
PUBLIC POLICY PROJECTS

I N S I G H T S

— INSIGHT • ANALYSIS • INTELLIGENCE —

**Collaborating to deliver
medicines optimisation
opportunities:**

*Bringing stakeholders together
within integrated care systems
to improve service access*

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spirithealth

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Foreword



YOUSAF AHMAD, CHIEF PHARMACIST AND DIRECTOR OF MEDICINES OPTIMISATION, NHS FRIMLEY ICB

In the landscape of the newly systemised NHS, the role of pharmacy is central in the delivery of system priorities, with pivotal roles in improving population health and tackling inequalities as well as enhancing productivity and value for money.

This report explores the potential for medicines optimisation, and by extension the wider pharmacy sector, to deliver the priorities of integrated care. It examines the structural barriers and system complexities that impede the effective delivery of medicines optimisation, highlighting collaboration within and across ICSs as a fundamental enabler.

Although the ability of pharmacy professionals to optimise the use of medicines provides a direct opportunity to influence system priorities, it also supports appropriate and efficient healthcare utilisation. Investment in pharmacy deliverables, such as medicines optimisation, has wider system impacts on patient flow, hospital admissions, and effective community care. However, unlocking this value is not without challenges.

The core message of this report advocates for a shift in how medicines optimisation is perceived and operationalised. The prevalent narrative of cost-centric approaches is challenged, recommending instead a patient centric and investment-oriented mindset that highlights the true value of pharmacy.

Moreover, the report examines the community pharmacy secondary care interface, highlighting the imperative of robust collaboration between hospitals and community pharmacies to harness the full potential of initiatives such as the Discharge Medicines Service (DMS) to drive patient safety and continuity of care.

The report also sheds light on the critical need for nurturing pharmacy leadership at system and community level in tandem with alleviating workforce pressures. It supports the establishment of leadership structures that empower pharmacy professionals to leverage their expertise to shape and deliver integrated care. It also proposes further enabling portfolio careers and more equitable resource allocation, nurturing the talent pipeline and supporting cross-sector collaboration.

As we navigate the complexities of integrated care delivery, this report highlights a significant opportunity for pharmacy to contribute in a more meaningful way. Through more effective collaboration to deliver medicines optimisation, pharmacy has the potential to drive positive patient outcomes and produce value-based efficiencies.

Through synthesising insights from a range of expert pharmacy professionals, this report offers actionable recommendations to support pharmacy to reach its full potential. It is our hope that stakeholders across the sector, NHS England and the Department of Health and Social Care will consider these in future reform.

Key Information

ABOUT PUBLIC POLICY PROJECTS

Public Policy Projects (PPP) is an organisation operating at the heart of health and life sciences policy delivery. We bring together senior leaders and practitioners in the public and private health and life sciences sectors to find realistic solutions to the most pressing issues relating to health and care delivery. We facilitate effective collaboration between

public and private sector organisations. We help businesses to grow their profile within the NHS and wider public sector. In turn, we support public sector leaders and organisations with practical recommendations on implementing policy to improve health and wellbeing outcomes for local populations.

ACKNOWLEDGEMENTS

Public Policy Projects' (PPP) Medicines and Pharmacy programme 2024 builds upon findings from PPP's 2023 report, Driving true value from medicines and pharmacy. The report underscored pharmacy's potential to become a system-wide strategic asset, with substantial value to bring to the delivery of integrated care. However, it also indicated significant barriers preventing pharmacy from becoming truly integrated within the nascent ICS structure.

The 2024 programme convenes stakeholders from across sectors of pharmacy, including community, general practice and hospital, as well as those from wider primary care, ICB and national leadership, to explore a pharmacy-led transformation of UK health and care.

PPP hosted the first of four roundtables of the programme, attended by more than 20 sector

leaders and key stakeholders. The insights from which have informed this report, which has been supplemented with additional research by PPP.

We would like to thank Yousaf Ahmad, Chief Pharmacist, NHS Frimley, whose knowledge and expertise helped to shape the discussion and this subsequent report. We would also like to thank our speakers, Claire Fuller, the National Primary Care Medical Director at NHS England and Duncan Richardson, Head of Service Delivery at Spirit Health, as well as all the delegates who gave up their time to contribute their insights.

Finally, we thank Spirit Health for being our industry partner on this roundtable. While Spirit Health contributed to the topics for discussion, PPP retained full editorial control of roundtable agendas, speaker acquisition and editorial output.

NEXT STEPS

The Medicines and Pharmacy programme is an evolving project with a series of planned roundtables and engagement activities across 2024. This is the first of four insights reports in the programme, which will be followed by a final report synthesising the recommendations from the series.

Using the insights produced in this report, PPP plans to further investigate the role of pharmacy in the delivery of integrated care and their contribution to wider system priorities, as well as recommend how the sector can be supported amid current funding and workforce pressures.

For those interested in getting involved in the programme, please contact Samantha

Semmeling (samantha.semmeling@publicpolicyprojects.com) or Lee Davies (lee.davies@publicpolicyprojects.com) for partnership opportunities.

PPP is also hosting a Medicines and Care Pathways theatre as part of the Integrated Care Delivery Forum, an event series highlighting exactly how ICSs are making place-based, personalised care a reality and the impact this is having on individual citizens and communities. The Medicines and Care Pathways theatre unites the pharmacy profession with wider ICS leadership to discuss and debate the contribution of pharmacy to the integrated care agenda, supporting the elevation of pharmacy as a system-wide strategic asset.

Key Insights

1. Medicines optimisation has a pivotal role in the delivery of integrated care. However, it remains challenging for the pharmacy sector to unlock this wider system value due to commissioning and contractual arrangements, and a culture, that centres medicines optimisation on its potential to deliver cost savings over patient outcomes.
2. As the second biggest cost to the NHS after staffing, it cannot be ignored that medicines present an opportunity to deliver better value for money. Shifting the narrative to highlight the opportunities for investment across the wider system that medicines optimisation could provide would help to drive engagement with key medicines optimisation priorities. However, this is reliant on greater stakeholder collaboration, particularly between industry and the NHS.
3. Medicines optimisation has significant potential to reduce patient harm and produce cost savings through the Discharge Medicines Service (DMS). For the DMS to be optimised, effective collaboration between community pharmacies and hospitals is necessary. However, engagement with the DMS is currently patchy across ICSs and requires more consistency and support.
4. There is an opportunity to unify the voice of pharmacy through effective leadership. However, pharmacy leadership across all levels of ICSs is inconsistent across England. This contributes to the lack of a single voice for the pharmacy profession, and its exclusion from essential contracting and commissioning conversations and decision making.
5. Workforce shortages across pharmacy have been exacerbated by the Additional Roles Reimbursement Scheme (ARRS). Siloed working between sectors of pharmacy has meant that the scheme has created more competition for skilled staff between sectors, furthering workforce pressures.
6. As the number of pharmacy training places increase as part of the Long Term Workforce Plan, the opportunity to develop and retain the future workforce must not be missed. Providing pharmacists with a breadth of cross-sector opportunities and adequate career development pathways is going to be critical as they take on additional clinical responsibilities.

Recommendations

1. NHS England should provide a template mandating ICBs to deploy a distributed leadership model across all ICSs. This should include the appointment of a Chief Pharmacist or similar senior leader of a pharmacy background. This would harness pharmacy as a strategic partner at system level and as a key voice in bringing industry partners to the table. It would enable the pharmacy voice to influence commissioning and contracting agreements, the better coordination of medicines teams and overall elevation of pharmacy as a profession in line with the other sectors of primary care.
2. ICBs should appoint pharmacy leadership at place and neighbourhood levels to ensure communication that drives the alignment of system priorities with local population health needs. Leadership at these levels would also support collaboration between sectors of primary care as well as providing a voice for pharmacy locally.
3. NHS England must facilitate a top-down shift in how the value of medicines optimisation is framed by implementing medicines policies and contractual frameworks which prioritise patient outcomes over cost savings. This will enable ICBs to commission, and in turn the pharmacy sector to deploy, value-based medicines optimisation and provide investment opportunities across the wider system.
4. NHS England should provide greater support for collaboration between community pharmacy and the acute sector to ensure the Discharge Medicines Service (DMS) is fully optimised. This would serve to reduce medicines-related harm after patient discharge and hospital readmissions, improving patient outcomes as well as producing significant cost savings.
5. To help address the community pharmacy workforce shortage, NHS England should implement an ARRS-equivalent scheme for community pharmacy. This funding would enable the transformation and implementation support required to significantly bolster the workforce. Decision making around the current ARRS deployment should include community pharmacy and investigate placing roles in community pharmacy instead of GP practices.
6. ICBs should work closely with professional bodies and regulators to ensure career progression structures and contractual arrangements allow pharmacists to undertake roles that facilitate cross-sector working. The current workforce mainly operates in silos between community pharmacy, general practice, and hospital pharmacy; promoting greater cross-sector collaboration will reduce the competition for skilled pharmacists across sectors.
7. With an increased number of trainees entering the system, the opportunity to develop and retain the pharmacy workforce should be maximised. Infrastructure akin to the medical deanery model should be implemented to enable joint posts and support for pharmacists' professional development throughout the entirety of their careers. Career progression must be adequately mapped out for advanced roles such as consultant pharmacists, as well as managerial and leadership roles, to promote pharmacy's competitiveness as a profession.

Introduction

Public Policy Projects' 2023 report, *Driving true value from medicines and pharmacy*, called for pharmacy to be leveraged to contribute further to the delivery of integrated care. The implementation of the Pharmacy First service in January 2024 has seen pharmacy demonstrate its increasingly central role in the delivery of health and care and goes some way to unlock pharmacy's contribution to the integrated care agenda. The service also addresses long-held calls to further elevate the pharmacy profession within the public eye.

Pharmacy is now taking on additional clinical responsibilities to support wider plans to alleviate pressure on general practice, but the sector is not without its own significant and well-documented challenges.

Following the establishment of integrated care systems (ICSs) in 2022, and the subsequent

systemisation of medicine optimisation, the ability of pharmacy to work together within and across ICSs to deliver on their key objectives has become increasingly difficult. The restructuring of medicines teams and leadership positions has created new challenges for collaboration across all parts of the system and with industry partners. This is exacerbated by wider sectoral challenges, including insufficient pharmacy leadership, workforce shortages and inadequate career development opportunities to retain the workforce. ICSs themselves sit within a challenging context, as they remain early in their development, vary in maturity and are adapting to increasing financial pressures.

This report focuses on the role of pharmacy in delivering wider system value through medicines optimisation. As part of this, it will address the systemic and structural challenges which act as barriers to effective medicines optimisation.

LEVERAGING SYSTEMISED MEDICINES OPTIMISATION

NHS England defines medicines optimisation as a strategy which *“looks at the value medicines deliver, making sure they are clinically and cost effective”*.¹ Medicines optimisation has demonstrated significant impact in the delivery of the four core priorities of ICSs; improving population health, tackling inequalities, enhancing productivity and value for money, and supporting broader social and economic development.² Despite this, it is often viewed as a transactional opportunity, relevant only to the pharmacy sector. Attendees explained that when medicines optimisation is discussed both within ICSs and at national level, it is viewed first and foremost as a cost saving exercise. As long as this narrative persists, it remains challenging for pharmacy and ICSs to work towards medicines optimisation strategies that unlock wider system value.

The perception and culture around medicines optimisation, as well as contractual arrangements that focus on cost savings over improved patient outcomes, contribute to feeding this narrative. The narrative at the national level focuses on cost savings, which filters down regionally, into ICBs, and wider systems. Attendees therefore reasoned that a top-down shift in how the value of medicines optimisation is framed is required.

While effective medicines optimisation strategies can support ICSs to deliver upon their core priorities, medicines remain an extremely high cost to the NHS (the second

highest after staffing).³ In 2022/23, the cost to NHS commissioners in England for medicines prescribed in primary care and dispensed in the community was £9.59 billion, 50 per cent of total medicines expenditure.⁴

It therefore cannot be ignored that medicines optimisation presents an opportunity to both improve patient outcomes but also deliver better value for money. Attendees recognised this but urged that narratives must shift away from cost savings towards opportunities for investment across the wider system. Further, the ability to demonstrate how pharmacy, through effective medicines optimisation, can free up funding to allow investment in other areas across an ICS would help to raise the profile of pharmacy and promote collaborative working.

Although demonstrating return on investment from medicines optimisation could be key to deploying valued-based practices and elevating the sector, generating the evidence can be challenging. Contributors explained that since pots of funding tend to be siloed, it is difficult to demonstrate the impact that medicines optimisation could have in other parts of the system. For example, medicines optimisation in community pharmacy may positively impact the acute sector by leading to fewer patients being admitted to A&E. Therefore, determining a methodology to gather evidence on investments the wider system could make is necessary to encourage support for pharmacy to deliver value-based medicines optimisation. The pharmacy sector also has a role to play in communicating this to system leaders.



Let's see medicines as an investment, not a cost





One of the biggest things that drives collaboration for me is about changing the narrative from the traditional conversation of bottom-line-thinking on medicines optimisation to what pharmacy in the wider sense does and can impact on in the system



Additionally, when contractual arrangements are centred around savings, pharmacists are limited in the medicines optimisation strategies they can employ. One attendee described this using the example of deprescribing. Deprescribing might be in a patient's best interests and an opportunity to improve their outcomes, however the community pharmacy contract does not incentivise deprescribing since it heavily revolves around the volume of prescriptions made.

A key aspect of medicines optimisation is preventing patients from taking unnecessary medications.⁵ Investing in good medicines optimisation practices and governance would support effective prescribing and thus produce a significant impact on patient outcomes. It must be ensured that the community pharmacy contract reflects this and provides the opportunity for pharmacists to take actions such as deprescribing.

As this report will discuss, establishing better leadership structures, governance arrangements and career development opportunities would also help to foster a collaborative approach to deliver more effective medicines optimisation. A report by the NHS Confederation suggests that pharmacy leadership at ICB level has enabled some systems to better coordinate the use of medicines.⁶ Similarly, deploying cross-sector roles for pharmacists would support enabling a more collaborative approach to service delivery. Facilitating collaboration to deliver medicines optimisation between all parts of the

system is essential to not only improve patient outcomes, but also to maximise value for money when working with industry partners.

THE COMMUNITY PHARMACY SECONDARY CARE INTERFACE

The most common causes of patient harm in primary care are medicines related, and primary care is where almost 40 per cent of medication errors happen.^{7,8} However, a significant proportion of harm occurs due to issues with medications after patients have been discharged from hospitals. Patients are often prescribed new medications while in hospital, which may interact with existing treatments, leading to readmissions. One study from 2022 estimated that adverse drug reaction related admissions cost the NHS in England £2.21 billion annually.⁹ This highlights a significant opportunity for medicines optimisation strategies, and pharmacy more widely, to reduce patient harm, improve outcomes and create financial savings.

To help address medicines-related hospital readmissions, the Discharge Medicines Service (DMS) was contracted in community pharmacy as an essential service in 2021. Studies supporting the DMS include research by the University of Bradford, which demonstrated that people over 65 are less likely to be readmitted to hospital if they are supported with their medications upon discharge.¹⁰ The DMS allows hospitals to refer patients who might benefit from extra guidance around prescribed medicines to their local community



Optimising the DMS is a great first step. The evidence base tells us this will prevent medicines-related harm and improve adherence, but we need support for secondary care to engage with us further



pharmacy. It has so far been identified as a significant contributor to improving patient safety during transitions of care, thereby reducing their risk of readmission to hospital.¹¹ This clearly demonstrates the huge potential of DMS to improve patient outcomes and reduce pressure on the acute sector.

Issues relating to medication changes at discharge are often the result of poor collaboration and communication between providers.¹² The success of the DMS is therefore heavily reliant upon effective collaboration, especially between hospitals and community pharmacy. However, roundtable attendees described the relationship between hospitals and community pharmacy as 'patchy' and reported that the interface between the two is not often adequately considered or supported.

Additionally, despite its enormous potential, attendees noted that the DMS is only thriving in a handful of ICSs. They highlighted the need for consistency over the current "cottage industry approach". There is therefore considerable untapped potential to optimise the DMS across ICSs to improve patient outcomes, prevent harm and reduce medicines related hospital readmissions. Further, optimising the DMS would help to maximise pharmacy's clinical skills, elevating the profile of the sector and making the role of a community pharmacist more satisfying.

DEVELOPING PHARMACY LEADERSHIP

As discussed, research suggests pharmacy leadership at ICB level has enabled some systems to better co-ordinate medicines teams, enabling collaboration and the more effective delivery of medicines optimisation.

Since their formation in 2022, many ICSs have worked towards embedding pharmacy across leadership structures, but there remains considerable variation in progress across systems. The inconsistency of pharmacy professionals in positions of senior leadership across ICSs is contributing to a disconnect among the wider profession. The Health and Care Act 2022 does not mandate the appointment of an integrated care board (ICB) Chief Pharmacist, and roundtable attendees noted that to date, only around half of ICSs have a Chief Pharmacist.¹³ This lack of representation is emblematic of the disparity in leadership between pharmacy and other sectors, and hampers the ability to offer a single voice for pharmacy within systems. Since ICBs are responsible for planning and providing health care for their localities, a lack of pharmacy leadership on ICBs also precludes pharmacy's involvement in contracting and commissioning conversations, as well as in major projects. As a result, the voice of the pharmacy sector is absent from the design and delivery of programmes relating to integrated care, despite the fact that medicines cut across all sectors of healthcare.

Without adequate leadership at ICB level, pharmacy has less opportunity to influence procurement opportunities that could drive transformation and efficiencies around the use of medicines. There are potentially vital improvements in patient outcomes as well as cost savings to be made through effective medicines optimisation. The role of industry in supporting ICSs to achieve this cannot be understated against the backdrop of workforce pressures within the pharmacy sector. Developing greater system level pharmacy leadership would therefore not only enable the better co-ordination of medicines teams but would also enable necessary procurement opportunities and collaboration across all parts of the system with industry.

Gaps in pharmacy leadership also hinder the ability of the sector to provide a unified voice, making it challenging for health and care leaders to understand pharmacy's potential to support system priorities. One attendee said, *"pharmacists need to organise themselves to make it easier for others to communicate with them,"* implying that often, healthcare leaders don't know how to communicate with the sector. Without adequate pharmacy leadership structures and support across ICSs, disconnect in the pharmaceutical voice will continue. Further, opportunities will be missed to leverage pharmacy's highly skilled workforce and unique positioning within communities to deliver integrated care and reduce pressures on wider services.

Roundtable attendees discussed the concept of distributed leadership models as a means of elevating community pharmacy to an equal partner within primary care commissioning. Such a model encompasses a form of provider leadership involving all sectors of primary care. For example, in Greater Manchester, a Primary Care Provider Board (PCB) was established in 2015 and consists of general practice, community pharmacy, dentistry, and optometry representatives.¹⁴ This structure facilitates an egalitarian and collaborative approach for primary care to contribute to delivering on their ICB's system priorities.

Local pharmaceutical committees (LPCs) offer an existing structure through which community pharmacy can speak with a single voice at the local level. LPCs are recognised by NHS England and ICBs (although they do not sit on ICBs) and are consulted on local matters affecting pharmacy owners.¹⁵ Some LPCs have begun to invest in Community Pharmacy Neighbourhood Leads (CPNLs), responsible for supporting community pharmacies within their locality, identifying unmet needs within their communities and communicating these to their local primary care network (PCN).^{16, 17} In Lambeth, CPNLs have proven effective at rebalancing pressures faced by primary care, and following a pilot scheme in 2023, saw a 300 per cent increase in referral activity for the Community Pharmacy Consultation Service, alleviating demand on general practice.¹⁸



Pharmacy is always an afterthought, even in major capital projects. How often is pharmacy forgotten about when rebuilding a hospital?





The mechanics of leadership are broken. We need to take a step back and see if the infrastructure of decision making and mobilisation is correct



Building on the work of LPCs to support medicines optimisation services should be a priority for ICBs. In 2020, Community Pharmacy England recommended that where an ICS covers multiple LPCs, “the constituent LPCs should identify a single representative of community pharmacy to join the system leadership group”. Enacting this recommendation could allow LPCs to replicate the success that general practice has had through Local Medical Committee structures, allowing community pharmacy a seat at system level and the ability to speak with a single, unified voice.

However, to build leadership structures successfully, learning and development programmes, as well as the time to complete them, must be made available to those who take on leadership roles. As one attendee explained, “it cannot be expected that they do this in addition to their day job”. Supporting this, a 2023 survey also demonstrated that CPNLs require support via protected and funded time, as well as communication and technology training, to ensure effective leadership development.¹⁹

Echoing the roundtable delegates, the recent UK Commission on Pharmacy Professional Leadership report, commissioned by the UK Chief Pharmaceutical Officers to determine what the future of pharmacy leadership should look like, found that there is insufficient collective leadership and a disjointed voice within the pharmacy profession.²⁰ The

report recommended the establishment of a collaborative pharmacy leadership council, The Independent Pharmacy Professional Leadership Advisory Board, which was launched in October 2023. The board is tasked with delivering on the recommendations of the report, which includes developing a more permanent arrangement for UK pharmacy leadership, allowing it to speak with one voice to government, regulators, patients and employers. With the board to have its first meetings over the course of 2024, exactly how it aims to meet these objectives is yet to be determined.

ACHIEVING AN INTEGRATED WORKFORCE

Substantial workforce vacancies, pressure from the Additional Roles Reimbursement Scheme (ARRS) and competition across sectors for the same staff are contributing to significant workforce pressures for pharmacy. These hinder the ability for pharmacists to effectively collaborate within their profession as well as with other healthcare professionals and industry to deliver on key system priorities.

It has been widely reported that the ARRS funding, implemented in 2019 with the aim of expanding the PCN workforce, has exacerbated the shortage of pharmacists in community pharmacy.²¹ The Hewitt Review noted that since the implementation of the ARRS, “pharmacists may now prefer to work within primary care rather than in the community or acute sectors, compounding the problem of community

pharmacy closures and delayed discharges”.²² Roundtable attendees explained that this has left many pharmacies relying on locum staff, disrupting the continuity of patient care.

ARRS funding is allocated to PCNs – which includes community pharmacy – and while pharmacy can access ARRS funding, attendees expressed concern that it is not receiving sufficient allocations. A roundtable delegate explained that general practice tends to have an outsized voice within PCNs, and by extension, in decisions around funding and resourcing. Moving decision making for the deployment of ARRS funding up to the ICB could therefore promote system level thinking and the greater inclusion of pharmacy.

Additionally, utilising existing funding, there is opportunity for ARRS roles to be placed in community pharmacies rather than in general practice. Another attendee reasoned, “a social prescriber could work out of a community pharmacy one day per week, helping to drive demand away from general practices and value into community pharmacy”.

However, for ARRS roles in community pharmacy to be successful, the sector will need similar levels of support offered to implement ARRS roles in general practice, including educational and training support. Research by PPP in 2023 recommended that separate funds should be established for an ARRS scheme dedicated to community pharmacy to address workforce shortages,

as this would not only “boost capacity for the sector but also make it a more competitive employer”.²³

To better integrate the pharmacy workforce and help to reduce pressures, more opportunity for cross-sector working must be made available. Currently, the workforce operates in silos between community pharmacy, general practice, and hospital pharmacy, resulting in competition for skilled staff. To address this, roundtable attendees stressed the need to facilitate workforce sharing across pathways and between the sectors of pharmacy, extending from trainee level up to consultant pharmacists. Deploying more cross-sector roles would also help to support an understanding of joint priorities across the system, promoting collaboration within the pharmacy profession itself as well as with industry partners.

The NHS Long Term Workforce Plan aims to grow the number of training places for pharmacists by 29 per cent by 2028/29 and to double all training places by 2031/32.²⁴ A potential influx of trainees presents a unique opportunity to shape the future workforce. This has already begun by preparing all newly registered pharmacists to be able to independently prescribe by 2026.²⁵ However, it is essential that pharmacists at all levels receive adequate support to enable their professional development. One attendee suggested this should be overseen by infrastructure akin to the medical deanery

Community pharmacy leadership should not have to challenge ARRS roles. Decisions should be based on good outcomes; it is sad that sector specific funding needs challenging.

model, which involves education and training for the profession mandated in the roles of senior clinicians and formalised professional development throughout the entirety of one's career. This structure could also facilitate joint posts to enable cross sector working across the often siloed sectors of pharmacy. This would enhance collaboration and communication across sectors of care, improving the delivery of medicines optimisation and wider integrated care priorities. The establishment of a deanery-equivalent structure would also promote equality between pharmacy and the medical profession, which is increasingly necessary as pharmacists take on additional clinical responsibilities.

To ensure workforce retention, pharmacy must break out of historically flat career progression structures. Advanced roles such as consultant pharmacists have gone some way to address this, however clear career pathways which encompass both clinical, managerial and leadership roles must be well mapped out and advertised to ensure pharmacy takes a competitive position as a profession.²⁶ Portfolio careers have also become more common, which allow pharmacists to work across sectors, but similarly, adequate career progression structures, as well as supporting contractual arrangements that support workforce sharing across different pathways are required to facilitate these.



There has never been a clear funding pathway to employ cross sector pre-regs and pharmacy students in the system. It is a major challenge as a profession to socialise these things, they should be completely normal



CASE STUDY

OPTIMISING DOAC THERAPY: A COLLABORATIVE APPROACH TO IMPROVED PATIENT CARE AND COST EFFICIENCY

By Selma Abed, Head of Medicines Optimisation, Spirit Health, and Duncan Richardson, Head of Service Delivery, Spirit Health.

Direct-acting oral anticoagulants (DOACs) are widely recognised as alternative anticoagulants to prevent strokes in patients with Atrial Fibrillation (AF). There are four DOACs available; the objective was to optimise care for all patients prescribed a DOAC for NV-AF and to review patients prescribed apixaban to see if a lower-cost alternative could be used. This medication needs to be reviewed annually, which requires high levels of collaboration between primary and secondary care.

When the work was undertaken, apixaban was the highest-costing drug to the NHS in England in the 2022/23 period. The work ensured patients were on the appropriate DOAC and dose regime for their renal function, liver function, weight, co-morbidities, and medication to ensure optimal oral anticoagulant (OAC) therapy.

The Spirit Active Implementation™ team identified all patients on existing DOAC therapy, checking patient eligibility to change through up-to-date patient blood records. To fulfil the objectives, the project required continual collaboration between the Spirit Active Implementation™ team with multiple GP practice staff, secondary care HCPs, and multiple stakeholders across the locality.

The review service not only highlighted those who were eligible to be switched to a lower-cost DOAC alternative but also identified drug interactions, patients requiring alternative medication, enhanced monitoring, and dosage adjustments.

Delivered change:

Improved Patient Care: Identified 1224 patients requiring intervention across 25 practices, including medication adjustments, discontinuation, or additional monitoring, impacting their individual health outcomes.

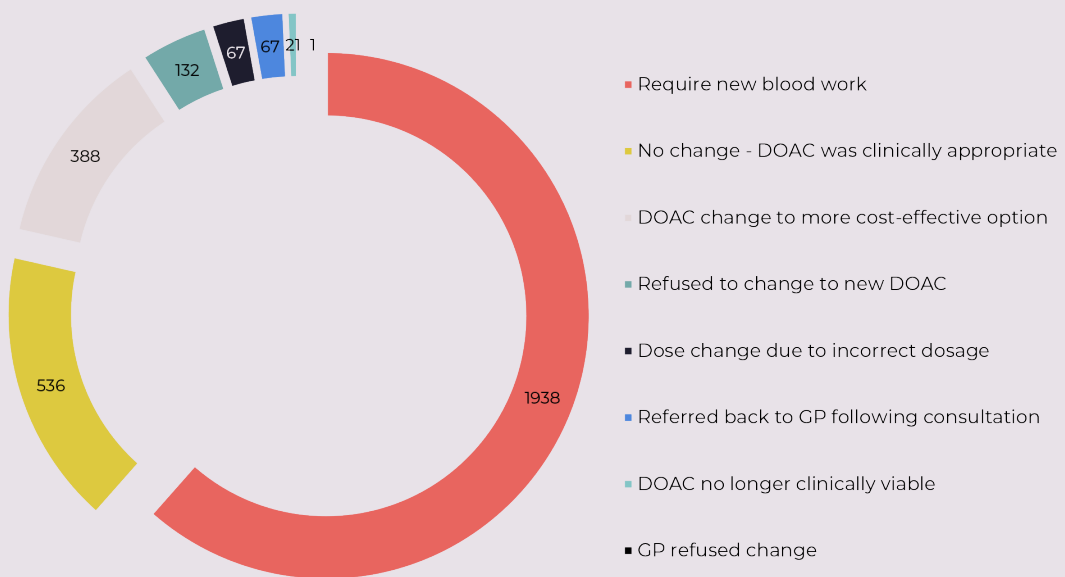
Cost-Effectiveness: Identified 32 per cent of patients potentially eligible for a more cost-effective medication, offering substantial savings for the locality.

Enhanced Collaboration: Actively supported collaboration between nine key stakeholders across primary and secondary care, with an

average of three meetings per stakeholder across a total of 3489 patients.

Proactive Approach: The project identified 1938 patients with outdated blood work and weight measurements, these findings were communicated to the locality for further assessment. Additionally, direct intervention was taken by Spirit for 1551 patients whose records were up to date. This two-pronged approach demonstrates a proactive strategy to address both immediate needs and potential future concerns before symptoms arise.

Number of interventions identified in locality DOAC review service



Potential impact:

- **Patients:** Improved health outcomes, reduced medication errors, and potentially lower medication costs.
- **Healthcare System:** Cost savings through prescription switches and potentially reduced hospital stays due to improved preventative care.
- **Healthcare Providers:** Up-to-date patient records and enhanced AF training, potentially leading to better patient outcomes.
- **Future Initiatives:** Provides valuable insights and a potential model for broader implementation of similar quality review programs.

The work demonstrates an innovative quality review project to optimise patient care for those prescribed a DOAC for AF. It is a compelling example of how such initiatives can improve patient outcomes, optimise healthcare systems, and empower providers.

To see how Spirit Health delivers results and to learn more about their success in optimising therapy areas, please [click here](#).

To explore how to improve patient care and reduce costs, contact Spirit Health today to discuss a partnership for your current and future medicines optimisation reviews.

Conclusion

Medicines cut across every sector of healthcare, but too often, pharmacy is an afterthought in the design and delivery of care. While some ICSs are developing better pharmacy leadership structures, there is significant variation in progress. ICSs that do give pharmacy a voice at ICB level are able to better co-ordinate medicines teams, ensure pharmacy is working collaboratively across the system and help colleagues to understand the sector's full potential.

Medicines optimisation provides the opportunity to support ICSs in delivering their core priorities as well as better value for money. Shifting the narrative from savings towards investment and embedding outcomes-centred contractual arrangements will help to make value-based medicines optimisation a reality. Enabling sufficient collaboration across all sectors of pharmacy with the wider system as well as industry partners will help to deliver services, holding promise for improving patient outcomes, system efficiency and value for money.

Workforce shortages and cuts to ICB running costs create a challenging environment for ICSs to develop truly integrated and collaborative pharmacy workforces. However, the evolution of both clinical and managerial roles within pharmacy has elevated pharmacy as a profession, helping to place it on equal footing with the other professions of primary care. Developing opportunities for cross-sector appointments, allowing pharmacists to work and collaborate with general practice, and more structured career pathways would further help to reduce the competition of skilled pharmacists across sectors and will ensure pharmacy's future competitiveness as a profession.

Stronger pharmacy leadership structures, the ability for pharmacy professionals to fulfil cross-sector appointments, and a narrative shift around medicines optimisation are just some of the essential steps necessary to truly integrate pharmacy services within ICSs. By addressing these challenges, the pharmacy profession can play a pivotal role in delivering high-quality and cost-effective care.

Attendees

The insights and recommendations of this report have been informed by a roundtable event which took place on the 15th February 2024. Thank you to all the participants of the roundtable, and those who supported and gave comment to the report.

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