A new settlement for health and social care
Royal Pharmaceutical Society submission

Medicines are the most common intervention made in the NHS and medicines move with patients across the health and social care boundaries. They are a significant cost to the NHS with £13.8 billion per annum being spent on medicines in England in 2011/12. This is around 12% of the annual NHS budget.

Medicines play a crucial role in maintaining health, preventing illness, managing chronic conditions and curing disease. In an era of significant economic, demographic and technological challenge it is crucial that patients get the best quality outcomes from the investment made in medicines.

Data and statistics show us that medicines use is currently sub-optimal:

- up to 50% of medicines are not taken as intended
- between 5 to 8% of all unplanned hospital admissions are due to medication issues (this figure rises to 17% in the over 65s)
- medicines waste is a significant and largely untackled issue (reported as £300 million in primary care alone, about half of which is avoidable) not to mention the opportunities forgone because patients haven’t take their medicines as intended
- medication safety data indicates that we could do much better at reporting and preventing avoidable harm from medicines
- resistance to antimicrobial treatments presents a very real and significant threat to modern healthcare.
- Multi-morbidity and polypharmacy increase clinical workload, so doctors, nurses and pharmacists need to work coherently as a team with a balanced clinical skill-mix
- In 2009, adverse drug reactions were estimated to cost the NHS in England £637 million a year

If medicines are not taken as the prescriber intended this can lead to a decline in the patient’s health and potentially end up with patients being admitted to hospital.¹

Pharmacists, as the experts in medicines use, can have a beneficial impact in this high cost area for the NHS. They have the skills and expertise to maximise the investment made in medicines and minimise the risks thereby improving efficiency and quality of patient care. Pharmacists must be at the heart of medicines optimisation, they are leaders as well as clinicians, and medicines optimisation needs to become a central agenda for the NHS.

A number of recent studies have highlighted the important role of pharmacists in improving patient outcomes where medicines are concerned. ²³⁴ These studies demonstrate that when pharmacists

² http://www.gmc-uk.org/about/research/12996.asp
are sited in the correct place in the system they can have a beneficial impact on prescribing errors, medicines waste and hospital admissions. Pharmacists must be involved when care pathways are being developed as almost all care pathways will involve medicines and pharmacist are the experts in medicines optimisation.

Because pharmacists are the experts in medicines use at both operational and strategic level, they must be involved in the redesign of services as new care pathways are formed.

The successful management of long term conditions is critical to the future sustainability of the NHS. As the majority of patients with a long term condition will be taking at least one medicine, pharmacists need to be fully involved in the management of long term conditions. Polypharmacy, the concurrent use of multiple medicines by one individual, is widespread and increasingly common. The evidence base for multiple interventions for several conditions in patients is poor and polypharmacy may be harmful in that it can increase the risk of drug interactions and adverse drug reactions, together with impairing medicine adherence and quality of life for patients. The recent Kings Fund report on Polypharmacy and medicines optimisation recommends that Multi-morbidity and polypharmacy increase clinical workload, so doctors, nurses and pharmacists need to work coherently as a team with a balanced clinical skill-mix.

It is widely accepted that when patients move between care providers the risk of miscommunication and unintended changes to medications is a significant problem and between 30 and 70% of patients have either an error or an unintentional change to their medicines when their care is transferred. Involving pharmacists in medicines reconciliation and at the point of discharge can improve the information about medicines and therefore improve patient adherence.

Incidents of avoidable harm to patients can result in unnecessary readmissions (around four to five percent of hospital admissions are due to preventable problems with medicines). And in some cases the impact on patients can be devastating.

We need to work much more collaboratively across health and social care boundaries to ensure that there is adequate support right across the medicines pathway to secure the desired outcomes for the patients as well as delivering value for money for the NHS. The medicines process needs to be integrated into care pathways and the NHS system.

Pharmacists are ideally placed as highly qualified medicines experts who have experience in advising and triaging people with common ailments, exacerbations of long term conditions and acute illness and can provide support and advice on self management as well as healthy interventions to help a patient maintain independence. Patients should be guided towards community pharmacy as a first point of contact for the NHS through a variety of mechanisms at the disposal of the NHS.

Pharmacists are the experts in medicines and their use and should be responsible and accountable for the pharmaceutical care of patients. This includes medicines adherence and safe and effective

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5 http://www.kingsfund.org.uk/publications/polypharmacy-and-medicines-optimisation
7 Care quality commission. Managing patients’ medicines after discharge from hospital. 2009 www.cqc.org.uk/_db/_documents/Managing_patients_medicines_after_discharge_from_hospital.pdf
treatment with medicines. This care should encompass the monitoring of the patient’s response to treatment, covering side effects and the monitoring and use of laboratory results to optimise the use of medication for the patient. Future models and information flows should enable and support pharmacists to do this.

The adoption of Pharmacy as a health and wellbeing centre should be universal. Community pharmacies are a prime outlet for public health messages and play a key part in prevention and health protection, such as vaccination programmes, and support and improve the health and wellbeing of their communities.

There are many fantastic examples of pharmacists bridging the gap between health and social care through joint funded projects or services funded by health care to support and to reduce the overall burden on social care services. The patient benefits from having a joined up approach to their care, with a reduction in errors, medicines waste and harm and improved communications. There are additional benefits in; reduced costs to the service, improved education and team-building. We have compiled just a handful of the great examples of joined-up working across health and social care that pharmacists have been active participants in developing or enhancing services.

1. Coastal West Sussex Clinical Commissioning Group (CCG): “Proactive Care”

The CCG commissioned a “Proactive Care” multidisciplinary team stretching across health and social care to identify patients at risk of admission and then proactively case-manage them to reduce risk. There were many demonstrated benefits from this project, and positive response from all members of the multidisciplinary team for pharmacists’ inclusion.

The benefits of including a pharmacist as part of a multidisciplinary team of health and social care professionals within the model of Proactive Care include:

- **Reduction in prescribing costs and potentially avoided hospital admissions**
  - 7 avoided hospital admissions based on the recommendations from the pharmacist with a net saving of £14,192.

- **Waste reduction**
  - Stockpiling medicines in patients own homes can be unsafe, is often a marker of non-adherence with prescribed treatments and can result in wasted NHS resources. Over £1000 of unusable or unwanted medicines were identified in the pilot.

- **Medicines optimisation and a reduction in polypharmacy**
  - Over 98 interventions were made over the pilot (equivalent of 26 pharmacist days)

- **Reduction in the likelihood and consequences of patient harm. For example:**
  - A patient with a diagnosis of dementia being prescribed an antipsychotic, which was not clinically indicated
  - A patient prescribed metformin at a dose too high for their level of kidney function
  - A patient being prescribed the wrong drug entirely – a tiotropium Respimat® device was being prescribed instead of a GTN spray for exercise-induced angina

- **Resolution of discrepancies on discharge from hospital**
  - Developing links with hospital pharmacy team, direct referral from hospital to Proactive Care team

- **Accessible source of advice for the proactive care team**
Improved communication with community pharmacists
Improved patient concordance with prescribed treatments
Education for GPs around medicines
Promoting the self-management of long-term conditions

A six-month pilot demonstrated numerous benefits of incorporating a pharmacist-led service as an integral part of the Proactive Care multidisciplinary team. These include benefits to other health and social care colleagues, to the local health economy and to the health and wellbeing of patients. Following the successful pilot the service was re-commissioned across 12 integrated care teams.

2. Sheffield Teaching Hospital: “Right First Time”
The Medicines Optimisation Project is a domiciliary medicines service, jointly funded by health and social care, focusing on compliance, adherence and reablement for patients with long term conditions. The project aims to address the gap in Sheffield in relation to domiciliary medicine services; assess the impact on patients, social services and GP practices and to inform the developments of the Integrated Care Teams (ICT) in relation to medicines/pharmacy input. The project covers the practice population of the 6 practices within the GPA (51,951) and accepts referrals for domiciliary medicines assessments from GPs and Social Services (via the Community Access and Re-ablement Service - CARS). Patients are assessed in their own homes and supported to independence in relation to medicines wherever possible.

The pilot has shown benefits to;

- Social Services - reduced calls (£55K saved to date, projected at £111K at project end)
- Medicines re-ablement expertise
- GPs time saved by referring patients to the medicines optimisation team to address the more time consuming medicines tasks.
- Savings are being made to the primary care drug budget through drug alterations and medicines optimisation.
- Significant interventions aid admissions avoidance. The total saving to primary care through prescribing savings and admissions avoided is £8.6k (projected at £17.2k at project end).

The outputs demonstrate the benefits of health and social care working in partnership and the benefits to patients from this approach.

3. Croydon CCG: “Domiciliary visits by community pharmacists”
Housebound people are often on multiple medicines and usually do not have access to the same information and support for their medicines as the ambulatory population. The Local Authority funded a cohort of community pharmacists to visit housebound patients to explore problems that the patient may have with medicines and to take steps to resolve them. Referrals are made by multi-professional teams, and links have been made with the “Home from Hospital” scheme run by Age UK and the British Red Cross.

The outcomes of the medication reviews were recorded and evaluated to assess the likelihood that the intervention may have avoided an emergency admission, cost avoidance was then calculated. The project started as a pilot in December 2011. In 2012/13, 314 patients received
the service which resulted in an estimated 158 avoided emergency admissions and a cost avoidance of £440,000. The projects costs for this year were £41,880. By January this year over 60 pharmacists, across 46 community pharmacies were accredited to provide the service (including a pool of locum pharmacists). There has been an estimated cost avoidance of £165,000 for an outlay of £23,795 i.e. for every £1 spent nearly £7 has potentially been saved.

The benefits have been shown to;

- **Patients**
  - Improved access for housebound people
  - Reduced harm and improved outcomes through better understanding and adherence

- **NHS**
  - Avoidance of preventable medicines related harm including possible hospital admission
  - Up-skilling of community pharmacists aligned with improved awareness and understanding
  - Reduced waste and improved outcomes for patients

The project showed that by providing proactive support adverse effects and hospital admission from sub-optimal use of medicines could be avoided and it supports the health care strategic priorities of; long term conditions, urgent care, self-management, prevention of ill health, medicines optimisation strategy, prescribing QIPP efficiencies

### 4. Needle Exchange

Needle exchange programmes have been in operation for many years, and show benefits in reducing the risks of transmission of diseases; the World health Organisation\(^8\) have confirmed that such programmes reduce the spread of HIV amongst intravenous drug users without increasing drug use at individual or societal levels. Pharmacists provide access to sterile needles, syringes and sharps boxes in an attempt to promote safe injecting practice, and hence lower transmission of diseases. The pharmacies that provide this service are non-judgmental and client-centered. The service is guaranteed to be confidential, and aims also to provide health promotion materials when appropriate. The pharmacists provide support in advising, or signposting, the client to other health and social care practitioners where and when appropriate.

### 5. Community pharmacists as primary care practitioners.

This is a proposal developed in South London by a Primary and Community Care Clinical Leadership Group linked to the London transformation. It will develop community pharmacists as primary care practitioners including broadening the number of prescribing pharmacists in the community to achieve total system change. The potential of using EmisWeb as an IT solution to provide pharmacy access to patients’ records in a federated structure is also being explored.

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For more examples of pharmacists providing care in innovative ways and the RPS vision for pharmacists in England please see ‘Now Or Never: Shaping pharmacy for the future’⁹, an independent report authored by Judith Smith, Director of Policy, Nuffield Trust.

**Prescription charges**

The English Pharmacy Board (EPB) of the Royal Pharmaceutical Society has called for greater flexibility in prescribing for patients with stable long-term conditions.

Prescription charges prohibits over a third of people from taking medicines as prescribed, and has an impact on their ability to work, as shown by the new Prescription Charges and Employment report from the Prescription Charges Coalition.

One way to help some patients would be to look at the duration of GP prescribing intervals for people taking medication for a stable long-term condition while maintaining their contact with the pharmacist. Repeat dispensing schemes enabling a prescriber to issue a batch of monthly prescriptions held by a pharmacy of the patient’s choice could be more effectively utilised, where identified to be appropriate.

Linking the prescription charge to the repeat authorisation, rather than to each prescription form, is likely to increase medicine adherence through reduced costs and inconvenience for this very specific group of patients. It would also relieve pressure on GP workloads, while maintaining oversight and effective medicines optimisation at pharmacy level.

This would shift the provision of care to individual patient needs and circumstances allowing agreement between the prescriber patient and pharmacist on the period of time between authorisation of a new prescription.

We strongly believe that patients should be able to access high quality care in an equitable way that does not disadvantage them because of an inability to afford prescription charges.

We have not answered the specific questions but wished to demonstrate the importance of medicines in an integrated system and the expertise of pharmacists in supporting patients to get the most from their medicines.

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For further information or any queries you may have on our submission please contact Heidi Wright at heidi.wright@rpharms.com or 0207 572 2602.

About us

The Royal Pharmaceutical Society (RPS) is the professional body for every pharmacist in Great Britain. We are the only body that represents all sectors and specialisms of pharmacy in Great Britain.

The RPS leads and supports the development of the pharmacy profession to deliver excellence of care and service to patients and the public. This includes the advancement of science, practice, education and knowledge in pharmacy and the provision of professional standards and guidance to promote and deliver excellence. In addition, it promotes the profession’s policies and views to a range of external stakeholders in a number of different forums.

Its functions and services include:

Leadership, representation and advocacy: Ensuring the expertise of the pharmacist is heard by governments, the media and the public.

Professional development, education and support: helping pharmacists deliver excellent care and also to advance their careers through professional advancement, career advice and guidance on good practice.

Professional networking and publications: hosting and facilitating a series of communication channels to enable pharmacists to discuss areas of common interest, develop and learn.