

# Are pharmacists key to modernisation of chronic disease management?

*This year's autumn symposium of the United Kingdom Clinical Pharmacy Association was held in Blackpool from 21 to 23 November. Harriet Adcock and Sonia Sanghani report*

Pharmacists, because of their wealth of knowledge about drugs and drug interactions, are ideally placed to assist in the delivery of chronic disease management services in order to achieve the stringent targets expected by the National Institute for Clinical Excellence and national service frameworks. This is the view of Dr Peter Hammond, consultant diabetologist, Harrogate, who presented the Bristol-Myers Squibb lecture at the UKCPA autumn symposium.

There is compelling evidence for intensive management of glucose, blood pressure and lipids in patients with diabetes. The more complications a patient has, the more stringent the targets set for clinical endpoints. However, even in a clinical trial setting with strict management and control techniques employed, these targets are not met in all patients.

Dr Hammond questioned the feasibility of achieving similar results within normal clinical practice as it is currently structured. To achieve target clinical endpoints in 90 per cent of their patients, he emphasised the need for new models of working within the health care setting.

A successful example is an autonomous, once weekly, pharmacist-led cardiology clinic that runs parallel to his own clinic. The main aim of the pharmacist-led clinic is to achieve blood pressure and lipid targets to evidence-based levels as well as to assess the need for antiplatelet therapy in accordance with NICE guidance.

Treatment algorithms were developed using data from major clinical studies. An audit performed after nine months showed that the mean blood pressure reading for 47 patients in the clinic had improved from 166/91mmHg to 146/80mmHg. Lipid levels were reduced from 5.2mmol/L to 4.4mmol/L and the average low density

lipoprotein cholesterol reading was an impressive 2mmol/L, said Dr Hammond. Communication with patients was good and communication with primary care had improved considerably.

Monitoring drug therapies is an essential factor in this success, as well as ensuring all relevant laboratory tests are undertaken in a timely manner. Compliance with treatment regimens also plays a vital role in ensuring that treatment targets are met. Many patients with diabetes are taking the equivalent of two agents for their glycaemic control, three agents for their blood pressure control, a statin and an antiplatelet agent, not taking into account medicines for other chronic syndromes.

Until a long-awaited "polypill" is available, patient education and involvement in the area of therapy management and target achievement is a key role for the pharmacists who run the clinics. Explaining to patients why it is necessary to increase the number of medicines they are taking, or why the dose needs to be changed, enables them to understand the management issues involved with their condition.

Attending the clinic at four-weekly intervals provides them, and the pharmacist, the opportunity and time required to discuss thoroughly issues related to the management of all their medicines, not just those related to their diabetes or cardiac control.

Dr Hammond alluded to what he sees as an excellent model of the self-managing patient from a German example. In Dussel-



*Peter Hammond: new models of working needed to achieve national targets*

dorf, patients have been provided with blood glucose and blood pressure monitors for the past 20 years. Patients regularly take measurements and adjust their antihypertensives accordingly. They then arrange to have their medication reviewed.

Future developments for the pharmacist-led clinic include use of supplementary prescribers and expansion of the service into primary care. As far as supplementary prescribing is concerned, Dr Hammond foresees no great issues. Most of the areas in which this activity will take place is protocol- and algorithm- driven. He also believes that independent prescribing is feasible, once pharmacists have developed experience under supervision and through supplementary prescribing.

Expansion of the diabetes service model into primary care is proving to be a little complicated, he said. Primary and secondary care traditionally have different visions as to how chronic disease management services should develop, and issues to be resolved include the financial support for the expanded service as well as the model used. The new contracts for general practitioners and community pharmacists may pave the way to resolving some of these issues. Dr Hammond reminded participants that patients, too, require educating if these models are to work well.

Patients have preferences as to the pharmacy and GP practice with which they most like to interact and setting up specialist pharmacies or practices on a regional basis would require a change in patient behaviour.

Dr Hammond said that, although most of the clinic's aims have been achieved, he was disappointed that they had not yet achieved the structural aim of fitting the pharmacist-led clinic with the IT infrastructure to enable seamless communication with primary care and GP practices.

The template for this has been developed and it is to be hoped that this situation will improve in the near future. The service model the clinic had developed for its diabetic patients was adaptable to a range of chronic diseases, and pharmacists and specialist nurses had specific and complementary skills that could be used to deliver on many of the NSF target areas.

## UK Clinical Pharmacy Association awards

The Merck Pharmaceuticals for Medicines Management Award lecture 2003 was given by Alison Dale, City Hospitals Sunderland NHS Trust. The Napp palliative care award 2003 was presented by Shirley Kelly, Victoria Hospital, Dundee. Awards sponsored by GlaxoSmithKline were presented for the best oral communications and research posters. Caroline Hollingshead, Pharmacy Alliance, Chessington, received the award for best first-time presenter and Mohamed Rahman was best overall presenter.

The award for best primary care poster was presented to Anne Cole (Medicines management in patients with chronic pain in a primary care based multi-disciplinary setting) and the award for best secondary care poster was presented to Timothy Rennie (Exploring choice of regimen in tuberculosis prevention).

The Pharmacia preregistration poster award 2003 was presented to Amanda Le Page for her poster entitled "Is there HOPE in Bromley?"

## Slow progress with Agenda for Change

Pharmacists working at hospitals that are not early implementer sites in the Agenda for Change process should not be having their jobs evaluated yet, Duncan McRobbie, principal clinical pharmacist, Guy's and St Thomas' hospital, London, told conference participants. "The early implementer sites should be seen as pilots. There are lots of bugs that we need to get out of the system," he said. "There is no point in doing anything in terms of job analysis until we have clarity on how we are going to go forward." He added that any job evaluations done now would not be signed off by the unions.

For pharmacy, progress appears to be slow, with no job profiles having been agreed. It had been hoped that pharmacists would know how their jobs would fit into the banding system by March 2004. "No early implementer sites will be ready anywhere near that date," Mr McRobbie said.

There had been no indication from the Government that the timetable for Agenda for Change could slip and trusts that were not early implementer sites were expected to have completed job evaluations by summer 2005, he said.

Mr McRobbie urged participants to join the Guild of Healthcare Pharmacists, the body representing pharmacists in the negotiations between health care unions and the Government. "Non-members will be starved of information and if you think you have been hard done by through the job evaluation process, you will not be represented."

## Future symposia

The United Kingdom Clinical Pharmacy Association spring symposium will be held in Newcastle from 7 to 9 May 2004. Next year's autumn symposium will be held in Blackpool from 19 to 21 November. Further details can be obtained from UKCPA Office, Alpha House, Countesthorpe Road, Wigston, Leicestershire LE18 4PJ (tel 0116 277 6999).

## Emergency hormonal contraceptive users welcome pharmacy supply

Women who have obtained emergency hormonal contraception (EHC) from community pharmacies (whether on prescription, through a patient group direction or by purchase over the counter) welcome the availability of EHC as a pharmacy medicine, Caroline Hollingshead, professional services pharmacist, Pharmacy Alliance, Chessington, told participants at the UKCPA conference.

She described a study, conducted in 2002, designed to explore patients' views on access to EHC and to establish their information needs. Participating pharmacists (n=250) were asked to recruit 10 customers requesting EHC who were in turn asked to complete a questionnaire. "On the whole, patients' views were supportive," she said.

Of the 785 customers who filled in a questionnaire, two thirds were aware that

EHC could be purchased over the counter. However, only 8 per cent of these customers had been informed about the availability of EHC as a pharmacy medicine by their community pharmacist. "This suggests community pharmacists can do more to increase awareness," Mrs Hollingshead said.

Of those who did purchase EHC, most did so because of speed of access and convenience.

Although most respondents (93 per cent) thought community pharmacies were a suitable place to obtain EHC and most (92 per cent) were satisfied with the advice they obtained, fewer respondents (76 per cent) agreed that pharmacies were a suitable place to discuss issues relating to EHC. Furthermore, about half thought they had not received sufficient information about sexually transmitted infections.

## Prescriptions more accurate when written by pharmacists

Discharge prescriptions written by pharmacists contain fewer errors and omissions than prescriptions completed by junior doctors, Mohamed Rahman, principal pharmacist, Royal Liverpool & Broadgreen University Hospital NHS Trust, revealed. Furthermore, prescriptions written by pharmacists are more complete and less ambiguous.

In a study conducted at the Royal Liverpool Hospital, discharge prescriptions written by 12 junior doctors over a two-week period were compared with those written by three senior pharmacists. A total of 755 interventions were made by pharmacists evaluating the 128 discharge prescriptions written by the doctors. In contrast, 76 interventions were made in connection with



*Mohamed Rahman: accurate prescriptions speed up discharge*

the 133 prescriptions written by the pharmacists. "Pharmacists prescriptions had only one 10th of the interventions."

Of the 10 alterations made by doctors to the pharmacist-written prescriptions, most were overcautious and some were unnecessary.

Mr Rahman pointed out that if prescriptions were written more clearly and accurately, the discharge process would be speeded up. He explained that the study had been carried out to find out if pharmacists were competent to take on the role of writing discharge prescriptions. "This is not about deskilling doctors. This would not be universal but is a service we can offer," he said.

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## Pharmacists should be involved in emergency care

Hospital pharmacists should become more involved in the delivery of emergency health care to patients, conference participants were told.

"The accident and emergency department is a key area for pharmacists, since clinical decisions are made in a heated environment. A&E pharmacists can develop policy and procedure and training to improve medicines use in this setting," said Duncan McRobbie, Guy's and St Thomas' Hospitals NHS Trust, London.

Mr McRobbie was chairman of a satellite session, sponsored by Boehringer Ingel-

heim, where the use of bolus thrombolytic agents in the treatment of myocardial infarction was discussed.

Javid Kayani, consultant in emergency medicine, University Hospital Birmingham, explained that in 2002, the Government had set a target that 75 per cent of eligible patients should receive thrombolytic drugs within 30 minutes of arriving at hospital.

A survey in the same year had shown that only one in three hospitals were reaching that standard. "Now, 75 per cent of hospitals are achieving it," he said. However, Mr Kayani said that to achieve administra-

tion of thrombolytic drugs in the fastest possible time, the drug had to be taken to the patient rather than the patient to the drug.

Dr Adrian Noon, medical director of Essex Ambulance NHS Trust, described how paramedics in Essex were trained to administer thrombolytic drugs to a heart attack patient before they reached hospital.

Mr McRobbie added: "The challenge is for pharmacists to engage with professions that have not traditionally been involved in delivering medicine. This is key to developing good systems of health care."