Can pharmacy make the giant leap forward?

Community pharmacy could be directing healthcare that is fit for the future but the sector needs to step up.

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Community pharmacy could be a vital player in developing new approaches and directing healthcare that is fit for the future. By Johnny Skillicorn-Aston and James Roach from healthcare consultancy Conclusio.

In our series of commentaries over the past few months, the focus has been on the place of community pharmacy in the changes that are happening across the NHS, which, in turn, are driving new ways of providing healthcare.

The approach has been to view these developments through a lens of opportunity. Each change presents an opening to draw down on the sector's experience, strength and position, and calibrate its multi-faceted offering to support existing and fresh purpose.

The pivotal point has centred on how the sector can create new dialogue, develop new operating models and lead decision-making. In other words, an initiative-taking dynamic for a frontline healthcare provider, fit for purpose, wherever that may lead.

Previous articles have reflected the views of a PCN clinical director and an NHS trust chief executive on the role and place of community pharmacy. The former viewed the sector as somewhat of a clinical appendage to GP-led, place-based care. The latter knew little of its place but was keen to explore how community pharmacy and trusts could work together.

Lack of understanding

The recent King's Fund report on integrating additional roles into primary care networks looked at team-based models of care in primary care networks (PCNs), within the context of the Additional Roles Reimbursement Scheme (ARRS). Clinical pharmacists were among the roles explored.

The report found: “A lack of shared understanding about the purpose or potential contribution of the roles, combined with an overall ambiguity about what multidisciplinary working would mean for GPs.”

It’s interesting that despite decades of clinical and care interactions between pharmacists and GPs, there is still a paucity of understanding about how to use pharmacists fully within the practice and primary care environment.

A recent conversation with a PCN clinical pharmacist revealed a growing sense of frustration with how this valuable resource is being deployed. The advent of support for additional multidisciplinary roles was welcomed in primary care and it seemed, sounding like Father Jack Hackett on Craggy Island, many were shouting: “ARRS! ARRS!”.

As multidisciplinary working should now be starting to motor along – and a driving factor in helping PCNs to mature – under-utilisation and a pre-occupation with structured medication reviews is discouraging.

It is a good motif for the experience of community pharmacy over the years – great service, loads of opportunities, everybody wants it… but a lack of understanding about how to use it to the greatest effect.

Provider models are a powerful way for the sector to gain traction as a co-designer of locally commissioned services that people need. Inter-pharmacy collaboratives, with a joint and extended offer that works at place and population level, could mean the sector functioning as a pivotal player within integrated care systems.

However, community pharmacy is commissioned by CCGs/ICSs and local authorities. In each case the roll of services is defined by the current responsibilities of each commissioner.

For instance, people who misuse substances who require a supervised consumption service will have other health and social care dependencies. People who live with multiple conditions have other wider needs too.

The stuff of transformation...

The spaces between these commissioning responsibilities, the gaps in care they create and the co-dependent needs of patients is where the stuff of transformation lies. It is here where community pharmacy can be instrumental in modelling innovative new service offers and take the lead in integrating services that provide a benefit at a personal, technical and allocative level.

Put simply, these services must be:

- Patient centred
- Optimal care focused
- Population led.

Words are important

How the sector communicates is important – what it says about itself to others. Articulating community pharmacy's value through always highlighting how it is mistreated and denied the status it deserves only serves to keep pharmacists in their place.

While it might serve as a contextualising gambit for a negotiation, it isn't a good strategy for pursuing a leadership position in how NHS services are conceived, planned, purchased and provided.

The sector has a right to be bold in the way it speaks about itself but it would benefit from looking at its own lexicon. For example:

'High street healthcare' is a catchy bit of nomenclature, often heard. We've used it ourselves to describe the proximity of community pharmacy to patients. But does it reinforce something else that has often been directed at the sector by other clinicians – a group of shopkeepers?

In turn, does that fix community pharmacy in the mind of the public and fellow clinicians as dispensers and retailers? The Healthy Living Pharmacy framework

addresses some of this… but anything wrapped up in a ‘framework’ will mean little to the public.

‘Contractor’ is another word used frequently in the sector. When did you hear a GP, a PCN or GP federation use the word? GP partners are indeed contractors but their self-descriptors speak of the value they bring and the needs they address.

As a collective, community pharmacy represents a high-performing, multidisciplinary team addressing a multitude of clinical and care needs where and when people need help. Each pharmacy could be seen as a community clinic or hub, serving health and wellbeing needs at the centre of an integrated health and care network.

It is said that words are cheap, but perhaps using them cheaply is the real issue and the costliest. With a new lexicon and a refreshed intra-sector dialogue, community pharmacy can continue to propose new models of care and establish new commissioning relationships.

Areas of interaction

NHS trusts are a good place to start. None of us will be strangers to those ‘burning platforms’ that crackle and spit at the centre of many hospitals. Common areas of interaction between community pharmacy and trusts are:

- Reducing preventable admissions
- Early and supported discharge
- Transfer of care.

Pharmacovigilance is a less-trodden path and provides the means for community pharmacy to take the lead in drawing primary and secondary care together to reduce medicine related issues.

The rise in polypharmacy, with over 1 million people taking eight or more medicines a day, and up to 10 per cent of all hospital admissions being medicine-related, demonstrates the need for greater collaboration in this area.

It is an area that can combine with other patient-centred development work within a ‘living lab’ approach. Living labs offer an opportunity for service-users, stakeholders and other interested parties to discuss and propose new service models that address unmet needs.

Free to explore innovation, the cross-cutting methodology can be instrumental in bringing down sectoral walls, removing barriers, targeting health disparities and addressing emerging needs.

Vital player

Community pharmacy could be a vital player in supporting a networked living lab with a focus on both place-based and population-led health transformation. As important, it places the sector in the vanguard of developing new approaches and directing healthcare that is fit for the future.

https://www.pharmacymagazine.co.uk/opinion/can-pharmacy-make-the-giant-leap-forward