Models of organisational and cross-sector working

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As part of our series of articles highlighting the recommendations made in the NICE guideline on Medicines Optimisation,1 this month we discuss the section of the guidance concerning medicines-related models of organisational and cross-sector working.

Taking medicines to prevent, treat or manage illnesses or conditions is the most common intervention in healthcare and the vast majority of care pathways involve medicine taking. With 18.7 prescription items dispensed per head of population in England in 2013,2 it is alarming to learn that between 30 and 50 per cent of medicines prescribed for long-term conditions are not taken as intended.3 The implication of these statistics is that every other patient prescribed a medication receives suboptimal benefit.

One could suggest that the entire evidence base that goes into making the decision to prescribe a medicine is wasted. This gives strong weight to the urgent need for medicines optimisation. Putting the patient at the centre of the decision-making process, medicines optimisation focuses on how to help the patient get the most from their medicines through actions taken by all health and social care practitioners. Central to the success of medicines optimisation are both patient engagement and professional collaboration across health and social care settings.

The recent changes in service design mean that many organisations have started to consider alternative models of care for patients to optimise their medicines. Some of these changes have come about because the medical model has evolved to recognise the benefit of other health professionals working together with doctors in their clinical roles to improve patient care. This is supported by greater flexibility of commissioning arrangements for multidisciplinary, cross-sector working, which will increase as the Five Year Forward View is embedded.4

What does the guidance say?

The NICE guidance recognises that medicines use is widespread and that the
care individuals receive is often from a range of health and social care practitioners who may be employed by a number of different organisations. It then goes on to make two recommendations, outlined in Table 1.¹

What does this mean in practice? Taking a multidisciplinary approach
The first recommendation requires health professionals to acknowledge the benefit to the patient of everyone in the wider team and to make use of the team when optimising medicines for people with long-term conditions who are prescribed many medicines. But how does this work in practice?

Medicines optimisation puts the patient at the centre of shared decision-making about their medicines, and all the different professionals and agencies that are involved need to “wrap around” the patient. Patient care must not be compromised because of the way healthcare and social care is delivered. While the prescriber may make the decision about whether a medication is needed for a particular indication, it is difficult for them to monitor adherence. It is often the carer who identifies poor adherence and so they need to be engaged in medicines optimisation in order to alert clinicians, for example, when medicines are piling up on the patient’s kitchen table. Using the wider network maximises the opportunity for all “intelligence” about how the patient is dealing with their medicines to be captured.

One of the difficulties of multidisciplinary working is its multiagency nature and it is often challenging to break down the organisational boundaries, especially those between health and social care. Integration of care is not a new concept and is part the Five Year Forward View.²

There have been some recent developments where pharmacists and pharmacy technicians have been included in the integrated teams and the benefits of medicines optimisation have been realised. In West Sussex, the proactive care teams are made up of health and care workers from many disciplines including community nurses, adult social care workers, physiotherapists, pharmacists and pharmacy technicians. The locality multidisciplinary team meeting is critical to how the team functions. Having pharmacy expertise within the team benefits the patient, the team and the health economy in many ways (see Table 2).

Similarly, in central London the proactive care home teams provide services across 19 care homes with around 1000 residents. As a result of including pharmacy in the team, every resident has had a medication review and cost savings have been realised through stopping unnecessary medications. In addition, there has been a review of ordering processes in each home to identify where improvements could be made. The team collected data on various outcomes and showed a decrease in falls, ambulance call outs and accident and emergency attendances.³

Involving pharmacists when making strategic decisions about medicines and when developing care pathways
This recommendation is made up of two parts: strategic decisions about medicines and care pathways. It is helpful to consider the care pathways first.

When a care pathway that includes medicines is developed, it is common to only consider the “clinical” aspects of medicines where, for example, drug A should be used instead of drug B. However, there are many steps and processes that need to be in place before the choice of medication stage is reached. Medicines optimisation continues after the point of prescribing, for example, to include adherence and administration. A pharmacist is well placed to consider all the steps required. Four key questions should be asked each time medicines are required within the care pathway. These are:
• Who will decide whether a medicine is needed?
• Who will supply the medicine?
• How will the medicine be taken or administered?
• How will the effects of the medicine be reviewed?

NHS Specialist Pharmacy Service has developed two resources. Optimising Medicines Use In Care Pathways using Pharmacy Support⁴ guides the reader

Recommendation 1.8.1. Organisations should consider a multidisciplinary team approach to improve outcomes for people who have long-term conditions and take multiple medicines (polypharmacy)
Recommendation 1.8.2. Organisations should involve a pharmacist with relevant clinical knowledge and skills when making strategic decisions about medicines use or when developing care pathways that involve medicines use

Table 1. NICE Medicines Optimisation guidance: recommendations on medicines-related models of organisational and cross-sector working⁵ through these four questions that need to be answered and Medicines In Commissioning Checklist⁶ gives more details about commissioning a new pathway. Both of these resources highlight the need for a pharmacist to be included in the development of new pathways.

Involving a pharmacist in the pathway development is only the start of the process. Organisations will benefit from involving a suitably qualified and experienced pharmacist in strategic decisions about medicines. With organisational change and new models of working that may emerge from the proposals in the Five Year Forward View, it is vital to ensure that the strategic pharmaceutical support is maintained and, where necessary, strengthened.

Multispecialty community providers may well see GP group practices expand, bringing in nurses and community health services, hospital specialists and others to provide integrated out-of-hospital care. These practices would shift the majority of outpatient consultations and ambulatory care to out-of-hospital settings. Over time, these providers may take on delegated responsibility for managing NHS budgets (or combined health and social care budgets) for their registered patients. Pharmacist expertise will be required to support these processes not only for the patient-facing clinical decisions but for the organisational decisions about medicines optimisation at board level. Emerging organisations will need to consider some strategic pharmaceutical questions, for example:
• How will your organisation demonstrate to the Care Quality Commission...
• Improved adherence and self-management
• Potential avoidance of hospital admission
• Reduced medicines-related risks
• Reduction in polypharmacy and waste
• Reduction in prescribing costs
• Improved communication with community pharmacy
• Medicines information source for the team

Table 2. Benefits of pharmacy expertise to multidisciplinary teams

(CQC) that all aspects of medicines optimisation meet the requirements to be safe, effective, caring, responsive and well-led?
• If an incident concerning medicines occurs, do you have the pharmaceutical expertise available to fully investigate this?
• Have all medicines-related patient safety alerts, including previous National Patient Safety Agency alerts, been implemented within the organisation?

NHS Specialist Pharmacy Service has developed a resource that summarises the requirement to have adequate pharmaceutical advice, highlights the risks to the organisation of failing to do so and explores the options open to organisations on how that support may be delivered.8

Future opportunities
NICE guidance makes it clear that medicines optimisation is not owned by one profession. Every health and social care professional involved in medicines has a part to play in medicines optimisation, which should be responsive to the needs of individual patients. By working together, health and social care professionals can deliver medicines optimisation through creating care pathways. These pathways must appropriately address how medicines will be utilised within them. Organisations must have appropriate ongoing access to strategic pharmaceutical advice to keep patients safe and to break down the professional and organisational boundaries. Together these approaches will support the patient being at the centre of medicines optimisation and the delivery of high-quality care.

References
5. Haigh C. Proactive care homes: Improving patient outcomes and care. PDF of presentation can be downloaded at: bit.ly/1Jxw3Hq

Declaration of interests
None to declare.

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