

# Adopting a successful cross-sector approach to medicines management

A positive attitude to change has led to an integrated approach to medicines management in Huntingdonshire. **Clare Bellingham** reports

Over the past year, Huntingdonshire Primary Care Trust and the local hospital Hinchingsbrooke Health Care Trust have radically changed the way they work. The restructuring of pharmacy services has been largely down to the attitude of the chief executives of the primary care and acute trusts. The opportunity for change was created by the appointment of a single director of medicines management across both organisations.

Three new roles were then created. The new team comprises the director of medicines management Sue Ashwell, and three associate directors. The three directors are Sati Ubhi, who is responsible for prescribing and medicines management and is based in the primary care trust, Janet Watkinson, who is responsible for clinical development of pharmacy in the hospital, and Darren Leech, who is responsible for pharmacy services delivery in the hospital.

The changes in Huntingdonshire started last March when Mrs Ashwell was appointed. The trigger was partially financial, with the two chief executives deciding that by working together they could make better use of the drugs budget, and partially down to a need to address clinical governance. A review conducted by the Commission for Health Improvement helped identify what needed to be done in terms of clinical governance. In its review, CHI said that the hospital trust's approach to medicines management needed to be reviewed and for a strategy on medicines management to be developed. The result of this review is the new cross-sector medicines management team.

"It is blinding common sense," points out Mr Leech. "If my granny goes into hospital, she cannot understand why the hospital doesn't get the right information from her GP and vice versa when she is discharged. From her point of view it is all one organisation: the NHS." Mrs Watkinson adds: "We know that what happens in the hospital has an impact in primary care and vice versa." And the cross-sector approach taken by the medicines management team means that these issues can be identified and tackled.

The team approach has worked because all those involved follow the same designated aims. "We came up with a clear set of values: quality, safety and making the money go further. Although a number of people are involved we still work to those core values. This means that patient care is more effective, safer and more efficient," Mrs Ashwell explains.



Discussing prescribing (left to right): Sati Ubhi, Sue Ashwell and Janet Watkinson

Mrs Ashwell's cross-sector role is key to the integrated approach. "As director of medicines management, I sit on both the professional executive committee in primary care and the executive committee in the hospital. This means that I am sitting among the lead clinicians and gives me the great advantage of free passage in both organisations," she comments. "We have spent £0.25m on developing the medicines management team and we will save £0.5m on prescribing costs this year to be spent elsewhere in health care." She emphasises that this is a recurring saving, not an initial one-off effect, particularly since the team has plans of new initiatives still to be introduced.

"One of the important outcomes of this arrangement is that if I turn up at a surgery, the GPs know who I am," comments Mrs Watkinson. "And when Sati walks around the hospital, the consultants know who she is. We really do have joined up working."

## Prescribing improvement agreement

Underpinning the medicines management team's work in primary care is a prescribing improvement agreement. It sets standards around quality of prescribing with practice pharmacists helping GPs to achieve the standards. This new agreement replaced the old prescribing incentive scheme.

The prescribing improvement agreement contains 10 quality improvement standards. Four are compulsory and all GP practices must achieve them. They tackle repeat prescribing improvements, monitoring high-risk drugs, ensuring National Institute for Clinical Excellence guidance is followed and reducing inappropriate prescribing.

## Organisation statistics

Hinchingsbrooke Hospital has 450 beds and serves a population of 150,000. Huntingdonshire Primary Care Trust covers 24 GP practices and is a rural community with 18 of the surgeries being dispensing practices. However, no distinction is made and all receive pharmacy input under the direction of the medicines management team. There are 22 community pharmacies in the PCT area.

"One size does not fit all practices so which of the other standards apply depends on what the practice needs to work on," explains Ms Ubhi. Examples of the other standards include ensuring monitoring tests are carried out and that the right services are offered for particular diseases. Every practice is given a folder outlining the standards that it has to achieve.

The prescribing improvement agreement might apply to GPs in primary care but drawing up the agreement took a cross-sector approach. "We shared the folder with the hospital's drug and therapeutics committee," comments Mrs Ashwell. This meant that what is in the prescribing improvement agreement fed into the hospital formulary and vice versa: the result is a joint formulary approach.

Ms Ubhi explains: "It is all about working together. The GPs used to say that they could not do anything about a medicine that was started in hospital. Now they are all working together so things can be done." Examples of how this works are provided in the panels overleaf. She adds that each GP practice has both pharmacist and pharmacy technician

input. "How much time each practice requires varies," she says. The pharmacy team looks at issues such as repeat prescribing, dose optimisation, high-risk drugs and appropriate prescribing of drugs such as proton pump inhibitors.

The team effort is not just about hospital and primary care pharmacists either. "All the pharmacists working in the practices are practising community pharmacists," Ms Ubhi says. This came about after community pharmacists were invited to an evening meeting to find out if any were interested in the role. Six pharmacists chose to take on the work in the GP practices while others felt that they could not leave their pharmacy. These pharmacists have not been excluded since they are paid to intervene on errors they find in prescriptions that arrive in the pharmacy. For each intervention they report to the PCT and the practice they are paid £2. "It is a closing of the loop," says Mrs Ashwell.

A lot of the work comes down to good communication, or as the team puts it "the tea and biscuits approach". Information is fed both ways so if a primary care prescribing problem is identified in hospital, the GPs are informed. And each month GPs are given a newsletter including information about prescribing decisions made in hospital. The medicines management team have to ensure they communicate too: they talk on the phone on a daily basis and meet up weekly so they are all acutely aware of the overall picture.

## The hospital roles

The division of work in the hospital between Mr Leech and Mrs Watkinson is interesting. Mr Leech, who is a pharmacy technician and president of the Association of Pharmacy Technicians UK, explains that his role is to run the pharmacy services. "I lift some of the management burden so that the pharmacists can be more involved in the clinical side," he says. His role includes ensuring that all the services run properly and dealing with issues such as staff management. "One of the things chief pharmacists say is that they cannot get on with clinical development because they have to sort out the service delivery first," he adds.

Since the arrangement works at Hinchingsbrooke so well, they have concluded that having a chief pharmacist is not the most effective way to deliver pharmacy services. In law, accountability has to fall to a single person and that person is Mrs Ashwell. But she points out that she depends on the associate directors. "It works because we all follow the single set of core values," she says.

## How it works: omeprazole

The PCT and hospital have just reached a joint agreement that omeprazole will be their proton pump inhibitor of choice. This means that if a patient consults either a GP or hospital consultant, the message will be consistent. A switch process is about to be implemented.

## How it works: new drugs

The PCT prescribing subgroup and the hospital drug and therapeutics committee have reached an agreement over assessing new drugs. A new drug is considered by the group where the majority of its impact, in terms of both workload and expenditure, will be felt. Mrs Ashwell explains that a recent example of this involved the hospital ophthalmologists wanting to prescribe a new eye drop. The impact of this would have been greater in primary care so it was the PCT prescribing subgroup that considered the proposal.

Within the hospital itself, roles are developing and good use of skill mix is demonstrated. Greater input of technicians on wards has had an impact. "Technicians are being used as guardians of pharmacists' expertise," explains Mr Leech. "Half of what wards contact a pharmacist about — inquiries about supplies, for example — can be dealt with by a technician. This means that pharmacists are able to react more quickly to clinical problems. Pharmacists are also on ward rounds where they can influence prescribing so the dose is right first time, rather than doing a mop-up several hours later." He adds: "Nurses should not be leaving the ward to collect items from pharmacy, instead they bleep the technicians who deliver it to the wards."

The pharmacists are able to amend junior doctor's prescriptions. If an error is identified, the pharmacist changes it and attaches a note to the prescription highlighting the alteration to the doctor. "We started with simple things like correcting amoxicillin that was prescribed four times a day to three times a day dosing, and ensuring maximum course lengths for antibiotics of seven or 10 days," explains Mrs Watkinson. This not only avoids errors but it also is a form of education for the doctor. The note system gives the doctors an opportunity to comment on the changes.

In addition, the pharmacists write many patients' discharge prescriptions. Mr Leech attends bed management meetings and can identify potential problem areas. He then informs the relevant pharmacists so that the discharge prescriptions can be prepared. By making other people's lives easier, pharmacy has gained credibility and support for the development of the pharmacist's role as part of ward teams, he adds.

Another concept that the team is keen to introduce is for pharmacists and technicians to have a "case load" rather than to see patients according to their location within the hospital. The aim is to improve continuity of care. For example, on the medical assessment unit, a pharmacist and technician are employed to liaise with local surgeries so that a clear picture of patients' medication histories is gained. If it is decided to admit a patient, the technician goes to the ward to check that the patients' medicines go with them. "It's about owning the patient until you hand them over," says Mrs Ashwell.

## Future plans

The team has plenty of plans for the future, too. Top of the list is for the hospital to fax community pharmacists with a summary of medication changes made in hospital when a patient is discharged. "Community pharmacists must be included as part of the clinical team," stresses Mrs Ashwell.

Another two cross-sector technician positions have been created. They will spend half their time in hospital on the wards addressing any issues that patients have about their medicines. The other half will be spent in primary care following patients up after they have been discharged from hospital, either doing this themselves or through co-ordinating community pharmacists to contact the patients, and working on the prescribing improvement agreement.

Preregistration trainees are also being given cross-sector roles. This will be operated on a rotational basis so that they spend some time in primary care, some time in hospital and some time in community pharmacy.

Could Huntingdonshire's approach to integrated medicines management be applied elsewhere? "The magic ingredient we started with was two chief executives who were willing to listen. But what made them listen was us addressing what mattered to them," says Mrs Ashwell. However, she acknowledges that the size of the health system — one acute trust and one PCT — made the changes easier than would have been the case if a number of organisations were involved. Whether cross-sector appointments would work so easily with four or five organisations is uncertain.

But the experience in Huntingdonshire is positive and much can be learnt from their approach even if the exact roles cannot be replicated elsewhere. "What made the difference was that we looked at how pharmacy services and medicines management could deliver on the wider agenda. This meant that we had lots of champions, such as the finance directors, consultants and nursing staff. The team took a step back and worked out what we could offer, without losing our core value as pharmacy," says Mrs Ashwell.

Or, as Mr Leech puts it, it is all about re-voicing the service around patients rather than around pharmacy.

## How it works: tramadol

"We used to spend a lot of money on tramadol," says Mrs Ashwell. The team decided that for many patients it was not the most effective painkiller, not the most cost-effective option and it had many side effects. "But there was a belief among GPs that the hospital wanted tramadol to be prescribed," says Mrs Ashwell. "We investigated this, spoke to the surgeons and the pain team and found that actually it is not recommended. So it was removed from the formulary and we were able to go back to the GPs and tell them that it is no longer being used in hospital so let's review your practice now."