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Response to APPG on Primary Care and Public Health NHS inquiry

PSNC is pleased to be able to submit a response to the All Party Parliamentary Group on Primary Care and Public Health inquiry into the survival of Bevan's NHS.

PSNC promotes and supports the interests of all NHS community pharmacies in England. We are recognised by the Secretary of State for Health as the body that represents NHS pharmacy contractors. Our goal is to develop the NHS community pharmacy service, and to enable community pharmacies to offer an increased range of high quality and fully funded services; services that meet the needs of local communities, provide good value for the NHS and deliver excellent health outcomes for patients.

The long-term survival of the NHS

NHS services are stretched more than ever before at the moment under the combined pressures of financial constraints and increasing demand for services. And with the patient base only set to expand further as the population ages and long-term conditions, some related to unhealthy lifestyles, increase in prevalence; the challenges are not set to go away.

The scale of the challenge is clearly illustrated by a Nuffield Trust report published last year (A Decade of Austerity), which estimated that unless health funding could increase beyond inflation the NHS is set to face a funding gap by 2021/22 of around £50bn. Improved productivity of 4% per annum across the NHS reduces the deficit by around 40%. But that is a massive demand and still leaves a large funding hole.

PSNC believes that the NHS can, and must, meet these challenges. But it will not happen without radical thinking and a commitment from all healthcare professionals to play their part. And PSNC believes that it will not happen unless community pharmacy is used effectively to play a key role in supporting patients to lead healthy lifestyles and make the most of their medicines and the care available to them. By reshaping the community pharmacy service, large savings in NHS resources and improvements in health outcomes can be made.

GPs are fully employed dealing with ill-health and the administration that surrounds it and secondary care is under increasing pressure. We therefore urgently need a new, third pillar of the NHS to support secondary care and GP-led primary care, and the community pharmacy network should be the foundation of that pillar. Pharmacies must become the health place, which people use to keep healthy, avoid disease and risk factors, and deal with minor episodes of illness. They should do so as part of a health system that is underpinned by communication and team-working, in which people are nudged towards using the right level of resource for their own needs. The NHS has trained people to look to general practice for all their healthcare needs, and GPs have sought to meet this demand but have in turn faced increasing workload and pressure on resources.

Unless we change this – and it cannot be done by pharmacy alone – and adopt community pharmacy as a third pillar, alongside the pillars of secondary and GP-led primary care, the system may crack under the strain. In the third pillar model the community pharmacy supports the patient in self care. For long term conditions centrality of supply of

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medication in pharmacies gives way to taking responsibility for ensuring the patient uses medication appropriately and effectively. The GP will normally diagnose and initiate therapy, but the community pharmacist takes responsibility for ensuring the patient gets the best outcomes and identifies any changes to therapy that may be needed.

The routine care of millions of patients shifts to the pharmacy, where it can be accessed more conveniently, and more cheaply, and patients have a range of providers from whom they can choose. The 'bricks and mortar' pharmacy service is supplemented by telephone, internet and where necessary, domiciliary support.

Improving productivity and health outcomes by working smarter, cutting waste and engaging health professionals

It is very clear that in many parts of the health service waste can be cut. It is a massive waste of NHS resource to use general practice for easily diagnosed, common and easily treatable conditions, and it is no longer affordable. IMS data showed that over 50m GP consultations a year, 18% of all GP consultations, were for minor ailments alone, costing £1.5bn a year in GP time. Community pharmacies can be used, through properly rewarded and designed minor ailments schemes, to free up some of this time and to promote self care to patients, giving them the knowledge to treat themselves in the future.

We also know that the NHS wastes millions of pounds every year on medicines that are not taken correctly by patients or even not taken at all. Figures for levels of non-adherence to medication regimens vary from 30-50%, and the costs associated with that are high. The IMS Institute for Healthcare Informatics report to the Ministers Summit held alongside the International Pharmaceutical Federation centennial congress last year, attempts to quantify the global cost of suboptimal use of medicines. They estimate that about 8% of total health expenditure or about $500bn (US) per year globally can be avoided with optimised use of medicines, which would prevent avoidable hospitalisations and improve medicines use.

Again, community pharmacies can play a key role here through medicines optimisation services such as the Medicines Use Review (MUR). The role of the MUR in helping people understand their medication and its effects is an important contributor to the goal of having people fully engaged with their own health – the Wanless objective. But lack of engagement by PCTs and GPs with the MUR service and the absence of effective targeting combined with lack of robust data capture and outcomes research has been problematic. The introduction last year of nationally agreed target groups and data capture requirements have started to help address these shortcomings. Research into respiratory MURs conducted on the South Coast provided strong evidence of improved control of patients' conditions and a correlation between the service and reduced hospital admissions.

In future iterations of medicines optimisation services we should focus on the patient groups for which medication problems lead to expensive episodes of care, primarily hospitalisation. This is where the pharmacy service, properly used, can achieve real cost savings for the NHS, and convenient care for patients. Ensuring blood pressure levels are monitored, ensuring inhalers are being used properly, ensuring that, so far as possible, patients do not give up on medication regimens prematurely but get optimal health outcomes.

These groups – those with high hospitalisation rates - form the eligibility cohort for the New Medicine Service, and its' introduction, initially in October 2011, has been far smoother: through implementation of MURs pharmacists had gained the skills and confidence to offer the service, and we worked with GPs in advance, to get their support for the service.

The productivity gain for the NHS from these services will come from improved patient adherence to their medicines, leading to reduced numbers of avoidable costs: GP consultations and hospital admissions. Early analysis of the NMS recorded using the PharmOutcomes platform shows significant gains in adherence, as indicated by the initial research that underpinned the development of the service.

We know that pharmacy can achieve efficiencies – it has to because of the cost application of efficiency discounts included in its contractual framework. Other healthcare professionals can do this too, but experience of GP and community pharmacy contracting demonstrates the importance of getting the incentives right. The success of a community pharmacy today is dependent on three core factors: location and volume of prescription business, procurement skills, and services. In that order. We need to manage a re-ordering so that future success is determined by services for patients and partnership with primary care, accessibility and efficiency.

Territoriality is always a barrier when it comes to changing the health service – this too could be addressed by getting incentives right at a national level across all healthcare professions.

Aspects of pharmacy practice are also in particular held back by regulations. Decriminalisation of dispensing errors could help to incentivise pharmacists to delegate certain tasks to staff, leaving the pharmacist time to deliver medicines optimisation and other services. Changes in the responsible pharmacist regulations could act as a further enabler.

And of course, patients themselves will need to be engaged, and they must be given information about health services and healthy lifestyles. Community pharmacy has a key role to play here through services focusing on medicines optimisation and also through advice given on healthy living and public health topics.

Educating individuals about being healthy through joint working

Many people in England still do not understand how to make best use of the health services that are available to them, and many patients do not receive consistent and efficient care when they have to deal with more than one health organisation. Patients going into and out of hospital can end up with duplications in their medicines, with primary care professionals unaware of the care they have received in hospital, due to poor communication between the different sectors of healthcare.

To address this and other problems, NHS care pathways need to be designed to ensure seamless care across organisations – the patient journey must be at the heart of these pathways, and they must promote the use of the most appropriate service providers and facilitate the transfer of information between health organisations. The radical changes currently being made to commissioning and the provision of health services may provide a good opportunity to examine local care pathways more closely to ensure this across all commissioned services.

More can also now be done to educate patients about these pathways and the care options available to them. The NHS has done this to some extent in recent years through its communications channels and NHS campaigns, but local authorities may have deeper links with their local communities and could be well placed to disseminate these messages.

Local authorities will also be well placed to think about how local communities can be educated more about the importance of leading healthy lifestyles. And here community pharmacies can play another key role by delivering health advice, potentially through the healthy living pharmacy (HLP) framework.

The HLP framework was developed and launched in Portsmouth in December 2009 and it led to quality and productivity improvements in community pharmacy with better access to health and wellbeing services for the public. As well as committing to and promoting a healthy living ethos, one of the distinctive features of an HLP is having health trainer champions on site. HLP community pharmacies in Portsmouth exceeded the PCT's stop smoking quit target by 138%, achieving 664 quits at 4 weeks for the year 2010/11. Evaluation results indicate that a person walking into an HLP in Portsmouth is twice as likely to set a quit date and give up compared with a person walking into a pharmacy which is not an HLP. Twenty sites are currently being evaluated to see if the outcomes from Portsmouth can be replicated in different demographies and geographies. Today there are over 400 HLPs and 1,000 healthy living champions in place. Expanding this type of service could make a very real difference to the health of populations.

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The role of the Government

A key barrier preventing pharmacy from improving patient outcomes across the country has been the limitations of local service commissioning – this has been patchy and inconsistent meaning patients in some areas have not been able to benefit from high quality community pharmacy services such as smoking cessation programmes, access to emergency hormonal contraception and minor ailments schemes. The NHS reforms and emergence of new commissioners present a chance to rectify this, but commissioners will need national direction from the government.

PSNC believes national service specifications and agreements improve efficiency in the health service by preventing duplication of work, and they improve the outlook for all patients by reducing the chance for inequalities in services to develop. For local commissioners, having national systems and directions in place to inform the services they should commission can have a similar effect. Public Health England in particular could play a key role in collating the evidence base for such services and the impact they can have to inform commissioning. As an example, pharmacy flu vaccination schemes have in recent years been extremely well received and used by patients and by putting them in place more consistently, pressure could be eased on GPs - who are the biggest providers of the service - and on the health service more broadly, by reducing flu cases.

The government also has a key role to play in the removal of regulatory barriers to better care and in tackling the territorialism that so often blights successful working relationships between professional groups. Tying contractual frameworks together to incentivise more efficient care and sharing of work is likely to be crucial to this. For example, by adjusting the General Medical Services contractual framework the government has the power to shift some patients away from GPs and into pharmacies and self-care. It could then also ensure that GPs are fairly rewarded for taking some of the secondary care workload away from hospitals. Without this oversight and intervention from above, encouraging GPs to refer patients to a pharmacy provided service may always be a struggle. With its oversight of both the GMS and pharmacy contracts the NHS Commissioning Board has the power to align the contracts and the incentives to ensure patients and the NHS get the best from both professions.

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