Making pharmacy accessible again

Effective pharmacist interventions can optimise medicines use. But there are a number of issues to be addressed before pharmacists' maximum contribution can be harnessed

By Peter Ellis of Pharmacist

The effectiveness of prescribed medicines is dependant on a number of factors involving the clinician, the pharmacist and the patient. The optimisation of these factors is a major challenge in developing effective medicine management systems. The failures are:

- The wrong medicine is prescribed;
- The patient fails to have his or her prescription filled;
- There are errors in the dispensing process;
- The patient fails to adhere to the required regime;
- The desired clinical outcome is not achieved.

Recently, a study conducted by Professor Nick Barber and other similar studies have indicated a minimum of 60 per cent of prescriptions fail to deliver their maximum potential benefit (see below). Thus any innovation that adresses the causes of these failures will:

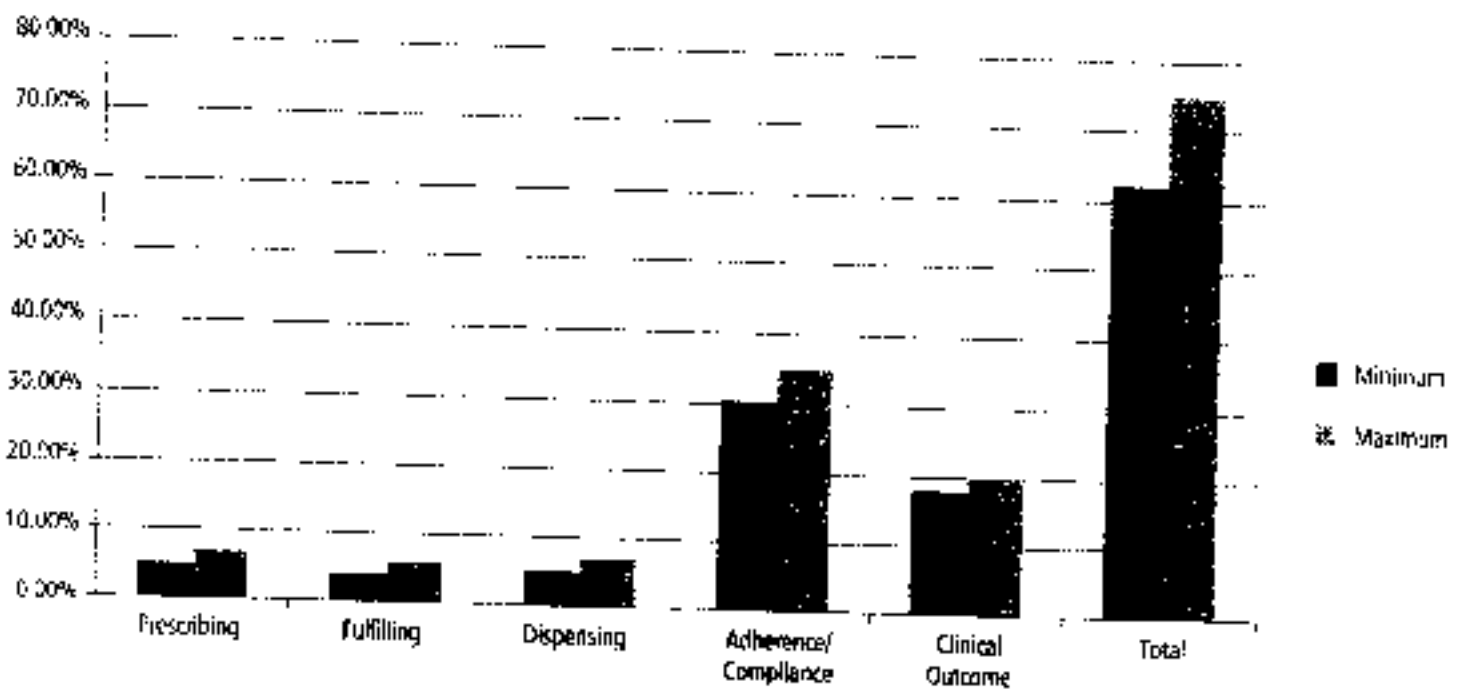
- Contribute to the improvement in patient outcomes;
- Reduce the frequency of untoward events that lead to complications;
- Avoid unnecessary hospital admissions/readmissions;
- Reduce the cost of waste and unused medicines.

As the debate over supervision and the role of the pharmacist in medicines management is fought out between the various interest groups within the profession, the overarching goal should not be lost. This goal is surely to reduce these failures by ensuring *all* patients receive the appropriate levels of service and pharmacist intervention that is proven to reduce such failures and dramatically improve adherence. These include:

- Immediate access by the patient to their medicines, preferably, at the point-of-care;
- Guaranteed communication with, and counselling by, a pharmacist at the time of dispensing;
- Subsequent follow up by a pharmacist to ensure concerns and medicine problems are addressed.

The new government has introduced a Health and Social Care Bill which provides the opportunity along with amendments to the outdated Medicines Act to remove outdated structural, reimbursement and practice standards. These are barriers to harnessing modern technology which would help achieve the key goals articulated above

Contribution by type to ineffectiveness of prescribed medicines



and position medicines management for further improvement and innovation. Below are outlined the concerns and the suggested approach to making the legislation more enabling.

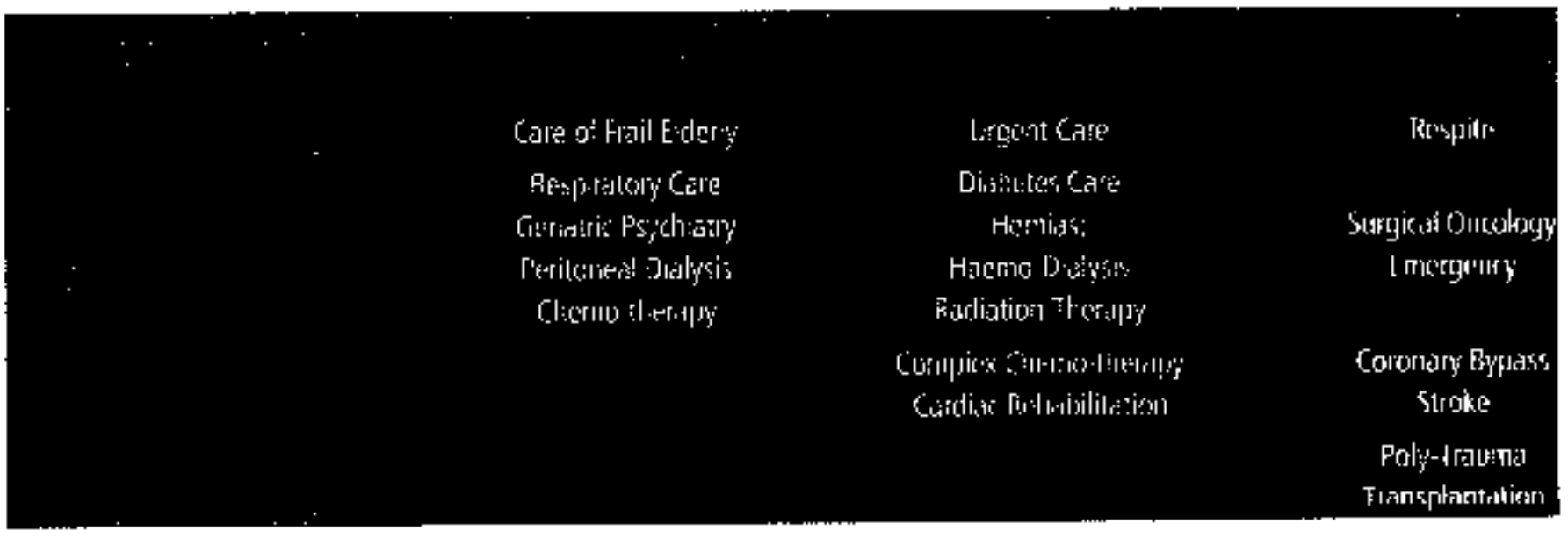
Key issues to be addressed

My premise is that the causes of some of these failures identified above are the behaviours and incentives that the current bifurcated structures and reimbursement systems encourage. With the review of the Health and Social Care Bill and revisions to regulations under the Medicines Act there is an opportunity to address some of the fundamental structural issues and barriers to facilitate a more integrated approach to medicines management, how it is reimbursed and how new integrated strategic innovation can be encouraged.

The most critical needs are that any new legislation and regulation will:

1. Ensure a **single integrated approach to commissioning of medicines** is established in such a way that funding and incentives will drive behaviours that are aligned with the patient's and the system's best interests. There are examples at present, where cost-shifting between Hospital Trusts and Primary Care Trusts causes patient delays in access to their medicines and pharmaceutical advice. The consequence is that some prescriptions remain unfilled and the lack of immediate and ongoing access to robust pharmaceutical advice contributes to the high level of potential errors or adherence issues identified above.
2. Ensure that the **structure and reimbursement systems are aligned to the goal of true integration of services.** Examples currently exist where, on a single campus, an accident and emergency department, an urgent care centre and a GP out-of-hours service co-exist; each separately reimbursed, and managed and operating from physically remote locations with no common triage. This leads to patient confusion and duplication and doesn't allow cost effective provision of integrated medicine management services.
3. Recognise that the **location of care is no longer an indication of the complexity of service** (see schematic below). Secondary and tertiary complex care is now delivered by specialists in home and ambulatory settings. The idea that all care delivered outside of hospitals is only delivered by GPs is no longer valid. To ensure provision for this trend there needs to be a single integrated approach to commissioning and funding of medicines management services. This should be aligned around the patient with the patient's best interest driving all decisions and not be subject to an arbitrary split between GP and Specialist services.
4. **Remove the protectionist and silo mentality.** This has led to **inappropriate lines being drawn between levels care** and the evident hostility that exists between prim and secondary care providers. These behaviours can, t some extent, be traced to the way that services have b independently organised and commissioned around ca levels rather than patient need. It should be recognise that care can be led and integrated by specialists into t community or vice versa. Both approaches are appropr and should be dependent on the circumstances and nature of the patient's condition and his or her needs.
5. **Enable the use of new technologies that allow innovat approaches to more effective medicines management** The ability of a pharmacist in a registered premises or designated call centre to oversee and intervene in dispensing in a remote location is essential to harness the capability of providing more accessible and safer access to medicines and pharmaceutical advice. This c be achieved through 'hub and spoke' models utilising th responsible pharmacist in an existing registered facili to supervise the MedCentres (spokes) or pharmacists purpose designed call centre with delegated responsit
6. **Different standards exist between hospital and comm pharmacy practices** through historic exemptions as to the role and ability of a pharmacist to intervene. Thus vulnerable patients can, in many out of hours situation handed medicines by non pharmacists without counse or an understanding of contra-indications or medicine history. The focus should be on professional activities that are aligned to reducing errors and incorporate requirements for a pharmacist to interact with and co the patient (or carer/representative) in all cases when new medicines are dispensed regardless of location.

Innovative technologies and remote service delivery capabilities exist which can help overcome many of the iss Such innovation will not only improve the failure rates dis above but also reduce the huge cost to the system as a wh the estimated 5–8 per cent of admissions and readmissior



The historic connection between location of service and level of care no longer applies

are medicine management related. An integrated approach to medicines management should produce improved patients' outcomes at lower costs. However, it requires flexibility in its governance, commissioning and reimbursement.

The issues identified above need to be addressed in the current review of both the legislation and regulation of the Health and Social Care Bill and the revisions to the Medicine Act. The changes relate to the structure and alignment of the commissioning functions. Such changes would assist in removing some of the existing barriers to effective remote supervision and intervention which would ensure consistent medicine management support at the point-of-care and ensure patients can have 24/7 unfettered and essential pharmacist support to address causes of failure or error.

Conclusions

To achieve the above goals it is suggested that a number of key next steps be followed:

- Government include key stakeholders, from all sectors, in the ongoing process to define an integrated and flexible commissioning process capable of driving and aligning the strategic imperatives, and that these participants also include non-traditional and/or new stakeholders;
- Proposed structures and models be designed to be flexible enough to anticipate the future integration of new technological approaches to increase efficiency, better management of medicines and truly put the patient at the centre of care;
- Legislation and regulation is drafted in a manner that encourages strategic goals and imperatives to be addressed and enables new and innovative models of care using the latest technology enablers, rather than protecting the status quo that presents barriers to innovation and becomes quickly outdated.

Effective medicines management can help relieve the disease burden and save patients and the NHS untold hardship and cost burdens. Medicine errors, non-adherence and other failures have been identified as major challenges to the system that add dramatically to unnecessary admission and readmission rates and cause unacceptable levels of morbidity and mortality. We currently have an opportunity to address some of the structural and alignment problems that are seen as major contributors to the problem. This opportunity should be embraced. ✚