LONG-TERM CONDITIONS: INTEGRATING COMMUNITY PHARMACY

EXECUTIVE SUMMARY

Foreword

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The RPSGB Long Term Conditions project has brought together, for the first time, evidence from published studies and evaluated practice in the UK and internationally to show the contribution of community pharmacists.

The findings show convincing evidence of the impact that community pharmacy can have in the care of people with asthma, diabetes and coronary heart disease. In other countries health commissioners are funding disease specific community pharmacy services, particularly in asthma and diabetes. Community pharmacists in other countries are also funded to carry out clinical medication review for housebound patients and those in care homes.

However in England only 1% of community pharmacies are currently commissioned to provide disease specific medicines management services (Health and Social Care Information Centre 2006). Commissioners can use this RPSGB work to include community pharmacy in local integrated patient care pathways for asthma, diabetes and CHD.

Royal Pharmaceutical Society of Great Britain

IN A NUTSHELL...

The Royal Pharmaceutical Society of Great Britain has been working with the Department of Health (England) to identify how pharmacists can contribute to the care of people with long-term medical conditions. This is a Summary of recent research - commissioned by the RPSGB - which looks at the evidence on what pharmacy can contribute, and how:

1. The Problem

The successful management of long-term conditions in the community is now - and will remain - a key objective for the NHS.

2. The Theory

We all know in theory that community pharmacy is an under-utilised resource which should have a major role to play (cost effective, skilled, patients like it, located in all communities)... but HOW?

3. The Answer

This paper shows how – in practical terms, based on evidence - local primary care organisations can realise the potential of community pharmacy, and knit it into a comprehensive and coordinated package of care for people with long-term conditions.

This summary is intended as a practical guide for use by PCTs, pharmacists and others who are seeking new and better ways of managing long-term conditions in the community.

It sets out the evidence - and some current examples – on the role of pharmacists, and then identifies the key leavers for realising that potential.

A copy of the full report is available from www.rpsgb.org

LONG-TERM CONDITIONS AND PHARMACY: AN OPPORTUNITY

The Potential of Community Pharmacy

The better management of long-term conditions is one of the key elements of the modernisation of healthcare. Such conditions affect large numbers of people, whose quality of life can be substantially improved if they are helped to manage their conditions appropriately. There has been an over-reliance on secondary care to support the health needs of this group – which is less inconvenient for patients, and an inefficient use of NHS resources. Partly as a result of this, the NHS has not always been very good at managing conditions *pro-actively* – sometimes exacerbated by the fact that patients (and their carers) don't know how to approach the service, and don't want to 'bother the doctor'.

The potential role of community pharmacy to contribute to the care of such patients has long been recognised. Research shows that the average community pharmacy can expect to serve the following numbers of patients with long-term conditions:

Asthma	452 patients
Diabetes	156
Angina	122
Heart attack (annual)	24
Hypertension	1390
Heart failure	78
COPD	78
Epilepsy	40
Rheumatoid arthritis	35
Parkinson's Disease	10

Many of these patients also have co-morbidities – recent research suggests that one third of patients with these conditions suffer from co-morbidity in respect of this set of diseases – so high quality care is vital.

Community pharmacy has several strengths:

- **Acceptable to patients** – most patients don't mind going to the pharmacy, because they don't need an appointment, they may well be shopping there anyway, and there is less 'social distance' between the 'customer' and the pharmacist than there is between the 'patient' and other healthcare professionals. This provides an excellent opportunity for planned as well as opportunistic interventions
- **Well-located** - They are accessible and widely located, including in disadvantaged communities
- **Increased coverage** – Those patients who do not attend GP or nurse clinics still collect prescriptions from their pharmacy, including those whose condition is less well controlled or might become uncontrolled. In addition pharmacies offer services when local surgeries are closed, including Saturdays
- **Skilled and willing** – Pharmacists already have great expertise in medicines management, and, in a recent survey, 65% expressed an interest in specialising in the management of long-term conditions
- **Cost-effective** – most of the costs of the community pharmacy network are already met via the NHS contractual frameworks, so additional services can usually be provided cost-effectively.

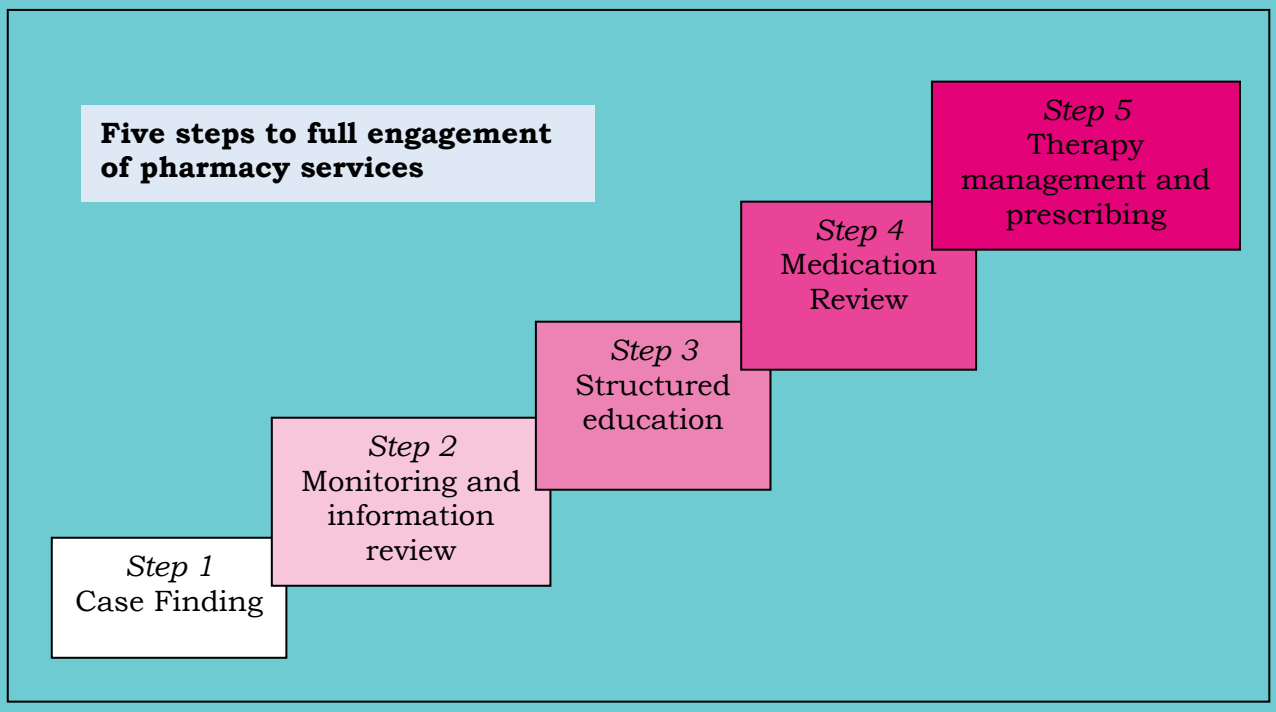
The evidence

This paper presents the results of recent research commissioned by the Royal Pharmaceutical Society of Great Britain from Professor Alison Blenkinsopp of Keele University and Gianpiero Celino of Webstar Health. They have reviewed the UK and international evidence on the role and effectiveness of pharmacists in the management of long-term conditions, and conducted a series of interviews and consensus work with key stakeholders in the UK (GPs, nurses, commissioners etc) to identify how the contribution of pharmacy could be realised. The work also draws on a survey of 272 community pharmacies in England between June 2004 and August 2005 conducted by Webstar Health.

WHAT COULD COMMUNITY PHARMACY CONTRIBUTE?

In general terms...

There are five key activities, of increasing complexity, which pharmacists can appropriately perform for people with long-term conditions:



Three example conditions

Three particular conditions are discussed in this paper – asthma, coronary heart disease, and diabetes – although the lessons probably apply to many other long-term conditions. For each, there is a brief summary of the evidence on the contribution of pharmacy, followed by two current case studies where pharmacists are already demonstrating what can be achieved. Overall the review findings indicate that the evidence base for effectiveness of community pharmacy services for people with the three example conditions is as convincing as that which supports primary care nurse input. Therefore when thinking about which health professionals can support patients with long term conditions, commissioners should consider community pharmacists as well as nurses.

Example: Asthma

Overview of the evidence:

1. The average community pharmacy serves around 450 people with asthma
2. We found and reviewed ten intervention trials of community pharmacy-based asthma services
3. Seven of the ten trials showed positive effects on asthma control
4. The most effective use of community pharmacy resources will be to focus on those whose asthma is less well controlled, or could become uncontrolled
5. Several models of community pharmacy based asthma care are offered in the UK, usually on a pilot basis
6. Community pharmacists have identified asthma as an area in which they would like to offer a more clinical service
7. Other countries are sufficiently convinced by the evidence that they are funding a pharmacy based asthma service.

Where it's already happening...

Case Study 1: Identifying sub-optimal asthma control

Lloydspharmacy, in partnership with Asthma UK, co-ordinated a targeted approach in which their pharmacists identified people whose asthma was less well controlled and offered them a Medicines Use Review. The results from 200 pharmacies showed that over half of the people for whom a MUR was conducted were using their reliever inhaler too frequently. Just over two thirds of the patients whose asthma was sub-optimally controlled were referred to their GP. Changes to prescribed treatment to improve asthma control were made in almost two thirds of these cases.

Case Study 2: Supplementary prescribing

A community pharmacist on Stirling University campus is providing a walk-in ad hoc supplementary prescribing clinic for asthma patients. GPs will offer the service at patient appointments. Pre-prepared clinical management plans provided by the pharmacist incorporating steps 1-3 of British Thoracic Society (BTS) guidelines will be used. The pharmacist has developed his own notes system based on that used by asthma nurses in the local practice so that the notes are in a format that the doctors are used to seeing. He plans to visit the surgery before each clinic to check the patient's medical record for any recent additions.

Example: Coronary Heart Disease

<table>
<tr><th colspan="2">Overview of the evidence:</th></tr>
<tr><td colspan="2">1. The average community pharmacy serves 122 people with angina and has 24 people each year needing treatment following a heart attack
2. The published literature includes several trials of community pharmacy-based services which aim to reduce risk factors for CHD
3. There is good evidence that community pharmacy based services result in improved lipid levels and more patients reaching lipid targets
4. There is some evidence that pharmacy services can improve blood pressure control
5. Point of care testing for blood pressure and lipids is increasingly offered in community pharmacies but connectedness with the wider NHS is unclear
6. We found one point of care testing service (the Greater Manchester SHA project) which could serve as a model for future developments
7. Community pharmacists identified CHD as an area in which they would like to offer a more clinical service.</td></tr>
<tr><th colspan="2">Where it's already happening...</th></tr>
<tr><td>Case Study 1: Point of care testing
22 pharmacies across Greater Manchester are regularly monitoring patients with diabetes and/or coronary heart disease and providing point of care testing. The pharmacists have completed relevant training and the premises facilities have been upgraded with NHS support. Patients can choose whether to continue using existing services or the new services. The service increases patient access and in addition offers the opportunity for more regular discussion between patient and pharmacist treatment with medicines in relation to the patient's condition.
Measures regularly taken include blood lipids, blood pressure; Body Mass Index and waist measurement. The consultation covers the impact that medication, lifestyle, diet and activity can make on the patient's condition and uses the test results to illustrate what changes can be made. Patients are seen at least twice a year. In exceptional circumstances, the pharmacist may need to refer the patient back to their GP for urgent review. Data gathered in the consultation are entered into an online IT system that inserts the information into the patient record and the GP's quality and outcome framework (QOF) record.</td><td>Case Study 2: Supplementary prescribing
A community pharmacist in Forth Valley, Scotland is running supplementary prescribing clinics for CHD patients on complex medication regimens. Patients are referred by the GP practice, which is moving to the pharmacy building once it has been extended. Patients are treated according to an agreed clinical management plan. The pharmacist will measure blood pressure, recommend any blood tests needed and adjust medicines as appropriate. Patients are signed off from the pharmacist's care once they have reached agreed therapeutic goals.</td></tr>
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Example: Diabetes

Overview of the evidence:

1. The average community pharmacy serves 156 people with diabetes, 133 of whom have Type 2 diabetes
2. The average pharmacy can expect to have 9 newly-diagnosed patients with Type 2 diabetes each year
3. The published literature includes several trials of community pharmacy-based diabetes services
4. Four out of five studies that measured diabetes control using a comparison with a control group showed a significant improvement
5. We found one pharmacy based diabetes care service in the UK (the Hillingdon service) with a robust evaluation
6. Both the trial results and the evaluation of the Hillingdon service indicate that the most effective use of community pharmacy resources will be to focus on those whose diabetes is less well controlled
7. Community pharmacists identified diabetes as an area in which they would like to offer a more clinical service
8. Other countries are sufficiently convinced by the evidence that they are funding a pharmacy based diabetes service.

Where it's already happening...

Case Study 1: Screening for diabetes Community pharmacists in the Durham Dales PCT area provide a service which identifies people at risk of diabetes. Where needed, referrals are made to GPs and other health professionals locally. Almost half of the first 100 patients screened were invited back for a second visit as their results showed they were at moderate risk of diabetes.	**Case Study 2:** Integrated diabetes service. Ten community pharmacies in Hillingdon PCT are commissioned to provide a diabetes service which is integrated with other local services. Evaluation showed that diabetes control improved in almost all patients receiving the pharmacy service. In those patients whose diabetes was uncontrolled at baseline, target levels were reached in half during the first year of the service. Positive effects were also seen on blood pressure control and total cholesterol.

MAKING IT HAPPEN: A PRACTICAL APPROACH

A good service looks like...

A 'good' pharmacist-supported service for people with long-term conditions can be defined through 8 key criteria, which in turn require 5 key enabling measures:

The pharmacist and the patient...	Enabling environment...
1. The pharmacist assesses the patient's readiness to change and adjusts the start date for the intervention where necessary 2. The pharmacist provides education on the disease, helps identify key issues (e.g. triggers in asthma) and works with the patient to develop an action plan for self management 3. The patient participates in all decisions (e.g. where the pharmacist intends to make a recommendation about a change in treatment) 4. Therapy is monitored by the patient together with the pharmacist. 5. The pharmacist takes responsibility for outcomes and promotes evidence-based care. Outcomes are measured across a range of indicators (patient acceptability, hospital admissions etc.). 6. The pharmacist-patient interaction is based on appointment and occurs in a private consultation area 7. The patient's GP is informed or consulted about all test results and interventions	1. Multidisciplinary involvement 2. Externally recognised certification of programme 3. Acceptance by referring doctors • requires credibility of both pharmacist and service processes, leading to development of trust with successful patient outcomes 4. Effective marketing to doctors and patients 5. Reimbursement for the pharmacist

The key criteria will also be useful for pharmacists in self-assessing their competence and as a basis for CPD. Key pharmacist competences include consultation skills and a patient centred approach to discussing the condition, the treatment, and what the treatment does.

Local Action Plans

It is not possible to be prescriptive about how to achieve a good pharmacy-supported service for people with long-term conditions - by definition, local circumstances vary across the country. Neither is it necessary – local commissioners, service providers and professionals are more than able to effect the necessary changes in their locality. Key elements will probably include:

1. Immediate involvement of pharmacy at local level in discussions on practice-based commissioning
2. Increased publicity to raise awareness of what pharmacists can do, based on evidence
3. An accessible evidence base to demonstrate community pharmacy contribution, explaining links to key NHS targets
4. Identifying service brokers, mentors and facilitators to link up providers and link them to commissioners
5. Skilling up, and provide tools for, local community pharmacy champions
6. Initially developing a model service specification for one long term condition including patient care pathway and outcome measures.

Funding

For the reasons set out earlier, community pharmacy can be a highly cost-effective part of the integrated package of care for people with long-term conditions. However, funding is required to meet additional costs, and experience shows that cash-releasing savings from disinvestment elsewhere cannot always be relied upon to fund new services!

Within the community pharmacy contractual framework, there are two options which PCTs can explore:

- **Develop the Medicines Use Review** service[1] by encouraging the use of a series of linked MURs (for example, quarterly) for individual patients with particular long term conditions who would benefit from increased and more systematic monitoring and support. Target groups for linked MURs can be agreed between individual pharmacies and local practices, perhaps facilitated by the PCT; and

- **Use of the Enhanced Services framework** to develop disease specific services, using or adapting protocols and learning outcomes from other countries (see full report for examples). As patient pathways are revised, there is a good opportunity to build in the contribution of community pharmacy.

Universal adoption of good practice

There is now abundant evidence that community pharmacy can make a valuable contribution to the care and support of people with long-term conditions. Community pharmacies are accessible by all sections of the population, offering an expert service building upon (but extending well beyond) the review of medicines. It is vital that their role is planned to integrate with – but not duplicate – that of GPs and others, and is often best focused on those people whose condition is not being optimally controlled. Community pharmacists themselves are very keen to specialise in this area, recognising it as a core element of the service they provide. The new community pharmacy contractual framework offer opportunities for funding new provision.

Above all, there are now many examples of successful, well-evaluated and practical models of pharmacy provision for this client group. The key challenge now is to ensure that this good practice is universally adopted.

[1] The current NHS specification states that an MUR "can be provided every 12 months" for patients with a long term condition

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This information sheet has been produced by the Royal Pharmaceutical Society of Great Britain, the regulatory and professional body for pharmacists.

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