TALKING IS THE BEST MEDICINE

A passionate debate over medicines optimisation embraced everything from reshaping the role of community pharmacists, to redesigning the prescribing process, to the urgent need to educate and communicate better with patients. By Alison Moore

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ROUNDTABLE PARTICIPANTS

Alastair McLellan *HSJ* editor and roundtable chair
Carol Blount NHS partnership director, the Association of the British Pharmaceutical Industry
Howard Catton head of policy and international, Royal College of Nursing
Professor Gillian Leng deputy chief executive, National Institute for Health and Clinical Excellence
Katherine Murphy chief executive, Patients Association
Simon O'Neill director of health intelligence and professional liaison, Diabetes UK
Dr Berkeley Phillips UK medical director, Pfizer
Keith Ridge chief pharmaceutical officer, Department of Health and NHS England
Ash Soni vice-chair of the English Pharmacy Board and Future Forum member
David Webb director of specialist pharmacy services for East and South East England

Getting the most out of the medicines the NHS purchases makes both common sense and hits a sweet spot by improving both quality for patients and potentially reducing costs and wastage.

But medicines optimisation is a complex area where good intentions can come up against a number of barriers which prevent some of the benefits being realised.

An *HSJ* roundtable, sponsored by the Royal Pharmaceutical Society with support from Pfizer, brought together a panel of experts to discuss this and highlight how some of these barriers could be overcome in the future.

HSJ editor Alastair McLellan, who chaired the roundtable, said it was important to think about the front line in health services, pharmacies and industry and have a debate that reflected the barriers, complications and conflicts they would encounter.

He started the debate by asking the panel to define medicines optimisation.

David Webb, director of specialist pharmacy services for East and South East England, said there was potential value in medicines that is not being realised for the benefit of patients in terms of better outcomes. "It rebalances the debate about the cost of acquisition and benefits and it starts to talk to us about the waste agenda and what are the responsibilities in a relationship between professionals and public," he said.

Director of NHS partnerships at the Association of the British Pharmaceutical Industry Carol Blount added: "The overall tenet is that focus should be on improving patient outcomes and how we can realise the full value of medicines to improve outcomes and not just the acquisition costs."

But there were three other areas which were important to this. One was patient adherence, which needed to improve so the benefits of medicines could be realised. Another was improving safety of medicines and the third was cutting wastage.

Keith Ridge, chief pharmaceutical officer for the DH and NHS England, said that medicines optimisation was looking at medicines use and the systems that surrounded it to deliver quality outcomes and best value. "I would translate this as working with patients, public and anyone else who is interested to get the best outcomes," he added.

Simon O'Neill, director of health intelligence and professional liaison at Diabetes UK, had a perspective both as a patient – he has type I diabetes – and professional. He said it was important to step back and look at why people were taking medicines in the first place and what information they had been given. Some type 2 diabetes patients, for example, were told they had a mild condition – which could discourage them from taking the medicines they needed. How to raise the level of patient understanding needed to be thought about.

Patients also often stayed on old medications for a long time, when they could have benefited from an earlier move to a new drug. If they were more aware of their conditions and the options available, they might choose to change earlier, he said.

English Pharmacy Board vice chair Ash Soni also stressed the importance of starting to think about optimisation at an earlier point: "We have to go back to when there is some indication of the need to take medications." Patients needed to have discussions about the benefits and risks associated with taking medicines and the value that medicines could add at that stage, he suggested.

"The most expensive medicines are those never taken. If the medicine is right and the patient understands why they should take it then they are much more likely to take it – that's optimisation."

But he added that patients did sometimes decide not to take medication, even when they were fully informed, and that was their choice.

Pfizer medical director Dr Berkeley Phillips highlighted the difference for patients receiving medication as part of clinical trials. The support they received included, for example, counselling. "But then you release the drugs into the real world," he said. "In order to try and realise the benefits and safety you saw in the clinical trial it would be great to help patients use it well."

Patients Association chief executive Katherine Murphy said: "Optimisation is a buzz word in the new NHS landscape. But what it does make you focus on is the outcome and experience for the patients rather than the process and system."

She stressed the need to get patients involved and understanding the benefits and risks. "If you have any questions and queries who do you go to? I see a big role for community pharmacists to work in partnership with clinicians around optimisation of medicines. It is an opportunity which will only be successful if the clinicians and patients are seen as equal partners."

> **'The most expensive medicines are those never taken'**

Professor Gillian Leng, deputy chief executive of the National Institute for Health and Clinical Excellence, stressed the importance of a patient centred approach. Optimisation was "medication that is right for a particular individual at the right time". The availability of new drugs that had been approved by NICE was part of this but not all of it, she added.

Howard Catton, head of policy and international at the Royal College of Nursing, said: "It's outcomes not process, it is safety, it is waste. But it is not just in the moment and it is the relationship with the patient over time. It can provide a window into the relationship between patient and professional that could be so much better." Talking about medicines could spark conversations about the patient's health and wellbeing and lifestyle.

Mr McLellan said: "We have

Left to right: Carol Blount, Howard Catton, Alastair McLellan (top), Gillian Leng (left) and Katherine Murphy, Simon O'Neill, Berkeley Phillips, (top) Keith Ridge, Ash Soni (left) and David Webb

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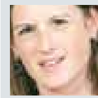

HEIDI WRIGHT ON OPTIMISATION

Most of us will choose to take medicines at some point. This might be for a short period or the rest of our lives. Medicines can help us to stop getting ill, help us stay healthy or sometimes cure an illness. But using medicines can be difficult. We need to take them at the right times and look out for unwanted effects or signs that we aren't getting better (or getting worse). We also need to make sure that we always have a supply of our medicines. This takes time and commitment especially for those of us taking many different medicines. Understanding how our medicines work, when and how we need to take them, and why we should take them as prescribed can help to make sure we get the best results for our health when we take medicines.

'Ultimately medicines optimisation can help encourage patients to take ownership of their treatment'

Medicines optimisation is a patient-focused approach to getting the best patient outcomes from the investment in and use of medicines. To achieve this, professionals across the health and social care system need to work collaboratively and more closely with patients, the public and pharmaceutical industry.

Medicines optimisation has taken a front seat in the current changes in the wider NHS in England. It is a patient-focused approach to getting the best from medicines that requires enhanced patient-centred professionalism and partnership between a clinical professional and a patient. By focusing on patients and their experiences, it may help patients to improve their outcomes, take medicines correctly and avoid taking unnecessary medicines, as well as reducing wastage and improving safety. Ultimately medicines optimisation can help encourage patients to take ownership of their treatment.

The Royal Pharmaceutical Society is the professional leadership body for pharmacists working across all sectors of pharmacy. Over the past few months, through a national engagement strategy, we have met with Royal Colleges, patient and lay representatives, health professionals and the ABPI to explore what medicines optimisation means to them and how to realise this important change.

With input from all these groups we have developed a document that provides four guiding principles for medicines optimisation that will help professionals to support patients to get the best outcomes. The principles describe how healthcare professionals can enable patients to improve their quality of life and outcomes from medicines use by having a sustained focus on the need to optimise patients' medicines.

Heidi Wright is practice and policy lead for England at the Royal Pharmaceutical Society

rightly, especially in the wake of Francis, focused on the patient's relationship with the optimal use of medicines. But I would encourage people to think as well... about the things that happen before the patient and afterwards."

He asked the panellists what barriers to change they would identify.

Ms Blount said what was needed was a better understanding of what patients needed and the benefits medication could bring. For example, she said that there were choices between warfarin and newer anti-coagulants but the question was which patients would benefit from which medicine.

Mr McLellan responded: "If the secret is better understanding of patient need... then what is the barrier?"

Ms Blount said time constraints for the prescriber were one barrier but community pharmacists were well placed to discuss medications with patients.

But Mr Ridge had another culprit in mind as a barrier: the old approach to medicines management, which had aspects more concerned with cost than quality. But he said the data showed that the best outcomes were not being achieved – for example, many patients did not take the medication in the way intended and 5 to 8 per cent of hospital admissions were related to problems with medications.

"There is a lack of recognition in the system on just where we are with medication use generally," he said. "The recognition is improving that we are not getting the best out of medicines – patients tell us that they don't get sufficient support. If you look internationally at evidence from the Picker Institute and other organisations this shows that the UK is behind others in that respect.

"I think medicines management has been too focused on the money aspect, I would say particularly in primary care. If you look at the economics, the demographics, the societal opportunities, then medicines management won't address that. That's where history is the barrier."

Mr O'Neill identified access to patient education as a barrier. "We know that education courses can improve outcomes and lead to better use of medicines," he said. Newly diagnosed diabetics, for example, can do a structured course which aims to help them achieve better insulin control. But access to this is variable. He suggested that education was still seen as a soft option.

"Although education with diabetes was a NICE target we know that only between 10 and 30 per cent of patients get that. We know that to save money commissioners are cutting these education courses back," he said.

The UK was worse than the rest of Europe for control of glucose levels in diabetics. He pointed to Germany where a very high proportion of children with diabetes and their families received education and time off work to do it – and outcomes were better.

"We need to change the ways commissioners think about what their priorities are. Things like education are not a soft option – they are absolutely crucial."

Mr Soni said that pharmacists should be recognised as experts in medicines – specifically community pharmacists as recognition was better in secondary care.

Mr McLellan asked why recognition was not forthcoming at the moment. Mr Soni said that general practice did tend to protect itself.

Mr Ridge added: "I would describe that as silos – and for me one of the important parts of medicines optimisation is collaboration and teamwork.

"My view is that it is not so much the recognition, it is the silos that we all end up working in although many of us try to avoid them."

Mr Soni argued that pharmacists could take a larger role. Currently the GP diagnoses and issues the prescription and leaves the pharmacist to dispense. Yet the pharmacist – talking with the patients – could add a great deal on which medication is needed. "Unless we recognise the role that the pharmacist plays we are missing a trick," he said.

Dr Phillips said: "There has been no national debate with the public and patients on what medicines are, where they come from and what their value is. The average patient will have no idea that it takes 15 years and £1.5bn to bring a drug to market.

"It may be that in other countries patients are more empowered... certainly in the US people will come in to see their doctor clutching the latest information from the internet.

"We have done a lot of work around counterfeit medicines. There is a huge number of people who think they can do [it] on the internet and buy medicines without a prescription

'In Germany, a high proportion of children with diabetes and their families receive education and time off work to do it – and outcomes are better'

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and that's fine."

When asked by Mr McLellan what was stopping the industry getting more involved with patient education, Dr Phillips pointed to the work the ABPI was doing with patient organisations but pointed out the restrictions on pharmaceutical companies directly approaching patients about medicines. "If we could do it through the patient organisations and have a debate that would be useful," he said.

Ms Murphy emphasised the lack of time to discuss individual patients and hear about their conditions and how it affected them. She urged co-production and shared decision making.

Professor Leng said: "We have a lot more medicines, a lot more patients with conditions and a lot more elderly. I don't think we have changed enough." Introducing some new drugs raised specific issues, such as the need for genetic testing, and cost-benefit approaches tended to be conservative.

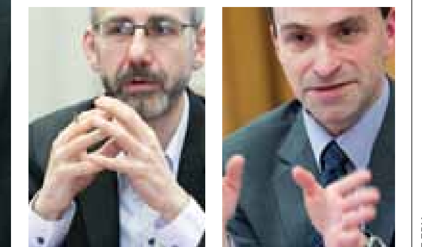
Mr Ridge added: "I think the word prescribing is a barrier. What we are talking about is much broader than that. In the past we have set up systems where the focus is on prescribing and the prescriber. That won't be enough. Breaking down the system and focusing on one part won't be enough."

Howard Catton suggested the low numbers of nurse prescribers – just 55,000, of whom only a minority are independent prescribers – was an issue. It was hard to get funding for nurses to do prescribing courses, and although attitudes towards them had softened, there was still resistance and the current position was ad hoc with little thinking about how the development of nurses could fit in with new services.

But he said a positive outcome of the Francis report could be a requirement to have nursing leadership at every level. "Whenever we ask nurses what care gets left undone if they don't have enough time, talking to patients comes at the top of the list. That time is when fears and so forth get expressed and can be addressed."

David Webb spoke of his concern about fragmentation and a concentration on episodes of care. "There is something about this being everybody's business," he said. Another aspect of fragmentation was how the relationships with patients would be affected by healthcare professionals changing and the continual need for patients to repeat their story.

Left to right: Howard Catton (top), Simon O'Neill and Keith Ridge, Katherine Murphy, Ash Soni, Gillian Leng, David Webb, Carol Blount (top), Alastair McLellan (left) and Berkeley Phillips



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Patients might be at different points in their journey and need different interactions.

Mr McLellan then asked the panel to hold the barriers to optimisation in their mind and ask what would overcome those barriers – and what specific levers could be used. He suggested they think about a timescale of two years.

Mr Ridge said that two years would be quite short for some of the issues they were discussing – but he would see awareness as important. "I want to get to the point where there is a common understanding between all those who are involved – whether that is professionals, patients, public, the industry."

Mr McLellan asked what would be the vehicle for driving this. Mr Ridge pointed to the NHS Commissioning Board's medicines strategy which would embrace medicines optimisation as one lever for change.

"There needs to be considerably more engagement with the public and patients," he said. Clinical commissioning group development might help this engagement process but would also cover expectations.

CCGs would offer an opportunity to think for the first time about how the primary care contracts interacted with each other, Mr Ridge said. "There will be some strong views about that! But we are dealing with some serious issues – quality and £13bn a year, £8bn of which is spent in primary care.

"We are going to have a multiprofessional approach to commissioning... there are mechanisms and networks beginning to develop which I think could be very helpful."

And Mr Ridge said that

'If pharmacists earn more, does that mean GPs will earn less?'

education and training needed to be on the agenda. Health Education England was thinking quite carefully around the requirements for this.

And, as examples of other work taking place, he said doctors' skills were improving following on from the General Medical Council report on the use of medicines. There would be prescribing assessment skills for undergraduates. NICE was producing a short clinical guideline on medicines optimisation.

"I think two years is not a long time. There are some significant cultural issues but there are some new levers in the system to use," he said.

Mr Ridge also highlighted academic health science networks as being useful structures. And he said there was renewed interest in how IT could help in drug administration. "There's renewed interest, whether in primary care or hospitals, about the use of medicines in the context of the evidence base... but inevitably also asking: are we getting value for money?"

Mr O'Neill said there were potential levers such as the shift towards outcome measures in the new paediatric diabetes tariff and the ability of CCGs to have more of a clinical focus in commissioning "Let's hope that they will recognise the broader agenda of health," he said.

Other positive signs included specialist diabetes teams moving into the community rather than hospitals – which could indicate a breaking down of silos.

But he identified some problems such as GPs being very good at monitoring cholesterol levels but less good at bringing them down. Practice nurses played a big part in diabetes care but were crying out for more education to do it better. "I think healthcare professional education is the key."

And he said that improving self management by diabetics could reduce the amount the NHS spent on their care. Longer term the focus would be on prevention of long term conditions, rather than treatment.

The importance of information flows was mentioned by several speakers.

Mr Ridge said: "I think the pharmacy profession will begin to recognise the importance of recording what it does and the interactions it has with the patients and public and the outcomes it delivers."

And Mr Soni said patient-owned information would be influential, as it would be moving to a system where they shared information when they thought it was appropriate.

"We need to try to get suppliers of IT to understand they need systems with interoperability across the NHS," he said.

But pharmacy contracts also needed to change "from a laundry service to a gardening service". As a laundry service they were paid per item whereas gardening was a service over a period of time.

"The change has to be from a contract based entirely on items of service to one based on care. It is saying we would be paid to support a patient over a period of time."

These changes could take place alongside changes in the GP contract and could enable pharmacists to assist patients to get the most out of medicines.

He said, as a provider of pharmacy services, he was capped in the number of medication reviews he could do.

Mr Ridge pointed out the new medicines service review – which pays pharmacists to support new medicines – was being evaluated. And he highlighted innovative work in pharmacy such as identifying patients with chronic obstructive pulmonary disease and offering interventions to improve outcomes. Evaluation of initiatives such as these would inform the development of the community pharmacy contract.

Mr McLellan asked the $64,000 question – if pharmacists earned more did that mean GPs would earn less? But Mr Ridge pointed out there was no more money and the likelihood was the first two years would get even more difficult.

Mr Soni said there was little information sharing with GPs but his area had introduced a common portal for sharing the outcomes of health checks.

"There is that driver to see how we can make it better and more efficient and effective," he said. "The contractual elements do need to be recognised – it is payment based on outcomes.

"It is about how we can make money more effective for the system."

He suggested that the NHS Constitution should talk more about patients' rights to information around medicines as well as NICE approval

Dr Phillips said the pharmacy industry had a big role to play around this. "We have done a lot already and can do a lot more over the year two years."

He highlighted joint working and the agreement between the ABPI and DH for some years to allow joint work between companies and NHS organisations on projects, including medicines optimisation. "A lot are about identifying patients and supporting the most appropriate management of them," he said.

Pfizer had a healthy partnership programme with community pharmacies which supported skills, some of which were relevant to medicines optimisation. Other work had looked at counterfeit medicines, patient information leaflets and better packaging which could reduce medication errors. All new medicines launched now have a risk management plan.

He asked whether more should be done to ensure patients were aware of the potential benefits of medicines prescribed, as a lot was said about risks and side effects.

Ms Murphy said she was concerned about the two-year time span and it was necessary to stop talking about was going to be done and just start doing it.

"How do we move away from silo working and change that? How can we move away from talking about health and start talking about care?"

She said that the range of things going on was positive "But I have heard a lot over the last couple of years so my plea is can we stop talking about it and do it?" Sharing good practice was necessary as was using "untapped resource" of patients.

"They want to help. Can they be listened to and can we use their views constructively?" she said. She hoped CCGs would move away from a tick box approach and would genuinely

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involve patients and public – but to do this well required time and resources.

Professor Leng said there ought to be electronic access to information between pharmacy, secondary and primary care. She said that without information patients did not know what drugs they were on, there were problems with patients in care home on inappropriate medications – Mr Ridge's department had sponsored research which showed seven out of 10 residents had an error in medications in one week.

"One of the key findings was that review of medications in care homes was not at the right level," she said. "We are hopeful that through improvement tools, a residents' charter and so on we will see some improvements in that area."

Mr Catton pointed out the challenge for nurses – who might be the only registered nurse with 30 or 40 residents requiring medications.

Mr Ridge added that review of medications in care homes was not always a priority for GPs.

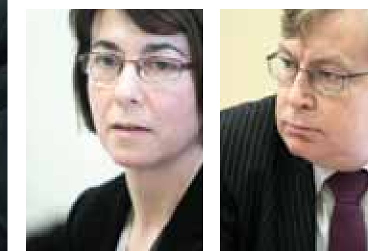
Professor Leng said some of this would need to be built into training and there was much work around outcome measures. But she was concerned about the 30 to 50 per cent of medications that were not taken as intended.

Howard Catton said it was important to be clear how advanced nursing practice developed. He felt there was a need for more independent prescribers among nurses but it had taken nearly 20 years to get to 15,000 of those – so a realistic goal might be to increase that number by 5,000 over the next two years.

David Webb suggested a form of patient map which would ensure patients had options explained to them, understood benefits and risks and got the chance to discuss problems once they had started on the medications. Mr O'Neill mentioned the insulin pass which some diabetics have.

Ms Blount said that a NICE collaborative was running a series of pilots which looked at barriers to appropriate use: there was a need to embed solutions into the system and academic health science networks had in their remit innovative technologies and sharing best practice.

So, overall, while many barriers remained to better use of medicines, the panel felt there were hopeful signs that the levers available over the next two years could trigger changes that should lead to benefits for both the NHS and patients. ●



Left to right: Ash Soni, Alastair McLellan, Katherine Murphy (top), Simon O'Neill (left) and Howard Catton, David Webb, Gillian Leng (top), Carol Blount and Keith Ridge, and Berkeley Phillips

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