

Management of patients with hypertension:

general practice and community pharmacy working together

Community pharmacy is a highly skilled resource that is untapped. As the dispensing process is further mechanised and drug costs squeezed, pharmacists could be performing more complex tasks than currently by contributing to clinical care and health improvement. This could enable GPs to change their case mix, allowing primary care to achieve more, as set out in the recent joint statement from the Royal College of General Practitioners (RCGP) and the Royal Pharmaceutical Society (RPS).¹ In Scotland, the Chronic Medication Service is a good example and will, ultimately, encompass prescribing. From 2015 all schools of pharmacy will have prescribing competencies embedded in their curricula. In England, the Medicines Use Review (MUR) and the New Medicine Service (NMS) represent a first step in the process.

However, the NHS is limited by capacity and cost. It is seeking to transfer work from expensive environments, like hospitals, to more cost-effective environments, like general practice. At Woolpit Health Centre (Richard West's practice), the consultation rate per patient/year has increased from 5.6 to over 6, and average time per patient has exceeded 11 minutes during the last 5 years.

Pharmacists are trained in the use of medicines and to reduce risk, and are effective at ensuring best practice is implemented. A shift to risk management needs to go alongside taking on more clinical responsibility for the care of patients.

General practice and community pharmacy could work together on the management of the chronic disease with the greatest prevalence in the UK: hypertension. The British Hypertension Society says that 32% of men and 29% of women are affected.² At Woolpit Health Centre 2400 patients, out of 14 000, have the condition. Accepting the argument in Wald and colleagues' work,^{3,4} that there is a case for reducing the blood pressure of the entire population aged >50/55 years, this is a key area of work for prevention in which workload will increase. In addition, Barbara Starfield⁵ argued that, although this is an important area of work, costly medical skills are being wasted on hypertension and lipid management. The NHS Health Check approach is symptomatic of this.

Clear guidance is available from

"... pharmacists could be performing more complex tasks than currently by contributing to clinical care and health improvement. This could enable GPs to change their case mix, allowing primary care to achieve more ..."

the National Institute for Health and Care Excellence (NICE) for managing hypertension.⁶ The Quality and Outcomes Framework (QOF) requires that patients get:

- their blood pressure measured every 9 months;
- advice about diet and exercise;
- weight management;
- their cardiovascular disease (CVD) risk assessed, as appropriate;
- a review/monitoring of the drug being taken; and
- discussion about adherence and side-effects.

All of the tasks are within the competencies of a pharmacist.

It would be sensible to divide patients into two groups:

1. those who only have hypertension and are controlled on three drugs or fewer; and
2. the remainder.

Our intention is to distinguish between those patients not taking medication as recommended, and those with physiologically complex needs.

Community pharmacy could be asked to manage the first group. After diagnosis or stabilisation in general practice, the pharmacist would be asked to monitor

the patient and carry out all the necessary investigations. If the patient's condition changes they should be referred back to the practice. The patient's hypertensive therapy should then be maximised along an agreed pathway. If the patient at any time develops a secondary condition, or any complications, then the practice would take back responsibility.

There are a number of obstacles to overcome, notably the lack of an appropriate communication system between pharmacy and general practice. Clear protocols need to be adopted to determine which professional would be responsible for the patient at the key stages of the pathway, like the current shared-care agreements between hospital consultants and GPs for certain drugs.

A cultural change would also be required. There is no doubt that where clinicians know each other and communicate well, the patient benefits. Most surgeries refer to a limited number of hospitals, if they believe the patient requires their particular expertise. The same would need to happen with general practice and community pharmacy. The pharmacy would need to take long-term responsibility for the patients it is monitoring, requiring some form of list system. This will mean a change in the risk profile for pharmacists, including appropriate indemnity insurance.

There will be a cost associated with this. Contractors will need to be paid at a premium in the first few years, for establishment costs and to encourage pharmacies to take

"General practice and community pharmacy could work together on the management of the chronic disease with the greatest prevalence in the UK: hypertension."

“There are a number of obstacles to overcome, notably the lack of an appropriate communication system between pharmacy and general practice.”

ADDRESS FOR CORRESPONDENCE

Matthew Isom

Dispensing Doctors' Association, Low Hagg Farm, Starfitts Lane, Kirkbymoorside, YO62 7JF, UK.

E-mail: matthew.isom@dispensingdoctor.org

on the work. Surgeries currently receive some money for managing patients via the QOF. However, changing where patients are managed will not reduce the costs or workload in general practice, because work will be transferred from secondary care to replace them. It will create capacity, which is just as important. The transfer of money needs to come from secondary care.

The other major challenge is finding the time for the pharmacist to do this work. Currently the pharmacist's work can be divided into four areas:

1. dispensing medicines;
2. management of the business;
3. provision of pharmacy services, some pre-booked; and
4. advice to patients.

This work would mean that the pharmacist would not be as available to patients who walk in off the street, so different pharmacies may have to specialise in different services. It seems clear that pharmacists need to delegate more of the work of dispensing either to a pharmacy technician, or to automated technology, in order to free up time in line with the thinking in the Responsible Pharmacist Regulations. [These regulations came into force in October 2009, creating a legal duty for the pharmacist to ensure the safe and effective running of the pharmacy at all times.]

The community pharmacy's contractual framework needs to encourage automation of the dispensing process. There needs to be a robust mechanism in place to ensure that contractors get paid when they take on extra work, allowing the pharmacy to take the risk and general practice to release the work, knowing that they can maintain income by taking on work from secondary care. Over the past 3 years work has been transferred, but practice incomes have fallen while hospital budgets have increased. This will cause resistance to any change as everyone tries to protect their income.

Good communication between GP and

pharmacy is essential, ideally by sharing of the patient record. Despite the recent announcements about the NHS going paperless by 2017, a paper-based system (like that for maternity care) could be a good short-term solution, backed up by letters. In addition:

1. a clear and simple pathway should be developed for all involved to follow;
2. there should be an acceptance that one practice may choose to work with one pharmacy and vice versa, with the pharmacist even performing the work in the GP practice; and
3. a pilot should be undertaken that would be subject to full academic evaluation. This should not hamper work that is obviously viable where professionals are prepared to cooperate. The NHS cannot afford to wait for another decade to see progress across primary care.

The NHS needs to continue to evolve if it is to be able to cope with the changing expectations of the people who use it.

Richard West,

Partner, Woolpit Health Centre, Suffolk, Chairman, Dispensing Doctors' Association.

Matthew Isom,

Chief Executive, Dispensing Doctors' Association.

Provenance

Freely submitted; not externally peer reviewed.

DOI: 10.3399/bjgp14X681553

REFERENCES

1. Royal Pharmaceutical Society and Royal College of General Practitioners. Joint statement. *Breaking down the barriers – how community pharmacists and GPs can work together to improve patient care*. <http://www.rpharms.com/public-affairs-pdfs/RPSRCGPjointstatement.pdf> [accessed 6 Aug 2014].
2. Joint Health Surveys Unit. *Health survey for England 2003. Volume 2 risk factors for cardiovascular disease*. London: The Stationery Office, 2004.
3. Wald NJ, Law MR. A strategy to reduce cardiovascular disease by more than 80%. *BMJ* 2003; **326(7404)**: 1419.
4. Wald N, Misselbrook D (eds). *The future of prevention in cardiovascular disease*. London: Royal Society of Medicine Press, 2011.
5. Starfield B, Hyde J, Gervas J, Heath I. The concept of prevention: a good idea gone astray? *J Epidemiol Community Health* 2008; **62(7)**: 580–583.
6. National Institute for Health and Care Excellence. *Hypertension: Clinical management of primary hypertension in adults*. CG127. <http://www.nice.org.uk/guidance/CG127/chapter/Introduction> [accessed 4 Aug 2014].