Developing the role of community pharmacy in diabetes care (**CPDSS**)

NHS Wessex Clinical Senate

CPSC Community Pharmacy South Central

West Hampshire Community Diabetes Service

Southern Health NHS Foundation Trust

Declarations

Richard Buxton BPharm(Hons) MRPharmS

- Pharmacist & Director of Buxton Pharmacist Services Limited

Financial and conflicts of interest disclosure:

- Professional Services Development Manager & Communications Lead for Community Pharmacy South Central (CPSC)
- Honorary contract with Southern Health NHS Foundation Trust (SH NHSFT) to enable work on this project on behalf of West Hampshire Community Diabetes Team - funding indirectly from Wessex Cardiovascular Strategic Clinical Network
- Community pharmacist independent locum service on Isle of Wight

What we'll cover

- The brief, aims and objectives
- Scoping - why diabetes, why community pharmacy?
  - where to pilot, what will happen?
- Service design
- Scoping - how will this be achieved?
- Remuneration
- Metrics
- Willingness & Barriers
- Educational considerations
- Summary & Conclusions

The brief

This project:

- scopes how the role of community pharmacists could be developed to become more integrated into the care pathway for targeted people with diabetes.
- assesses current competency and confidence levels in community pharmacy
- scopes education opportunities
- assesses willingness and capacity of community pharmacists in being developed to being able to deliver greater care to people with diabetes.

Aims & objectives

- For community pharmacy to collaborate with existing primary and secondary care specialist services and engage with people with diabetes that are more hard to reach
- For community pharmacy to become an integral part of the care pathway for people with diabetes
- To deliver sustainable patient centred care that will improve patient safety and clinical outcomes for diabetes patients and leave a legacy of education for healthcare professionals

Scoping – Why diabetes?

National Picture

- more than 15 million people in England have at least one long term condition
- people with diabetes commonly have more than one long term condition
- cost to treat & manage diabetes rising (2015 over £1 billion)
- net ingredient cost of drugs rising, almost double the spend of 10 years ago
- % of annual NHS budget spent on diabetes care rising, now 10%
- number of people with Type 2 diabetes rising
- 75% of people with Type 2 diabetes are overweight or obese people
- projection that 70% of people will be overweight or obese by 2034
- 1 in 10 overweight or obese people will develop Type 2 diabetes
- estimated that number of people with non-diabetic hyperglycaemia in 2015 is 5 million

Scoping – Why diabetes?

National Picture

- % of hospital beds occupied by patients with diabetes is increasing
  - Doubles the risk of CVD
  - Most common reason for end stage kidney disease & blindness in people of working age
  - 135 amputations per week in England (National Audit Office 2015)
- large variance in care process and treatment standard performance by CCG's
- engagement variance by age
  - particularly low with people with: Type 2 <40 years old, and Type 1 diabetes (especially those typically at work)

Scoping – Why diabetes?

Local Picture WHCCG

- 37.2% of people with Type 1 are receiving all 8 care processes (cf 37.3% nationally)
- 56.4% of people with Type 2 are receiving all 8 care processes (cf 53.9% nationally)

- 19.8% of people with Type 1 are achieving all 3 treatment targets (cf 18.3% nationally)
- (20.4% in <40's)
- 37.5% of people with Type 2 are achieving all 3 treatment targets (cf 40.4% nationally)
- (only 25% in <40's)

- trend for both these measures is not improving.

- structure education invitations are rising for both Type 1 & 2 diabetes, however attendance is still stubbornly low in line with national average for Type 1 and three times lower for Type 2.

- high amputation rates – well placed to sign-post appropriately

Scoping – Why community pharmacy?

- Adults in England visit a pharmacy on average 16 times a year, there are 1.2 million health related visits each day across the 11,700 community pharmacies in England
- Frequency of access means ideally placed to recognise the early signs and symptoms of LTCs and preventing their progression
- Convenient location and unique regular touchpoint to build relationships with hard to reach patients, especially those <40's and working
- Additional HCP opportunity to utilise more
- Several previous pilots have demonstrated positive results and learnings
- Pharmacists have a crucial role in the support of people with LTCs

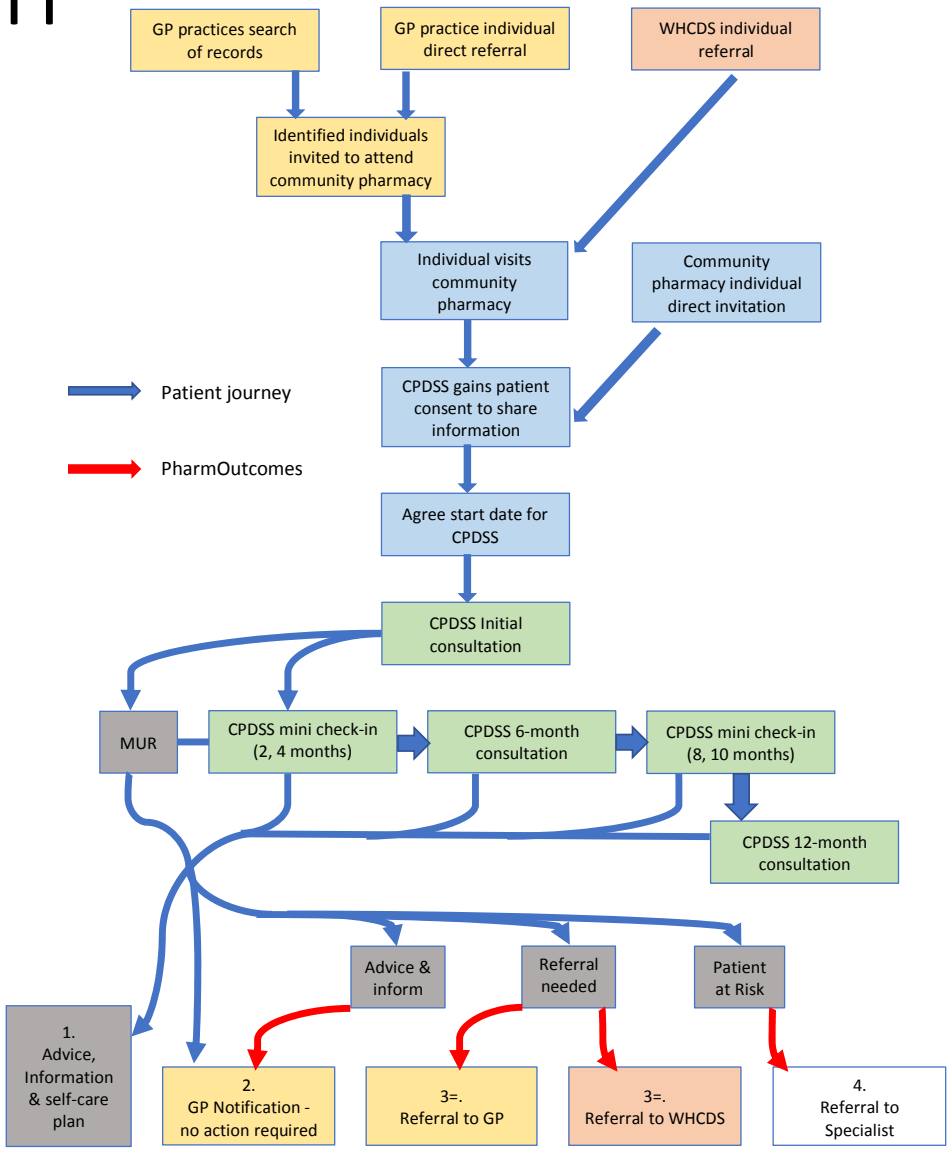
Scoping – Where will we pilot?

- pharmacy participation is dependent upon having the right pharmacy, in the right location, with the right pharmacist & the right team at the right time
- service delivery going forward can be predicted upon recent past and current other commissioned service performance
- selection of participating pharmacies must be assessed for suitability within each targeted locality
- GP practice team engagement is crucial to ensure collaborative working to engage the hard to reach people with diabetes (recommend incentivised engagement payment)
- 15 pharmacy locations have been provisionally identified for a pilot within WHCCG boundaries

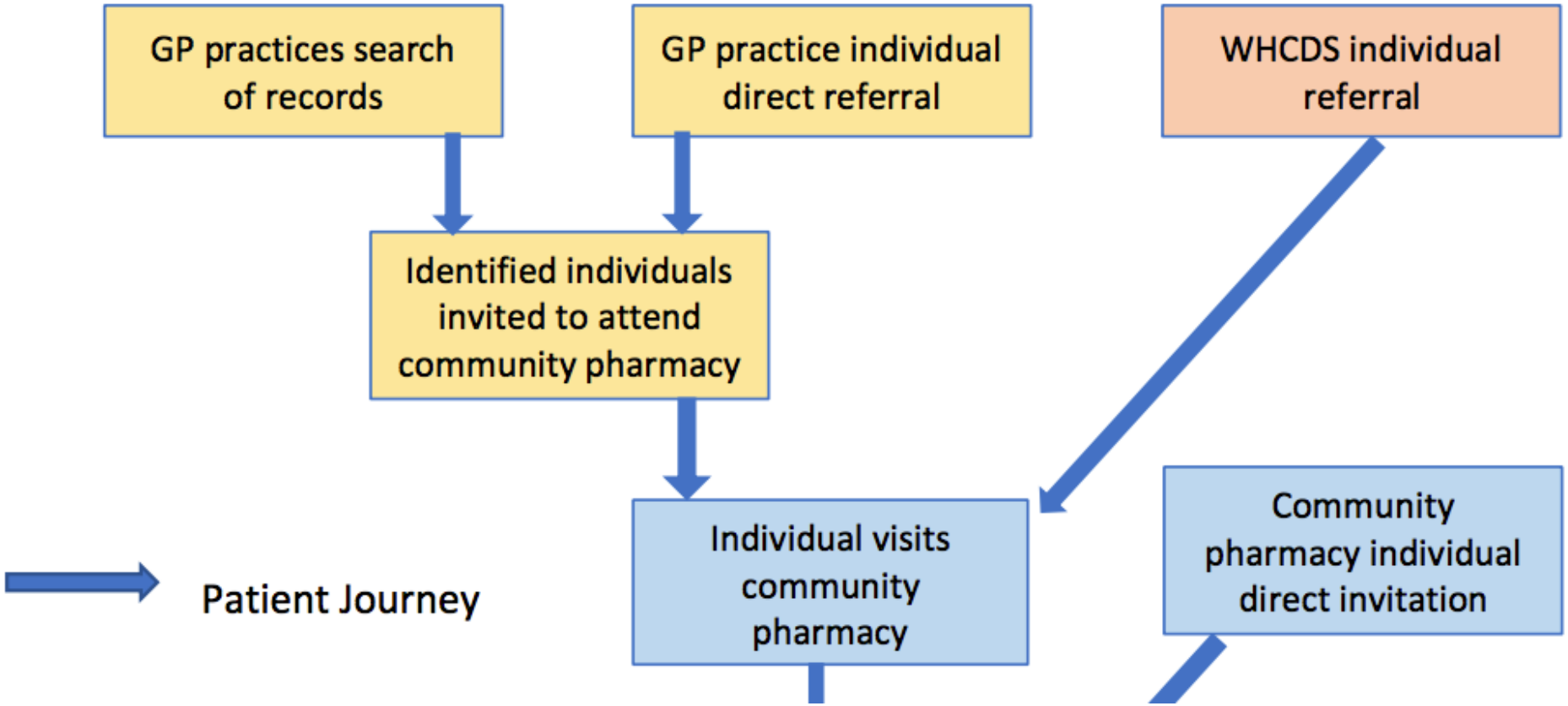
Scoping – What will happen?

- targeted individuals identified at participating GP practices in West Hampshire,
- invited to visit a community pharmacy and have a discussion about their medicines that could improve their care
- engaged on free support programme, provides opportunity for increased engagement, support, care, advice, mutually agreed motivational goals
- pharmacist notifies/refers appropriate information direct to GP / WHCDS / specialist

Service design



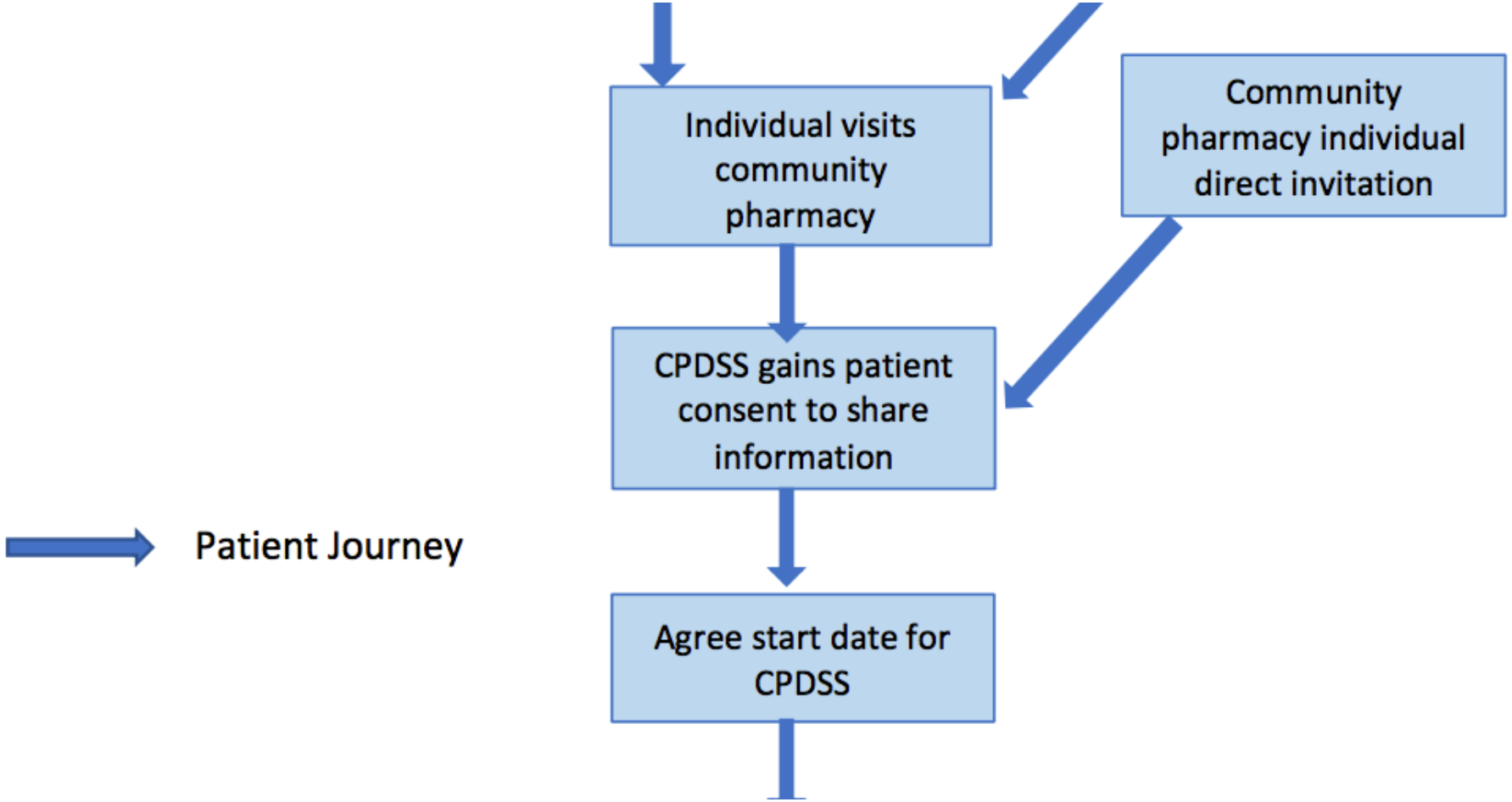
Service design – suitable participants



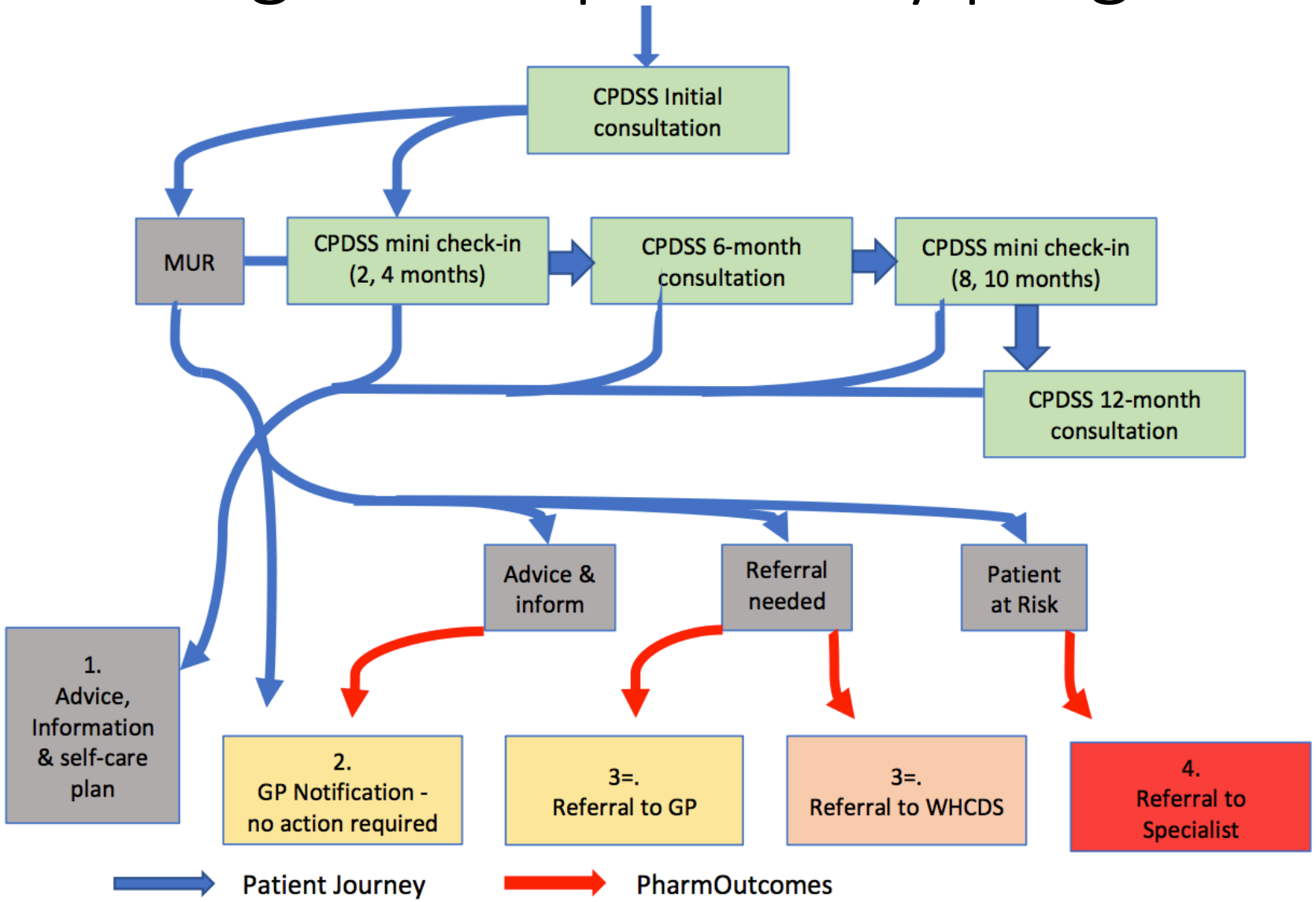
GP practice led invitation letter & postcard

- Currently used in Atrial Fibrillation NMS project in West Hampshire led by Wessex AHSN.
- Card will be posted to persons not responding to their annual review invitation, or others with known poorly controlled diabetes, to informally invite them to see their pharmacist as a convenient alternative place to give them help, support and advice; as well as review their medicines use and suitability.

Service design - engagement



Service design – the pharmacy program



Service design – the pharmacy intervention

CPDSS Initial consultation

Welcome, explanation, what can we do to help

Key measurements & questionnaire; PAM® score

Motivational interviewing

What's important to the participant -> agree Personalised Care Plan (PCP)

Other help or information

CPDSS mini check-in (2, 4, 8, 10 months) **MUR**

Quick Personalised Care Plan progress update

Any new or outstanding issues or questions

MUR – Engagement, medicines use, adherence: doses, any issues, are they working, side effects, missed doses, anything else, healthy living advice

CPDSS 6, 12 months consultation

Celebration, continued motivation, what next?

Commitment to attend annual reviews , understanding of their importance

Key measurements

Questionnaire (at 12 months) & sign off

Service design – notification & referral

1. Help, advice, Information & self-care plan	General health advice Not deemed significant to warrant notification to other HCPs Capture information for comparison and evaluation
2. GP Notification - no action required	Advice given which does meet criteria to share with GP. e.g. medicines compliance issues
3=. Referral to GP / WHCDS	Concerns identified for the persons on-going health that needs follow up. e.g. serious medicines compliance issues, medicines optimisation required, high blood pressure or cholesterol levels, undiagnosed hypoglycaemic incidents, insulin titration issues, willingness to engage with structured education programme
4. Referral to Specialist	Potentially life threatening undiagnosed conditions observed e.g. dangerously high blood pressure or visible signs of diabetic foot deterioration

Scoping – How will this be achieved?

PharmOutcomes is a web-based system which helps community pharmacies provide services more effectively and makes it easier for commissioners to audit and manage these services.

By collating information on pharmacy services it allows local and national level analysis and reporting on the effectiveness of commissioned services, helping to improve the evidence base for community pharmacy services.

Two Clear Objectives

- To capture the evidence of community pharmacy's benefit for patients
- To ease the burden of record keeping, service management and financial tracking for services provided by community pharmacies

PharmOutcomes® Delivering Evidence

Remuneration for service

- Incentive remuneration for GP practice for people with diabetes successfully engaged onto CPDSS
- Tiered payment structure that pays community pharmacy at beginning, mid-point and end of service programme for each individual engaged.

Metrics – at patient level

Number of:

- patients seen over the life of the project
- patients invited to participate in service
- patients attended service
- patients referred to diabetes specialist
- new primary diagnosis made
- comorbidities identified
- poor diabetes control identified
- patients compliant with medication
- patients given lifestyle advice
- hypoglycaemic episodes quantified
- patients who report an improvement in their quality of life
- working days lost due to diabetes disease decreased
- patient satisfaction

Metrics – at primary & secondary care level

Number of:

- community pharmacies engaged
- Have they attended their annual review
- record of the cost delta as a result of medication changes
- patients referred to community diabetes services
- patients referred to lifestyle services
- hypoglycaemic episodes, out of hours and emergency primary care appointments compared to prior 12 months
- increased prevalence rates seen in other locations (control)
- patients referred to secondary care
- hospital admissions and ED visits compared prior 12 months

Willingness & Barriers

Assessment of workforce competency, capabilities, skills and capacity to deliver by:

- Survey Monkey questionnaire developed and reviewed by CPSC
  - completed by 70 pharmacists across the locality
  - 68.6% & 93.9% confirmed they see Type 1 & Type 2 patients respectively everyday
  - 98.3% reported very low levels of diabetes specific training in the past 5 years
  - confident in providing general advice, but low competence and confidence for more specific diabetes advice
  - 63.9% expressed an interest in participating in a pilot, attending training and engagement events to develop their role
  - developed service not suitable for delivery in all pharmacies, however with 93 pharmacies across West Hampshire, realistic to achieve 15 pilot sites
- Personal conversations, telephone calls and email correspondence with the CPSC committee, pharmacy contractors, practicing pharmacists.

Educational considerations

- Median of 98.3% of pharmacists had not completed specified diabetes training from a list of 25 recognised courses
- 87.1% of pharmacists would be prepared to attend training with 213 positive format choices in total
- Suggested training would include:
  - communication skills, Motivational interviewing & Goal setting
  - PAM® score (Patient Activation Measure®), < 40 years old
  - hypoglycaemia awareness (Hypo pack rollout Autumn 2017)
  - condition training - condition, pathways, annual review, medication, Apps (Red flags)
  - monitoring & titration (Red flags)
  - injection technique

Summary

The Project is designed to:

- integrate care pathway
- jointly manage person with diabetes
- encouraging engagement with healthcare professionals to support and manage LTCs
- target people with diabetes identified as hard reach
- create new opportunities to proactively identify potentially undiagnosed deteriorating conditions
- make interventions that potentially could save lives

Conclusion

Community pharmacy is willing & able to:

- step-up and develop role to meet growing demand of diabetes care upon the NHS
- collaborate working with existing primary and secondary care team
- increase diabetes specific training to enable service provision to identified people with diabetes that are difficult to reach
- receive direct referrals to facilitate increased engagement, support, care, advice, mutually agreed motivational goals for participants
- directly refer appropriate participants to primary or secondary care specialist team to improve access to care, streamline patient journey, improve cost efficiency

Adopting this strategy will mean community pharmacy will be:

- focussing on a significant cohort of patients with diabetes
- encouraging proactive self care to reduce LTCs associated with poor control
- reducing financial cost burden on health and social services

Contact details

Richard Buxton

Professional Services Development Manager
Community Pharmacy South Central
Sentinel House
Harvest Crescent
Fleet
Hampshire
GU51 2UZ

tel: 01252 413776
mob: 07887 952421
fax: 08716 613991

email: richard.buxton@cpsc.org.uk

CPSC Community Pharmacy South Central