A Guide to National and Local Primary Care Contracts and the Role of Clinical Pharmacists

September 2022

Contents

Introduction 3

Searches 3

Coding 4

Network Contract DES 5

IIF 10

ECF 21

Further Support 28

Appendices 29

Introduction

This document will focus on THREE key contract frameworks which Primary Care Networks (PCNs)/GP practices within the Hertfordshire and West Essex Integrated Care System (HWE ICS), are required to participate in for reimbursement and contractual purposes, as well as outline the role of Clinical Pharmacists in fulfilling these contracts. Note: there is some overlap between indicators in the different contracts and QoF indicators, therefore be aware not to duplicate work.

The definition of a **PCN** is "*a practice or practices (and possibly other providers) serving an identified Network Area with a minimum population of 30,000 people*"[1]. Below is a summary of the three contracts covered in this document:

1. **The Network Contract Direct Enhanced Service** **(DES)** – A national contract that underpins the role of PCNs in improving primary care services delivered to the PCN population.

2. **The Investment and Impact Fund** **(IIF)** – Forms part of the DES contract. It is an additional financial incentive scheme for PCNs. The scheme focusses on delivering high quality care to the PCN population, particularly in cohorts that require additional support towards recovery following the Covid-19 pandemic.

3. **The Enhanced Commissioning Framework (ECF)** – a local level contract for GP practices. An incentive scheme set by the Hertfordshire and West Essex ICS, for GP practices to improve the quality of care delivered to its registered patients.

This document will only outline the relevant areas and indicators in each contract deemed suitable for Clinical Pharmacists to participate in, including practical advice and suggestions for each area, which are optional tasks to complete.

The complete list of indicators and criterion are available in the full guides to each contract (see links above).

Each Clinical Pharmacist is recommended to support in delivering the outlined indicators in this document (where competent), however can also support with other indicators outside of this guidance, if requested to by a PCN/GP practice or feels competent to do so.

Searches

The related searches for each contract should have already been imported and embedded into your clinical system. If this is not the case or you are unable to locate the searches, consult your practice/PCN lead.

---

[1] NHS England Network Contract Directed Enhanced Service Contract specification 2022/23 – PCN Requirements and Entitlements March 2022

Coding

For all three contracts, to guarantee payment for a completed indicator (for example, completion of a Structured Medication Review) it is imperative that the completing clinician ensures the designated SNOMED codes are recorded in the patient notes. This includes when exception/exclusion reporting, also known as Personalised Care Adjustments (PCAs), for example a patient who declines a statin under IIF CVD 03 indicator, the practice is still eligible for payment even if the patient makes an informed decision and declines treatment, as long as the correct code is recorded in the patient notes.

The correct codes, more often than not, are already embedded into templates related to the indicators, such as Ardens templates, however, for more detail see the full contract or the NHS Digital website.

Network Contract DES

Summary

Below is a summary of the key areas as part of DES for Clinical Pharmacists to support, including practical advice and suggested activities/optional training (unless stated otherwise).

The following criteria are to be achieved at PCN level, therefore coordination amongst PCN pharmacists may be required.

The table below provides an overview of each indicator, and it is recommended that you read the full criteria in the contract before undertaking related tasks.

DES Service Requirement: Medication Review and Medicines Optimisation (8.2)				
Requirement	**Criteria**	**Additional criteria/detail**	**What can I do?**	**Resources and training**
Structured Medication Reviews (SMRs) (8.3)	Undertake SMRs with priority patients including those: • In care homes • With complex polypharmacy (10 medicines or more) • Medicines associated with errors • With severe frailty (including those isolated/housebound/recent hospital admission and/or falls) • Using one or more potentially addictive drug (including opioids/gabapentinoids/benzodiazepines/z-drugs)	• Overlaps with IIF indicators • The number of SMRs delivered is to be determined by the PCN Clinical Pharmacists capacity • Clinical Pharmacists must be appropriately trained/competent (that is they have a prescribing qualification, advanced assessment and history taking skills, or be enrolled on a relevant training pathway) • Focus on optimising the prescribing of antimicrobials/medicines associated with dependency/switch from pMDI inhalers to	• Consider focussing on a priority group • Does the PCN have Care Home Pharmacists that may be able to assist with your registered care home residents • Plan with your practice/PCN lead, how many SMR sessions a week you could complete and agree a suitable length of time for each appointment, for example 20 minutes per patient • Decide whether some SMRs may be suitable for a	• NHS England: Structured medication reviews and medicines optimisation • Specialist Pharmacy Service (SPS): Polypharmacy SMR consultation • SPS: Care homes - SMRs through remote consultations

		DPIs/medicines of low priority • Work with community pharmacies to utilise the New Medicines Service (NMS)	telephone appointment vs. face to face	

Requirement	Criteria	Additional criteria/detail	What can I do?	Resources and training
DES Service Requirement: Cardiovascular Disease (CVD) Prevention and Diagnosis (8.7)				
Improve Hypertension diagnosis (8.7.1)	• Appropriate follow up of patients with clinic BP ≥140/90mmHg or home BP ≥135/85mmHg • Proactive review of patient records with previously elevated BP recorded and no appropriate follow up • Increase opportunistic BP measurements in patients with no recent BP reading (>5 years since last recorded)	• Utilising community pharmacy for this indicator is acceptable, only if BP readings taken in a pharmacy are then coded onto the GP system • Offering BP checks at suitable outreach venues is encouraged to help improve access	• Consider conducting a 'notes review', there may be cases where patient records have not been coded correctly following diagnosis • Contact eligible patients, for example via text, inviting them for a BP check • Utilise a self-monitoring BP machine if available to avoid appointments, or • Collaborate with community pharmacies who are able to take a BP reading; refer to the Hypertension Case Finding Service • If a self-monitoring machine is used, ensure staff receiving BP readings have a written	• NICE: Hypertension in adults: diagnosis and management NG136 • British and Irish Hypertension Society (BIHS) – resources available, including guidelines and template blood pressure diaries • UCL partners: Proactive Care Frameworks CVD resources – includes protocols, training and communication training videos for different members of staff to help support

			protocol to follow (see Appendix 1 for a template protocol)	the delivery of this indicator
Additional CVD Prevention Areas (8.7.2)	Improve identification of Atrial Fibrillation (AF) by increasing opportunistic pulse checks	• Can be completed alongside BP checks	• As part of BP check, a manual pulse check should be taken in order to identify irregular pulses and the suitability of an automated BP machine, therefore this indicator goes in hand with 8.7.1	• NICE: Atrial fibrillation: diagnosis and management NG196 • British Heart Foundation: How to check your pulse training video
	Identify those at high risk of Familial Hypercholesterolaemia and refer where indicated	Identify patients: • <30 years of age with total cholesterol > 7.5mmol/L OR • ≥30 years of age with total cholesterol >9mmol/L	• Consider reviewing the notes of patients with raised cholesterol (as specified) and confirming whether a referral was done and if correct coding was completed • If not, refer patient as per local guidelines	• NICE: Familial hypercholesterolaemia: identification and management CG71
	Offer statin therapy to patients with QRISK score >10%	• Can use QRISK 2 or 3	• Notes review all patients with a recent (e.g. past 6 months) with a raised QRISK – have the already been offered a statin and declined? Ensure coding is correct	• NICE: Cardiovascular disease: risk assessment and reduction, including lipid modification CG181

			• If they have not been offered a statin, contact patient via text or letter, providing information on their blood test and QRISK result and invite to book a telephone appointment • Ensure all clinicians reviewing pathology results calculate QRISK when cholesterol is tested (when applicable) and use a template letter to contact patients if it is raised to offer a statin	• UCL partners: Proactive Care Frameworks CVD resources
DES Service Requirement: Personalised Care (8.10)				
Requirement	**Criteria**	**Additional criteria/detail**	**What can I do?**	**Resources and training**
Social Prescribing and Shared Decision Making (SDM) (8.10.1)	• Proactively refer patients to social prescribing services, where appropriate • Complete the Personalised Care Institute's e-learning training for Shared Decision Making (SDM) conversations		• Include social prescribing referrals as part of SMRs, where appropriate	• Personalised Care Institute's e-learning training for Shared Decision Making (SDM) conversations • The Kings Fund: What is social prescribing?

IIF

Summary

Below is a summary of the key indicators from IIF for Clinical Pharmacists to support, including practical advice and suggested activities/optional training (unless stated otherwise).

The following criteria are to be achieved at PCN level, therefore coordination amongst PCN pharmacists may be required.

The table below provides an overview of each indicator, and it is recommended that you read the full criteria before undertaking related tasks.

Domain: Prevention and tackling health inequalities				
Area	**Indicator**	**Additional criteria/detail**	**What can I do?**	**Resources and training**
CVD prevention	**CVD 01/02:** Review patients (over 18) with a previous recorded elevated BP (≥140/90mmHg) with no previous follow up or hypertension diagnosis to exclude or confirm hypertension diagnosis	• Overlap with DES 8.7.1 • Confirm or exclude hypertension diagnosis • Proactively follow up patients, depending on the cohort they fit into, with a clinic BP reading for those with w raised BP taken two years prior to 1 April 2022 • Or for those with a raised BP on or after 1 April 2022, Home Blood Pressure Monitoring (HBPM)/Ambulatory Blood Pressure Monitoring (ABPM), or a change to antihypertensives which is then followed by a BP reading <140/90mmHg • Or the patient is added to the QoF hypertension register and is commenced on medication (if patient agrees) or referred for a same day urgent review • Patients who decline follow up clinic BP readings alone will not trigger a PCA, however those who decline HBPM or ABPM will trigger a PCA	• As with DES, contact eligible patients (via text or letter) inviting them for a BP check, with no appointment required • Utilise a self-monitoring BP machine if available to avoid appointments, or • Collaborate with community pharmacies who are able to take a BP reading; refer to the Hypertension Case Finding Service • If a self-monitoring machine is used, ensure staff receiving BP readings have a written protocol to follow (see Appendix 1 for a template protocol)	• NICE: Hypertension in adults: diagnosis and management NG136 • British and Irish Hypertension Society (BIHS) – resources available, including guidelines and template blood pressure diaries • UCL partners: Proactive Care Frameworks CVD resources – includes protocols, training and communication training videos for different members of staff to help support the delivery of this indicator

		• Follow up can be completed by a GP practice or community pharmacy (ensure coded correctly on GP system)		
	CVD 03: Offer statin treatment to patients (agreed 25-84 years) with a QRISK 2 or 3 >20%	• Overlap with DES 8.7.2 • Can use QRISK 2 or 3	• As with DES, contact patients via text or letters providing information on QRISK and inviting to book a telephone appointment • Going forward ensure a protocol is in place for all clinicians reviewing pathology results to calculate QRISK (where suitable) when cholesterol is tested and send a template letter or text to discuss starting a statin, where applicable	• NICE: Cardiovascular disease: risk assessment and reduction, including lipid modification CG181 • UCL partners: Proactive Care Frameworks CVD resources
	CVD 04: Refer patients identified as high risk for Familial Hypercholesterolaemia, including: • Aged ≤ 29 with total cholesterol >	• Overlap with DES 8.7.2	• As with DES, review the notes of those with raised cholesterol (as specified) and confirm whether a referral was or was not completed and if so, whether	• NICE: Familial hypercholesterolaemia: identification and management CG71

	7.5mmol/L OR • Aged ≥30 with total cholesterol > 9.0mmol/L		correct coding was used in the record • If the patient was not referred, follow local guidelines	
	CVD 05: Ensure all patients on the AF register and with a CHA2DS2-VASc score of 2 or more (1 or more for males) are prescribed anticoagulation	• Preferred anticoagulation is a DOAC, however Vit K antagonist is acceptable where DOAC was declined or clinically unsuitable (ensure coded on patient record) • A PCA can be triggered if anticoagulation is declined or is clinically unsuitable	• Invite eligible patients for a telephone appointment – provide information on anticoagulation prior to the appointment so they are informed • If a patient has previously declined, this should be reviewed annually	• MD Calc: CHA2DS2-VASc score calculator
	CVD 06: Review all patients prescribed DOACs for AF (with a CHA2DS2-VASc score of 2 or more (1 or more for males)) and offer preferred DOAC, Edoxaban		• HWE ICB has created a template letter for patients explaining and offering a switch to Edoxaban, along with other resources • Ensure patients are informed that there is no current reversal agent for Edoxaban	• HWE ICB Edoxaban resources, including FAQs for clinicians

			(compared to other DOACs)	
Domain: Providing high quality care				
Area	**Indicator**	**Additional criteria/detail**	**What can I do?**	**Resources and training**
Personalised Care	**PC 01:** Refer eligible patients to Social Prescribing services	• Overlap with DES 8.10.1	• Include social prescribing referrals as part of SMRs, where appropriate	
Access	**ACC 09:** Refer suitable patients to the Community Pharmacist Consultation Service (CPCS)	• Refer suitable patients with a minor illness for a same day appointment with a community pharmacist	• Confirm what the locally agreed pathway for referring is (usually agreed amongst the PCN) • Raise awareness of the scheme amongst other healthcare professionals • Place posters listing conditions that can be referred under the CPCS service in all clinical rooms (see Appendix 2) • Consider training to reception/triage staff	• NHS England: Community Pharmacy Consultation Service • PSNC: CPCS resources, including slides to present to the practice/PCN for training purposes

			to assist in referring (reducing GP workload)	

Structured medication reviews and medicines optimisation	**SMR 01A:** Conduct an SMR with patients identified as at risk of harm due to medication errors	• Overlap with DES 8.3
		• The following are definitions of patients at risk of harm due to medication errors, those:
		  ○ ≥65 years prescribed an NSAID and no gastroprotection
		  ○ ≥18 years prescribed an NSAID with a history of peptic ulceration
		  ○ ≥18 years prescribed an antiplatelet with a history of peptic ulceration
		  ○ ≥18 years prescribed an NSAID and anticoagulant within 28 days of each other
		  ○ ≥18 years prescribed an antiplatelet and aspirin within 28 days of each other
		  ○ ≥18 years prescribed an antiplatelet and anticoagulant within 28 days of each other
		  ○ ≥18 years with heart failure and prescribed an NSAID
			• Plan with your practice/PCN lead, how many SMR sessions a week you could complete and agree a suitable length of time for each appointment, for example 20 minutes per patient
			• Decide whether some SMRs may be suitable for a telephone appointment vs. face to face
				• NHS England: Structured medication reviews and medicines optimisation

		○ ≥18 years with an eGFR <45ml/min and prescribed an NSAID ○ ≥18 years with asthma and prescribed a non-selective beta-blocker		
	SMR 01B: Conduct an SMR with patients identified as severely frail	• Overlap with DES 8.3		
	SMR 01C: Conduct an SMR with patients using potentially addictive medicines	• Overlap with DES 8.3 • The following two cohorts are patients eligible under this criterion • Cohort 1 - those prescribed 2 or more of any other following medicines over 3-months: ○ Gabapentinoids ○ Benzodiazepines ○ Z-drugs ○ Oral or transdermal opioids (NOT including codeine, dihydrocodeine, meptazinol, heroin substitutes e.g. methadone/buprenorphine) • Cohort 2 – those prescribed oral/transdermal opioid which is	• The outcome of these SMRs may be a patient wishes to start withdrawal from the addictive medication - confirm whether you have a specialist local team to refer patients to who assist with withdrawal of addictive medicines	• Specialist Pharmacy Service: Tool to calculate estimated dose equivalences of oral morphine to other oral opioids

		>120mg oral morphine equivalent (in a single prescription) • This indicator excludes patients with a cancer diagnosis (recorded in the past 6 months, including new/recurring/ongoing diagnosis)		
	SMR 01D: Conduct an SMR with patients over 18 years and are permanent care home residents	• Overlap with DES 8.3	• Does your PCN have care home pharmacists to collaborate with on this indicator?	
	SMR 02A: Conduct an SMR with patients 18 and over who are prescribed both an NSAID and anticoagulant	• The aim of this indicator is to either stop prescribing the combination of agents (remove the NSAID), or if not suitable, to add gastroprotection		
	SMR 02B: Conduct an SMR with patients 65 and over who are prescribed an NSAID with no gastroprotection	• The aim of this indicator is to either stop prescribing the NSAID, or if not suitable, to add gastroprotection		
	SMR 02C: Conduct an SMR with patients 18	• The aim of this indicator is to either stop prescribing the		

	and over who are prescribed an oral anticoagulant and an anti-platelet	combination of agents (remove the antiplatelet), or if not suitable, to add gastroprotection		
	SMR 02D: Conduct an SMR with patients 18 and over who are prescribed aspirin plus another antiplatelet	• The aim of this indicator is to either stop prescribing the combination of agents (remove either agent), or if not suitable, to add gastroprotection		
	SMR 03: Conduct an SMR with patients who are prescribed a DOAC and have a recent renal function test (interval depends on Creatine Clearance (CrCl) – see resources section) and have a recording of their weight and CrCl, plus a recording that their DOAC dose was either changed or confirmed (not changed)	• The aim of this indicator is to ensure patients are prescribed the correct DOAC dose based on renal function • Following the SMR, it must be recorded whether the DOAC dose was 'changed' or 'confirmed (not changed)'	• Plan ahead of these SMRs – ensure all patients booked in for an SMR have a recent weight, height and renal function test in advance of the review • NB: each time a patient has an updated renal function and CrCl, the correct code, with 'changed' or 'confirmed (not changed)', must be recorded, even if it is within the same financial year. The more recent CrCl will override any previous codes. This is	• NHS Herts Valley: Guidelines for oral anticoagulation of patients with non-valvular atrial fibrillation (AF) to prevent stroke in adults • MD Calc: Creatinine Clearance calculator

Area	Indicator	Additional criteria/detail	What can I do?	Resources and training
			particularly important for patients on 3 or 6 monthly monitoring	

Respiratory care	**RESP 01:** Review asthmatics who are not on an Inhaled Corticosteroid (ICS) but are prescribed a short-acting Beta agonist (SABA) inhaler (see exclusions)
	
	RESP 02: Review asthmatics who have been prescribed 6 or more SABA inhalers in the past 12 months
		• Conduct an asthma review to overlap with QoF requirements and IIF ES 01/02 (see below)
		• Aim is to increase ICS prescribing where appropriate and to reduce patient reliance on SABAs/risk of exacerbations
		• Definition of ICS includes ICS/LABA inhalers and MART therapy
		• Patients excluded from this indicator include those:
		  ○ Where an ICS is not indicated
		  ○ Diagnosed with mild asthma (rather than moderate/severe)
		  ○ <3 SABA prescriptions in a 12-month period (<4 if under 18 years)
			• Consider prioritising patients prescribed the highest volume of SABA inhalers
			• Utilise the community pharmacy New Medicine Service for support with follow up
				• NICE: Patient Decision Aid: Inhalers for asthma

Domain: A Sustainable NHS

Area	Indicator	Additional criteria/detail	What can I do?	Resources and training

Environmental sustainability	**ES 01:** Offer patients prescribed Metered Dose Inhalers (MDI), more environmentally friendly Dry Powder Inhalers (DPIs) or Soft Mist Inhalers (SMIs) where clinically suitable **ES 02:** Offer patients prescribed MDIs inhalers with lower carbon emissions (kg CO2e), where suitable	• Conduct an asthma review to overlap with IIF RESP 01/02 and QoF requirements	• Consider prioritising patients prescribed the highest volume of MDI inhalers • Utilise the community pharmacy New Medicine Service for support with follow up • Provide training to prescribers and other healthcare professionals on prescribing MDIs (where still indicated) by brand based on carbon emission levels • See Appendix 3 for list of inhalers and associated carbon emission levels. This list can be shared amongst prescribers to encourage clinicians to choose lower carbon emission inhalers	• NICE: Patient Decision Aid: Inhalers for asthma • Greener Practice: High Quality and Low Carbon Asthma Care – includes training for healthcare professionals and a toolkit to help practices achieve IIF targets • PrescQIPP: Bulletin 295: Inhaler carbon footprint – further resources for practitioners and patients

ECF

Summary

Below is a summary of the key indicators from ECF for Clinical Pharmacists to support, including practical advice and suggested activities/optional training (unless stated).

The following criteria are to be achieved at GP practice level.

The searches for ECF are provided by Ardens and will be integrated into the GP system.

The table below provides an overview of each indicator, and it is recommended that you read the full criteria before undertaking related tasks.

A: Compliance and Engagement				
Area	**Indicator**	**Additional criteria/detail**	**What can I do?**	**Resources and training**
Mandatory Elements (A1)	**A1.1: Engagement.** Actively engage with local GP practices, PCNs and the wider ICS	• Work together to identify and learn from incidents (including significant events and serious incidents)	• Ensure the practice maintains an incident log – a summary of this, including learnings from the incidents and improvements made to practice, could be shared with other practices to meet this criterion	• NHS England: Report a patient safety incident • NHS England: Learn from patient safety events (LFPSE) service
	A1.2: Local Pathways. Use and adhere to locally agreed clinical pathways	• Adhere to all ICS policies and guidance relating to prescribing	• Provide training and raise awareness amongst prescribers in the practice where to find relevant prescribing policies (see resources section)	• NHS Hertfordshire and West Essex ICB – see 'Information for clinicians'
Pharmacy and Medicines Optimisation (A2)	**A.2.1:** actively engage with the pharmacy and medicines optimisation team, adhere to cost effective prescribing through adherence of local and national prescribing guidelines	• Participate at practice/local/ICS Prescribing Meetings • Use systems to support best practice prescribing such as ScriptSwitch and Eclipse Live	• Provide training and raise awareness amongst prescribers in the practice where to find relevant prescribing policies (see resources section)	• NHS Hertfordshire and West Essex ICB – see 'Information for clinicians'

Anticoagulation (A3)	**A.3.1:** Safer anticoagulant prescribing (as part of Level 1 local service)	• Develop and maintain an anticoagulant register (warfarin and DOACs), which must include: ○ Patient name ○ DOB ○ Clinical indication ○ Length of treatment ○ Target INR (where appropriate) ○ Whether self-testing INR • Ensure the most recent INR result and next INR due date is recorded (where applicable) • Ensure all patients newly started on anticoagulants have verbal and written information including being provided with a Yellow Book or DOAC alert card • Ensure all patients self-testing INR are following an approved protocol (as per anticoagulation service), including reporting results and making dose adjustments • Agree an algorithm with patients who self-test INR – record the frequency of testing and how long 1 pack of 24 strips is expected to last – include this on the label • Ensure all clinical staff are competent regarding anticoagulation (see resources for	• See Appendix 4 for template anticoagulation register • Example of the INR self-testing algorithm: Patient X tests every 8 weeks, therefore a pack of 24 strips will last approximately 192 weeks/3.5 years. Add onto the dose/label, *'Patient tests every 8 weeks. Next prescription due March 2025'* • Update the practice Repeat Prescribing Policy, to address the safety of warfarin and DOAC prescribing, see Appendix 5 for an example	• BMJ Learning: Starting patients on oral anticoagulants in primary care: how to do it • BMJ Learning: Maintaining patients on oral anticoagulants: how to do it • NPSA: Anticoagulation competence assessment and statements

		suggested training and competence statements) and keep a record of all training completed • Ensure the prescribing of warfarin, INR monitoring and recording is included in the practice repeat prescribing policy • Have a DOAC prescribing policy in place • Report all emergency admissions related to anticoagulants to the ICS Medicines Team within 72 hours of becoming aware		
B: Clinical Transformation				
Area	**Indicator**	**Additional criteria/detail**	**What can I do?**	**Resources and training**
Chronic Obstructive Pulmonary Disease (COPD) (B2)	**B2.1:** Assess and record disease severity using GOLD stage during annual review	• Overlap with QoF • Complete and record COPD Assessment Tool (CAT) • To determine GOLD stage use CAT score, number of exacerbations in past 12 months and MRC breathlessness scale	• Utilise Ardens templates to complete reviews	• The COPD Assessment Test (CAT): Clinical Practice • The Primary Care Respiratory

	B2.2: Refer to appropriate services as part of annual COPD review	• Use GOLD stage to determine suitable services to refer to • Includes community respiratory services, pulmonary rehabilitation, mental health services and social prescribing (links to DES 8.10.1 and IIF PC 01 indicators)		Society: MRC dyspnoea scale • NICE CKS: COPD (including exacerbation management)
	B2.3: Agree a self-management plan for patient during annual review	• Self-management plans should include goal setting, monitoring symptoms, an exacerbation plan and ongoing treatment		

CVD (B.3)	**B3.1:** Review all patients on the CKD register annually	• Overlaps with QoF
		• Annual review to include:
		  ○ Monitoring/updating CKD stage (using eGFR and urine ACR)
		  ○ Check BP and treat where necessary
			• Utilise Ardens templates to complete reviews	• NICE CKS: Chronic Kidney Disease

	B3.4: Review all patients on the AF register annually	• Overlap with DES and IIF indicators • Include review of signs and symptoms (pulse check, cardiac symptoms, breathlessness, leg oedema) • Plus, review of bleeding risk, using ORBIT bleeding score	• Utilise Ardens templates to complete reviews	• NICE: Atrial fibrillation: diagnosis and management NG196 • British Heart Foundation: How to check

				your pulse training video
	B3.5: CVD secondary prevention	• Overlap with QoF • Review patients with established CVD/on CVD register and are not currently prescribed a statin (for those who do not have a record of previously declining or a contraindication/allergy/intolerance) • Offer statin treatment and record outcome (statin commenced or not initiated with reason)	• Invite patients via text or letter to book a review to discuss statins – include background information on CVD risk and statins so patients are informed before the consultation	• NICE: Cardiovascular disease: risk assessment and reduction, including lipid modification CG181 • UCL partners: Proactive Care Frameworks CVD resources

Diabetes and Non-diabetic hyperglycaemia (NDH) (B4)	**B4.1:** Review patients with NDH	• Review must include:
		  ○ Updated BMI
		  ○ Lifestyle advice
		  ○ Refer to appropriate services (e.g. weight management/social prescribing – link to DES and IIF)
			• Utilise Ardens templates to complete reviews	• NICE 8 care processes
				• Nice Diabetes: Patient Decision Aid – supports discussions with patients on treatment options, including assessing the

	B4.2: Ensure diabetic patients have a recent BMI, cholesterol and urine albumin check	• Compliments QoF requirements • 'Recent' can be defined as annually or more often, dependent on patient factors such as renal function		

	B4.3: Review all patients with high-risk diabetes in line with the 8 care processes, review medication and signpost to psychological support, where suitable	• Use UCL Partners risk stratification tool to identify individuals with high-risk diabetes • Use NICE 8 care processes to review patients • Review medication in line with UCL Partners guideline • Signpost patients for social and/or psychological support • Before referral to specialist/secondary care for diabetes management, trial the combination of at least 3 hypoglycaemic/diabetes agents		risk of hypoglycaemia and importance to the patient

	B4.4: Review patients with poorly controlled hypoglycaemia	• Review patients who are:
		  ○ >75 years old and,
		  ○ On a sulphonylurea and,
		  ○ HbA1c <48
		• In such patients, review ongoing need/current dose of sulphonylurea
		• In addition, review patients who:
		  ○ Have been prescribed >3 glucagon injections within the past 12 months
		• For these patients, review glucagon use and optimise diabetic treatment where required		

	B7.3: Review patients with frailty who are at high risk of harm from medication or polypharmacy	• Overlaps with DES and IIF
		• Can be undertaken as an SMR
		• Prioritise the following groups:
		  ○ Patients on ≥10 medicines
		  ○ Patients with an anticholinergic burden 6+
				• Calculate anticholinergic burden: ACB calculator

Further Support

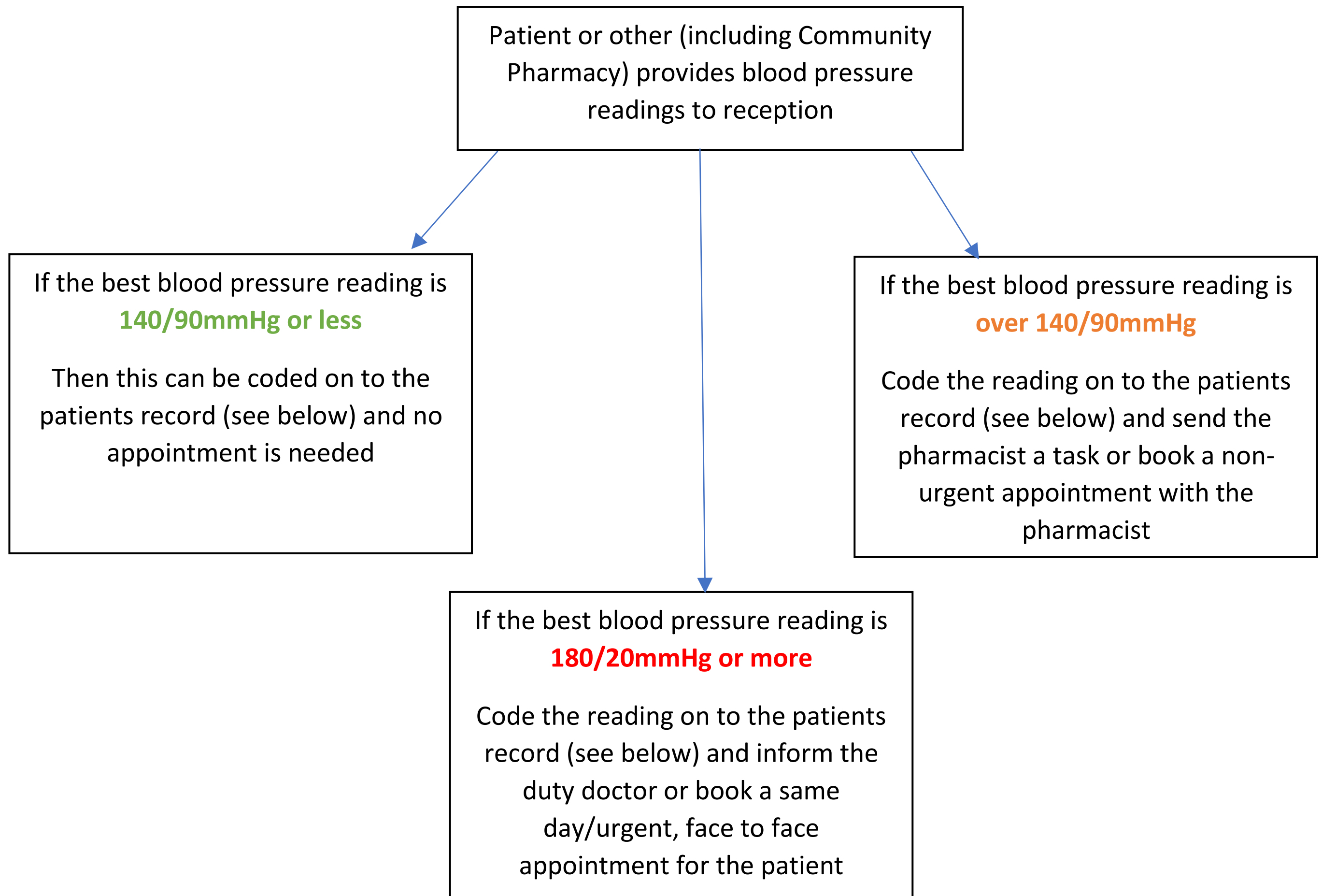
If you require further support, please contact:

Hollie Ryder (Primary Care Clinical Pharmacist Tutor), hollie.ryder2@nhs.net, or
Scott Downham (ICS Pharmacist Ambassador), scott.downham1@nhs.net

Appendices

Appendix 1

Reception Protocol for Blood Pressure Readings



To enter the reading into a patient's records please do the following:

- Consultation
- Add consultation
- Change consultation type to 'externally entered'
- Select 'Examination'
- Click on the lightning bolt next to the word 'examination'
- Select blood pressure and a box pops up
- Enter the BP reading. The first box is the Systolic number and the second box is the diastolic number
- Click on the green tick to accept the figures you entered
- Save the consultation

Appendix 2

Community Pharmacy Consultation Service: Eligible Conditions

This list is not exhaustive

Acne, spots and pimples	Lower limb pain or swelling
Allergic reaction	Mouth ulcers
Ankle or foot pain or swelling	Nasal congestion
Athlete's foot	Pain and/or frequency passing urine
Bites or stings, insect or spider	Rectal pain
Blisters	Scabies
Constipation	Scratches and grazes
Cough	Sinusitis
Diarrhoea	Shoulder pain
Ear discharge or ear wax	Skin rash
Earache	Sleep difficulties
Eye, red or irritable	Sore throat
Eye, sticky or watery	Teething
Eyelid problems	Vaginal itch or soreness
Hair loss	Vomiting
Headache	Wound problems – management of dressings
Hearing problems or blocked ear	Wrist, hand or finger pain or swelling
Itch	Vaginal itch or soreness
Knee or lower leg pain	Vomiting
Lower back pain	

Appendix 3

Carbon emissions for different salbutamol inhaler types

Prescribing term	Carbon emissions per inhaler (kg CO_2e)
Ventolin Accuhaler 200 microgram	0.58
Easyhaler Salbutamol 100 microgram	0.62
Easyhaler Salbutamol 200 microgram	0.62
Salbulin Novolizer 100 microgram	3.75
Airomir 100 microgram	9.72
Airomir Autohaler 100 microgram	9.72
Salbutamol CFC free breath actuated inhaler 100 microgram (GENERIC)	11.79
Salamol CFC-Free Inhaler 100 microgram	11.95
Salamol Easi-Breathe 100 microgram	12.08
Salbutamol CFC free Inhaler 100 microgram (GENERIC)	25.24
Ventolin Evohaler 100 microgram	28.26

Appendix 4

Anticoagulation Register template

Patient name	DOB	Anticoagulant	Clinical indication	Length of treatment	Target INR (for warfarin)	Self-testing? Y/N
Example Joe Thomas	*01/01/61*	*Warfarin*	*AF*	*Lifelong*	*2.5*	*N*
Example Shirley Jones	*02/02/52*	*Rivaroxaban*	*DVT*	*6 months*	*N/A*	*N/A*

Appendix 5

Repeat Prescribing Policy Update - High Risk Drugs and Safety: Warfarin

Reception/admin team

When a prescription request for warfarin is received, check when the patient last had an INR check (patient's yellow book) and when the next INR is due. This may be every 4-12 weeks depending on the patient.

Check if this information has been recorded in the patients record already. If it is not, add a consultation note including the following information:

- Date of last INR
- INR result
- Current warfarin dose
- Next INR due date

If INR is overdue, refer to Clinical Pharmacist/GP.

Prescribers

When issuing a warfarin prescription, the prescribing clinician must ensure:

- Prescribing is in line with the most recent INR test result
- The patient is reminded to inform the anticoagulation clinic if they will be having a surgical procedure to ensure that the anticoagulant is adjusted as appropriate.
- Quantities and strengths prescribed are appropriate for the dose the patient is administering and not in excess.
- Prescribing of 5mg warfarin tablets is not usually recommended to avoid confusion with 500microgram strength.
- If a patient is co-prescribed one or more clinically significant interacting medicines, that arrangements are made for additional INR blood tests, and that the anticoagulant clinic is made aware that an interacting medicine has been prescribed.
- The anticoagulant clinic is informed if the patient has any factors that may contribute to poor control including: -
    - Lack of patient education
    - Poor cognitive function
    - Poor adherence to prescribed therapy
    - Illness
    - Interacting drugs
    - Lifestyle factors including diet and alcohol
- Doses are expressed in mg and not in number of tablets.
- All dose changes, originated by the surgery, for patients in care homes are confirmed in writing.

Repeat Prescribing Policy Update - High Risk Drugs and Safety: DOACs

When initiating and issuing a DOAC prescription, the prescribing clinician must ensure:

- Choice of anticoagulant should be based on patient characteristics.
- DOACs (dabigatran, rivaroxaban, apixaban and edoxaban) to be initiated in line with local guidelines.
- Risk and benefits of anticoagulation in AF, to be discussed with patient and decision to start treatment, including choice of product, to be agreed with patient.
- Baseline renal function, haemoglobin, platelets, renal function, CHADS2-VASc and ORBIT score undertaken and recorded in the notes (NB: HAS-BLED may need to be used until ORBIT is embedded in clinical pathways and electronic systems).
- Patient to be reviewed after one month to check whether treatment is tolerated, and blood and repeat renal function are the same as the baseline.
- Complete compliance/adherence checks: The protective effect of DOACs on the risk of stroke may fade 12 to 24 hours after dose is taken
- Ongoing face to face adherence checks and renal function management to be undertaken in line with local guidance and drug choice and dose adjusted accordingly:
    - Annually if CrCl > 60ml/min
    - 6 monthly if CrCl 30-60ml/min
    - monthly if CrCl < 30ml/ min, ≥ 75 years or expected decline in renal function e.g. during acute illness
    - 6 monthly weight to calculate CrCl
- Calculate creatinine clearance (CrCl) using the Cockcroft-Gault formula within the prescribing system or online calculator, such as MD Calc