

WEST MIDLANDS REGION

Involving patients in medicines decisions

The Royal Pharmaceutical Society's West Midlands region held a conference on April 1 at which it examined the first six months of the National Health Service plan for England

Involving patients in decisions about their medicines could reduce avoidable illness and cut waste, LORD HUNT (Parliamentary Under-Secretary of State for Health) told the West Midlands regional meeting. For that reason, the Government was to invest £1.3m in improving patient concordance (see p448).

Lord Hunt said that a task force would be established to implement a national strategy to integrate partnerships in medicine taking in the way the NHS worked at all levels. It would develop ways to improve advice and support for patients on their medicines and how to take them, and to improve patients' understanding of the action and use of their medicines, of side effects and how to manage them, and of the treatment options available to them. It would ensure that best practice was spread and built into NHS services, including the new medicines management schemes announced and the training of health professionals.

On the NHS plan, Lord Hunt said pharmacy was an important and integral part, and 25 per cent of the Health and Social Care Bill, now going through the House of Lords, was about pharmacy. Obstacles to distance supply and on-line pharmacy would be removed, and prescribing rights introduced. It would not be too long before the first pharmacist prescribing occurred. That was an important signal to the developing role of the pharmacist.

The Bill would also establish locally tailored pharmacy services, targeting specific groups or issues. The Government was interested in ideas that could exploit the good health opportunities offered by pharmacists' combination of retail and clinical expertise. Pharmacies of all sizes would be involved. The local pharmaceutical services would unlock innovation and creativity and exploit opportunities for further development.

Hospitals would be given self-assessment tools for medicines management. The medicines management framework would lead to the better use of medicines, but would not be confined to pharmacy. It would apply to all hospital staff concerned with the use of medicines. Every step taken forward in hospital pharmacy would also need to be matched by community pharmacy. It was important for primary and secondary care to work together to help patients obtain the best from their medicines.

Pharmacy was important to the National Service Framework for Older People. People over 75 years would have their medicines reviewed at least annually, with six-monthly reviews for those taking four or more medicines. By 2004, every PCG or PCT would have schemes in place so that older people get more help from pharmacists in using their medicines.

Lord Hunt predicted an increased demand for the professional services of pharmacists and a growing appreciation of what the pharmacy profession could offer, from clinical services to good clinical governance. Pharmaceutical advisers' roles would change, but they would still be needed. Health authorities would need to be more proactive on pharmacy issues.

Hospital pharmacy would work in a more open environment, with less demarcation and would be more concerned with its staff. Hospital pharmacists would be the first to prescribe.

Community pharmacies would be more involved with the best use of medicines and their direct input into patient care would grow. There would be new opportunity for a new NHS relationship, with changes to NHS contracts, with a framework of quality not just volume of work. Change would be needed, and those who did not want to change could not expect things to continue as before.

Pharmacy would rise to the challenge and had a bright future ahead of it. There was now a clear strategy for pharmacy.

In recent Lords debates, particularly on emergency hormonal contraception, some had questioned the professional integrity of pharmacists. The debate reinforced the view that pharmacy needed to demonstrate its professionalism and contribution to health. It was Lord Hunt's opinion that the profession was entering a golden era.

SIGNIFICANT CHANGES

MARSHALL DAVIES (Vice-President of the Society), welcoming Lord Hunt's announcement about the national task force to promote partnerships in medicines, said that the project would bring about some of

the most significant changes to relationships and outcomes that the NHS had seen. With the coming of genetically-targeted therapies and diagnostics, this partnership would become more crucial than ever.

Focusing on issues affecting practising pharmacists, Mr Davies said that patient-centred care was the shared goal, but pharmacists needed to be in a position to deliver it. If pharmacists did not understand the way ahead and the barriers to change then the goal would remain elusive.

Both hospital and community pharmacists had experience of working at the interface of formal and informal care and helping people understand and feel confident about their medicines. New terms came and went but the reality was that pharmacists had been working in partnership with medicines users for generations. This was what lay behind the modern pharmacist's task, however one might interpret such terms as medicines management and pharmaceutical care.

Mr Davies added that one of the hardest tasks for health professionals was to accept that their jobs were not about being in control, but about helping those they served take better control over their own lives. This applied to serious illness as well as minor illnesses.

Benefits of medicines management

Pilot trials of medicines management systems would show a clear benefit, predicted Mr Allen Tweedie (Pharmaceutical Services Negotiating Committee). The pilots would allow the development of a true model of service to roll out nationally.

Mr Tweedie described a medicines management process that consisted of a structured assessment of the patient's needs, a structured discussion with the patient and then with the doctor, and a review of the effectiveness of changes. Involvement of medical staff would be a key issue in taking medicines management forward, he said. If they were not fully engaged, it would not work.

A balance had to be struck between the

best results and costs minimisation. Health economics would become important in medicines management. National protocols would need to be looked at and tweaked locally.

Mr Tweedie suggested that pharmacy was repositioning itself so that in future pharmacists would deal with patients rather than FP10s. They would face more patients' problems and would become a lever of change in primary care, because of their relationships with doctors, nurses and other professionals. This value-added service would mean extra funding, and £30m was to be spent over the next three years. Medicines management would help change primary care.

The pharmacy plan and the hospital service

Reshaping care around the patient, improving quality and making better use of the skills and dedication of NHS staff were the key issues in the pharmacy plan for the hospital service, Mr Ron Pate (head of pharmacy services, Dudley Group of Hospitals) told the West Midlands conference.

Pharmacy departments had expanded out-of-hours and on-call services, although the working time directive had to be taken into consideration and out-of-hours payments for hospital pharmacists had not risen in 2000/2001.

Hospital pharmacy had shown a commitment to continuing professional development and had a long-standing record of postgraduate education.

Information technology was another area in which hospital pharmacists led. Electronic ordering and invoicing was used, and consignment stockholding (where the wholesaler owned the stock until dispensing) was being investigated. Electronic prescribing was due in 2004, but different parties were developing different specifications, which was a matter of concern.

Hospital pharmacy was helping patients get the most out of their medicines with patients' own drugs schemes and counselling. The real key was re-engineering pharmacy services to ensure patients got the best from their medicines. The ability to move budgets between primary and secondary care would also create beneficial changes. Increased communication at discharge, including the use of information technology,

would be developed. In the future discharge information could be downloaded to the general medical practitioner and preferred community pharmacy.

Pharmacists were involved in various clinics. There was increased scope for such involvement, hypertension clinics being a good example of an area to which pharmacists could bring a valuable contribution.

Many centres had been quick to introduce patient group directions. However,

there was a wide variation, and standards and quality were a concern. But there were resources, including a website [see letter, p464], that enabled pharmacists to share best practice in this area. Hospital pharmacists' ability to transcribe inpatient treatment to a discharge prescription had been known for some time but had not been well developed.

The "Improving working lives" campaign was a national initiative and a pharmacy specific toolkit would be issued to help pharmacy managers to deliver on services, to recruit and retain and to create a better work environment for staff.

The role of pharmacy technicians was changing. They were being employed in medicines information and as directorate support staff. Clinical technicians were appearing, although their role needed defining and could be progressed further by technician registration.

On prescribing, Mr Pate said that hospital pharmacists had always amended prescriptions, switched intravenous therapy to oral, and supported formulary substitutions.

Discussing clinical governance, he said that errors still occurred, and it was disturbing to see the same serious errors repeated year after year. Hospital pharmacies had developed incident and near miss reporting for both external and internal errors. Controls assurance had helped in delivering on governance issues. There was a need to rebuild patient confidence in the benefits of medicines and health care professions.

Improving workforce strategy

The Royal Pharmaceutical Society and the Government were working together on improving workforce strategy in pharmacy, Dr JIM SMITH (chief pharmacist, Department of Health) told the conference during a panel session. Neither party had been successful in the past. Although some growth in pharmacist numbers was expected, it was likely to be mopped up by changes and expanding roles. A debate on skill mix was needed to use the pharmacy workforce to ease the pressure.

MARSHALL DAVIES (Vice-President of the Society), confirming that the Society would in future look at the workforce in a more integrated manner with the Government, said that the matter needed to be addressed urgently.

JOHN D'ARCY (chief executive, National Pharmaceutical Association) felt that too little had been done for too long. Changes in working patterns and the higher proportion of women on the register taking career breaks affected the workforce. People should be encouraged to return to practice.

ANDREW MURDOCK (superintendent pharmacist, Lloydspharmacy) said that graduates' expectation were much higher than in the past, and finding themselves in "pick, stick and pour" operations did not help retention. New roles might tempt them to stay in the profession.

Mr D'ARCY argued that pharmacy had to look at the environment in which it was practised. Community pharmacy had to make itself more attractive. With the four-year degree, graduates would want to put what they had learnt into practice and could be frustrated. Other jobs existed with opportunities, but all sectors of the profession needed to give professional fulfilment.

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