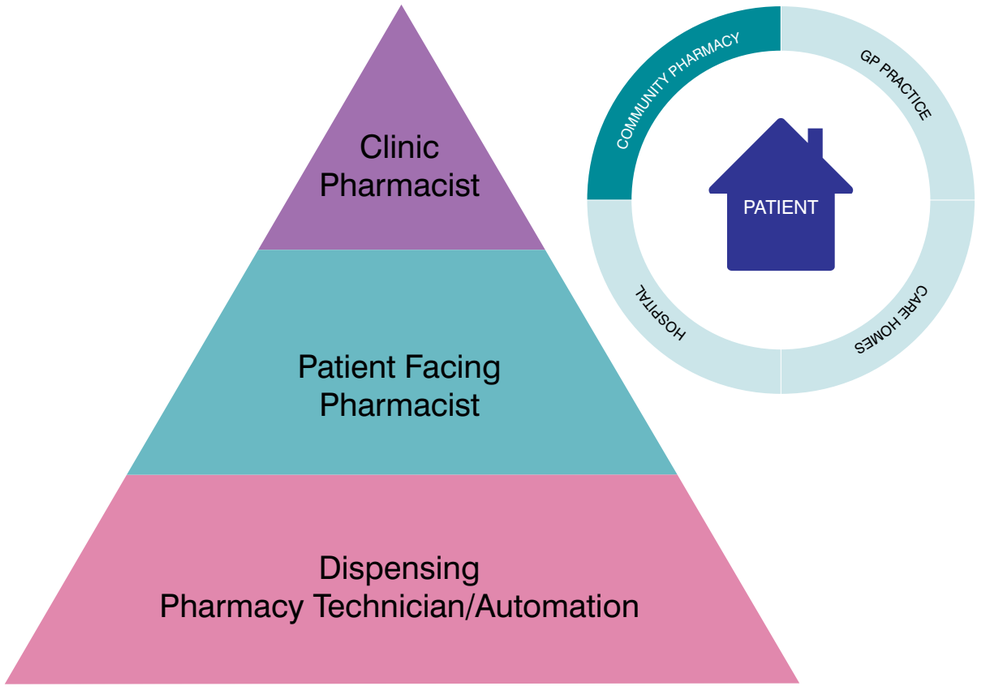
Interventions could also target specific groups of high risk patients who present at the pharmacy such as those with COPD, asthma and diabetes. A change of role for the pharmacist of this magnitude would have to lead to a radical rethink of how the pharmacist could be freed from dispensary-based medicines assembly duties. This might include a greater reliance on automation and pharmacy technicians. It would however, rely upon patients coming to the pharmacy for their prescribed medicines.

Operating a Pharmaceutical Care clinic from the community pharmacy

Over and above these opportunistic interventions, a second pharmacist, the "clinic pharmacist", could deliver more structured pharmaceutical care in the community pharmacy consultation room. The 'clinic pharmacist' would pay close attention to the often more complex pharmaceutical care needs of patients taking many medicines simultaneously; this is often called polypharmacy and it brings with it its own specific problems associated with Adverse Drug Reactions and interactions. As indicated by focus groups with patients taking many medicines, it is a service that would be highly beneficial to both patients and the NHS alike, but it currently attracts insufficient attention on any scale as part of a national service operated in community pharmacy.

This service would likely be on a registered patient basis to ensure continuity of care involving caseloads of stable Long-term Condition patients referred to them from the GP surgery. Referring whole case-loads of patients to a specialist 'clinic pharmacist' who could be based in the local community pharmacy or other accessible health care locations would give the GP more capacity to be able to handle more acute presentations from urgent care patients and to operate 'virtual ward' clinics. As well as being a more convenient option for patients, referring patients with polypharmacy issues to a community pharmacy would reduce the log jam pressures in the GP surgery and make a much better use of the other physical resources available in primary care to be found in a community pharmacy. These activities would all combine to help reduce the unnecessary flow of patients to A&E departments.

Community Pharmacy



Integrating the community pharmacy into the emerging healthcare service.

The Managed Local system – orchestrating the delivery of cross sector services in a locality

If pharmacy could be integrated more widely throughout the health system, then its success could be measured by metrics that are far greater than just how much extra capacity can be given to GPs. The current pharmacy structure does not allow for the coordination of the work of pharmacists across different settings such as hospital, GP surgeries or community pharmacies. With a degree of coordination, this problem can be addressed driving considerable benefits for the healthcare system generally and for patients specifically.

A local primary care organisation, currently the CCG or Health Board, must operate at the centre of this more comprehensive 'pharmacy service'. It has a comprehensive and unique 'helicopter view' understanding of the wider population health and health economy related challenges facing the geographical areas that it serves. It, like the conductor of an orchestra, is best placed to marshal the available financial and intelligence resources. Through commissioning, it can ensure that the efforts of all the pharmacists and others working in a variety of settings can be coordinated and integrated into the wider healthcare system. It can go a long way in supporting the creation of an integrated community of practice.

These locally managed systems would focus upon pharmaceutical care and medicines safety and they would recognise that the needs of one local community will be different from that of another.

In the model for community pharmacists described above, it would be the local primary care organisation which would work out what the local priorities should be and how they should change over time to reflect local needs; it would be best placed to commission these services. For example, in communities with former mining or heavy industry history, the prevalence of patients with respiratory conditions might be best served by a pharmacy service for COPD patients to help redirect patients away from GPs and acute care.

A group practice of pharmacists – a new vehicle providing resilience and flexibility

Over and above the existing pharmacy infrastructure, an integrated health system could benefit further from establishing a group practice of pharmacists. Similar in structure to a barristers chambers, it may comprise of several pharmacists with backgrounds in a range of settings (community, hospital and primary care practitioners). It could also include others such as nurses and pharmacy technicians.

This Multi Pharmacy/Disciplinary Team approach would go some considerable way in breaking down the barriers between the sectors improving collaboration through greater understanding. Without doubt, the creation of a group practice would considerably underpin and secure the possibility of creating a community of practice. The skills contained in these group practices would be available to the local commissioners to provide the glue/resource that would keep the overall local service viable. It could provide additional backup, resilience and expertise to parts of the existing system that otherwise might struggle to provide the wide range of new pharmaceutical care services that would be required.

A Group Practice of Pharmacists

What is it?

- A group of pharmacists/others practicing together
- A vehicle for clinical supervision, governance and training
- A range of delivery models; **creating resilience for a geographical footprint**

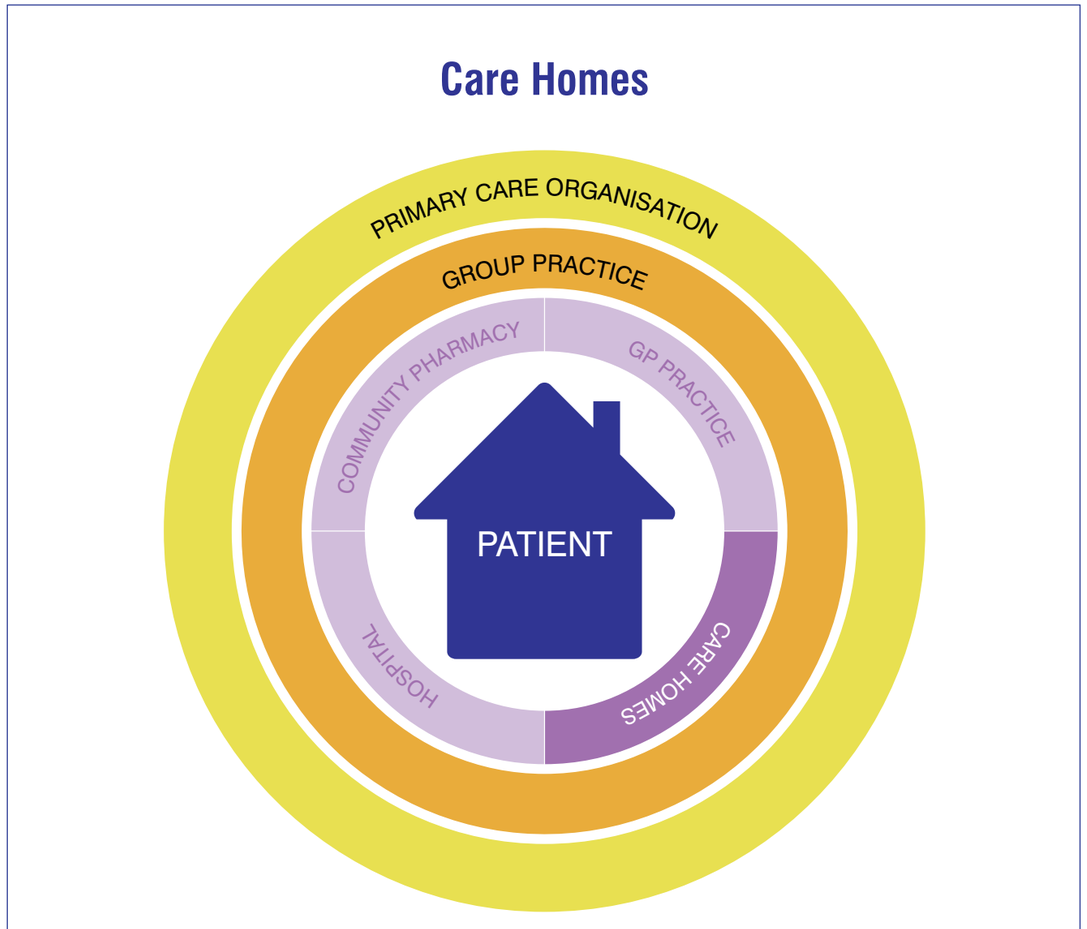
Potential

- Managing care homes agenda
- Clinics in community pharmacies
- Supporting domiciliary care
- Participating in MDTs
- Providing bespoke support for GP practices

Care Homes – creating relationships with residents based on pharmaceutical care

With increasing numbers of the population now living much longer, the care home sector will be expanding for the foreseeable future. Pharmacy must develop a much more comprehensive relationship with the elderly patients who reside in care homes based upon their pharmaceutical care needs and medicines safety.

A pharmacist acting as the patients very own 'medicines champion' can provide care home residents with that all-important continuity of care. This is an ideal activity that can be supported by a group practice of pharmacists. They too will need to be managed in an orchestrated way by the commissioners overseeing the managed local system. The NHS has recently initiated some exciting developments in this area that are congruent with the thrust of this policy paper.



Patients in Care Homes supported through pharmaceutical care, organised by a primary care organisation and delivered by a Group Practice of pharmacists.

Pharmacists working in GP practices – driving quality services through a focus upon unique pharmacy expertise

The early experiences of pharmacists working in GP practices have been inconsistent, with some working well, whilst others experiencing strained relationships with GPs and frustrated patients.

Each healthcare professional in the GP practice, though part of a team, works at their optimum best when they focus upon their unique skills. Ways in which the various GP practice team members can work to their unique skills, whilst still working as a team can be applied, but this is an organised process, not one left to chance. Processes must be developed that seek to enable the GPs to primarily focus upon diagnosis and for pharmacists to work competently and safely by focussing upon medicines and pharmaceutical care.

GP practice-based pharmacists must be supported properly and need to be able to work under the supportive umbrella of the local network and collective expertise of the established local medicines management teams that are based in CCGs and Health Boards.

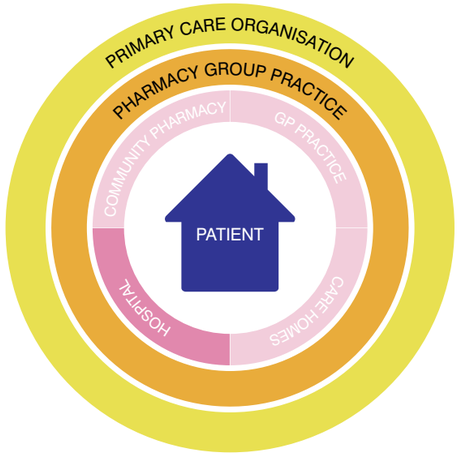
As well as access to support and guidance, the locally managed system will be able to ensure a greater concordance with local priorities, tried and tested methodology, a greater level of clinical governance and above all, a more consistent and supported service for patients.

Importantly, the GP practice-based scheme, must not be developed in a silo fashion, as this perpetuates the current problems. Instead it must be a part of the joined up wider system that is focussed upon medicines safety and pharmaceutical care as described in this discussion paper. An example of this may be that GP practice-based pharmacists are the ones who identify the patients with stable long-term conditions and refer them to 'clinic pharmacists' working in the community pharmacy as described earlier. In turn, the GP practice-based pharmacists may be the ones who, when they receive the results of blood tests that have been initiated by their 'patient facing' community pharmacy colleagues, could instigate the necessary dosage changes.

Pharmacists working in Hospital practice – extending benefits from secondary to primary care

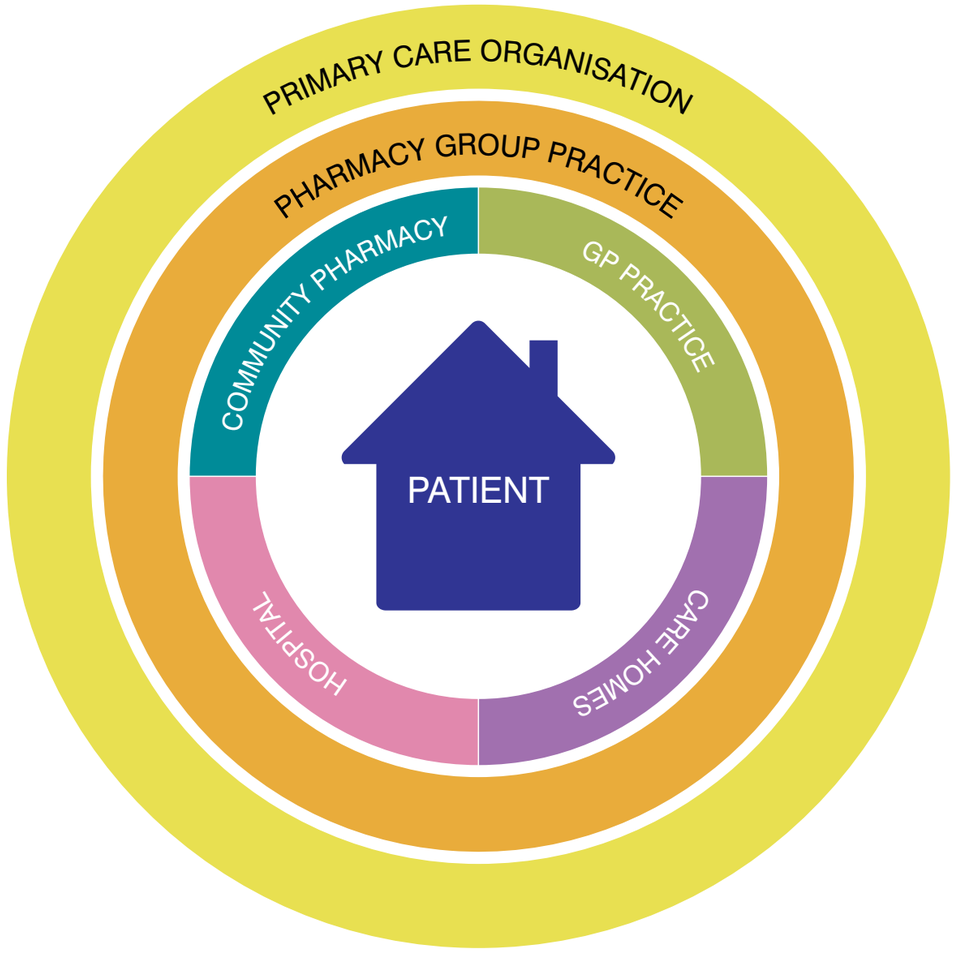
In hospitals, pharmacists are increasingly required to spend their time on discharging patients to release beds. As a result, some patients on wards requiring pharmaceutical care interventions are not receiving them. This pressurised discharge process also leaves the interface between secondary and primary care in a poor condition. A greater collaboration between all sectors of pharmacy is required to improve this and a specific series of collaborative programmes must be researched, trialled, and developed between senior hospital pharmacy management and the local CCG and Health Board pharmacy teams to improve the patient journey as they move between secondary and primary care at discharge. This greater collaboration could also benefit in an orchestrated way from a managed local system. Patients moving between the secondary and primary care systems, particularly at both admission and discharge and especially insofar as it relates to the use of medicines, have a very significant amount to gain through the creation of a community of practice involving pharmacists from both sectors.

Hospital



Improving the interface between primary and secondary care through improved collaboration

Pharmacy in the evolving health system



Joining all of the pharmacy sectors through a community of practice

Joined up care through a managed local system – replacing inefficiency with good ideas and new delivery systems

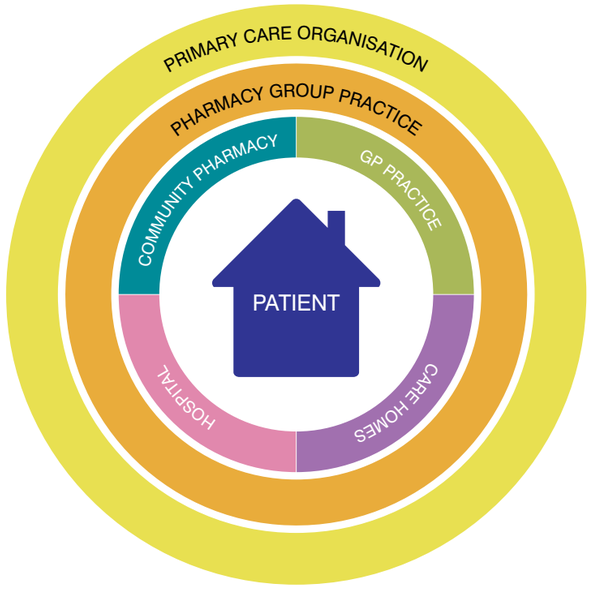
An intelligent managed local system can provide wider and much more comprehensive benefits to patients than would be provided by any sole individual healthcare provider working in a vacuum. For if the individual healthcare professionals cannot deliver their service within an organised framework, then this is likely to result in poorer outcomes for the patient.

The new system must not only improve the collaboration between pharmacists working in the different sectors, but crucially, it must integrate with other teams across the whole of health and social care.

A new system must be about the creation of a community of practice where various members of the healthcare team can work as part of a joined-up initiative whose focus- irrespective of their specific area of work is to improve the patient journey by making the service far more efficient and effective. Collaboration, coordination and innovation would be the hallmarks of this new emerging healthcare system.

Whilst many healthcare providers are working hard, they are not working smart and these inefficiencies result in a waste of limited resources. The focus of pharmacists in the system in the future must be upon the provision of pharmaceutical care and improving the safety of medicines.

The time has come to address these issues through a much more planned and joined up service in the interests of the respective healthcare professions, the NHS, the taxpayer and most importantly of all to dramatically improve the patient journey.



Creating a community of practice

- An orchestrated intelligent locally based system delivering joined up patient care
- A focus upon pharmaceutical care and medicines safety

About the PDA

The Pharmacists' Defence Association (PDA) is a not-for-profit defence association and trade union for pharmacists. We are the only organisation that exclusively looks after the interests of employee and locum pharmacists across all sectors of pharmacy, we currently have a membership of more than 27,000 and this continues to grow.

Delivering more than 5,000 episodes of support provided to our members who have found themselves in a critical incident situation in the last year alone, provides the PDA with a rich vein of up to date experiences which have informed our policies and future strategy. Many of these incidents involve episodes where patient may have been harmed by their medicines or other inefficiencies that are inherent in the system. The proposals put in this document are largely built upon this experience and the lessons that should be learned. They are overlaid onto the current challenges facing the NHS and they are also reliant upon the views of other healthcare professionals and patients gathered through consultation.

Surveys of our members indicate that many of them relish the prospect of being able to take greater clinical responsibility for their patients. Many have highly ambitious and creative aspirations for providing vastly superior and much more clinical services to patients out in the community than they are able to currently; helping to keep them out of hospital. These aspirations if harnessed properly could go a long way in assisting with the significant challenges faced by the NHS both in the short and the long term. However, these pharmacists will need to be able to practice with much more patient facing operability and flexibility than is currently the case. They must be allowed to work in a way that focusses upon their unique skills around medicines and in a way that allows them to fully integrate in to the work of other primary and secondary care providers.

The proposals put in this submission build strongly upon that ambition. They describe practical measures that are specifically directed at solving some of the most difficult problems faced by the NHS today.

What next?

The PDA is gathering views on the ideas put in these high-level proposals. To that end, the PDA will be holding a series of engagement events throughout the whole of the UK to which we are inviting pharmacists and others. Please let us know what you think by contacting us.

www.the-pda.org

The Pharmacists' Defence Association
The Old Fire Station
69 Albion Street
Birmingham
B1 3EA
Contact information
General Enquiries: 0121 694 7000
Fax: 0121 694 7001
Web: www.the-pda.org
Email: enquiries@the-pda.org

pda
the pharmacists' defence association