Royal Pharmaceutical Society Principles of Medicines Optimisation

Interview with Catherine Picton, *Lead author, RPS Principles of Medicines Optimisation and Healthcare Consultant*

Correspondence to: catherinepicton@t-online.de

Interview conducted by Barry Jubraj, *Clinical Senior Lecturer (Medicines Optimisation), King's College London*

Correspondence to: barry.jubraj@kcl.ac.uk

How did you get involved in developing the RPS guidance on medicines optimisation?

In the last fifteen years of my career I have specialised in the development of guidance that helps translate policy into practice. Much of my work has touched on problems and issues around the use of medicines in practice and medicines optimisation, for example shared decision-making, transfer of care and local decision-making processes.

Although there is a lot of evidence that patients experience problems with their medicines, relatively little research exists around how patients actually use their medicines in practice. In other words, we're not good at looking at what patients do once they have their medicines. NHS England wanted to tackle this and medicines optimisation was seen as a way to do so. As a result, I was asked by the RPS to lead on the development of this guidance as a way to capture some principles for medicines optimisation.

How did you find doing it e.g. consulting with stakeholders, managing a variety of views, and settling on the principles that are mentioned?

The start was to look at literature and practice. I wanted to elucidate a narrative. There wasn't a definition of medicines optimisation but there were plenty of examples of it in practice as well as all the examples of the problems that sub-optimal use of medicines caused for patients and the system. I looked at the problem from both sides in order to pull out the principles.

It was an iterative process using expert groups and focus groups. Interestingly, participants tended to want to define medicines optimisation before the principles were identified. I resisted this because of the danger of a definition limiting our thinking. It wasn't too tortuous a process because we knew what the problems were and also what the evidence was. The principles aren't complicated but they illustrated the problems. We tried to keep it simple.

You drew on your experience of previous projects for this work. Were there any differences?

Yes – there are always differences. This was simple and complex at the same time; keeping things simple is often much more difficult than putting in a lot of detail. The need to look at this in a very multidisciplinary way and with an absolute focus on patients added complexity and I was struck by the pressure to get it right.

Were then any 'lightbulb' moments or things that stand out?

I think it helps to see medicines optimisation as a way of thinking about medicines for their whole journey, the way they are researched, commissioned, prescribed and used. There had been a mindset of looking at medicines in isolation, often focusing on them as a cost pressure rather than looking at getting best value and outcomes for the patient. For me, the real challenge for all healthcare professionals is in Principle 1, having an ongoing, open dialogue with the patient and/or their carer about the patient's choice and experience of using medicines to manage their condition. It sounds straightforward but it's a change in mindset.

Do you think that medicines optimisation can avoid being a 'fad' and can it be here to stay?

At a national policy level, medicines optimisation has been driven and, I have to say, embraced by NHS England. They can see the potential to improve patient outcomes and to promote the best use of medicines. There is a common cause with the pharmaceutical industry where we need to ensure that appropriate innovations are used and also a common cause with the RPS – hence the guidance document. It has come to be accepted at the strategic and practical levels.

I don't see any sign of the commitment to medicines optimisation diminishing. We have the medicines optimisation dashboard and

other practical tools. It is important to link the principles to implementation, measurement and monitoring; particularly at a local level. Local policies are needed to win hearts and minds and to embed medicines optimisation organisationally.

In hospital pharmacy we see systems change happening and there is strong leadership there that, if harnessed, could really help drive medicines optimisation.

Where do we as a profession need to go next with medicines optimisation?

There is a huge issue around system leadership and pharmacists truly owning medicines optimisation. It is everyone's business. We need to equip local leaders and the RPS leadership framework is important here along with links to the NHS Leadership Academy. Pharmacists ranging from Trust Chief Pharmacists to community and practice pharmacists and CCG pharmacists need to be relentless in recording and measuring their work and taking a leadership role. The medicines optimisation dashboard can help. The February 2016 report of Lord Carter's review of productivity in acute trusts in England is a good example of where we need local leadership in ensuring that the local plans being developed as part of the Hospital Pharmacy Transformation Programme have a focus on medicines optimisation and the clinical services that are required to support delivery.

There is a tailwind around medicines optimisation at the moment on which pharmacists need to capitalise. It is absolutely clear that NHS England and the Department of Health sees a future for pharmacists and their teams in providing clinical services to patients. What the pharmacy profession needs to do urgently is to capitalise on this view and ensure that medicines optimisation activities are firmly integrated into any transformation plans or local development.

It is also important to communicate effectively with patients, which we're not so good at right now. We are still coming to terms with whether we are a patient-facing profession. Community pharmacists need to spend more time with patients, but this is hard. Yet community pharmacists' added value is when they are with patients e.g. helping with adherence and MURs. This is where we add value.

If a community pharmacist asked 'give me one thing I could do to move forward with medicines optimisation', what would you say?

I would say audit how much time you spend with patients in comparison with your other activities. See how your system works and explore possible changes. Identify where you can claw time back e.g. through skill mix. If you are an employee pharmacist, this will be harder. Can you realise efficiencies from the medicines process?

I think it is clear that to secure future roles we need community pharmacists to focus much more on clinical and medicines optimisation roles. This is something that was highlighted in the RPS Commission report 'Now or Never: Shaping Pharmacy for the Future' and is becoming increasingly urgent.

How would you like medicines optimisation to be taught in pharmacy?

I think that there needs to be greater effort in equipping pharmacy teams to communicate with patients, including health literacy, adherence and health coaching. One-to-one clinical engagement and consultation needs to improve.

Barry described that Kings College London have two health psychologists and run consultation skills training from year 1:

CP: This teaching shouldn't be an add-on in year 3 just before placements. Pharmacists need to be very self-aware and able to engage on a human level.

Barry described a student told on his Saturday job by a pharmacist not to talk to patients – just dispense:

CP: That's not surprising given the historical funding model for community pharmacy, although I think we can now see that there is already pressure on that funding model. We mustn't lose sight of the way that the profession dispenses safely for patients. But the 'Now or Never' report is clear about how pharmacy needs to change. We need to tell pharmacy students that the future is clinical and skill mix is a key to this. We need to be realistic about the future pressures and tell them about new roles that are emerging. Community pharmacists need to fight for and embrace clinical practice.

We need to train clinical leaders who will take ownership on patient issues, cascade that training and act as role models. We need these leaders to say 'this is about the patient'. These may be in LPFs. It may be a community pharmacist who owns a patient's problem about, for example, a 'special' and communicates with the hospital and the GP. This is a system leader.

LPCs can support, for example 'Community Pharmacy West Yorkshire' is well set up doing good work in establishing systems and processes. For example, a common ailments service that is commissioned and co-produced with GPs within the system. It's about co-ordination, communication and, importantly, implementation; this is the thing we fall down on too often - great ideas not implemented well.

The NHS has fragmented systems around medicines and needs leadership.

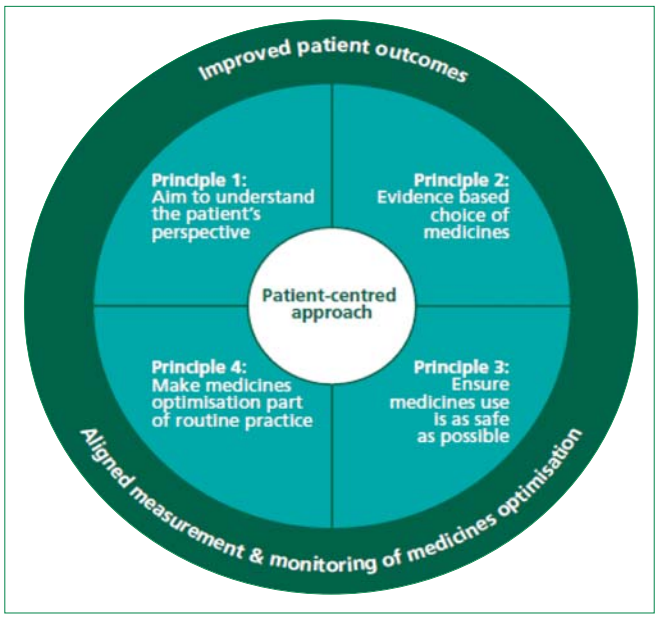
Declaration of interests

The author and the interviewer have nothing to disclose.

Editorial notes

- *Royal Pharmaceutical Society. Medicines Optimisation: Helping patients to make the most of medicines. Good practice guidance for healthcare professionals in England. London: 2013. Available at: http://www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf .*
- *Royal Pharmaceutical Society. NOW OR NEVER: SHAPING PHARMACY FOR THE FUTURE. November 2013. Available at: http://www.rpharms.com/promoting-pharmacy-pdfs/moc-report-full.pdf*

- *NHS Leadership Academy. Available at: http://www.leadershipacademy.nhs.uk/ .*
- *Medicines Optimisation Dashboard. Available at: https://www.england.nhs.uk/ourwork/pe/mo-dash/ .*
- *RPS Medicines Optimisation principles*



- *Terminology:*

  RPS – Royal Pharmaceutical Society
  CCG – Clinical Commissioning Group
  MUR – Medicines Use Review
  LPC – Local Pharmaceutical Committee
  LPF – Lead Provider Framework