Medicines Optimisation Centricity

Is it creating health inequalities?

A review by **HSJ Advisory**
in partnership with Aspire Pharma Limited

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Foreword

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> **Medicines use can be a driver of health inequalities, an indicator of the extent to which they exist, or a lever to address them. Understanding this and using medicines well will allow us to improve the health of our population.**

This roundtable presented the opportunity to take a step back and consider medicines optimisation in the new integrated care environment, and through the lens of health inequalities. It considered whether medicines optimisation does in practice deliver what it is intended to, or whether in fact the established approach and interpretation of the concept worsens those inequalities and adversely affect particular cohorts of our population.

The individuals involved brought a range of experience and insight which informed a broad discussion, from the theoretical and purist through to the practical and pragmatic. One example of where there was broad agreement was that there is a common disparity between what medicines optimisation is as a concept, versus the organisational understanding of medicines optimisation and consequently what many medicines optimisation teams do.

Medicines are the most common and most evidence-based intervention in healthcare and offer the greatest impact on outcomes of all healthcare activities. They are too often seen at commissioner or organisational level as an expenditure to be managed closely and an opportunity for efficiencies to be extracted, rather than an investment in the health of a population. That is not to say that efficiencies are not available - in a budget of that size and where there is significant waste there will always be opportunities to improve the cost efficiency of prescribing. The era of switching patients from one product to another however is over; not only is that a zero sum game, it creates significant lost opportunity cost for both patients and clinicians. The genuine efficiencies in medicines optimisation in the new system come from engaging patients in their treatment and giving them agency to understand and express preferences for their treatment options, focusing on safe and effective prescribing which includes deprescribing as often as it does prescribing. Investing in evidence-based prescribing for the prevention of long-term health problems and a relentless focus on quality, recognising that short-term expenditure on a medicine can drive very significant long-term improvements in outcomes and reductions in health inequalities.

A major system barrier to this approach being implemented is the availability and accessibility of non-pharmacological treatment options. The metaphorical prescription pad is too easy to reach for in a short consultation and is most commonly the solution a patient is looking for. The system needs to create capacity for proper detailed patient-centred medicines reviews, stronger links with social prescribers and the voluntary sector, and holistic multidisciplinary reviews.

The world of medicines prescribing, supply and optimisation can be opaque to non-specialists, but medicines are a part of almost every clinical pathway in the NHS. One of the recommendations therefore from this round table was the development of a training approach for non-specialists - ‘medicines for managers’. As we move towards competency-based regulation of NHS managers there is an opportunity to increase awareness of medicines in the next generation of decision makers, which will result in better systematic understanding of the importance and challenges of using medicines well across a population.

Background

HSJ Advisory has partnered with Aspire Pharma to consider key issues around medicines optimisation.

In 2023, HSJ Advisory (formerly Wilmington Healthcare) ran two roundtable events with key pharmacy and NHS stakeholders, creating a white paper report on the way forward for Medicines Optimisation Centricity.

A wide range of stakeholders from across pharmacies in England were involved and contributed to the development of the white paper. This included advisors in pharmacy clinical leadership roles, which involve issues such as workforce and resilience of pharmacy services across the system, and pharmacy teams involved in medicines optimisation on the ground.

A thought leadership article was published in the *Health Service Journal,* linking to the report and stakeholder video interview content.

Medicines optimisation

Over the past few years, the NHS has attempted to implement a programme of medicines optimisation via its organisations and processes. Several initiatives have been launched to support this agenda:

1

NHS England (NHSE) has promoted the **Royal Pharmaceutical Society's** guidance **Medicines optimisation: helping patients make the most of medicines**,[1] which was developed in collaboration with patients, the medical and nursing professions, and the pharmaceutical industry.

2

The **National Institute for Health and Care Excellence (NICE)** has published guidance: **Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes.**[2]

3

In organisational terms, **regional medicines optimisation committees (RMOCs)** have been set up to drive the changes needed in prescribing and medicines use, including reducing waste, improving health outcomes from medicines, and making the best use of NHS skills and resources. In particular, RMOCs have carried out work on **biologic and generic medicines.**[3]

4

A medicines optimisation **commissioning for quality and innovation (CQUIN)** – part of the incentive scheme for providers to **implement quality and innovation goals**[4] – is in operation for secondary care.

5

A **medicines optimisation dashboard**[5] is in place, allowing local medicines optimisation teams to see crucial data from their territory and monitor trends, including patient experience, although this is of limited benefit for secondary care.

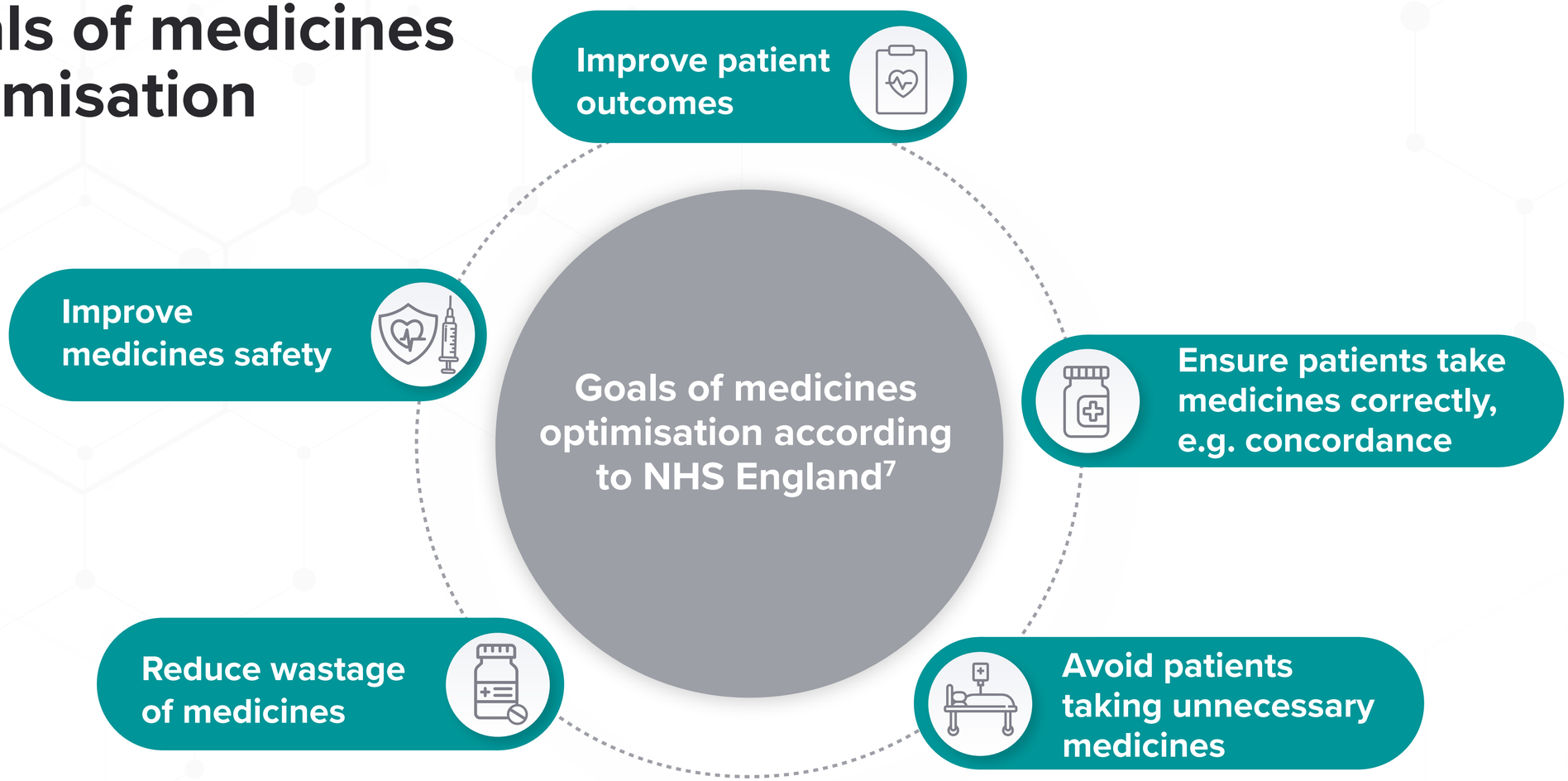
6

On 1 July 2022, the new Health & Social Care Act came into force, meaning commissioning moved from now defunct clinical commissioning groups (CCGs) to 42 **integrated care systems (ICSs)**, with 200 provider collaboratives being the new decision-makers to look at requirements based on local population needs. This will have the single biggest impact on commissioning in years to come.

7

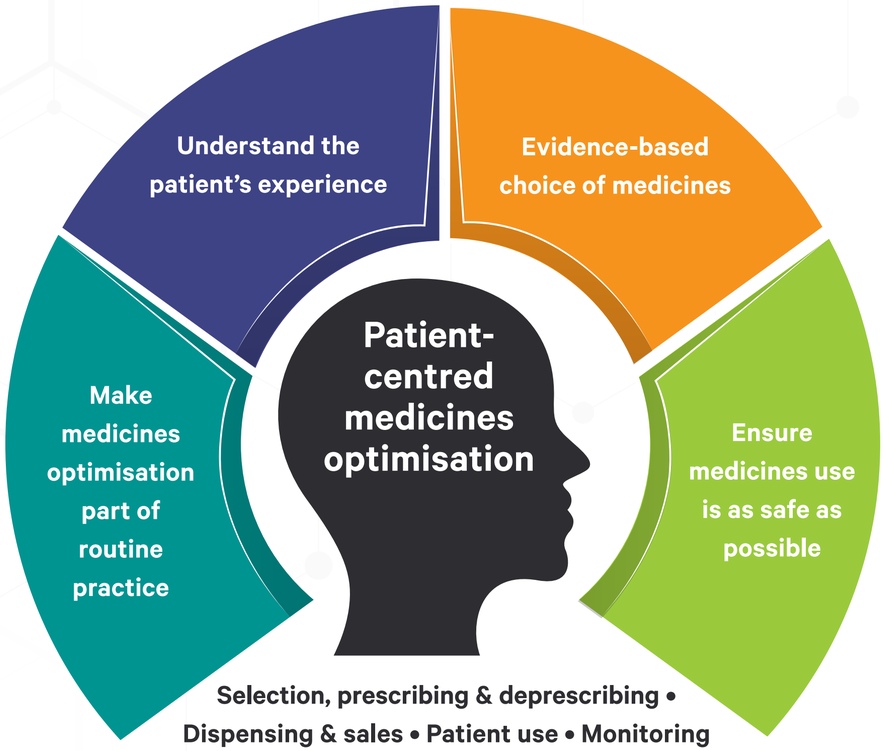
NHSE published **National medicines optimisation opportunities 2023/24**,[6] which describes 16 national medicines optimisation opportunities for the NHS in 2023/24 and signposts to resources to help with their implementation.

Goals of medicines optimisation



‘Although the high-level intention has been clear, how has medicines optimisation really worked over the past decade?’

Vision of patient-centred medicines optimisation[8]



- Improves outcomes in population health and healthcare
- Tackles inequalities in outcomes, experience and access
- Enhances productivity and value for money
- Supports broader social and economic development
- Combats global issue of antimicrobial resistance (AMR) and reduces risk of harm
- Aids delivery of a 'Net-Zero' NHS
- Is everyone's responsibility

Purpose of this paper

In July 2024, HSJ Advisory ran a single roundtable event, bringing together key pharmacy stakeholders (Appendix) to debate and discuss medicines inequalities, specifically considering how the current practice of medicines optimisation could be creating health inequalities/inequities.

Medicines optimisation has taken us to the next level from the traditional medicines management. It has cemented the importance of medicines and their need to be used effectively in patient care. It has provided the much needed focus and steer to improve patient care and safety. However is it fit for our future needs?

The aims were to:

- provide an understanding of the Medicines Optimisation Centricity programme
- look at some of the existing medicines health inequalities and inequities that patients are experiencing
- discuss what needs addressing to reduce these inequalities and how this can be achieved
- generate an understanding of the expected impact by the change in the current system
- discuss how partnerships can help reduce the inequalities
- identify the call to action and elevator pitch to address the issues.

Under Chatham House Rule, delegates were asked to give their views on the state of medicines optimisation today, barriers for patients, and whether medicines optimisation is creating inequalities. They then discussed how medicines optimisation could be changed to reduce inequalities. Finally, they discussed the role of industry and the next steps for all stakeholders.

This white paper summarises the key themes of the discussions, with a view to helping address some of the issues raised by delegates and pointing the way towards how inequalities created by medicines optimisation can be addressed effectively in the NHS.

> **Quotes included throughout this paper are adapted from the discussions at the roundtable meeting, have been edited for sense, and may reference individual examples provided by attendees.**

Medicines optimisation has been doing a great job,
but is it putting the patients at the heart of the equation enough?
Is medicines optimisation the way forward?

Is it time for medicines optimisation to be scrapped?

The problem with medicines optimisation

> **What medicines optimisation is meant to be and what medicines optimisation teams actually do are two very different functions.**

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There are many problems with medicines optimisation, most of which lead to inequalities:

1. The ideal *versus* the reality
2. Unclear focus and remit
3. Pressures to save more financially and make in-year savings
4. The absence of a patient-centric approach
5. Systemic barriers leading to inequalities
6. Issues with primary care engagement
7. Lack of understanding of the role of medicines
8. Focusing on easy wins by avoiding complex situations
9. Issues with tariffs
10. Focus on short-term costs negatively impacts patient experience
11. Low prioritisation of health inequalities
12. The challenges of community pharmacy and the community pharmacy teams

1. The ideal *versus* the reality

The **care of the patient should be at the centre** of all decisions relating to medicine, with all the challenges they face taken into account in decision making, such as **access** to pharmacy, **supply** issues, **correct and appropriate** intervention, clinical **effectiveness**, and patient **safety**.

The ideal:

> **Medicines management teams are tasked with bringing the organisation into financial balance**

The reality:

In reality, medicines optimisation has become more about **finances** and **budgeting**, underpinned by a **lack of understanding** of the role of medicines by non-clinical management teams who end up driving the focus of medicines optimisation teams on **in-year costs** rather than the bigger picture of system savings and improvements in patient outcomes.

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2. Unclear focus and remit

What medicines optimisation is **meant to be** and what medicines optimisation teams **actually do** are **very different.**

Medicines optimisation has become a **task rather than a philosophy.** It seems, especially since devolution of contracts, like medicines optimisation is a **scapegoat issue** for **anything that does not fit anywhere else** because of diminishing teams'.

> **Is everything else that is being put into the bucket of medicine optimisation stopping us from achieving our intended aims?**

> **I used the Additional Roles Reimbursement Scheme (ARRS) funding[9] that came through in 2019 during COVID-19 to set up a training plan. I went to the Centre for Pharmacy Postgraduate Education and looked at their 18-month training pathway, and I built a training pack for our pharmacies and technicians to bridge the gap between what medicines optimisation does and what we do differently. The problem is that their role is not what we think their role is – it is shoring up primary care, and what they do actually is not maximising their potential, but without them, primary care will probably fall.**

3. Pressures to save more financially and make in-year savings

Medicines optimisation has become a term to describe the management of the impact of medicines on budget. With the immense pressure on organisations to make savings, the decisions made can seem disjointed and short sighted. Medicines are perceived as the primary **line of expenditure** and the drugs budget is often seen as a **budget to be raided** in a financially-led NHS. Saving money in-year is sometimes the focus rather that the prevention of future admissions which is not a 'cashable' saving, unlike a drug expenditure. This distracts medicines optimisation teams from being able to plan to develop and implement mid- to long-term, cost-effective **system wide improvements**.

> **Budgets are increasing by about 2% but in real terms inflation is 9–10%, so you are already running at a deficit when you get your budget. Then you are told to make efficiency savings of £3 million, £5 million or even £15 million and the quality falls off. There is little thought about the value of medicines to the patient, because the only value medicines optimisation is bringing is efficiency savings to a wider system for a short period of time.**

> **Medicines optimisation teams know what needs to happen, we just do not seem to be able to get to it.**

Often large-scale medicines switches result in **national shortages** of the drug being switched to. Wholesalers then stockpile and increase prices. This is compounded by the membership system, with pharmacies in practices and hospitals on different membership packages, which means some can get molecules while others cannot, and with different pricing. The net result is often that patients do not get the drugs they require.

Is this really a saving?

> **When we're talking about saving money for a particular line in an ICB budget, we aren't saving money, we're shifting the cost elsewhere.**

4. The absence of a patient-centric approach

Patient centricity is often missing from the current approach to medicines optimisation as wider pressures around cost can focus on national targets or ICB priorities rather than the individualised approach that may benefit the patient.

NHSE identified **16 opportunities for medicines optimisation** based on alignment with **ICB priorities**.[6] NHSE recommends that ICBs choose at least five of these opportunities to deliver on alongside identified local medicines optimisation priorities.

National medicines optimisation opportunities 2023/24[6]

Appropriate use, access and uptake

1. Addressing problematic polypharmacy
2. Addressing low priority prescribing
3. Improving uptake of the most clinically and cost-effective medicines
4. Obtaining secondary care medicines in line with NHSE commercial medicines framework agreements
5. Standardising product formulations of aseptically compounded medicines
6. Using best-value biologic medicines in line with NHSE commissioning recommendations.

Specific clinical areas

7. Addressing inappropriate antidepressant prescribing
8. Appropriate prescribing and supply of blood glucose and ketone meters and testing strips
9. Identifying patients with atrial fibrillation and using best-value direct-acting oral anticoagulants
10. Identifying patients with hypertension and starting antihypertensives where appropriate
11. Improving respiratory outcomes while reducing the carbon emissions from inhalers
12. Improving valproate safety
13. Optimising lipid management for cardiovascular disease prevention
14. Reducing course length of antimicrobial prescribing
15. Reducing opioid use in chronic non-cancer pain
16. Switching intravenous antibiotics to oral.

5. Systemic barriers leading to inequalities

Issues with the underlying structure and historical set up of organisations within the NHS can **create** and **exacerbate inequalities.**

- **Lack of understanding around medicines**
- **Resistance to change**
- **Workforce, workloads and developing new approaches**
- **Understanding the demand (current and future) along with inequalities**
- **Lack of review, benchmarking and recognising local achievements**
- **Structural changes within the NHS**

The local landscape can impact on approaches to healthcare:

- Areas with hospitals and universities working and researching in collaboration with industry can lead to new opportunities, encourage more forward thinking and willingness to push boundaries and drive new approaches to healthcare and medicines. Conversely, areas without this impetus to change and look forward can get stuck in a rut and perpetuate outdated and legacy approaches.
- Areas with smaller medicines optimisation teams may struggle to cope with the workload and to develop new approaches and so may need support from larger neighbouring teams to plan and implement new projects and initiatives.

As local populations increase and diversify, without any deliberate planning to adapt and without increases in resources in affected areas, existing inequalities are exacerbated and new inequalities are introduced.

There is inadequate review of how the system is performing, particularly on a local basis, with national benchmarking providing a false narrative that does not recognise local frontline issues and achievements. When change is needed, leadership is often not willing to make transformational or transactional change.

Constant restructuring of the NHS is an issue. By the time structural changes are up and running, government introduces another reorganisation, so you never see the long-term impact of all the restructuring work.

> **“There’s an enormous dichotomy between the importance of medicines to patients and clinicians and what it means in the system… I’m used to being in a room where people just do not understand medicines… If you say, “name six medicines that are important for this pathway”, they can’t answer that. It’s just a financially-led NHS.”**

6. Issues with primary care engagement

Prescribing system aids

The British Medical Association (BMA) has issued a notice that **general practitioners (GPs)** are **taking collective action** in nine key areas, including **prescribing systems**. GP partners are torn about switching off prescribing decision support systems, because there are **real benefits in terms of safety**. However, as these systems **save millions of pounds locally each year**, switching them off will **draw attention quickly**.

- **Is there a 'hands off' transfer of responsibility issue between the medicines optimisation teams and the general practice, each wanting to make decisions but do not want the responsibility that sits behind it?**
- **Where is the distinction between using clinical judgment to treat, approval of processes to provide the treatment compared to what the ICB is handling with medicines optimisation?**
- **Why does community pharmacy commissioning fall under medicines optimisation within ICBs when it should sit within the primary care team?**

Additional Roles Reimbursement Scheme (ARRS) roles

Funded pharmacist roles within general practice support GPs with prescribing and monitoring a cohort of patients **in line with their competencies**.

Physicians' assistants (PAs) are intended to **work alongside GPs**, but **clarity** is often needed **around their roles and responsibilities**. In some cases, **GPs do not want to supervise**, which **impacts** on PAs' **ability to undertake their roles safely**. In terms of medicines optimisation, PAs can **recommend medicines** and, in some cases, **prescribe from a limited formulary under the supervision of a GP**. However, PAs must still **ensure their recommendations** are in line with the **principles of medicines optimisation**.

> **"The challenge is trying to get all the additional funded roles in primary care to align with wider system working. This means supporting the roles and having levers like the Investment and Impact Fund (IIF), which has been taken away and re-introduced, to help drive system working."**

7. Lack of understanding of the role of medicines

The **positive aspect of what medicines do in care** is often **forgotten,** yet a **patient rarely leaves** a GP practice or outpatient appointment **without a prescription for a drug.**

Service redesigns are often **financially led, without considering the role of medicines,** There is enormous **dichotomy between** the **importance of medicines to patients and clinicians** and what it means **in the system.**

People involved in **decision making** or **pathway development and redesign** often **do not understand** what **medicines** are, **their role,** which **drugs** are relevant for **specific pathways,** and even that there are **approved formularies.**

There is often a **disjoint between what should be prescribed and what is prescribed** – for example, patients are often **started on an antihypertensive but not a statin** or are **started on a statin but not an antihypertensive.**

> The term ‘prescription’ is widely misunderstood – a prescription is not necessarily a medicine but can also be advice such as diet, lifestyle, or counselling.

There is **reluctance to undertake deprescribing** – not initiating or not stopping treatments that are not appropriate. This is **often due to lack of medicine reviews,** which can mean that **patients stay on medicines for years** when they no longer require them, resulting in stockpiles at home. The **budget impact** for **low-cost medicines** that go under the radar but are **taken by many people builds up.**

A tendency towards **over-medicalisation and over-medication** has led **patients to expect a prescription for a drug for every condition.** This can lead to **patient disappointment** when they leave their appointment without a prescription and **puts prescribers under pressure** to meet that expectation.

> Lack of understanding of medicines can ultimately lead to patients not trusting the system. Those who are more confident and better educated may self-activate and push compared with those who are less confident and educated, which can lead to inequities.

8. Focusing on easy wins by avoiding complex situations

Given the task of **Medicines optimisation** teams who are **under-resourced** and **under pressure** to deliver demonstrable change will **prioritise easy wins**, and easy-to-reach patients with **good communication** and engagement, **who can be reached through traditional routes.**

People who do not engage because they **do not have English as a first language** or **find it difficult to communicate** or understand for other reasons, such as **learning disabilities, poor literacy, lack of IT connectivity or social mobility,** cannot be reached through traditional means. **Clinicians** may **leave patients with communication difficulties** on overused and **potentially ineffective medicines** to **avoid challenging conversations**. These groups **tend to be overlooked,** because the **savings achieved** will be **lower for more effort.** (As mentioned previously, poorly managed population increases can exacerbate and introduce inequalities.)

Poor communication between the patient and pharmacist can mean that a patient may not be clear on what to do with their medicines, presenting a safety risk, and meaning that the medicines may not achieve the aim that was intended. Doing a switch for a cost saving benefit for example therefore presents **a risk if the patient-specific factors** are not considered.

Lack of engagement with complex patient cohorts can exacerbate health inequalities in people already disadvantaged in the system.

Buy-in from general practice and **motivation for highly qualified clinicians and pharmacy technicians** to undertake medicines optimisation work **decreases** if they feel they are **not making a difference.** This is **further exacerbated** by the fact they are working in much **smaller teams** due to 20–30% reductions in workforce in ICBs and are **expected to do more with less resource.**

> **“I work in a very deprived area, very inner city, one of the top 10 in the country, and we find that if it’s not your first language or you’re actually not very good with English…the lack of communication [means] the patient goes back onto their original medication. So, actually, now we create all this work for nothing across the system.”**

9. Issues with tariffs

The **Category M tariff**[10] and associated additional monies are intended to **allow pharmacies to survive financially.** However, **ICBs** are being **told to take money** from the **£800 million** associated with Category M prescribing because that is where we can make a saving. This is **not done uniformly,** and we are simply **creating a loss elsewhere.**

Furthermore, the **cost of molecules and sales of drugs** have **increased 30%** in the 14 years **since Category M was introduced,** but the **£800 million retained buying margin has not increased** over the same time period.

Retained margin (Category M)[10]

Community pharmacy received £2.592 billion per year from 2019/20 to 2023/24. Of this, £800 million was delivered as retained buying margin – the profit pharmacies can earn on dispensing drugs through cost-effective purchasing. The retained margin element is a target the Department of Health and Social Care (DHSC) aims to deliver on by adjusting the reimbursement prices of drugs in Category M of the Drug Tariff, which was introduced in April 2005 when the new community pharmacy contractual framework was launched. The Drug Tariff is used to set the reimbursement prices of more than 600 medicines.

Category M is the principal price adjustment mechanism to ensure delivery of the retained margin. It uses information from manufacturers on volumes and prices of products sold plus information from the Pricing Authority on dispensing volumes to set prices each quarter. As reimbursement prices have to be set in advance, estimated volumes are used. Where the delivery rate of margin to community pharmacy is estimated to be under or over the £800 million target, DHSC re-calibrates Category M Drug Tariff prices.

One problem is products not available to purchase at the Category M reimbursement price. The DHSC sets Category M prices at levels substantially above the prices notified by manufacturers, but when the Category M reimbursement price for a particular product falls, it may take time and sustained pressure from pharmacies for wholesale prices to respond.

Category M prices are set to include an element of purchase profit, so reimbursement prices may be higher than manufacturer's list prices. To save money, some ICBs (formerly Clinical Commissioning Groups, CCGs) may encourage branded prescribing. When products are prescribed generically, pharmacies seek to obtain the best available generics prices, driving down the prices charged by wholesalers and manufacturers and in turn the drug tariff reimbursement prices and costs for the NHS. Prescribing branded generics or off-patent branded medicines profoundly affects the competition that drives down prices in the generics market and acts to drive up costs to the NHS. It can also lead to unequal geographical distribution of the funding under the contractual framework.

10. Focus on short-term costs negatively impacts patient experience

By **controlling costs,** the system makes it **harder for patients to see the person they need to see** by directing them towards staff with **lower qualifications** and so **lower associated costs.**

This **likely increases long-term costs**, as patients may not necessarily be seen by the **person best suited to provide optimal management**.

If **patients feel fobbed off and misdirected**, they will wait longer on waiting lists and are **more reluctant to use the NHS** in the future, which can **impact on** their **long-term health** and **healthcare costs**.

This also **drives inequalities**. More **educated** populations **understand how to work the system** to **access the person they want to see**. More **affluent people** will be able to **fund alternatives** such as **private practice**. **Less educated and more deprived** populations **do not have** the **knowledge or opportunity** to seek out and pay **for alternative healthcare**.

11. Low prioritisation of health inequalities

Although **health inequalities** are an **NHS priority,** they are **not necessarily prioritised or taken seriously in a resource-constrained environment**. The **focus** is typically **on more visible issues** such as **long waiting lists, ambulance call times** and **finance.**

There is **reticence among healthcare providers and the public** for adoption of **altruistic approaches** in which **money is redirected from services that are working well,** with the risk of reducing service quality, **to services that are performing poorly** to help them improve.

Ultimately, this is a **shortsighted viewpoint,** as **services shared between these areas** are likely to be **overused** in the future by **people from poor service areas,** which will **reduce access for all** and **cost more** due to **increased use of more costly healthcare resources.**

12. The challenges of community pharmacy and the community pharmacy teams

The **current NHS** structure is **set up for** one community viewpoint – that of **general practice.** GPs speak with one voice and have a **presence in NHS organisations and systems** – often the medical director and chief operating officers are GPs or clinicians. In contrast, **community pharmacies** are **multiple separate entities** with multiple voices across one area and **rarely have any representation within NHS organisations.** Notably, the **chief medical officer** is an **NHSE-mandated role for ICBs,** but the **executive role chief pharmacist** is **not mandated at executive or any other level.** This difference is **not just** apparent at **executive level,** as a **large proportion of ICBs** have **no chief pharmacist** and where there is **chief pharmacist,** they tend to **work in this role 1–2 days a week** on a **secondment** from elsewhere. This all results in a **lack of organisational focus or priority for medicines.**

Community pharmacists are the **most accessible healthcare professionals** in any community, particularly **with changes in provision of general practice.** There is potentially a **huge opportunity** for community pharmacy. However, as a sector, community pharmacy is currently **struggling** because of, for example, **difficulties staying financially afloat,** numerous **changes in ownership,** and **changes in opening hours.**

Community pharmacists are increasingly **demoralised** and **moving out of community pharmacy,** resulting in a high turnover of locums.

> **Community pharmacy:**
> **under-represented and under-valued**
>
> **Community pharmacists and their teams:**
> **under-used**

How medicines optimisation is causing inequalities

Inequalities in access to medicines for patients

Patient access to medicines has a number of challenges, including some overarching system issues such as:

- working in silos across the system
- knowledge/education
- transient population

Treatment choice	Treatment understanding	Treatment access	Treatment monitoring

■ Over-medicalisation/over-treatment
■ Genomics – the future of treatment
■ Access to private services
■ Lack of personalisation
■ Patient understanding of choices, e.g. no drug/medicine treatment
■ When ICBs do not commission
■ History of healthcare in area affects availability/value of medicines
■ Varying size of ICB workforce and medicines optimisation teams
■ Training practice/teaching hospitals/ universities
■ Commissioning directed centrally
■ Wealth (negative and positive)/public health
	■ Hard to reach
	  ■ Language barriers
	  ■ Literacy
	  ■ Learning disability
	  ■ Understanding and perception
	■ Prescribing understanding and specialism
	■ Digital/artificial intelligence
	■ Projected characteristics
	  ■ Cultural expectations
	  ■ Ethnicity
	■ Public health programmes
	  ■ Lack of
	  ■ Impact
	  ■ Review
	■ Joined-up care
	■ Wealth (negative and positive)/ public health
		■ Access to information (mass media)
		■ Point of initiation
		■ Self-activation
		■ Difficult to navigate systems
		■ Digital
		■ GP priorities
		  ■ Inner city
		  ■ Recruitment
		  ■ Demands
		■ Joined-up care
		■ Hard to reach
		  ■ Language
		  ■ Literacy
		  ■ Understanding and perception
		  ■ Gender dysphoria
		■ Local champions
			■ Lack of regular review by GPs
			■ Genomics
			■ Digital/artificial intelligence
			■ Winterbourne review
			  ■ Patients with learning disability
			  ■ Patients with mental health conditions

So, is it time to revisit the purpose of medicines optimisation?

> Medicines are invaluable and are the second highest cost within the NHS, which brings cost pressures, so you cannot kill off the term medicines optimisation entirely.

Medicines optimisation has an indispensable role, but changes are needed...

How medicines optimisation could change

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How medicines optimisation could change to address inequalities

1. Recognise the value of medicines in patient care
2. Shift focus from quick in-year cost savings to long-term benefits
3. Recognise the importance of localisation
4. Pharmacists need to have a seat at the table as they have a key role in the system
5. Work to make independent pharmacy prescribing practical and sustainable
6. Restore pharmacy to the heart of community for better patient-centric care
7. Revisit contracts and funding streams
8. Be brave about change

1. Recognise the value of medicines in patient care

Using guidance and audit to optimise therapy

Optimising medicines can have a **positive impact** not just for **patient care** but for the **system** as a whole. We need to make sure that **medicines** are used effectively as a **central part of care** and that **managers** and those involved in pathway development **understand the core role of medicines**.

Competency-based registration for NHS managers

To **ensure** that all **those involved in medicines decision making understand** the **role of medicines** within the healthcare system and the **benefits to patients**, **so they can better run healthcare organisations**. For this, supportive **training may be required**.

The National Institute for Health and Care Excellence (NICE) recommends combination therapies as the most effective options for chronic obstructive pulmonary disease (COPD), although it advocates continuing monotherapy in patients with symptom control, unless clinical needs alter, to avoid unnecessary treatment changes.[11]

A recent review at one of the delegate's localities audited 51 patients on long-acting muscarinic receptor agonist (LAMA) monotherapy for COPD. The review found that:

- **About 4% (2 patients) of the 51 patients had been misdiagnosed and did not have COPD. Of two who did not have spirometry, one was found to have no signs of obstruction and one was coded as having asthma. This may explain why they appeared to have symptom control on monotherapy, and they therefore may have been taking LAMA treatment unnecessarily.**
- **About 18% of patients continued on LAMA therapy.**
- **Optimising treatment in the patients with confirmed COPD by switching from LAMA monotherapy to dual or triple therapy reduced the number of hospital admissions from five to one and the number of exacerbations from nine to three.**
- **System savings due to the reductions in exacerbations and hospital admissions were much greater than the drug costs associated with switching from monotherapy to dual or triple therapy.**

2. Shift focus from quick in-year cost savings to long-term benefits

Medicines optimisation needs **rebranding**, with a **transition from the quick in-year cost-saving approach towards long-term development plans**.

We need to start thinking about:

- the **long-term ramifications of actions** such as switching drugs months and even years down the line rather than the current short-term approach
- the **impact and benefit for the whole system**.

To achieve this, **the central, national and local bodies will need to dictate** that medicines optimisation is **not just about saving money**. And medicines optimisation will need to encompass **pure contracting, commissioning, pathways, service redesign and optimisation**.

> **“Drugs are the second highest cost in the NHS and we need medicines optimisation, but there needs to be a rebranding and shift away from just quick savings...to thinking about the ramifications 6 months, 10 months, 2 years, 3 years down the line, instead of the knee-jerk approach and move on to the next thing.”**

> The impact of doing medicines optimisation properly, the way it is meant to be, will probably have an adverse effect on a specific budget line but be very positive for the whole system.

3. Recognise the importance of localisation

The increase in **politically driven, top-down mandates** makes it **hard to implement localisation**. Yet, **localisation is essential to tackle health inequalities**, as each system has **different needs depending on their patient cohorts**. What is appropriate in rural and north London may be very different from what is needed in inner city London and in the Lake District.

Each ICB is funded differently, and some may receive more money per capita due to varying patient pressures. **Different ICBs might have the same resource but choose to allocate the resources differently**. Discrepancies in how resources are allocated to and by ICBs might be perceived as an inequity, but this may actually be **addressing inequalities due to differences in populations**.

> **“Medicines optimisation is not always at the centre. For example, our terminations of pregnancy are increasing but our use of oral contraceptives is declining. This is an obvious inequality, because an educated woman is likely to be aware of a service, but if you’re not educated, you may not realise you can access this service.”**

4. Pharmacists need to have a seat at the table as they have a key role in the system

Pharmacy needs to have **representation, connections and a unified voice in organisations and systems in their area** – just as GPs do – to show that the role of pharmacy is valued within the NHS and to have genuine input into its position within the system. The **ICS partnership structure, development funding, training hubs and leadership programmes** should help with this by **supporting pharmacists with core activities** that lead to growth, such as writing business cases and understanding contracts.

At an **individual level**, we need to make **community pharmacy an attractive portfolio career** that works across the system and allows **pharmacists** to feel they are **making a difference to their patients**.

For community pharmacists to feel that their contribution is valued across the system and individually, community pharmacy should **move away from the narrow dispensing model** and be brought back **to the hub of the community**, where pharmacists have time to get to **know their patients** and **provide advice** on a wide range of healthcare issues.

GPs do not have time to keep up to date on new and forthcoming medicines. **Pharmacists** need to promote and **reactivate** their **key role in horizon planning**.

> **From the perspective of medicines, pharmacy and prevention, specifically heathy weight and obesity, there is going to be an increasing appetite for treating obesity in late 2024/2025 with the first NICE-approved weight loss drug available in the community via general practice.**
>
> **The day that announcement is made, GP practices are going to see an influx of patients wanting access to this drug. This provides a once-in-a-10-year opportunity with large numbers of people with cardiovascular and other risk factors coming to general practice rather than the system having to find them. We need to make sure that they come into a system that is ready for them so that we can capitalise on the broader opportunity to address all of their risk factors rather than telling them they will not meet the criteria for the new drug or they cannot see a doctor for six weeks.**
>
> **This could be an opportunity for community pharmacists to get involved, as they are already familiar with these drugs and capable of looking at the overall risk assessment by positioning themselves as a wellbeing and prevention hub along the lines of the former concept of Healthy Living Pharmacies. To achieve this will require levelling up of the skills and abilities of community pharmacies.**

5. Work to make independent pharmacy prescribing practical and sustainable

The **Pharmacist Independent Prescribing (PIP) initiative**[12] was going to be a significant move to **enable community pharmacists to become high-street prescribers**. This would mean that when primary care cannot offer a GP appointment for six weeks, or the patient has missed all appointments when they call on the day, properly trained **community pharmacies could see patients and prescribe** instead.

This is closer to the model of care 80–90 years ago – before the inception of the NHS – and would **increase access for patients to the NHS by offering them another option**. Pharmacists would also be able to **access drug records** and **perform medicines review** for patients on long-term drugs or **direct them for consultations** with a GP or specialist.

Pharmacist prescribers would be able to **respond to drug shortages** themselves. So, if a patient brings a prescription for a drug that is not available, the pharmacist will be able to **switch that out-of-stock prescription for an alternative** that is available on the shelf – for example, switching tablets to capsules. This would **reduce the current back and forth between pharmacy and GPs** that is needed when a drug is out of stock.

Unfortunately, the **PIP trials** have **not launched** yet due to **issues around technology and access to electronic prescribing**, which is extremely disappointing.

The route for **PIP commissioning** also **discourages pharmacy from buying into this pathway**. NHS England will only fund backfill for pharmacist time, without any consideration of the overheads or activity costs, which makes it **unsustainable**.

6. Restore pharmacy to the heart of community for better patient-centric care

We need to talk about a **new model for community pharmacy**, because sustaining the current model is not the answer without more money, which is not available. As **care shifts from secondary care to primary care to community**, we need a different approach to be able to **build on the role of community pharmacists** as the **accessible healthcare professionals** in the community **on the high street** that knows their population.

Interoperability will be needed to achieve this. For example, pharmacists will need:

- **access to systems such as GP Connect** so they can view patient records
- **access to templates that general practice use** so there is no double coding or system issues and so there is transfer of knowledge across a wider system
- **common targets**.

Pharmacies should focus on **literacy, education, concordance/compliance**, **prevention** and **public health**. For example, **social prescribing** within pharmacies can help with issues such as smoking cessation and vaping in children so that **general practice can focus** their time and resources on **patients with complex disease**. This also represents a **cost saving**, as a smoking cessation pharmacy outreach would be cheaper to the system than GPs who are paid for additional practice.

Community pharmacy needs to be more integrated into primary care and needs more funding

> **We piloted a hypertension case finding within the city. It worked really well. We got about 10 pharmacies together with voluntary action, communities, and third-party stakeholders, and the numbers went through the roof – about 900 people within 3 weeks and about 100 people referred to GPs. But the GPs didn't like it because it's more work for them... This is why people in pharmacies don't want to have conversations with people, because they get tired of it. I can see, and we all see, there's lots of private practice in community pharmacies, so there is that scoping already happening, but they're saying, well, actually, we tried that, tried to do all of this, and it doesn't happen.**

> **We did this around winter fit: "Are you eating well? Are you staying warm? What issues are you having?" People coming and talking to pharmacists about pension credits. I had pharmacy staff calling me saying, "After a long time, I want to go back into work, because I feel like I'm making a difference." That's absolutely huge. So how do we start to make things more attractive and make people feel more useful?**

7. Revisit contracts and funding streams

Contracts that compete **across primary care** are a **barrier**. **Section 75** – where we can work under a single NHS contract as separate bodies – **could fix a lot of the problems** if it comes through.

> Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services.[13] This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and commissioning of integrated services.

The current GP contract, the BMA collective action about the issues coming down from hospitals, and the responsibility that general practice would need to take is not the real issue to integration. The real **barrier to integration** is the **contractual mechanisms around payments for prescribing and services**. If prescribing that counts towards Quality and Outcomes Framework (QOF) payments in the GP record is entered by pharmacies, will GPs still meet the requirements for contractual mechanisms for income and still receive QOF payments? If we could fix that, **community pharmacy could take on a lot more responsibility** and we could start to think about the real issues of how we **initiate and manage treatment** within community pharmacy rather than just trying to do the basics.

We had system funding through primary care network (PCN) funding, while the rest of primary care sat within NHS England, until this was devolved to ICBs. We have system development funding for training hubs and transformation within the system, but most **ICBs** have not **used any transformation funding other than in general practice**, which means that we are **not transforming the whole system** – just the primary care silo. Until we start to work as systems under a devolved area, it's not going to work.

The core thing that stops that happening is the governance of an ICB and the Constitution that sits behind it. **CCGs** had very solid constitutions – they were **responsible for a geography** of healthcare, but their **constitution** had an **addendum** that **included general practices**. **ICBs do not have that addendum** linked to their constitution, but their membership is exactly the same.

We have tried to create community pharmacy hubs before, but **community pharmacy, foundation trusts and ICBs are all working in different silos**. If we can break through the contractual issues, there will be real opportunities. We also need to use current resources in a different way. The BMA has an attractive new primary care contract that brings this together.

> **"We have to look at our systems holistically, and we have to assume that there is no new money in the system, so we can only make plans with the available resources."**

8. Be brave about change

Rather than an absence of more money, there is a **lack of want, desire and courage to take the steps that are needed**.

Trust NHS managers who have taken 20 years to get into that position are now faced with the fact that they have to be **courageous enough to take risks to redefine and relocate services**, but the **potential repercussions** are so high that it could be a **career-breaking move**. We need to **incentivise senior management to take those courageous decisions** instead of kicking them if they go wrong.

We need to go **back to basics**, with an **overall review and assessment** of the current position to **identify changes needed** and **develop plans** to address these.

Stability and **long-term vision** are needed.

> **We have to allow ICBs to be brave to try new ideas and make mistakes without serious repercussions.**

> **If we're really going to manage the shift to community care, we need to look at other programmes that have been run, what it takes for activity to come from acute to any part of primary care including community pharmacy, because the shift left will drip down in different forms. Then you have to keep that activity out of secondary care for at least a year – enough to keep a ward not needing to be used – and then you've got to prove the business case, which would take another year, by which time a lot of people have lost the will to live and commissioners will have moved on to something more glossy and exciting.**

What can be done with and without funding?

What ICBs can do with no new funding
Identify local priorities and the local inequalities

With any change, the typical first request is for funding. However, change can happen with little or no funding, and finance teams need to be able to navigate and support the system even if funding is not available.

Inequalities means different things to different areas, so the first step is to identify how local areas carve out inequalities:

- Ethnicity
- Gender
- Mental health

Complex to manage

- Access
  - Private
  - Knowledge
  - Educated
- Age
- Affluence
- Local policies
- Technology and infrastructure
- System integration
  - Breakdown of relationships between stakeholders

> **“Transgender patients have a lack of access to healthcare for various reasons, such as fear, misunderstanding, lack of clinician knowledge, previous experiences, which drive inequality.”**

What the ICB should do with inequalities funding they have access to: Identify and mapping the inequalities

The key action is around mapping the inequalities across the locality.

- Identify priorities
  - Subset the areas that need focus
- Define with criteria
  - Replicable
  - Outcomes
  - Impact
  - Quality tool process
- Have a programme of work and ensure it is followed through

Engage with the key stakeholders

> **“Once inequalities are mapped, and that map is maintained, it should be used to place new services that need to be physical where they will have the greatest impact. Where new services are not physical, the map should be used to increase education about that service in the areas that are most likely to need it while not closing off services to all.”**

How to bring about change with no new funding? Collectively implementing change

There are many examples of how change is brought about in practice starting with ‘going back to basics’ and ‘engagement’. Others to consider are:

Better use of resources

- Open up access and community pharmacy estates
- Half-day clinics
- Use seconded consultation rooms
- Hub models
- Are there any pockets of money or other funding?
- Health innovation networks

Get people to understand the impact of doing nothing

- Advocacy
- Risk–gain share

Work with other providers and third parties

- Local authorities
  - Joint commissioning approach
- Pilots with other organisations
- Engage in research
- Engage with pharma
- Volunteers/voluntary sector

Redefine policies on how we can engage

- Support resources, e.g.
  - Deprescribing tools
  - Patient information
- Are we good enough at articulating the data?

Correct leadership, frameworks and patient engagement

- Clinical leadership
- Maximise core contract
- Patient voice

Where ICBs have access to significant funding: Make community pharmacy the 'heart of the community'

If we have learnt anything from the COVID-19 pandemic it is that community pharmacies are an integral and important part of our healthcare system. Creating a locality of hubs that allows them to feed into, engage with and impact on different elements of the system allows for better care, better patient experience, better patient outcomes.

A number of actions can be taken to place community pharmacy in the heart of a system including:

Integrating and creating a locality/ place/virtual hub

- Set up locality/place hubs
  - 3–4 per 100,000–120,000 population
- Commissioned services in the hub
- Learning from each hub
- Equip hub to help the most deprived 30% of the population
- Sharing learning and best practice

Monitoring of the impact at system level

- Key metrics to measure outcomes
  - Reduce emergency admissions
  - Improve literacy by teaching English
  - Compliance/concordance
  - Volume of treatment
    - Antibiotics
    - Opioids
    - Antidepressants
- Health inequalities
  - Decrease body mass index
  - Decrease type 2 diabetes and Syndrome X
  - Decrease smoking
  - Decrease blood pressure
  - Increase uptake of vaccinations and immunisation
- Research
  - University
  - Industry
  - Digital
- Flexibility of workforce/staffing

Measure what matters for the patient

- Improved access for patient, and those providing care, to:
  - Opening times
  - Minibus and local transport for patient appointments
  - Funding for local bus routes
  - Funding for car parking
  - Digital access for those who cannot attend in person
- Patient engagement

What should our aspirations look like?

What should the Health Secretary do?

What can medicine optimisation teams do?

Pharmacy aspirations for next three years

To make change, medium and long term aspirations are needed. There are a number of these that are achievable and inexpensive, but most of all would support the future of pharmacy.

- Focusing on medicines adherence, impact on patient and medicines waste rather than constant medicines switches
- Identify and focus on local priorities, understanding how they impact local populations and services
- Be aware of inequalities across the system at all levels, with those involved in decision making aligning system priorities with these inequalities
- Develop a menu of opportunities to address each potential inequality
- Ensure a chief pharmacist is on the board of every ICS or ICB
- Introduce mandatory training on healthcare and medicines for senior managers, similar to the previous Medicine for Managers programme
  - Role and value of medicines
  - Formularies
  - Short-term finance models vs long-term planning
  - Population health management
  - Warranted and unwarranted variation
  - Joined-up working
  - Plan, Do, Study, Act (PDSA)[14] quality tools
- Be more open to engage with and accept above-brand support from industry (in accordance with the code)
- Break down barriers to prevent silo working and encourage more collaboration and whole-system viewpoints
- Share best practice on platforms such as PrescQIPP
- Create evidence for change to highlight what works and what does and does not work

What the Health Secretary can do (1)

There are a number of activities that government should intervene in for a more effective medicines optimisation service. These include contracting, structural changes, funding, education and awareness, and promoting the NHS outside of the UK.

Contracting

- Ensure that contracting in the NHS is fit for function and includes primary care (including GP practices). Change the GP contract to clarify what is in and out of contract, as this causes major nationwide problems for commissioners and patients across the NHS.
- Change trust contracts to allow them to manage more community service and ensure use of medicines and services that tackle inequalities.
- Consider Section 75, how joint working under a single contract can facilitate delivery, and how we can make this easier to work in the population's interest.
- Revise the performance assessment framework and create a new operating framework with embedded health gain targets.

> Look at people that deliver – not the contracts that stop them

Structural changes

- Consider structure of GP, primary care and NHS together.
- Separate out clinical and commercial decision making.
- Revise the community pharmacy contract to be sustainable, but without perverse commercial decisions interfering with clinical service delivery.
- Develop frameworks and competencies on ICB/ICSs medicines optimisation activities, behaviours, pharmacy dispensing models and services are fit for purpose.
- Develop offer to support systems for focus capacity.
- Speed up the development of integrated neighbourhood teams.

> Recognise that the NHS is not just London or urban centres

What the Health Secretary can do (2)

Funding

- Broaden the ARRS funding to include community pharmacy
- Hold systems to account on inequalities over a 5-10 year cycle rather than short term year-on-year funding to demonstrate some work on inequalities
- Make chief executives focus on improving the health of their population, not just the final year accounts
- Understand savings are not made in silos
- Empower and inspire people to make savings whilst improving quality
- Identify ways to reinvest parts of savings in innovation and bringing the system together

Education and awareness

- Remove the concept of ‘free’ or change the language around ‘free’ throughout the NHS, as this undermines what we are trying to achieve in medicines optimisation in terms of prescribing, surgery and people taking responsibility for their own health
- Educate and empower ICBs to make devolution happen and for it to be true representation, with diversity of thought and voice

Promote the NHS outside of the UK

- Promote the UK as the global centre of medicines for R&D, manufacturing and evaluation – e.g. NICE is the envy of the world
- Sell the NHS brand abroad to recoup money into the system like other countries – for example, German hospitals in Saudi Arabia

What medicines optimisation teams can do (1)

There are a number of activities that medicines optimisation teams can engage with to improve their services. These include contracting, facilitation of partnership working, education and awareness, and research, development and evaluation.

Contracting

- Introduce shared improvement contract between community pharmacy and GPs to remove opposition of one side trying to dispense as much as possible and the other trying to deprescribe

Facilitation of partnership working

- Bring the pharmacy profession outside its box so it can start to change how medicines are seen
- Look for support for a different approach than current lengthy procurement processes where this would meet local needs so that we can work locally with private providers to introduce new services
- Work more creatively with the Agenda for Change[15] restrictions, including use of Annex 21, rotational posts, inter-ICB roles – e.g. workforce, medicines safety and recruitment and retention premia, and offer bonuses because holding salary rises provide disincentives
- Work with organisations and patients to develop what local areas actually need
- Empower providers to support them make changes and innovate

Be brave in decision making

What medicines optimisation teams can do (2)

Education and awareness

- Change how medicines are seen within the context of healthcare as part of a whole life course, not as a transactional kind of intervention
- Develop and educate all those working within the system on medicines, including patients
- Create frameworks and competencies to train and share best practice

Research, development and evaluation

- Develop prescribing reporting data to be used as a tool and linked to inequalities
- Implement effective evaluation
- Have proper back offices for evidence gathering and support to make sure we're seeing the value of change

Call to action

HSJ Advisory

NHS call to action

Recognise medicines use as an investment

- Ensure system-level policymakers recognise medicines use is an investment and not an expenditure
  - Understand the benefits not just the cost.
  - Stop using medicines optimisation as a cost-cutting exercise.
  - Educate NHS staff, particularly high-level management, on the role and use of medicines
  - Reconsider use of the phrase ‘deprescribing’

Optimise use of existing resources

> **“There’s lots of opportunities in there to really change the way that we’re working, but we just haven’t got the resources to be able to do that…It’s about using current resources in a different way”**

Ensure contracts are fit for purpose

- Ensure contracts that providers are operating under are fit for the current environment, which is shifting to the left – from secondary care to primary care to the community – and will have huge ramifications for medicines, health inequalities and the general functioning of the NHS

Recognise the link between primary care and secondary care

- Make the link between how decisions in secondary care impact on resource use in primary care

Simplify partnership working with industry

- Reset needed for working with industry
- Reduce the number of standard operating protocols (SOPs) for industry interaction

Industry call to action

HOME

Work towards NHS priorities

- Invest in NHS priorities or support the system to deliver against its stated priorities – not what industry thinks the priorities should be
- Link development and inputs to the priorities of the NHS, including value and sustainability

Demystify industry

- Approach the NHS with the most appropriate industry staff to demystify what industry is about and discuss partnerships not sales
- Think above brand

Take a collaborative approach to working

- Speak to the regulators about moving away from what the Association of the British Pharmaceutical Industry (ABPI) code[16] has become and a code that reflects true partnership working

> **Where is industry in this? Why aren't they sitting at the table right now with us?**

Simplify the code of conduct

> **Industry is caught up in a very restrictive code of conduct, which is inappropriate. We know the industry's moved on. We know the industry's not full of scandals. So why can't a company sponsor or get involved in true partnership? Our industry partners are here in observational capacity only, I would love to see more meetings where the NHS and industry are there together as true partners, not an NHS meeting that's sponsored by a company or something that the NHS has done and reluctantly brought people in from pharma because they think they have to as a token gesture.**

Abbreviations

ABPI	Association of the British Pharmaceutical Industry
AMR	antimicrobial resistance
ARRS	Additional Roles Reimbursement Scheme
BMA	British Medical Association
CCG	clinical commissioning group
CEO	chief executive officer
COPD	chronic obstructive pulmonary disease
CQUIN	commissioning for quality and innovation
DHSC	Department of Health and Social Care
GP	general practitioner
ICB	integrated care board
ICS	integrated care system

IIF	Investment and Impact Fund
LAMA	long-acting muscarinic receptor agonist
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
PA	physician's assistant
PCN	primary care network
PDSA	Plan, Do, Study, Act
QOF	Quality and Outcomes Framework
R&D	research and development
RMOC	regional medicine optimisation committees
SOP	standard operating protocol

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Appendix: Contributors

The roundtable event was chaired by Ewan Maule, Clinical Director for North East and North Cumbria ICB, North East and North Cumbria NHS. Jyotika Singh, Principal Consultant at HSJ Advisory, acted as facilitator.

Delegate	Role
Ewan Maule (Chair)	Clinical Director for North East and North Cumbria ICB, North East and North Cumbria NHS
Zafran Azam	Head of Pharmacy – Implementation and Place, NHS Derby and Derbyshire Integrated Care Board/Joined Up Care Derbyshire
Jo Loague	Head of Service: Medicines Optimisation and Individual Funding Requests, NHS Arden and Greater East Midlands Commissioning Support Unit
Alex Molyneux	Chief Pharmacy Officer, NHS South Yorkshire ICB
Amit Patel	Chief Executive, Community Pharmacy South West London
David Thorne	Transformation Director, Well Up North PCN, The Northumberland Medical Alliance

> **To my mind...medicines optimisation for people who are not pharmacists or clinicians has become a line of expenditure and, often, a budget to be raided. And the only question is, "So what's your cost improvement programme this year?"**

HSJ Advisory