Clinical Pharmacy in GP Practices Pilot in the West New Forest Vanguard

Ginny Ward
Locality Lead Pharmacist

30th November 2016
West New Forest Vanguard
7 practices included

1. Arnewood Practice
2. Barton Surgery (Barton Webb-Peploe Partnership)
3. Chawton House Surgery
4. Cornerways Medical Centre
5. Fordingbridge Surgery
6. Forest Gate Surgery
7. Forestside Medical Practice
8. Lyndhurst Surgery
9. New Forest Medical Group
10. New Milton Health Centre
11. Red and Green Practice
12. Ringwood Medical Centre
13. Testvale Surgery
14. Totton Health Centre
15. Twin Oaks Medical Centre
16. Waterfront and Solent Surgery
17. Wistaria and Milford Surgeries
Aims of the Pilot - Exciting, innovative, fully integrated clinical pharmacy service embedded in practices which has clinical medication review, particularly in the frail elderly, as a focus

• Supplement and complement the current services provided
• With a move to being a much more patient-facing role
Traditional role of Medicines Management in primary care

- WHCCG Meds Optimisation Incentive Scheme cost and quality initiatives including deprescribing problematic polypharmacy
- Other Financial Recovery Plan savings
- Other quality and safety issues (e.g. SIRIs, MHRA)
- Medicines queries from practices and prescribers
- As 0.67wte pharmacist and 0.5wte technician across 8 practices so about 1 “session” a week
Team working across the 7 Vanguard practices

• Increased to allow approx. 2-3 days a week of clinically-focussed pharmacist input to each practice and doubled technician input

• We see the “extended roles” as an important and natural development as already involved in focussed med reviews

• (e.g. in 2014/16 approx 2,500 problematic medicines for elderly patients were de-prescribed across the whole CCG area)
3 interlinked and important aspects to balance

- Patient outcomes
- GP workload support
- Financial sustainability
Working in practices

- **REPEAT PRESCRIBING SUPPORT** including problem-solving for individual patients and increasing use of e-prescribing to reduce workload
- **INTEGRATED COMMUNITY CARE TEAM SUPPORT** re meds
- **CLINIC SESSIONS** and DOMICILLIARY VISITS
- **MEDICATION REVIEW** plus BP, pulse, temp, BGs assessment in relation to meds use and review.
- **RESOLVE QUERIES**
- **KEEP A FOCUS ON WORKPLAN** and SAVINGS
- May or may not be independent prescriber
Working with Hospital Trusts

• Develop LINKS to achieve better SEAMLESS CARE on admission and discharge
• Contribute to MEDICINES RECONCILIATION on admission & discharge
• SUPPORT PATIENTS TO PREVENT RE-ADMISSION patients referred who need follow-up post discharge to prevent readmission (starting with LNFH)
• Take on some of the INTERFACE issues and follow-up on behalf of GP
Working with local Community Pharmacies

• LIAISE AROUND SUPPLY ISSUES (problems and alternatives) and discharge issues particularly e.g. MDS for individuals
• And around MANAGED REPEATS over-ordering especially PRNs, inhalers and skin products and
• REDUCE WASTE from unnecessary repeats requested
• Whilst also

• Encouraging appropriate referral for NEW MEDICINES SERVICE and MEDICINES USE REVIEWS
Working with Nursing Homes

- Focus on CLINICAL MEDICATION REVIEWS and APPROPRIATE DEPREScribing of problematic medicines
- perform basic clinical assessment – e.g. BP, pulse etc. in relation to meds use
- advice on appropriate SIP FEEDS (nutrition) and DRESSINGS use
- advice on PRACTICAL ASPECTS OF MEDICINES USE e.g. PEG tubes or swallowing difficulties
- RATIONALISING and REVIEWING ORDERING and handling of meds to REDUCE WASTE
The 7 Practices individualised
“Top 5” focus

• **nursing homes**: med reviews on admission, and relating to falls, annual reviews, sip feeds, ordering and reducing waste

• **other med reviews**: polypharmacy in frail elderly, post discharge, from virtual ward/ICT

• **monitoring** high risk drugs

• **up-titrating/ follow-up** of meds changes

• **meds reconciliation** admission/ discharge

• **domiciliary visits** for housebound if needed

• **repeat prescribing**: dealing with queries, reviewing processes and systems and managed repeats to reduce waste

• **liaising with community pharmacies** about out-of-stocks, ordering and problems
Where are we now?

- Gradual go-live from 19\textsuperscript{th} September to 31\textsuperscript{st} October
- First month joint induction
- Now developing the roles in practice
- Monthly Locality team meeting with BLC and GPs
- Rolling out to neighbouring area already
### Prioritising patients for review

| EMIS Number | Name          | Age | GP | Residential Institute | No. of repeat meds | Identified in Polypharmacy reviews | Priority?
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>6720</td>
<td>SURNAME, Forname (Mrs)</td>
<td>79</td>
<td>B, A (Dr)</td>
<td>16 Y</td>
<td>Y</td>
<td>Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y</td>
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<tr>
<td>501949</td>
<td>SURNAME, Forname (Mrs)</td>
<td>85</td>
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<td>16 Y</td>
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<tr>
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<td>82</td>
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<tr>
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<td>SURNAME, Forname (Mr)</td>
<td>81</td>
<td>B, A (Dr)</td>
<td>13 Y</td>
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**Quality services, better health**
Prioritising patients for review – filter for digoxin and low eGFR

<table>
<thead>
<tr>
<th>EMIS Number</th>
<th>Name</th>
<th>GP</th>
<th>No. of repeat meds</th>
<th>Over 75 yrs?</th>
<th>Y/N</th>
<th>Identified in Polypharmacy reviews</th>
<th>Priority? Counts the number of ‘Y’s if higher numbers are higher priority</th>
<th>Patient reviewed by Pharmacist and date if sent to GP</th>
<th>Patient reviewed by GP</th>
<th>Patient review status</th>
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<tbody>
<tr>
<td>7314</td>
<td>SURNAME, Fomame (Mr)</td>
<td>B, A</td>
<td>13</td>
<td>Y</td>
<td>Y</td>
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<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>9</td>
</tr>
<tr>
<td>6746</td>
<td>SURNAME, Fomame (Mrs)</td>
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<td>9</td>
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<tr>
<td>6282</td>
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<td>9</td>
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<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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</table>

Quality services, better health
Prioritising patients for review – filter for diabetic drugs and low HbA1c

<table>
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<tr>
<th>EMIS Number</th>
<th>Name</th>
<th>GP</th>
<th>No. of repeat meds</th>
<th>Identified in Polypharmacy reviews</th>
<th>Patient appears in Practice 2% list</th>
<th>Priority? Counts the number of “Y’s” therefore higher numbers are higher priority</th>
<th>Patient reviewed by Pharmacist and date if sent to GP</th>
<th>Patient reviewed by GP</th>
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<tbody>
<tr>
<td>9235</td>
<td>SURNAME, Forname</td>
<td>71</td>
<td>12</td>
<td>Q92a, Aspirin &amp; dipyridamole</td>
<td>Y</td>
<td>YYY</td>
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<td></td>
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<tr>
<td>5060</td>
<td>SURNAME, Forname</td>
<td>77</td>
<td>10</td>
<td>Q92b, Statins or clopidogrel</td>
<td>Y</td>
<td>Y</td>
<td>YYY</td>
<td>5</td>
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<tr>
<td>17976</td>
<td>SURNAME, Forname</td>
<td>75</td>
<td>6</td>
<td>Q92c, Dibenzacine</td>
<td>Y</td>
<td>Y</td>
<td>YYY</td>
<td>4</td>
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<tr>
<td>500916</td>
<td>SURNAME, Forname</td>
<td>85</td>
<td>9</td>
<td>Q92d, Quinine</td>
<td>Y</td>
<td>Y</td>
<td>YYY</td>
<td>3</td>
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</tbody>
</table>

Quality services, better health
Other Resources in development

• Scope document for practices to sign up to (no surprises!)
• Resources to support patients with their meds taking
• Templates being developed in TPPSystem One and Emisweb for these med review
• Amended STOPIT tool for primary care use
### STEP 1: IDENTIFYING Potentially Inappropriate Prescriptions

<table>
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<tr>
<th>Freetext Notes</th>
<th>Date of form Completed by</th>
<th>Patient Number</th>
<th>Age</th>
<th>Usual GP</th>
<th>Number of repeat meds</th>
</tr>
</thead>
</table>

### Possible solution
- Include all regular prescription medicines, eye drops, 'prn' except topical, OTC items except herbal, topical or food supplements/vitamins
- Antiadrenergics eg Terodolone, oxbutinin (see ACB list above)
- Can cause confusion, agitation, urinary retention, constipation, diarrhea, falls. Offer drug holiday and stop if possible
- ACE inhibitors, ARBs, CaCs, Alpha blockers eg Tamsulosin
- Vasoconstriction in HF eg Tissueadef MN
- Commonly cause antidiurethics
- Less well tolerated by older people - Stimulation
- Antidepressants: old eriaining
- Can cause confusion, other ACB/AD
- Anticonvulsants (concurrent with): Antidesiphen, tic A Spins, (≥150mg), NSAIDS (if <6 months), SSRIs, oral steroid
- Can cause confusion, falls. Some also AS&P 476, risk of stroke in dementia (see RPSD guidelines)
- Benzodiazepines, x2-drugs
- Sedative can cause impaired balance, confusion, falls. (Withdraw benzodiazepines gradually if ≥2/6) or
- Bisphosphonates
- Contraindicated in history of upper GI disease or bleed or PUD. Review continued duration if ≥2/6 and consider drug holiday
- Wigman
- No benefit for Heart failure if normal systolic ventricular function. Reduce 25mg doses in DF
- Diuretics
- Can cause osteomalacia/diuretics
- Factor pump inhibitor long term use>2 weeks/No Ind
- Can cause confusion, also A 1β/6, dyspnoea, distress
- Spinal (for leg cramps)
- In line with MRCM recommendation offer drug holiday with stretch or cushion pad
- Antifungals: cycle current medication to continue TFC, TFC.
- Antihistamines: using current medication, may need to continue
- Antidepressants: older earing
- Metformin and renal function, hyper risk, RAAs and sulphonylates
- Narrow therapeutic index
- Metformin, diuretics, lithium, renal function, HbA1c and sulphonylates
- Medications listed in this with stated safe guidelines
- TMARs
- Requires data monitoring
- Prednisolone and oral steroids
- Systemic side effects, GI risk, skin thinning, bone health, reducing doses
- Bleeding and/or dropping HB
- Consider ASA, combinations with antithrombotics, aspirin, NSAIDs, GPs, prescribing
- Confusion
- Consider review of all antithrombotics and psychotropic drugs, sedatives (infectious)
- Metabolic/electrolyte imbalance
- Consider diuretics. ARBs inhibitors, ARBs, anti-depressants, Metformin
- Renal Impairment / liver impairment
- Consider medicines that may accumulate and need dose reduction or stop if long term use, moderate risk if in combination with other medicines known to interact/caus e interactions, etc
- Constipation
- Consider SFD drugs (if >3months), if unable to reduce or stop if possible
- Other issues identified

### STEP 2: ADHERENCE and CONCORDANCE

#### Identified

<table>
<thead>
<tr>
<th>Problem</th>
<th>Possible solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eysight</td>
<td>Increase font size, provide symbol-based label, braille labels, colour/highlighting</td>
</tr>
<tr>
<td>Manual dexterity and co-ordination</td>
<td>Cannot manage blister strips? Cannot open or close child resistant packaging? Swallowing or other usage problems</td>
</tr>
<tr>
<td>Understanding</td>
<td>Cannot understand medication instructions? Does not know which medicines to take or takes too many medicines</td>
</tr>
</tbody>
</table>
| Complexity | Taking medication with variable 

#### Other issues identified

- Is there an appropriate alternative medicine?
- Has Medication been documented in the clinical record?
- Has Medication found or prescribed?
- How many medicines are on the repeat meds list?
- How long did the review take to complete and record?
FAQs

How will these roles be recruited and what say will practices have?

• Joint interviews with two of the BLC GPs
• Discussed priorities with practices prior interview

Who is setting their objectives?

• Jointly between CCG Meds Optimisation team and the lead GP/Practice Manager in the practice

Won’t it increase GP workload and queries?

• Aim is to reduce not increase workload but inevitably there may be an embedding process during induction phase
FAQs

Insurance liability

• Does not fall on the practice – CCG vicarious liability for activities in Job Description and most have own professional indemnity as well

Are there advantages in being hosted by CCG team?

• Yes. Back up from wider team includes formulary support, DPC, commissioning of high cost drugs, provides professional support and leadership, avoids duplication, promotes networking etc.
FAQs

• What is the difference between a pharmacist and a pharmacy technician? What can and can’t they do?
The Pharmacist Perspective:
6 weeks in

• Mrs Helen Plumb
• Medicines Optimisation Pharmacist
• Wistaria and Milford Surgery
• West Hampshire CCG
This is my 6th week working in the practice. Previously I covered all 8 practices in the WNF so working with just one practice is quite a big change to my role.

The first few weeks, I have been spending having a practice induction so I am aware of the practice policies & procedures.
Getting to know more about individual members of staff and their roles in the practice.

I sit in with the GP secretaries at both surgeries as I always have done, I have been actively listening to the queries that are coming in to the practice and have been offering my help where I can. I am now being approached by GPs and practice staff within the practice with queries.

The practice has asked me to look at the electronic prescription service cancellation rejection messages coming in to the practice and I look at these on a daily basis. I have had to liaise with the community pharmacies when required.

As part of developing my new role in the practice I have attended the multidisciplinary practice meetings at both Milford & Wistaria. As a result of that I did a joint visit with the consultant geriatrician Gill Turner to a patient in their own home as she thought that they may be having problems with their medication.
The visit with the consultant was a really good experience for me especially with regard to our new roles as we will be seeing patients with medication issues either in their own homes or in the practice.
The patient’s medication was reviewed, some medication was in the monitored dosage system, some was loose in boxes and the patient was also taking lots of herbal and vitamin supplements. Between us we agreed to simplify the patients medication regime so the patient was only using the monitored dosage system, some drugs were stopped and some dose was reduced.
I had a meeting with the practice last week and agreed 2 areas of work that they would like me to concentrate on:

Polypharmacy medication reviews – starting with care home and nursing home patients. One of our pharmacy technicians has developed a polypharmacy tool to identify patients at risk of problematic polypharmacy; this is so we know where to prioritise our efforts. It runs on both Emis Web and SystmOne clinical systems.

The other area of work that the practice has asked me to focus on is high risk drug monitoring in the practice to ensure that all the necessary test are being done.

Over the next few weeks I expect my role to develop within the practice and I will start focusing on the work that the practice has asked me to do. As a pharmacist this is an exciting opportunity for me to work with the practice to try and improve patient care and help patients who may be having problems taking their medication. The practice very much wants this pilot to work and have been very supportive and welcoming.
The GP Perspective:
6 weeks in

- Dr Sally Johnston
- GP Chawton House Surgery, Lymington
- Clinical Lead, West Hants MCP (BLC)
Hello I’m Dr Sally Johnston and I’ve been asked to talk to you about what it feels like to have a Clinical Pharmacist in our practice from a GPs point of view. To help you picture this I want to share with you a list of things our Pharmacist Wendy (who is allocated to our practice for two days per week) ever so helpfully and politely suggested she might do for us.
Sort out our repeat prescribing system- believe me it needs it.
Sort out our patients’ hospital discharge meds- yes please.
Sort out medication changes from out patient clinics...
Issue acute medications...
Manage our Dosettes and Nomads...
Reauthorise drugs and align the dates and quantities...
Add notes to repeat or acute scripts for example your BP check is due/Take this PPI on days you take an NSAID/Sick day rules...
Set and monitor reauthorisation dates for high-risk drugs and request appropriate blood tests
Tie reauthorisations in with invites to disease monitoring clinics...
Optimise drug form e.g. liquid to crushable...
Undertaken coded medication reviews directly into our patients’ notes...
Amend generic drug name to trade and vice versa...
And best of all telephone and visit patients to optimise their meds or to answer their drug related queries.
As you can imagine it felt like all our Christmases had come at once, especially as she got right on with it. She is visiting our local community pharmacists. She is also visiting our nursing homes to work with them around frailty, falls, nutrition, and so on. She attends our practice MDT meetings and takes away relevant tasks to action, or may organise a joint visit. She has expressed an interest in respiratory care, which we hope to develop for our practice; for the integrated clinical pharmacy team skillset and to support our locality MCP teams.

In summary, this is an all-round good thing. They are skilled health care professionals, who are really keen to apply their skills to improve our patients care in a really practical way, which frees us up to concentrate at what we are best at and gain most reward from, namely being a general practitioner. There aren’t many things to be positive about at present, but this new model of care is definitely one of them.

Thank you.