Achievements

Consultant Pharmacists
Care of older people
16th June 2015

Hillary McKee  Older people  N. Ireland
Carmel Darcy  Older people  N. Ireland
Tim Banner  Community healthcare  Wales
Heather Smith  Older people, interfaces of care  England
Nina Barnett  Care of older people  England
Lelly Oboh  Care of older people  England
Expert practice, Innovation, Service
development, Evaluation, Research

• Develop, implement and evaluate innovative clinical pharmacists-led models of care for older people
  – Intermediate care
  – Care homes
  – Domiciliary care

• Demonstrate optimal use of medicines, improved outcomes, reduced medicines related risks, cost effectiveness, efficiency

• Adding to evidence base

• Strategy for spread, dissemination and adoption across NHS and Social Care
Northern Ireland 2012
Carmel Darcy, Hillary McKee

• Intermediate care- Responsible from admission, up to 30 days post discharge
  • British Geriatric Society Award, RPS Award 2014
  • 1100 clinical interventions, 84% clinically significant
  • Drug cost savings £164K p.a
  • Significant reduction of MAI on admission and discharge

• Care homes “outreach” clinics in 16 homes
  – 727 patients, 14.4% reduction in A&E presentations
  – Drug cost savings £107k pa

• NI Executive Change Fund for roll out
Wales 2014

Tim Banner

• 6 month project placement of a pharmacist with a community resource team

• Preliminary results (first 3 months)
  – 33 reviews (telephone and domiciliary).
  – Ave 9.6 items per pt per review.
  – 94 interventions (incl. 28 falls specific)

Collaboration

• Local Health Boards, Wales on NICE SC1 guidance, pharmacy schemes in the Domiciliary care/reablement sector.

• WCPPE to provide expert review for learning packages.

• Government and Carers Trust Wales to develop an All Wales Community Pharmacy health campaign to support carers and uptake of flu vaccination.
England (Leeds) 2013
Heather Smith

IMPACT Post discharge medicines project

- Identify older people at high-risk of med. related problems
- Care planning, referral and sign-posting to primary care
  - 204 medicines care plan (MCP) on discharge letter
  - Patient Needs: 86% clinical, 36% medicines support
  - Re-admission within 30 days: 16%MCP vs 22% non-MCP
- Now routine on all CoE wards, ? Vascular, orthopaedics
- Collaboration with Leeds West CCG for f/up medication reviews in domiciliary or care home settings
- Collaboration with Adult Social Care: Medicines support assessments for patients with re-ablement post discharge
- MaPPs across Trust to support staff talking to patients about medicines
- City-wide work on prevention of falls to reduce number of # neck of femur (medication reviews)
England (London) 2007

Nina Barnett

Pharmacy-led integrated medicines management (IMM) project

• Managing Preventable Medicines Related Readmission (PMRR)
• Parallel cohort study (836 patients)
  – Development and use of tool to identify high risk patients PREVENT©
  – Referral to the IMM pharmacist team for medicines reconciliation & review, discharge planning and post discharge follow up
  – Innovative coaching approach to consultation and post discharge support
  – Collaboration across multidisciplinary health & social care teams
• Readmissions within 30 days discharge 16% (IMM service site) vs 18% (standard service site)
• PMRR 0.3% (IMM site) vs 4.4% (standard service site) statistically significant reduction (P=0.002).
• Saving: £3 for every £1 spent on an IMM pharmacist
• Future work ⇒ patient experience, coding to identify high risk patients on admission, linking with primary care to identify and manage patients in the community
England (London) 2008
Lelly Oboh

Medicines optimisation integrated in frail older people care pathway

- Medication reviews and care co-ordination led by Advanced Clinical pharmacists in community

- **Domiciliary Care** (>500 patients)
  - Case management, Enhanced rapid response, supported discharge, Re-enablement, Virtual ward teams and CMDTs
  - Vulnerable/high risk patients identified and referred for domiciliary reviews
  - Ave. 79 years, 14 medicines, 9LTCs (n143)
  - 376 interventions, improved patient outcomes
  - Winner PresQIPP Shared Decision Making Award 2014

- **Care homes**, 549 patients (9 homes)
  - 293 patients data⇒, 1044 drug queries, Drug cost savings £100K p.a

- Explored role of community pharmacists to deliver ongoing care

- Other benefits: reduced polypharmacy, reduced wastage, improved medicines adherence, improved collaboration across agencies/disciplines, positive patient and staff experience
GSTT care Model in the community: Integrating medicines optimisation into frail older people pathway

STEP 1
Practitioners proactively identify those at high risk from medicines during routine care/post discharge and refer to integrated clinical pharmacist (ICP)

STEP 2
ICP Undertakes face to face patient centred comprehensive assessment of needs at home & Jointly agrees a care plan

STEP 3
Liaises with GP, referrer and others to facilitate Implementation of care plan

STEP 4
Monitor & review until stable

STEP 5
Community Pharmacist/team implements specific long term goals within care plan. Access to advice and referral to specialists as needed

Older person during vulnerable periods & deteriorating health
Receives advanced level pharmacist input to optimise medicines use

Stable frail older person
Receives generalist pharmacy input to optimise medicines use

Leadership and Collaboration

- Polypharmacy
- Adherence incl. health coaching approach
- Frail older people incl. dementia, care homes
Leadership and collaboration

• Facilitating professional networks
  – Older People Pharmacy network (OPnet) England
  – N.Ireland Pharmacy network

• Collaboration with Higher Education Institutions

• Collaboration with Research bodies

• Clinical guidance and Medicines Optimisation Resources

• Learning events

• Publications and Posters

• Conferences
Pharmacists supporting GPs to reduce antipsychotics in dementia: A London experience

Lelly Oboh, Consultant Pharmacist, Care of older people, NHS Specialists Pharmacy Services

1. The problem
** Two thirds of antipsychotics prescribed for dementia patients are inappropriate and cause 1,800 additional deaths and 1,620 cerebrovascular adverse events yearly in England
** Antipsychotics are often initiated by specialists in acute settings, so GPs are reluctant to discontinue without support

2. The Opportunity
** The Care Services Minister set a 66% reduction target
** NHS London (NHSL) set up a clinically led Dementia and Prescribing Antipsychotic Project to support 31 London Primary Care organisations (PCOs) to achieve the target
** The team consisted of 6 GP cluster leads and 1 Pharmacist lead

3. The Solutions and Actions taken (With support from project team)
- Strategies developed to raise awareness about the problem and existing support available, engage with and educate GPs e.g. newsletters, learning events led by local champions
- Local experts identified to provide clinical support to GPs and champions to facilitate collaborative working between primary, acute & mental health teams
- Practices were incentivised to undertake an Antipsychotic Audit and Reduction exercise
- Practices with high care home or ageing population targeted to receive extra support
- Local solutions developed for expert clinicians to provide decision making support to GPs and facilitate referral of complex or difficult cases
- A post audit action plan developed to sustain ongoing clinician engagement

I think the audit helped bring an issue that people “knew” about into the open, and helped develop better care. The project highlighted to specialists, the need to be clearer with treatment plans, duration and review “advice and GPs have a better relationship with psycho geriatricians, feel more supported and find it easier to discuss ‘tricky’ cases, monitor treatment and adjust doses.

PCO pharmacist

4. The Pharmacists’ role
- The project pharmacist led the development of the primary care audit tool, a step-by-step reduction exercise guide, key prescribing messages and other practical resources such as templates for letters and monitoring charts to ensure safe and effective reductions
- PCO pharmacists proactively supported the practices through the audit and reduction exercise process.
- Senior PCO pharmacists engaged with and influenced local opinion leaders across 10 and 20 care to drive the agenda

5. The Results and Benefits
- There was a reduction in antipsychotics across the 31 PCOs
- Improved partnerships between all practitioners involved in patient care
- PCOs developed systems post audit to ensure ongoing review
- Publication HSJ September 2014 [http://m.hsji.co.uk/5047502/article](http://m.hsji.co.uk/5047502/article)
- Resources developed are freely available for wider NHS use at [http://www.medicinesresources.nhs.uk/upload/documents/Communities/GPS_F_SE_England/Lon An_AP_Audit_and_Reduction_Exercise_in_Primary_Care_Vol_Sep52013.pdf](http://www.medicinesresources.nhs.uk/upload/documents/Communities/GPS_F_SE_England/Lon An_AP_Audit_and_Reduction_Exercise_in_Primary_Care_Vol_Sep52013.pdf)

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<th>Primary Care Organisation (PCO)</th>
<th>Dementia patients prescribed antipsychotics (% of total)</th>
<th>Patients eligible for reduction as in NICE guidance</th>
<th>No. of patients stopped or reduced</th>
<th>% of total eligible Stopped or reduced</th>
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6. The Conclusion
- With the right support, GPs can reduce inappropriate prescribing by using standardized, structured tools tailored for primary care settings and obtaining timely clinical input from specialists to support timely decision making
- PCO pharmacists have strong links with GPs and the skills, expertise and networks to manage and drive large scale prescribing changes in primary care. They are able to clearly state the case for change, solicit commitment and facilitate joint working with clinicians across primary and secondary care

Acknowledgements
Thanks to Jen Watts (Project manager NHSL) & PCO Pharmacists - Chirag Patel (Richmond), Clare Fernee (Bexley), Barbara Jesson (Croydon), Vicki Patel (Wandsworth) & Julia Rollinson ( Bromley) for their contributions.
Peer Support Meetings for Pharmacists Undertaking Medication Reviews for Older People in Care Homes and Domiciliary Settings

Overview

The number of pharmacists and pharmacy technicians working in clinical roles in care homes and domiciliary settings is slowly increasing, often involving the care of complex older adults. A number of these post holders work in isolation without adequate support from their organisational structure and would therefore benefit from peer support.

An innovative pilot using facilitated peer group meetings to support such pharmacists to improve patient care showed that there is a need and some benefits. Pharmacists found this networking and participating in the face to face peer review useful. Improved clinical knowledge in the care of older people and the ability to apply clinical knowledge in complex situations as well as delivering better patient centred care were the main areas that will positively impact on their daily practice.


Although aimed at primary care pharmacists, technicians, community and hospital pharmacists in similar roles could also benefit.

Feedback from Meetings

66 people (61 pharmacists and 5 technicians) have attended 5 meetings (4 in London and 1 in Leeds) and evaluation of feedback from each meeting has been positive.

When asked about the best aspect of the meetings, the top reasons were:

- Networking
- Peer review of the cases
- Group discussions and sharing ideas

London Meetings: Main role % of respondents (n=53)

- Care Home: 53%
- Domiciliary: 22%
- Other: 20%
- Both: 5%

To what extent do you think attending meetings like this will impact positively on your day to day practice?

- 62% Very large extent
- 27% Large extent
- 11% Moderate extent

How would you rate usefulness of the format for the case scenario discussions?

- 67% Extremely useful
- 38% Very useful
- 5% Somewhat useful

Feedback from the Leeds meeting was similar with all respondents finding the meeting extremely or very useful and 92% of respondents finding the case scenario discussions extremely or very useful.

"The focus on first identifying the problem rather than jumping straight into problem solving is a very important skill to master"

Attendee Feedback

"Upon discussing the case and hearing other people’s experiences, I gained the confidence to take on a more hands on role at the care home I work at, taking it upon myself to make the changes as an independent prescriber and then make a plan of monitoring...... prior to that I had always left it up to the GP to make the change and sometimes this would be a huge delay in the process"

Attendee Feedback

Acknowledgements to Catherine Leon, Integrated Care Dispenser Pharmacist Older People COT NHS Trust Community Health for her role in facilitating the Leeds meeting and to Nicola Shaw, Clinical Care Homes Pharmacist Service Manager (Professional Services), Leeds Teaching Hospitals NHS Trust for her role in facilitating the Leeds meeting.
A patient centred approach to optimising care for patients taking multiple medicines

The practitioner’s guide

Nina Barnett, Lelly Oboh, Katie Smith

Seven steps to managing polypharmacy in practice

1. Assess patient
2. Define overall treatment goals
3. Identify inappropriate medicines
4. Assess each medicine for specific risks and benefits in patient context
5. Stop or reduce dose
6. Communicate actions with prescriber
7. Monitor and adjust as appropriate