Author’s response to reviews

Title: Community pharmacy integration within the primary care pathway for people with longterm conditions: a focus group study of patients’, pharmacists' and GPs’ experiences and expectations

Authors:

Ali Hindi (ali.hindi@manchester.ac.uk)

Ellen Schafheutle (Ellen.schafheutle@manchester.ac.uk)

Sally Jacobs (Sally.jacobs@manchester.ac.uk)

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Author’s response to reviews:

Editor

1. Comment: We are happy to accept your interesting manuscript pending some minor revisions. Can you carefully proof read and correct the grammatical errors and typos which remain in the manuscript when you submit your final version.

Response: We are delighted for the opportunity to revise the minor revisions for this journal. The authors have proof read and corrected any grammatical errors and typos identified in the manuscript.

2. Comment: We request that a point-by-point response letter accompanies your revised manuscript. This letter must provide a detailed response to each reviewer/editorial point raised, describing what amendments have been made to the manuscript text and where these can be found (e.g. Methods section, line 12, page 5). If you disagree with any comments raised, please provide a detailed rebuttal to help explain and justify your decision.

Response: Point-by-point responses to all comments are provided below. Track Changes mode has been used to highlight changes. IMPORTANT NOTICE: The lines and page numbers in this document refers to the Microsoft word document of the amended manuscript we have submitted.
Reviewer 1

1. Comment: I would like to thank the authors for their detailed and helpful responses to my initial review. The changes have improved the clarity of the paper and I am happy that the authors' responses adequately address all the issues raised. There are just two points I feel may still benefit from reconsideration at the discretion of the authors.

Response: Many thanks for the comments. We are pleased that the changes have adequately addressed all the issues raised. We detail our responses and how we addressed all the remaining comments below.

2. Comment: In my opinion, what is meant by "integration within the primary care pathway for LTCs" is still not well defined and in most cases is referring principally to "integration with primary care or primary care services" or more specifically to "collaboration with GPs" (rather than to specific primary care pathways for long term conditions). The authors may wish, at their discretion, to reconsider their wording/definitions in light of this being an essential element of the aims of the study?

Response: This is a good point. For clarification, we have now provided a definition of what is meant by the “primary care pathway for patients with LTCs”:

“The primary care pathway for patients with LTCs is the healthcare route these patients take for ongoing treatment and management of their conditions [4, 6]. GPs are central to this patient pathway, but community pharmacy services have traditionally been quite separate and GPs may not be aware or necessarily supportive of extended services due to concerns about pharmacists’ financial motives, competencies, and encroachment of professional boundaries [27]. This lack of GP support/awareness also impacts patients’ awareness, demand and use of community pharmacy services as many patients seek GPs endorsement for use of healthcare services [25, 26]. A lack of community pharmacy integration within this patient pathway prevents benefits to patients or the healthcare system through the optimal use of extended pharmacy services [27]. It is important to identify how community pharmacies could be better used and integrated within
the patient’s primary care pathway, as effective collaboration between GPs and community pharmacists will be an important factor to optimise patient care [25, 26]". (page 4, lines 16-30)

3. Comment: I accept the authors' response in relation to my comment about the discussion/interaction within the focus groups. However, I would still recommend that they reconsider this issue in relation to the way the results are reported for clarity purposes. The results do not always provide a very clear description of the level of shared understanding or disagreement within the groups. (The following examples are just to try and illustrate this point: p10 line 8: "public health services were not usually discussed by any of the stakeholder groups" - does this mean they were discussed or not? Was there agreement within/between the groups on this issue or not? P13 line 31 "some patients were wary of pharmacists workload pressures" Is the quote provided as an example of a shared understanding/beliefs or was this just the opinion of one person? Was this issue discussed in both patient focus groups or just one? Is the fact that some patients were wary of this, an indication of a lack of shared understanding? What were people's opinions about this once the topic was raised?

Response: Having reviewed the data, we have followed through with this recommendation by highlighting the level of shared understanding or disagreement within the focus groups in the following sections:

• “Public health services were not usually discussed by any of the stakeholder groups. Even when stakeholder groups were probed about public health services, all stakeholders mentioned that patients rarely used them and were unaware of them being offered by community pharmacies. Moreover, participants in all focus groups considered public health services to be expanded rather than standard community pharmacy services”. (page 10, lines 1-6)

• “Overall, there was a shared agreement between all focus groups that patients with LTCs would benefit from community pharmacies regularly providing check-ups and medication reviews”. (page 10, lines 21-23)

• “GPs and practice nurses were viewed by most patients and all GPs as more experienced and authoritative healthcare professionals to manage patients’ conditions and perform clinical services. Only a few patients in the respiratory and diabetes focus groups argued that pharmacists were well-suited to manage patients’ conditions and perform clinical services”. All pharmacists
also believed that patients would be more comfortable with GPs and practice nurses managing their conditions and performing clinical services. (page 11, lines 1-8)

• “Similarly, most GPs supported pharmacists providing minimally invasive procedures but needed to be assured that the pharmacists providing these services were competent”. (page 11, lines 18-20)

• “None of the patients recalled GPs referring them to pharmacy services. Similarly, most GPs did not recall referring patients to any pharmacy services”. (page 12, lines 18-20)

• Most pharmacists and GPs proposed developing community pharmacy services that had clear specifications and focused on a single, specific intervention, mentioning flu vaccination and inhaler technique services as examples. “All of the patients in the respiratory and diabetes focus groups similarly expressed preferences for community pharmacy services that focused on one particular intervention such as cholesterol and blood tests emphasising that procedures for these services were easy for them to understand”. (page 13, lines 5-13)

• Some patients in the respiratory and diabetes focus groups were wary of pharmacists’ workload pressures and doubted their capacity to provide extra services beyond dispensing medications. When discussed, all stakeholder groups generally agreed that pharmacists’ workload was a major barrier to providing extra services beyond dispensing medications. (page 13, lines 22-26)

• All GPs in one of the focus groups also discussed including community pharmacies as part of care plans for patients with LTCs. (page 14, line 13)

• Patients in all focus groups often referred to their relationship with their pharmacists and how it influenced their perceptions of community pharmacies. (page 15, lines 28-29)

• All pharmacists mentioned the importance of having the whole pharmacy team engaged with delivery of services in order to reduce workload pressures on pharmacists and enhance workflow. (page 16, lines 23-24)
• “Some patients in the respiratory focus groups were also aware of these funding conflicts which made them question collaboration between pharmacists and GPs. Regardless of funding conflicts awareness, patients in all focus groups were in agreement that their pharmacists and GPs did not collaborate with each other. (page 16, lines 28-31)

• “Pharmacists and GPs in all focus groups argued that unless both were adequately remunerated for joint working, they were unlikely to prioritise the promotion or provision of extended pharmacy services”. (page 17, lines 6-8)

• “All of the pharmacists also discussed GPs’ unwillingness to recognise pharmacists as healthcare providers as another barrier to collaboration. They believed GPs did not have an understanding of what pharmacists could offer to patients with LTCs. Conversely, all GPs often discussed community pharmacists’ potential to expand and become an integral part of patients’ primary care pathways”. (page 17, lines 15-21)

• A few pharmacists in both focus groups mentioned instances of successful collaboration when they had invested time and effort to communicate their roles and demonstrate their skills to GPs. When discussed, all the pharmacists and GPs believed that although GPs were receptive to such approaches, they wanted pharmacists to be more proactive. (page 17, lines 27-31)

• “All patients were generally unaware of the considerable heterogeneity in community pharmacy types and organisations”. (page 20, lines 2-3)

• “In addition, GPs in all focus groups did not want to risk referring patients to community pharmacies for services that may not be offered”. (page 21, lines 19-20)

4. Comment: P.3. line 26 - the inclusion of the definition of signposting is a useful addition, however how the sentence is structured does not make it clear that the definition relates to "signposting". Could the addition of i.e. help clarify this?
Response: We have now included “i.e.” to help clarify that the definition provided relates to signposting. (page 3, line 24)

5. Comment: P4 - line 10 - the revised contract is mentioned - however there is no explanation as to what this is.

Response: When referring to the revised contract, we meant the new community pharmacy contractual frameworks in the UK which we have explained in the background section (page 3, lines 18-32 & page 4, lines 1-7). However, for consistency, we have replaced the term “revised contract” with “new community pharmacy contractual frameworks”:

“Despite the new community pharmacy contractual frameworks in the UK, there have been barriers to pharmacists providing extended services such as…” (page 4, lines 8-9)

6. Comment: P4 line 14 - should this be "within primary care" (rather than "within the primary care")?

Response: This has now been amended (page 4, line 13)

7. Comment: P5 line 3 - patient's should read patients'

Response: This has now been amended (page 6, line 1)

8. Comment: P7 line 6 - the revised sentence does still not read clearly

Response: This sentence has now been amended again for clarification:
“The characteristics patients were selected on were that they had one or more of the common long-term conditions: type 2 diabetes, asthma, chronic obstructive pulmonary disease (COPD). Many community pharmacy services already exist which are relevant to patients with these conditions such as: medication reviews, health checks (blood pressure, cholesterol tests etc.), influenza vaccinations and smoking cessation [46-50].” (page 6, lines 24-27 & page 7 lines 1-3)

9. Comment: P20 line 25 - "the pharmacy" - would it be clearer to say "their usual pharmacy" or "the pharmacy/pharmacies they had previously used"? It is unclear what "the pharmacy" refers to.

Response: This is a good point. For clarification, "the pharmacy" has now been replaced by "their usual pharmacy" (page 20, line 5)

10. Comment: P27 - line 7 - should this read: "the study is applicable" or "the findings are applicable"?

Response: This sentence has been amended and now reads “…further research will need to establish whether the study findings are applicable to other LTCs”. (page 26, lines 3-4)