

# Moving services successfully from acute trusts into the community

A conference focused on shifting care into the community and how pharmacists and pharmacy services can contribute to this. **Iben Altman**, from South Downs Health NHS Trust, and **Theresa Rutter**, from East and South East England Specialist Pharmacy Services, report

**M**oving services into the community from acute trusts will need to happen on a scale of “population” proportions, said Martin Samuels, priority programme head for the care outside hospital team at the NHS Institute for Innovation and Improvement. Dr Samuels told listeners about the contribution of the institute, which helps the NHS to transform health care for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership. It supports projects that allow identification of the key factors that will enable successful change. The institute’s website includes tools and techniques to support service redesign and development.

The capabilities of commissioning organisations are a key focus for the next stage in shifting care into the community, said Dr Samuels. A set list of competencies for these organisations is being developed, including one for safety that may address medicines management issues. Dr Samuels explained that changes within the NHS involve large and complex systems. When setting up new patient pathways within the community the NHS must ensure that other things do not “fall off” somewhere in the process so that a change project will be successful.

Judith Davies, interim director of community and specialist rehabilitation services at South Birmingham Primary Care Trust Provider Services, described options for the future configuration of PCT provider services and some of the new models that may develop. Commissioners will have to shape their local market by applying criteria such as innovation, quality and value for money to each service. They must also consider acceptability to stakeholders, how robust governance systems are, and whether the service is collaborative and capable of clinical sustainability, etc. Priorities will differ depending on local circumstances as will decisions regarding the best organisational model. The model selected will also be dependent on the size of the provider arm, eg, working towards a Community Foundation Trust will only be viable for larger PCTs.

Pharmacy education needs to change to meet future needs and there should be a stronger commitment to the education of future pharmacy professionals from the profession itself. Chris Langley, lecturer in pharmacy practice and director of professional liaison at Aston University,

Birmingham, explained that a mono-based pharmacy university system may not meet the new roles that are emerging for pharmacists as their involvement in more traditional roles such as dispensing and managing medicines supply decreases.

Dr Langley said that the concept of multi-disciplinary learning and teaching at undergraduate level had widespread support. However, logistical problems such as organising shared curricula, identifying shared components within the degree courses and the differences in the funding structure of various undergraduate degrees (eg, between pharmacy and medical degrees) are barriers that would have to be addressed to introduce truly multidisciplinary learning.



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**Chris Langley:** a mono-based pharmacy university system may not support the new roles that are emerging

## Pharmacy team essential in major incidents

The contribution of the pharmacy team when dealing with major incidents is essential, said Mary Golding, senior community services pharmacist from West Kent Primary Care Trust. She described her involvement in the “Black crocus incident” organised by the Health Protection Agency. This was a practical exercise played out in a local leisure centre that functioned as a mass distribution

centre for issuing medicines to the public with hundreds of local volunteers attending armed with scripts to tie in with the scenario.

Mrs Golding said that issues such as the safe storage of medicines, distribution of the pre-packed medicines, training nurses to use patient group directions (PGDs), dealing with medication enquiries and finding practical solutions to problems were part of the pharmacists’ role. The pharmacy team also had to adapt to the situation, for example, by changing the set-up of the pharmacy dispensing area (a squash court) mid-way through the

exercise by introducing a reception area to solve problems around congestion of patients and to maintain the security of medicines. The pharmacists taking part brought their own BNFs and these were in great demand. The pharmacy team recommended after the event that BNFs be made available in future major incidents. Mrs Golding said: “It was difficult at times to treat an ‘18-month-old child’ when he or she was actually an 18-year-old volunteer, but participating in this event was a valuable experience of how to manage a major incident”.

The 21st annual conference of the **Primary and Community Care Pharmacy Network** took place in Birmingham from 7–9 October

# Pharmacists will contribute to shifting care from the “middle ground” into community settings

Pharmacists and other practitioners with special interests will contribute to shifting care from the “middle ground” into community settings, said Beth Taylor, national project lead of the Primary Care Contracting Team. There will need to be consistency in “high level” practice and all practitioners will need to use the right tool, whether independent or supplementary prescribing, patient group directions, etc, to provide medicines as an integral part of their practice. Service examples likely to be provided from community pharmacies include drugs misuse and sexual health services.

Community hospitals provide intermediate care, which includes admitting patients on a “step up” (patients admitted directly from the community) and a “step down” (patients admitted from an acute hospital) basis. Jan Marriott, director of clinical change at Gloucestershire Primary Care Trust and member of the National Committee of the Community Hospital Association (CHA), said that in future community hospitals may also get involved in blood transfusions, diagnostics and other treatments traditionally associated with acute hospitals. Mrs Marriott said that the CHA defines a community hospital as a local hospital unit or centre that includes inpatient beds but may also include other departments such as theatres. Community hospitals generally have a high level of local community ownership and community lobbying has “seen off” several closures.

## Pharmacy support

Laura Bucknell, medicines management pharmacist at Gloucestershire Primary Care Trust, described the pharmacy support available to the 10 community hospitals within the PCT. This support is provided via a service-level agreement (contract) with a local acute trust for eight of the community hospitals and input by a PCT-employed clinical pharmacist for the remaining two. Ms Bucknell stated that the pharmacy cover for the community hospitals within the PCT was not equitable and that the PCT’s medicines management team is currently seeking to address this.

Good communication is essential when patients on intravenous therapy are being discharged from an acute hospital to their own homes where IV therapy will be administered by community nurses. Mel Snelling, lead HIV and infectious diseases pharmacist from Oxford Radcliffe Hospitals NHS Trust, said that inclusion of a pharmacist in the multidisciplinary team when establishing IV therapy in patients’ homes was essential. As this scheme is now established, Ms Snelling’s input now focuses on specific issues including using her skills as an independent prescriber. A drug that can be given once a day as a bolus



**Beth Taylor: all practitioners will need to use the right tool**

or short infusion would be the ideal choice for IV administration in patients’ homes. Ms Snelling also explained that standardising the type of IV line, procedures for selection of the patients for home IV therapy (eg, access to a telephone, the patients past history, the patient agreeing to home IV therapy), support of an IV community therapy team and a robust shared care process between the hospital and community had contributed to the success of this scheme in Oxford. Ms Snelling stated that, locally, two doses of the IV therapy would be administered in hospital before home administration, due to the possibility of an anaphylactic reaction. She was aware that this was currently a topic being discussed within the health community as there is a greater move towards acute hospital admission avoidance by initiating IV therapy in the community.

Managing risk is the bedrock of improving patient safety declared Tony Jamison, head of medicines governance, Leeds PCT, and pharmacists are well placed to encourage the safe management of medicines. Mr Jamison described the different risk management processes such as risk acceptance, risk avoidance, risk reduction, risk sharing and risk transfer. Risk avoidance is where a physical barrier is put in place. An example is a der-

matology service run by nurses requesting stock of prescription-only medicines without being able to confirm how these prescription-only medicines would be prescribed. No POM supplies were provided thus avoiding any risks until a mechanism was in place to administer the POMs legally.

## Understanding differences

When moving services from an acute hospital into the community to provide care closer to home it is important that the people running these services understand the differences between the two settings. Mr Jamison gave an example of ophthalmic surgeons performing minor operations under local anaesthetic within a new community clinic. The ophthalmic surgeons were unaware that in the event of an emergency, access to a crash trolley and crash team would not be available in the community premises. Mr Jamison affirmed that excuses for unsafe practice such as “we have always done it and nothing has ever gone wrong” should always be challenged.

Ann Darville, out-of-hospital care and provider liaison pharmacist from Cambridgeshire PCT, described a scheme where trained home carers administer medicines from a pack dispensed by the community pharmacist to service users in their own home as specified in the individual’s care plan. The involvement of all stakeholders was essential to the success of this scheme.

Despite your best efforts a project may not always be successful, said Hartish Mangat, senior pharmacist (community services), at University Hospitals Birmingham NHS Foundation Trust. She cited incidents where children in local schools had needed to be sent to hospital as a result of asthma attacks when their prescribed inhalers were not available. A multidisciplinary group had been convened to look at the feasibility and benefits of having “reliever” inhalers, spacers and a flow chart of instructions available in schools to reduce the risk of this happening in future. There did not appear to be a system for implementation that complied with medicines legislation and other options are currently being examined.

Jane Swan, head of pharmacy, specialist services, at Nottingham County Teaching Primary Care Trust, described a wound care project carried out on behalf of Nottingham City PCT. The aims and expected outcomes were to increase adherence to the wound care formulary, increase prompt access to treatment and to decrease expenditure and waste. The project is ongoing and will be monitored by PCT audit officers. Outcome measures will include logging of adverse incidents and complaints as well as evaluation of the opinions of patients and community nurses.

## PCCPN membership

Pharmacists or pharmacy technicians supporting community health services, including community hospitals, or pharmacists involved with the regulation of health care who would like to join or find out more about PCCPN, should contact David Green, PCCPN membership secretary (e-mail [david.green@essexrivers.nhs.uk](mailto:david.green@essexrivers.nhs.uk)).

An application form is also available on the PCCPN website [www.pccpnetwork.org](http://www.pccpnetwork.org)