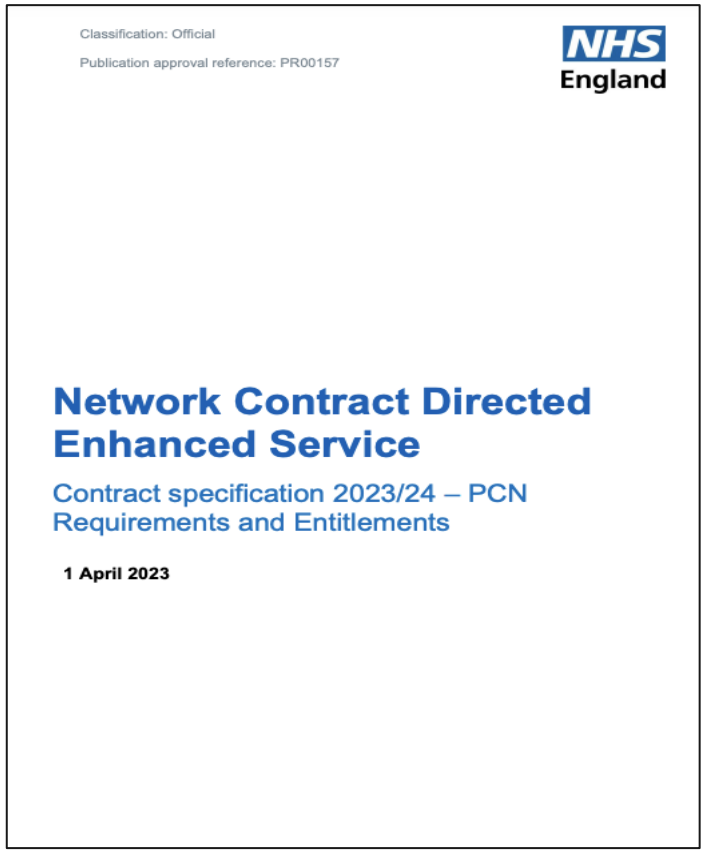
Practice Plus Webinar

24th May 2023

Steve Williams

Lead Clinical Pharmacist
PrescQIPP Practice Plus



Classification: Official

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NHS England

Network Contract Directed Enhanced Service

Contract specification 2023/24 – PCN Requirements and Entitlements

1 April 2023

8.2. Medication Review and Medicines Optimisation

8.3. A PCN is required to:

a. use appropriate tools to identify and prioritise the PCN's Patients who would benefit from a structured medication review (referred to in this Network Contract DES Specification as a "**SMR**"), which must include patients:

i. in care homes[50];

ii. with complex and problematic polypharmacy, specifically those on 10 or more medications;

iii. on medicines commonly associated with medication errors[51];

iv. with severe frailty[52], who are particularly isolated or housebound patients, or who have had recent hospital admissions and/or falls; and

v. using one or more potentially addictive medications from the following groups: opioids, gabapentinoids, benzodiazepines and z-drugs;

b. offer and deliver a volume of SMRs determined and limited by the PCN's clinical pharmacist capacity, and the PCN must demonstrate reasonable ongoing efforts to maximise that capacity;

c. ensure invitations for SMRs provided to patients explain the benefits of, and what to expect from SMRs;

d. ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs. The PCN must also ensure that these professionals undertaking SMRs have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop this qualification and skills;

e. clearly record all SMRs within GP IT systems;

f. actively work with its CCG in order to optimise the quality of local prescribing of:

i. antimicrobial medicines;

ii. medicines which can cause dependency;

iii. metered dose inhalers, where a lower carbon device may be appropriate; and

iv. nationally identified medicines of low priority;[53]

Triggers for a structured medication review

Proactive

Polypharmacy data tool or similar identifies person as being potentially 'at risk' or as being 'at risk from harm' from multiple medicines.

Reactive

Crisis or incident such as admission to hospital should be explored to see if polypharmacy is a contributory factor. Consider also if carer becomes poorly then medication issues may become acute for the person they care for.

Reactive

Person highlights concern about the growing number of medicines they are being asked to take.

Reactive

Healthcare professional or healthcare worker highlights concern about the growing number of medicines a person is trying to manage.

Holistic, structured medication review should aim to:

- Identify and discuss the person's goals
- Identify and discuss any adherence issues
- Identify and assess medicines with potential risks to cause harm
- Identify and assess the use of any unnecessary medicines
- Agree with the person the actions to be taken regarding medicines, including stopping
- Share any decisions with the person, their carers, healthcare professionals, pharmacist
- Review and adjust as needed or refer if required.

Healthcare professionals to ensure they are skilled in good consultations and shared decision making

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SMRs 2023/24 : Points for PCN discussion

- Pharmacist availability
- Role of Pharmacy Technicians
- Agree PCN prioritisation list
- Need better data analytics to help stratify patients
- Booking system
- Consider a quality and outcomes measurement (23/24 QI DES)
- Link to QOF / Long Term Condition reviews if possible

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SMR Evidence

Syafhan et al. J of Pharm Policy and Pract (2021) 14:4
https://doi.org/10.1186/s40545-020-00279-3

Journal of Pharmaceutical Policy and Practice

RESEARCH Open Access

General practitioner practice-based pharmacist input to medicines optimisation in the UK: pragmatic, multicenter, randomised, controlled trial

Nadia Farhanah Syafhan[1,2], Sayer Al Azzam[1,3], Steven D. Williams[4,5], Wendy Wilson[6], Jayne Brady[6], Peter Lawrence[7], Mark McCrudden[8], Mustafa Ahmed[9,10], Michael G. Scott[11], Glenda Fleming[11], Anita Hogg[11], Claire Scullin[11], Robert Horne[12], Harblas Ahir[13] and James C. McElnay[1*]

Abstract

Background: Changing demographics across the UK has led to general practitioners (GPs) managing increasing numbers of older patients with multi-morbidity and resultant polypharmacy. Through government led initiatives within the National Health Service, an increasing number of GP practices employ pharmacist support. The purpose of this study is to evaluate the impact of a medicines optimisation intervention, delivered by GP practice-based pharmacists, to patients at risk of medication-related problems (MRPs), on patient outcomes and healthcare costs.

Methods: A multi-centre, randomised (normal care or pharmacist supplemented care) study in four regions of the UK, involving patients ($n=356$) from eight GP practices, with a 6-month follow-up period. Participants were adult patients who were at risk of MRPs.

Results: Median number of MRPs per intervention patient were reduced at the third assessment, i.e. 3 to 0.5 ($p<0.001$) in patients who received the full intervention schedule. Medication Appropriateness Index (MAI) scores were reduced (medications more appropriate) for the intervention group, but not for control group patients (8 [4–13] to 5 [0–11] vs 8 [3–13] to 7 [3–12], respectively; $p=0.001$). Using the intention-to-treat (ITT) approach, the number of telephone consultations in intervention group patients was reduced and different from the control group (1 [0–3] to 1 [0–2] vs 1 [0–2] to 1 [0–3], $p=0.020$). No significant differences between groups were, however, found in unplanned hospital admissions, length of hospital stay, number of A&E attendances or outpatient visits. The mean overall healthcare cost per intervention patient fell from £1041.7 ± 1446.7 to £859.1 ± 1235.2 ($p=0.032$). Cost utility analysis showed an incremental cost per patient of − £229.0 (95% CI − 594.6, 128.2) and a mean QALY gained of 0.024 (95% CI − 0.021 to 0.065), i.e. indicative of a health status gain at a reduced cost (2016/2017).

Conclusion: The pharmacist service was effective in reducing MRPs, inappropriateness of medications and telephone consultations in general practice in a cost-effective manner.

Trial registration: ClinicalTrials.Gov, NCT03241498. Registered 7 August 2017—Retrospectively registered, https://clinicaltrials.gov/ct2/show/NCT03241498

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The effectiveness and cost of integrating pharmacists within general practice to optimize prescribing and health outcomes in primary care patients with polypharmacy: a systematic review

Aisling Croke[1], Karen Cardwell[2], Barbara Clyne[1], Frank Moriarty[3], Laura McCullagh[4,5] and Susan M. Smith[1,6*]

Croke *et al. BMC Primary Care (2023) 24:41*
https://doi.org/10.1186/s12875-022-01952-z

Abstract

Background Polypharmacy and associated potentially inappropriate prescribing (PIP) place a considerable burden on patients and represent a challenge for general practitioners (GPs). Integration of pharmacists within general practice (herein 'pharmacist integration') may improve medications management and patient outcomes. This systematic review assessed the effectiveness and costs of pharmacist integration.

Methods A systematic search of ten databases from inception to January 2021 was conducted. Studies that evaluated the effectiveness or cost of pharmacist integration were included. Eligible interventions were those that targeted medications optimization compared to usual GP care without pharmacist integration (herein 'usual care'). Primary outcomes were PIP (as measured by PIP screening tools) and number of prescribed medications. Secondary outcomes included health-related quality of life, health service utilization, clinical outcomes, and costs. Randomised controlled trials (RCTs), non-RCTs, interrupted-time-series, controlled before-after trials and health-economic studies were included.

Screening and risk of bias using Cochrane EPOC criteria were conducted by two reviewers independently. A narrative synthesis and meta-analysis of outcomes where possible, were conducted; the certainty of evidence was assessed using the Grading of Recommendations, Assessment, Development and Evaluation approach.

Results In total, 23 studies (28 full text articles) met the inclusion criteria. In ten of 11 studies, pharmacist integration probably reduced PIP in comparison to usual care (moderate certainty evidence). A meta-analysis of number of medications in seven studies reported a mean difference of -0.80 [-1.17, -0.43], which indicated pharmacist integration probably reduced number of medicines (moderate certainty evidence). It was uncertain whether pharmacist integration improved health-related quality of life because the certainty of evidence was very low. Twelve health-economic studies were included; three investigated cost effectiveness. The outcome measured differed across studies limiting comparisons and making it difficult to make conclusions on cost effectiveness.

Conclusions Pharmacist integration probably reduced PIP and number of medications however, there was no clear effect on other patient outcomes; and while interventions in a small number of studies appeared to be cost-effective, further robust, well-designed cluster RCTs with economic evaluations are required to determine cost-effectiveness of pharmacist integration.

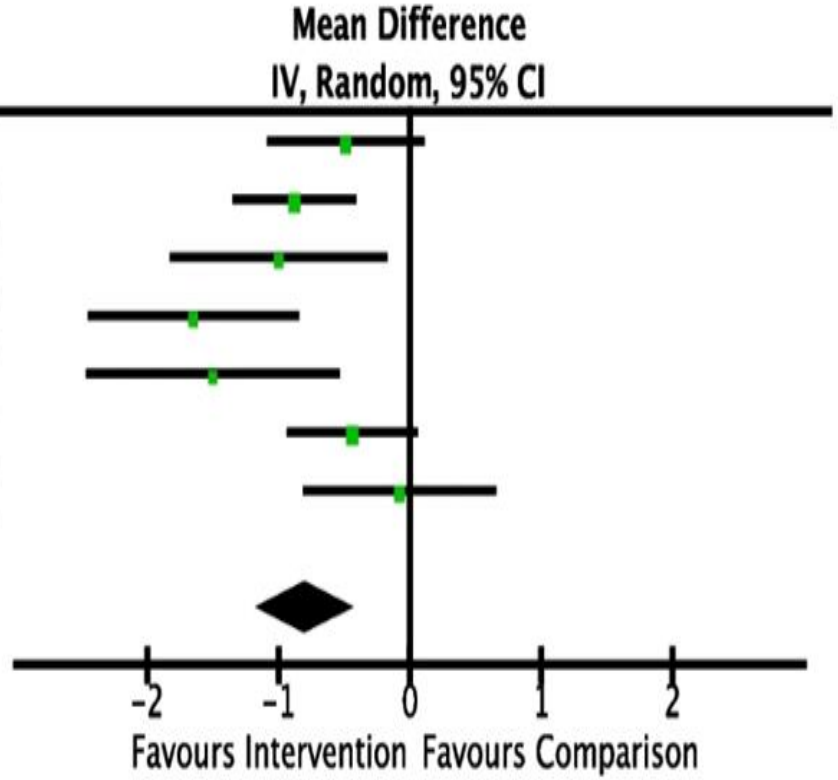
Trial registration CRD42019139679.

Keywords Polypharmacy, Potentially inappropriate prescribing, Primary care, Systematic review, Clinical pharmacist, Medication review

Study or Subgroup	Intervention Mean	SD	Total	Control Mean	SD	Total	Weight	Mean Difference IV, Random, 95% CI
Britton 1991	8.51	3.54	315	9	3.47	257	16.0%	-0.49 [-1.07, 0.09]
Campins 2017	10.03	2.52	252	10.91	2.65	251	18.9%	-0.88 [-1.33, -0.43]
Hanlon 1996	6.9	2.6	105	7.9	3.3	103	11.7%	-1.00 [-1.81, -0.19]
Leneghan 2007	8.68	2.33	69	10.33	2.33	67	12.1%	-1.65 [-2.43, -0.87]
Taylor 2003	4.7	2	33	6.2	2	36	9.7%	-1.50 [-2.44, -0.56]
Verdoorn 2019	9.53	2.8	292	9.97	3.1	295	18.3%	-0.44 [-0.92, 0.04]
Vinks 2009	8.32	2.5	87	8.4	2.3	87	13.3%	-0.08 [-0.79, 0.63]
Total (95% CI)			**1153**			**1096**	**100.0%**	**-0.80 [-1.17, -0.43]**

Heterogeneity: $Tau^2 = 0.14$; $Chi^2 = 13.96$, df = 6 (P = 0.03); $I^2 = 57\%$

Test for overall effect: Z = 4.22 (P < 0.0001)



Meta-analysis of number of medications

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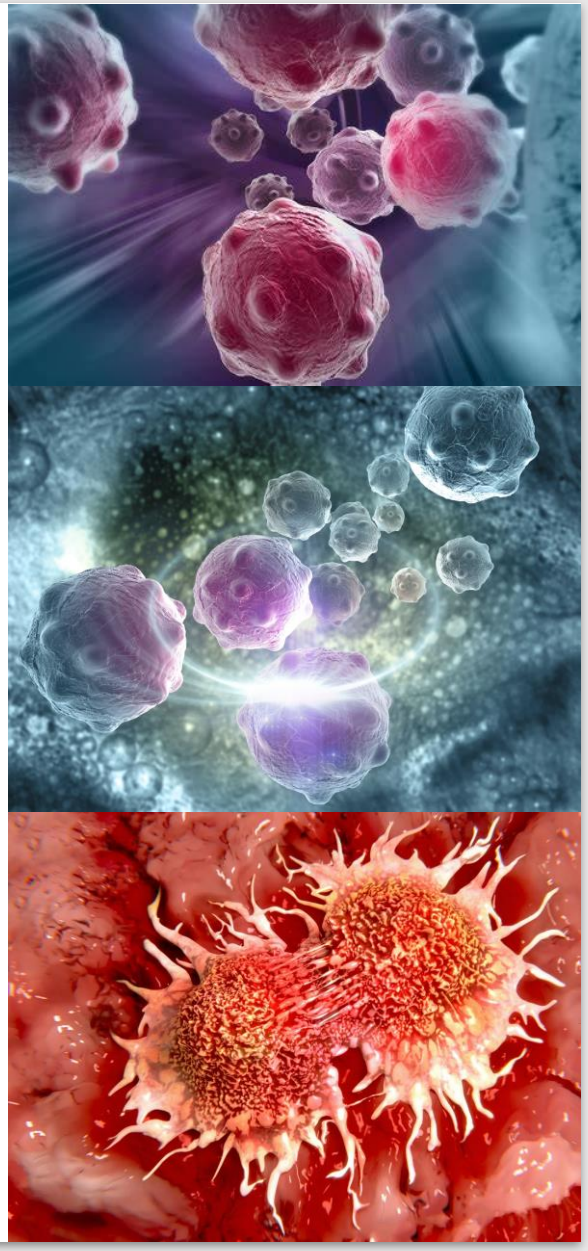
Pharma & the Big C

Emma Foreman
Consultant Pharmacist at The Royal Marsden NHS Foundation Trust



Important cancer vocabulary

Stage

Grade

Subtype

Curative

Adjuvant

Radical

Palliative

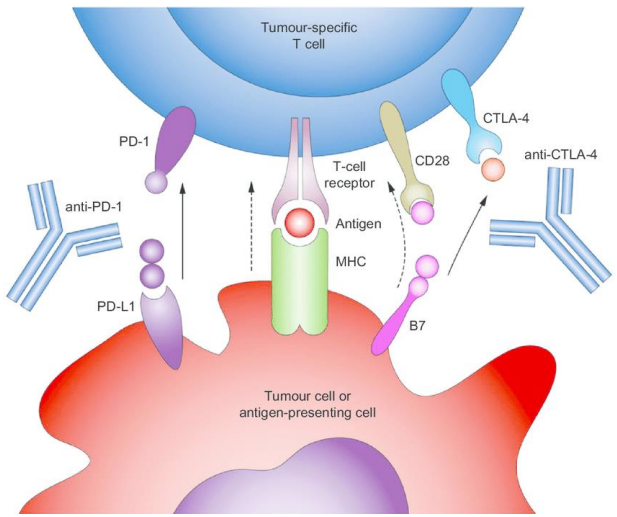
Symptom control

Terminal

End of Life

Cytotoxic chemotherapy

TKi's and other small molecule targeted treatments



Immune checkpoint inhibitors and other immunotherapies

Targeted monoclonal antibodies and ADCs

-nibs, sibs, ciclibs and paribs!

BRAFV600E and MET (melanoma, GI cancers)
Da**braf**enib+tra**met**inib, enco**raf**enib + bini**met**inib

VEGF (renal cancer, sarcoma, thyroid)
Sunitinib, cabozantinib, lenvatinib, axitinib

BCR-ABL (CML, leukaemia, GIST)
Imatinib, nilotinib, dasatinib

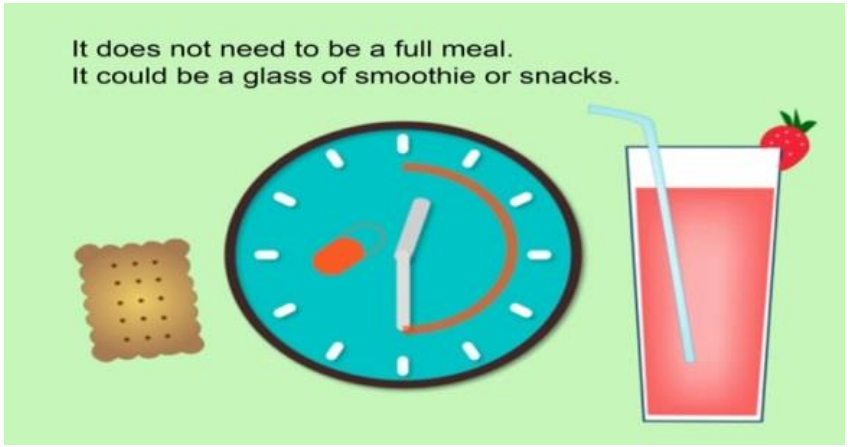
PI3K (CLL, FL)
Idelali**sib**

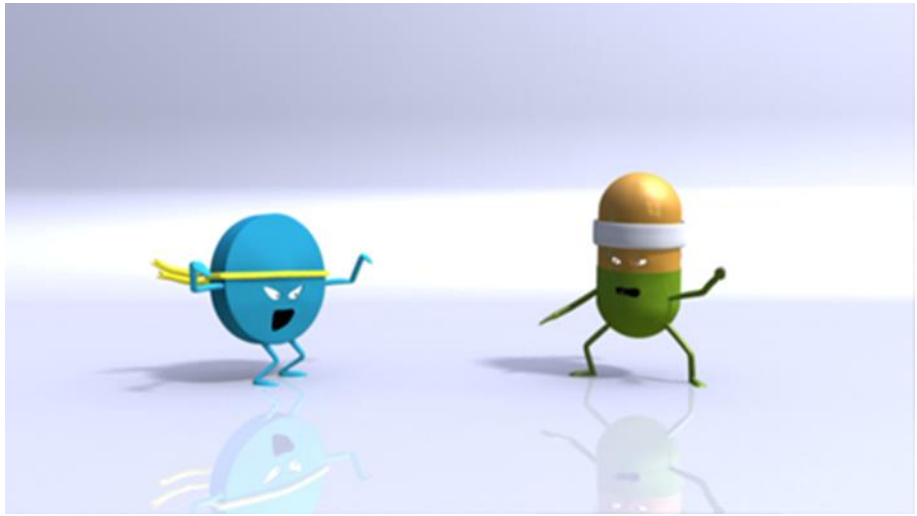
CDK inhibitors (breast cancer)
Palbo**ciclib,** ribo**ciclib,** abema**ciclib**

PARPi (ovarian, breast, ?prostate)
Ola**parib**, nira**parib**, ruca**parib**

TKi's and other small molecule targeted treatments


Nexavar 200mg
SUTENT
12.5 mg


It does not need to be a full meal.
It could be a glass of smoothie or snacks.



MABS!

HER2 (breast)
Trastuzumab (Herceptin), pertuzumab, Phesgo©, trastuzumab emtansine

EGFR (colorectal)
cetuximab, panitumumab

CD-20 (NHL, B-cell leukaemias)
Rituximab (aka vitamin R!), obinatuzumab

VEG-F (ovarian, colorectal)
Bevacizumab

CD-30 (HL)
Brentuximab vedotin

Targeted monoclonal antibodies and ADCs

Toxicities of targeted therapies

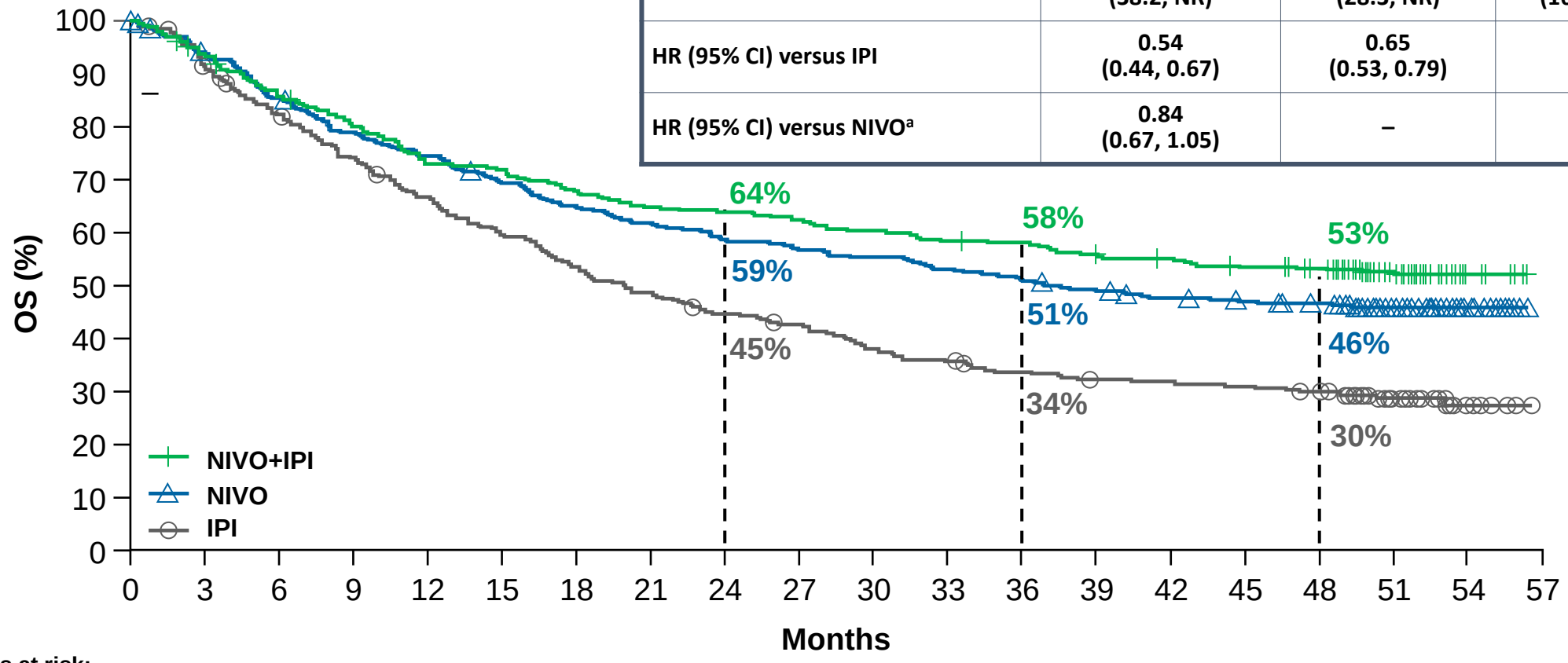
- On target
  - Related to the pharmacological mechanism of the drug
    - E.g. VEGF targeted Tkis – hypertension, poor wound healing
    - E.g. EGFR rash
    - E.g. HER2 targeted MABs – impaired LVEF

- Off-target
  - Unpredictable, mechanisms not (yet) fully understood

Immunotherapy

Overall Survival from Checkmate 067 trial (advanced melanoma)

	NIVO+IPI (n = 314)	NIVO (n = 316)	IPI (n = 315)
Median OS, mo (95% CI)	NR (38.2, NR)	36.9 (28.3, NR)	19.9 (16.9, 24.6)
HR (95% CI) versus IPI	0.54 (0.44, 0.67)	0.65 (0.53, 0.79)	–
HR (95% CI) versus NIVO[a]	0.84 (0.67, 1.05)	–	–



Patients at risk:

NIVO+IPI	314	292	265	247	226	221	209	200	198	192	186	180	178	171	166	160	154	96	13	0
NIVO	316	292	266	245	231	214	201	191	181	175	171	164	158	150	144	140	135	85	18	0
IPI	315	285	253	227	203	181	163	148	135	128	113	107	99	94	93	90	86	50	11	0

[a]Descriptive analysis

Side effects of immunotherapies

- Auto-immune related side effects include:
  - Pruritis
  - Colitis
  - Pneumonitis
  - Hepatitis
  - Endocrinopathies including hypothyroidism and hyperthyroidism, diabetes
  - Nephritis (severe)
  - Neuropathy
  - Adrenal insufficiency
  - Myocarditis

STEROIDS!!!!

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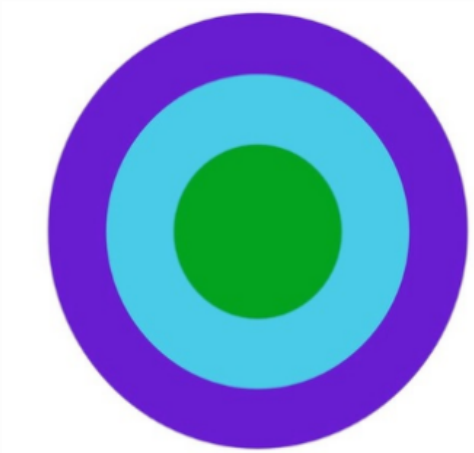

NEW E-LEARNING Let's Communicate Cancer

By BOPA on 31st March 2021

BOPA are pleased to launch the 'Lets Communicate Cancer Series'

Let's Communicate Cancer is free and easily accessible e-learning where you can learn about cancer from basics to detail. It is presented as bite-sized videos, animation, quizzes and slide shows. The e-learning will give you confidence and knowledge to help your cancer patients – from early diagnosis through treatment.

Lets Communicate Cancer is aimed at ALL staff working in the pharmacy and beyond.

Go to www.bopa.org.uk and click on the logo or access via the Courses section. You must be a FREE or PAID member to access.

Join here for FREE

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Financial support was provided by Pfizer Limited as a Medical and Educational Goods and Service

Future Practice Plus Webinars

Date	Key themes	Guest Presenters
21st June 2023	Clinician Decisions Aids for SDM around preventative medicines	Dr Julian Treadwell Research Fellow and GP Nuffield Department of Primary Care Health Sciences
19th July 2023	SMRs in patients with active Cancer Part 2	Emma Foreman Consultant Pharmacist at The Royal Marsden NHS Foundation Trust
16th August 2023 TBC	Medico-legal prescribing issues	Steve Williams Lead Clinical Pharmacist PrescQIPP Practice Plus ANO

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