

Taking an active approach to medicines management

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Getting the best value out of medicines and NHS resources is a key determinant of sustainable healthcare in the UK. As the next steps of the NHS Five Year Forward View (NHS, 2017) affirmed in March 2017, 'every pound of waste saved is a pound that can be reinvested in new treatments and better care'. It is, therefore, no surprise that efforts to drive medicines optimisation are intensifying. The next steps review (NHS, 2017) urges clinical commissioning groups (CCGs) and medicines optimisation teams to 'take action' on medicines and products. Cheaper, clinically equivalent alternatives are available to many drugs, to ensure that prescribing budgets are spent on interventions that have the greatest impact on patient care.

However, revising the formulary—on its own—is not adequate. Formulary decisions need active implementation if they are to realise anticipated gains.

New models

Despite the best efforts of medicines management to identify both the areas of prescribing that yield low clinical value and the potential cost savings of using cheaper clinically equivalent alternatives, the combination of limited resources and long-standing behaviours embedded in NHS culture often prevents these evidence-based evaluations from being maximised in clinical practice. With pressure on NHS resources continuing to escalate, we have now reached a critical juncture: if medicines management is to deliver the outcomes that its endeavours richly deserve, it is time to consider new models of working to help these teams optimise prescribing budgets.

A first consideration might be to review a well-established principle of medicines formularies: the need to offer choice. The concept is understandable; choice is undoubtedly a good thing. However, in certain clinical areas, it can be an unintended barrier to medicines optimisation.

Take, for example, blood glucose (SMBG) test strips, which form a significant part of the cost of caring for patients with diabetes. In 2017/18, the NHS spent £173 million on these strips in England alone (NHS England, 2018a). There are many different blood glucose meters and

strips available in the UK, with a wide range of prices. The NHS has analysed the spend variation between CCGs and identified the opportunity for massive efficiency savings, while retaining high standards of accuracy.

With increasing numbers of people being diagnosed with type II diabetes, there is a clear desire—indeed need (NHS England, 2018a; 2018b)—to realise these cost savings. Moreover, rationalising the number of SMBG systems in use will make it easier to educate health professionals, who, in turn, can better assist patients with their testing.

However, evidence shows that, on its own, producing a formulary is not enough. The intended outcomes of medicines optimisation strategies rarely materialise if formulary changes are not proactively supported by efforts to drive implementation at the local level.

Implementing change

The importance of formulary implementation programmes cannot be underestimated. However, medicines optimisation teams rarely have sufficient resources to support primary care teams and patients in this crucial area.

Best practice in medicines optimisation should, therefore, involve a team of experienced clinical pharmacists and nurse educators, supported by collaborative implementation programmes carried out as a value-added service wrapped around the product itself. This model allows all stakeholders in the change process to work together to develop a programme that is tailored to meet the needs of both patients and CCGs.

The active implementation process can be broken down into four key steps, and nurses are instrumental in each of these:

1. Communicate the change. It is vital that all GP practices within a CCG are made aware of the formulary change and the reasoning behind it. Through proactive engagement, primary care organisations—including GP practices, practice and community nurses, and community pharmacies—can establish a good understanding of what the CCG is hoping to achieve and prepare for the next stage of implementation. This phase should also include

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product training and support for practice nurse and local pharmacy teams. This includes explaining the ongoing support that is available for local resources.

2. Identify the right patients. This step is crucial and is one where nurses play a vital role. It may not be appropriate to switch every patient in the target therapy area of the chosen product. It is, therefore, important to carry out transparent audits of practice lists to identify suitable patients. Audits are typically conducted by nurses working on behalf of the implementation team, who apply strict criteria to patient selection. The final list should be validated and authorised by the specialist lead at the practice before any intervention is made.
3. Train and educate patients. The next step is to introduce the new product to patients and train them on how to use it. Again, this is normally carried out via nurse-led 'training clinics', held at the practice, where small group sessions (or one-to-one meetings, if required) provide practical training with the new product and an opportunity for discussion and questions. The clinics also present a valuable opportunity for nurses to provide education that can help patients better manage their condition. With adherence still a major barrier to medicines optimisation, training clinics provide high-value patient engagement that can support the long-term utilisation of treatments. Again, taking SMBG test strips as an example, such a flexible implementation model could factor in any local priorities, such as educating patients with type II diabetes on the importance of diet, lifestyle and exercise while undertaking the training.
4. Switch. The final step is to physically make the switch. This typically involves an implementation team nurse updating practice data so that the repeat prescription details of every consenting patient can be amended accordingly.

Such a targeted approach to formulary management, underpinned by a collaborative focus on active implementation with nurses playing a vital role in the communication, identification, training and education of patients (Swift et al, 2017).

With nurse-led implementation teams able to conduct multiple clinics a day, practices can quickly switch large numbers of patients to more cost-effective products, and make immediate savings that may otherwise take months to achieve if they adopted a more passive approach. This is why, as CCGs battle the enduring challenge of medicines optimisation, the most effective medicines management teams will be those who work with implementation partners that can help them drive targeted and productive formulary change.

Evidence of success

Evidence reinforces the promise. For example, in 2015/16, two CCGs in Greater Manchester—NHS Bury and Heywood, Middleton and Rochdale (HMR) CCGs—each realised savings of around £10000 every month simply by switching suitable patients with type II diabetes to a preferred system of blood glucose monitoring. In this example, and many others across a range of therapy areas and treatments, savings accrued quickly, in year and have been sustained in the longer-term without compromising patient outcomes (Swift et al, 2017).

In another changeover project facilitated by the author's organisation, the Isle of Wight CCG evaluated a number of blood glucose meters and SMBG strips in December 2017. The subsequent implementation programme included training courses being run in practices across the island as well as training for care home staff. To date, the implementation programme has achieved an 89% changeover of the target patient population on the Isle of Wight and is delivering consistency across different care settings. In the first 6 months, the CCG has seen a reduction of £2.34 in average unit cost, with overall cost savings of 11% in the first 11 months.

These examples underline both the size of the opportunity and the tangible benefits of collaborative models of medicines optimisation. Moreover, they highlight what is possible if medicines optimisation teams rethink how they work with primary and community care. Medicines management performs hugely valuable work in making recommendations to drive down the cost of care, but success is typically left to chance.

There is a better way. By focusing, where appropriate, on abbreviating formulary choice and adopting a collaborative model, medicines management teams can assume greater control in achieving the outcomes their work deserves. And in the process, the NHS will start to get the savings it needs. If CCGs are to fulfil NHS England's directive and take action on medicines and products of low clinical value, new implementation models of medicines optimisation must be considered. **BJCN**

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