

Bridging the gap — joint formularies and leadership

The development of joint formularies and leadership across primary and secondary care was discussed at the *Hospital Pharmacist* conference.

Haley Hill reports

Secondary care prescribing influences 40 per cent of the drugs prescribed in primary care, said Sharon Hems, formulary pharmacist, St John's Hospital, Livingstone, Lothian in explanation for the need for joint formularies. Ms Hems explained how her team developed a joint formulary, covering 130 GP practices and four NHS hospitals with a medicines expenditure of £100m per annum.

The definition given to the Lothian joint formulary is: "A formulary designed to provide guidance on first and second choice drugs in primary and secondary care for the treatment of common conditions in the vast majority of patients." Ms Hems said that the aim was to reach an agreement between primary and secondary care about which drugs should be prescribed, to promote safe, effective and economic prescribing and to produce greater familiarity with a limited range of drugs. It was hoped that the formulary would provide a seamless approach to prescribing and that it would help manage the introduction of new drugs, avoiding "information overload". Finally, from a budget perspective, the aim was to increase generic and other cost-effective prescribing.

Development

Initially a subgroup — the area Drug and Therapeutics Committee — was formed and a formulary pharmacist appointed. "We sent out a questionnaire to the GPs in Lothian to obtain views on the content and format," Ms Hems said. The survey showed that over 80 per cent of GPs requested that information on dosing, adverse effects, contra-indications, guidelines and first- and second-line drugs be included. "Before the formulary was developed, a working group was set up comprising a multidisciplinary team including doctors, nurses, dietitians, etc," she said. "There were 40 groups each made up of eight to 10 members." She commented that this gave ownership of the formulary to the multidisciplinary team and ensured all the users' needs were taken into account.



Sharon Hems: joint formularies promote safe, effective and economic prescribing

The formulary pharmacist prepared the initial draft for discussion, basing the choices on safety, efficacy, patient acceptability, cost-effectiveness and evidence, Ms Hems explained. This initial draft was then reviewed by the working group, further meetings were arranged as necessary and the final draft was submitted to the formulary sub-committee for approval.

An implementation working group was set up with a strategy to increase the awareness and use of the joint formulary. Ms Hems said that, aside from promoting and distributing the formulary, the group produced patient information leaflets and learning modules for doctors and pharmacists. They also produced a regular Lothian Joint Formulary news update and distributed posters, mugs, pens and lanyards promoting it. "Formulary adherence and implementation was added to the objectives of pharmacists and doctors in Lothian," Ms Hems added.

Format "Initially the formulary was produced in a ring binder with the idea that updates could be sent out when required," Ms Hems said. However, it proved too difficult to ensure that the updates were received

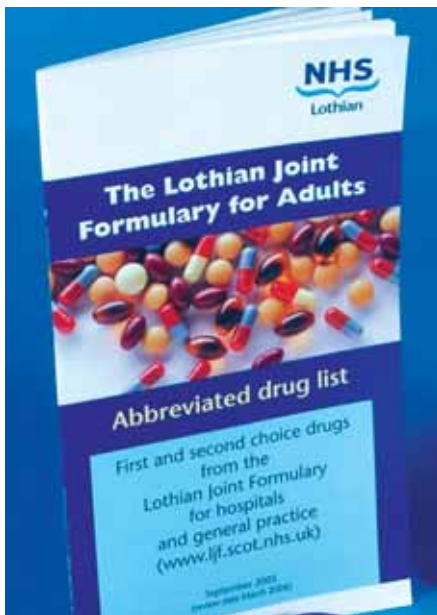
and incorporated into the formulary. Therefore, it was decided to update the formulary on an annual basis instead.

"The formulary follows the same format as the British National Formulary. We thought this would be more user-friendly. First- and second-line treatment for most common conditions were listed," she said. "We decided not to include the cost of therapy as we felt this would be difficult to keep up to date." She said that they expected drugs to be prescribed outside the formulary in various situations, for example, drugs prescribed in specialist practice and alternatives if the first- and second-line drugs were not tolerated.

Ms Hems explained that the formulary is also provided in a variety of other formats. Electronic copies are available via the internet (which can be accessed by the public) and via the trust's intranet site. She said that a CD format, which was provided in case there were access problems to the internet, was not used much so has not been reproduced since the first formulary. Ms Hems explained that the electronic format aids dissemination, increases access, facilitates updating and increases the amount of information that can be included. "The formulary is also downloadable onto hand held computers," she said.

She added that an abbreviated drug list is also provided that includes the drugs (first- and second-line) listed in the formulary but with no prescribing or dosing advice. "This list is updated every six months and is an ideal reference source because it is easy for staff to carry around," she said.

GP prescribing The electronic formulary also operates within the General Practice Administration System for Scotland (GPass) which is the national primary care system for Scotland. Ms Hems said that the electronic formulary within GPass offers decision support for GPs on drug choice, dose, frequency, formulation and quantity. The drugs are organised under disease-based formulary headings. "The risk of error is reduced because the GPs have to confirm



The Lothian joint formulary

the disease before they can select the drug,” said Ms Hems. She went on to explain that the formulary within GPass provides other prescribing guidance: “Advice is offered where no drug treatment is recommended for the condition, for example, tonsillitis”. She said that the BNF-recommended doses for paediatric formulations have been adopted.

Formulary applications Ms Hems said that there are two methods of requesting an amendment to the formulary. For the addition of a new drug, the pharmaceutical company must submit an application to the Scottish Medicines Consortium and the SMC decision is then forwarded to the formulary committee. The committee and the working group then make the final decision about whether the drug should be added to the formulary. “If the SMC approves a drug, we generally add it to the formulary, although we do not accept all SMC approved drugs — there are some exceptions,” she said.

For existing drug additions or amendments, a nominated pharmacist requests the addition and then the formulary pharmacist submits the application to the formulary committee and working group, which again, has the final decision, she explained.

— Future

Ms Hems pointed out that the main obstacle in developing programmes such as this is the cultural change for information users. She commented that communication is key and that this extends from the introduction of the formulary to any subsequent changes or updates that are made. She said that, in

future, they intend to include recommendations from the National Institute for Health and Clinical Excellence and from the Scottish Intercollegiate Guidelines Network as part of the formulary, but she added that this would require regular updating. She also suggested the possibility of giving GPs feedback on their adherence to the formulary and providing a comparison with other GPs’ prescribing practices.

Ms Hems commented that the new general medical services contract within the Scottish Executive Health Department can award points as medicines management quality indicators from formulary implementation. She believes that this will encourage GPs to use the formulary.

She said that the formulary has been successful in terms of influencing prescribing practices but that further measures should be assessed. “We need to look at factors such as the impact on patient care and expenditure, although these are difficult to measure,” she said.

Ms Hems believes that the success of the formulary is due to the wide ownership and because it is dynamic, constantly evolving and reflects local advice and expertise. She concluded that an implementation strategy is essential to encourage use of the formulary in primary and secondary care and to impact prescribing practices.

Leading the way across complex interfaces

There are many interfaces between primary and secondary care, proposed Sue Ashwell, director of medicines management at Hinchingsbrooke Health Care NHS Trust and Huntingdonshire Primary Care Trust. “We should not be able to see where the organisations join because patients neither know nor care and should not have to know or care,” she said.

Discussing how to bridge the interface between primary and secondary care, she posed the question to delegates — Are joint posts the answer? “We have very few formal joint posts — we have in-reach and out-reach,” she said. Ms Ashwell explained that she was PCT employed: “50 per cent of my time is spent working in the PCT, 20 per cent is in hospital and 30 per cent is in public health.” She said that her colleagues inside the hospital pharmacy service are the “in-reach” and the primary care team is the outreach of the hospital service. “We solve the problems together; we talk to our community pharmacist so it is much more joined up,” she said. However, she commented “Simply having joint posts is not the answer.” She said that how you behave in such posts is fundamental. “You need to behave with integrity in order to be trusted by both sides — rela-



Sue Ashwell: there are many complex interfaces

tionships are pivotal,” she advised.

Ms Ashwell said that the NHS is changing at a fast rate and that pharmacists need to adapt accordingly. “In terms of payment by results, practice based commissioning and other changes — if you don’t understand them and you are a hospital pharmacist, you need to — it will transform your life,” she stated. She emphasised that the organisation

has to be genuinely committed to such changes and that pharmacists sitting at the management table is part of that visible commitment. She also commented that integration and development, both vertically (ie, within the profession) and horizontally (between professions and organisations) needs to occur to maximise quality, safety and equity.

Speaking in terms of what the pharmacy profession needs to deliver, Ms Ashwell said that systems and processes which help GPs, consultants, other clinical staff and managers should be developed in order to deliver a quality of care that is recognised, within finite resources. There should be executive involvement and accountability across the whole system for medicines use. Ms Ashwell also believes that shared agreement outcomes through joined-up working between PCTs and hospitals will improve the health care service.

“In order to achieve all of this, we need leadership from within each organisation,” she stated. Pharmacists should offer clear policy advice on medicines that supports, facilitates and enables integrated working for pharmacists, prescribers, nurses, and other health care professionals.

Val Shaw, chief pharmacist, Greater Peter-

borough Primary Care Partnership also spoke on the topic of leadership across and within primary and secondary care. She began by commenting on how the NHS has changed over the last 12 months. She said, "The NHS has become much more of a business, it is no longer just there for the patient, it is there to make sure we make good use of the tax payer's money."

She explained that in her role she spends equal time in hospital and primary care. Within her trust there is a whole health economy for pharmacy services, with many interfaces, some historic and others relatively new. She gave an example of a new private prison that opened in Peterborough in March. Currently, it has 794 inmates, 502 of whom are having four or more medications. "It is like having another hospital," she said. "We can take the opportunity to talk to the patients, many of whom have not had much interaction with the health service before, explain their medications and offer counselling on issues such as smoking cessation."

Ms Shaw described the benefits that "bridging the gap" has achieved within pharmacy at her trust. "We have a joint formulary for drugs and wound care," she stated. She said that a good relationship has developed with social services that has helped them solve many problems that they



Val Shaw: pharmacists should embrace change

used to have regarding Medidose systems and carers. She also said that she has built good relationships with private hospitals in Peterborough. "When I first started we had lots of service level agreements with private hospitals which are just supply functions. Now we have representatives from two private hospitals sitting on our drugs and therapeutics committee. Therefore patients are not given drugs in private hospital that are outside our formulary," she said.

Explaining how communication between community and hospital pharmacists and the

ambulance service has improved the accuracy of patients' drug histories she said: "The ambulance service brings in the patients own drugs in a green bag. The community pharmacist supplies a tub in which the repeat prescription is placed. These are kept in the fridge and the ambulance service picks this up with the patient to provide a current drug history on admission to hospital."

She said that in her trust, hospital pharmacists can refer patients who have a medicine-related issue that needs to be followed up to medicines management practice pharmacists working in primary care. Giving an example of a surgery patient whose regular medicines are inappropriate, Ms Shaw said that the surgery team are often reluctant to change drugs prescribed by the GP. Therefore, the hospital pharmacist would refer this patient to the medicines management pharmacist in primary care who would then take it up with the GP. "We are getting patients down from 20 items that have been prescribed inappropriately to five or six," she said.

With a patient-led NHS moving services out of secondary care into primary care Ms Shaw advised that skill mixes may need to change as hospitals deal with more complex patients. "There are many challenges and many benefits in the future and pharmacists need to step outside their box and take these opportunities," she concluded.