A Vision and Strategy for Medicines Optimization
2014 – 2017

INTRODUCTION

"Medicines optimisation is a vital agenda, not an agenda added on to something else we are trying to do, this is absolutely central to it." Sir David Nicholson, Chief Executive, NHS.


Key to all these publications is the change in attitude required to optimise the cost effective and safe use of medicines in secondary and primary care by putting patients and carers at the centre of what we do. Medicines must not be viewed in isolation but rather as treatments that complement other approaches like psychological therapies and sleep hygiene.

The DoH’s report, An organisation with a memory (2000), found that 10,000 hospital patients each year had serious adverse reactions to medicines and studies have found that over 10% of medical patients experience an adverse event. On average each event increases hospital stay by 8.5 days but almost half are judged to be avoidable. To minimise these problems, that are associated particularly with the elderly, the NSF for older people stated that by 2002 all hospitals should have one stop dispensing or dispensing for discharge schemes and, where appropriate, self-administration schemes for older people. This is yet to be fully introduced in the Trust although well over 90% of admission wards have implemented it. Exploring the same theme, The Sainsbury Centre for Mental Health report, Delivering the Government’s Mental Health Policies - 2007, highlights the importance of involving pharmacy staff in community settings as well as with inpatient teams. If the recommendations of this report had been fully implemented the Trust would have been employing 32 pharmacists and 25 pharmacy technicians by 2010/11. Even in 2013/14 this is still more than double the number we currently employ.

A patient survey done for the Healthcare Commission found 92% of patients using mental health services were prescribed medicines. If we are to ensure that the Trust maximizes the benefits of medicines while minimising the clinical and financial risks, we need a vision of where we want to go and a strategy to get us there. It is proposed that these be widely shared and debated throughout the Trust, not only via the Drugs & Therapeutics Group, but also through the various strategic governance groups.

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A VISION FOR 2017

If a new member of staff were appointed on 1st April 2017 what would the Trust want them to find with regard to medicines optimization?

Keeping medicines optimization high on the Trust's agenda

There is a co-ordinated medicines optimization team made up of pharmacists, nurses and medicines optimization technicians who help deliver the Trust’s medicines optimization strategy. The Trust’s structure and its reporting mechanisms ensure medicines optimization is high on the Trust’s overall agenda. There are two Chief Pharmacists directly accountable to the Executive Medical Director. Each has defined strategic and operational areas to lead on, covering the medicines optimization agenda at a corporate level. Robust and timely mechanisms exist through the Executive Drugs and Therapeutics Group to manage the introduction of new drugs and changes in use of existing drugs. Consultants understand the benefits of good planning and the need for robust business cases to support this process. Feedback on drug usage, to consultants and locality management teams, addresses clinical as well as financial outcomes. Decisions take into account the impact on both primary and secondary care. The Executive Drugs and Therapeutics Group also has a responsibility for ensuring safe and effective medicines use by commissioning audits, reviewing medication errors and adverse reactions and commissioning appropriate training. Guidelines for clinical care and the Trust's formulary are regularly reviewed in response to NICE guidance, the availability of new treatments, clinical advances and drug price changes. A culture of reporting on and learning from medication related incidents and near misses are embedded in the Trust’s culture. ‘Report and Learn’ articles in the quarterly Drugs and Therapeutics Newsletter highlight risk areas and solutions to reduce risks. Clinical audit is utilised to monitor actions taken. The Clinical Governance Team work closely with the Chief Pharmacists to monitor the implementation of NICE guidance, manage the use of Patient Group Directions and monitor the use of guidelines for clinical care.

A Chief Pharmacist is a member of the Effective Care Domain Group or any future equivalent. This group receives reports from the Drugs and Therapeutics Group and ensures medicines optimization remains a high priority for the Trust. Business cases for new developments and consultant posts recognize the impact on drug costs and pharmacy services.

The service user experience

Large numbers of staff involved with patient medication have received adherence therapy training to help them understand the beliefs and concerns their patients have about medication and other treatment options. The patient, and if appropriate the carer, are put at the centre of any treatment decision and their experiences will be listened to. Patients, and carers, if appropriate, will have been given information about both non-pharmacological and pharmacological approaches to treating their condition. Patient and carer representatives also sit on the Drugs and Therapeutics Group.

All patients admitted to inpatient units have been actively encouraged to bring all their medicines with them including over the counter medicines and herbal remedies. If this does not happen, carers are approached to bring medicines in after admission. These continue to be administered to the patient if assessed as suitable. Assuming patients (or carers) give permission; unsuitable medicines are destroyed in a way that minimizes the impact on the environment. Where appropriate, all patients assessed as competent are encouraged to self-administer their own medicines and any medicines supplied by the hospital for the patient are stored in individual patient drug drawers or cupboards and are pre-labelled for issue to the patient on discharge. Patients (or carers) are assessed so those requiring additional pharmacy support can get it. This will have included a detailed discussion about their beliefs and concerns about taking medicines, more detailed information on how to use their medicines in a format or language best suited to their needs, an assessment with regard to use of monitored dosage systems or a review of their ability to cope unsupported at home. Inpatients will have access to one to one counselling by a member of the pharmacy team and will also be able to attend a medication education group if there is local demand for.
these to be run. Advice on cultural and religious concerns, relating to medication, will be available from pharmacy. Medicines optimization technicians undertake at least one drug round per week on each admission ward in order to meet all the patients and discuss their medication with them. On discharge there is a high level of confidence that the patient (or carer) will continue to use the medication as prescribed.

Communication between primary and secondary care is well established and effective. Information on why drugs have been stopped, started or changed is always sent to the GP. The quantities supplied on discharge ensure the patient does not have to rush to their GP within the first few days, but have also been assessed to pose no additional risk to the patient. By encouraging patients to bring all their medicines to hospital, no inappropriate medicines are left at home to confuse the patient or carer following discharge.

In the community, patients likely to be on long-term medication are able to discuss their beliefs and concerns about medication with a member of the multidisciplinary team. Access to advice from a specialist mental health pharmacist is available to patients and carers when needed as each assessment and treatment service has some dedicated pharmacist time to support the multidisciplinary team. Pharmacists are fully integrated into the early intervention teams, assertive outreach teams and crisis response teams to ensure better use of medication and management of side effects. Service users are directed to suitable websites on medicines information via staff, posters and the Trust’s website. Information in other formats or languages is available if needed. Clinical guidelines have been drawn up using robust mechanisms incorporating the patient perspective, are updated regularly and remain readily available.

Minimising Clinical and Financial Risk

Most inpatients bring their own medicines in with them to allow compilation of more accurate medication histories and reduce the risk of unwanted medicines being in the home after discharge. 90% of patients have their medicines reconciled by a medicines optimization technician within one working day of admission. A ‘fair blame’ and ‘near miss’ reporting system is well established. The culture in the Trust ensures all significant medicine related incidents and near misses are reported. These are systematically reviewed and used to improve systems, monitor tensions within the system and provide feedback to all clinical staff involved in medicines optimization. The role of reviewing this data is undertaken by a multi-disciplinary team representing all those prescribing, administering and dispensing medication at both locality and trust level. Mandatory medicines optimization training is provided for all trained nurses via a variety of formats and nurses are given adequate time to complete this. A less intensive programme is available for other professions, assistants and care workers and additional training in high-risk areas such as prescribing, administering drugs and Rapid Tranquillization is well established and is equally well attended and completed.

Electronic patient records, electronic discharge summaries, electronic prescribing and electronic medicines administration recording are all well established throughout the Trust and contribute to high quality data capture and data transfer.

Regular audits relating to medicines optimization issues are undertaken in all specialities, including at the primary/secondary care interface. All significant adverse drug reactions are reported to the pharmacy team. These are investigated and where appropriate processed through the incident reporting system and channelled through the national yellow-card reporting scheme.

Financial risk has been minimised by effective purchasing, the managed entry of new drug treatments, new generic availability, reduction in wastage and better feedback to prescribers on drug usage and costs.
Extending the role of prescribing

Where appropriate, nurses and pharmacists have become fully qualified non-medical prescribers. Individual patient management plans, clear monitoring arrangements, ongoing training and audit underpins these extended roles and complement well established use of Patient Group Directions and medicines administered under protocols (MAUPs).

Improving prescribing

Robust training and assessment of new prescribers ensures that only those deemed competent are able to prescribe. Mechanisms are in place to allow junior medical staff to prove their competence to prescribe safely. Similar training is provided for staff administering drugs and those involved in dispensing. The Medicines Optimization Team is actively involved in training medical students to improve their prescribing and links are well established with the medical school. Good use is made of on-line training initiatives. Online drug chart training is completed by 100% of new junior doctors and nurses joining the Trust and by new to post senior doctors prescribing on the wards. In addition all new junior doctors complete an online clinical training programme before they start or within one week of joining the Trust.

A fully staffed, well structured clinical pharmacy service has developed to actively promote good prescribing and all acute wards receive this service five days a week. Both community and ward based clinical teams have ready access to the pharmacy team to assist them in prescribing decisions, anticipating errors, undertaking medication histories, medication reviews and discharge planning and to develop the medicines optimization skills of the whole team. A wide range of guidelines for clinical care have been drawn up that incorporate the latest evidence on drug treatment. Information technology is utilised to allow 24-hour access to prescribing decision support tools as well as to an emergency medicines information service provided by the on-call pharmacist.

Working with Clinical Commissioning Groups (CCGs)

Trust and CCG medication committee structures ensure ownership of drug use decisions by all partner organisations. The Trust Drugs & Therapeutics Group has members representing CCGs and the Chief Pharmacists attend the various Sussex CCG area prescribing committees regularly and when needed to for services outside of the County. Communication systems are in place to ensure prescribers and if appropriate service users, are consulted about guidelines for clinical care (and formulary changes) and any resulting changes are implemented smoothly. Joint formularies have been established with each CCG that include all relevant NICE Technology Appraised medicines.

The entry of new drugs into use is managed in a timely way with regard to evidence, cost effectiveness and national and local guidance. Horizon scanning takes place to improve business planning for new drug developments.

The Trust has recognized the need for local ownership at CCG level while maintaining a consistency across the services.

Robust mechanisms are in place to identify problems at the interface. These are addressed at a systems rather than individual level.

Procurement

Tendering has taken place to establish the most cost effective supply model and this is kept under regular review against performance indicators. Whenever possible, regional and national contracts negotiated by the NHS are widely utilized to get the best prices. Local purchasing consortiums are also utilised where regional or national contracts do not exist and where greater cost efficiency can be obtained through local negotiation.
A Strategy for Medicines Optimization

Vision 1

Service users (and carers where appropriate) are consulted on their beliefs and concerns about medicines and given well informed information about medication. They are empowered to be partners in medication treatment decisions.

Strategies to achieve this:

1. Invest in adherence therapy training for appropriate clinical staff to help ensure patients and carers concerns and beliefs about medicines are understood.
2. Aid service users (and carers) in exercising treatment choices by ensuring multidisciplinary team members have adequate and appropriate knowledge of medicines and have access to a dedicated pharmacist for their service.
3. Provide service users and carers with easy access to medication information in a suitable format and or language to empower them to make informed choices around treatment options in every clinical area.
4. Develop Medicines Education for service users (and carers) incorporating psychosocial and health belief models.
5. Develop the role of medicines optimization technicians to undertake drug rounds to engage with all inpatients about their medication.

Vision 2

There is a fully staffed, structured and co-ordinated medicines optimization team to help deliver the medicines optimization strategy.

Strategies to achieve this:

1. Further invest in medicines optimization technicians to cover all admission wards, across all care groups, (the majority of the costs being offset by savings generated by using patients own drugs during admission).
2. Further invest to extend the pharmacy team to include a medicines optimization nurse to assist in medicines optimization, e.g. training, error reduction, audit etc.
3. Further develop the role of pharmacists in supporting community mental health, learning disability services, substance misuse services, child and young peoples mental health services and developmental services.
4. Succession plan for future Chief and senior pharmacists.

Vision 3

The risks associated with medication have been significantly reduced.

Strategies to achieve this:

1. Ensure induction training adequately covers prescribing, administration and incident and near miss reporting.
2. Ensure all professions are involved in reviewing drug-related incidents and near misses.
3. Continue to develop web-based medication related training and e-learning to cover high-risk areas, such as Rapid Tranquillization.

4. Pilot electronic prescribing, medicines administration recording and discharge summaries with a view to full roll out.

5. Ensure all medicine related policies are up to date, evidence-based, and fully implemented.

6. Establish a robust link with the patient safety team at the NHS Commissioning Board.

7. Further develop medicines optimization training for non-medical and non-nursing staff involved in care-coordinating patients or handling and administering medicines.

8. Ensure adequate support is in place for non-medical prescribers.

9. Ensure the Internet is fully utilised to provide easy access to appropriate up to date medicine related policies, guidelines and information.

Vision 4

The cost effective use of resources has been achieved.

Strategies to achieve this:

1. Explore and maximise opportunities for consortium purchasing and other cost optimization strategies.

2. Keep service level agreements/contracts for pharmacy services under regular review to match the needs of the Trust, going out to tender if appropriate.

3. Proactively manage the introduction of new drugs and new indications through the Executive Drugs and Therapeutics Group.

4. Utilize clinical audit to monitor the introduction of new treatments and support robust business cases.

5. Routinely review mechanisms for cost effective, patient centred prescribing and drug administration taking place nationally and internationally, and ensure those utilised by the Trust are appropriate, effective and current.

6. Produce regular reports for prescribers and for the Trust finance team on cost effective prescribing, individual and team prescribing performance, and progress against agreed savings targets.

Vision 5

The organisational structure and reporting mechanisms ensure medicines optimization is high on the Trust’s agenda.

Strategies to achieve this:

1. The Executive Drugs and Therapeutics Group pro-actively promotes the reporting of medication related incidents and near misses.

2. The Chief Pharmacists regularly produce medicine management reports and prescribing bulletins.

Vision 6

Non-medical healthcare professionals will undertake prescribing and/or initiate treatment where appropriate.

Strategies to achieve this:

1. Ensure service reviews and development plans take account of the opportunities presented by non-medical prescribers.

2. Ensure clear roles, funding and support is provided for non-medical prescribers.

3. Ensure medicines information, on going training and prescribing support is available for all new prescribers.

4. Maintain a process to produce, monitor and update Patient Group Directions (PGDs) and protocols for medicines administration (MAUPs).

Vision 7

There is a pro-active approach to help ensure all patients admitted to the Trust’s inpatient units get the full benefit of their drug treatment with minimised risks.

Strategies to achieve this:

1. Invest in adherence therapy training for staff involved in patients’ medication.

2. Encourage all patients to bring all their medicines with them on admission to inpatient units. If this does not occur carers and relatives to be asked to bring the medicines in after admission.

3. Further invest in medicines optimization technicians to manage and facilitate patient focussed medicines management schemes, to include:
   - Reuse of patient’s own drugs
   - One stop dispensing
   - Medicines reconciliation
   - Participation in patient and carer medicine education
   - Medication administration rounds

4. Develop easier access to medicines information in suitable formats and languages, utilizing both IT and traditional methods of communication.

Vision 8

Day to day prescribing has improved.

Strategies to achieve this:

1. Maintain and update prescribing competency assessments and training packages for new medical staff

2. Increase the availability of clinical pharmacists to all teams by increased investment in pharmacy staff and developing the role of medicines optimization technicians.

3. Develop and maintain guidelines for clinical care and ensure these are easily accessible.

4. Develop the role of pharmacists in training medical students to improve their prescribing.
5. Invest in IT to allow electronic prescribing and medication administration recording, and discharge summary production. Ensure the system includes a comprehensive prescribing decisions support tool and access to an emergency medicines information service out of hours.

6. Involve patient/carer representatives in guideline development and in the work of the Executive Drugs and Therapeutics Group.

Vision 9

Primary and secondary care work together to improve the cost effective use of medicines

Strategies to achieve this:

1. A Chief Pharmacist will work closely with the Clinical Commissioning Groups (CCGs) prescribing leads and medicine management leads, regularly attending their area prescribing committees.

2. CCG medicines optimization leads (or deputies) will be invited to sit on the Drugs & Therapeutics Group and will receive the agenda and minutes.

3. A system to learn from and prevent future medication related errors occurring at the interface will be developed.

4. Mechanisms for developing evidence based interface guidelines will be strengthened in all CCG localities.

5. Mechanisms to reduce duplication of work will be developed.

6. The Drugs & Therapeutics Newsletter will be shared with partner organizations.

Ray Lyon                Jed Hewitt
Chief Pharmacist       Chief Pharmacist
Strategy               Governance & Professional Practice

February 2014