Final report

November 2017

Innovating for Improvement

Using community pharmacy to improve care for asthma patients who do not attend for yearly review: A pilot service evaluation

Rosedale Surgery

The Health Foundation

About the project

Project title:

Using community pharmacy to improve care for asthma patients who do not attend for yearly review: A pilot service evaluation

Lead organisation:

Rosedale Surgery

Partner organisation(s):

Great Yarmouth & Waveney CCG
Norfolk Local Pharmaceutical Committee
James Paget University Hospital
Academic Health Sciences Network
East Anglia Pharmacy Local Professional Network
Centre for Postgraduate Pharmacy Education (CPPE)
University of East Anglia

Project lead(s):

Dr Richard James

Contents

Part 1: Abstract

Inappropriate asthma treatment and management are known to cause unplanned hospital admissions and premature death. A high proportion of asthma patients do not attend their medical practice for their yearly review but still collect asthma treatment from their Community Pharmacy (CP). The innovation was for medical practices to provide non-attendance lists to patients' community pharmacies to enable them to offer a review when they collect their medicine.

Ten community pharmacies and five medical practices participated in the pilot project as planned. Training and a support pack was provided to all community pharmacists over two evenings. 27 patients received their annual review who would not have received it otherwise.
A number of interventions were made some of which would be very likely to enhance patient care. Outcome and cost data were successfully collected on 26 patients 3 months before and after the service was delivered.

Recruitment was significantly less than originally anticipated due to timing of the service, different organisation strategies within the medical practices, the fact that patients deliberately choose not to attend their yearly review and movement of pharmacists in and out of their community pharmacies.

Stakeholder focus groups with pharmacists and practice staff identified high levels of satisfaction with the service. Pharmacist training, pharmacy accessibility and pharmacist competence were seen as service enablers, whilst the pharmacy consultation room, differences in medical practice organisation and different IT systems were seen as barriers. Offering the service to all patients with asthma was believed to be an acceptable future strategy.

Part 2: Progress and outcomes

Background

Approximately 30% of people with asthma do not attend for their yearly review. They do however continue to collect their prescriptions from their community pharmacy. Our innovation is for the community pharmacist to offer and provide the annual asthma review at the point of prescription collection. The innovation is that this would be achieved by medical practices providing a list of non-attenders, which is a step toward integrated working envisaged by the UK government. The review could be delivered by the community pharmacy at no additional cost through the nationally funded Medicines Use Review (MUR) scheme.

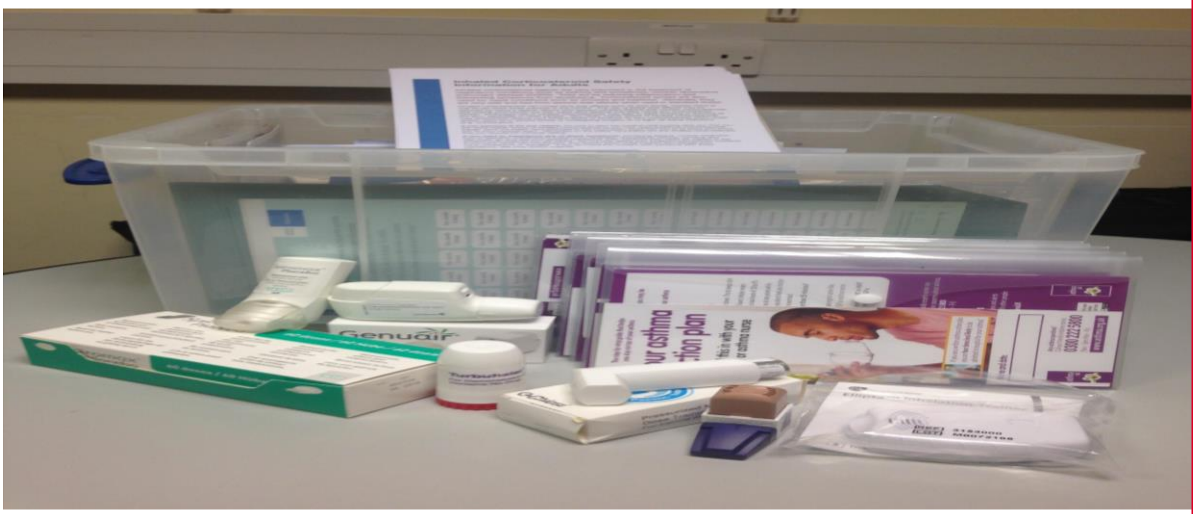
We did not know if this idea would be acceptable to patients, whether community pharmacists could provide the review to the expected standard or whether the additional workload would be justified by the increased proportion of patients who receive their review. We therefore planned to pilot the service and consequently no significant adjustments were made as the plan was to learn from the process and inform wider roll out.

Working with five medical practices in Great Yarmouth & Waveney CCG we would identify those patients who had not received an asthma review in the previous 12 months and inform their community pharmacist of the need to review the patient, with their consent, when they present for a prescription.

The training was conducted over two evenings and 15 pharmacists from 10 pharmacies were trained and consisted of (Appendix 1):

- Introduction to the project rationale and aims
- Asthma management revision lecture
- Introduction to resource pack (Figure 1, plus summarised in Appendix 2) and how and when to use different devices
- Guidance on asthma review service provision
- Role play with actors
- Completion of clinical scenarios

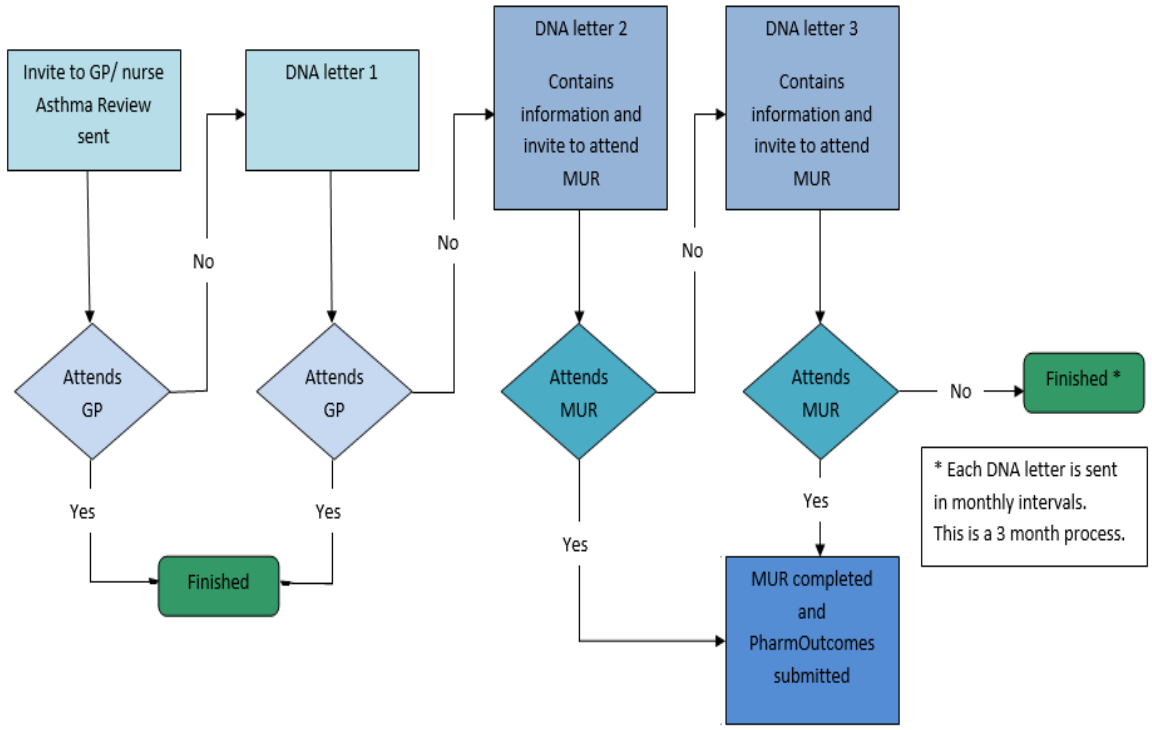
Figure 1 Resource pack (Appendix 2)



Service delivery

The service design is summarised in Figure 2

Figure 2 Sum



mary of service design

Evaluation

The following quantitative and qualitative data were collected:

- The exact nature of the pharmacist review through PharmOutcomes software package designed for this purpose
- Patient satisfaction survey posted one month after service provision (Appendix 3)
- Anonymous data collection from surgeries (Appendix 4)
- Patient, pharmacist and medical practice staff feedback on the service via focus groups (Appendix 5)

Nature of the service

27 patients received the service. Community pharmacists recorded delivering all elements of the service using the SIMPLE model:-

Smoking cessation

- 100% of patients asked about smoking status
- 11.1% of service recipients were smokers
    - All smokers were offered and declined smoking cessation

Inhaler technique

- 100% patients had their inhaler technique assessed
- 65% of patients were identified as having either an inappropriate technique or inhaler
- All patients with inappropriate inhaler devices were referred back to their medical practice
- Counselling addressed inhaler technique in all remaining cases

Monitoring

- 100% completed the Asthma Control Test
    - 56% of patients had controlled asthma
- 44% of patients had a peak expiratory flow rate (PEFR) of 80% or more of their predicted PEFR
- 41% of patients had a peak flow meter at home to enable self-monitoring

Pharmacotherapy

- 18.5% of patients had more than 3 short acting beta agonists (Relievers) in 6 months
- 7.4% of patients considered for a reduction in the dose of their inhaled corticosteroid (Preventer)
- 11.1% of patients required spacer device for their inhaler

Lifestyle

- 100% patients were questioned about asthma triggers and plans to manage these triggers

Education

- 100% patients asked about asthma management plan
- 52% of patients referred to obtain a plan from their GP or asthma nurse

Patient survey

- 7 patients completed the survey, all of whom were female, 3 between age of 31 and 50, 3 between 51 and 65 and one over the age of 65
- Survey responses came from patients from four different community pharmacies
- 6 patients rated their asthma control as well controlled and 1 patient completely controlled
- All agreed that they were satisfied with the information provided during the consultation
- All would have the review at the pharmacy again
- 6 would recommend the service to others and one was unsure
- Three comments were made regarding the unsuitability of the consultation rooms

"*The consulting room was private but really small and with the privacy curtains drawn felt rather claustrophobic*"

- Two patients reported a better inhaler technique
- One reported taking their preventer inhaler more often
- One reported monitoring their condition more carefully

Outcomes and cost data

27 patients received the community pharmacy asthma review service (CPARS) and data were collected for 26 patients. There were six recorded unplanned asthma related visits to the GP in the 3 months prior to the service and 10 in the 3 months after, although 4 of those were due to one patient only. There were no unplanned hospitalisations due to asthma recorded before or after CPARS. The use of reliever and preventer inhalers 3 months before and after CP led review are summarised in Figures 3 & 4. A greater proportion of patients were using preventer inhalers after the intervention. No differences when comparing before or after data were significant ($p>0.05$, Wilcoxon Matched Pairs).

Figure 3 Summary of asthma reliever use 3 months before and after CPARs

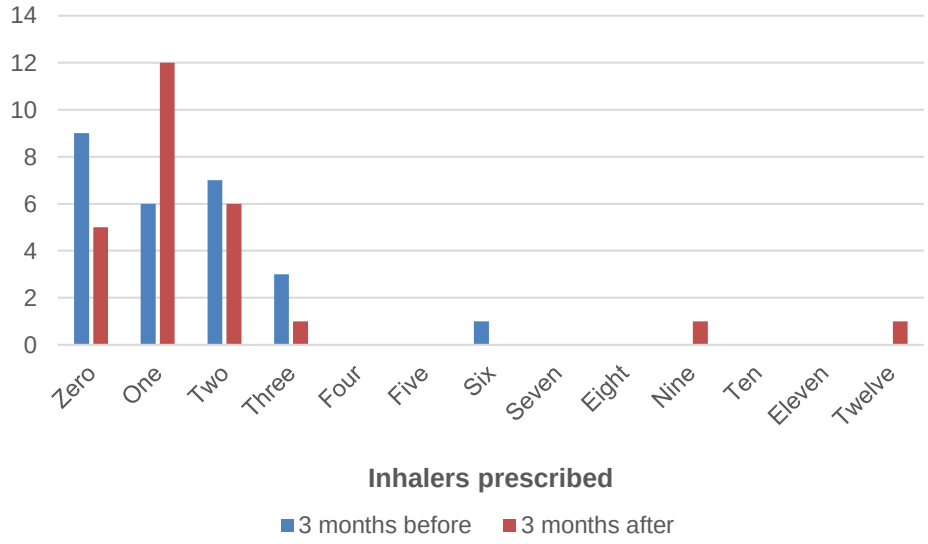
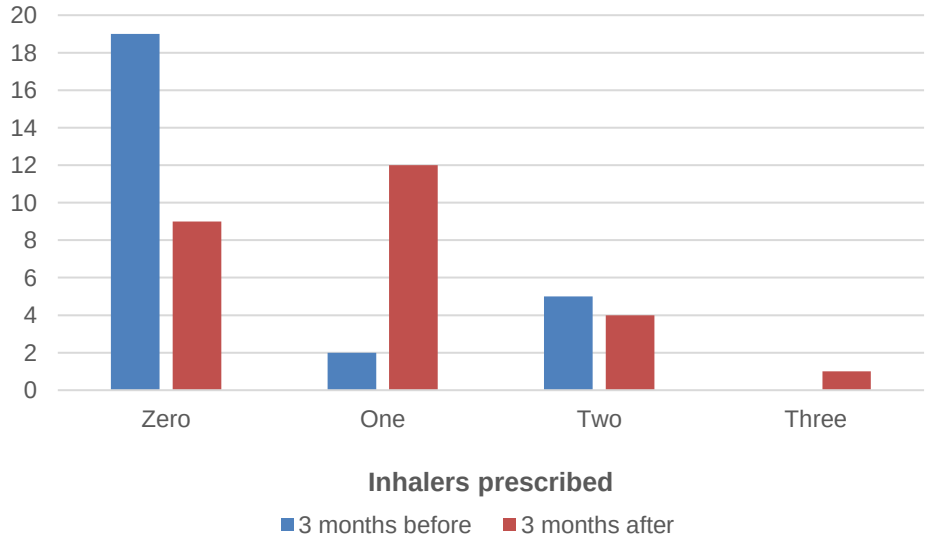


Figure 4 Summary of asthma preventer use 3 months before and after CPARs



Stakeholder feedback

Medical practice staff (Appendix 6)

Five medical staff from three different practices attended.

Enablers
- Reduce practice nurse time
- Opportunistic service nature

Barriers
- CPs do not have access to patient notes
- IT systems are not compatible

Solutions
- Ensure all CPs located around the practice are involved
- Enable CPs to be part of the initial invite to patients
-

Pharmacists (Appendix 7)

Four pharmacists from four different community pharmacies attended plus one additional pharmacist from another pharmacy was interviewed.

Enablers
- Training program increased confidence
- Support pack
- Improved patient relationships

Barriers
- Increased time taken to complete reviews
- Inability to amend prescriptions
- Non-attenders at medical practices are also pharmacy non-attenders i.e. use relatives

Solutions
- Improve awareness of service
- Use pharmacy technicians
- Offer service to all asthma patients

Patients (Appendix 8**)**

5 patients who are deemed usual 'non-attenders' attended the focus group.

Enablers
- Community pharmacist's competency
- Convenience
- Ease pressure on GPs
- Increased patient choice

"I'd be more than happy if I called up Reception to book in for my annual review and they said you're seeing a pharmacist - it wouldn't bother me at all"

Barriers

- No perceived need for asthma review
- Privacy, inadequacy and stigma of consultation rooms
- Lack of rapport with community pharmacist
- Lack of service awareness
- Pharmacist unable to change prescription

Solutions

- Better consultation rooms
    - Provision of on-line appointment system
- Screen for patients most at need through inhaler consumption
- Compatible GP CP computer systems

Part 3: Cost impact

The Medicines Use Review service (£28 per consultation) is paid for from a national contract. Its design, delivery and mode of remuneration are currently under review. The Quality Outcomes Framework for GPs remunerates them for providing yearly asthma reviews for up to 70% of their patients with asthma.

As a pilot study no formal health economics evaluation was undertaken. However in line with the MRC guidance on the evaluation of complex interventions[1] we have identified the costs from different perspectives and whether the data can be collected to a sufficiently high standard for use in a future definitive study. It was found to be possible to collect data of sufficient quality.

The main costs relating to the management of asthma patients from an NHS perspective are provided in Table 1.

Table 1 Summary of tariff costs for service delivery

Activity	Assumption	Cost*
Practice nurse	One hour	£36
Community pharmacist	Equivalent to Band 8A salary for one hour	£52
Pharmacy technician	Equivalent to Band 4 salary for one hour	£30
Practice staff time	Equivalent to Band 2 salary for one hour	£22
Medicines and device utilisation	Per consultation	£27
Unplanned medical practitioner visit	Per 9.22 minute visit including direct care staff costs	£36
Unplanned hospitalisation	Long stay	£2,926

* PSSRU Costing book 2016. NB: Locally negotiated costs may be significantly lower

The focus groups identified that the average time allocated to practice nurses for yearly asthma reviews was 20 minutes, which would cost £12, whereas the pharmacist service was estimated to last for between 20 and 30 minutes on average which is between £17 and £26.

NHS Perspective

If we assume equal outcomes from both providers i.e. take a cost-minimisation approach then the nurse service dominates from an NHS perspective. If the community pharmacist used a pharmacy technician to deliver the service then the cost differential would be less. Furthermore, the pharmacists recognised that as they became more proficient then the service time would reduce. Therefore with appropriate use of skill mix and a set time of 20 minutes per review then the community pharmacy route for asthma reviews is likely to be economically appropriate.

Medical practice perspective

If we assume equal outcomes and that the medical practice does not pay for the CP service i.e. it is nationally funded, then it is in their interests to direct patients to the CP and use the time freed up for the practice nurse to provide other income generating services.

Outcomes

It is not appropriate to assume equal outcomes from the CP service trialled here as it is being provided to those patients who would not normally attend for their review.

Table 2 provides a summary of cost estimates before and after intervention. This is based on 26 patients and hence too small to identify meaningful change in any parameter, particularly those which are likely to reduce costs overall such as unplanned hospitalisation or medical practitioner visit. The increase in cost of the use of preventer inhalers after the intervention is anticipated as poor adherence to using such inhalers is seen as a major cause of unplanned hospitalisation and death. The increased costs of the inhaler use should be offset by reduced unplanned NHS resource utilisation. Furthermore, greater asthma control should improve quality of life and mortality therefore provide additional Quality Adjusted Life Years. The next stage is to undertake a research project to determine the cost/QALY of this service.

Table 2 Comparison of costs from a primary care perspective before and after intervention

	Total (£)	
Activity	3 months before	3 months after
Reliever inhalers*	52.50	72.00
Preventer inhalers#	89.04	170.66
Unplanned medical practitioner visit	216	360
Unplanned hospitalisation	0	0
Total	**357.54**	**602.66**
Mean per patient	13.75	23.18

* Assumed 100% salbutamol inhalers # assumed 100% beclomethasone inhalers

Reference

1.Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M. Developing and evaluating complex interventions: the new Medical Research Council guidance. International journal of nursing studies. 2013;50(5):587-92.

Part 4: Learning from your project

The project achieved all that we had hoped for and more. Designed as a pilot study, we feel that it has given us sufficient information to enable the development of a persuasive business case and guidance for effective implementation. Furthermore, we can now confidently develop a research project around these findings.

The project was initiated, driven and supported throughout by an asthma nurse specialist who was purely motivated by the need to enhance the quality of patient care and reduce unnecessary NHS resource utilisation and this provided the inspiration for team delivery. The creation of a stakeholder group, which consisted of all parties who were interested in the project success was pivotal as they provided common-sense advice and frequently helpful altruistic contributions. The inclusion of an academic pharmacist in the management team resulted in funding being successfully obtained for the project. Splitting the project support role between a motivated community pharmacist and experienced research associate proved to be very effective. Similarly, the support and rapid response from the team in the medical practice ultimately ensured the project was completed on time and to standard.

The PharmOutcomes software package provided prompts to the pharmacists when delivering the service and enabled accurate data collection. Whilst its use may have created the 'tick box' approach impression by some stakeholders, we believe that this was due to its relatively limited use and that as experience develops then pharmacists would become less reliant on it as a memory cue. PharmOutcomes is an excellent platform for recording services and a standard requirement for recording and reporting in a community pharmacy setting.

The national recommendation to review the MUR service and use it for the management of chronic conditions was also a good driver.

Risks of recruiting sufficient numbers of community pharmacies and medical practices were mitigated by the involvement of both local pharmaceutical committee leads in the management group and by centralising the project in a medical practice with good working relationships with other local practices.

The project relied somewhat on goodwill particularly with the limited amount of remuneration provided for participation. Involvement with the local research networks in any future research project would be necessary to ensure that adequate incentives were available.

The regular movement of pharmacists between pharmacies surprised us, creating unexpected difficulties in ensuring that there was sufficient opportunity for patients from different medical practices to obtain a review through a participating community pharmacy. Ultimately, we lost a medical practice from the project due to this and subsequently recruit a new one; due to its late involvement and changes in infrastructure, failed to deliver any referrals.

The most predictable risk was always going to be patient recruitment. Without this pilot we only had data on the proportion of patients who do not attend for their asthma review to guide sample size estimation. We sincerely believed that less than 4 patients per month per pharmacy was eminently achievable however, we ultimately failed to achieve anything like this. The reasons for this included intentional non-attendance by patients, patients not visiting community pharmacies as a result of using third parties to collect their medicines and due to community pharmacies, who were responsible for significant proportions of participating medical practice patients, not

participating in this pilot. Whilst including all pharmacies in a future service would overcome many of these problems, addressing intentional non-attendance may require a different intervention. We did not obtain data on why patients do not attend but felt from the stakeholder meetings that not perceiving reviews to be needed represented a significant proportion.

The timing of the start of the service at the end of the financial year and close to Easter resulted in patient recruitment delays due to increased workloads at GP practices and a backlog of prescription services at pharmacies. Limiting the service to those patients who do not routinely attend was a barrier to uptake and the proposal from both medical staff and pharmacists was that community pharmacy-based reviews should be made available for all asthma patients.

What perhaps surprised us most was the fact that medical practices have IT systems which are incompatible with pharmacy IT systems and varying approaches to inviting patients for their yearly reviews, which resulted in different methods for communicating lists of potential patients to pharmacies.

The training over two evenings, outside of normal working hours, was seen as demanding for most pharmacists after a full day at work. A preference for one day out of work for the training was stated. Though well delivered, the didactic element of the training was the least effective and consequently training time needs to be focussed on active elements.

We were already aware of the variability in quality and size of pharmacy consultation rooms and the frequency of usage in the delivery of services. The strength of negative patient perceptions associated with a pharmacist consultation in a private room resulting from this pilot was however also surprising. This information needs feeding upwards to ensure that consultation room quality is better standardised. As they are more ubiquitously used for provision of services e.g. influenza vaccinations, then the reported stigma associated with their use should diminish.

The project demonstrated to us the value of true multi-professional working, the contribution that higher education institutes can make, the need to engage representatives from all local stakeholders in the process and the value of patient and public involvement (PPI). Our two PPI members provided excellent guidance throughout the project, actively supporting delivery of the patient stakeholder group.

Our key recommendations before service roll out would be to:

- Review medical practice processes for identifying asthma patients to enable effective working with local community pharmacies
- Provide one day of active training to all participating pharmacists to ensure that service quality is standardised
- Identify those elements of the service which can be delivered by a pharmacist and which by a pharmacy technician
- Involve all community pharmacies in the locality of participating medical practices
- Offer the asthma review service through community pharmacies to all patients as usual practice

Part 5: Sustainability and spread

Sustainability

To sustain the project funding would need to be found to cover the costs of the training and provision of the resource pack. These costs are not insignificant when considering the number of community pharmacists requiring training and therefore would need to be built into any business model.

The project will not be continued within the CCG in which it was piloted in the short term. The plan is to use the evidence created from this and other similar projects to inform work within local STPs around the management of respiratory conditions.

We will send a one page project summary to NHS England STP Primary Care Leads who are linking with RightCare Respiratory Leads to ensure that community pharmacy is included in pathway redesign.

West Norfolk CCG which is covered by Norfolk CCG is interested in the study and wanting to more actively encourage the community pharmacists to use MURs in the management of asthma.

There is a national strategy to change the Medicines Use Review service to a chronic disease management service and learning from this project will be used to inform that process. Asthma is anticipated to be an area which is likely to be an early focus for this service.

The pharmacists who were trained for the purposes of the pilot have reported using the support pack and consultation skills training to enhance the services they currently deliver.

External interest

We have received interest from the Chemist & Druggist who published a positive report on the pilot study (Appendix 10). We have presented the initial results from the project at the Pharmacy Show (Appendix 11). This was very well received.

We are aware of another CCG which has produced a business case for a similar service using what has been learned from this project. This resulted from the presentation by MC of the project at the Pharmacy Show.

The pilot has significantly altered our view of the intervention, how it needs to be set up and delivered. We now believe that the service should be offered to all asthma patients, through all community pharmacies servicing participating medical practices, that pharmacists need additional training and support to deliver the service effectively and the service needs to be better promoted to patients from the outset.

The main change, which we had not anticipated, would be to encourage the use of pharmacy technicians to provide this service with the support from their pharmacist and to identify how to optimally deliver this service through the two professionals working together.

At a national level there may be a need for incentives to make consultation rooms in pharmacies meet a minimum expected standard which would encourage patients to use pharmacies for services.

Whilst the funding model for community pharmacy remains, there is no reason why medical practices cannot include pharmacies in their offer of yearly asthma reviews providing community pharmacists have received appropriate training. The MUR is nationally funded and therefore provides an opportunity for medical practices to meet their Quality Outcomes Framework through a different route and thereby free up resources to meet other elements within it.

Spread the improvement

We intend to present the results at two local dissemination events through the local pharmaceutical committee and at a national asthma conference next year.

The results of the pilot will be published in an open access pharmaceutical research journal in the next six months. Additionally we will prepare an education piece for the Clinical Pharmacist journal based on the study findings.

Dr Michael Twigg from the School of Pharmacy at the University of East Anglia is applying for an NIHR funded clinical fellowship to enable him to move this project forward. The title of his application is ''Community pharmacy asthma services: How can community pharmacy and general practice integrate more effectively to improve patient care?"

We intend to apply for Health Foundation round 7 spreading improvement funding. We will plan to deliver 10 dissemination events across England whereby local clinical champions will be identified and invited to attend through local pharmaceutical committee networks. The day will consist of the provision of an evidence pack to support a business case for the service, practical tips from this project regarding service set up and delivery plus delivery of the training, which we developed for this pilot.

Milestones and activities

The milestones therefore what we want to achieve post project completion are:

Within 6 months of completion

- Presentation at two local dissemination events through the local pharmaceutical committee
- Presentation at a national asthma management conference
- Publication in an open access journal
- Application for NIHR clinical fellowship
- Application for Health Foundation Round 7 Spreading improvement funding

Within 12 months of completion

- Integration of learning into community pharmacy services at a local level

Within 24 months of completion

- Integration of learning into revised national MUR contract

Appendix 1: Pharmacist training sessions

Before the session:
Read
An article which outlines the SIMPLE approach to asthma care http://www.pharmaceutical-journal.com/news-and-analysis/feature/make-asthma-simple-for-your-patients/11138140.article
The new BTS guidelines https://www.brit-thoracic.org.uk/document-library/clinical-information/asthma/btssign-asthma-guideline-quick-reference-guide-2016/

Session 1:
6.30 Arrive and food
7.00 Introduction to project (DJW)
7.20 John Bell Presentation on theory of inhaler technique (CD)
8.00 Break
8.10 DPI v MDI inhaler technique / use of in-check dials and peak flow meters (CD & HM)
8.50 Training evaluation
9.00 Close

Session 2:
6.30 Arrive and food
7.00 Review of session 1
7.00 PharmOutcomes Guidance and Pharmacist tool kit(MC)
7.30 SIMPLE reminder (HM)
7.40 The pharmacist and asthma reviews (Hetal Dhruve)
7.50 Face to Face and paper based asthma reviews
8.50 Training evaluation
9.00 Close

Session 1 : Thursday 9th February 2017 at the Gt. Yarmouth and Waveney CCG office, 1 Common Lane North, Beccles NR34 9BN
Monday 13th February 2017 at James Paget University Hospital, Lowestoft Road Gorleston, Great Yarmouth NR31 6LA

Session 2: Tuesday 21st February 2017 at the Gt. Yarmouth and Waveney CCG office, 1 Common Lane North, Beccles NR34 9BN
Monday 27th February 2017 at James Paget University Hospital,Lowestoft Road Gorleston, Great Yarmouth NR31 6LA

Appendix 2: Resource pack contents

- In-check dial and disposable (white) mouthpieces
- Air Zone Standard peak flow meter and disposable mouthpieces (red)
- Space chamber compact spacer device
- Placebo inhalers
    - Ellipta
    - Respimat
    - Nexthaler
    - Easy haler
    - DuoResp Spiromax
    - MDI (fostair/ ventolin/ clenil)
    - Turbohaler
    - Genuair
- Training devices
    - Ellipta training device
    - Turbohaler training whistles
- Asthma support pack (Peak flow diary and blank asthma management plan in A5 wallet)
- Steroid cards for patients receiving high dose Inhaled Corticosteroids (ICS)
- Summary of BTS treatment guidelines with current CCG prescribing guidelines
- Information for patients: Staying in control of asthma

Appendix 4 Data collection summary from medical practices

Asthma Study

Post–Service Data collection

Number and type of reliever and preventer inhalers ordered in 3 months prior to and after service delivery

Number of asthma-related visits to medical practice in 3 months before and after service delivery

Number of asthma-related hospital admissions three months before and after

Asthma Study - Indicative topic guide

Patients (whether used the service or not)

	Stem questions	**Probes/ follow ups**
1	What could the GP practice do to help you attend your annual asthma review?	
2	What is preventing you from attending your annual asthma review appointment?	Availability of appointments Appointment process Relationship with GP/nurse
3	What are your thoughts about community pharmacists providing asthma reviews?	Pharmacist competence What would help / hinder delivery of the service
4	What would we need to do if pharmacists were going to provide this type of service?	
5	Is there anything else you would like to say?	

Asthma Study - Indicative topic guide

Pharmacists

	Stem questions	**Probes/ follow ups**
1	What are your thoughts about community pharmacists providing asthma reviews?	Benefits/advantages Disadvantages Effect on relationships
2	What things helped the delivery of the service? What things hindered the delivery of the service?	Method of communication from/with GP practices PharmOutcomes data entry Availability for appointments Consultation room
3	What are your thoughts on pharmacist training and support?	Training sessions Resources Support from project team and Pharmacy What has helped you / barriers?
4	How has the service affected your role?	Increasing/reducing workload Effect on work colleagues
5	What advice would you give to us if we wanted to upscale/expand this service?	
6	Is there anything else you would like to say?	

Appendix 5 Stakeholder meeting topic guides

Asthma Study - Indicative topic guide

GP practice staff

	Stem questions	**Probes/ follow ups**
1	What are your thoughts about community pharmacists providing asthma reviews?	Benefits/advantages Disadvantages Effect on relationships
2	What things helped the delivery of the service? What things hindered the delivery of the service?	Method of communication from/with pharmacies
3	How has the service affected your role?	Increasing/reducing workload
4	What would we need to do if pharmacists were going to provide this type of service?	
5	Is there anything else you would like to say?	

Appendix 6 Medical practice staff feedback

Asthma Project

Focus Group with GP Practice Staff – 09/10/17

SUMMARY

- Asthma review with nurse 15-20 minutes
- Pharmacist does not know the patient's background / have access to previous asthma review notes
- Pharmacist does not make consultation notes, mainly makes use of the tick boxes – would be useful in case of exacerbation and also from a safety point of view – training req'd
- IT systems are not compatible between GP practice and Pharmacy
- Summary care record does not provide relevant information / difficult to access with few computers available in pharmacies
- Response may be improved if pts invited on first reminder letter (pts who ignore the first letter tend to also ignore the 2nd and 3rd letters)
- Relationship between GP staff and pharmacy already good but working together on this project improved it
- DW – good idea for GP staff to be involved in training to gain greater understanding of the pharmacist role
- Time-consuming to check patient's record to ensure they are signed up to a pharmacy
- Other work not time-consuming for GP staff however there were very few participants
- Opportunistic appointments likely to be more successful although could be difficult in terms of pharmacist availability
- Patients need to get used to the pharmacist's evolving role
- Asthma nurses sometimes combine pt's appointment with review of other conditions eg diabetes – not possible for pharmacist
- Need more communication between pharmacist and asthma nurses especially if eg a follow-up appointment is recommended – safety net to ensure follow-up

Appendix 7 Pharmacist feedback

Asthma Project

Focus Group with Pharmacists x4 – 27/09/17

SUMMARY

Service Delivery:

- Pharmacists took between 20-40 minutes to carry out an asthma review; need to be more upskilled to be able to deliver the service quicker
- Patient lists: late, bad timing (Easter), patients included who should have been excluded
- No message on patient's script to indicate they required a review
- GP practice staff didn't appear to know the service was taking place
- Great to have all the materials to support the service
- Patient recruitment - need to change the patient's mind-set as to what the pharmacist can do
- Problems with relatives collecting medications and "no shows"
- Some pharmacists carried out review immediately or made appointments

Advantages of service:

- In patient's eye it is an identical service
- Patients get more contact time with a pharmacist than with GP/asthma nurse and can come back easily with further queries; patients trust the pharmacist and are more likely to provide honest answers; build up more of a relationship, don't always have to make an appointment
- The more services in pharmacy the better so we are accessible; pharmacists happy to do something different; promotes the role of the pharmacist
- Develops pharmacists' confidence – carries through to other patient contact opportunities
- Patients who had review all came back regularly for further advice

Disadvantages:

- If patient needs a new prescription they need to go back to the GP practice
- Pharmacist time – backlog of work – patients expect prescriptions to be dispensed quickly. Extra pressure with the consequence that mistakes are more likely to occur

Training:

- Fantastic; as a result of this training, improved MUR and NMS consultations
- More time should be devoted to role playing – 2-4 role play exercises
- Probably not feasible to have observation/feedback exercise with real patient (consultation room size, patient may not turn up)
- Day course instead of 2 evenings
- Resources good; good support post-training
- Skills need to be maintained
- 2 permanent pharmacists per pharmacy adequate for training

Upscale/expand the service - recommendations:

- Separate asthma review from MUR
- Pharmacist technician to carry out ACT/incheck with pharmacist summing up
- Experience asthma nurse carrying out asthma review
- Consent to phone patients to make appointments (like with MURs)
- More sharing of information / communication between GP practices and pharmacies
- Advertise service with a poster
- Patient approach is important – with MURs patients respond better to the pharmacist asking for a review rather than other pharmacy staff

Asthma Project

Interview with Rosedale Pharmacist – 05/10/17

SUMMARY

- Patients need more awareness of the service and that pharmacists are competent to carry it out
- No issues with the lists provided by the GP practice (correct, no timing problems)
- Project team provided useful resources and good training
- Reviews took at least 20 minutes
- Recruitment strategy could be improved: GP/nurse could suggest patient has next annual review with a pharmacist; GP could write to patient explaining the role of the pharmacist and suggesting they see pharmacist for review
- Training – struggled with practice assessment because instructions not clear
- Support - MC provided good encouragement to try and improve recruitment
- PharmOutcomes useful as a checklist
- Negative aspects: time to carry out review; time needed to input patient details from GP list to pharmacy system; delay if patient needs further intervention (could be resolved with a PIP); reduced service for patient if pharmacist needed in Pharmacy
- Strategy was to try and provide review with patients straight away, otherwise patients unlikely to return for an appointment
- Workload can realistically absorb 1 patient review a day
- Could have an accuracy checking technician to mitigate backlog of work whilst pharmacist carrying out reviews

Appendix 8 Patient feedback

Asthma Project

Patient Focus Group Meeting – 17/10/17

Summary of Discussion Points

What could the GP practice do to help you attend your annual asthma review?

They do enough with the reminder letters – its our choice as adults whether to attend or not. I'm a non-attender anyway so sending me a pharmacy letter would be no different from sending me a nurse letter.

What is preventing you from attending your annual asthma review appointment?

- Forget
- Feels its under control so don't think its necessary / waste of time
- Don't feel the need for nurse input as patient works in a similar profession
- Time – travel, waiting time plus appointment time
- Pointless as will not change the way they manage their asthma anyway
- Patient refuses to believe they have asthma – symptoms are periodic so self adjusts medication when feels it necessary
- Manages condition by making lifestyle adjustments eg not running
- Normal – had it all my life – just have to deal with it – doesn't know any different

I asked whether they attended other appointments eg dental check-up appointments. 1 pt said yes because they received a text reminder. Two pts said they attended because they would be charged for the appointment if they dna'd. 2 rarely went to the dentist (one hadn't been for 40 years). I asked whether the GP practice should send out an appointment date with the letter – some felt this was a good idea and that they would attend, however they thought that generally it may lead to lots of DNAs. 1 pt felt the GP practice could make some money for charging for the DNAs.

What are your thoughts about community pharmacists providing asthma reviews?

- Good idea in principle for routine check-ups but patients with poorly controlled symptoms are not suitable

- Feel that pharmacists are competent to carry out the reviews – "anyone can be trained" and the more reviews they carry out, the more competent they'll become

- 1 patient would not see the pharmacist for their review: pharmacist turnover is high at their pharmacy and the patient feels confident in attending the GP surgery where the

patient is known, they have the patient's records and the patient feels that the GP/asthma nurse wouldn't miss anything so feels safer

- Their knowledge of drugs is probably(!) better than that of a GP because that's their job
- One patient's drugs were delivered to their house so they don't see the pharmacist so would miss the opportunity for a drop-in appointment
- Doesn't like the environment in a pharmacy - there would be little confidentiality/privacy when arriving for an appointment – everyone in the pharmacy would know you have asthma and the consultation room looks small and claustrophobic
- Prefer GP or nurse as they have your records and you have built up a rapport with them
- Most did not know what services pharmacists offer and agreed that greater awareness was needed. Never know who the pharmacist is in the pharmacy – its not clear. Some were aware of some very good pharmacists who 'save' you from going to the doctors with non-serious symptoms
- Dr or nurse may pick up on something that a pharmacist might not
- Would only attend if convenient for me and when I was picking up my inhalers
- Although it may save time for Drs/nurses we don't know enough of what is going on behind the scenes – would like to see written evidence from all the parties concerned eg what the drs / nurses / pharmacists think of it and the training involved
- If pharmacists unable to prescribe then there's no point if you have to go back to the Drs
- Don't think pharmacists would be able to cope without an appointment system
- If they are carrying out a medication review they may as well do the asthma review as well
- Stigma associated with having a consultation with a pharmacist / perception of what the pharmacist does – eg people may assume a woman seeing the pharmacist in private is requesting the morning after pill
- Pharmacists could ease a lot of pressure from GPs in general
- This could just give patients more choice of who to see for a review rather than being forced to see a pharmacist
- Nobody likes change and there will always be some resistance however cuts have to be made in the NHS and this is a good opportunity however things are never going to be as good as were offered before

Only 1 patient had had a review with the pharmacist: they turned up during a convenient time in their working day and asked for an immediate appointment and it clearly wasn't a

good time – just before lunchtime and there was a queue of customers. However the patient was seen straight away. The review took about 15 minutes, maybe less; it was very "tick boxy" and because the patient's symptoms were poorly controlled the pharmacist told them they'd have to see the Dr. The consultation room felt like they were sitting in a cupboard.

What would we need to do if pharmacists were going to provide this type of service?

- Pharmacists need protected time for drop-in appointments
- On-line appointment system with choice of times
- Suitable consultation room with privacy
- Training and review/update training
- Pharmacists need more experience of carrying out reviews to be competent and for the public to be confident in them
- Patients could be screened based on inhaler consumption and those with symptoms which are well controlled could see a pharmacist and those with more severe symptoms should see the GP/asthma nurse
- Computer systems need to be compatible with those in the GP practices
- Pharmacists need to have access to patients' medical records (happy with that so long as privacy/confidentiality ensured) and be adequately trained

Is there anything else you would like to say?

Is this the tip of the iceberg – we have been directed from doctors to nurses to pharmacists - who next? And what conditions will be pushed onto the pharmacists next. It's a slippery slope.

1 patient suggested it would have been a good idea to have had a doctor, pharmacist and nurse at the meeting to find out their opinions.

Appendix 11 Project summary for dissemination

Offering Asthma Reviews through Community Pharmacy:

'Improving patient care through integrated working'

Proposal

- Offer patients option to access asthma review when collecting their inhalers
- Inform community pharmacist of need for review through prescription notification

Rationale

- Non-adherence with preventer inhalers causes unplanned hospitalisation and death
- Prolonged unnecessary use of high dose preventer inhalers wastes NHS resources
- Recommended that all asthma patients are reviewed once a year
- Up to 30% of patients do not attend for yearly review despite repeated follow up
- Offering the review at the point of prescription collection can increase service uptake
- National funding, Medicine Use Review Scheme (MURs), in place to facilitate community pharmacist service provision

Service Quality & Standardisation

Training

- Asthma service requirements
- Assessment of peak flow and inhaler technique
- Resource pack provision
- Counselling on use of different devices
- Clinical case studies
- Role play with actors

Service delivery

- Asthma control test
- Offer of smoking cessation
- Trigger factors
- Inhaler technique
- Peak flow
- Referral where appropriate
- Standardise recording system

Benefits

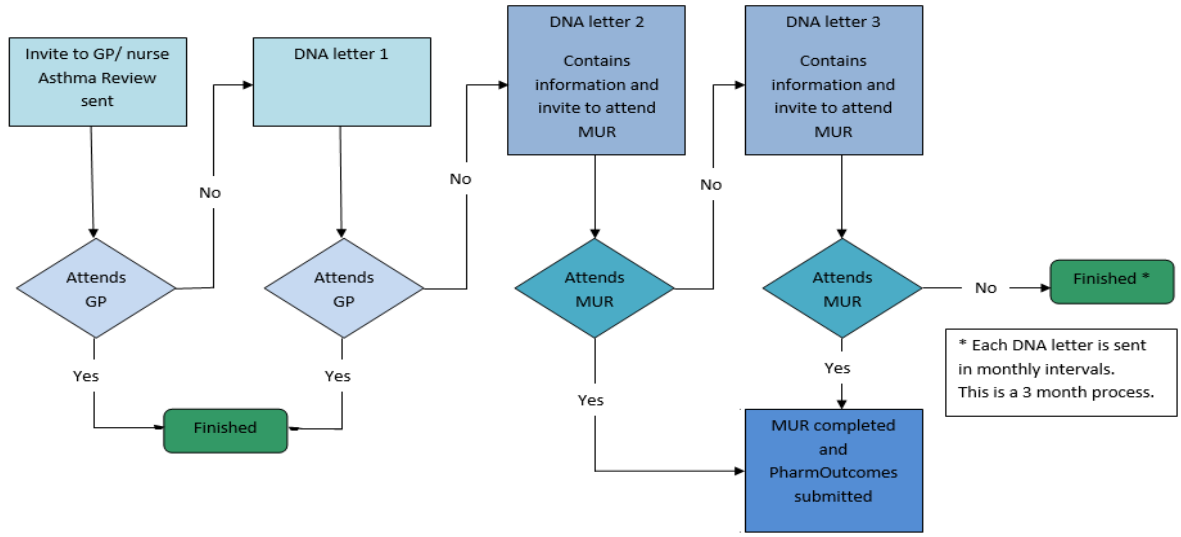
Patients	Medical practice	NHS	Pharmacy
Convenience			

Confidence in service quality Build relationship to enable ongoing support	Workload transfer Ease QOF target achievement Reduced unplanned medical practice visits	Reduced unplanned hospitalisation and mortality Focussed use of MURs	Build relationships with patients and medical practices Upskilled for role Better quality service provision

Health Foundation Funded Pilot Project

To pilot the offer of yearly asthma review through community pharmacy for patients who do not attend (DNA) following initial request

Service design



Evaluation

Record of interventions

PharmOutcomes®
Delivering Evidence

Patient survey

Stakeholder groups

Data collection

Results

- 5 medical practices, 10 community pharmacies, 27 patients seen over 3 months
- 100% of service requirements delivered (n=27)
- 100% of patients who responded (n=7) would recommend service to others
- Stakeholders believed that the service should be offered to all patients

Recommendations

- Provide one day of active training to all participating pharmacists

- Optimise pharmacy team skill-mix for delivery
- Involve all community pharmacies in the locality of participating medical practices
- Offer the asthma review service through community pharmacies to all patients as usual practice

"I'd be more than happy if I called up Reception to book in for my annual review and they said you're seeing a pharmacist - it wouldn't bother me at all"