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# SUPPORT ON PRESCRIBING ISSUES AND POLICY AT THE INTERFACE BETWEEN PRACTICES, PRIMARY CARE GROUPS AND HOSPITALS

**M**any prescribing and medicines usage issues span primary and secondary care, with prescribing trends in one sector often influencing the other significantly.

Pharmacists working for GP practices, PCGs or HAs will find themselves involved in work crossing the primary and secondary care interface. Similarly, HAs, PCGs and social services will increasingly be working together to improve health/social care delivery; for example in nursing and residential homes.

Policies on some aspects of prescribing are, therefore, best developed at a level above the practice. Where HAs have sought to keep an overview of prescribing and medicines usage in primary and secondary care, PCGs will also increasingly want to start getting involved.

Many medication-related problems can occur in individual patients on admission and discharge from hospital; good communication and reliable flow of information can help prevent these problems and promote seamless pharmaceutical care.

## 4.1

# SEAMLESS PATIENT CARE ON ADMISSION AND DISCHARGE FROM HOSPITAL

## Key points

- Good flow of information about patients and their medicines on admission and discharge should reduce risks to patients and improve outcomes.
- The use of checklists can assist communication between hospitals and the community about the pharmaceutical requirements of patients with complex medication needs.
- Prescribing support could help with resolving queries, implementing medication changes and better follow-up.

**G**ood communication about individual patients, between primary and secondary care, is essential but does not always happen smoothly.

For example, on admission or discharge it may not be clear what medicines a patient is taking, or should be taking. The exact rationale for the treatment may not be clear from the GP referral note or the discharge letter and similarly the reason for changes may not be stated.

Changes in patients' medication regimens may not be implemented by the practice. Patients may inadvertently continue to take medication prescribed for them prior to admission but stopped for an important clinical reason whilst in hospital. Paperwork containing key details may not be available at the point of admission or discharge when it is needed; for example when the GP first needs to write a prescription in line with hospital recommendations.

By following the principles of integrated care on admission, during the patient's stay in hospital, and on discharge, risks should be minimised, with better outcomes for patients achieved and the cost-effectiveness of the healthcare provided improved.

Various initiatives have sought to improve communication between primary and secondary care. Advances in IT and its application within the NHS should further enhance some of these initiatives.



The Royal Pharmaceutical Society has produced different checklists to assist communication between hospital and community pharmacists about the special pharmaceutical requirements of:

- patients with complex medication needs
- the elderly
- the mentally ill
- patients with learning difficulties
- other patients for whom liaison on pharmaceutical support is particularly important

One checklist is for community pharmacists to provide information to hospital pharmacists when such patients are admitted to hospital and another is for hospital pharmacists to provide information to community pharmacists when the patient is discharged. (see appendix 7)

A prescribing support service could act as a focal point within the practice for medication issues associated with patients' admission to, and discharge from hospital. This might include:

- resolving medication-related queries
- ensuring that changes to patients' therapy, or recommendations for treatment monitoring following hospitalisation or out-patient consultation, are followed through within the practice
- helping patients with medication-related issues following discharge, such as inhaler technique or ensuring they understand their new or complex medication regimens



More pro-active liaison between all relevant practitioners in primary and secondary care is bound to improve understanding, promote seamless care for patients and minimise risk.

Hospital pharmacists, by becoming more involved in the discharge process, are in a position to target the pharmaceutical needs of patients at greatest risk, e.g. elderly patients living alone. Such needs may include additional labelling, medicine reminder cards or other information, compliance aids (so-called community dosage systems), or a recommendation for a domiciliary visit. Effective communication pathways must also include GPs, social services and district nurses.

In Stockport Acute Services NHS Trust, a Discharge Planning Service has been established to help patients who are thought to be pharmaceutically at greatest risk e.g. the elderly living alone, those with known or suspected poor compliance etc.

- Patients who may benefit from the Service are identified whilst in-patients, and referred by any member of the multidisciplinary team e.g. occupational therapists, physiotherapists, nurses, pharmacists or doctors.
- Patients are then individually assessed by a pharmacist and assistance is provided to cover their own special pharmaceutical needs e.g. medicine information reminder cards, compliance aids or counselling about their medication.
- Hospital pharmacists liaise with the patient's nominated community pharmacist to ensure continued provision of any special requirements.
- A Community Pharmacist Care Plan, detailing all discharge medication is sent out on the day of discharge.
- Letters are also sent to the patient's GP to inform them of any services that have been initiated for their patient, such as collection and delivery of medication or provision of compliance aids.

The service has now been operating for over 18 months and so far 380 patients have benefited from the service

*Pharmacy Department, Stepping Hill Hospital, Stockport*



## PRESCRIBING POLICIES ACROSS THE INTERFACE

### *Key points*

- Common prescribing choices between practices, and also between hospitals and primary care, can facilitate seamless care and help make best use of resources.
- Unified budgets may bring opportunities to align clinical responsibility and prescribing responsibility with resources.

**P**rescribing-related tasks within the practice are many and complex. However, in moving towards more effective management of the resources spent on medicines there needs to be input into, and support of prescribing issues on a more macro level, as well as at the individual GPs and patient level.

Since their creation from District Health Authorities (DHAs) and Family Health Service Authorities (FHSAs), HAs have taken an overview of medicines issues across all practices and between primary and secondary care. PCGs will want to engage with this agenda; this will need appropriate levels of prescribing support.

### **District-Wide Guidelines and Prescribing Choices**

For some issues there can be real advantages in agreeing policies on certain prescribing issues across a whole geographical area. Rather than attempting to implement a complete district-wide formulary, some clear policies on particular topics, or agreed prescribing choices in certain therapeutic areas, can reap genuine benefits.

This can be especially relevant for problems spanning the primary-secondary care interface, where agreed policies can facilitate seamless care and help make best use of wider NHS resources. Examples where prescribing support might produce benefits include:

achieving consistency in selected areas of prescribing. This may be for groups of products such as use of combination analgesics, calcium antagonists or ACE inhibitors.

agreeing on a particular branded product for specific drugs such as modified-release diltiazem products where the BNF advises that patients remain on the same formulation

local implementation of national guidelines

drawing up local policies on particular issues such as the transition to CFC-free inhalers or anti-microbial use policies

agreeing policies around the use of products whose cost in primary care is higher than in hospital

improving shared care arrangements and clarifying prescribing responsibilities between hospital clinicians and GPs

improving communication flow, for example associated with admission and discharge arrangements

## Unified Budgets and Prescribing Responsibility

The advent of a unified local budget means that in future it will be possible to shift funds between its former constituent elements; for example between the hospital and the primary care prescribing elements. This will make it easier to ensure that clinical responsibility and prescribing responsibility remain together, with resources being made available in the right place.

Some of the national “virement” initiatives have already been testing models of transferring money across primary-secondary care interfaces to the benefit of cost-effective patient care.



South Cheshire Health Authority undertook a virement project involving interferon alpha, dornase alpha and erythropoietin. The HA received agreement from the Local Medical Committee to top-slice the GP prescribing budget and vire an amount equivalent to the expenditure on these drugs, by GPs, into secondary care. Prescribing responsibility for these specialist drugs therefore also transferred back into secondary care.

General practitioners received information packs and advice from the HA to support them through the changes in prescribing and funding. Patients were informed of the changes by the practices themselves, also supported by the HA.

Patients can now receive their prescriptions on FP10(HP) forms, after attending a consultant appointment or an outpatient clinic, rather than by the regular FP10 prescriptions from their GP. Patients are able to receive their prescribed medication from either the hospital or community pharmacist.

This additional flexibility could also enable new approaches to other interface-related aspects of prescribing such as extending the duration of discharge medication.

## **Increasing the Input and Influence of PCGs within Local Policy-Making**



As PCGs increasingly pick up the wider locality agenda from HAs, they will have to develop appropriate communication and liaison networks in order to have the relevant input and influence when wider prescribing policies are being planned and implemented.

In particular, PCGs will want to have some effective representation on the local committees dealing with prescribing issues, likely to be Drug and Therapeutics Committees (DTCs) and Area Prescribing Committees (APCs). DTCs have a duty to deal with hospital issues, and historically have been largely hospital-focused. APCs have been more recently introduced to consider cross-sectorial issues and policies, e.g. for the planned introduction of new drugs. The links between these committees and their approach to different issues will vary, but increasingly they will need to be working together.

Depending on local circumstances, PCGs may want to involve their own representatives, perhaps a GP or a prescribing support professional, or work through the HA who have tended to be represented on both. In any case, considerable work will be required to develop an appropriate and agreed PCG policy to be presented.

Agreeing policies with local Trusts or with other practices takes significant time, energy and specialist input. Those wanting to do this need someone with the right knowledge and experience to make it happen. This will include an ability to understand the therapeutics, relevant local issues and the complexities of pricing and budgets, whilst having the respect of key players.

This work is likely to be a prescribing support activity taken on at a PCG level rather than by an individual practice.