Local professional network

19th November 2014

South Yorkshire and Bassetlaw Pharmacy LPN Engagement Event

LPN Chair Introduction

Dear Colleague

The LPN Engagement Event held in November at the Holiday Inn in Barnsley, supported by the RPS, was extremely well attended and generated a great deal of useful discussion and debate.

The workshop format of the event was successful in supporting participation and engagement and within each workshop there was an attempt made to capture the main points in order that these could be shared with all of those who came and contributed.

These notes are now being sent out with this communication and I hope that they will stimulate you to consider how you can get involved with the work of the LPN. The pharmacy profession needs this to happen; the steering group of the LPN simply cannot hope to accomplish what needs to be done alone.

If you want to help, please get in touch with me, or any member of the steering group. As you will have seen at the evening event, we are building on the Call to Action in South Yorkshire and Bassetlaw – but we need to do more, and for that to happen the network needs to expand, so don't stand on the side-lines and spectate – get involved!

Yours sincerely

Peter Magirr BSc MSc MBA PhD FRPharmS

Chair: Pharmacy Local Professional Network.

NHS England (South Yorkshire and Bassetlaw)

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Break-out Group Notes and comments:

(Note - comments may not always fit with questions asked)

1) MEDICINES OPTIMISATION

Hosted By Matt Auckland and Nick Hunter

1. **What is Medicines Optimisation?**
    a. A GP in the group gave a "story" of what MO isn't – a polypharmacy patient with an MDS given everything in one go. This generated much discussion around whether MDS was required at all

2. **What are you already doing to support Medicines Optimisation?**
    a. MURs
    b. NMS
    c. Barnsley Managed Care scheme – key benefit is the formalised communication pathway. Discussed in both groups and not initiated by either NH or MA
    d. Bulk dispensing for care homes in Sheffield, but withdrawn due to problems
    e. Synchronisation of scripts
    f. CPWY Emergency Supply Scheme

3. **What would improve this further?**
    a. Domiciliary visits where appropriate – some of the most vulnerable patients in the most need get the least amount of contact with a Healthcare Professional
    b. Look in to the medicines optimisation Pfizer scratch cards – pdf copies appended to email
    c. Sheffield scheme – better use of skill mix
    d. Pharmacy repeat ordering schemes – wider implementation of repeat dispensing would solve many of the GP concerns which was backed up by a GP in the group
    e. Someone questioned – "how well do pharmacists intervene?" and when they do, how is it communicated and recorded

4. **What else could be done?**
    a. Named pharmacist for over 75's – could this be a local scheme? – perhaps an extension of EPS Nomination in terms of process, but would need a more robust nomination process to avoid current EPS nomination issues
    b. Research needs to be built into the design of an new service
    c. Joint / inter-professional training / learning
    d. Formalising communication / referral routes
    e. Wider commissioning of Not Dispensed schemes
    f. Extend the cap on MURs

5. **Are there any barriers to this?**
    a. Access to records – ideally need access to enriched SCR – with ability to write to as well
    b. Current contractual framework funding model – counter incentive to dispense
    c. Lack of access to ICE (?) – for patient test results

Other considerations:

1. We should set up a real or virtual task and finish group / single meeting to discuss further
2. Sarah Olton (not sure of spelling) is interesting in being further involved

Further suggested reading: http://www.rpharms.com/what-we-re-working-on/medicines-optimisation.asp

2) PATIENT SAFETY AND RESEARCH

Hosted By Richard Harris and Tom Bisset

1. Out of Stocks

a. One of the suggestions made last week was for "solutions and not problems" with regard to out of stocks.
b. From the discussion it was felt that it was unreasonable to expect GP's and Medicines Management Teams to keep up to date with manufacturer shortages and that this was best done on a local level with information coming from community pharmacies.
c. It was also felt that phone calls to surgeries were not always the best way to communicate this information.
d. As an appendix to this report, a “Dear Doctor” note has been drafted that could be handed to patients to take back to the surgery with some basic information (which should be self-explanatory).

2. The safety agenda.

In the reformed NHS and following the Francis report, there is a need for all healthcare professionals to refocus on patient safety and to demonstrate that they are putting it at the heart of all their work. Improving patient safety is consequently a key objective for NHS England. We wanted to address 3 points:

- **What are the Safety Issues in Pharmacy?**
- **What can we do about those issues?**
- **How do we (as an LPN) take these forward?**

1. **What are the safety issues in pharmacy?**
    a. Issues with Prescribing
        i. Capacity for prescribers - Workload & keeping up to date
        ii. Quality of prescribing – Medics not traditionally trained in prescribing

iii. Transfer of information between sectors – timeliness and quality – medicines reconciliation process on both admission and discharge
iv. Access to clinical records and information for pharmacists
v. Monitoring of drug therapy
vi. Shared care protocol management
vii. Handwriting is still an issue – even more so since pharmacists are less conditioned to deal with poor quality
viii. Poor prescribing system management of 'Red Drugs'

b. Issues with Dispensing
   i. Out of stocks – need managing better – communication with prescriber (see APPENDIX A – example of form that could be used)
   ii. Communication with prescriber is problematic – both parties have different perspectives – interruptions during surgery is dangerous v's pressures on pharmacy
   iii. Volume
   iv. Public perception of pharmacy/dispensing. Expectation that everything is right (dispensing and prescribing) and so quality judgment defaults to speed
   v. Owings can lead to situation where medicines are supplied inappropriately – patient is given an alternative and then collects original at later time
c. Issues with Administration
   i. 'As Directed' should never appear on the label
   ii. Concordance/ adherence
   iii. Carer education
   iv. MDS pressure from patients/carers/care home companies

2. What can we do about those issues?

a. Manage out of stocks situation – promote a 'solution v problem' culture. Encourage better formalized communication channels
b. Robust reporting and learning system – action and feedback need to be seen from area team
c. Look at skill-mix – right across medicines pathway
d. Education for prescribers
e. Lobby IT providers for 'Red Drug' management
f. Pharmacy/Surgery liaison around communication channels
g. Pharmacy handling of SCPs
h. Information access for pharmacy

3. How do we (as a LPN) take things forward?

a. Robust reporting and learning system with actions communicated and meaningful feedback
b. Read/write access to records for pharmacy
c. Promote communication systems
d. Focused short term campaigns
e. Education on prescribing for GPs
f. Promote a 'solutions rather than problems' culture in pharmacy

Resources:

Medication safety in community pharmacy: a qualitative study of the sociotechnical context

Denham L Phipps[1*], **Peter R Noyce**[1], **Dianne Parker**[23] and **Darren M Ashcroft**[1]

BMC Health Services Research 2009, **9**:158 doi:10.1186/1472-6963-9-158

The electronic version of this article is the complete one and can be found online at:
http://www.biomedcentral.com/1472-6963/9/158

http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Improvement%20Guide%20Pharmacy%20%28web%20version%29.pdf

http://psnc.org.uk/contract-it/essential-service-clinical-governance/patient-safety-incident-reporting/

3) GENERAL PRACTICE / PHARMACY JOINT WORKING

1. Need to facilitate the building of bridges between pharmacy and general practice : communication.
2. Problems of multiple pharmacies linking with multiple GP practices.
3. Consistent schemes – e.g. minor ailments.
4. Prescription charging + exemption.
5. Reducing waste – Increased efficiency of medicines systems – patient safety issues. Shared learning.
6. Joint training / development opportunities.
7. I.T. Shared records: registration.
8. Evaluation – what are the measures – patient outcomes: system outcomes: financial outcomes.
9. Shared management of vulnerable patients.
10. Reproducibility of the model: How would this fit with the desired local variability.
11. Time management :

4) CROSS SECTOR WORKING

Background

- STH 2,000 inpatient beds + OPD + Day Cases + community services (< 5,000 patients)
- 500,000+ population in Sheffield alone
- Less than 1% of the population for average inpatient Length of stay of circa 5 days
- Circa £1 billion pa costs (albeit not all acute care)

Language

- E.g. “Admission & Discharge” or “Transfer of Care / Shared Care”

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Five Year Forward View

- Health and Wellbeing Gap
    - Smoking, alcohol, (& to a lesser extent illicit drugs)
    - Diet, exercise, obesity, diabetes
    - Mental Health
    - Sexual Health
    - Employment, workplace health, prevention
- Care and Quality Gap
    - Medicines Optimisation
- Funding and Efficiency Gap
    - New care models

Organisational Barriers

Other Barriers

- IT systems
    - Single medication record
    - Clinical portal
    - Integration/Interface
    - Communication (nhs.net email)
- Data sharing/Information governance
- Training needs (specialist care)
- Workload pressures

- Funding /commissioning arrangements

Future Vision

- Shared access to Electronic Health Records
    - LPN's progress SCR PoC work in Sheffield
    - What next? — e.g. ICE, GP Systems, hospital EPR
- Hospital discharge summaries routinely communicated to community pharmacies
- Robust referral mechanisms for post-discharge MUR and/or NMS review (+ feedback loop)
- Linking hospital Shared Care Protocols into point of dispensing checks during repeat dispensing arrangements, for Traffic Light "Amber medicines"
- Medicines Optimisation & "re-ablement" for at risk patients
- Increased community pharmacy role in public health and preventative measures

How do we make this happen?

1) Read and write access to a shared electronic health record, e.g. SCR
2) Wider roll out of the SCR in the current format would be a good start. Exploring what remote access to GP systems, might be possible
3) An electronic referral system from secondary care to pharmacies could be explored, to allow referrals to be made quickly and integrate with the workflow of the hospital pharmacy teams
4) Integration of community pharmacy referral and notification into secondary care e-discharge systems
5) Wider adoption of Healthy Living Pharmacy initiative by local commissioners to increase the role of pharmacies in public health interventions
6) Integration of medicines re-ablement work with community pharmacies for continuity of care, to include communication and follow up, domiciliary visits may add a lot of value.
7) Exploring how community pharmacies may contribute to Shared Care Protocols and the use of PharmOutcomes for recording data.

APPENDIX A

Drug Manufacturer Shortage Problem:

Dear Doctor.

We regret to inform you that a medication you prescribed:

_____

is **currently unavailable**. This is a *short /long-term problem that may not be resolved for a number of *weeks/ months.

In the meantime your patient may require one of the following alternative medications:

_____

_____

_____

_____

I have explained the situation to them and suggested that they contact the surgery.

Patient Details:

Please contact the pharmacy should you wish to discuss this further:

Name: _____

Pharmacy: _____

Telephone Number: _____