GSK promotional material

Medicines optimisation in respiratory – a pharmacist’s perspective

An interview with Bernadette Hutton, clinical pharmacist

Chronic Obstructive Pulmonary Disease (COPD) is characterised by airflow obstruction that is not fully reversible. COPD affects around three million people in the UK and costs the NHS over £800 million annually. Medicines optimisation is about ensuring that the right patients get the right choice of medicines at the right time. It is a patient centered and holistic approach that focuses on a partnership between clinical professionals and the patient.

Berny, tell us about your role working with Bradford’s Clinical Commissioning Groups (CCGs).

I am a clinical pharmacist in Bradford, employed by a medicines optimisation provider commissioned by NHS Bradford Districts and NHS Bradford City CCGs and also other individual practices.

The medicine optimisation provider has a long history working with Bradford’s CCGs to implement an evidence based approach to achieving the best outcomes from their investment in medicines. This means agreeing guidelines, pathways and formularies with expert practitioners and establishing them across the CCGs.

I currently work with five practices in Bradford, and in four of them support them with their prescribing medicines management. This helps reduce the GPs’ workload and frees them up to spend more time with patients with complex medical needs. My work involves auditing, reviewing medicines, reconciliation of letters and discharge forms, addressing patient compliance and managing repeat prescribing systems.

The role I perform in each practice is partly governed by the key objectives of the CCGs, and the rest is guided by the needs of the individual practices.

The role of the pharmacist has evolved over the last couple of years. How?

I started working in general practice around 14 years ago at a time when many didn’t have chronic disease registers. At that time, pharmacists involved in medicines management in general practice were responsible for creating disease registers and deciding what medicines should sit on the pharmacy list.

The role has since evolved and we now help manage chronic diseases to improve prescribing in those areas. This may include holding medicine use reviews, amongst other things, but being hands on allows us to better check that patients are on the correct and most cost effective medication for their condition.

Pharmacists have always played a role in cost saving, but this has accelerated in recent years as the cost and number of drugs on the market has increased.

How does your role impact on what medicines a patient is prescribed and how they use them?

My extended duties in practice may include managing the care of people with self-limiting illnesses and those with long-term conditions, and therefore I spend a bit of time in clinics. I’m also often asked by respiratory healthcare professionals (HCPs) to get involved with cost saving exercises. For example, if a HCP is considering changing a patient’s medicine they may seek my advice to help identify the most appropriate new medicine for that individual, taking into account the cost effectiveness of the products. I am often also involved in clinical paper review and can be responsible for updating the disease register, patient’s notes and also making and communicating medication changes to the patient.

What problems do you typically come across with your respiratory patient population?

A lot of problems stem from patients not knowing how to use their inhaler properly, such as using the correct technique. They may not have been shown, have forgotten or it could be down to their dexterity, which is a real issue in older patients, many of whom have co morbidities.

As a result we see a lot of waste, often because they are not regularly seen by a HCP to gain advice. This may result in them not using their medication properly or regularly, although they may continue to order repeat prescriptions as a safety net.

This gives a false picture of the effectiveness of the medicine being prescribed, wastes money – and of course the biggest concern is that this has a negative impact on a patient’s health.

References:
1. Chronic obstructive pulmonary disease in over 16s: diagnosis and management. 23 June 2010. Available at: nice.org.uk/guidance/cg101 Last accessed April 2017
2. NHS COPD Commissioning toolkit. Available at: www.gov.uk/government/publications/commissioning-toolkit-for-respiratory-services Last Accessed April 2017
5. GSK Uptake Tracker Model UK/RESP/0329/15(13) August 2016

UK/RESP/0165/18(2) Date of preparation: September 2017

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What focus do Bradford’s CCGs place on respiratory patients?
Due to the prevalence of COPD in the area, Bradford CCGs have put a lot of resource into smoking cessation – making sure clinics, resources and information are widely available and easily accessible for patients.

The CCGs place a lot of emphasis on treating respiratory patients efficiently and cost effectively, which is why last year, the medicine optimisation provider worked with Bradford’s CCG on a medicine optimisation initiative to create a simpler Formulary and easy to follow Respiratory Guidelines for HCPs, particularly practice nurses who hold most GP respiratory clinics.

What does medicine optimisation mean to you?
If we get this right, the medicines optimisation of respiratory inhalers will improve adherence and ultimately reduce hospital admissions and also reduce cost.*

We have done a lot to try and achieve this by developing a new formulary with a shorter, but we think more manageable, list of respiratory inhalers.

Our respiratory medicine change programme may have been driven by a need to save money, but we have identified different inhalers for each class of respiratory medicine and positioned them on the local respiratory guideline. For example, HCPs can now prescribe a medicine in an inhaler which is easy for patients to use; an example being the Ellipta inhaler which patients only have to use once a day for each medicine delivered by that inhaler. It also means patients using more than one maintenance medicine can be treated using the same type of device and don’t have to swap device when they change medication. We have seen consistency of prescribing increase across the CCG.

We know, however, that switching patients’ medicines following a clinical review is not always an easy task so have ensured patients and HCPs have had a voice in all of our plans. And when a decision is made, we communicate this to them.

How are COPD patients now being treated with triple therapy (ICS/LABA in combination with a LAMA) in the CCGs?
Our Respiratory Guidelines clearly set out when and how to prescribe triple therapy and the CCGs have done a lot to raise awareness of this by educating HCPs and publicising them in Bradford.

Numerically, I could not say what the shift has been to triple therapy, but anecdotal feedback tells me that the practices I work in have been following the guidelines for a while.

How long has this new approach been in place and what outcomes have you had?
The new Formulary and Guidelines, and CCG cost saving incentives, were launched in July 2015 following a thorough respiratory medicines review carried out by Bradford CCG’s Medicines Management team, leading respiratory clinicians in the Bradford area and medicines optimisation pharmacists.

We still have three months to go before we can use Key Prescribing Performance Indicators (KPPPI) to collate a full year of data showing how well we have done in terms of saving costs. However, from a patient perspective, anecdotal feedback suggests it is going really well. Most of the patients who were switched to the alternative therapies are happy. There weren’t many that were switched back, which means hopefully they are benefiting from the alternative inhalers.

What has made this change programme easier is our drive to continually be open and honest in our communication with our patients. It has also helped that we have exacting standards and all our HCPs have bought into the changes.

Our patients have also been open to change as they know we are not just giving them a cheaper alternative, but something that we feel will benefit both them and the CCGs in the long-term.

What advice would you give to other pharmacists looking to achieve the same level of success with their own medicine optimisation programme?
Simple; forge a strong relationship that is built on trust, respect and two-way collaboration. The medicine optimisation provider is fundamentally an information provider, but we can’t do that without truly understanding our clients’ needs. Work as a team to gather information and do so from multiple sources.

In Bradford, we built the formularies collaboratively, agreed and produced our guidelines (based on national guidelines) and disseminated them across the CCGs. I think this joint approach worked well.

What are your views on the role of GSK’s COPD Ellipta portfolio in the management of respiratory disease?
The Ellipta portfolio has been introduced in Bradford and usage has increased over the last year.

The portfolio is on our Formulary, and because our Formulary guidance is extremely clear, HCPs have a good understanding of when and how to use each medicine and how they fit into a patient’s treatment pathway.

GSK has also provided a lot of supporting resources, such as placebos and patient information leaflets, which again help support the use of the Ellipta inhaler.

Personally, I think the portfolio is very easy for patients to use, which is key.

* GSK ran a report from their Budget Impact model for Bradford Districts CCG. This report showed a 10.2% reduction in cost per script from the start of the medicines optimisation initiative between Q2 2014-15 and Q4 2015-16 in the following classes of respiratory medicines; ICS/LABA, LAMA and LAMA/LABA.

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**Relvar Ellipta Prescribing information**

Please consult the full Summary of Product Characteristics (SmPC) before prescribing.

**Relvar Ellipta (fluticasone furoate/vilanterol [as trifenatate]) inhalation powder.** Each single inhalation of fluticasone furoate (FF) 100 micrograms (mcg) and vilanterol (VI) 25 mcg provides a delivered dose of 92 mcg FF and 22 mcg VI. Each single inhalation of FF 200 mcg and VI 25 mcg provides a delivered dose of 184 mcg of FF and 22 mcg of VI. **Indications:** Asthma: Regular treatment of asthma in patients ≥12 years not adequately controlled on inhaled corticosteroids (ICS) and “as needed” short-acting inhaled β2-agonists, where a long-acting β2-agonist (LABA) and ICS combination is appropriate. COPD: Symptomatic treatment of adults with COPD with a FEV1 <70% predicted normal (post-bronchodilator) and an exacerbation history despite regular bronchodilator therapy. **Dosage and administration:** Inhalation only. Asthma: Adults and adolescents ≥12 years: one inhalation once daily of Relvar 92/22 mcg for patients who require a low to mid dose of ICS in combination with a LABA. If patients are inadequately controlled then the dose can be increased to one inhalation once daily Relvar 184/22 mcg. Relvar 184/22 mcg can also be considered for patients who require a higher dose of ICS in combination with a LABA. Regularly review patients and reduce dose to lowest that maintains effective symptom control. COPD: one inhalation once daily of Relvar 92/22 mcg. Relvar 184/22 mcg is not indicated for patients with COPD. **Contraindications:** Hypersensitivity to the active substances or to any of the excipients (lactose monohydrate & magnesium stearate). **Precautions:** Pulmonary tuberculosis, severe cardiovascular disorders or heart rhythm abnormalities, thyrotoxicosis, uncorrected hypokalaemia, patients predisposed to low levels of serum potassium, chronic or untreated infections, diabetes mellitus, paradoxical bronchospasm. In patients with moderate to severe hepatic impairment 92/22 mcg dose should be used. Acute symptoms: Not for acute symptoms, use short-acting inhaled bronchodilator. Warn patients to seek medical advice if short-acting inhaled bronchodilator use increases. Therapy should not be abruptly stopped without physician supervision due to risk of symptom recurrence. Asthma-related adverse events and exacerbations may occur during treatment. Patients should continue treatment but seek medical advice if asthma symptoms remain uncontrolled or worsen after initiation of Relvar. **Systemic effects:** Systemic effects of ICSs may occur, particularly at high doses for long periods, but much less likely than with oral corticosteroids. Possible Systemic effects include: Cushing’s syndrome, Cushingoid features, adrenal suppression, decrease in bone mineral density, growth retardation in children and adolescents. Eye symptoms such as blurred vision may be due to underlying serious conditions such as cataract, glaucoma or central serous choroiditis (CSCR); consider referral to ophthalmologist. More rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression (particularly in children). Increased incidence of pneumonia has been observed in patients with COPD receiving inhaled corticosteroids. **Risk factors for pneumonia include:** current smokers, old age, patients with a history of prior pneumonia, patients with a body mass index <25 kg/m² and patients with a FEV1 <50% predicted. If pneumonia occurs with Relvar treatment should be re-evaluated. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take Relvar. **Interactions with other medicinal products:** Interaction studies have only been performed in adults. Avoid β-blockers. Caution is advised when co-administering with strong CYP3A4 inhibitors (e.g. ketoconazole, ritonavir, cobicistat-containing products). Concomitant administration of other sympathomimetic medicinal products may potentiate the adverse reactions of FF/VI. Relvar should not be used in conjunction with other long-acting β2-adrenergic agonists or medicinal products containing long-acting β2-adrenergic agonists. **Pregnancy and breast-feeding:** Experience limited. Balance risks against benefits. **Side effects:** Very Common (≥1/10): headache, nasopharyngitis. Common (≥1/100 to <1/10): candidiasis of the mouth and throat, dysphonia, pneumonia, bronchitis, upper respiratory tract infection, influenza, oropharyngeal pain, sinusitis, pharyngitis, rhinitis, cough, abdominal pain, arthralgia, back pain, fractures, pyrexia, muscle spasms. Other important side effects include: Uncommon (≥1/1,000 to <1/100); blurred vision. Rare (≥1/10,000 to <1/1,000) paradoxical bronchospasm and hypersensitivity reactions including anaphylaxis, angioedema, rash, urticaria. See SmPC for other adverse reactions. **Legal category:** POM. **Presentation and Basic NHS cost:** Relvar Ellipta 1 inhaler x 30 doses. Relvar Ellipta 92/22 - £22.00. Relvar Ellipta 184/22 - £29.50. **Marketing authorisation (MA) nos.** 92/22 mcg 1x30 doses [EU/1/13/886/002]; 184/22 mcg 1x30 doses [EU/1/13/886/005]. MA holder: Glaxo Group Ltd, 980 Great West Road, Brentford, Middlesex TW8 9GS, UK. **Last date of revision:** September 2017. UK/ FFT/0227/15(3). Trademarks are owned by or licensed to the GSK group of companies. © 2017 GSK group of companies or its licensor Relvar Ellipta was developed in collaboration with Innoviva Inc.

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