QIA Presentations

Health Education England

1	**Teklit Gebrekirstos and Dr Leanne Rhodes**
2	**Habiba Akhtar and Dr Jonathan Bigwood**
3	**Liam Herrity and Dr Alice Sherwood**
4	**Danielle Brown and Dr Valerie Osuoha**
5	**Fiby Paul and Dr Joanna Wykes**
6	**Lisa Morgan and Dr Dharam Dickinson**

NHS
Health Education England

Participant Feedback

Participant Feedback

Health Education England

What was the best part of the placement programme and why?

"Participating at a CCG meeting which the GP had with the CCG pharmacist…. gave me a broader perspective of the work between local commissioning body and primary care."

Pre-reg pharmacist

"Being able to observe the different members of the GP practice and knowing everyone's role."

Pre-reg pharmacist

"Understanding the workings of the GP practice"

Pharmacist tutor

Participant Feedback

Health Education England

What was the best part of the placement programme and why?

"Spending time with the local pharmacy and getting a detailed insight into the workings of a community pharmacy, the services they provide and how we can work to improve relations."

GP Trainee

"Pharmacist trainee gained understanding of prescribing dilemmas in primary care, especially with complex patients"

GP Trainer

Participant Feedback

Health Education England

"Many thanks for all of your work in organising this educational exchange which I have found enormously useful.
I am certain that the knowledge and understanding of pharmacies' ways of working that I absorbed insidiously whilst being there will remain relevant and indispensable throughout my career, benefitting me, my patients and my local pharmacies."

GP Trainee, South London

The Quality Improvement Audit (QIA)

Objective:

*"To develop **inter-professional learning** between CP and GP trainees and instil a culture of inter-professional learning and a **multidisciplinary approach** to practice that **reduces** profession based **silo working**"*

QIP: OTC medication

01/07/17

Dr Leanne Rhodes

Tek Geb

Content

- Background
- Aims of QIP
- Methodology
- Results
- Recommendations

Background

- Up to 18% of general practice workload is estimated to relate to minor ailments
- Prescribing OTC medication can encourage repeat attendance for minor ailments
- Pharmacists are well equipped for recognising common conditions such as hayfever or rhinitis and suggesting an appropriate OTC remedy

sky high.

Southbank Research

NHS chiefs say: 'Please don't ask for antihistamines on prescription'

NHS Greater Huddersfield and North Kirklees CCG urges antihistamine users to save cash on prescription charges

Categories of OTC medication

- Area 1: paracetamol and ibuprofen
- Area 2: vitamins e.g. vitamin D, folic acid, riboflavin
-
- Area 3: antihistamines, skin creams e.g. benzyl peroxide, antacids/alginates

Audit at Practice

- Emis computer search 1/6/17-7/6/17
- Prescriptions for certirizine
- Included patients from 3 sites

Audit results

- 97 patients
- 33 male, 43 female
- Age range 10 months- 92 years
- 47% patients paid for their prescriptions
- All prescriptions were issued for allergy symptoms (72% for hayfever symptoms)

Audit at Pharmacy

- Search in electronic register for cetirizine prescription from 1/06/2017 – 7/06/2017. 19 patients identified age ranging form 6 month to 89 years.
- Children = 6
- Elderly above 60= 8
- Paying adults = 5 (26%)

Recommendations

- Patient and GP education to stop the prescribing of OTC items for minor ailments
- Promote self care through purchasing of medications and products from local pharmacies or supermarket
- Reduce our spend on OTC medicines

Recommendations

- For the exempt patients there is minor ailment service in some pharmacies were patients can pick medication without prescription. Therefore they can get free medicine through that service.

- However not all pharmacies provide that service

Proposal

Therapeutic area/group of drugs	Examples of preparations in each area
Vitamins and minerals	Vitamin A, B,C,D,E,K, multivitamin, zinc, calcium and magnesium supplements
Analgesics for short term use	Paracetamol, ibuprofen, topical analgesic
Seasonal rhinitis	Steroid nasal spray, antihistamines, sodium cromoglycate eye drops
Eye treatments/ lubricating products	Chloramphenicol eye drops/ eye ointment, Hylo-tears
Antifungal treatment	Clotrimazole cream/ pessaries, fluconazole oral, ketoconazole shampoo, amorolfine nail lacquer
Indigestion remedies	Antacid tablets and mixtures e.g. Gaviscon
Laxatives for short term use (<72 hours)	Senna tablets, isphaghula husk sachets, docusate sodium 100mg capsules, lactulose solution

Therapeutic area/group of drugs	Examples of preparations in each area
Topical steroids for short term use (up to 1 week) for example bites/stings, mild dermatitis	Hydrocortisone 1% cream/ointment
Mouth wash and mouth ulcer treatment	Chlorhexidine mouth wash, bonjela
Cough and cold remedies	All cough and cold remedies
Anti-diarrhoeal medication for short term use (< 72 hours)	Loperamide, rehydration salts
Head lice treatment, scabies treatment	Malathion liquid, permethrin, dimethicone lotion/spray
Haemorrhoidal preparation for short term use (5-7 days)	Anusol
Warts and verruca treatment	Salicylic acid preparations
Topical acne treatment	Benzyl peroxide

Therapeutic area/group of drugs	Examples of preparations in each area
Cold sore treatment	Aciclovir cream
Ear wax removers	Sodium bicarbonate, otex, cerumol
Nappy rash treatment	Metanium nappy rash ointment
Threadworm treatment	Mebendazole tablet/suspension
Colic treatment	Simeticone
Antiperspirants	Aluminium chloride hexahydrate
Herbal and complimentary supplements	Homeopathic preparations, tonics, health supplements

- Clinical judgement should be used when considering whether it is acceptable to ask a patient to purchase their medication

- Examples of scenarios:
  - products with OTC licensing restrictions
  - patients with chronic long term treatments e.g. paracetamol in OA
  - possible safeguarding concerns e.g. in children who may not otherwise be provided with treatment
  - possible significant clinical risk to the patient if they did not purchase the product e.g. thiamine in patients with alcohol use disorders.

Pharmacy first scheme

- The scheme is aimed at any many common ailments such as acute conjunctivitis, bites, stings and allergies, constipation or diarrhoea, earache, sore throat, athletes foot, threadworm, haemorrhoids and warts and verrucas.

- The patients just need to bring the ID, NHS number, proof of exemption.

- The pharmacist assess the need and can see pharmacist up to two times for most conditions. The pharmacist can then refer to GP if more treatment is needed.

- Referral points include: age < 6, pregnancy, signs of infection, symptoms of longer than 14 days, and already taking antihistamines.

Proposal

- Encourage pharmacy first scheme for minor ailment, where patients get registered at the surgery and hands the form to pharmacy.
- May be having a poster for OTC items at the surgery might encourage patients to go to pharmacy first and will help to educate patients.
- Pharmacies may raise awareness to the patients.

References

- http://www.nhs.uk/Livewell/Pharmacy/Pages/Commonconditions.aspx

- https://psnc.org.uk/?our-services=minor-ailments-service-6

Monitoring prescribing errors and providing feedback between pharmacy and GP surgery

Habiba Akhtar, Pre-registration trainee pharmacist
Jonathan Bigwood, GP registrar

Why did we chose this QIP?

- Patient issued apidra insulin, having requested novorapid. They had never received apidra before.
- Pt reported to pharmacy who flagged to surgery
- Potential for serious harm
- No formal recording by pharmacy as pharmacy issued prescription correctly.
- No formal protocol to provide feedback to surgery
- Monitoring may flag up other issues that surgery is currently unaware of.

Background

- 12% UK primary care patients may be affected by a prescribing error per year
- 38% over 75
- 30% if taking 5 or more drugs
- Total of 5% prescriptions contained errors

Avery A, Barber N, Ghaleb M, Franklin BD, Armstrong S, Crowe S, et al. Investigating the prevalence and causes of prescribing errors in general practice: the PRACtICe study. London: General Medical Council; 2012.

Factors influencing medication errors

- Inadequate knowledge of drugs or patient
- Workload/time pressures and distractions or interruptions
- Communication issues
- Complexity of clinical cases
- System issues – e.g. picking default dose/regimens

Suggestive protocol for recording errors

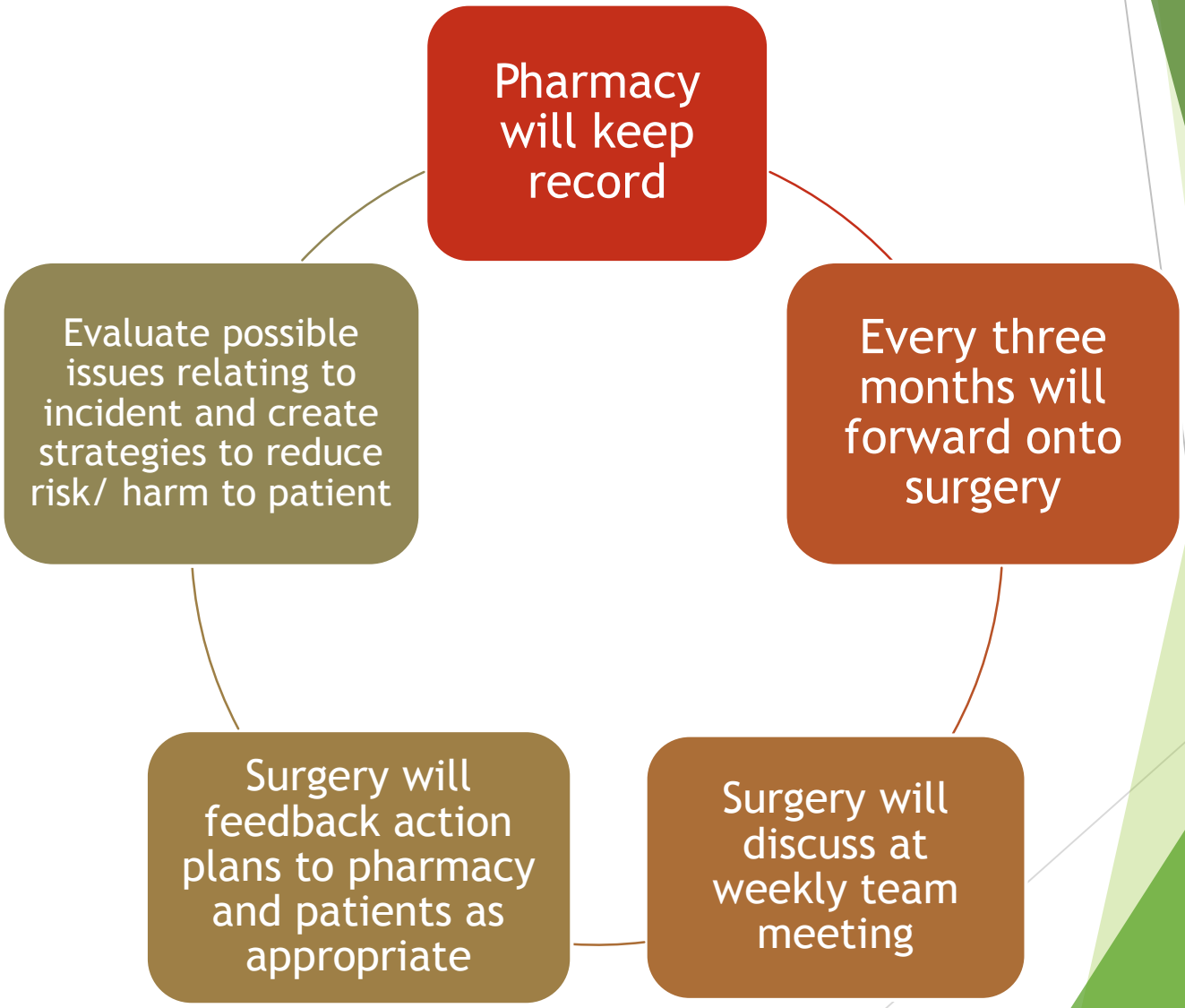
Filled in by pharmacy

Completed by surgery

Initials (patient)	D.O.B	Date of incident	Type of Incident	Details	Action taken by pharmacy	Action taken by surgery
..	..	..	Incorrect medication issued	Pt reported received insulin type that they had never received before and were unaware of change	Informed surgery and requested correct medication on prescription	Prescriber notified, correct medication issued, reviewed at team meeting

Proposing a way of tabulating data for audit purposes

Monitoring & providing feedback



Potential benefits

- Reduced medicine wastage – currently a massive problem
- Increased efficiency for surgery and pharmacy
- Improve patient experience
- Build culture of communication between pharmacy and surgery
- Ensure serious incident are highlighted and followed up
- Reduce risk of further serious incidents

GP and Pharmacy Joint Project: Smoking Cessation

ALICE SHERWOOD AND LIAM HERRITY

Smoking cessation

- A service offered by both GP surgery and Pharmacy
- Aim to enhance smoking cessation service to patients
  - Identifying patients who are smokers – at both GP Surgery and Pharmacy
  - Support patients – Individual needs, Appropriate follow up
  - Aim for service offered at pharmacy and GP surgery to compliment each other and not duplicate – Target patient groups/psychological support
- Aim to reduce GP workload/free appointments/maximise clinic use
- Promote pharmacy smoking cessation/utilise skills and services

Smoking

- Biggest preventable cause of death and disease
- >50% of long term smokers die prematurely from smoking related diseases
- Current UK prevalence 17%, Average consumption 11 cigarettes a day
- Power of addiction
  - 60% smoke post MI
  - 50% after laryngectomy
  - 50% after pneumonectomy
  - 80% don't stop during pregnancy

Quit attempts each year

70% want to stop

30% try to stop

Test for smoking :

Breath CO – elevated after smoking, last only for hours – used to motivate and monitor

	No Medication	Medication
Willpower alone	2-3%	4-6%
Support – trained	10-15%	20-30%

GP Surgery Service

- Smoking cessation clinic – every Wednesday – nurse led (Quit51)
- Patients referred by GP - identified during consultation either via brief intervention or patient request
  - Advantages – dedicated appointment, follow up, psychological support, experience
  - Disadvantages – patients can't always attend appointments – lack of support
- If GP led – prescribe medication – tends to be more patient led – relying more on patient motivation
  - Knowledge – Individually dependant

Day Lewis Service

- Smoking cessation service – Led by staff
- Advantages - patients who have limited time, patient preference – not wanting support
  - Catching patients from store advertising, brief intervention
  - Often more convenient than appointments at the surgery
  - Healthy Living Stand catches would-be quitters' eyes
  - Able to supply NRT and Champix through PGD
  - Intervention through other services such as MURs, Health Checks
- Disadvantages
  - Limited psychological support
  - Patients' expense (as PGD is a private service)

Healthy Living Campaign

Smoking Cessation

- Target services to patients
  - Idea was to identify smokers and promote services – After establishing they wanted to quit and were currently READY

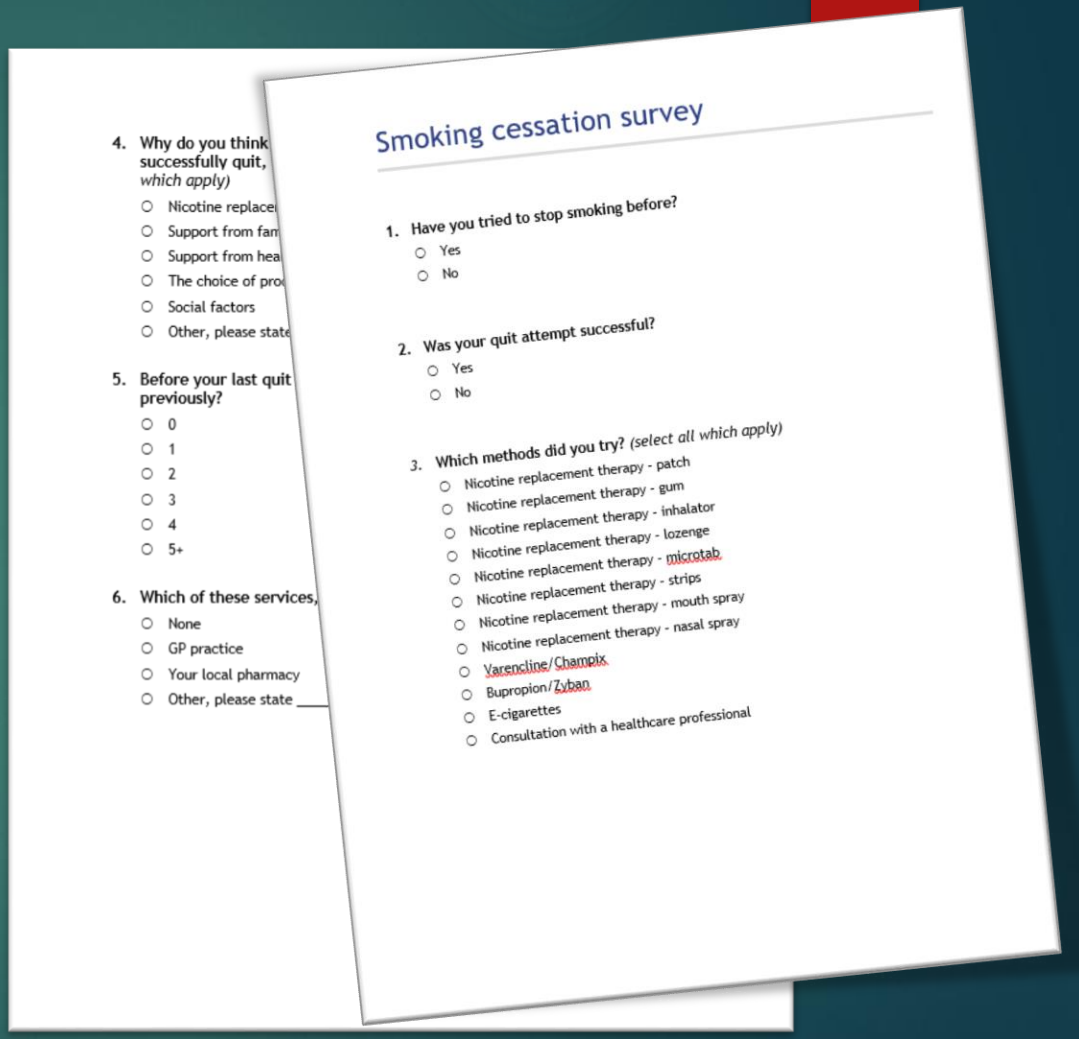
    Evidence shows that patients do much better with support and we therefore wanted to advertise support available and direct patients appropriately. Look at maximising strengths of GP surgery and pharmacy individually and in conjunction with each other.

    Pharmacy has monthly healthy living campaigns – co-ordinate smoking cessation to maximise potential – eg. Stoptober, National No Smoking Day (March)

    Patient survey – previous attempts – why failed?, type of support?, preference – re medication and Input

Survey

- Designed to be simple, tick boxes to ease completion by patients
- Completed by smokers and ex-smokers, both in GP consultations and in the pharmacy

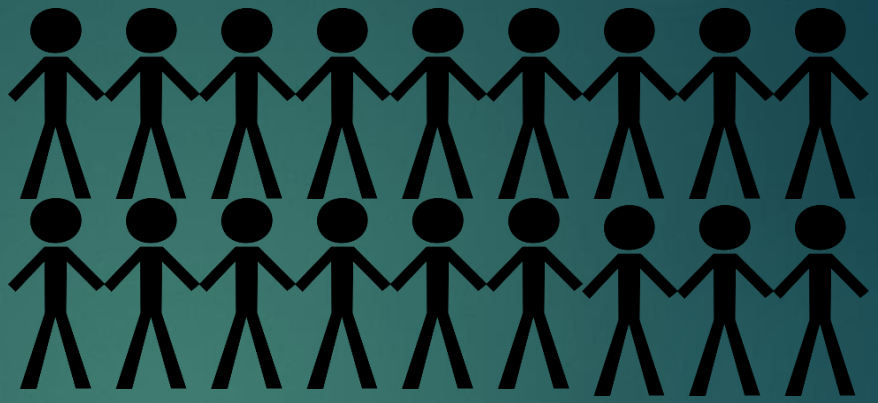


Smoking cessation survey

1. Have you tried to stop smoking before?
   - Yes
   - No
2. Was your quit attempt successful?
   - Yes
   - No
3. Which methods did you try? *(select all which apply)*
   - Nicotine replacement therapy - patch
   - Nicotine replacement therapy - gum
   - Nicotine replacement therapy - inhalator
   - Nicotine replacement therapy - lozenge
   - Nicotine replacement therapy - microtab
   - Nicotine replacement therapy - strips
   - Nicotine replacement therapy - mouth spray
   - Nicotine replacement therapy - nasal spray
   - Varenicline/Champix
   - Bupropion/Zyban
   - E-cigarettes
   - Consultation with a healthcare professional

4. Why do you think
   successfully quit,
   which apply)
   - Nicotine replace
   - Support from fam
   - Support from hea
   - The choice of pro
   - Social factors
   - Other, please state
5. Before your last quit
   previously?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5+
6. Which of these services,
   - None
   - GP practice
   - Your local pharmacy
   - Other, please state

Initial results



- 18 correspondents in total – time limited
- Of these, 15 (83%) have tried to quit previously.
- 7 (46%) of those attempting to quit had done so on their last quit attempt.

Reasons for success/relapse

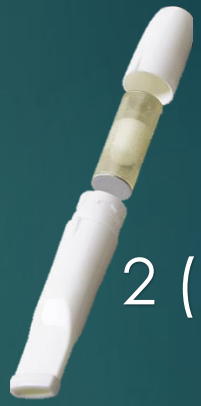
- The most cited reasons for failing to quit were:
  - perceived product effectiveness
  - support from friends & family
  - support from healthcare professionals and
  - "others" where respondents mentioned "lack of support " and "stress" as the main factors.

- The key to success (it seems from this survey) is support from those around them, with "family & friends" and "healthcare professionals" the main driving factors according to patients. Product choice was the next most important reason.

Products used

5 (33%)

6 (40%)

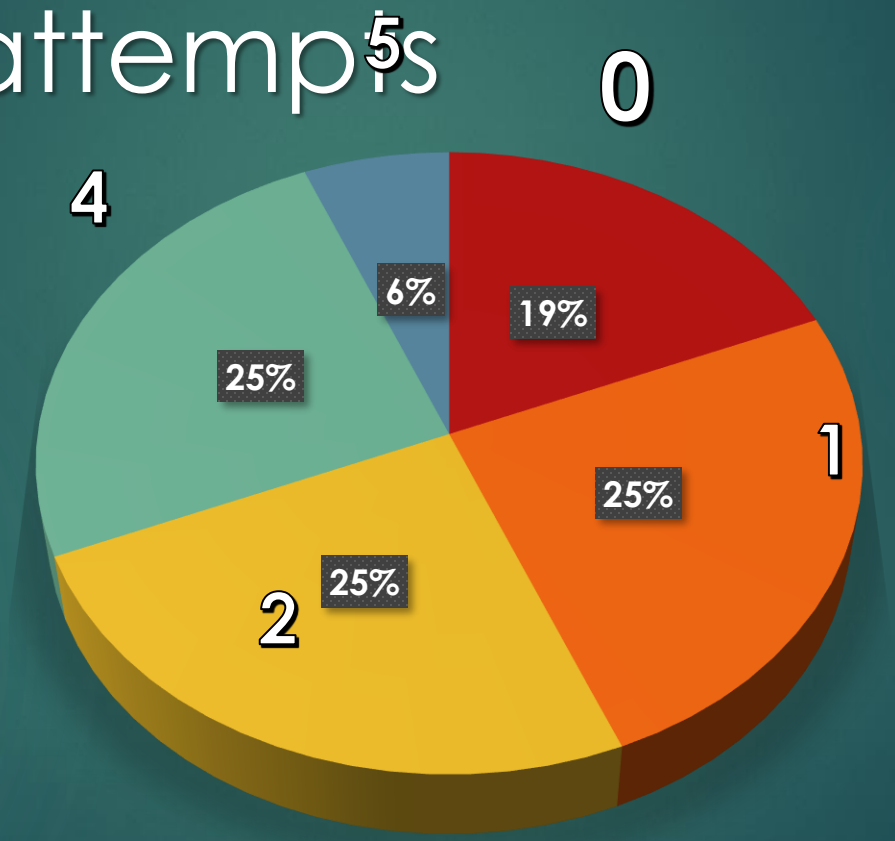


2 (13%)

5 (33%)

7 (46%)

Number of previous quit attempts



Where they sought help to quit

5 (33%)

MEDICAL PRACTICE

7 (47%)

Pharmacy

5 (33%)

Limitations

- Short time frame for survey
  - Limited results –small sample size
    - Unable to follow patients up through their journey
    - Biased sample selection depending on whether successful
    - Contributing life factors

Findings

- Since the GP practice and pharmacy offer very similar services for smoking cessation, collaboration to harness the strengths of both teams would benefit patients, with support from both parties.
- The pharmacy setting is a good place to engage patients with other related services offered, visual displays and carbon monoxide readings being used to spur those considering or attempting to quit on.
- Quite a few people attempted to quit without help from either the GP or pharmacy, and as proven in our survey (and other much larger studies), those who quit with help they are much more likely to be successful.
- A collaborative approach in all patient care will yield much better results for patients.

Recommendations

- Psychological support via pharmacy and follow up
- Promoting pharmacy services in GP setting
- Improve knowledge of product/services available across GPs, nursing staff and all staff at Day Lewis – organise more interprofessional training
- Pharmacist to refer to smoking cessation clinic if needed
- Patient choice - tailor their needs to what is available – look at things from patient perspective and not focus on either GP or pharmacy
- Add smoking cessation service to GP surgery and pharmacy websites

EPS: The Patient's Perspective

DANIELLE BROWN
VALERIE OSUOHA

What is EPS?

The Electronic Prescription Service permits the electronic generation and transmission of prescriptions between community prescribers, dispensers and reimbursement agencies.

Patients have the option to choose or 'nominate' up to three dispensing contactors which include;

one community pharmacy,

one dispensing contractor and

one dispensing GP practice.

Benefits to our Practices

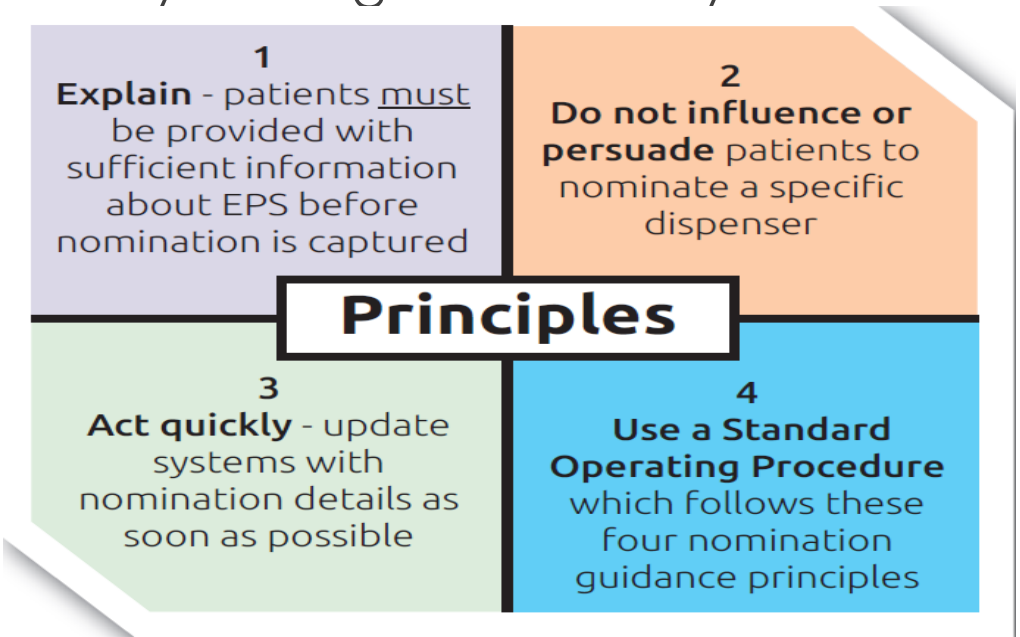
GP Surgeries		Community Pharmacy	
Advantages	Disadvantages	Advantages	Disadvantages
-Can Process Rx more effectively -Have Greater control of the prescriptions -Spend less time dealing with Rx queries	Solely dependent on an electronic system which can fail/breakdown. -More effort to clinically check prescriptions	-Reduce administration at End of month submissions. -Reduced dispensing errors -Reduced need for collection service -Improved stock control -consistent/ guarantied business from patients.	Solely dependent on an electronic system which can fail/breakdown.

What Does EPS Promise Patients?

- Reduced waiting times in the pharmacy.
- No paper prescriptions to lose
- No need to pick up repeat prescriptions from the surgery.
- Flexibility to choose and cancel nominations, based on patient convenience
- Reliable, Secure and confidential Service

How do patients access EPS?

1. Find out which dispensing contractors provide EPS in your area
2. You'll then need to nominate the chosen contractor
3. You can always change or cancel your nomination.



QIA: Aim

- To assess Patients understanding of the service
- To assess patients confidence in the EPS
- To assess whether EPS had been beneficial to patients

QIA: Method

Generate a Questionnaire to give out to patients at the pharmacy and GP surgery. Questions:

1. How did you hear about the service?

2. Were you asked for consent (either written or verbal) before being nominated for this service?

3. Was joining the Electronic Prescription Service a simple process?

4. Do you consider the Electronic Prescription Service to be reliable?

5. Do you consider the Electronic Prescription Service to be secure and confidential?

6. Have you noticed a shorter waiting time at the pharmacy now that you use the Electronic Prescription Service?

7. Have you ever had to change your nominated pharmacy/dispensing appliance contractor/ dispensing GP practice? If you answered "yes" for question 7, was it a straightforward transfer?

8. Would you recommend this service to a friend?

QIA: Results

The questionnaires were available for patient to complete at both practices and results were collected over a week.

We gathered a small sample size of 15 completed questionnaires

"Quite happy with Service"

100% expressed that joining EPS was a simple process.

QIA: Results

How did you hear about the service?

QIA: Results

Were you asked for consent (either written or verbal) before being nominated for this service?

QIA: Results

Do you consider the Electronic Prescription Service to be reliable, secure and confidential?

QIA: Results

Have you noticed a shorter waiting time at the pharmacy now that you use the Electronic Prescription Service?

Conclusions

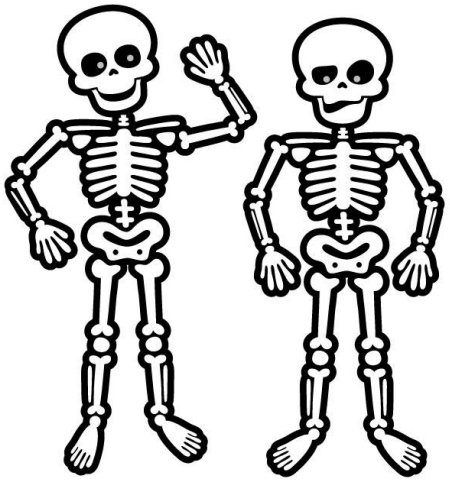
- Most patients heard about the services from their pharmacy. Endorsement from GP surgeries needs to improve.
- Not all patients recall being asked for consent, written documentation of this needs to be completed.
- Not all patients feel that their waiting time has shortened.
- EPS is a trusted service
- Waiting times are not significantly improved for all patients
- Overall most patients would recommend it to a friend
- Further research with larger sample size may reveal more accurate picture of patient satisfaction

Thank you

The Use of Long-term Oral Bisphosphonate Therapy

Fiby Paul

Joanna Wykes



Introduction!!

- Recent studies have shown that the long-term use of oral bisphosphonate treatment (>5 years) may be associated with increased risk of atypical hip fractures.[1]

- Discontinuation of bisphosphonate therapy in patients suspected as having an atypical femur fracture should be considered and future treatment for osteoporosis should proceed only after weighing the benefits and risks.

Focus group

- **Inclusion Criteria**:

  -Postmenopausal women on Alendronic acid for > 5 years

- **Exclusion criteria**
  - >75 years
  - previous history of a hip or vertebral fracture
  - occurrence of one or more low trauma fractures during treatment
  - current treatment with oral glucocorticoids ≥7.5 mg prednisolone/day or equivalent

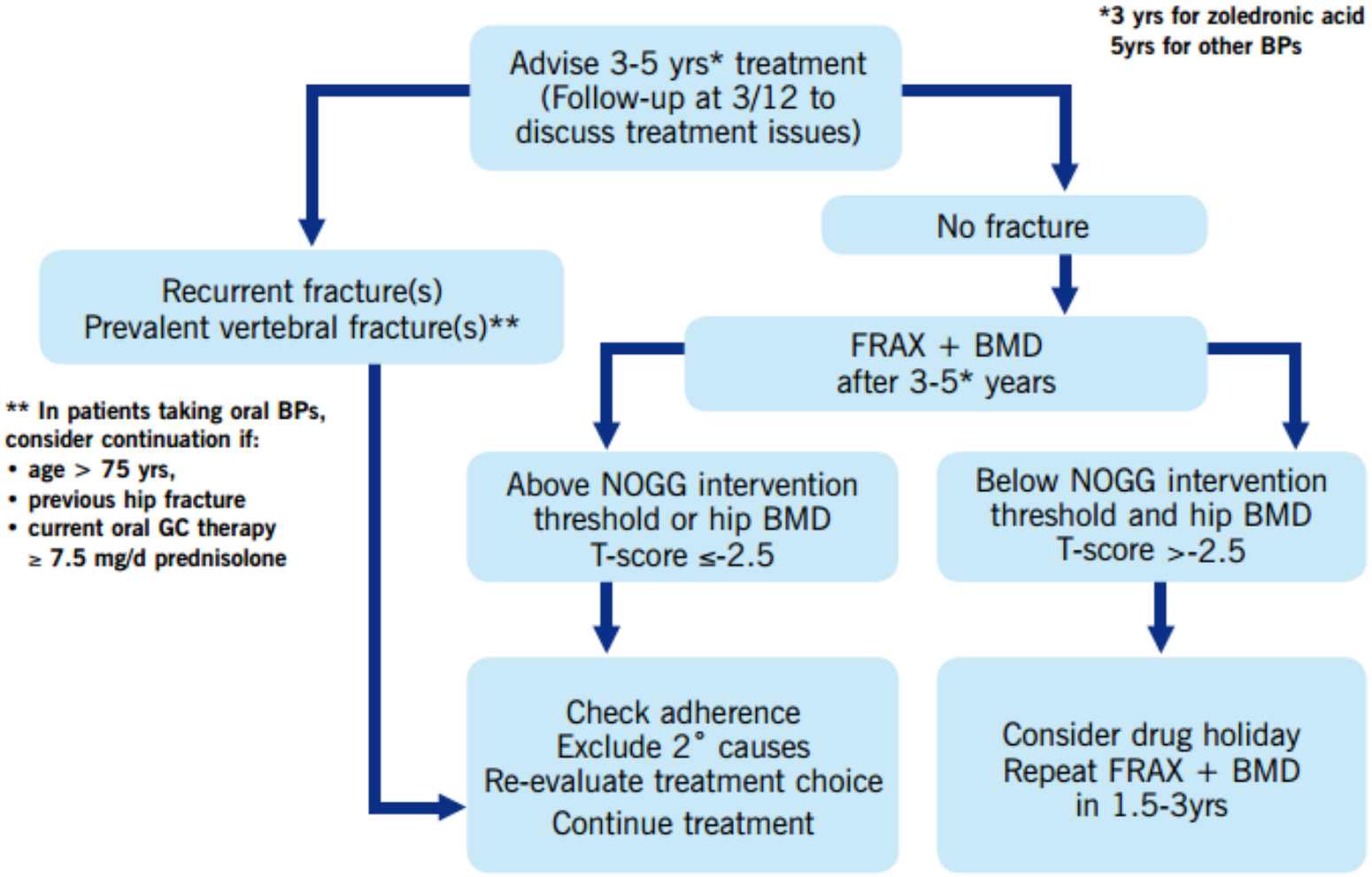
FRAX tool

- FRAX has been validated as an effective assessment tool for fracture risk in individuals on bisphosphonate treatment.

- FRAX (+/− BMD) can be used to calculate an individual's risk and used alongside NOGG intervention thresholds to guide the decision as to whether treatment can be stopped for a period of time.

- https://www.sheffield.ac.uk/FRAX/tool.jsp

Bisphosphonates: algorithm for long-term treatment monitoring



Compston et al 2014

BPs – bisphosphonates

GCs - glucocorticoids

- **Low risk** – Reassure, give lifestyle advice, consider a bisphosphonate ‘drug holiday’

- **Intermediate risk** – Measure BMD. − If BMD > −2.5 SD consider bisphosphonate ‘drug holiday’ − Use FRAX® and BMD measurement to recalculate fracture risk. If below the intervention threshold consider bisphosphonate ‘drug holiday’

- **High risk** – Continue treatment without the need for BMD assessment, although it may be appropriate to measure BMD in certain clinical situations

Reassessment

- For patients on bisphosphonate holiday:
  - after a new fracture regardless of when this occurs.
  - if no new fracture occurs, after two years

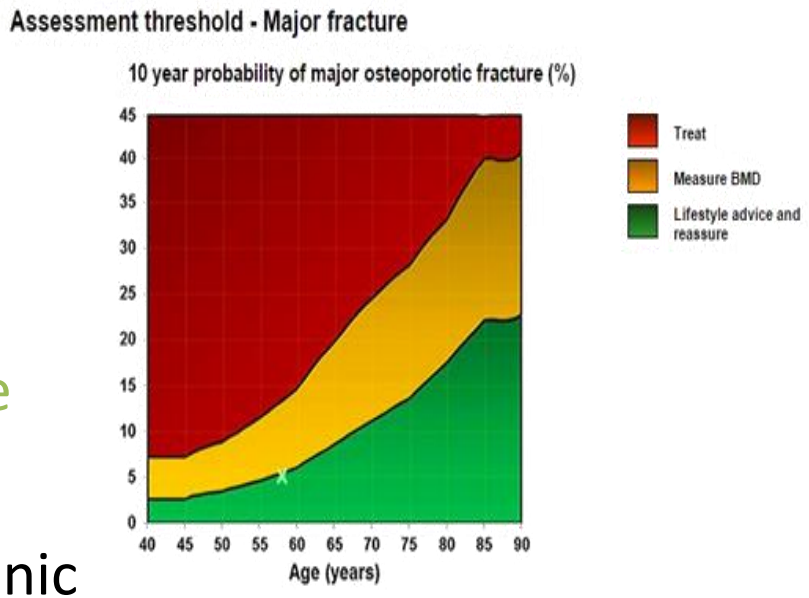
- Ensure adequate intake of Ca and Vit D in all patients.

Data collection

- Search on EMIS
- Patients with alendronic acid for at least 5 years and ongoing currently
- Excluding
  - >75 years
  - Previous hip fracture
  - Previous vertebral fracture
  - Low trauma fracture since treatment
  - Current treatment with oral glucocorticoids ≥ 7.5mg prednisolone or greater

Results: risk assessment

- 5 patients identified
- FRAX scores



- **Patient 1**: FRAX score: lifestyle advice and reassurance but… recurrent courses of prednisolone and alendronic acid started by rheumatology… offered scan

- **Patient 2**: FRAX score: lifestyle advice and reassurance but… T score on last DEXA -2.7 which would suggest treatment… offered scan

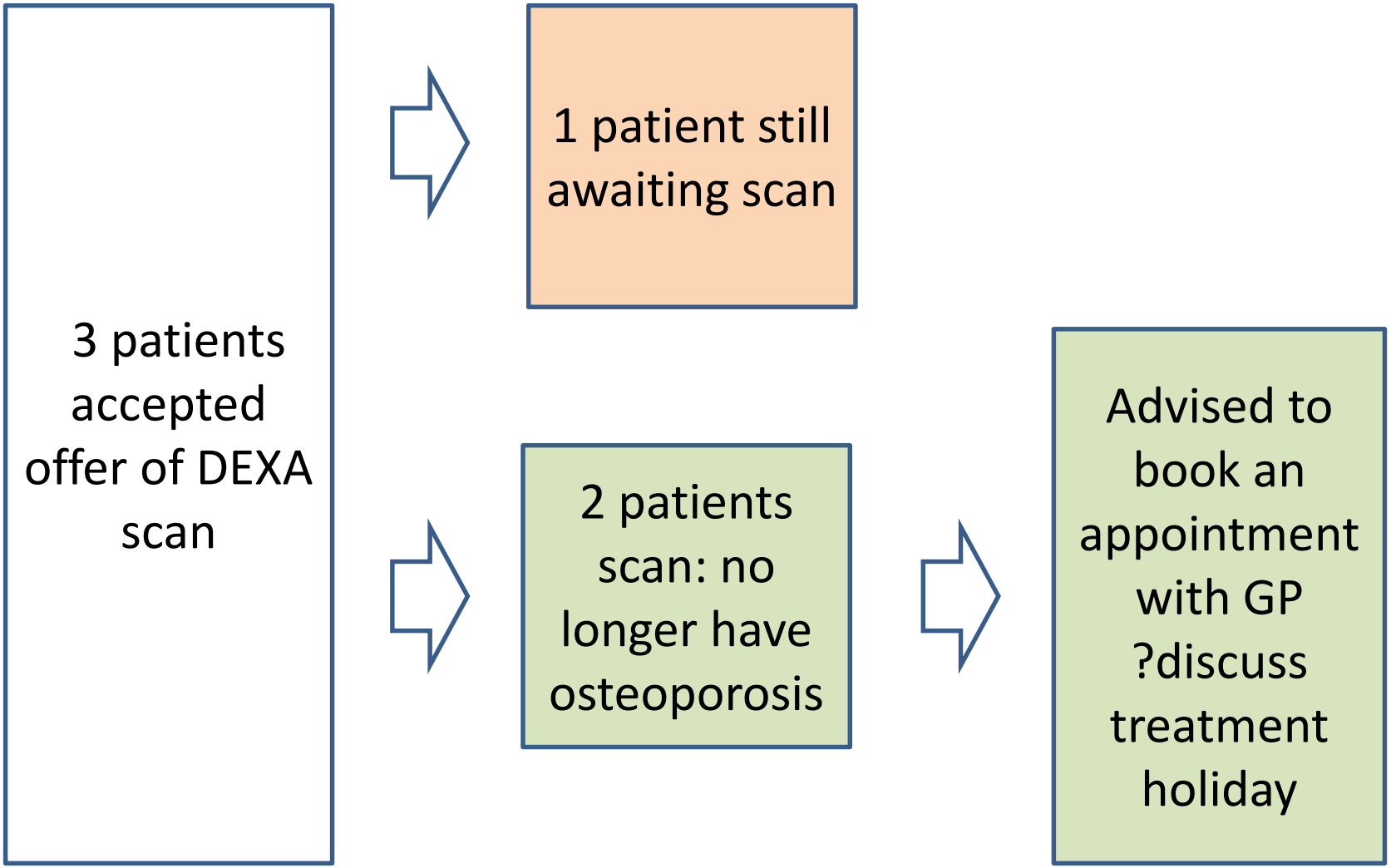
Results: continued

- **Patient 3:** FRAX score: measure bone mineral density, patient happy to have scan

- **Patient 4:** FRAX score: needing treatment, continued

- **Patient 5:** FRAX score: lifestyle advice and reassurance. Patient called, told by rheumatologist “spine crumbling” and loosing height. Treatment continued without scanning.

Results: continued



Conclusion

- Low numbers of patients on alendronic acid > 5 years who need reassessment

- Some areas of uncertainty not covered by the guidelines e.g. “losing height due to “crumbling spine””, recurrent previous courses prednisolone

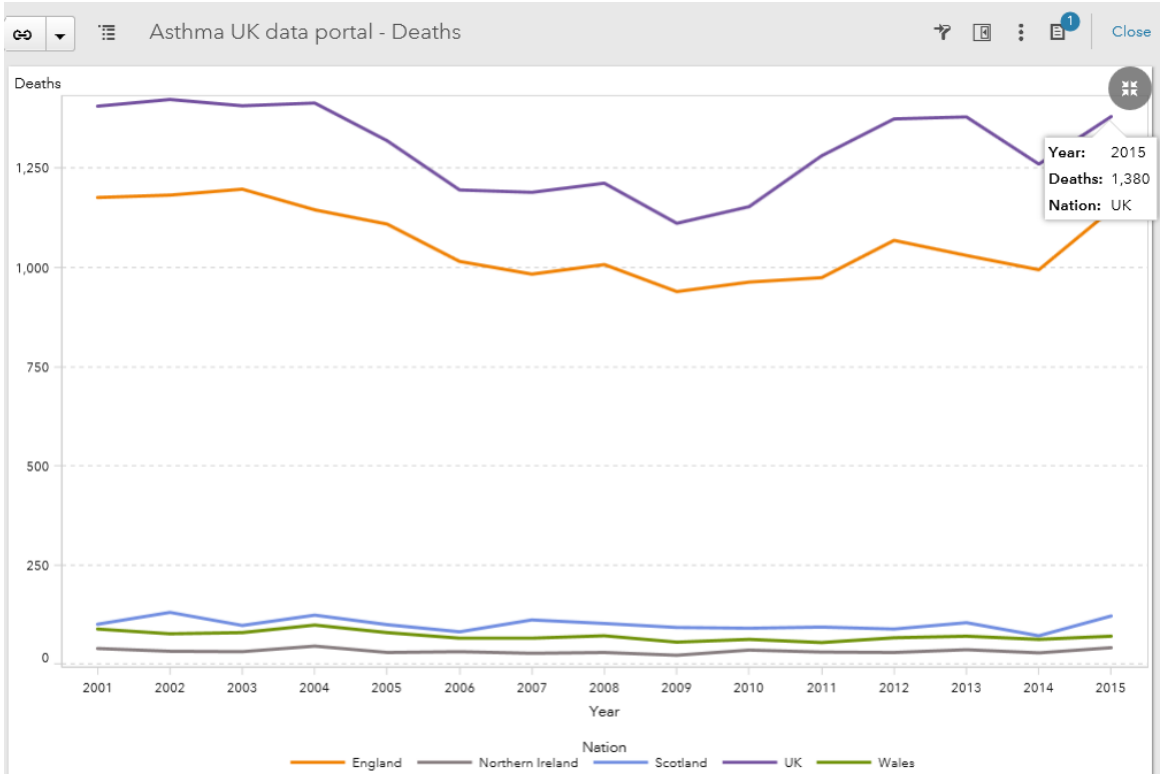
- Relatively high cost audit
  - 3/5 people having a scan
  - Not stopped anyone’s alendronic acid (yet!)

- On the positive side
  - Able to reauthorise 12 months alendronic acid for several patients
  - We have reviewed 5 patient’s alendronic acid

VENTOLIN PRESCRIBING IN PEACEHAVEN

Presented by Dr Dharam Dickinson
& Lisa Morgan

DEATHS FROM ASTHMA IN UK 2015 = 1,380
21 WERE BETWEEN 0-19 YEARS OLD



AIMS OF AUDIT

- Identify overuse of short acting beta agonist – Ventolin inhalers in patients
- Highlight these patients to pharmacy staff to counsel on inhaler use
- Flag patients for review and inform their GP of their overuse of Ventolin

BRITISH THORACIC SOCIETY GUIDELINES

PHARMACOLOGICAL MANAGEMENT

The aim of asthma management is control of the disease. Complete control is defined as:

- no daytime symptoms
- no night-time awakening due to asthma
- no need for rescue medication
- no asthma attacks
- no limitations on activity including exercise
- normal lung function (in practical terms FEV_1 and/or PEF >80% predicted or best)
- minimal side effects from medication.

APPROACH TO MANAGEMENT

1. Start treatment at the level most appropriate to initial severity.
2. Achieve early control.
3. Maintain control by:
   - increasing treatment as necessary
   - decreasing treatment when control is good.

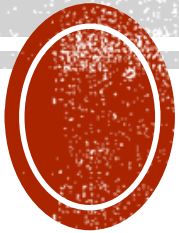
✓ Before initiating a new drug therapy practitioners should check adherence with existing therapies, check inhaler technique and eliminate trigger factors.

METHODS

Sample – Search on Proscript: Patients prescribed "Ventolin Evohaler 100mcg/ in last 6 months

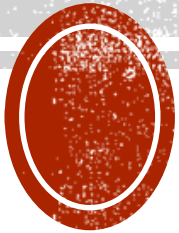
Sample size = 256 patients

Results checked and patients requiring more than 8 Ventolin inhalers selected for audit

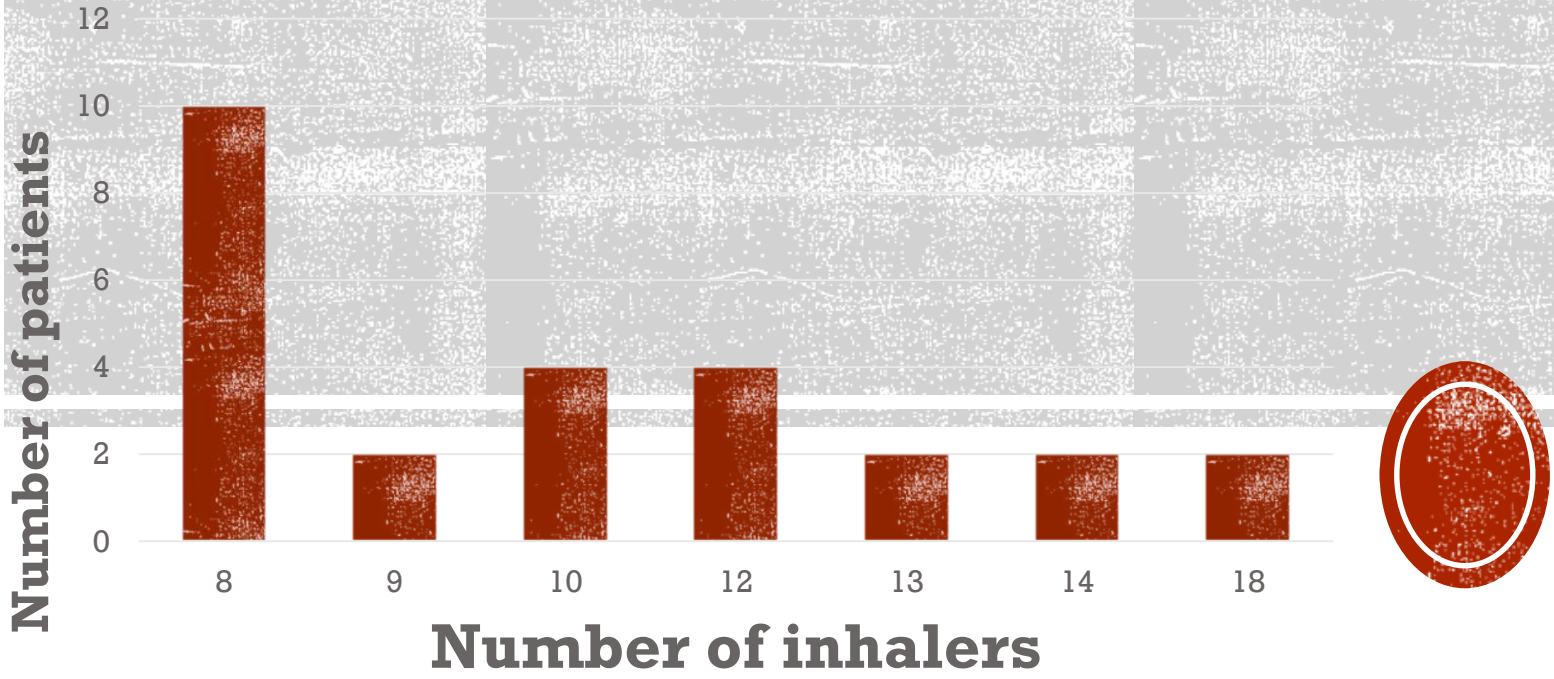


RESULTS

26 patients had received over 8 Ventolin Inhalers within the 6 month period



Ventolin inhalers in last 6 months



RECOMMENDATIONS FOR PHARMACIES

For pharmacist to intervene if patient prescribed an average of more than one per month

- Ad hoc checking history of dispensed inhalers:
- Invite review at pharmacy – ring / sticker
- Is a spacer issued / inhaler technique
- alert GP email / fax / send back token with note on

RECOMMENDATIONS FOR GPS

For patients who continue to require high volume of inhalers who have not attended a review gp to consider:

Escalation procedure

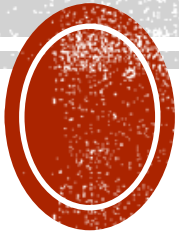
We assume script messages and letter invitations for reviews have been attempted

Contacting patient by phone / personal letter

Limit quantities – how can this be done safely?

Change to private script - discussion point

Children - engage parents, may need to consider social services

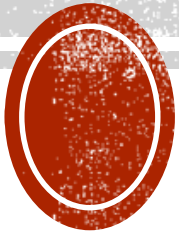


LIMITATIONS

Patients could be stockpiling inhalers, i.e. does not represent poor control.

Those patients who are high use most likely non responders for GP review so unlikely to attend pharmacy review?

We only looking at one reliever medication (not included generic salbutamol, easibreath or other SABAs)



We are not looking at maintenance therapy in this audit.

PROBLEMS WITH POOR ASTHMA CONTROL

Impact on quality of life / limitation of daily activity > co morbidities

Patients should be able to live symptom free, this aim often not being achieved based on data from reliever medication dispensing.

Cost:

Costs to NHS- No. of hospital admissions / GP visits / medications

Loss of earnings impact on overall economy

QUESTIONS?

REFERENCES

- https://data.asthma.org.uk/SASVisualAnalyticsViewer/VisualAnalyticsViewer_guest.jsp?reportName=Asthma+UK+data+portal&reportPath=/Shared+Data/Guest/&reportViewOnly&_ga=2.107334914.1044130918.1499250437-1648531196.1499250437

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