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The impact of the introduction of a specialist HIV pharmacy service (SHPS) to satellite HIV clinics

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Disclosure: Gilead Sciences have not had any involvement with this project

25th Annual Conference of the British HIV Association
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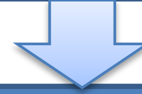
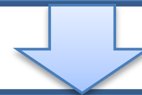
2015

- Our NHS Foundation Trust acquired 2 satellite HIV outpatient clinics; A and B
- Approx 800 patients



No specialist HIV pharmacy service (SHPS)

- ARV prescriptions unscreened/screened remotely by dispensary pharmacist, with no access to notes/bloods
- No HIV pharmacist support for MDT or patients
- Added to Trust risk register



2017/2018

- 2017 – SHPS introduced to Clinic A
- 2018 - service expanded to Clinics B and C
- 2.5days/week across Clinics A, B and C
- Currently approx 1050 patients

**Clinic A =Stevenage, Clinic B = Watford, Clinic C = Harlow*

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Aims of the SHPS

Standards and guidance
• Department of Health and Royal Pharmaceutical Society[1]
• BHIVA Standards of Care[2]
• NHSE CRG Service Spec[3]
• NHSE CRG MDT Standards[3]
• NHSE Regional ARV guidance[4]
• Lord Carter Report[5]
• NICE Medicines Optimisation[6]

Aims
• clinically screen ARV prescriptions
• improve patient safety
• counsel patients on ARVs
• support the MDT
• support cost-effective use of ARVs
• support prescribing to guidelines
• reduce medication wastage
• reduce time spent by non-pharmacy staff dealing with medication queries

1. Hackett M. Homecare Medicines "Towards a vision for the future". Department of Health; 2011.
2. British HIV Association (BHIVA). Standards of Care for People Living with HIV [Internet]. Bhiva.org. 2018. Available from: https://www.bhiva.org/file/KrfaFqLZRlBhg/BHIVA-Standards-of-Care-2018.pdf
3. NHS Commissioning Board (now known as NHS England). 2013/14 NHS Standard Contract for Specialised Human Immunodeficiency Virus Services (Adults). Available from: https://www.england.nhs.uk/wp-content/uploads/2013/06/b06-spec-hiv-serv.pdf
4. NHS England. Midlands and East Region: Antiretroviral Therapy (ART) Prescribing implementation guidance for Adult and Adolescent patients Starting and Switching Treatment 2017. Available from: https://www.hivbirmingham.nhs.uk/wp-content/uploads/Final-UPDATED-NHSE-ME-ART-GUIDANCE-VERSION-F4-20-02-2017.pdf
5. Lord Carter of Cole. Operational productivity and performance in Englash NHS acute hospitals: Unwarranted variations. Department of Health and Social Care; 2016.
6. NICE. Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes. Nice.org.uk. 2015. Available from: https://www.nice.org.uk/guidance/ng5/chapter/1-Recommendations

Methods

Service Evaluation undertaken to assess impact of SHPS

1. Prospective recording of pharmacy-led interventions (15 month period at Clinic A* and 10 month period at Clinics B* and C*)
2. Prospective recording of drug savings data through CQUIN/QIPP (12 months at Clinic A)
3. Service evaluation survey to 16 MDT members at clinic A, B and C (end of data collection period)
4. Retrospective review of pharmacist-led clinic (10 months at Clinic A)

**Clinic A =Stevenage, Clinic B = Watford, Clinic C = Harlow*

Results: 1. Pharmacist-led interventions

514 Intervention episodes across 3 clinics over a 15month period
Categorised into 789 interventions

1. Drug-drug interactions (DDIs)
2. Other clinical interventions (e.g. identifying potential ARV changes)
3. Patient counselling
4. Patient safety (e.g. responding to MHRA Drug Safety alerts)
5. Prescribing errors
6. Proactive patient follow-up and engagement (e.g. patients identified as overdue clinic review or requiring early follow-up)
7. Reduction of drug wastage
8. Prescription quantity adjustment

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Results: 2. Savings through QIPPs/CQUINs

Drug Switch	% of switches which were pharmacist-led
Atripla to TFV/generic EFV	67%
Kivexa to generic ABC/3TC	96%

A total of ~ £98,000 was saved through pharmacist-led switches at Clinic A over a 12 month period

By making savings we fully achieved our CQUIN

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Results: 3. MDT survey feedback

- 13/16 MDT members completed survey

support_to_the_whole_team
treatment
significant_contribution
drug-drug-interactions
greatly_improved_patient_safety
very_important_part_of_team
working_for_clinicians
One_to_one_input_with_patients
queries
enormous_impact_on_our_clinic
Vital_source
team/MDT
huge-benefit
approachable
adherence
better
necessary
safety
better-service
service
discuss_patients
information
recording_errors
counselling
highlighted
fantastic
time
checking
advice
dedicated
hardworking
expertise
efficiency
specialised
support_patients
prescribing
clinical-screen
knowledgeable
patients
difficult
prevent_toxicity
provision
monitoring
reduced_potential_errors
prevent_ART_failure
Making_us_aware
concerns_or_questions
liaising_with_Homecare_provider
invaluable
positive_impact

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Results: 4. Pharmacist-led clinic

- Clinic A (~360 patients) over a 10month period

Type of appointment	Number of appointments
Starting/switching ARVs	89
DDI	11
Side-effects advice	8
Adherence support	7
Other	9
Total	**124**

Limitations to data collection

- Time constraints to recording interventions
- Missing interventions made directly to HCP
- Underestimation of pharmacist-consultations

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Key challenges in implementing service

- Part-time role
- Cross – site
- Paper notes, EPR and IT differences at each site
- Future funding for post
- Continuity of service

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Conclusions and Summary

- ✓ Improvements in patient safety
- ✓ Cost-saving delivered on ARVs
- ✓ Specialist HIV pharmacist advice to patients and HCP
- ✓ Meeting national, regional and Trust standards of care and guidance
- ✓ Improved use of staff skill-mix

Funding for SHPS extended for further 12months and business case for permanent post

Opportunities of further service development e.g. non-medical prescribing clinics

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Acknowledgements

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Co-authors

BHIVA for inviting me to speak today