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Pharmacy Role in Supporting Medicines Optimisation in Respiratory Medicine

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Pharmacy Adherence Support in Respiratory Medicine

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1. Introduction to the National Asthma Biologics Programme

Four biologics Reslizumab[1], Benralizumab[2], Mepolizumab[3] and Omalizumab[4] have NICE approval for use in severe asthma in England. They were selected as part of wave two of the Accelerated Access Collaborative (AAC) Rapid Uptake Products programme (RUP) in September 2020 because of their seemingly low uptake at a national level, where the estimated eligible population was 47,300 people, but the actual uptake was less than 20% of that[5]. The overall aim of the Asthma Biologics RUP programme is to improve patient outcomes by reducing inequalities and improving access to biologics for eligible patients. The objectives of the programme are shown in Figure 1.

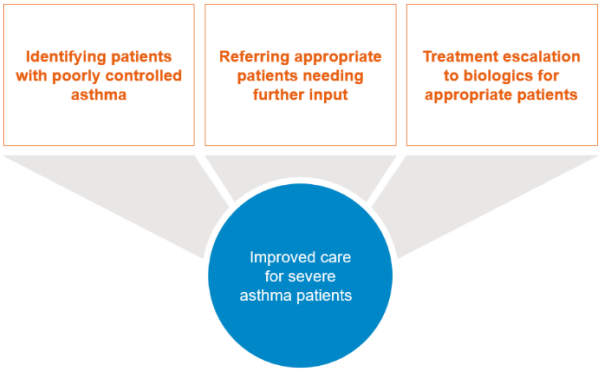

Figure 1. AAC Asthma RUP Programme objectives

A panel of experts including expert clinician champions in respiratory medicine, representatives from NHS England, the Academic Health Science Network (AHSN), Asthma UK, National Institute for Health and Care Excellence (NICE), Primary Care Respiratory Society, and the National Clinical Director for Respiratory agreed key priorities for the programme (Table 1). This paper focuses on the enhanced role of pharmacy included in Priority 4.

Table 1. Asthma Biologics Programme Priorities

Understanding the current picture and potential barriers to adoption	**1.**	Development of an adoption scoping report to investigate barriers in prescribing biologics
	2.	Modelling on variation in prescribing and referral practices across Trusts and regions as a tool to engage and discuss changes in practice
	3.	Attempt audit of wait times for initiating biologics
Early identification and enhanced roles	**4.**	Early identification, healthcare professional training and enhanced roles (GPs, nurses and pharmacists)
Looking at opportunities in the system to reduce variation and improve pathway	**5.**	Development of an algorithm/pathway whilst awaiting updated guidance
	6.	Grow home/self-administration
	7.	Grow home monitoring
Capturing great practice and looking at how we disseminate	**8.**	Partner with specialist centres (via AHSN) and gather best practice and utilise case studies
	9.	Develop Spread and Adoption Toolkit
Reimbursement and coding mechanisms	**10.**	Development of a code for severe asthma
	11.	Develop financial impact evidence

2. Background to the Role of Pharmacy in Respiratory Medicine

The framework for providing better care is outlined within the NHS Long Term Plan (LTP)[6]. It includes direction on the care of people with respiratory disease and more specifically, the part pharmacists play in delivering it.

We also believe that pharmacists in all sectors of practice, with every level of expertise in respiratory medicine, have a valuable role to play in caring for people with lung disease. In this paper, we outline our vision for delivery of these enhanced roles using existing policies, specifications, and guidance, shown in figure 2, to support its delivery.

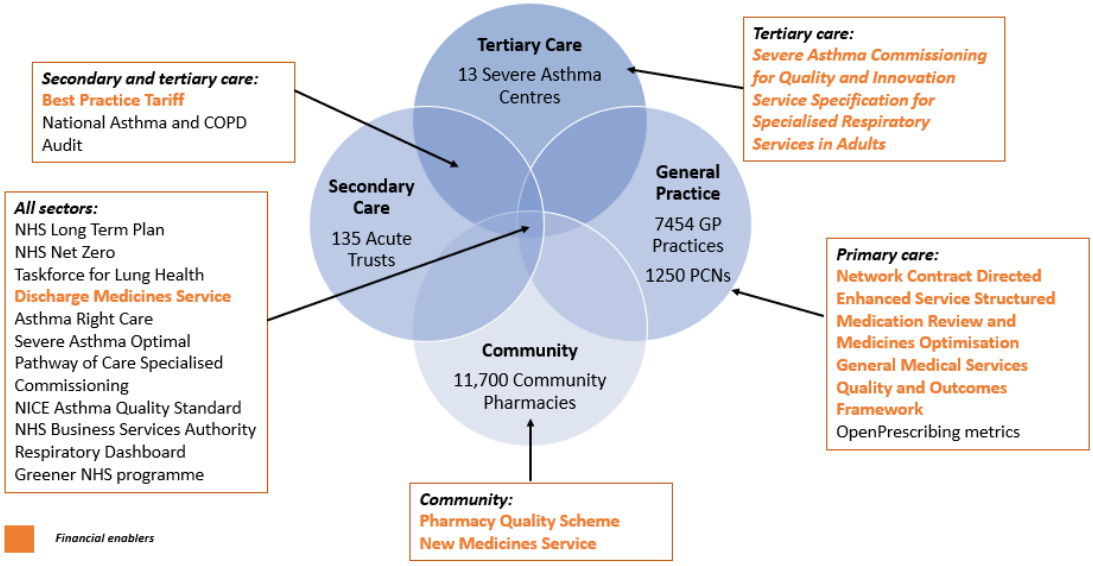

Figure 2. National enablers for pharmacists to contribute to respiratory care

For primary care, the LTP recommends that Primary Care Network (PCN) pharmacists are embedded in the multidisciplinary teams (MDT) to deliver structured medication reviews (SMR). The focus being to optimise treatment for example, through education on inhaler technique. Furthermore, the network contract Direct Enhanced Service[7] prioritises patients at highest risk of harm, a cohort that will include patients with respiratory disease. PCN and community pharmacy contracts offer pharmacists new opportunities to be involved in respiratory care and reimburse services for this.

For secondary care, achievement of the asthma best practice tariff[8] requires successful completion of the discharge bundle which includes, checking inhaler technique and a medication review. The newly commissioned NHS Discharge Medicines Service enables hospital pharmacy teams to refer patients to their designated community pharmacy for specific interventions or medicines support and other onward care. While pharmacists in hospitals are ideally placed to provide respiratory medicines optimisation, a lack of dedicated funding for specialist respiratory pharmacist roles is a significant limitation to progress.

In tertiary severe asthma centres, the National Service Specification for Adult Specialised Respiratory Services[9] recommends that the MDT includes a pharmacist. The role of the pharmacist within the MDT is not defined, which has led to variation in roles. However, direction has recently been

provided in NHS England and NHS Improvement's severe asthma toolkit[10]. This recommends that pharmacists should be instrumental in identifying non-adherence and leading on adherence support.

In October 2020, Oxford AHSN surveyed pharmacists on their current respiratory activity and how the profession could contribute further. Responses were received from 29 pharmacists, from all sectors of care. Most pharmacists reported involvement in monitoring and training however, respondents from all sectors, felt there was potential to contribute much more. Pharmacists fed back that roles could be enhanced by:

- Pharmacists supporting the identification and referral of at-risk patients
- Pharmacists screening in-patients
- Pharmacist-led clinics where medicines are optimised
- Pharmacist-led training for healthcare professionals on asthma management and pharmacotherapy

3. Pharmacy Contribution to Integrated Care for Asthma

Following the survey, a Pharmacy Clinical Subgroup consisting of pharmacists from all sectors and geographical regions was established to review the survey suggestions and where appropriate, develop these further. The overall aim agreed upon by the group was:

'To foster an integrated role for the pharmacist where they lead on medicines optimisation and adherence support for people with asthma.'

The rationale being, inhaled corticosteroids (ICS) are the cornerstone of asthma treatment, yet adherence rates vary widely from 30% and 70%[11]. This suboptimal adherence is associated with significant morbidity and mortality and often results in inappropriate escalation of therapies. Non-adherence is multifaceted but includes someone not being prescribed or collecting their ICS, it being used less frequently than prescribed or that their inhaler technique is poor. Pharmacists are well placed, across all sectors, to detect non-adherence and to deliver interventions to improve medicines use. Such interventions include:

- Completing a medication history to confirm appropriate asthma regimens are prescribed, assess need for additional therapies (to treat asthma, its sequelae, or comorbidities) and identify concomitant medicines contributing to symptoms
- Confirming the patients' understanding of asthma, its treatment, and the principles of self-management
- Assessing and correcting inhaler technique and where applicable, technique with nasal preparations

To ensure optimal patient outcomes, it is crucial that pharmacist roles and responsibilities are defined, and we have described our vision of this in figure 3.

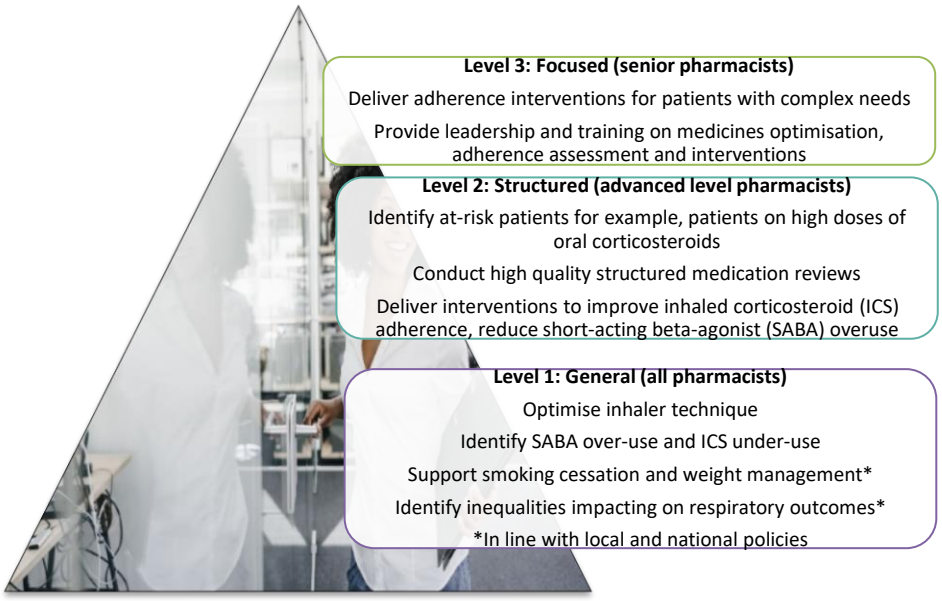

Figure 3. Integrated care model to maximise clinical contribution pharmacists can make to asthma care

4. Embedding the Pharmacist as the Asthma Adherence Lead

The core elements to integrate and embed the pharmacist as the lead for medicines optimisation, adherence assessment and support are detailed in figure 4. This integration of the pharmacy workforce to deliver medicines optimisation aligns with the ambition of NHS England and NHS Improvement's plans to transform services[6,12].

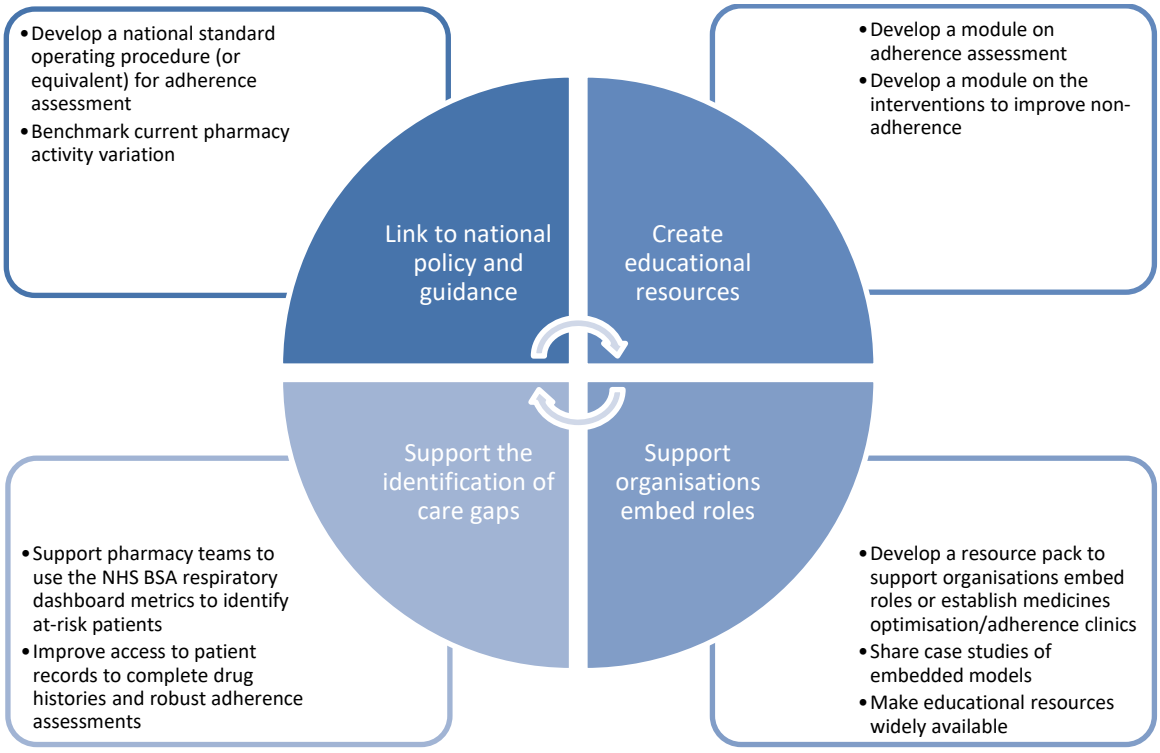

Figure 4 Core elements to embed a system-wide adherence role for pharmacists

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