

# SHARED CARE AGREEMENTS — HOW TO OVERCOME THE BLANK PAGE

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*This article describes how prescribing problems that occur across the primary-secondary care interface are being tackled by by pharmacists and others in the West Midlands*

It is more than 10 years since the Department of Health published "Responsibility for prescribing between hospitals and GPs".<sup>1</sup> This Executive Letter recommended that a transfer from hospital of drug therapies with which general practitioners would not normally be familiar should not take place without full local agreement and the dissemination of sufficient information to individual GPs. Despite efforts to develop and implement shared care agreements to facilitate this process, prescribing across the interface remains problematic.

In the West Midlands the Midland Therapeutic Review and Advisory Committee (MTRAC) was established in 1995 to provide a review system to identify the clinical value, safety and suitability for use of pharmaceutical products in primary care, and to enable and encourage their optimum introduction in the West Midlands region, including proposed transfers and requests from secondary care (Panel 1).

## Panel 1: About MTRAC

The Midland Therapeutic Review and Advisory Committee (MTRAC) has 30 members, most of whom are practising GPs from the West Midlands region. The chairman is a GP. Other members include (from primary care trusts within the region) a chief executive, a director of public health, a medical adviser and a pharmaceutical adviser. The committee also receives advice from a hospital clinical director (to represent hospital medicine), a lay member (to represent patients' views), and experts in the areas of clinical pharmacology, ethics, pharmacy, medicines information, prescribing analysis and health economics. The committee meets 10 times a year and discusses two or three products at each meeting. For each product the committee issues a verdict (guidance) of "appropriate", "restricted use" or "not appropriate", which relates to prescribing of the product by a GP:

- Appropriate — for prescribing in primary care
- Restricted use — appropriate for prescribing in primary care but requires input from a specialist, eg, confirmation of diagnosis, initiation of treatment, sharing of care
- Not appropriate — not recommended for prescribing in primary care

## THE TEMPLATE SHARED CARE AGREEMENT

MTRAC often recommends prescribing within the guidance of an effective shared care agreement (ESCA). The committee has always had a document outlining a minimum dataset that should be in place when developing or negotiating a shared care agreement. Despite this, the committee was aware that there was still considerable difficulty with the production of ESCAs within the region. From April 2001, MTRAC decided to help with the local development of ESCAs by producing templates when it recommends that prescribing should occur within such an agreement.

The template was developed in-house and was based on the minimum dataset already in place, and on the format and content in use in other areas, eg, Trent, South and West Devon, Northern and Yorkshire. The first template ESCA was developed in May 2001. The process for the production of these template ESCAs is outlined in Panel 2.

MTRAC does not produce finalised ESCAs: local consultation is essential to make the ESCA acceptable to those who will be required to operate within its terms, since shared care agreements apply to individuals and not to organisations. Such local adaptation also allows differences in health care delivery between primary care trusts to be incorporated.

The template ESCA document covers two sides of A4 paper. The format and content is outlined in Panel 3.

When the committee first embarked on the production of template ESCAs, it decided to conduct an evaluation of their usefulness and applicability after one year. By this time, five ESCAs had been developed, ratified and distributed by MTRAC, with a further three in

## Panel 2: How ESCAs are developed

At the MTRAC meeting where the product is discussed, members run through a checklist that covers diagnosis, initiation and stabilisation of treatment, dosage adjustment, monitoring (laboratory tests, response to treatment etc), follow up, adverse event reporting and discontinuing treatment, identifying key issues for the drug involved. The Keele office then develops the template.

The first draft is circulated for comment to the chairman of the committee, two other GP members, and the specialist who attended the committee meeting to discuss the product. Amendments are incorporated into the final template, which is then circulated to prescribing advisers within PCTs (and historically to health authority prescribing advisers) and to chief pharmacists of NHS hospital trusts for information.

The ESCAs are also available from the MTRAC website ([www.mtrac.co.uk](http://www.mtrac.co.uk)).

development. The five finalised ESCAs were for cyproterone acetate, dalteparin (for extended surgical prophylaxis), darbepoetin, exemestane and tobramycin nebuliser solution.

## EVALUATION

The evaluation was undertaken in June 2002. A two-page questionnaire was developed which was piloted by two prescribing advisers. The questionnaire was designed to identify awareness of MTRAC ESCAs, whether the ESCAs had been received, what action was taken on their receipt, and to obtain feedback regarding the content, presentation, level of detail and usefulness of the ESCAs. A copy of the template ESCA produced for exemestane accompanied the questionnaire in case recipients were not familiar with their content and layout.

In June, 76 questionnaires were sent by e-mail to the ESCA distribution list: prescribing advisers within primary care organisations, including some historical health

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authority advisers (n=53), and chief pharmacists (n=23). Completed questionnaires were anonymous. Non-responses after the two-week deadline were not followed up.

A total of 17 questionnaires (22 per cent) were completed and returned before the deadline. Of these respondents, 13 were advisers within PCOs, and four were secondary care pharmacists (chief pharmacists or formulary pharmacists).

Fourteen respondents were aware that MTRAC has been developing template ESCAs. Ten had received four of the five ESCAs; nine had received the one on dalteparin. Of the respondents who had not received the ESCAs, seven were advisers within a PCO.

Six responded to the question of what action had been taken on receipt of the ESCAs. The action taken by respondents included the following:

- All ESCAs were circulated to local practices without change
- Three of the ESCAs were adapted for local use
- All ESCAs were discussed by a district prescribing group
- Two ESCAs were copied to the relevant hospital consultant
- The exemestane ESCA was taken to the West Midlands Cancer Network oncopharmaceutical group

In general, feedback regarding content, presentation, detail and usefulness was positive. Respondents considered the template ESCAs useful for local adaptation. Respondents made a number of positive and complimentary written comments and made suggestions for change. These are summarised here:

- Put the responsibilities on the first page and the general information on the second
- Spread the responsibilities over two pages; numbering would make the responsibilities stand out
- The length of the document should not exceed two pages, and might be easier to read if the layout of the first page was the same as on the second, ie, no columns
- Having tick boxes/checklists might help the GP check that everything was in place before prescribing
- Recommend that the patient reports side effects to GP, specialist or specialist nurse, not just to the GP
- Add the statement "Explain to the patient what is the responsibility of the GP and what is the responsibility of the specialist"
- Discuss monitoring requirements in more detail, especially action to be taken in the event of abnormal results
- Make the date of publication clearer, especially on the first page
- Provide a patient leaflet outlining details of their care, so that patients are aware that it is a "shared care" agreement and of their responsibility to report back to clinicians

- Have a mechanism of communication between MTRAC and PCT advisers following the demise of health authorities
- Avoid duplication of work, and share information, eg, by having links to other ESCA sites via the MTRAC website
- Clarify whether there is specialist input in the development of the template

## DISCUSSION

The response rate to the evaluation was disappointing but this may be due to the timing in relation to changes in NHS structure. An area of concern is that many advisers within PCOs had not received the template ESCAs. To prevent this in future, we now have a comprehensive list of PCT advisers following NHS reorganisation.

Among respondents, the template ESCAs produced by MTRAC have been well received, and useful comments were provided. Of note is that the evaluation suggested that the template did well in identifying the specialist's and GP's responsibilities, but respondents were less satisfied with those set out for the patient. The feedback from the evaluation has been helpful in identifying key areas for potential improvement.

**How the template ESCA will be changed — evolution not revolution** Many of the suggestions for change have been incorporated into a revised version of the template which will be used for future ESCAs. The changes include:

- Altering the layout so that responsibilities are on the first page, with numbering
- Having a tick list for the responsibilities of specialist and GP
- Clarifying adverse drug reaction reporting, and the shared care arrangements for patients
- Wherever possible specifying the frequency of monitoring and action to be taken in relation to the results, although local agreement on this is recommended
- Stating the date of development on both sides of the document, together with reference to the summary of product characteristics and the relevant MTRAC verdict and summary sheets

We will also direct people to other ESCA sites known to us from our home page so that information can be shared. For this purpose we welcome information on other units or areas who also develop shared care agreements ([mtrac@keele.ac.uk](mailto:mtrac@keele.ac.uk)).

Following this evaluation we will also provide an explanation of how the templates are developed on the MTRAC website ([www.mtrac.co.uk](http://www.mtrac.co.uk)).

## Panel 3: Format of original template ESCA

### PAGE 1

- Introduction (background information about the condition or illness being treated)
- Licensed indications (taken directly from the summary of product characteristics)
- Dosage and administration (including contraindications and cautions)
- Therapeutic use (brief summary of trial data considered by the committee)
- Side effects
- Monitoring (based on SPC, evidence base, and specialist advice)
- Drug interactions
- Cost

### PAGE 2

- Generic statements inviting the GP to participate in shared care, and highlighting where responsibility lies with respect to writing the prescription
- List of specialist's (suggested) responsibilities
- List of GP's (suggested) responsibilities
- List of patient's (suggested) responsibilities
- Contact details for back-up advice and support
- Date of development

## LESSONS LEARNT

For shared care agreements to be accepted and used in practice, ownership is important. A team approach, involving key personnel in the development of shared care agreements is essential. MTRAC involves GPs and specialists from the outset but local involvement of other health care personnel is also necessary to promote ownership and implementation. In future it should be easier to facilitate a team approach from within PCTs.

Other researchers discovered a lot of scepticism with regard to the use of shared care agreements in practice.<sup>2</sup> Negative views were born of poor knowledge of local availability and on failures in implementation rather than of the concept itself. Following the demise of health authorities, MTRAC must ensure that the ESCAs are effectively distributed. Information technology is the key to facilitate awareness and to allow easier dissemination and sharing of information.

## REFERENCES

1. NHS Executive. Responsibility for prescribing between hospitals and GPs. EL(91)127. London: Department of Health; 1991.
2. Duggan C, Beavon N, Bates I, Patel S. Shared care in the UK: failings of the past and lessons for the future. *Int J Pharm Pract* 2001;9:211-6.