APPG on
Primary Headache Disorders

The Role of the Pharmacist in the Management of Primary Headache Disorders

4pm, 18th July 2016, Committee Room 21

Meeting Summary

Chair: Jim Fitzpatrick MP

Officers in Attendance: Pauline Latham MP, Baroness Masham of Ilton, Viscount Simon

Speakers: Sandra Gidley, Ade Williams, Stuart Weatherby, Victoria Harman

Intro

JF opened the meeting and welcomed the officers, speakers and members of the public in attendance. He explained that the purpose of the meeting was to understand the role of the pharmacist in the management of headache disorders and to explore opportunities to improve patient outcomes and experience through pharmacist-led care.

Sandra Gidley. Chair of the English Royal Pharmaceutical Board

SG began her presentation by describing the pharmacist as a registered health professional with 5 years training and subsequently a very large wealth of knowledge. She explained that the pharmacist has huge, relatively untapped, expertise to offer patients and clinicians. She described examples of the potential for pharmacists to deliver services beyond simply prescribing. SG explained that where the condition is straight forward the pharmacist can take some pressure off GPs by delivering some of the role that would traditionally be provided by the doctor. She explained that for this to be successful there needs to be clear guidelines to instill confidence in all parties in the delivery of care. SG explained that the pharmacist is often the first professional that a person with headache would speak to so they can play a pivotal role in their care as well as identifying concerns with repeat visits and the need for further investigation.

SG explained that although much progress had been made for pharmacist led care for people with common ailments such as headache progress was at risk due to expected cuts to community pharmacy. A government announcement on this is expected and exact details are not clear at this stage. This is likely to mean reduction in staff and reduced hours which is contrary to the desired direction of travel. The implications of this will put more pressure on sector rather than embracing the potential for pharmacy to reduce the burden elsewhere in the health system.

Ade Williams, Community Pharmacist, Bedminster Pharmacy

AW echoed the points made by SG and emphasised that seeing a pharmacist provides access to a highly skilled medical professional. He explained that since the pharmacy is often a first point of contact the pharmacist can play an important role in screening and diagnosing certain patients. He expressed concerns regarding the cuts and suggestions that the pharmacist could be taken away. He stressed the importance of having a person who could support and inform people. AW also highlighted that advice from the pharmacist is very beneficial to patients who are most economically active and do not always have time to visit the GP. He explained that as well as providing medication pharmacists have the opportunity to explore therapeutic means and lifestyle factors for people with long-term conditions, particularly those who come back with repeat prescriptions. Where concerns arise the pharmacist will refer people back to their GP or health professional.

AW outlined initiatives to improve communication between pharmacists, GPs and patients through health records. With the patient's consent pharmacists can have access to patient summary care records, this enables them to check medication history and identify any issues and reasons for concern which can be addressed with the patient. The ability for pharmacists to write on the patient's records means that these concerns can be followed up by the doctor if required. AW stressed that this relied on patients' consent and ensuring that they understood the purpose of the process.

AW described the opportunity for pharmacies to promote awareness of headache disorders in migraine awareness week and at similar key times. He concluded that an integrated way of working could provide a better model of care for people with long-term conditions. HE also highlighted the benefits that specialist pharmacists could have in spreading good practice and better awareness of particular conditions such as headache disorders.

Stuart Weatherby, Consultant Neurologist, and Victoria Harman, Neurosciences Pharmacist, Derriford Hospital, Plymouth

SW explained that stroke, epilepsy and headache are the most common neurological reasons that people come to hospital and account for the highest outpatient numbers. He stressed the importance that this was recognised despite not necessarily being in line with current political focus.

SW explained that our health system is structured in such a way that once patients are able to see a neurologist they then have to wait a very long time for a follow up appointment. During this time a number of personal and lifestyle changes may have occurred which impact on their condition, self-management and the support they require. SW explained that in Plymouth his team found that most of their patients had been living with migraine for 10 years or more, most with severe problems, before being referred to the service. They identified an untapped need for better long-term follow up. He concluded his section of the talk by explaining that different teams can effectively deliver different aspects of care and the challenge was to find the right formula to sit patients' needs best.

VH went on to explain that pharmacists are involved in patient management in other conditions, and represent an untapped resource in headache. She echoed SG's comments on the role that the pharmacist can take and described the pharmacist-led clinical service, set up in Derriford Hospital in 2008, which integrated within the existing headache service (see slides for full explanation of the service). VH concluded that there was a high level of satisfaction with the

pharmacist-delivered service. Both patients and clinicians reported overall positive experiences. VH explained that there was the opportunity to take this wider into the community and the potential to explore a bespoke model where pharmacists can bridge primary and secondary care. VH said this was particularly beneficial in places where transport links were poor. However both SW & VH noted that the number of organsiations involved created a stumbling block to successfully taking the modell out to the community.

Q&A

In response to a question about compliance and follow up SW said that patients need to be followed up through to resolution. However he explained that how to monitor and when to follow up is not so well understood by headache patients as other conditions e.g. diabetes. SW & VH both emphasized this as why follow up telephone service from the pharmacist was so beneficial.

In response to a concern regarding a possible conflict of interest for pharmacists regarding the sales of certain medications e.g. migralieve and concern from 2 suadience members about the increasing number of patients at headache clinics who have been taking opiods AW responded. H explained that pharmacists have professional obligations and are strongly regulated. He also described a pregnancy advice service delivered by pharmacists in Bristol where all pregnant patients were given a specific number to call if unsure their medication was unsuitable, as a positive example of how pharmacists could give specific advice to subgroups of patients.

In response to a question about the response of GPs to initiatives to share patient summary care records SG responded that that the current situation is positive. She explained that GPs have been on a journey over the past 10 years and are now more receptive to sharing. She cited that her work with the RCGP showed that most were in favour. SG explained that she agreed with the Secretary of State fro Health that the patient should have access to their own record and decide when to give consent for other professionals to see it and that this could be beneficial.

In response to a concern that the pharmacist was not best suited to identify and flag up concerns about trigeminal neuralgia SW responded. He explained that a lot of things come from making a diagnosis of TN and as part of a team it is much easier for a rapid response to flow. SG emphasized that within the framework of a system diagnosis is easier. He also suggested that an IT solution could help patients to become more educated and informed to trigger their own follow ups. He described a neurology app produced by a colleague which won and award and highlighted the potential to develop such an app within headache.

Close

JF thanked the speakers, officers and ll in attendance for a very productive and useful meeting.

Contact

For more information about the meeting and the work of the APPG please contact the group's coordinator hverghese@migrainetrust.org