

Medicines optimisation in primary care: can community pharmacies deliver?

One pound in every eight of NHS spending is on medicines, yet it is generally agreed that up to half of all the medicines prescribed are not used as the prescriber intended.¹ The problem of sub-optimal use of medicines in chronic diseases has been recognised for many years, but only recently has 'medicines optimisation' been on the agenda of policy makers. Medicines optimisation refers to the process of making the use of medication by patients as safe, effective, and efficient as possible. A key part of the government's strategy towards achieving this has been to extend the role of community pharmacies, and to make better use of pharmacists' specific medicines-related skills and knowledge.

This strategy for medicines optimisation began with the 2005 Medicines Use Review (MUR) service, and received another fillip in October last year with the launch of the New Medicines Service (NMS) in England.² Whereas the focus of the MUR was on improving medicines use by patients already taking multiple medicines for a period of time, the NMS aims to provide early support to patients who are newly prescribed a medicine for a long-term condition. Similar services have been introduced in Scotland and Wales. Given the investment of scarce NHS resources (up to £55 million pounds per annum until 2013 in England for the NMS) what are the chances of success? Here we explore the potential, the evidence, and the challenges of the NMS service.

THE POTENTIAL

The NMS seeks to improve medicines use in people with long-term conditions who are newly prescribed a medicine, with the initial rollout targeting asthma and chronic obstructive pulmonary disease, type 2 diabetes, antiplatelet/anticoagulant therapy, and hypertension. The aim is to establish whether patients have started taking the newly prescribed medicine appropriately, and to address associated problems or concerns. Recruitment of patients to the service is 'by prescriber referral or opportunistically by the community pharmacy'.² Once consent is given, patients are invited to return to the pharmacy (or to receive a telephone call) within 2 weeks of starting the new medicine, with a follow-up consultation 3 weeks later. This is a key difference from MUR which involves a single consultation and is almost always face to

face. If a review of the medication by the GP is indicated, the pharmacist sends a NMS feedback form to the patient's practitioner. This service has the potential to benefit patients through improved long-term health, and also the NHS through savings made in the subsequent treatment that these chronic conditions might otherwise need. But these benefits will only come to fruition if the NMS is implemented successfully.

THE EVIDENCE

The NMS builds on the recommendation that pharmacists should play a greater role in the care of people with long-term conditions.³ However, the evidence base is sparse, with only one study in which pharmacists followed up patients and discussed any problems they were experiencing with newly prescribed medicines.⁴ This randomised controlled trial of a telephone-based intervention demonstrated reduced non-adherence and NHS resource use in the intervention group.⁵ Systematic reviews show mixed findings from trials of community pharmacist interventions,^{6,7} most of which have been conducted without formal linkage to wider primary health care.

A review of literature appraising MURs⁸ identified few studies where medicine optimisation was successfully achieved and highlighted several areas likely to impact effectiveness. Many pharmacists cited lack of time during the normal working day and availability of support staff as barriers to delivering MURs, although they were generally positive about the service, seeing the extended role as an opportunity to promote the value of community pharmacy. GPs were less enthusiastic, expressing concerns about the types of patients being reviewed and difficulties in communicating effectively with pharmacists. Our own recent pilot work for a trial of community pharmacy adherence support in hypertension highlighted similar workload and

communication issues (A De Simoni *et al*, unpublished data, 2012). Feedback also suggested that patients tended to be equivocal about the intervention, but may have been more willing to take part if initially directed by their GP.

THE CHALLENGES

An estimated 70% of pharmacies may now be ready to provide the NMS, yet community pharmacies still face many practical challenges. Some, but not all, pharmacy computer systems now flag the record of those patients prescribed a medicine eligible for NMS. If patient recruitment is done opportunistically, pharmacy staff will need to take time away from routine work without prior notice. Moreover, delivery of the NMS intervention and follow-up has to be arranged and booked in advance with patients. Organising these appointments may also prove challenging, particularly if additional pharmacist cover is needed for face-to-face consultations.

Moreover, during a busy clinic how many GPs will have the NMS in mind when issuing a prescription? The professional bodies of pharmacists and GPs recently issued a joint statement, the first of its kind, to urge closer working practices.⁹ Delivering this commitment in everyday practice will be a key determinant in successful implementation of the NMS.

The NMS could potentially be delivered in other primary care settings and was commissioned as part of the community pharmacy contract in line with the strategy to make better use of pharmacists' specific medicines-related skills and knowledge.⁵ Recent literature^{6,7} shows a worldwide interest in promoting pharmacists as deliverers of primary care services, and the NMS in the UK is a forefront effort in this direction. The study by Geerts *et al* featured in this issue of *BJGP* illustrates how patients can benefit from the enhanced role of community pharmacists working in harmony with GPs.¹⁰ The process of

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expanding the role of community pharmacists, the experience of MURs, and our pilot work outlined time pressures of pharmacists as the main challenges ahead. The MUR service has familiarised some patients with pharmacist-provided medicines consultations. There is some evidence that although patients find consultations with pharmacists helpful, they continue to view their GP as the primary source for decisions about medicines.¹¹ This may reflect perceived isolation of pharmacists from the healthcare team.

The NMS has a complicated payment structure that was recently revised in response to widespread criticism.³ In year 1, the targets will be 20%, 40%, 60%, or 80% of NMS opportunities met, with the expected maximum set on a month-by-month basis at 0.5% of the prescription volume for each pharmacy. Contractors will be paid for the interventions that are above one target but below the next. The Department of Health Impact Assessment for NMS provision envisaged 20–25 minutes in total per NMS (engagement, intervention, follow-up, and record keeping). For example, a pharmacy with a prescription volume of 10 000/month will need about 13–16 hours of a pharmacist's time (if the pharmacist conducts all parts of the NMS process) to deliver the 40 NMSs for an 80% target payment of £1120. This payment strategy differs from that of the MUR (£28 per MUR provided).

The Department of Health Policy Research Programme has commissioned an evaluation of service impact and cost effectiveness to ‘... determine whether continuing the service beyond 2012/13 can be justified’.¹² The implementation and evaluation of NMS is likely to attract international attention. However, the true value of the service may only become evident with time, as patients become accustomed to receiving this type of advice from their pharmacist, and as pharmacists are able to incorporate the NMS within their routine workload. Over the next months the NMS will show whether community pharmacy teams, and to a lesser extent general practice teams, can change their practice and systems to ensure that patients

can receive the NMS in order to realise its potential benefits.

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Competing interests

The authors have declared no competing interests.

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