From idea to action: Practical steps to release the potential of pharmacies in health reform

Roundtable seminar with Rt Hon Stephen Dorrell MP, Chair, Health Select Committee

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Reform comment

Thomas Cawston,
Research Director, Reform

The NHS, like all health systems, needs to find ways to deliver high quality, affordable and accessible healthcare. There is growing interest in innovative ways to deliver healthcare and the role of new providers in transforming the NHS. In particular, other health economies have made considerable use of extended pharmacy services to improve access to preventative healthcare.

Both this and past governments have recognised that pharmacies are still undervalued in the English health system. As recent reports have found, high street pharmacists are well placed to improve access to healthcare, encourage patient-centred services, promote prevention and wellbeing and prevent unnecessary hospital admissions. The key question now is to identify the practical steps to achieve this in practice. In December 2013 Reform partnered with Celesio to explore practical steps that can unleash the potential of pharmacies. The seminar was led by Rt Hon Stephen Dorrell MP, Chair of the Health Select Committee.

The value of pharmacies
Health and care services are changing to meet the needs of tomorrow. In the face of an ageing population and the growing prevalence of chronic conditions, many experts and NHS leaders have advocated the joining up of health and care services. In this new system of integrated, patient-centred and accessible care there is a pivotal role for pharmacy. The potential of pharmacies is clear: built on strong public-private partnerships, responsive to consumers, effective users of technology, based in the community, convenient opening times and an excellent source of clinical advice.

Yet pharmacy remains an untapped resource. Compared to other professions pharmacists are relatively isolated, lack strong national leadership and need to achieve greater “inter-professional respect”. A fragmented commissioning landscape and inflexible national contracts also act as a barrier to more innovative use of pharmacies across the NHS.

Unleashing the potential
While expanding the role of pharmacies has been on the agenda for years, the stars are aligning for rapid reform. There is recognition that primary care needs to move away from a GP focused cottage industry to primary care at scale offering a wider range of clinical services. Consumer demand for services that are more convenient, accessible, responsive and available online will challenge the NHS to give pharmacy a bigger role. There are many potential national levers to get more out of pharmacy: better data sharing between services, engaging patients on the value of pharmacies with social marketing, more closely aligning hospital and community pharmacy and improving inter-professional training.

Show and tell
The biggest opportunity for innovation however is to “just do it”. In the past pharmacy providers have waited for commissioners to design a new system of care and local leaders have looked for permission from above. The NHS should challenge those on the front line to develop new models of care and support these experiments. Many in the private sector are willing to take the risk to invest in such models. Being able to “show” examples and evaluations of effective partnerships between the NHS and pharmacy will help diffuse these innovations.
From idea to action

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We all know the world is changing – people have busy lifestyles, they are looking for more convenient access to solutions to make their lives easier, technology is advancing with pace and the healthcare system, including community pharmacy, cannot ignore these changes.

We also know community pharmacy is the most accessible health profession and for many people the community pharmacist is their only regular contact with a healthcare provider. Whilst some changes have been seen in the range of services provided the profession has not kept pace with the environment around them.

Pharmacists are experts on self care and experts on medicines. They are also a profession with a passion to do more, indeed pharmacy could be considered a national treasure of knowledgeable people ready to engage… just think of the additional value for money pharmacy could deliver if it was truly integrated and fully utilised within the local health community.

So, right now, the pharmacy industry needs a different approach and there needs to be a mindset change regarding what community pharmacy can deliver.

Investing in the future

At Celesio UK we are willing to invest in the future of pharmacy by developing new experiences and solutions. One example is the introduction of new technology that will allow much of the dispensing activity to be done by robots. Not only will this make the process more efficient, it will also free up the pharmacist’s time to spend with the patient in order to improve health outcomes.

Another is the effective use of data to identify patients who are experiencing difficulties with their medicines and providing an intervention programme that support these patients – personalised, outcome focused and making best use of the skills of the pharmacist. Studies in the US have shown that for every $ spent on improving compliance and closing gaps in treatment leads to a much greater reduction in overall healthcare costs. The key to this is simple – take the pharmacist’s expertise with medicines, use technology to ensure we get true insight from our patient data, and pro-actively support patients to ensure they are getting the most from their medicines. We are working with a number of CCGs to build these models.

Breaking down the barriers

The commissioning environment has seen changes recently and in some cases this has brought about a new degree of complexity, some of which are already proving challenging for pharmacy to engage with. At a time when there seems to be an increasing voice for pharmacy to do more we are seeing barriers being erected rather than walls coming down. Integrated models, encouraging professions to work together rather than feel they are competing must be a step forward that we all need to take and NHS England needs to work with all healthcare provider, including pharmacy, to make that happen.

Making it happen

Change is rarely easy and there will be uncertainties and challenges along the way, however these must not become barriers. All healthcare providers need to work collaboratively and must believe they each have an important role in a future healthcare system. Pharmacy cannot expect change to be handed to them on a plate and they must have the desire to succeed – it will take leadership, innovation, a willingness to partner and invest in a future that puts patients at the centre. This is something I firmly believe we can achieve – but we have to stop talking and start to deliver.
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Attendees

Denis Berg
Competition Policy Advisor, Monitor

Dr Mike Bewick
Deputy Medical Director, NHS England

Dr David Branford
Chair, Royal Pharmaceutical Society English Board

Katie Brennan
Pricing Development Manager, Monitor

Rt Hon Paul Burstow MP
Former Minister of State for Care Services

Thomas Cawston
Research Director, Reform

Damian Child
Chief Pharmacist, Sheffield Teaching Hospitals NHS Foundation Trust

Cathy Corrie
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Rt Hon Stephen Dorrell MP
Chair, Health Select Committee

Mike Farrar CBE
Former Chief Executive, NHS Confederation

Chris Frost
Market Development Director, Celesio UK

Clare Kerr
Head of External Relations, Celesio UK

Professor Sir Robert Lechler
Executive Director, King’s Health Partners

Eleanor Masters
Project Officer – Transformation (Strategy and Delivery), NHS England

Cllr Jonathan McShane
Local Government Association, Community Wellbeing Board

Dr Richard Oliver
Joint Clinical Director, Sheffield NHS Clinical Commissioning Group

Stephanie Parker
Partnerships Manager, Health and Wellbeing Directorate, Public Health England

Dr Jo Roberts
Clinical Lead for Innovation, Communication and Engagement, Medicines Optimisation, South Devon and Torbay NHS Clinical Commissioning Group

Dr Judith Smith
Head of Policy, Nuffield Trust

Cormac Tobin
Managing Director of Celesio UK

Dr Jo Watson
Head of Medicines Optimisation, South Devon and Torbay NHS Clinical Commissioning Group
Rt Hon Stephen Dorrell MP, Chair of the Health Select Committee, opened the discussion by setting out his thoughts on the potential of pharmacy in a reformed NHS. "Which healthcare profession is it that sees more patients every day, every week, than all other healthcare professions in the entire healthcare system put together? And the answer is pharmacists because they are on the front line. They offer immediate access to an under-exploited clinical expertise in our healthcare system."

Stephen noted that the need to reform services to meet changing healthcare needs coincides with the “Nicholson Challenge” to improve productivity in the NHS: “You’re taking 10 per cent of the UK economy and you’re saying that this highly sensitive, highly politised service, instead of growing productivity at half the national average as it has done over the last 60 years, looking forward it’s going to grow productivity at twice the national average rate.”

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However this rise in demand "shouldn’t be thought about as a total number of £125 billion. It ought to be thought about as changing needs of individuals, of individual people who place demands on the system and that the system needs to change in order to meet their needs. If it’s going to change effectively, it has to understand who those people are likely to be and what is the nature of the demand that they’re going to place upon the system as we think forward...people later in life with multiple morbidities where the objective is to provide care and support on a progressive basis that allows them to avoid unnecessary clinical interventions while of course ensuring that acute episodes can be dealt with in a timely and high quality way when those needs arise."

As Stephen argued pharmacist services need to be part of a reformed system of community services, which is about “breaking down the institutional barriers we’ve inherited between primary care and community health, and I would add in the same breath the other relevant community based services which are obviously social care and, less obviously but also important in this context, social housing.” Going forward “we have to stop thinking about a health system with a care adjunct and start thinking about a care system with medical, clinical support available when necessary.”

When thinking about the future of the health and care system policymakers need to start with “the people who use the service and think about the demands that are being placed upon it because if what we’re seeking to do is to break out of the boxes of inherited structures and think about what the care model needs to look like for the future, the obvious place to start, and indeed in my view the only place to start is the nature of demand being placed upon it by individuals who use the service...The typical user of these services is somebody who signs on for the rest of their lives whose needs tomorrow will be different from their needs today. If we think about those individuals and how we can provide the support that enables them to enjoy their life for as long as possible, then we end up with a different set of health and care institutions...and pharmacy, in my view, has a much, much bigger role to play as a kingpin of that system, a point of contact, point of support, point of advice."

“It’s a challenge for pharmacy to think about the role that it can play in that service. It’s probably an even bigger challenge for the commissioners and funders of health and care services to think about how they drive change into a very traditional service.

“...It’s a national treasure of a resource hidden away from what it can potentially achieve.”

Already there have been many
innovations in pharmacy services. Celesio for example has piloted First Care clinics. As Cormac described “we’ve launched three First Care clinics which are designed to provide a quick and convenient way to support those with minor ailments and injuries. With GPs and A&E departments coming under increased pressure we are working to provide the public with alternative solutions. Our pharmacists can gauge, with the training we are providing, how to deal with the issues and take some pressure out of the system in a more modern way…we’re actually funding the development cost of this. We’re also in discussions with a number of Hospitals to assess some innovative solutions that can support their immediate needs and I am quite confident we’ll move forward and demonstrate how we can work in an integrated way that has clear benefits to patients. It’s just we need the faith to do it.

Pharmacists need stronger, more focused professional leadership nationally and locally…Our commitment into government to make change and change policy isn’t strong enough.

The challenge is “consumer change…because the default position with anybody with a sick child or a sick somebody is go to a GP. Can’t get there? A&E. Or probably got to A&E first…And that is built over tradition and years. Now we need to change that. We need to say there are alternatives. We need to do it moderately, but none of the marketing around the NHS does that.”

In recent years there have been successive reports that have set out the potential of pharmacy and most highlight the specific opportunities “about working closer with the GPs, making pharmacists more engaging, relationship building, medicines management, optimisation…”. However there has still only been limited progress. “Pharmacists need stronger, more focused professional leadership nationally and locally…Our commitment into government to make change and change policy isn’t strong enough. We hope at Celesio to play a bigger role. We intend to play a bigger role because we passionately believe about people living healthier lives. It’s in our vision and mission statement.”

Dr Judith Smith, Director of Policy at the Nuffield Trust, argued that it is “very interesting that the wider health

Cormac Tobin, Rt Hon Stephen Dorrell MP and Cllr Jonathan McShane
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“Primary care is wising up very rapidly to the fact it needs to be operating at greater scale, seven days a week, 24/7. There is a huge opportunity for pharmacy there.”

Mike Farrar CBE, the former Chief Executive of the NHS Confederation, described three key levers to develop the role of pharmacies in the NHS: commissioners, providers and consumers. As Mike described “it seems to me that primary care is being redefined as we speak, not by doctors and pharmacists in the UK but actually the fact that there is more direct to consumer product. There is more testing. There is more diagnosis. There is online conversation. I mean the whole first response of a service is being defined around us, and the key thing is general practitioners and pharmacists sat there...”

Mike Farrar CBE

policy and organisation world is not always fully aware of all the things that pharmacy can be doing.” A key opportunity to expand the role of pharmacy is “the debate about primary care, urgent care, some of the big presenting problems of the service at the moment are so amenable to having pharmacy step up and take on its role.” Too often “general practice does probably dominate too much the debate about primary care.” However there have been positive developments. Many surgeries are “getting together in networks, federations, super...” 

judith added that many pharmacists and particularly those working in the community “are potentially isolated.” “They’re out there working very much in communities and high streets, but they don’t benefit always from quite the sense of perhaps organisation or collegiality that other professions do.”

An interesting example of where there may have been greater progress in using pharmacy is Scotland. As Judith described “they have been doing a lot of very interesting work to take forward particularly community pharmacies in quite different ways. They’re sharing records, for example, between general practice and community pharmacists... you can choose if you’ve got a set of long term conditions to nominate a pharmacy that will be your sort of lead pharmacy for managing those conditions. That pharmacy then has some funding for you being registered with them. Then your records, the pharmacy generates sort of a care plan to work with you over a year, but that’s all shared with the GP...so essentially it’s a shared care arrangement”

Judith added that many pharmacists and particularly those...
trying to think about minor contractual changes isn’t quite going to cut it...I wouldn’t underestimate the power of getting consumers to expect more from pharmacies and to challenge our system and look for pharmacists to have a bigger role. Then of course you commission the providers to play catch-up to support the consumer demand.”

David Brandford, Chair of the Royal Pharmaceutical Society English Board, discussed some of the challenges of retaining pharmacists in primary and community care. “For the last 15 years we’ve had a four-year pharmacy course, then post-graduate training afterwards. We’ve also massively increased the number of pharmacists. So we have a huge number of potential pharmacists coming on-stream available to you. But at the moment they’re leaving the profession in droves because the kind of work that you’re expecting them to do in primary care is to stick labels on boxes. So what we need to be focusing on is what we can do to enable the community pharmacist to have a really interesting, exciting, patient-centred role for these additional 10,000 pharmacists who are coming on-stream over the next few years...The profession are desperate for this to happen. We’ve got thousands of pharmacists who really want this to be their life and they’re dedicated to it. They don’t want to be just isolated, on their own, in a store, basically controlling dispensing. So I think that from the professional person’s point of view you’ve got green lights all the way down the line.”

David offered three specific factors that are leaving community pharmacists isolated. Firstly, “the medicines network is not linked up...the isolated pharmacist is not linked in in terms of records. They’re completely isolated. They’re overwhelmed by volume. They’re just having to pour out hundreds and hundreds of prescriptions on a daily basis, and the whole funding mechanism is just focusing completely on volume and not on intervening and making sure that Mrs Smith is getting the right medicines...The second thing is care homes are a real, real problem. We really have got to sort out care home medicines. The third one is domiciliary visiting. We really have got to sort out care home medicines. The third one is domiciliary visiting. We desperately need pharmacists to be going into people’s homes and sorting out the medicines. Now we have a crisis around district nursing. We are never going to get enough nurses. We have all these pharmacists coming on-stream. It’s clearly obvious a lot of these roles which are being done by doctors and nurses at the moment should be done by a pharmacist.”

Dr Jo Roberts the Clinical Lead for Innovation, Communication and Engagement, Medicines Optimisation at South Devon and Torbay NHS Clinical Commissioning Group, agreed that “pharmacists are undervalued, underutilised greatly, and I think one of the first things would be to increase their self respect but also the inter-professional respect... I think just at the moment if we went to a lot of GPs and said we’d like you to have a pharmacist they would go, ‘But why? I prefer a nurse or nearly anyone else actually.’” Yet “actually a pharmacist brings very different skills – accountability, responsibility – and possibly some risk management as well, or ability to take risk management, which complements that of general practice.”

Dr Roberts suggested that the commissioning structure was a cause for concern, because “at the moment primary care pharmacists are commissioned by the Local Area Team, and I don’t think they are the most innovative of people. Actually I think that as a CCG we would value being able to commission, community pharmacy.”

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Dr Jo Watson, Head of Medicines Optimisation at South Devon and Torbay NHS Clinical Commissioning Group, added that “in South Devon and Torbay what we’re doing around that is actually pharmacists are very good at what they do, and with their heads down doing the work and doing it very well. But the problem is they’re not looking upwards and outwards. I think it’s really important that the first step is that the pharmacy sectors work better together.”

Dr Richard Oliver, Joint Clinical Director, Sheffield NHS Clinical Commissioning Group, observed that “when I think about a GP-led commissioning group, I struggle to work out how that is going to deliver primary care. Most of the GPs, tend to think about what GPs need and think of primary care as being GP led. Moving forward certainly there is a need to think about how you deliver more effective, more efficient care outside of hospital. The care outside of hospital has to be delivered by a group of professionals working together.”

Essential to delivering this ambition is “good integration of care records”. At the moment there is a lot of contention of who can access records and one possibility to improve access across professions. “You probably need to think about registration of patients through pharmacies as well. As you move in that direction you begin to get registration attached to a primary healthcare team which includes community pharmacy and pharmacy-led skills.”

Dr Oliver also noted that the reorganisation of the NHS into CCGs has brought some challenges. Firstly, “in the old days of the primary care groups and primary care trusts, pharmacies were actively represented on the governing board”. Secondly, “we’re all shackled by a nationally determined contract held by GPs, hospital doctors and for pharmacists.”

Cllr Jonathan McShane, Local Government Association, Community Wellbeing Board, argued that pharmacies have a role in the three areas of greatest concern for Health and Wellbeing Boards: public health, urgent care and social care. However, Health and Wellbeing often struggle to engage with NHS England’s Area Teams. But nonetheless there is a big opportunity for pharmacy to transform public health such as smoking cessation services. Moreover “I think it also allows pharmacy to prove to doubting people – whether that’s in Westminster or whether it’s in the medical profession – just what they can do to show their wider set of skills… Let’s look at the skills that pharmacists have and see what can we do…perhaps now it’s about showing rather than telling and using that as a way of negotiating a bigger role in the future.”

Following the discussion on the structures and challenges of the commissioning landscape Rt Hon Stephen Dorrell MP commented that “finding your way to a decision maker about anything frankly in our commissioning system at the moment it seems to me is virtually impossible”. “One of the challenges facing Simon Stevens when he starts as Chief Executive at NHS England is to make commissioning work. Move the commissioning process to have a single focus so if you’ve got a good idea as a provider about how you’re going to change the boundary between social care, general medical services, pharmacy and repackaging it into something different for a particular population, you know where to go. You don’t have to go through umpty-nine different committees. There is one body with a budget that can use the authority to change care, which is what we’re talking about…if we don’t want another reorganisation but we want the system to evolve, the obvious catalyst to break down the national silos to create more horizontal interchange within local health economies rather than vertical responses to national bodies is the Health and Wellbeing Board.”

Stephen expressed his concern that too often commissioning takes the approach “Where do I go to get a slightly different version of today’s service?” Yet “that doesn’t begin to match up to the scale of the challenge or the opportunity.

Finding your way to a decision maker about anything frankly in our commissioning system at the moment it seems to me is virtually impossible.

What we should be engaging people, including the hospital service because that’s where the money is and it’s where people go when they don’t need to, in the reimagining of care in the local health economy. The providers have to be present, but if they’re going to justify themselves within a local health economy the commissioner needs to be a major driver for the reinvention of change.”

As well as improving the quality of commissioning national contracts also present a barrier to local flexibility: “whether you’re looking at pharmacy or general medical services or all the other national contracts, it’s simply inconsistent with all the rhetoric about reinventing care, local ownership of solutions, integration of services, to use all those words and then to actually reinforce, which is what we’ve done over the last three years, the concept of a national contract for GMS or for pharmacy or for
other clinical services”

Cormac Tobin agreed that the commissioning structure is also potential hampering the development of pharmacies in NHS care: “We go to see one; they want it this way. We go to see the next; they want it that way. We go to the other one; they’ve got that priority. While they should be local, I think there is too much local now and perhaps not enough standardisation”. So for “mundane repeat ailments, you need a standardisation around it because if you don’t have standardisation there, you will never be able to do specialisation where you’re going to be required to do specialisation because your resources will be absorbed in that area.”

Cormac also offered that copayment may drive further expansion of pharmacy services. “While our system relies upon NHS funding and all that, there is a cohort who are moving to private payment or copayment or whatever because they believe this is better. I’m a consumer. It is better for me. Somebody is looking after me better. I’m actually willing to pay somebody now. That might be a strange alien thing today. I’m not quite sure it’s strange and alien in a decade.”

Rt Hon Paul Burstow MP, former Minister of State for Care Services, responded that “there was no halcyon day when commissioning was perfect”. “The notion that it was so much better when PCTs were in existence because pharmacists were sitting around some of the tables. Well, if that were the case, then why are we sitting around this table. Why were there and are there so many different visions for pharmacy?”

Paul agreed with Stephen that Health and Wellbeing Boards have the potential to coordinate the different commissioners. They “allows ta balance between what you’re very tight about gripping from the centre, what the things are that you should set standards for, and at the same time being much looser about those things that allow relationships to form at a local level.” Specifically the Health and Wellbeing Boards also have role through the £3.8 billion Integration Transformation Fund. One opportunity “is to look to delegate the contracting and budgetary holding authority for primary care to health and wellbeing boards”. NHS England could continue to oversee to ensure and satisfy us all that every Health and Wellbeing Board can do it. There is then then “the potential to pool the social care budget, the social housing budget, the primary care budget, the community care budget, in one place and start to take perhaps some really significant decisions about how that money is better used.” This would have significant implications.
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for the role of pharmacy.

Similarly, the greater emphasis on prevention and self-care also bring new opportunities for pharmacy services. Paul noted that “we do need models that allow the sharing of risk across a range of different organisations and the sharing of reward as well. We’re talking about two sets of independent contractors in pharmacy and general practice. There is a standoff in some places. They have competitive interests. Well, we need to have contracting arrangements that allow them to work together in a way that is in the public interest.”

As others noted engaging consumers and changing consumer behaviour is key to getting more from pharmacy services. Consequently, “social marketing has an incredibly big part to play in changing where people see as their primary destination when they need to consume health services. There are really very good skills in this country for that sort of marketing. They’ve been used quite well in terms of educating people about stroke. They’ve been used quite well in terms of awareness of signs and symptoms of cancer. We need something similar over time and at scale to do the same about educating people away from the presumption which is they turn up at the A&E department as their first call.”

Dr Mike Bewick the Deputy Medical Director of NHS England noted that “one of the big problems I think we’ve got for pharmacy is this parity of esteem thing. I really just don’t think that people see a pharmacist in the same way they would see a doctor or a nurse providing healthcare in an effective way. We’ve really got to get some social marketing in that talks up the skills of this profession...The local pharmacist is not as obvious as they used to be.”

There is now growing support and momentum towards a “complete transformation in how we deliver out-of-hospital care. To prescribe a model for all of the country I think would be wrong…. For sustainable services we’ve got to work differently with other crafts and make sure that happens. We’ve got to break down the barriers, the walls between primary and secondary care and possibly tertiary care as well. To do that we’ve can’t have commissioners operating without the help of other parts of the system. My belief is that we should be strongly promoting co-commissioning of these services. Now I think we can use the health and wellbeing boards to keep that safe so that the professionals involved are not seen to be partisan or have a conflict of interest. But if we don’t actually do that co-commissioning well, then we’ll end up with disarray and fragmentation much more than we have now…The stars are almost aligned because the professional bodies that I talk to and the colleges are not as opposed to this as people might think. I think there is a realisation for sustainable services now. We can’t just keep having more of the same.”

Sir Robert Lechler, Executive Director of King’s Health Partners, argued that “the long term sustainable success of this agenda is proportional to our success in developing really innovative models of integrated care because I see the pharmacist at the heart of an integrated care system.”

One central opportunity is multi-disciplinary education. King’s Health Partners “trains lots of different kinds of health professionals, tonnes of doctors and dentists and nurses and pharmacists and dieticians and physiotherapists. Yet we train them in silos. If we’re really going to have integrated care, we need to train people to work in integrated care models. I don’t know of anywhere in the UK that’s really doing that. We do do inter-professional education. So we get doctors and nurses to work in teams. That’s fine, but it’s very hospital-centric.”

A second opportunity is to improve the evaluation of pilots of expanded
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The NHS has this great habit of changing things all the time and never evaluating. So it goes round a great big circle and comes back to the beginning again. So I think we just really do need to be rigorous about evaluation."

Damian Child, Chief Pharmacist of Sheffield Teaching Hospitals NHS Foundation Trust, noted that in acute settings pharmacists do more than “shifting boxes.” In Sheffield “pharmacy technicians are probably the biggest section of our workforce that has been growing. We have pharmacist prescribers. We have pharmacists managing patients on long term conditions in clinic.” As Damian argued “They’re doing absolutely the right thing. They’re just doing it in the wrong setting. Pharmacists within the hospital can and do manage these patients. Pharmacists out in the community could do exactly the same as well.”

Key to the success of hospital pharmacists have access to healthcare records. “The pharmacist needs to be able to input into the patient healthcare record so that their GP, their community nurse can see what the pharmacist has done.” Damian argued that IT is one of the biggest barriers to harnessing the role of community pharmacists as often it is hard to share information between providers and professionals. “What we’d love to do when we’re discharging the patient is rather than push them out of the hospital would be a proper handover to the community pharmacist. But we don’t include community pharmacists at the moment in our shared care protocols between the hospital and the GP. I think that’s a major failing.”

David Branford argued that one of the last remaining barriers to change is the absence of “authority”. In the case of Scotland, “NHS Boards has a chief pharmacist who is responsible for everything to do with medicines in the whole of the health board, regardless of whether it’s primary or secondary care… what is completely lacking in the whole of primary care at the moment, now that the PCTs have gone, is that there is nobody with any level of responsibility for medicines and making the whole medicines process work across the whole of primary care. We have no pharmacists with default positions within the current NHS commissioning outposts."

Stephen Dorrell responded that while there was broad consensus on the value of pharmacy in the NHS “the frustration is that the opportunity has been clear. The requirement has been clear. What is different in the modern world is the resource background, which is an impending train crash unless we do something about it. But apart from that this could be argued to be a depressingly familiar landscape.”

Stephen also encouraged local leaders to simply take the initiative rather than wait for permission. “If the opportunity is there in a particular health economy to find a solution which works better than the current structure, supported by evidence, preferably more than 50 miles from London because that is beyond the reach of the national press, you can actually change something, make a difference, and then draw attention to yourself when you’ve done it. But waiting for the commissioning system to get itself into a perfect organisation to set this process off I really do think is waiting for Godot.”
It does seem to me it’s no good to sit and wait for clever commissioners to think about how the system is going to reinvent itself.

“It does seem to me it’s no good to sit and wait for clever commissioners to think about how the system is going to reinvent itself. Actually the challenge is to people in your area, including the hospitals, to come and say how are we going to change care here to use the resources more efficiently to meet the needs of these patients. It’s the people who do the care day by day who know where it doesn’t work and who can think of ways how it could work better. To them I would say come forward with a solution, because if you can define a problem and solve it, then dare anyone to oppose you. If it’s against the law, you’ve got a problem. But if it’s against the rules, just do it.”

Sir Robert Lechler agreed that while the debate is similar to those in previous years “the grounds for optimism are the financial pressures in a sense. I mean that’s what’s driving, in our integrated care partners, it’s as much threat as intent.”

Mike Farrar added that “we shouldn’t fall into the trap of is just thinking this is about better, more efficient use of resource actually because you’re going to a more accessible community professional. It’s actually value-adding because you keep the responsibility and the power with the consumer of healthcare in a way which is different from going through the door of general medical services. I think we should play that bit of the story up, particularly, I think, for local government for whom that ethos of empowering citizens is much more compelling than this is a different way of avoiding cutting.”

Responding the comments on local leaders taking the initiative Dr Mike Bewick said that “CCGs phone me up all the time – ‘Can we do this?’ – and I just say: ‘Why are you asking?’ To be honest, we don’t have all the information, all the intelligence. To be honest, if you ask me and I have to go through the systems that are around me, the chances are nothing will happen.”

Chris Frost, the Market Development Director of Celesio UK, added that Celesio are doing more to demonstrate what pharmacies are already doing. “We are working with Oldham CCG as part of an integrated care model for managing high risk patients. Our clinical pharmacist will support improved patient management and outcomes using data analytics and informatics to provide a comprehensive medicines optimisation service. We’re also speaking with West Cheshire CCG, to help define a medicines optimisation service specifically focused on care homes and reducing medicine accidents in the elderly. This service analyses patient medical and dispensing data against a set of algorithms that allows us to look at common mis-prescribing in terms of things that shouldn’t be prescribed in the elderly but often are… the use of technology can particularly free up pharmacists but also support clinical knowledge and start to allow us to play a more active role rather than just rely on putting more bodies in place, actually starting to use technologies to allow us to free that time up and make those interventions more real.”

But as well as experimenting with new ways of using pharmacy the NHS also needs to be mindful that organisations adopt innovations. Sir Robert Lechler highlighted the role of AHSNs and noted that there is a senior pharmacist on the board of the South London AHSN. It would be a nice challenge to give to AHSNs actually to think about some of this stuff.”

The day job does get in the way in that while you are trying to, in effect, build a new model of healthcare delivery, you’ve still got to deliver the old one because you’ve got to have something to transfer the patients into.

Dr Jo Watson described how South Devon and Torbay is already one of the pioneer sites for integrated care and pharmacy leads are involved with reforming local services. What is needed to harness the enthusiasm from clinical needs is the “the support and the time to put into it. It’s that time on the ground to take that step back, get off that sort of rollercoaster and think and take it forward. The day job gets in the way sometimes. It’s how you make that time to think innovatively and really get behind pushing those things forward.”

Damian Child agreed that to “some extent we have been doing it just a little bit too piecemeal and possibly not pushing it far and fast enough.” “The day job does get in the way in that while you are trying to, in effect, build a new model of healthcare delivery, you’ve still got to deliver the old one because you’ve got to have something to transfer the patients into.”

Summing up the themes of the discussion Mike Farrar argued “we should be slightly bolder now about this. As we look to the next decade we should be able to see the percentage of overall expenditure that the government puts through going into out-of-hospital care grow. I think within that expenditure we should try to see the amount of resources for community pharmacies grow as well because I do think that would be the great marker that we were actually starting to get the point that we could do more and better with better outcomes through community pharmacy.