Medicines Optimisation Centricity

The way forward

A review by Wilmington Healthcare

in partnership with Aspire Pharma Limited

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FOR HEALTHCARE LEADERS HSJ

Wilmington Healthcare

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Foreword

The pharmaceutical industry plays a vital role in supporting the English National Health Service (NHS) by providing essential medicines, vaccines, and medical devices that are needed to prevent and treat illnesses. Without the pharmaceutical industry, the NHS would not be able to provide the level of care and treatment that it currently does. With this in mind, one could reasonably assume that the relationship between these two macro entities (the NHS and Big Pharma) would be symbiotic, with completely integrated strategies. Herein lies the core of the issue in relation to medicines optimisation. Approximately 18% of the total annual NHS spend is attributed to medicines and medical devices, yet the relationship with industry does not reflect the importance of this contribution. There still exists a cultural dissonance despite decades of trading together. Surely this has to change in order to ensure the NHS and the public optimise improved Triple Aims (clinically assured outcomes, improvements in care experience and optimal Year of Care value).

The pharmaceutical industry invests heavily in research and development to create new drugs and treatments that can help patients recover from illnesses or manage chronic conditions. These drugs are rigorously tested and evaluated to ensure they are safe and effective, and those that are approved by regulatory bodies such as the Medicines and Healthcare products Regulatory Agency (MHRA) are made available to patients through the NHS.

In addition, the pharmaceutical industry also provides support to the NHS through funding for research and development of new therapies, education and training of healthcare professionals, and other initiatives aimed at improving patient care and outcomes. Effective management of medicines involves a range of activities, including prescribing, dispensing, administration, monitoring, and review. These are integrated activities and should be carried out by appropriately trained and qualified healthcare professionals working together for common purpose, to ensure that patients receive safe, effective, and high-quality care.

Overall, to truly gain improvements on the optimisation of medicines to the triple aims described above, the pharmaceutical industry has to be a more integral and critical partner of the NHS, in order that its contributions help ensure that patients receive the best possible care and treatment.

Denis Gizzi

Former Chief Accountable Officer at NHS Lancashire and South Cumbria ICB

Background

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

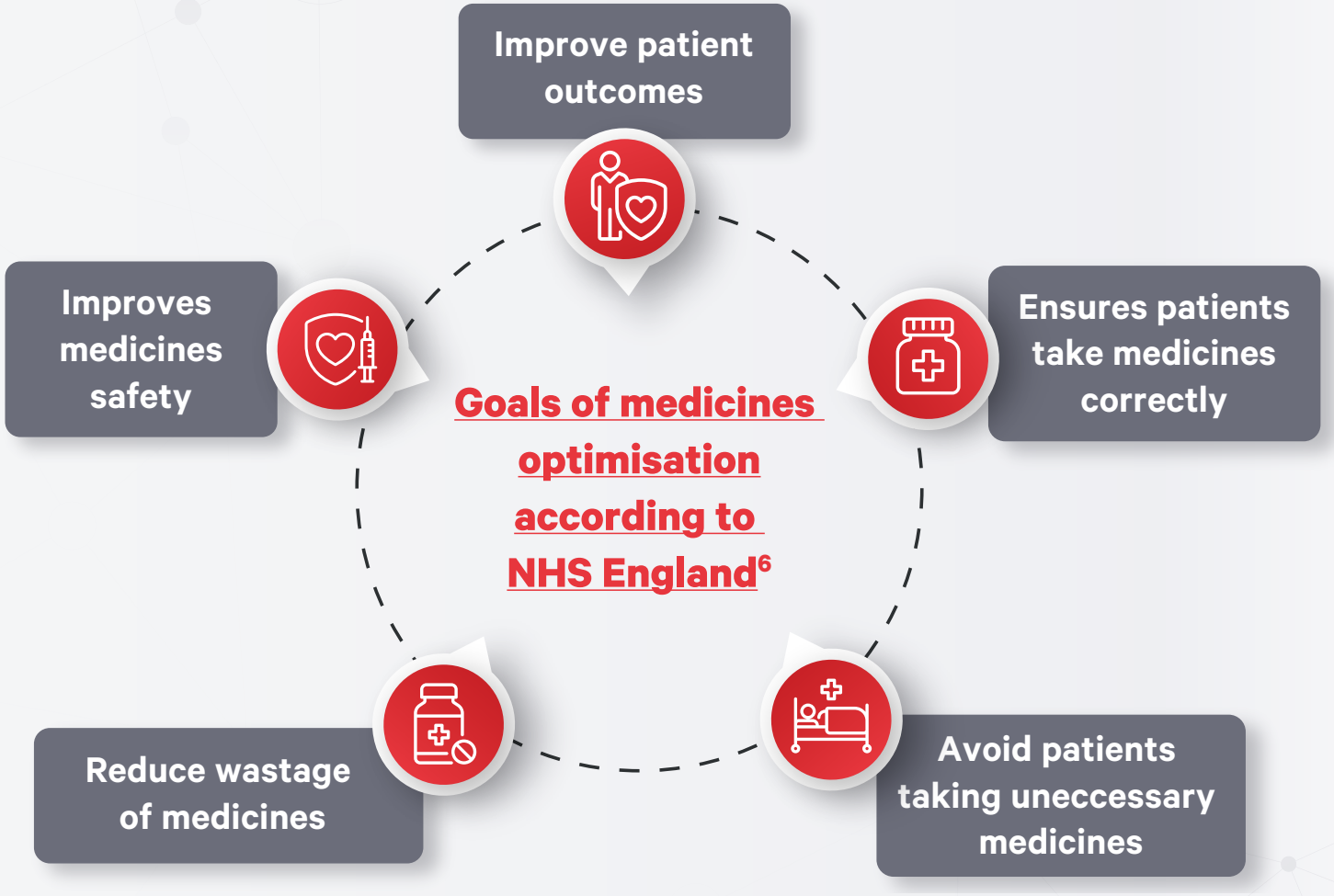
3. In organisational terms, **regional medicines optimisation committees (RMOCs)** have been set up to drive the changes needed in prescribing and medicines use, including reducing waste, improving health outcomes from medicines, and making the best use of NHS skills and resources. In particular, RMOCs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

Goals of medicines optimisation



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

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Wilmington Healthcare has partnered with Aspire Pharma to bring together senior pharmacists and decision-makers responsible for medicines optimisation across England (Appendix) to debate and discuss a number of issues during two roundtable events in February 2023:

- **What is medicines optimisation doing currently – and what could it do better?**
- **How has medicines optimisation settled in the new landscape of integrated care systems (ICSs)?**
- **What are the barriers to patients getting a better medicines service?**
- **How can industry help the NHS in its implementation of medicines optimisation?**
- **What is the call to action for all parties?**

Put simply, what is the way forward for medicines optimisation?

Under Chatham House Rule, delegates were asked to give their views on the state of medicines optimisation today, barriers for patients, and whether systems were doing enough to mobilise. They then discussed the concept of Medicines Optimisation Centricity and how that was progressing in NHS decision-making. Finally, they discussed the role of industry and what the next steps for all stakeholders should be.

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 medicines optimisation could work more effectively in the NHS.

> Quotes included throughout this paper are adapted from the discussions at the two round table meetings, have been edited for sense and may reference individual examples provided by attendees.

The problem with medicines optimisation

> I would describe medicines optimisation to my patients and the people I care for in five key steps: it's about improving the outcomes they get from the medicines; helping them take the medicines correctly; avoiding any medicines that are not needed; reducing waste; and improving overall methods and safety.

The problem with medicines optimisation

Medicines optimisation should involve:

1. **Patient-centred treatment** with medicines and patients' informed decisions
2. Achieving **better outcomes** from medicines rather than just focusing on cost or waste
3. **Patients being enabled to choose** what is best for them and understanding what factors influence this choice
4. Establishing the **best patient journey and experience** in the context of the whole pathway
5. Achieving **adherence**

Medicines optimisation challenges

Medicines optimisation teams are still working their way around the new ICSs and, as such, **may not be involved or included in decision-making processes.** Conversely, acute/secondary care and primary care/community personnel **often do not fully understand medicines optimisation**. Care is moving into **primary care,** but the **system is not equipped** to support this.

Most integrated care boards (ICBs) have overspent on budgets in 2023–24 due to many reasons, such as costs rising due to supply difficulties and because of funding for mandatory guidance and NICE technology appraisals not being added into existing budgets; however, this is where a more system-wide overview may provide benefits. Medicines optimisation strives to cut costs, but this must be patient centric.

Medicines pathways often focus on **treatment escalation rather than de-escalation** and prescribers may be afraid of doing nothing, so **prescribing is an easy option,** which means that **overprescribing**[7] is a serious problem. **Medicine wastage** is also a major issue, and **concordance** with prescribed medicines is often overlooked.

The number of medicines taken by many of the 3% of the population with long-term conditions who are on ten or more medicines could be reduced if they had detailed annual reviews. Although widespread **structured medicines reviews** to address polypharmacy are thus imperative, systems lack the infrastructure to perform them. **Community pharmacies** have the potential to undertake more reviews if given training, but they are not funded by systems, not in effective communication with primary care network (PCN) pharmacists, and under-resourced. There may be conflicts of interest with a community pharmacist both providing a medication review and dispensing, as the system does not incentivise de-prescribing when the pharmacists are paid per item dispensed.

> We can write a prescription on the back of a few minutes' consultation that someone might take for the next 10 years – with side effects in some cases. Yet we don't actually have a well-developed way of involving the patient in that prescribing decision and informing them about and consenting them on the treatment pathway that they're embarking on when we give them a medicine. And very often, indeed, we don't know.

Supply and pricing concerns

Multiple issues around stock outs and supply create barriers to patients accessing the medicines they need. There is a concern that many pharmaceutical companies **do not see the UK as a good investment,** which can lead to lack of availability of some medicines and so **restricted treatment options** or higher prices. Furthermore, **access is being reduced** by unintentional outcomes of a bad pharmacy contract not fit for the future – such as the **closures of leading chains of community pharmacies**. Endemic issues in supply can result in **more time spent sourcing medicines** than medicines optimisation. System and ICB teams are pushing to increase **capacity**; however, **medicines optimisation is not yet a priority**, as patient access is currently felt to be more important, although this may change because of the **worsening financial picture**.

Fluctuating prices are a constant issue due to the UK market having **only one supplier** now other suppliers are pulling out, meaning the core supplier can **"name their price". Prices also vary locally** but such variation should be unnecessary when a drug is supported by the same evidence and costs across the NHS. The **difference in tariff between hospital and community creates** confusion and disincentivisation.

A common **assumption is that most patients want to access medicines closer to home,** but is this really the case? We need to more fully **understand what patients want and what influences their decisions.** How do we balance the desire to "get better" with easy access to healthcare? How do we measure how much choice patients actually want?

> I think the inherent tension that a lot of us feel today... is what do we mean by the best outcome for both the individual and at the population level and the fact that those will not always align.

> As far as I'm concerned, these stock issues didn't happen before Brexit.

Issues around stock, supply and pricing

Challenges

- **ICB medicines optimisation teams** are often considered to be **detached** from the **clinical setting,** which presents new opportunities in the new structure.
- Current **emphasis** is on **initiating medicines,** which means **analysis of the effectiveness of and concordance with medicines** are limited.
- Systems are not set up to measure **de-prescribing.**
- **Care** is moving into **primary care**, but the system is **not equipped** to support this.
- **Clarity and transparency** around prescribing, costs, primary care access issues, guidelines and benefits for patients are **lacking**.
- **Stock outs** are an issue for numerous reasons, resulting in **restricted treatment options**, **price increases** and more time **sourcing supplies** than undertaking medicines reviews.
- **Community pharmacies** are well placed to undertake medication reviews but are **under-resourced and underutilised**.
- **Patient access to healthcare** is currently prioritised over medicines optimisation.
- **Interactions** and **ownership** of care **by patients** are limited.

> Medicines are not complied with. And I don't think we focus enough on that.

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> For me, medicines optimisation still focuses on initiating medicines when patients have a particular clinical marker. But there is very little in terms of review and analysis of the effectiveness of that medicine. So hence you're getting hospitalisations, you're getting poorer outcomes, and patients are getting poorer experiences. I think there's something about changing our emphasis when it comes to medicines and prescribing to more review-and-stop.

Opportunities for the NHS to look at and change to Medicines Optimisation Centricity

> In a handful of years, I will be able to predict your ability to get the best outcomes from thousands of medicines.

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Opportunities for the NHS to look at and change to Medicines Optimisation Centricity

The purpose of medicines optimisation strategy nationally should be reviewed. Collaborative working and understanding are needed across ICSs and the whole NHS, with a golden thread from strategic representatives of medicines optimisation through stakeholders in hospital trusts to those working in GP practices. Numerous system savings can be achieved, and working within systems affords the right opportunity to have the right conversations at board level.

Medicines optimisation practice should be enhanced, including:

Moving

towards more 'value-based' medicines optimisation

Increasing

understanding of polypharmacy and overspending

Progressing

patient choice and understanding of the medicines they are taking via better education and engagement

How can the NHS improve medicines optimisation?

An **agile, resilient and competently changed workforce** is needed, which will be achieved by better and targeted training opportunities with the appropriate backfill. Major opportunities will arrive with a **broadening of the range of prescribers** in the system in the next few years. For example, **all pharmacists leaving university will be prescribers from 2026** and will have a greater stake in decisions. The NHS needs to **better use the largest force in pharmacy, community pharmacists**, who know which patients struggle with which medicines. Developing **targeted multidisciplinary clinics** could divert frequent visitors to GPs and free up capacity.

Prohibition-based arrangements in which **prescribers cannot initiate certain medicines** do not work well – there is therefore a need to **move from autocracy to autonomy**. Incentives to make changes are needed and can work well.

More emphasis on **medicines review** is needed, with the goals of **deprescribing, reducing polypharmacy, and improving safety and concordance**. Extensive work around polypharmacy is expected to occur in the future – in line with the Royal Pharmaceutical Society (RPS)'s report **Getting our medicines right**.[8] The ability to understand **patients' susceptibility to certain medicines over** others through genetic phenotyping will form the basis of future medicines optimisation principles. The **genomic strategy**[9] published in October 2022 gives credence to the use of pharmacy professionals in a different light altogether.

It is important to take stock of what has been achieved in terms of medicines optimisation and build on the wins so that the benefits can be better realised within systems.

Decision-making needs to be simplified – could this be achieved by delegating drug budgets to an expert programme committee?

> We should tell people what things cost. How many NHS pounds do you use? £1,800 per head per year is the allocation. Some use none. Some use ten times that. If they knew, would it change their minds?

> We need to be careful though, as we would not want to put patients off using services and products they need for fear of costing too much – it is an ethical issue.

Putting the patient in the picture

A **patient-centric system** could be financially more sustainable, as not **accessing a good medicine first** is ultimately more costly. Although organisations have been better at **involving patients more**, this needs to become mainstream in decision-making. Self-referral, self-management and shared decision making with the patient need to increase: what innovations can we provide to patients and citizens to enable this?

Better communication with patients about costs – for example, making them aware that **prices vary for different treatment options** – may positively influence patients' choices around treatment selection and concordance. However, sharing costs with patients could also have a negative impact. Brand awareness can lead patients to believe the more expensive medicine is better, but cheaper is not necessarily better and choosing the right medicine for the right patient is key. The 'green story' also changes minds – for example, awareness of the environment impact of inhalers – and this could be harnessed to awaken patients' minds to issues of sustainability.

In line with the **NHS digital transformation strategy**,[10] information technology has a role to play. For example, it should be possible to combine information about abnormal test results with datasets about patients who are on high-risk medicines to flag those patients for GPs within electronic prescribing systems. Information on discharge medicines should always be provided to community pharmacy.

Medicines optimisation should look at the value medicines deliver, making sure they are clinically effective, that people are getting the right choice of medicines at the right time, and that it involves more than just the healthcare and clinical prescribing elements.

> One of the things that I've really reflected on is thinking about the difference between managing patients in a kind of transactional context, against managing patients who present with complexity, and how we need to work differently there. Often these are the people for whom we may not be getting the best outcome from our medicines.

Opportunities

- Review the purpose of medicines optimisation strategy nationally, involving ICB, PCN and regional lead chief pharmacists.
- Improve access to data on medicines use.
- Increase collaborative working and understanding across ICSs and the whole NHS.
- Take advantage of the broader range of prescribers, including community pharmacy.
- Move to more value-based optimisation.
- Undertake focused and structured medication reviews to facilitate deprescribing and reduce polypharmacy.
- Recognise the benefits of a patient-centric system and improve interactions with patients to involve them more in their care and get buy-in on their journey.
- Use technology to optimise communication around patients and medicines.

> Industry can create models that the NHS can 'plug' its own local values into. Perhaps a model that isn't NHS derived should be used, based on what is possible rather than what is happening at the moment.

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How industry can support the NHS with Medicines Optimisation Centricity

> I think that partnership with industry has sort of disappeared over the years.

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How industry can support the NHS with Medicines Optimisation Centricity

Industry can offer thought leadership and "navigation of thought processes" and has a key interest in data management and outcomes.

Industry excels at providing training and educational resources. The NHS could benefit from more **educational initiatives** supported and developed by pharma, including **case studies**, **intelligence and information on best practice** gathered around the country.

Industry also excels at identifying opportunities that fit with the agenda of the time. Companies can therefore help with a range of initiatives – from **structured medication reviews** to **virtual wards** and **service co-design**.

Working within systems is key, with **local issues solved by local organisations** finding their own way to achieve what they need. More positive examples, that can be easily conveyed, are needed to set out **how and why industry can be helpful**.

The NHS is seeking to partner with private organisations in the new integrated care landscape. The expertise and resources of the pharmaceutical industry should be harnessed to push forward the medicines optimisation agenda.

> The only way to solve this is to get clever people doing clever things together, with an incentive. You can't restructure your way to victory.

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> We need to be thinking about the outcomes we get from the products that we prescribe and how those are aligned to...building on the data they've collected through the trial setting, which we know is different.

> How do we get some of that post-surveillance data to inform our assessment of outcomes for the medicines that we are using? I don't think we take advantage of that between us to learn about the real-life implementation of products.

> Some pain relief patches that did not stick are an example of when you need pharma in to resolve things quickly.

Medicines optimisation collaboration

The NHS has some **natural reticence** to working with industry, but pharmacists and organisations are aware that they will always need some support with complex patient processes. On both sides, but particularly within the NHS, there is uncertainly around **legality and compliance** and about what is and is not allowed. For example, not all **pharmacists are aware of current regulations** from the Association of the British Pharmaceutical Industry (ABPI) around joint working, so training sessions on relevant ABPI regulations would be helpful.

Not many NHS staff really understand pharma – for example, the difference between sales and market access, what they are trying to do and how they can help. Better understanding of "which conversation am I having with whom" would be helpful.

Several obstacles hinder effective partnership with the NHS.

Companies could be more forthcoming with pharmacists and medicines optimisation on a range of issues. It is in industry's interests for medicines to be used correctly, and pharmacists may be the best people with whom to have conversations about a value proposition rather than traditional prescribers.

Bureaucracy around systems and how difficult it is to mobilise **attention and resource on industry-derived ventures** is an issue. Suppliers are often not included in discussions relevant to them – for example, supply issues.

> Industry could help with patient support programmes for particular groups of patients, especially those patients [who] do need more support than…they're currently being given. Again, industry probably has the resources and the skills to do that better than…we currently do…and it's also utilising experience from elsewhere.

> Pharmacy is distant from industry.

> Often there is money sitting there on the table for partnership that can and should be accessed.

> I think there would be real value in us working out where we would work together best, because industry always feels a bit like a sort of awkward dance partner at the moment, where each of us is not quite sure on the rules of engagement and where we can really get the value out. I think it would be beneficial to have a bit more of an open conversation about that.

> Mass disorder breeds innovation. We need localism not monopolies.

Opportunities

- The NHS desires clarity on the **value proposition** that industry brings.
- **The NHS needs understanding** and **awareness** around industry codes of conduct and practice, ABPI code and engagement processes.
- The **NHS benefits** from the **data and insights** that have often been **provided by industry, especially** when the **data aligns to national and local agendas**.
- The NHS would like to see practical applications through case studies especially those **that are aligned to** to the local priorities, **and encourages collaborative working across the system**.
- **Innovation, strategic thinking, and engagement** for potential projects can often be supported or sponsored by industry and allow creative testing of concepts.

The switch from 'cost neutral' to 'fixed' budgets has changed the mindset, with a reluctance to make changes to services or prescribing if there is no reasonable incentive to do so.

> Does industry have skills that the NHS can learn from? They have skills in expertise around delivering messages well and clearly and concisely and in a much more appealing format than the NHS is able to do.

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Call to action - medicines optimisation collaboration

> We should work together on pathways, be more innovative. Opportunities are there. We could co-create value propositions.
>
> Succeed locally. Make locally driven projects work and people will pay attention.

Reconsider the current role of medicines optimisation

With current organisational changes and priorities, the NHS should take the opportunity to reconsider medicines optimisation and its wider principles with a different lens. For example, each ICS has its own decision-making committee – and with current organisational changes will there be 42 prescribing committees or will there be a consideration to revert back to seven? Although products can bring value to the health system, there are few incentives to achieve this in practice.

In the future, collaboration does not necessarily need to involve "blue-sky thinking" but should address achievable or existing challenges that have not been well met to date.

> If we can identify any common themes, hopefully preventative approaches can build. One of our geriatricians has stated that 50% of her admissions are related to polypharmacy, so prevention and early intervention are needed.

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What can be done?

Address the challenge of “frequent flyers”

So-called “**revolving-door” patients** comprise around 5% of people – for example, about 50,000 patients of the 1.1 million population in Devon are in this category. The NHS needs to consider how best to serve patients who are using a wide variety of medicines and interventions for many conditions and consider what is stopping them doing things differently. Addressing the issues with this section of the population would **free up resource**, which could be diverted to other areas. Could **social prescribing** be beneficially applied?

Increase collaboration and workforce skill-mix

Can expertise be **pooled to get best outcomes**? More joint opportunities could “make the matrix work better – hospital, PCNs, and community services”. Disparate partners who are siloed need to **work together more effectively**.

Increase and target the workforce skill-mix

Establishing the **right workforce and skill-mix** will be crucial for change to happen. More could be done by encouraging local horizon scanning to inform **wider-scale decision-making**.

A ‘Medicines Dragons’ Den’ would give the NHS opportunities to hear business cases.

Revolving-door patients

50,000 of the

1.1 million population

in Devon are in this category

In the **South West**, community pharmacy administered

1/3

of all COVID-19 vaccines

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Engagement with other stakeholders and partners

Capitalise on the resource of community pharmacy

During COVID-19, the **resilience** of community pharmacy was displayed. In the South West, **community pharmacy administered** one third of all COVID-19 vaccines. Community pharmacy should be engaged in more ambitious schemes, and all stakeholders need to understand how best to use **community pharmacy as an asset**, including increased understanding about how community pharmacy is funded among finance directors.

Change the conversation with industry

The **conversations** the NHS is having with industry need to change, and the NHS needs to ask industry for more than has been asked before. Far closer **collaboration** in ambition, scale and scope could be beneficial, with a range of actionable endeavours on which the **NHS and pharma could partner**, beyond meeting support.

Reasons to **engage** could and should be more **compelling**. For example, some sales and marketing approaches around distribution of information to pharmacy are not relevant or up-to-date.

As well as questions around **value and outcomes**, industry could help improve **capacity and efficiency**, for example by supporting nurse recruitment. Companies could also **help drive cost-improvement pathways**. Examples could be seen where the private sector may get and test products before the NHS.

> We could have a massive step up from 'Can you buy the sandwiches for the meeting?'

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> Pharma are excellent at communications – can we harness this skill to create a more integrated pharmacy communication channel with cross-referrals across organisations to include the whole patient pathway.

> What's the point of giving me a leaflet when I can download it.

> Better collaboration is needed, with organised prescribing committees featuring different groups, including ICB and PCN medicines optimisation leads and community pharmacy. New drug reviews and pathways should be a core function. This could then be fed up to a group chaired by senior people – e.g. medical directors, specialists and chief pharmacists. The second group would make decisions based on recommendation of the first group.

When I see someone from pharma, I ask them for six things:

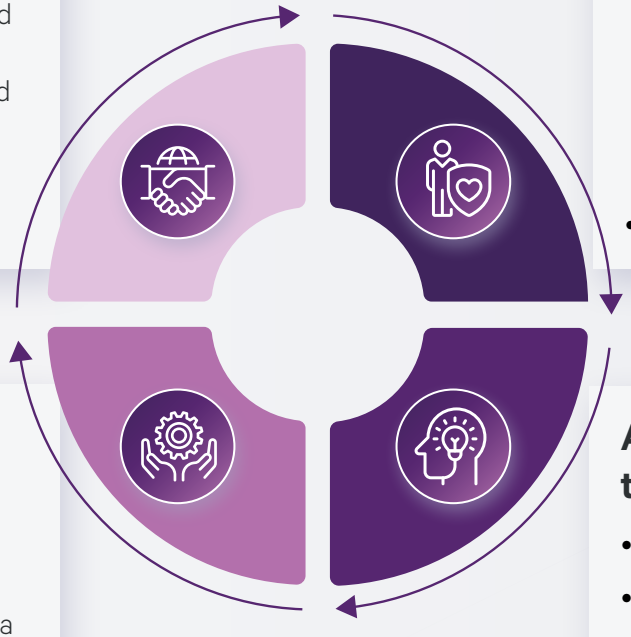
1. **Data pack**, including bench-marking, market sharing data, PCN-level data, target and objectives linked with data.
2. National, regional and local **insights**.
3. Service design model resulting in **efficiencies**.
4. Evaluation of the change, featuring follow up, work with a university, **outcomes and a value piece**.
5. **Case studies** showing where it has worked – for example, London or Manchester – and I'd recommend working alongside commissioning support units, which are outside the health and social care systems support organisation but in and already do a lot of this work.
6. The **right team**! Come with a medical science liaison representative and a key account manager to answer the full range of concerns. If you're going to do it, do it right.

NHS call to action

NHS internal collaboration

System collaboration

- There is a need for **integrated care**.
- **Improved collaboration is needed** with organised prescribing committees featuring 2 or 3 different groups including medicines optimisation leads and community pharmacy.
- A focus on **succeeding locally,** if locally driven projects work, people will pay attention.



Patient collaboration

- Looking at **complex and frequent service user patients** and how they could be managed differently.
  - How to filter off these **frequent users?** These types of patients can make up to 5% of the local population and have specific needs.
- How to develop **social prescribing** elements.

System support

- **Workforce** - people are going to be required to implement any change.
- There need to be more **joint opportunities** and a need to make the **matrix** work better, with **cross opportunities** between hospital, acute trust, PCN networks and community pharmacy.

Awareness, understanding and transparency

- Understanding of **system** issues.
- **Decision** making to include all.
- **Transparency** of costs, systems and processes across the system.
- Consideration of care **outside** of the NHS - in community and private care.

NHS external collaboration with industry

1. Change the lens

Look at medicines optimisation through a different lens - **opportunity and rebalance**.

2. Remove barriers and look to co-create

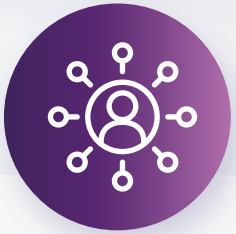
Look at new ways of working with industry to create an 'NHS Dragon's Den' type platform and working together to **create value proposition** and innovation.

3. Managing expectation from Pharma

Inform pharma what they need to **come prepared** with: the right team members - MSL and KAM, right local information, and right data.

4. Understand the value Pharma brings

How can they **help support more cost improvement** programmes (CIPs)?



5. Whole-system approach and understanding

Ensure system understanding, and that development considers all areas, such as community pharmacies, whether it is **capacity** release or **funding**.

6. Incentivisation and value

Incentivise and value those companies that consistently bring high quality product supply and **recognise** the value they bring.

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Appendix: Contributors

Both roundtable events were chaired by Denis Gizzi, Chief Accountable Officer at NHS Lancashire and South Cumbria ICB. Jyoti Singh, Principal Consultant at Wilmington Healthcare, acted as facilitator.

Round table 1 – February 2023

Delegate	Role
Beverley Bostock	Advanced Nurse Practitioner Primary Care Network Nurse Coordinator
Chris Goldsmith	Deputy Chief Pharmacist – Clinical Support Services, St George's University Hospitals NHS Foundation Trust
Mildred Johnson	Chief Pharmacist/Clinical Director of Pharmacy and Medicines Optimisation, Maidstone & Tunbridge Wells NHS Trust
Amit Patel	Chief Executive Officer, Merton, Sutton and Wandsworth Local Pharmaceutical Committee
Rupesh Thakkar	Chief Pharmacist, Solihull Healthcare Partnership
Dipak Vaidya	Group Chief Pharmacist and Head of Clinical Procurement, Aspen Healthcare

Round table 2 – February 2023

Delegate	Role
Yousaf Ahmad	Chief Pharmacist and Director of Medicines Optimisation, Frimley Integrated Care Board
Liz Butterfield	Clinical Lead Medicines Optimisation, Kent Surrey Sussex Academic Health Science Network
Sarah Crotty	Deputy Head of Service, Pharmacy and Medicines Optimisation Team, Herts West Essex Integrated Care Board
Paul Foster	Director of Pharmacy, Torbay and South Devon NHS Foundation Trust
Andrew Lane	Chair, Gloucestershire Local Pharmaceutical Committee and Chair of the National Pharmacy Association
Minesh Parbat	Chief Pharmacist, NHS North Solihull Primary Care Network
Ellen Rule	Director of Strategy and Transformation, Gloucestershire Integrated Care Board

> Everyone who wants to support the NHS's ambitions should be part of the discussions.

FOR HEALTHCARE LEADERS HSJ

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