

# When all pharmacists work together...

In one West Midlands PCT area pharmacists from the trust, practices and the community work together. **Debbie Andalo** reports

**P**harmacists in the West Midlands have co-ordinated medicines management of elderly patients in the community in an initiative which brings together different members of the pharmacy team. The scheme was originally developed to meet the needs of the National Service Framework for Older People but pharmacists involved also believe it fits comfortably with the demands of the new pharmacy contract. They are confident that while other primary care trusts may be making similar links across primary care to deliver medicines management, their scheme stands apart because it brings together PCT, practice and community pharmacists as well as other health professionals.

Pharmaceutical adviser for Redditch and Bromsgrove PCT Sue Lunec said: "I think what makes our scheme different is the comprehensiveness of what we are doing in medicines management. We are pulling all the different strands together."

### Support needed

The initiative is being led by PCT pharmacist Mary Shaw who is supported by a pharmacy technician, eight practice-based pharmacists and a handful of community pharmacists. The idea to bring together all the different pharmacists across the trust to help deliver the medicines management demands of the NSF came about because of the high number of elderly patients in residential and nursing homes. Mrs Lunec said: "We have 1,032 old people living in 18 nursing homes and 17 residential homes — it's impossible for one person to do all those medicines reviews. And although Mary did face-to-face reviews and made notes for the GP, we felt that some GPs acted on the notes, while others didn't."

The PCT decided to harness support from the practice-based pharmacists, who between them spend four hours a week in each of the 23 practices. They provide additional information for the medicine review of patients registered with the practice living in the homes as well as taking up the results of individual reviews with the patient's GP. Mrs Lunec said: "I think in the past it was this step, the follow through with the GP, which wasn't being done

properly — especially if the practice had only one patient in each of 35 different homes."

Miss Shaw added: "I found that in the past where I was doing the medicine reviews, in more rural areas where all patients were registered with one practice, I was able to go through the results of the review with the GP. But it was not so straightforward in Redditch and Bromsgrove where maybe a GP had only one patient in a home and it would have taken me forever to get to all the practices."

### Medicines risk assessment

The medicines management programme also focuses on the discharge of elderly patients from the local community hospital where there are two wards for GP patients. Pharmacy technician Susie Hands carries out a medicines risk assessment before a patient is sent home. She said: "Sometimes the patient has been in hospital for so long that the medicines have changed since admission. I look at the patient's repeat prescription and compare that with the medicines being taken on discharge. I assess about six patients a week."

She gives each patient a medicines information chart which she discusses with them as well as answering any questions they have about their medication. She said: "I can also rationalise their medication if they are confused about it so that it can be given in a different form." She relishes the professional satisfaction the new role offers. "I can see a patient who is unsure about their medication and why they are on it, and by the time they go home they are able to understand what they are doing."

Community pharmacists have also been given a medicines management role as part of the initiative. Five of the 25 local pharmacies have already agreed to take on responsibility for managing the medicine management plan of individual patients in the community in return for an annual fee. The fee varies from £140 for taking on responsibility for patient medication within a locked box at home to up to £380 for detailed monitoring of a patient's medicines for a year. The fee comes out of £30,000 the PCT has put aside for recruiting community pharmacists into the initiative. Mrs Lunec said: "The community pharmacists have

been contracted to do the work. Mary can identify a problem which a patient may be having with their medication but, again, because she is on her own she can't follow things up with every patient. What our scheme has done has passed on that responsibility to the community pharmacist and paid them for that responsibility. What we have tapped into is the reliability of the community pharmacist — they are always there in the shop."

Working across the different pharmacy teams in primary care has been straightforward, according to the project co-ordinator Miss Shaw. She said: "I worked in the acute trust for 10 years and in the community for a few years before moving to the PCT so I already knew a lot of the community pharmacists and had a good relationship with them." But as the scheme, which also applies to medicines management of the elderly in sheltered accommodation, has become well established it is reaching out beyond pharmacy. Miss Shaw now often gets referrals from care workers or social workers who are concerned about a client's medication. "I had one call the other day about a patient who had to take her medication three times a day but the carer was only visiting twice a day. I had a word with the patient's GP who rearranged the medication to be taken twice daily. It was as staggeringly simple as that but, in the past before this scheme was set up, social services wouldn't have had anybody to refer to."

### Time for new roles

Sharing patient responsibility for medicines management across the different members of the pharmacy team has also allowed Miss Shaw to take on other new roles including monitoring blood pressure of elderly patients as part of a heart disease audit, and how becoming involved in medicines reviews can be used to prevent falls in the elderly.

Miss Shaw is confident that the initiative in Bromsgrove and Redditch could be developed by other PCTs and she had this advice for others keen to follow its lead: "I think you have to build up respect to start with and then build up peoples' confidence in you and let people know what you can do."

# Supplementation with calcium and vitamin D: Isle of Wight PCT strategy

In this article, **Paul Jerram**, head of medicines management, **David Turner**, chairman of the PCT prescribing committee, and **Margaret Squibb**, lead nurse Isle of Wight prescribing team, describe a local initiative to reduce hip fractures through supplementation with calcium and vitamin D

The Isle of Wight has a large elderly population, many of whom may be at risk of osteoporotic fracture. Analysis of prescribing data showed local prescribing of calcium and vitamin D, a cost-effective treatment for preventing osteoporotic fracture, to be below the national average.

A strategy was consequently devised by the multidisciplinary island falls group, in conjunction with the PCT prescribing team. By using a number of novel approaches to targeting at risk patients, the usage of this cost effective drug has increased threefold during a two-year period. New approaches to identify and treat at need patients include the use of patient group directions for housebound patients, bulk prescriptions for nursing home patients and medication reviews for care home patients and patients taking oral steroids.

## The burden of osteoporotic fractures

Currently there are 310,000 osteoporotic fractures each year in the UK at a cost of £1.7bn.<sup>1</sup> The National Service Framework for Older People aims to reduce the incidence of, and deaths following, hip fracture. Standard 6 suggests: "Older people who are frail or housebound or who have had previous fragility fractures may benefit from supplements of calcium and vitamin D to help prevent fractures. Institutionalised or housebound females over 70 are known to be particularly at risk of hip fracture as a result of falling and identifying these should be a priority in primary care." Calcium and vitamin D has been found to reduce the incidence of fractures in men and women. In one study calcium and vitamin D reduced hip fractures by 43 per cent.<sup>2</sup> Applying this percentage to the annual cost of hip fracture on the Isle of Wight in the over-75s, a potential saving of £2m can be identified.<sup>3</sup> This estimated saving does not take into account the costs of fractures other than hip fractures and so is probably conservative.

## Raising awareness of the benefits

GPs have been advised of the value of prescribing calcium and vitamin D for certain risk groups by a series of regularly repeated messages in local prescribing newsletters issued by the island prescribing team. This team consists of pharmacists, technicians, nurses and doctors supported by multiple disciplines within both primary and secondary care.

## Choice of preparation

Compliance with calcium and vitamin D is often regarded as poor because of the size, taste and consistency of the product. A taste test, undertaken in an island nursing home, found that residents preferred Calcichew D3 Forte. Taste tests were repeated elsewhere with similar results and Calcichew D3 Forte was therefore chosen to be the product available on the island. Although this is not the most robust piece of research it was important to choose one preferred product to simplify both PGDs and bulk prescriptions.

## Targeting patients

Four groups of patients at risk of osteoporotic fractures were identified as being suitable for calcium and vitamin D supplementation. These included:

- Residents in care homes
- Patients living in nursing homes (These were viewed as distinct from residential care homes because of the availability of trained nurses.)
- The housebound elderly
- Patients taking oral steroids

## Treating our four key groups of patients

**Residents in care homes** Residents living in care homes have their medication reviewed by a medication review pharmacist employed by the PCT. Medication review is undertaken at least once per annum and six-monthly for those residents on four or more medicines. During the review, appropriate patients, who it is believed may benefit from calcium and vitamin D, are identified and GPs advised according to a standard protocol. With GP and patient agreement, calcium and vitamin D is added to the patient's repeat medication file.

**Patients living in nursing homes** Here trained nurses working to protocols can initiate treatment with calcium and vitamin D from bulk prescribed stock or refer the patient back to the GP as appropriate. A bulk prescription is one that is written in the name of the nursing home and meets certain criteria laid down in the Drug Tariff.

**Housebound patients** Since this group may rely on third parties to pick up prescriptions, patient/doctor interaction may be limited. District nurses are probably the professionals most frequently in contact with

the housebound and locally are able to initiate Calcichew D3 Forte under a PGD for appropriate patients. The nurses counsel the patients and check that they are able and wish to take the tablets before making the initial supply and advising the GP, who then adds the medication to the patient's repeat medication profile. Practice nurses who identify appropriate patients during their clinics can also initiate treatment under the same PGD.

Patients on long-term steroids are identified by audit with computer searches undertaken by technicians or nurses at GP surgeries. GPs are then advised and nurse-led clinics are undertaken for these patients.

## Safety is the number one priority

To ensure patients are receiving the correct medicine at the correct dose and in a safe manner, a six-monthly review of all registered patients is conducted within surgeries. A technician undertakes computer searches and uses the information to complete a PowerPoint template, which is then presented by nurse and pharmacist members of the prescribing team to GPs in the surgery.

## Interim results

In the long term it is hoped that this targeted approach to treating patients at risk of osteoporotic fracture will lead to a measurable reduction in fractures as well as the concomitant associated health costs. However, as an interim marker of success, the PCT has studied prescribing data for calcium and vitamin D. The number of prescriptions issued has increased threefold from 1,027 in the third quarter of 2001/02 to 2,990 in the fourth quarter of 2003/04.

## Conclusion

Medicines management initiatives are able to dramatically increase use of a cost-effective treatment.

## References

1. Torgerson DJ, Iglesias CP, Reid DM. The economics of fracture prevention. In: Barlow DH, Francis RM, Miles A, editors. The effective management of osteoporosis. London: Aesculapius Medical Press; 2001.
2. Chapuy MC, Arlot ME, Duboeuf F, Brun J, Crouzet B, Arnaud S, Delmas D, Meunier PJ. Vitamin D3 and calcium to prevent hip fractures in elderly women. *New England Journal of Medicine* 1992;327:1637-42.
3. Strategic approach to meeting standard 6 of the NSF. Isle of Wight: IOW Falls Group; 2003.

# Training receptionists on repeat prescribing designed to improve safety

In this article, nurse **Sam Bolaniakis**, medicines management project facilitator at Kingston Primary Care Trust, describes a project undertaken over the past 10 months intended to improve the safety and efficiency of repeat prescribing

It is common knowledge that repeat prescriptions typically account for the majority of primary care prescribing. Therefore, it is of paramount importance that the repeat prescribing process in each GP surgery is both safe and efficient. Receptionists and prescription clerks play a significant role in this process yet the training they receive is often unsatisfactory. The more they understand about repeat prescribing, and current issues in medicines management, the better they can respond to patient needs and help to provide a safe and efficient service. With this in mind, the pharmacy team at Kingston Primary Care Trust created repeat prescribing training workshops specifically designed to suit the requirements of receptionists and prescription clerks.

## Creating the workshops

The idea was to develop workshops that reflected the specific interests and needs of our local GP practices, relating every issue back to the two central themes: patient safety and practice efficiency.

We formed a multidisciplinary working group which included local receptionists and prescription clerks, practice managers, community pharmacists and PCT pharmacists. The group was tasked with determining the content and style of training. Our discussions resulted in a preliminary list of repeat prescribing topics to be covered. In the guise of an informal training needs analysis, we surveyed GPs, practice managers and receptionists from every GP surgery within our PCT area, using a short, simple questionnaire. We asked them to indicate which of the proposed topics they deemed desirable for inclusion in the training. They also fed back on the format and duration of the workshops.

We obtained a return rate of 36 per cent, mainly consisting of replies from receptionists and practice managers. The feedback was analysed and two distinct half-day workshops were created.

## Flexibility and variation

The working group recognised that the challenge was to balance the needs of experienced and less experienced receptionists, while maintaining the interest and active participation of all parties. It was, therefore, critical to create a flexible programme and learning environment that catered to different learning styles and, similarly, to vary the con-

## Topics covered

### Workshop 1

- The key elements of a repeat prescribing process using a process map
- The concepts of risk, error prevention and receptionist responsibility
- Common problems with repeat prescriptions
- Current repeat prescribing issues, including waste and patient compliance
- Acute versus repeat prescriptions, and private prescriptions
- Synchronisation

### Workshop 2

- Generic versus branded medicines
- Medicines liable to be abused, Controlled Drugs and prescription fraud
- Common drugs requiring monitoring
- Repeat prescribing issues, including emergency supplies, blacklisted medicines, incomplete prescriptions, common misconceptions about what a pharmacist can and cannot do
- Abbreviations
- Sources of information and points of reference for further learning

tent and delivery depending on the needs and level of each group. Without being dogmatic or authoritative, we intended to raise awareness and stimulate reflection and discussion about the chosen repeat prescribing issues, while illustrating at all times how they relate to safety and efficiency.

We hoped that a friendly, open environment would encourage receptionists to participate freely and learn as much from each other as they would from us. It would also provide the PCT pharmacy team with an insider's view of current local issues in repeat prescribing, allowing us to target prescribing advice and to provide more relevant support to practices in this area.

Workshops included group work, an interactive question-and-answer game, open discussion and flipchart notes, a medicines management video, props and displays of items commonly supplied on repeat prescriptions, along with a slideshow presentation. As medicines management project facilitator, I hosted the workshops with help from a local community pharmacist and members of the Kingston PCT pharmacy team to answer clinical questions.

## Raising GP practice interest

Creating carefully balanced and locally relevant workshops was one challenge; drawing in adequate numbers of participants was certainly another. We needed to identify ways of sparking interest in these workshops and remove the practical barriers which prevented GP practices from sending their staff.

Within Kingston PCT, this training initiative was viewed as a major contributor to improving safety and efficiency within local practice and, as such, was included in the trust's 2004–05 prescribing incentive scheme. This removed any financial barriers which can often limit the willingness of GP practices to release their staff for training purposes. Also, the PCT would be assured that any money spent on this part of the scheme would be tied into explicit improvements in repeat prescribing.

More specifically, one-third of this year's prescribing incentive scheme payment was based on practices sending staff to the training workshops and then drawing up and implementing agreed action plans for improvements in both safety and efficiency in their repeat prescribing process. A payment will be made to GP practices to help offset the costs incurred for locum cover and the working time spent writing and implementing the action plans. Implementation will be verified by PCT prescribing advisers at the end of the current financial year during their general medical services medicines management visits. GP practices will not be eligible for any of the partial payment unless they have implemented their safety and efficiency action plans by that time.

## Results and outcomes

Three sessions of each workshop were held with 75 per cent of local GP practices taking part. Attendance stood at 117, including three practice managers and one GP. A short quiz given at the end of the second workshop revealed that the main topics covered were well understood, as the average mark for the quiz was 83 per cent. Complete speaker notes and handouts for both workshops were sent to all GP practices as a training package, both for reference and to be used in training new staff.

Currently, GP practices across Kingston are busy producing and submitting their action plans. By the end of the fiscal year, we expect to see many improvements in safety and efficiency within repeat prescribing across the majority of GP practices in the Kingston PCT area.

# Scheme publicly puts to the test the industry's confidence in its own drugs

**Debbie Andalo** describes a programme in which GP practices in North Staffordshire teamed up with a drug company with the aim of reducing patient risk of coronary heart disease, reducing costs to the NHS and meeting Government clinical targets

A unique partnership between the pharmaceutical industry and the health service is helping to reduce patient risk of coronary heart disease, saving the NHS money and meeting government clinical targets at the same time. The scheme, which has now been rolled out to 17 primary care organisations across the UK, publicly puts to the test the confidence that the industry has in the ability of its own drugs. If the drug involved in the programme fails to meet clinical targets which are set by independent academics, the drug company has to repay the drug costs to the NHS. Stephen Chapman, professor of prescribing studies at the department of medicines management at Keele University, who developed the programme, said: "This is a win-win situation for everybody involved."

## Coronary heart disease

Professor Chapman piloted the programme around the prevention of coronary heart disease and the prescription of statins. The pilot was tested on practices in North Staffordshire because the district had one of the highest levels of cardiovascular heart disease in the country and was one of the lowest users of statins. Professor Chapman said: "There was a need for the local health economy to do something urgent about cardiovascular disease and to adopt best practice but they didn't have the resources to do it."

The solution, according to Professor Chapman, was to develop a new kind of partnership with the private sector which would benefit both sides. He was keen that the scheme should be transparent and was not dependent only on a drug company sponsoring practice nurses running a CHD clinic. Professor Chapman said: "I don't believe that the alternative option, which would have been to use drug company sponsored nurses, is a model which works. When a sponsored nurse goes into a practice, it doesn't matter what people say, there is an increase in that particular drug being prescribed. There is a lot of anecdotal evidence to support that. What we wanted to do was develop a more open and transparent system which was based on the premise that we will help you, the drug company, find the patients but if you want us to use your drugs these are the conditions we impose."

With this framework in mind, Professor Chapman designed an "outcome guaranteed programme" and invited drug companies to

become involved. Pfizer took up the challenge. Professor Chapman developed a matrix which had a series of clinical targets, reflecting a reduction in cholesterol, which the Pfizer statin, atorvastatin, had to meet.

Pfizer agreed that if its drug failed to achieve the targets, which reflected the targets of the National Service Framework for Coronary Heart Disease, then it would reimburse the NHS for the cost of atorvastatin which had been prescribed. At the same time Pfizer agreed to pay for the cost of practice nurses to draw up a register of patients at risk from coronary heart disease and to run CHD clinics to monitor those patients whom GPs had identified as potentially benefiting from being prescribed statins. GPs were free to prescribe patients on the programme whatever statin they wanted although the cash reimbursement from Pfizer for failure to hit the programme's clinical targets only applied to atorvastatin.

The pilot involved 27 practices which between them identified 1,408 patients who were at risk of CHD; 877 were prescribed statins and 669 were still taking them at the end of the programme. Of these, 402 patients met the clinical targets. All patients whose dose was titrated according to the outcomes guarantee matrix achieved the target, so Pfizer did not have to reimburse the NHS for the cost of its statin. The initiative also improved patient compliance — with a success rate of 80 per cent. Professor Chapman said: "This is extraordinary for statins but I think it was achieved because these patients were

being carefully monitored and had regular contact with a nurse."

Professor Chapman was keen to emphasise that the GPs involved in the pilot had complete clinical freedom to prescribe the statin of choice. He said: "We did a qualitative survey of GPs and none of them had a sense that they felt under any obligation to prescribe atorvastatin — *au contraire* they thought that it was an open and transparent process."

## Benefits for the drug company

The outcome guarantee programme brings cost savings for the NHS because drug wastage is reduced and the drug company contributes to the costs of chronic disease management in primary care. National service framework targets are met and patient compliance increases, which reduces their risk of heart disease. But what are the benefits to the drug company, which is prepared to risk the reputation of its product and faces financial penalties if the clinical targets are not met? According to Professor Chapman the rewards are many. The company wins a very public vote of confidence in its own drug and is involved in a partnership with the local health service, rather than remaining on the outside looking in.

He said: "The company has the opportunity for its drug to be tested and proven, doctors become aware that the drug exists and it gives the company market access and a share of the market." Richard Lomas, who led the pilot programme for Pfizer, was also quick to sing its praises. In a statement he said: "Many people who could benefit from statin treatment do not receive it. This is often due to resource issues as it can be difficult to manage statin use in primary care to the best benefit of NHS budgets. The programme provided a solution in the form of a best practice framework for ensuring that patients who needed treatment had access to it, and that NHS resources were used responsibly to help more patients reach the targets set out in the NSF for CHD."

## Future programmes

The outcome guarantee programme was deliberately designed around statins because, according to Professor Chapman, the drug has simple and obvious "proven markers" which are the levels of cholesterol. So, could a similar programme be developed for other prescribed drugs? Professor Chapman is confident that will happen. He added: "Providing you have proven markers and the programme meets local health needs and fits in with local health policy." He is currently in the process of discussing future programmes, which focus on two clinical areas with four pharmaceutical companies including Pfizer. He would not go into detail because negotiations were still ongoing but he predicted a decision would be made within the year.

## Further reading

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## Correction

Sam Bolanakis's name was misspelt in his article on pPM3.