

# Thinking outside the box

Reconfiguring and re-engineering services was the theme of this year's *Hospital Pharmacist* conference. Speakers described areas in which their trusts are working in innovative ways to improve patient care. Hannah Pike and Gareth Malson report

**T**he pharmacy profession has, and has had, leaders who push the boundaries of practice, said Keith Ridge, chief pharmaceutical officer for England. He likened these pharmacists to a "renaissance" pharmacist. The renaissance pharmacist brings a breadth of experience and skill to help patients get the most benefit from their medicines, takes the lead on medicines safety issues and does not offload the risks to others. "The renaissance pharmacist isn't content to stay put within his or her box or, putting it another way, to export medicines-related risks to other professions, other parts of an institution or sectors of care," he said.

Dr Ridge outlined some "out of the box" landmarks, including publication of "Clinical pharmacy in the hospital pharmaceutical service" in 1996 by the Clinical Resource and Audit Group in Scotland. "To my knowledge, this was one of the first attempts in the UK to lay out a systematic approach to personalised medicines-based care... that could be translated into action and could be widely understood," he said.

## — Still much to do

There is still much to do to make medicines-based care safer, said Dr Ridge. It is not enough to supply a medicine accurately. Pharmacists need to adopt a broader view of the whole drug use process, which includes determination of need, prescribing, access, administration and identification of benefit.

Current levels of medication-related morbidity are a public health issue and the incidence of preventable adverse drug events in patients outside hospital is too high. In the UK it is estimated that preventable adverse drug events are responsible for 4 to 5 per cent of admissions to hospital and may affect a similar proportion of patients while they are in hospital, said Dr Ridge.

The *Hospital Pharmacist* conference "New directions for pharmacy — reconfiguring and re-engineering services" was held at the Royal Pharmaceutical Society's headquarters on 31 January. It was chaired by Ray Fitzpatrick, chair of the Hospital Pharmacists Group Committee of the Royal Pharmaceutical Society. Presentations from the conference can be accessed at [www.pjonline.com/hpconference](http://www.pjonline.com/hpconference)



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Keith Ridge: medication-related morbidity is a public health issue

The Department of Health is supporting the Paediatric Chief Pharmacists Group in work to determine variations in the preparation of total parenteral nutrition for neonatal and paediatric patients across the UK. This will be an example of pharmacy showing leadership in seeking to improve medicines-based care, he said.

Good system design and risk assessment of new services are also essential. The recent "rapid response report" from the National Patient Safety Agency on oral anticancer medicines is a timely reminder of the importance of translating safeguards, such as those applied to parenteral chemotherapy products, to dosage forms that can be used in a variety of settings.

Specialist teams need to think outside the box in determining what should be done to ensure safe use of these medicines by all practitioners — and this is not limited to oral anticancer medicines. Similar thinking is needed for high dose opioids in palliative care, unlicensed medicines in paediatrics and the newer biological agents.

Another issue is the need to recognise that discrepancies can arise at the interface of primary and secondary care in terms of prescribing intention and what is actually supplied. In the late 1990s, one study estimated that over a quarter of discharged patients had discrepancies between the different supplies of medicines in their homes. The same work demonstrated that

these discrepancies were reduced by sharing a written summary of discharge medicines with the patient's community pharmacist.

There are things that the Government can do to promote innovation and innovative practice, but it is also incumbent on the NHS and pharmacy managers to instil an appetite for innovation in the hospital pharmacy workforce, said Dr Ridge.

"As the number of approved consultant pharmacist posts in England increases, we should be making sure that these practitioners have been set challenging goals in terms of rethinking service delivery," he said. Partnership with higher education will be key to this.

"Thinking outside-the-box took hospital pharmacy from the dispensing bench and into the clinical arena. We cannot afford to let that be the highpoint of our history and, from talking to you, I am certain you will not let that happen," he said. Pharmacy is better equipped as a clinical workforce than it has ever been and current policy changes bring significant opportunities to make use of these skills, he said.

"Think outside the box, act within and across the profession, demonstrate real leadership in patient safety, health inequalities, and medicines, and define the next stage for pharmacy," he urged.

## New regulator

Keith Ridge, chief pharmaceutical officer for England, said that patient safety and independent regulation are particularly important at this time of increasing clinical involvement by the profession. Referring to the establishment of the new pharmacy regulator, the General Pharmaceutical Council (GPhC), he said: "Remember, independent regulation is not just about discipline. It will also be the key to promoting improved care and quality". He said they are aiming for the GPhC to be open by January 2010. "We will be listening during this two year journey and consulting when we can. Needless to say, we will be working closely with those building the new approach to professional leadership to help ensure all this is as seamless as possible for pharmacy," he said.

# Where's the pharmacy please? — the case for decentralisation

Over the past 30 years there has been considerable progress in the way pharmacy services are delivered, said Derek Swanson, deputy director of pharmacy, Royal Liverpool and Broadgreen NHS Trust. Ward-based pharmacy services are relatively well established across the UK, and in most cases the pharmacist is an integral part of the ward team, attending ward rounds, prescribing and running clinics. Ward-based technicians who used to look after stock are now running the whole supply service in some cases, and pharmacy automation has had a big role in facilitating modernisation.

However, most pharmacy services are still centralised, and the pharmacy is usually located in the basement of the hospital. Staff and stock still have to travel up and down between the wards and the pharmacy. "Eventually, sometimes by good luck rather than good management, the staff and the stock actually reach the patients to do what they are supposed to do. A lot of our time is spent running around chasing things up," he said.

"What we do with automation is great, but what we actually do in the dispensing process hasn't changed," he said. "It is still all happening in one place, with a huge queue of work, which, if you are lucky, you might get through by [the end of the day]."

Problems with the system include inefficient use of staff and poor stock control. For example, nurses are known to have "just in case" cupboards where they hoard stock that they are concerned might run out.

"About 6 per cent of our issues, whether stock or dispensing, comes back as returns. We recycle about £1m of stock through the dispensary each year. It's a ridiculous waste of time, partly because of the way we work," he said.

There is a need to "work smarter" to solve these problems and meet the demands facing pharmacy. Mr Swanson described how the new hospital that will be opening in Liverpool in 2015 is being designed to avoid some of these problems, by decentralising the pharmacy services.

## — New model

In the new model of working most of the pharmacy work will be done away from the pharmacy. A pharmacist, a technician and a support worker will form an entirely ward-based team. Patient medicines will be stored in bedside lockers and ward stock will be



Derek Swanson: there will be no drug trolleys on the wards in the new hospital in Liverpool

kept in electronic drawers. "In our new hospital there will be no medicines trolleys on the wards at all," said Mr Swanson. All the dispensing will be done at ward level, using ward-based automated storage. "It gives us better stock control, it gives us ease of dispensing, and, with some of the modern barcode matching systems, you can do a very accurate final dispensing check, validating what has been done against the prescription," he explained.

All of the prescribing will be electronic, so it will be possible to do the clinical work on the ward, and view prescriptions from anywhere in the hospital, linking electronically to the dispensing system.

## — Stock

Stock will be ordered automatically by the "intelligent" stock systems, and will be delivered directly to each ward and put away by ward staff. Stock held at ward level will therefore be based on actual use rather than anticipated use, Mr Swanson explained. Medicines storage will be shared between two wards for efficiency of space and ease of access.

A storage area will still be needed for IV fluids because they cannot be put into robots. "In our hospital I am not planning a decentralised IV fluid service because I don't think any of the IV fluid suppliers would give us the sort of delivery schedule we would need. We will still probably have to have a centralised pharmacy IV store,

decanting the stock up on a daily basis to the ward".

There will be an integrated database of all the storage areas so that if an item is not available on a certain ward during the night it is easy to find out where to get it from.

## — Vestigial pharmacy

Mr Swanson said that a "vestigial" pharmacy will still be needed in the new hospital for tasks such as goods receipt, outpatient clinical trials dispensing and some extemporaneous dispensing. This will be much smaller than current pharmacy premises, and he hopes that it will be "pharmacist free". The licensed aseptic unit might also be in this area, or it might be located nearer oncology wards, for example.

"I already know that the vestigial pharmacy [will be] in the basement, and I have been assured that there is absolutely no chance of it being anywhere else — some things you just can't change," he admitted.

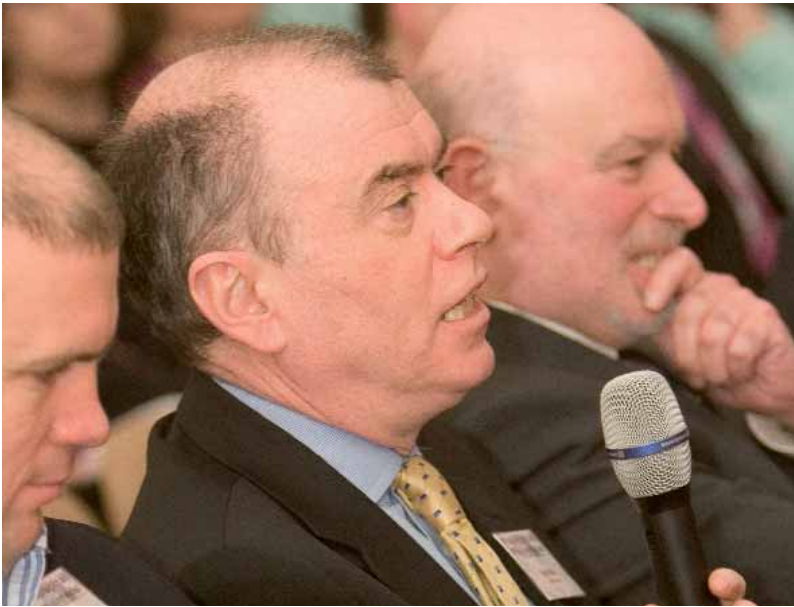
## — Benefits and risks

The main benefit of the new model of working is a responsive medicines supply system. Prescriptions will be written electronically on the wards, validated by the ward-based pharmacist and picked and labelled by robots. It then only needs a final check before administration. "It could happen within minutes — compared to the paper prescription being written two hours later, to go down to the pharmacy, to join the queue and come back at five o'clock — [after the patient has] missed a dose," said Mr Swanson.

He acknowledged that there are risks with such a system and it will require a considerable culture change. There will be a big reliance on information management and technology. "The integrity of the infrastructure will be critical."

Another concern is that staff will become deskilled in some areas. This is a concern that has been realised across pharmacy with the introduction of automated processes. Mr Swanson suggested that there could be a rotational system through the vestigial pharmacy to enable staff to keep up with their extemporaneous preparation skills, etc.

"I believe that decentralisation will radically change hospital pharmacy service delivery. I believe that it will bring a major culture change, however I believe it will fully realise patient-centred medicines management," he said.



Top left: Delegates take part in a question and answer session. Top right: Networking at the conference exhibition. Middle: Delegates listen to speakers. Bottom left: David Miller gives his presentation. Bottom right: Anne Tyrrell (chief pharmacist, St Mary's Hospital, Paddington) and Ray Fitzpatrick (conference chairman) turn to look at slides.

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Top left and middle left: Company representatives talk to delegates in the exhibition. Top right: Katie Davies from Mid Cheshire Hospital NHS Trust, winner of the *Hospital Pharmacist* Life-long Learning competition. Middle right: Ray Fitzpatrick (conference chairman) and Ian Simpson, chief executive of the College of Pharmacy Practice. Bottom: Delegates listen to a presentation and Sue Kilby, a member of the Royal Pharmaceutical Society's Council, takes part in a question and answer session.

# The pros and cons of providing a homecare service

**Homecare services**, where medical and clinical supplies are delivered directly to the patient, have many advantages, but there are some important factors to consider before setting up such a service.

Anne Tyrrell, chief pharmacist at St Mary's Hospital, Paddington, part of Imperial College Healthcare NHS Trust, described "the good the bad and the ugly" of the homecare service in operation at St Mary's. The hospital currently runs a home delivery service for all antiretroviral drugs, as well as a small number of other drugs.

It is unknown how much is currently spent on homecare services, said Ms Tyrrell, but it is a big business (estimates lie at about £500m). On the NHS Purchasing and Supply Agency website there are currently 29 companies either offering homecare services or looking into it.

Homecare services can be broadly classified as "low tech" or "high tech". "Low tech" means that the medicines simply need dispensing and delivering, such as enteral feeds, antiretroviral drugs and immunosuppressants. "High tech" supplies need compounding and nurse support. Examples would be total parenteral nutrition or intravenous antibiotics in cystic fibrosis.

The initiative at St Mary's has been running since 2006, and patients who have been on the same antiretroviral treatment for six



Anne Tyrrell: a robust homecare service will deliver efficient and effective care

months or more, and who are stable on the treatment, are eligible to taking part in the scheme (see Panel 1). There are currently 514 patients on the scheme, 50 of whom are paediatric HIV patients.

A steering group was set up at St Mary's to establish the homecare scheme, and a "clinical champion" was nominated to take it forward. A patient representative was also recruited to give feedback about the service. The initial target was to enrol 300 patients on the service, and Ms Tyrrell explained that considerable competition soon developed between consultants to meet their targets.

A homecare delivery co-ordinator was funded. Ms Tyrrell explained that a band 5 pharmacy technician was selected to take this position. The post is not just about dealing with invoices, she explained, but the postholder is also responsible for dealing with, for example, any confidentiality issues that may arise.

## — Advantages

Drivers for developing homecare include a determination to treat patients closer to home as well as capacity issues. Ms Tyrrell explained that there is not the capacity to care for the number of patients who are on the homecare scheme directly from St Mary's.

One of the main economic drivers for setting up homecare schemes is VAT savings — medicines dispensed for homecare are zero-rated, unlike medicines dispensed for

hospital inpatients. Ms Tyrrell explained that they encourage patients to receive four months worth of medicines at a time, but it is up to the patient to decide. "If somebody wants a monthly van, that negates any savings, but you have to give patients that choice," she explained.

As well as financial benefits and capacity advantages, homecare schemes can allow earlier discharge of patients, reduced waiting times and improved patient choice. Other benefits include earlier discharge, reduction of non-essential admissions, and reduced incidence of patients developing hospital acquired infections.

Ms Tyrrell described a patient survey which found that patients liked the fact that they do not have to wait in the hospital to get their medicines. Patients and consultants also liked the fact that they were saving money for the trust, she said. "A robust homecare service will deliver efficient and effective care."

## — Disadvantages

Challenges of homecare schemes include problems with the postal service (eg, during strikes) and the fact that patients must be contactable before all deliveries. Interaction between the patient and the pharmacist is reduced and the risk of patients missing doses can be increased (eg, if there is a delivery problem and patients had already used their buffer supply). Patients need to come off the homecare service if their therapy is changed, and must be stable on their new therapy for six months before they can go back on the scheme.

Homecare is only suited to certain patient groups. Some of the main reasons homecare does not work is when patients are not at home to receive deliveries, are not contactable or do not turn up for appointments. It is important that the patients selected for the scheme understand the importance of being reliable, she explained. It is therefore

### Contacting the editorial office of *Hospital Pharmacist*

Readers of *Hospital Pharmacist* who would like to submit articles can seek advice from the editorial staff. Contact Hannah Pike (telephone 020 7572 2425, e-mail [hannah.pike@pharmj.org.uk](mailto:hannah.pike@pharmj.org.uk)) or Gareth Malson (telephone 020 7572 2419, e-mail [gareth.malson@pharmj.org.uk](mailto:gareth.malson@pharmj.org.uk)).

## Panel 1: How the service works

Ms Tyrrell explained that patients who are eligible for the scheme complete a registration form at their first clinic appointment. The consultant completes a prescription form and a "buffer supply" of one month of medicines is dispensed so that the patient has a back up in case of any problems. The paperwork is posted to the homecare company within two days, and within five days of receipt the company contacts the patient to arrange delivery.

Patients have the option to collect their medicines from the local post office, to have them posted to their home or, if they live within the M25 area, to have them delivered by a van. At subsequent clinic appointments blood tests are taken to confirm whether the patient is stable on the medicine and thus whether homecare can continue.

not an option to put all patients on homecare to try to increase VAT savings.

With outsourcing comes a number of governance and quality issues around contracts, commissioning and tendering. These are outlined in Panel 2. "It is not out of sight out of mind, the hospital is still responsible for those patients," said Ms Tyrrell.

Confidentiality and disclosure can also be an issue – especially with HIV patients. Ms Tyrrell described a situation in which drugs were delivered to a patient's place of work, but the patient was not present to collect them. Because the drugs needed refrigerating they were handed to another person, resulting in the patient believing that his confidentiality had been compromised.

## — Paperwork

Ms Tyrrell warned that a lot of administration is required to keep proper records of homecare services. At St Mary's Hospital all the homecare data is put through the pharmacy computer system. This is not always the case at other trusts, which is a contributing factor to the lack of clarity about the scale of this business. Maintaining records provides an audit trail and a complete drug history for the patients, but it is time consuming. "I've been told that some pharmacies actually generate more paperwork through homecare than they do through their wholesaler," she said. There is a need for an e-commerce solution to reduce this problem. "Don't underestimate the sources required in terms of skill mix that you would need to start homecare," Ms Tyrrell advised.

### Panel 2: Governance and quality issues involved with running up a homecare service

#### Clinical and technical issues

- Responsibilities and liabilities of each party
- Prescription validation
- Ongoing monitoring
- Product quality (especially unlicensed medicines including specials)
- Quality of advice
- Training of staff
- Quality systems
- Error monitoring
- Performance standards
- Transport and delivery

#### Financial issues

- Product and service costs
- Tendering
- Compliance with standing financial instructions (SFIs) and standing orders
- Invoice matching
- Order generation
- Data management and reporting

# Managing the consequences of changing working practice

Managing a change in working practice includes managing the consequences of the change, said David Miller, chief pharmacist at City Hospitals Sunderland NHS Foundation Trust. Over the past few years, the trust has implemented ward-based medicines management and electronic prescribing (EP), following a £350,000 investment.

## — Medicines management

As part of the medicines management programme, all pharmacists and pharmacy technicians now spend 90 per cent of their contracted hours doing clinical activities. The programme ensures that:

- All patients receive an up-to-date medicines list and appropriate counselling on discharge
- The patient's GP receives a complete summary of medication changes when the patient is discharged
- All problems with discharge prescriptions are identified and resolved on the ward

Before implementation of the programme, the average discharge time (time taken between a consultant deciding that a patient should be discharged and the patient leaving hospital with their discharge medicines) was approximately five and a half hours. "We're now down to [an average discharge time of] around 45 minutes," said Mr Miller.

He added that the resulting reduction in drug expenditure had recouped a considerable portion of the initial investment in the new way of working. The use of patient's own drugs, both those that were brought in by the patient and those issued using one stop dispensing during admission (but paid for by the primary care trust as discharge medicines), resulted in a saving of around £250,000 per year. In addition, the trust no longer needs to use taxis to transport discharge medicines to patients who have left the hospital — a bill that had previously amounted to £15,000 per year.

Mr Miller added that other benefits of the programme include:

- Reduced medicine-related errors (confirmed by audit)
- No duplicated medicine supplies to patients who are moved between wards
- Increased recruitment and retention of staff
- Increased patient satisfaction



David Miller: a ward-based service now runs for 12 hours a day, seven days a week

## — Electronic prescribing

EP has been embedded across all wards, putting an end to errors involving the misinterpretation or erroneous transcription of doctor's prescriptions, said Mr Miller. The system provides a full audit trail for all prescribing and dispensing, and has prevented any prescriptions from being lost between the ward and the dispensary.

**Prioritisation** Mr Miller said that pharmacy staff no longer have to walk around the ward checking the prescription charts. The computer highlights prescriptions for which there has been a change, allowing the pharmacist to prioritise his or her time to view the prescriptions for which a drug has been added, deleted or amended.

This review process can be done anywhere in the hospital, not just at the patient's bedside. In addition, the pharmacists spend less time correcting prescriptions, because the system does not allow doctors to prescribe a medicine without specifying the strength or an appropriate route of administration.

**Decision constraint** The software for EP includes decision support functions. "I consider this to be decision constraint," said Mr Miller, "it stops doctors from making bad decisions rather than ensuring they make the right decision." There will always be a human element to prescribing and administering medicines, therefore there are always potential mistakes that a computer will not detect.

## — Management issues

The new way of working has created some problems, all of which required management solutions.

**Prescribing consequences** One of the unintended consequences of EP is linked to the fact that that it ensures the doctor specifies a stop date for every course of antibiotics prescribed. "This can result in the patient only getting four days of a seven day course, if the nurses do not order the drug [until three days after it is prescribed], because the computer will automatically stop the prescription when the 'stop date' is reached," said Mr Miller.

Shortly after implementing EP, Mr Miller said that formulary control went "absolutely haywire". This was because all drugs were put on the system without formulary restrictions, to allow patients' own drugs to be prescribed. "Therefore we had to come up with a way of getting [adherence to the formulary] through to the doctors," he said.

**Staffing consequences** "We are heavily-dependent on pharmacists [to deliver the medicines management programme], therefore we have to recruit excessively into the training programme," said Mr Miller. "We also have band 3 checking dispensers, because most of the errors are taken out by the computer system." These checkers have proved successful because the competencies required to dispense a prescription are similar to those required for checking it.

When clinical staff only spend one day per month in the dispensary, this can create a gap between the dispensary staff and the clinical staff, Mr Miller warned. As a result, the dispensary staff can be unsure of some prescription requirements, such as the pack size required for an analgesic prescription. To correct this, the electronic prescribing system was modified to ensure the pharmacists included sufficient information on each prescription to allow the dispensers to do their job, he said.

Because pharmacists and technicians are now so heavily involved in dealing with discharges, this has deskilled other professions in this area, said Mr Miller. "[The nursing staff] are used to the pharmacists doing everything." This caused a problem when the pharmacy only offered its full service on Monday to Friday. The pharmacy now runs a ward-based service for 12 hours a day, seven days a week.

# Reducing risk at the interface of primary and secondary care

**Mike Scott**, head of pharmacy and medicines management at Northern Health and Social Care Trust, described progress in Northern Ireland with not only improving the hospital pharmacy service, but improving care in the community.

Spending reviews over recent years identified that a saving of £55m could be made on pharmaceuticals in Northern Ireland between 2005 and 2008, and that a further £40m could be saved in 2008–11. The safer patients initiative and the associated performance indicators [Editor — see *The Pharmaceutical Journal* 2007;279:95] was another driver for change. In addition to putting patient safety high up the healthcare agenda, this initiative highlights what the pharmacy profession can do, not just in terms of reducing spending, but in improving patient care, Dr Scott said.

Dr Scott described the Pharmaceutical Services Improvement Programme (PSIP) that was established in 2005. This consisted of the following eight workstreams:

- Repeat dispensing
- Minor ailments
- 28-day dispensing
- Generic substitution
- Medicines governance
- Integrated medicines management
- Therapeutic tendering
- Pharmaceutical clinical technology

Dr Scott described progress in these areas, concentrating on those that have the biggest impact on hospital pharmacy.

Regarding 28-day dispensing, he explained that until 2004 it was standard practice to give a three-day supply of medicines on discharge. It sometimes took

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Mike Scott: we are improving patient care and improving efficiency

an average of 33 days for discharge information to reach community pharmacists and GPs, the worst being 91 days, he said. Discharge medicines are now given for 28 days and this has resulted in a saving of £3.6m per year. The hospital did get some of this money back, and it was reinvested.

In terms of generic substitution, Northern Ireland is still about 10 per cent behind England in its level of generic prescribing, but improvements are being seen in this area.

The medicines governance network of pharmacists is being expanded and integrated medicines management [Editor — see *Hospital Pharmacist* 2008;15:65] is now the standard model in Northern Ireland.

Integrated medicines management has improved care at the interface between primary and secondary care in a number of ways, including more accurate drug histories being taken and more appropriate use of medicines. Dr Scott said that further work is under way in this area.

Initial funding for the integrated medicines management programme was £600,000. Based on the evidence of improvements to patient care, £6m has been invested in the hospital pharmaceutical service over the last three to four years. "It is payback in that sense, because we are improving patient care and improving efficiency," he said.

Turning to homecare systems, Dr Scott described a system that is run by the hospital to supply medicines to nearly 1,000 patients in the community, costing about £600-700,000 per year. "How they get these

medicines is up to them. It is really a patient-friendly system."

## — STEPS

The STEPS (safe, therapeutic economic pharmaceutical selection) process [Editor — See *The Pharmaceutical Journal* 2005;275:738] was designed to help maintain consistency of the medicines patient receive when they move between care sectors. Dr Scott said that work is under way with the Association of the British Pharmaceutical Industry, and they are close to agreeing a working document about how this process links to procurement. The aim is to standardise medicines use across a region, and contract for both primary and secondary care where possible. To date, savings of £55m have been achieved, of which £29m has been reinvested into patient care.

## — Wound management

A review of wound care provision across Northern Ireland highlighted varying practices between primary and secondary care. In 2005 219,277 prescriptions were written for 773 different wound care products in the community. Only 136 different products were available in hospital, which meant that patients might be denied improved or enhanced wound care products. Work in this area has resulted in creation of a wound management formula for use in both primary and secondary care. "It is fully evidence-based, so not only have we enhanced patient care and enhanced accessibility, but we have actually achieved an efficiency gain in excess of £1m per annum," said Dr Scott.

He explained that the aim was to remove structural obstacles at the interfaces between GPs, community pharmacists, and hospitals, to make sure that patients were not disadvantaged.

Dr Scott concluded by saying that their future work is still directed at the eight workstreams identified by the PSIP programme, some of which are almost complete. "We are trying to do it in a holistic fashion" he explained.

## Conference presentations

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# Pharmacy mental health services should move into the community

Community-based mental health services require community-based pharmacy services, said Ian Maidment, senior pharmacist at Kent and Medway Partnership Trust and chairman of the UK Psychiatric Pharmacists Group.

Over the past few years, mental healthcare has been re-engineered with the intention of preventing hospital admissions by treating increasingly complicated patients in the community. However, Mr Maidment said that clinical pharmacy services for community mental health teams were largely non-existent — a statement backed by a workforce survey conducted in 2006.

## Community knowledge gap

Mr Maidment acknowledged that there are barriers to delivering a community-based clinical pharmacy service, in particular a lack of staff and training. He highlighted evidence that community pharmacists lack clinical knowledge about mental illness and healthcare. “Many community pharmacists are more comfortable delivering a medicines use review [of medicines that treat] asthma or diabetes than they are in [reviewing medicines for] mental health.”

Mr Maidment emphasised that community-based mental health services should not be deprived of the mental health expertise that currently exists in secondary care pharmacy. “The existing experts could act as a training resource to develop community-based practitioners, or be involved in the accreditation of pharmacists with a special interest in mental health,” he said.

## Increasing exposure

Increasing exposure to mental health pharmacy for young pharmacists and pharmacy students is essential for correcting the current shortfall in staff delivering these services, said Mr Maidment. A report produced by the Sainsbury Centre for Mental Health in 2007 suggested that there would need to be a fourfold increase in the number of pharmacy staff working in mental health, in order to deliver the objectives set out in the Department of Health’s national service framework for adult mental healthcare.

“It’s not unusual for a preregistration pharmacist in a hospital to spend two weeks working in quality assurance, but no time in mental health,” said Mr Maidment. He



Ian Maidment: clinical pharmacy services for community mental health teams are largely non-existent

commented that he found this strange, considering that 25 per cent of prescribed medicines are psychotropics. He commended a preregistration training programme that is currently in place in Norfolk, where pharmacy graduates undertake a four month rotation in a community pharmacy, a mental health trust and an acute hospital trust.

Mr Maidment added that exposure to mental healthcare should continue after registration. “Pharmacists should receive at least six months of experience in mental healthcare pharmacy before making their decision to specialise,” he said.

## Technician roles

The required fourfold increase in staffing, highlighted by the Sainsbury report, also applies to pharmacy technicians, said Bev Faulkner, pharmacy services manager at Oxfordshire and Buckinghamshire Mental Health Partnership NHS Trust. In addition, a perceived lack of career development for technicians in mental health is a barrier to recruitment.

However, there are opportunities for pharmacy technicians to develop their careers through involvement in procurement, specialist medicines management and service management, said Ms Faulkner. “There are technicians in mental health who are banded at 8b. We need to make sure that people are aware that



Bev Faulkner: there is a perceived lack of career development for pharmacy technicians working in mental health

career prospects in mental health are very good,” she said.

Mental health pharmacy technicians could also perform several tasks that are already undertaken by technicians who work in acute hospitals, added Ms Faulkner. These include discharge planning and conducting medication safety audits.

Ms Faulkner highlighted the need to provide training for pharmacy technicians. General training in medicines management would be the same as that available to all technicians, she said. However, there was also a need for some training that is specific to mental health. She commended the University of Aston for allowing pharmacy technicians to study modules from the postgraduate certificate in mental health pharmacy — a course usually studied by pharmacists and nurses who have specialised in mental health [Editor — see *Hospital Pharmacist* 2008;15:28].

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# Developing technician and assistant roles to help pharmacists

Never underestimate the importance of job satisfaction for staff, said Steve Acres, pharmacy services manager at Leicester Royal Infirmary (LRI). The pharmacy department at LRI have implemented several new technician roles over the past four years that have improved skill mix.

Mr Acres explained that opportunities to make service alterations could be identified from difficulties that present in the workplace. Traditionally, they have had difficulties in retaining band six pharmacists, possibly because of the requirement to do night shifts, he said. On reviewing the tasks undertaken by a pharmacist working on a nightshift, it was realised that many of these tasks could be undertaken by technicians. Therefore, pharmacy technicians now join pharmacists on the nightshift to assist with dispensing duties, answer the telephone and use their experience to help the pharmacist.

A robot has been installed in the pharmacy at LRI, which has reduced the



Steve Acres: challenge the status quo

number of staff needed to run the dispensary. To prevent redundancies, the existing staff have been shifted into new

roles, including that of medicines management assistant. Mr Acres explained that before the role was developed, drug supplies to wards and individual patients were often duplicated, drug doses were omitted when nurses were unable to locate a drug supply in an untidy cupboard and pharmacists were being distracted from clinical duties to solve "simple, supply-related issues".

Medicines management assistants have been introduced on 14 hospital wards to be the first point of contact for drug supply issues and maintain the drug stock cupboard. The result has been a 50–80 per cent reduction in stock requisitions, a reduced number of duplicate drug supplies and a saving of approximately five hours of nursing time from not having to search for a drug, said Mr Acres.

The assistants also dispense medicines, ensure that all medicines issued to patients are placed in the bedside drug lockers and take responsibility for dealing with requests

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for newly prescribed drugs — which now arrive on the ward within five to 10 minutes, he added. “This role releases technician time, which in turn releases pharmacist time. Job satisfaction is increased for everyone involved and the importance of teamwork is developed.”

### — Discharge co-ordination

A desire to reduce patient delays has been another driver for change, Mr Acres explained. The trust recently appointed a member of staff to the role of discharge co-ordinator, to reduce the time patients spent waiting for their discharge medicines. The role was originally given to a pharmacist, but a review of the tasks conducted by the postholder revealed that little clinical input was needed. Consequently, the role was allocated to a band 5 pharmacy technician and a part-time dispensing assistant. The co-ordinator now acts as the single point of contact for all problems or queries relating to discharge prescriptions.

“All of our discharge prescriptions are now prioritised on the basis of the time required,” said Mr Acres, “whereas previously they were prioritised by the time that they reached the dispensary.” In addition, high priority prescriptions are dispensed on the ward or sent to the dispensary with the urgency of the

prescription clearly indicated. He added that the co-ordinator attends daily meetings with bed managers, which has improved communication between the pharmacy and trust management, and allows the dispensary manager to proactively prepare for “peaks in discharge activity”.

### — Technician managers

Mr Acres described his role as pharmacy services manager, which was performed by a senior pharmacist until about four years ago. The role requires strong management and leadership skills, yet does not need any clinical expertise. Consequently, it is now preformed by two pharmacy technicians and one manager with no pharmacy background.

Mr Acres believes that pharmacy technicians are well suited to this role, because they have an understanding of the ethical and professional issues that surround pharmacy services and the needs of the patient. The role also offers a possibility of career progression for pharmacy technicians.

### — Retaining core services

The core supply service of the department must always be fulfilled, warned Mr Acres,

and this may require the staff in these extended roles to return to dispensary duties. This situation can create tension between dispensing staff and clinical teams that needs to be diffused.

A change to the split of staff time between the dispensary and the wards was necessary, said Mr Acres. “At one time we worked on a 50-50 split. Now, we operate a more flexible approach.” He explained that if a pharmacy directorate created a large workload for the dispensary, then that directorate should be expected to provide staff to perform dispensary duties. Open communication between the dispensary and the clinical directorates is needed for this approach to work, he added.

### — Take a step back

Mr Acres emphasised the importance of taking a step back and viewing the “whole system” without being involved in it, to make sure you optimise your investment. “It is not just about looking at what people are doing in other trusts, but looking at situations that arise in your own trust and making best use of your workforce.” He encouraged conference attendees to challenge the status quo and examine every aspect of taxpayer’s investment, to ensure that the right people are doing the right jobs.

# Sharing pharmaceutical care between hospital and community

**Hospital pharmacists** will need to communicate patients' problems with their medicines to community pharmacists when a patient is discharged from hospital, to ensure continuing pharmaceutical care, said Norman Lannigan, lead pharmacist for acute care, mental health and innovation at NHS Greater Glasgow and Clyde.

The proposed chronic medication service within the new community pharmacy contract in Scotland offers remuneration based on the number of patients that the pharmacy registers, rather than volume of prescriptions that are dispensed. The pharmacy will then provide the patients with all of their pharmaceutical care needs.

"The new community pharmacy contract offers huge opportunities for the pharmacy profession to contribute significantly to real, clinical problems," said Mr Lannigan. "If you can contribute significantly to patient outcomes, that is something worth buying." He described the community contract as the "most exciting development" in his 25 years in hospital pharmacy. It means that community pharmacists are now talking the same language as hospital pharmacists, he said.

## — Sharing care

Pharmaceutical care provision will be shared between community and hospital pharmacy, according to the proposed new way of working in Scotland. Care plans will be written, in hospital or in the community, and will follow the patient wherever he or she goes. If a medicine-related problem is identified in hospital and cannot be resolved by the time the patient is discharged, a care plan should be passed to the community pharmacy with whom that patient is registered. The community pharmacist will then ensure that the care plan is followed. An example is shown in Panel 1.

A culture change for hospital pharmacists will be required to deliver this new way of working, said Mr Lannigan. "Hospital pharmacists need to move away from the thought that their job begins when the patient enters a bed and finishes when they leave it." The average length of stay for a hospital patient is becoming shorter and hospital pharmacists do not have time to resolve all the problems they identify, he added.

Specialist pharmacists in hospitals will also need to become a point of reference for community pharmacists, who will have to deal with patients with increasingly complex diseases. "There are some patients with diseases



Norman Lannigan: a culture change is needed

that used to be treated in hospital, but are now managed totally in primary care. Specialist knowledge will be needed in primary care in order to deal with these patients."

## — Changing healthcare

In modern healthcare, patients are being moved out of hospital more quickly, said Mr Lannigan. Where patients used to stay in hospital until they were well and stable, now they are discharged into a supported care environment despite still being unwell.

**Medication problems** Often, patients are discharged even though their medication is not stable, and this causes problems, said Mr Lannigan. "We bring patients into hospital and take all their medicines off them. Then we expect them to be able to take them [again] when they go home. That doesn't seem right to me." Hospital patients should be expected to self-medicate and only offered support in taking medicines if it is needed, he added.

Other methods need to be made available for patients who have difficulty taking their medicines. "There are a large number of people who are unable to self-medicate and the only solution that we have to that is to fill a compliance aid — which is a nightmare for our community pharmacy colleagues."

**Information transfer** Ensuring information is passed to community pharmacy and primary care regarding any medication changes during a hospital admission, and why, is a common failing by hospitals, said Mr

Lannigan. A study in Edinburgh examined all patients who had been readmitted to hospital within 12 weeks of a previous discharge. After excluding patients who had deliberately overdosed, 30 per cent of the remaining patients were admitted wholly or partly because of their medicines. "If we could dent that problem, [the solution] would be well worth buying," he said.

**Health service reform** The new contract resulted from a reform of the health service by the devolved Scottish Government. The key objectives of the new service are to:

- Integrate healthcare between primary and secondary care
- Empower patients to take responsibility for their own health
- Provide continuous, preventive care outside hospital

Mr Lannigan commended the Scottish Government for deciding not to completely reorganise the health service after devolution. "This allowed us to build on the existing system."

## Panel 1: How will Scottish proposals benefit patients?

Norman Lannigan, lead pharmacist for acute care, mental health and innovation at NHS Greater Glasgow and Clyde, offered the following example of how the new arrangement in Scotland would benefit patients:

**Problem** Mrs X is admitted to hospital with congestive heart failure. The doctor prescribes ramipril, with the intention to increase the dose as high as can be tolerated. She is discharged from hospital with the dose at 2.5mg daily. After three months, she is readmitted to hospital with an exacerbation of heart failure. The dose of ramipril is still 2.5mg daily.

**Scottish solution** Mrs X is discharged on ramipril 2.5mg daily. The community pharmacy with whom she is registered receives a care plan stating that the ramipril dose is to increase. The pharmacist reviews Mrs X's clinical progress, increases the dose according to the care plan and passes all relevant information to her GP.