SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	11.
Service	Community Pharmacy Led Hypertension Service (Pilot)
Commissioner Lead	Gary Barnfield
Provider Lead	Community Pharmacies
Period	1 July 2019 – 31 March 2021
Date of Review	January 2020

1. Population Needs

1.1 National/local context and evidence base

Hypertension is one of the most important modifiable risk factors for cardiovascular disease. It is estimated that over 15000 patients in Sheffield already identified as having hypertension are still not achieving blood pressure readings <=150/90mmHg (Public Health England, 2018). With an aging population and increasing pressures on GPs it is important to utilize the wealth of skills available in the wider community of healthcare professionals, in order to improve health economy in our region.

The aim of this service therefore is to offer patients an additional avenue through which they can attain adequate blood pressure management. This service utilizes the already established relationship between the GP, patient and community pharmacist and allows for the joint management of care by both the GP and community pharmacist. It is envisioned that this service will improve overall patients' blood pressure control to target levels and reduce workload pressures on general practitioners.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**Y**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**Y**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	**Y**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**Y**

2.2 Local defined outcomes

- Improve clinical outcomes and medicines optimisation for patients with hypertension: better control of hypertension – often the first long term condition for patients – leads to avoidance or delay in development of further co-morbidities and hence better health for the population and savings for the system. (Measure: lower blood pressure)
- Increased short and longer term patient activation in the management of their condition – supporting prevention strategy. (Measure PAM scores)
- Maximising skills of an underutilised workforce, reducing pressures on general practice.(Measures: ability of community pharmacy to respond to this new clinical challenge and the impact on GP workload)
- Expanding patient choice, accessibility and improving patient experience. (Measure: patient survey)
- Transformation of scope of pharmacy workforce and practice. (Measure: engagement of participants)

3. Aims and Objectives

3.1 Aims and objectives of service

This a 2 year pilot project aimed at improving the management of hypertension in Sheffield:

- Reduce the number of strokes and heart attacks resulting from hypertension;
- Increase the number of adults with high blood pressure treated to recommended levels;
- Provide better patient experience and greater choice aligned to a neighbourhood approach;
- Develop an innovative shared care arrangement between general practice and community pharmacy;
- Transform joint working for hypertension and use this as a model for the management of other long term conditions;
- Reduce pressures on general practice by working with another primary care workforce;
- Expand the scope of pharmacy practice.

3.2 Service description and care pathway

Consultation 1

In accordance with the Shared Care Protocol for Community Pharmacy Management of Hypertension (appendix 1) the community pharmacist will:

- Establish and record patient's preferred contact details (noting Accessible Information Standards);
- Explain the service to the patient and undertake patient activation measure (PAM);
- Record the patients BP as well as patient's BMI, smoking status, approximate weekly alcohol consumption and level of physical activity unless already available on the patient's GP record;
- Recruit the patient to the community pharmacy New Medicines Service if new drug treatment has been started;
- In agreement with the GP, up-titrate the patient's anti-hypertensive medicine(s), in line with the Sheffield Hypertension guidelines and current NICE guidelines for managing hypertension;
- Make suggestions for any dose or medication changes to the GP and will follow these up for action in a timely fashion;
- Where appropriate advise on and offer the use of 'Florence' (telehealth system).

Consultation 2

- Community pharmacist will record the patient's BP, changes to the patient's BMI, smoking status, approximate weekly alcohol consumption and level of physical activity.
- Until they reach target BP levels the patient should be invited back for a monthly review.
- Once a patient has reached target BP levels, this should be clearly annotated in the patient's record and patient invited back for annual review. The second patient activation measure (PAM) should be carried out.
- If after using 3 different classes of anti-hypertensive medicines at maximum tolerated doses the BP is still uncontrolled, patients should be referred back to the GP, once non-compliance has been ruled out.
- Pharmacies should have a robust call and recall system in place to ensure that all patients receive Hypertension monitoring in line with the service delivery / care pathways.

Consultations 3-12

- Should a patient be invited back for monthly reviews these should be recorded on PharmOutcomes as having taken place (as well as entries on the GP clinical system).

Annual review

- Once blood pressure is under control invite patients for an annual review to monitor blood pressure.

Note: Annual Review
The annual review may not be required under the timeframe of the pilot.

3.3 Clinical assurance

At any point during this service the community pharmacist can refer to the GP for advice in the case of patients whose hypertension remains uncontrolled despite medicines optimisation and improvements to lifestyle e.g. failing to respond adequately to treatment, concerns about blood test results, or side effects affecting the patient's hypertensive control.

In some cases it may be appropriate for the patient to be referred to the GP to ensure the best care and outcomes for the patient.

3.4 Self-care and patient information

Patients that have been identified as requiring lifestyle advice/support (weight management, smoking cessation, alcohol consumption, exercise advice) will be provided with the necessary written material and/or access to on-line resources.

Where possible the patient should be encouraged to utilize technological support such as home blood pressure monitoring, 'Florence' teletext health messaging system.

3.5 Communications

Patient: Where possible the pharmacy will send make use of SMS or email to send out reminders, such as for appointments. It is expected that pharmacy will attempt to contact patients on three separate occasions should they fail to respond to invites for reviews or do not attend appointments. These should be recorded on the clinical system. If there is still no response from the patient the pharmacist should inform the patients GP practice.
GP: The pharmacist should agree on communications with the GP, whether these should be via Task, NHS mail, telephone or face to face.
Commissioner: The pharmacist should raise any queries regarding delivery of the service

with the appropriate person at NHS Sheffield CCG.

Accessible Information Standard:

The service must have processes in place to ensure that it meets the requirements of the Accessible Information Standard. The service must proactively identify, record, flag, share and meet the communication and information needs of patients and carers, including ensuring that specific details of patients' and carers' communication and information needs are included in referrals to other services. The service must regularly review its compliance with the Accessible Information Standard, and make improvements where required. The service must proactively seek feedback from people with communication and information needs about their experiences of the service. The service must ensure that appropriate feedback routes are available to enable people with communication and information needs to provide feedback, and must respond to that feedback in a format that meets people's communication and information needs.

3.6 Staff training

Pharmacists delivering the service will need to demonstrate that they have participated in ongoing CPD and the following training:

- Specific hypertension training e.g. CPPE
- Patient Activation Measure (PAM)

3.7 Population covered

Patients newly diagnosed with Hypertension

Individuals newly diagnosed as being hypertensive by their general practitioner, and who meet the inclusion criteria (see appendices) will be offered the choice of whether they want their management to continue within the surgery or whether they would like to be managed by a named community pharmacist. Once consent for community pharmacist (CP) - led management has been obtained, the patient is then referred to the community pharmacist.

Patients already diagnosed as hypertensive but with uncontrolled BP

Patients with uncontrolled BP can be identified through clinical system searches. Those deemed as appropriate for management in the CP-led hypertension management service, in accordance with the inclusion criteria, will then be offered the choice of whether they want their management to continue within the surgery or whether they would like their BP to be managed by a named community pharmacist. Once consent for community pharmacist (CP) - led management has been obtained, the patient is then referred to the community pharmacist.

3.8 Any acceptance and exclusion criteria and thresholds

GPs will use their clinical judgment in determining which patient is excluded from the service, even if they fit the inclusion criteria listed in the appendices.

Community pharmacists will use their clinical judgment in determining which patient they do not feel competent to manage, even if they fit the inclusion criteria.

3.9 Interdependence with other services/providers

The service operates within a primary shared care protocol with the patient's general practice. A multi-disciplinary team approach, including practice nurse staff, should be adopted.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Providers will be required comply with the Contractual Framework Clinical Governance requirements regarding standards of premises ensuring timely submission of Contractual Framework self-assessment to NHS England.

Providers will be required to comply with relevant NICE standards on hypertension.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Royal Pharmaceutical Society Medicines, Ethics and Practice – The professional guide for pharmacists, July 2018
(https://www.rpharms.com/resources/publications/medicines-ethics-and-practice-mep)

4.3 Applicable local standards

- The Sheffield hypertension pathway.
- Sheffield Formulary https://www.intranet.sheffieldccg.nhs.uk/sheffield-formulary.htm.
- The Provider must ensure that any and all parts of the service covered by this specification are carried out by; a General Pharmaceutical Council (GPhC) registered Pharmacist.

5. Location of Provider Premises

The Provider's premises are located at: