ALL-PARTY PHARMACY GROUP

DEVELOPING HOSPITAL PHARMACY SERVICES

A report to Health Ministers

Background

There are some 6,000 pharmacists working in hospitals in Great Britain. Their principal focus is the efficient procurement, distribution and safe handling of medicines within the hospital. In recent times, however, this traditional function has been increasingly supplemented by a range of clinical pharmacy services. Despite this, the government has itself recognised in *Pharmacy in the Future* that more can be done to utilise the skills and expertise of pharmacists to ensure better use of medicines.

Having spent much of our time in the past year examining issues relating to the development of community pharmacy, we were keen to explore current best practice in the secondary sector and to highlight areas where service developments should be initiated or accelerated for the benefit of patients and the NHS.

Our findings

In November 2000, members of the Group visited St Thomas' Hospital, London, to observe the work of the Pharmacy Department and to receive presentations from the Chief Pharmacist of Guy's & St Thomas' NHS Trust, Tony West, and his team. We take this opportunity to express our gratitude to Tony West and his colleagues for a most informative and interesting visit. Also present were the chief pharmacists from Royal London, Hammersmith, Chelsea & Westminster, the Royal Free, and Addenbrooke's. We are grateful to them too for their input.

We have identified four areas of pharmacy practice where changes developed at St Thomas' can be rolled out throughout the country, or where that roll-out process – already under way –should be accelerated, to deliver clear patient benefits and efficiencies.

'Near patient' pharmacy

Generally, when a patient is admitted to hospital they bring with them little or no accurate medication history, and their medication, supplied to them in the community, is discarded in favour of a new regime. Patients receive little information about their medication and post-discharge medicines are often not available before the patient is ready to be discharged. All in all, pharmacists, despite being the experts in medication, spend little time with patients. This strikes us as wasteful, inefficient and unlikely to lead to optimal patient care.

St Thomas' is one of several hospitals in the UK which have sought to improve on this traditional approach. Their alternative 'near patient' approach consists of encouraging patients to bring their existing medication with them upon admission and, where appropriate, ensuring that these medicines continue to be used during the hospital stay. It also allows hospital pharmacists to gain a better understanding of patients' drug history and, following assessment, patients may be permitted to self-medicate from a locked bedside cabinet. Traditional drug trolley dispensing is thus avoided. Pharmacists have more time to spend with patients, nurses are more satisfied with the drug round and from a medication perspective, discharge is planned and orderly. This approach also helps to ensure that EU Directive 92/27/EEC on patient information is implemented.

We note that Mid Sussex Trust recently won a clinical risk initiative award for a similar project.

At St Thomas', the outcomes have been impressive. The hospital saves £5 per patient; on an annualised basis it is saving around £100,000 on its drugs bill. 80% of medicines to take home are available at the time of discharge. 81% of nurses are more satisfied with these new arrangements. Team working between pharmacists, nurses and doctors is encouraged, and overall medicines are managed more efficiently and effectively.

Pharmacy services to post-take ward rounds

Significant work has been undertaken at St Thomas', and elsewhere to rationalise and improve the role of pharmacists in post-take ward rounds (PTWRs). This has been manifested in two ways.

First, a clear and rigorous methodology has been attached to the selection of pharmacists involved in PTWRs, in order to maximise the added value that pharmacists can deliver. Each PTWR pharmacist must have at least five years post-qualification experience and possess a postgraduate clinical qualification or equivalent. They are all trained in anti-coagulation therapy.

Second, the hospital has introduced a peer review process, the aim of which is to ensure that information and advice provided by pharmacists on PTWRs is consistent and evidence-based.

This new approach to PTWRs has been in place since November 1999. Data is available for the first nine months which shows that pharmacists attended 477 PTWRs; the care of 5928 medical patients was reviewed; 6703 contributions to care were made; 53% of contributions were made on out of hours rounds (evenings and weekends); and a pharmacy contribution was required for 66.5% of patients.

The contributions ranged from an initial discussion on choice of therapy to identifying adverse drug reactions, to supplying in-patient medication.

Anticoagulation in pharmacist led clinics under patient group direction
As well as developing the role of the pharmacist in the hospital setting, the Pharmacy Department at St Thomas' has identified an opportunity to deploy the expertise of clinical pharmacists in medication management among outpatients and beyond the confines of the hospital.

St Thomas' pharmacists have been engaged in providing anticoagulation therapy in outpatient clinics and in GP practices. Anticoagulation was selected for several reasons: there are increasing indications; the risks to patients are high if the condition is mis-managed; patients need to have access to a high level of support; and the skills of clinical pharmacists are well-suited to facilitate anticoagulation management.

Under this initiative 1500 patients are managed at Guy's and 100 are managed in their local GP practice. Pharmacists make around 300 patient visits per week. Patients benefit from the provision of thorough and accurate information, and concordance is promoted. The pharmacists involved are specifically trained and externally accredited.

Anticoagulation therapy offers a guide to the future. Similar practice could develop in relation to HIV patients, cardiac rehabilitation, oncology and paediatrics.

We acknowledge the clear benefits that this service development brings, and we see several ways in which it can be delivered both by hospital pharmacists and those based in the community.

Promoting competence and best practice
We wish to see the highest standards of care and expertise throughout the NHS and we are encouraged by the renewed emphasis on competence, clinical governance and best practice. We wish to see this drive for quality in all areas of practice, not least - from our perspective - that of pharmacy.

We are therefore encouraged by the manner in which St Thomas' have sought to develop their own solutions to the quality and competence challenge. St Thomas' have taken their lead from common practice in medicine by ensuring that the appropriate pharmacist is allocated to the appropriate task, and by introducing a systematic approach to grading pharmacists for this purpose.

Whilst pharmacy degree courses have been improved significantly in recent years, pharmacy students do not graduate with all the skills required of a fully-fledged clinical pharmacist. The same is true of their medical counterparts.

This has long been recognised in medicine, but – perhaps surprisingly – not in pharmacy practice. St Thomas' approach is simple yet sensible and, we believe, effective. It consists of categorising pharmacists according to experience, and ensuring that each is matched to appropriate tasks. Three categories have been established: junior; mid-grade; and practitioner.

Junior pharmacists possess some knowledge but have limited experience. Their skills reflect taught situations. Much like House Officers, they are deployed to provide a basic level of service which simultaneously offers them the opportunity to gain

knowledge and experience. The role might also encompass teaching of students and data collection.

Mid-grade pharmacists are able to relate their knowledge to practice and are capable of clinical problem solving, teaching juniors, undertake research and audit whilst also gaining further knowledge, skills and experience. They might equate in general terms to Registrars.

Practitioner pharmacists are able to recognise situations from prior experience, and are capable of applying prior experience to new situations rapidly and effectively. Much like consultants in medical practice, they are team leaders, able to monitor service provision, undertake therapeutic review, provide pharmacoeconomic evaluation, teach juniors, lead research and audit, run patient care clinics, and are accountable for the activities of the pharmacy team around them.

The outcomes of using this team approach are better patient care, more efficient use of resources, and clearer career development for pharmacists themselves. We are pleased to see that St Thomas' is one of several hospitals utilising this approach; the St Thomas' team have been working in collaboration with others in London and the South East region. Nevertheless, our understanding is that it is not widespread in hospital pharmacy practice. We believe there are persuasive grounds for making it so.

Recommendations

In the light of these findings, we make the following recommendations to Ministers:

1. The encouraging preliminary results of the 'near patient' project at St Thomas', and in several other hospitals elsewhere in the country, should be encouraged and, where necessary start-up funding should be allocated. Such funding is likely to be modest, but if the St Thomas's experience provides a reliable guide, should pay dividends.

2. Just as is the case in community practice, hospital pharmacists should be encouraged out of the dispensary so that patients may benefit from their clinical skills and knowledge. Pharmacists' involvement in PTWRs at St Thomas' appears to have been a success for all concerned. We recommend that the government offers explicit support for such initiatives, if necessary making available – or encouraging Trusts to make available- the necessary funds.

3. In a previous report we have highlighted the value to be gained from fostering the development of medicines management in community pharmacy. St Thomas' have provided us with an alternative vision of how such practice developments might be achieved. The two, to our minds, are not mutually exclusive; there is ample opportunity to operate both models and perhaps others besides. The anticoagulation therapy service provided to out-patients is but one variant of medicines management, but the principle of hospital based pharmacists using their skills in the community, in concert with GPs and community pharmacists, is attractive. We recommend that information on this initiative, and others of a similar nature, is disseminated widely to encourage service development. Trusts

need to be assured that funding will be made available to facilitate developments that will deliver benefits to patients and improve the efficient operation of the NHS.

4. The competence based model of pharmacy practice that has been developed at St Thomas' is an effective management tool, designed to ensure that the skills of pharmacists are appropriately deployed to best effect. We see no need to be prescriptive about the manner in which other pharmacy departments address issues of competence and quality, although we do see clear merits in the St Thomas' approach. We are however keen to see the government help to build and maintain a momentum for change and improvement; and we recommend that more is done to spread information about innovative approaches to the issue.

'Pharmacy in the Future'

We acknowledge that the government has expressed in general terms its objectives and plans for the development of pharmacy in the document *Pharmacy in the Future*. The next step is to develop detailed proposals that will meet those objectives.

In our view, the practice developments being engineered at St Thomas' provide a pointer that can assist the profession – and the government – in moving from the expression of general objectives to the development of practical solutions. Our wish, in drawing the St Thomas' example to the attention of Ministers, is to elicit from the government its view as to whether these specific initiatives offer effective responses to the objectives set down in *Pharmacy in the Future*. If so, it is in our view incumbent on the government to use its influence to promote awareness of them, and to ensure that they are adequately funded.

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