A multi-perspective evaluation of specialist mental health clinical pharmacist prescribers practising within general practices in NHS Highland

Elizabeth Buist¹, Rebecca McLelland¹, Gordon Rushworth¹, Derek Stewart², Katie MacLure², Andrew MacLure², Katie Gibson Smith² and Scott Cunningham²

¹NHS Highland, Inverness, UK
²Robert Gordon University, Aberdeen, UK
Contact email: elizabeth.buist@nhs.net

Background/introduction: The Scottish Government has strategic plans (Scottish Government, 2017a, b) to transform services so that every GP practice has multidisciplinary teams (MDTs) that can support patients with mental health issues. A 12-month pilot service was implemented in two general practices where specialist mental health clinical pharmacist prescribers sought to improve the pharmaceutical care delivered to patients with anxiety and/or depression. An independent research evaluation was conducted by researchers from Robert Gordon University.

Aim and objectives: To conduct a multi-perspective evaluation of specialist mental health clinical pharmacist prescriber care for patients with anxiety and/or depression in GP practices.

Methods/design: The pharmacists collected anonymised routine data of clinical issues, actions and outcomes. Quantitative data were subject to statistical analysis in MS Excel 2013. Questionnaire packs were posted to patients who had attended consultations, with questionnaire items including the CARE Measure (CARE SW Mercer, Scottish Executive, 2004) plus 5-point Likert scale attitudinal statements. Members of the MDT were invited to participate in a researcher-led, telephone audio-recorded semi-structured interview. Qualitative data were analysed thematically. University ethical approval was gained; the service evaluation was exempt from NHS ethical and research and development review.

Results: 75 (84.3%) of the 89 patients referred attended their first consultation, around two thirds of whom (n=47, 62.7%) had a diagnosis of mixed depression and anxiety followed by depression alone (n=22, 29.3%). The three most common reasons for referral were to monitor response to treatment (n=25, 33.3%), to review antidepressant treatment due to lack of effectiveness (n=24, 32.0%) and to discuss choice of treatment for new presentations (n=16, 21.3%). A total of 324 consultations were held with the 75 patients (median 3, IQR 2-5, range 1-14). The two key pharmacist actions, other than prescribing or further referral, during patient consultations were assessing patients for response and tolerability to antidepressants (n=281, 33.5%) and reviewing patients’ understanding and medication adherence (n=235, 28.0%). Patient status on completion of the pilot highlighted that just under half (n=34, 45.3%) had PHQ-9 and/or GAD-7 scores reduced by 50% compared to their first consultation with the pharmacist. 15 (21.4%) of the 70 patients mailed the questionnaire pack responded. Almost all patients responding to items in the CARE measure gave a rating of excellent or very good across all items. All responses were positive when rating aspects of the pharmacist consultations and attitudinal statements. 8 members of the MDT were interviewed and three key themes were identified: integration, enablers and barriers. Analysis of interviews with members of the MDT identified that the service had been well-integrated within primary care and interviewees expressed their openness and willingness to change within the context of the new GMS contract. There was overwhelming expression of the benefits of the service from the perceptions of patient and members of the MDT. That the pharmacists were registered independent prescribers was considered a particular enhancement. Identified barriers to the service were overcome in planning and service set up.

Discussion and conclusion: Although limited geographically and by sample size the study triangulation promoted trustworthiness of the results. The evaluation has identified that the pilot was successful from a number of key perspectives. These results should be considered in planning further mental health services within NHS Highland and beyond.

References

Pharmacist independent prescriber working in a Community Learning Disability team – releasing psychiatry time and delivering STOMP

David Gerrard
Northumberland Tyne and Wear NHS Foundation Trust, Newcastle, UK
Contact email: David.Gerrard@ntw.nhs.uk

Background/introduction: The report into the care of people with a learning disability in the Winterbourne View facility highlighted concern that people should be treated at home rather than in an institution (Department of Health, 2012). Deep concern was also expressed at the use of powerful psychotropic medication, in the absence of a serious mental illness, presumably for behaviours that challenge. This led to the development of the STOMP (Stopping over-medication of people with a learning disability, autism or both) agenda to challenge this medication use (NHS England, 2016). A pharmacist was invited to join a Community Learning Disability treatment team to develop a clinic process to meet the above issues at a time of Psychiatrist recruitment shortfall.

Aim and objectives:

- To embed the role of a pharmacist independent prescriber within a community learning disability team,
- To release psychiatry time by managing a caseload of people with a learning disability, autism or both who present with a mental health issue or behaviours thought to be challenging, and
- To develop a clinic process to deliver high quality STOMP reviews supported by alternatives to medication.

Methods/design: The pharmacist attended the community team and worked with the consultant psychiatrist receiving supervision in relation to specific clients. The pharmacist then took on a caseload from the psychiatrist for management. The pharmacist also designed a STOMP clinic based on a medication challenge supported by behavioural intervention. This was modelled on the principles of NICE NG11 focusing on alternatives to medication (National Institute for Health and Care Excellence, 2015). The pharmacist ensured all clients received physical health monitoring with appropriate interventions. A side effect profile was carried out with all clients on relevant medications. Intervention data was collected by the pharmacist and from the staff team.

Results: The pharmacist (15 hours/week for 52 weeks) has released significant psychiatry time by focusing on managing a caseload of stable clients allowing psychiatry to be used for cases of diagnostic uncertainty and complex presentation. Over 60% of the time spent in the team has been used to release psychiatry time (and expense).

The pharmacist has initiated the following medication interventions:

- Caseload 62
- Medications initiated 20
- Dose alterations 56
- Medications stopped 12
- Physical health 165
- Side effect rating scales 104
- Reviews 223
- Psychiatry time released 150 hours

Discussion and conclusion: The role has been successful in releasing significant psychiatry time given the challenges in recruitment of medical staff. This new role has demonstrated that a pharmacist can manage a caseload safely and effectively increasing the focus on physical health and well-being with clients who suffer a significant burden of ill health and reduced life expectancy. The STOMP clinic has resulted in 8 people becoming medication free with several more undergoing the reduction process. The clinic model has also raised awareness of the role of Positive Behavioural Support in line with the STOMP agenda. The pharmacist has brought additional role awareness and training opportunities for the team allowing better medication awareness and data capture to the clinical recording system. The clinic was highlighted as a NICE shared learning example in 2017 (National Institute for Health and Care Excellence, 2017).

References


A retrospective audit assessing clozapine utilisation in a high secure forensic hospital

Li-Ying Huang and Nikki Holmes
Nottinghamshire Healthcare NHS Foundation Trust, Retford, UK
Contact e-mail address: Li-Ying.Huang@nhs.net

Background/introduction: People with schizophrenia have increased mortality associated with comorbid physical conditions,
socioeconomic factors and elevated suicide rates (Saha et al., 2007). Clozapine is superior to other antipsychotics for treatment resistant schizophrenia, however, utilisation is lower than ideal due to, for example, patients’ fear of side effects and clinicians’ general negative beliefs (Patel, 2012).

**Aim and objectives:** The National Institute for Health and Care Excellence (NICE) clinical guideline for the prevention and management of schizophrenia (National Institute for Health and Care Excellence, 2014) states clozapine should be offered to people with schizophrenia whose illness has not responded adequately to treatment despite the sequential use of adequate doses of at least two different antipsychotics. The objective of this audit was to assess compliance with this guideline, and the expected compliance standard was set at 100%.

**Methods/design:** Patients were identified by the Trust’s Applied Informatics Department based on the inclusion criteria: 1. Diagnosed with schizophrenia (F20), 2. Currently an inpatient, and 3. Admitted for >12 weeks (as stated in the British National Formulary, “Patients should receive an antipsychotic drug for 4–6 weeks before it is deemed ineffective” (British Medical Association and The Royal Pharmaceutical Society of Great Britain, 2018), two antipsychotics trialled for adequate periods as per NICE recommendations would be a maximum of 12 weeks). Patients were assessed for clozapine eligibility based on the definition of adequate doses and durations for previous antipsychotics from a New Zealand guideline (Waitemata District Health Board, 2011) as a pragmatic approach in the absence of agreed guidelines. Exclusion criteria were: 1. Current or previous treatment with clozapine, and 2. A documented allergy or hypersensitivity to clozapine. Each eligible patient’s clinical notes were reviewed for any record of being offered clozapine. Only their current admission and electronic notes were used. Audit committee comments were sought and sign off gained. Ethics approval was not required.

**Results:** Ninety-eight patients were initially identified based on the inclusion criteria. Three were excluded immediately due to incorrect diagnoses and responding to current treatment, therefore ninety-five patients’ data were collected and analysed. Twenty-four patients were eligible for clozapine; fifteen were offered clozapine (63%).

**Discussion and conclusion:** Not all eligible patients were documented as being offered clozapine. Patients deserving of a clozapine trial are possibly not being offered one and the hospital may not be compliant with NICE guidance. Patients’ responses to antipsychotics must be actively assessed and clozapine considered as soon as appropriate. Clinical pharmacists should perform medication reviews and make patient-centred recommendations to facilitate treatment optimisation. Trigger points could be embedded within relevant clinical systems to prospectively identify potential clozapine patients. A re-audit should be performed manually identifying eligible patients as a part of data collection due to data extracted by Applied Informatics being incorrect. The re-audit should also monitor the adherence with routine antipsychotics in real time. Re-audit should occur 12 months after audit report dissemination and any agreed actions being put into place in response to the audit report. Qualitative analyses using the results of this audit should also be considered, for example, an analysis of the specific reasons why clozapine therapy was not offered, rejected or ceased, and if these reasons were documented. These analyses can be used to inform future guidance on re-introducing clozapine.

**References**


**Evaluating how limited pharmacy team resources are prioritised in order to provide pharmaceutical care to inpatients in a mental health trust**

Richard Keers1,2, Ruby Lawson1, Man Lo1, Joanne Nguyen1,2 and Penny Lewis1,3

1The University of Manchester, Manchester, UK
2Greater Manchester Mental health NHS Foundation Trust, Manchester, UK
3Manchester Universities NHS Foundation Trust, Manchester, UK

Contact email: richard.keers@manchester.ac.uk

**Background/introduction:** The National Health Service (NHS) is under unprecedented financial pressure, and trusts may consider using existing resources more efficiently to maintain care quality (The Kings Fund, 2017). One example of this approach is using tools to prioritise the provision of limited pharmaceutical care resource to inpatients in general hospitals, with some trusts already implementing such systems (Lewis, 2017). However, it is currently unclear whether mental health trusts are utilising such approaches currently, and to our knowledge there is no published literature on the topic.

**Aim and objectives:** To evaluate how pharmacy teams in a mental health trust prioritise their time and resources to meet the pharmaceutical needs of inpatients. Objectives:

- To develop and launch an online survey for pharmacy staff to determine which approaches are used to prioritise inpatient pharmacy resource for pharmaceutical care and how appropriate these are perceived to be in practice,
- To identify and determine the impact of factors such as staffing level and experience on how pharmaceutical care is currently prioritised,
- To identify barriers and enablers to effective prioritisation of inpatient pharmacy resource for pharmaceutical care provision, and
- To produce recommendations to help optimise the prioritisation of limited pharmacy resources in future.

**Methods/design:** An anonymous online questionnaire was developed and distributed by email to all inpatient-based trust pharmacy teams to prospectively identify potential clozapine patients. A re-audit should be performed manually identifying eligible patients as a part of data collection due to data extracted by Applied Informatics being incorrect. The re-audit should also monitor the adherence with routine antipsychotics in real time. Re-audit should occur 12 months after audit report dissemination and any agreed actions being put into place in response to the audit report. Qualitative analyses using the results of this audit should also be considered, for example, an analysis of the specific reasons why clozapine therapy was not offered, rejected or ceased, and if these reasons were documented. These analyses can be used to inform future guidance on re-introducing clozapine.
staff (pharmacists, pharmacy technicians, assistants, managers) working across seven hospital sites between February-March 2018. The survey contained twenty four multiple choice and free text responses spread across four sections: background, typical day, workforce allocation and patient prioritisation. The study received approval from the University of Manchester ethics and trust audit committees. Data were analysed using both descriptive/statistical and thematic analysis.

**Results:** There were a total of 20 respondents, including 16 pharmacists and 4 technicians. Respondents reported that workforce allocation and prioritisation of care were influenced by factors including staffing, experience, skill mix, availability of senior support and numerous patient/medication factors including clinical complexity and readmissions. Pharmacists identified a need to reduce administrative burdens and improve IT support in order to more effectively prioritise clinical services, and there were mixed views towards the utility of locum staff. Although some respondents cited pharmacy technician screening as a potentially useful model for workforce allocation and prioritisation of pharmaceutical care, there was notable variation in models/services described across hospital sites along with a lack of awareness from some of what local policy was in this regard. A review of current pharmacy staff activity (including introducing staff sharing) and the expansion of the role of pharmacy technicians were suggested by participants to facilitate optimal workforce allocation and care provision.

**Discussion and conclusion:** This study has revealed variation in the type of approaches used to prioritise inpatient pharmaceutical care provision as well as their awareness amongst pharmacy teams at the trust. Important factors were identified that could influence successful provision of efficient patient care, and which could be considered further given recent calls to enhance clinical pharmacy input in mental health services (Lord Carter of Coles, 2018).

**References**


Minimising risk in high dose antipsychotic therapy

Amy King

East London Foundation Trust, London, UK

Contact email: amy.king5@nhs.net

**Background/introduction:** High Dose Antipsychotic Therapy (HDAT) lacks evidence of benefit but evidence of harm is compelling (Royal College of Psychiatrists, 2014; Taylor et al., 2015). POMH-UK audits the use of antipsychotics in the country. In 2012 the national average rate of prescribing of HDAT was 21% whilst the trust average was higher than this at 27% (Prescribing Observatory for Mental Health, 2012). An October 2017 medicines management audit showed the local directorate had a rate of prescribing of HDAT of 40% which was substantially higher that the reported trust average rate of 14%. In the same medicines management audit it was shown that the rate of HDAT monitoring in the directorate per the trust policy had dipped to 24%. The combination of high prevalence in prescribing of HDAT and inadequate physical health monitoring represented an area of potential risk and it was decided to start a Quality Improvement (QI) project to mitigate this.

**Aim and objectives:** The aim was to minimise risk in high dose antipsychotic therapy by ensuring prescriptions are appropriate and that adequate monitoring takes place. The specific objectives were:

- Increase rate of HDAT monitoring from 24% to 100% in 6 months,
- Ensure all antipsychotic prescriptions are reviewed weekly, and
- To reduce the number of inappropriate HDAT prescriptions.

**Method/design:**

1. A QI team was assembled. The team is formed of pharmacists, ward managers, doctors, nurses and consultant psychiatrist. The team was sponsored by the clinical director and a QI coach was assigned.
2. An initial brainstorming meeting was held to formulate aims and change ideas.
3. The QI team then met regularly to discuss implementation of these change ideas;

- Weekly Audit of HDAT by pharmacy
- Weekly MDT reviews
- Junior Doctor training session and pharmacist session at Academic Meeting
- Sharing of audit results weekly
- HDAT calculator shared with nursing staff
- Dose reckoner posters placed in clinical rooms
- Ward patient boards updated with HDAT status

4. Parameters measured included:

- Rate of HDAT monitoring (outcome measure)
- Prevalence of HDAT prescribing (outcome measure)
- Number of weekly reviews by MDT (process measure)
- Number of weekly reminders sent out by the pharmacy team (process measure)

**Results:** The rate of monitoring of HDAT patients increased by 53% (from 24% to 77%) in the duration of the project. All wards saw an improvement in rates of monitoring. The overall mean increased from 45.8% to 61.65%. In addition, the rate of prescribing of HDAT was reduced by over 20% (from 40% to 19%).
There was a mean reduction in prevalence of prescribing of HDAT from 30.5% to 23.17% during the project. 

**Discussion and conclusion:** HDAT monitoring has improved. This and the overall reduction of HDAT prescribing represents a reduction in risk to patients. The current rate of HDAT monitoring is less than the aim of 100%. The next phase will concentrate on 2 inpatient wards where rates of monitoring were just 17% and 33% respectively. It has been noted that one of the wards, a PICU, has a rapid turnover of patients, and so often data is collected on or close to the admission date, before the monitoring is completed. This may need to be taken into consideration to give a true reflection of practice on this ward. Further data collection should continue before it can be concluded that the improvements are embedded into practice.

**References**

