NHS

MEDICINES MANAGEMENT
NetWork | North West

Medicines in Unplanned Care Toolkit

Supported by the Department of Health

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Helen Allanson November 2008

Contents

1. Introduction

Use this guide to:

1. Introduction

The purpose of this guide is to help all those involved in the delivery of Urgent Care, to review current roles and medicine service provision and therefore ensure that they are fit for purpose.

At all times the responsibility for locating a source of urgent medicine should not lie with the patient or carer but with the service provider.

In the year 2000, the Carson review of GP out-of-hours services identified that patients and their carers often encounter difficulties in securing prompt and easy access to the medicines they need, especially at times when they see a clinician in a setting other than the primary care practice, or at a time when the local community pharmacy is closed.

Since then, progress has been made in implementing the guidance, and its realistic character has been demonstrated by the fact that every element of it has been implemented somewhere. On the other hand, few local health communities have succeeded in implementing it in full.

This toolkit has been developed to help both commissioners and providers of out-of-hours services look again at the manner in which they ensure that the patients they serve have access to the medicines they need. It sets out a series of steps that can be taken to review current practice, identify those areas in which it still falls short of the standards that were set out in the Guidance, and suggests ways in which those shortcomings can be tackled successfully.

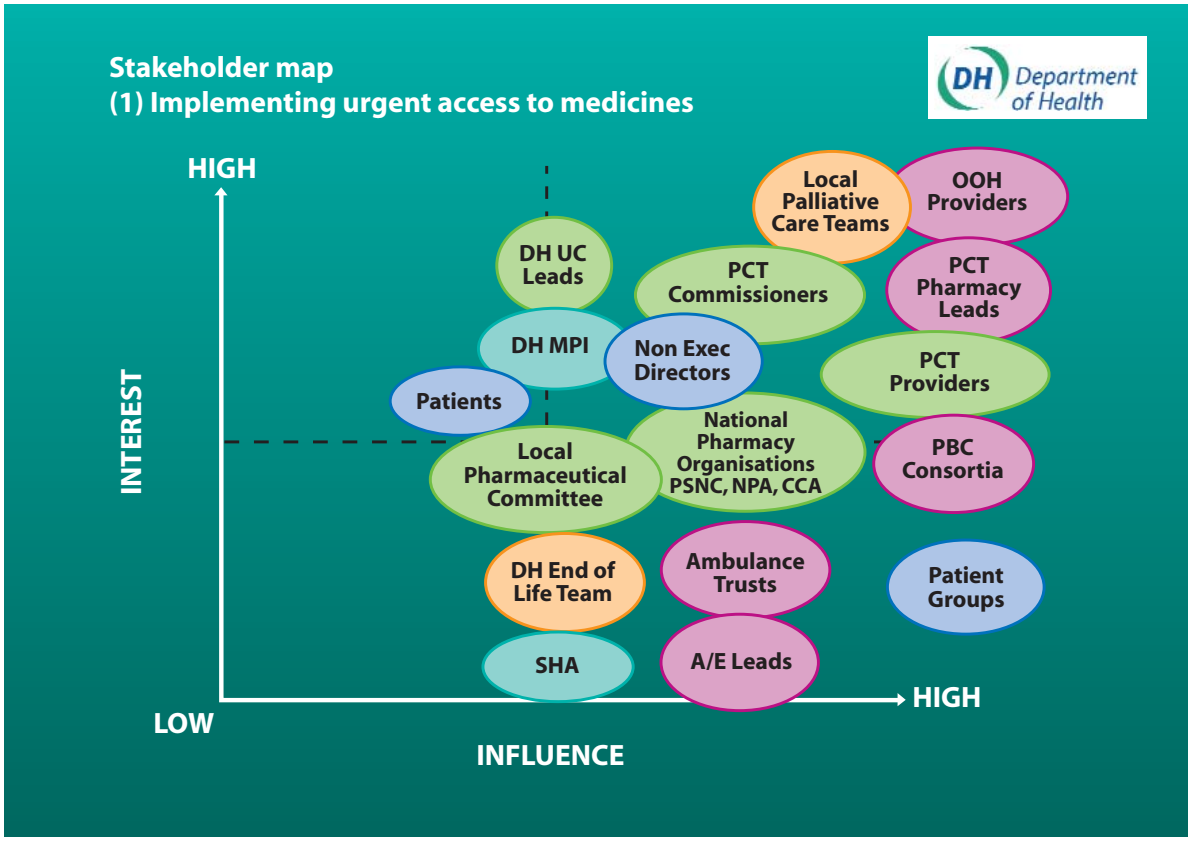
a) Audience for this Document

Table 1 Organisations and groups who may find the toolkit useful

PCT Commissioners **PCT Providers**	Palliative and End of Life Care leads	**Independent, supplementary prescribers**
Practice Based Commissioners	Minor Injury Units, Walk in Centres	**Patient Representatives or carers**
Non- Executive Directors	Independent providers of Urgent Care	**Any organisation with a role which impacts on Urgent Care - e.g. mental health services, crisis teams, social services, Care Homes, voluntary sector**
Ambulance Trusts	Strategic Health Authorities	
Acute and Foundation Trusts providing A/E services and/or front end primary care	Out of Hours Providers	
Doctors and Pharmacists	Ambulance paramedics and Emergency Care Practitioners	
	Nurses	
	Health Care Assistants	

b) Stakeholder Mapping

During the development of *Securing Proper Access to Medicines in the Out-of-Hours Period" Dec 2004* and *Delivering urgent access to medicines outside 'normal' hours Notes for Commissioners and Providers* November 2007, we produced our own stakeholder map which is shown below.



Every local health community faces regular demands for the urgent supply of medicines, either as a result of an unplanned consultation, for an urgent requirement for a repeat medicine, or as a result of a consultation with other practitioners who are required to supply and/or administer medicines. There is a wide variety of different services or models which could be used to enable this supply – understanding the nature of local service providers is the first step towards enabling you to plan appropriately and select the best solution for your locality, bearing in mind that it is likely that several different models will be required depending on the time of day, the particular health professional or the setting. Local commissioners will need to review for themselves how these issues are best addressed, although in very many circumstances commissioners will find that a whole health economy approach to planning and commissioning will hold the key to effective solutions.

This toolkit introduces some self assessment checklists to enable you to benchmark your local service against national standards, national policy, appropriate peers and national and local governance standards.

Before undertaking further assessment it may first be useful to map your own local key stakeholders using the model above.

Note: This list is not exhaustive; you may have other relevant local champions, voluntary groups or partnership organisations, mental health or social care leads.

2. Diagnose

Medicines are the most common healthcare intervention and indeed are one of the main reasons for patients to seek an urgent consultation. Patients, particularly those who present for an unplanned consultation, can often have their care delivered by more than one healthcare professional or even organisation.

For example, a repeat medicine for a long term condition may have been initiated in an acute/specialist hospital, been continued by a GP and then requested in an urgent care setting, where there may be little or no history available other than that provided by the patient or their carer.

Given the increasing complexity of care provision and the significant potential for problems to occur with medicines management services across interfaces, it is critical that commissioners and all providers of services ensure that medicines are well managed across the whole patient journey or pathway.

The input of all stakeholder organisations is required in order to achieve safe and effective choices and equitable access for patients, (see section 2). Poor organisation of services can often lead to low public confidence in clinicians, unmet targets, inappropriate allocation of resources, inefficient services, risk and unsatisfactory patient outcomes. Some specific examples of these include: medication errors emergency admissions to hospital which could have been avoided, failure of patients to maintain their independence or remain/die at home, early re-admission to hospital/care homes.

a) Self assessment or performance progress check

The following questions are designed as a way of performing a quick diagnosis to identify strengths and weaknesses in your out-of-hours medicines provision.

- The most valuable information can often be gained from frontline staff
- Why not do the stocktake from a couple of different perspectives e.g. strategic and provider and compare what you find?
- Use regular scheduled meetings, groups or agendas to gain quick and honest insight
- Check out some tools and tips for taking stock (summarised below) taken from Improvement and Development Agency Feb 2008; the Performance Management Improvement Journey Taking Stock.

  http://www.idea.gov.uk/idk/core/page.do?pageId=1295463

DO:

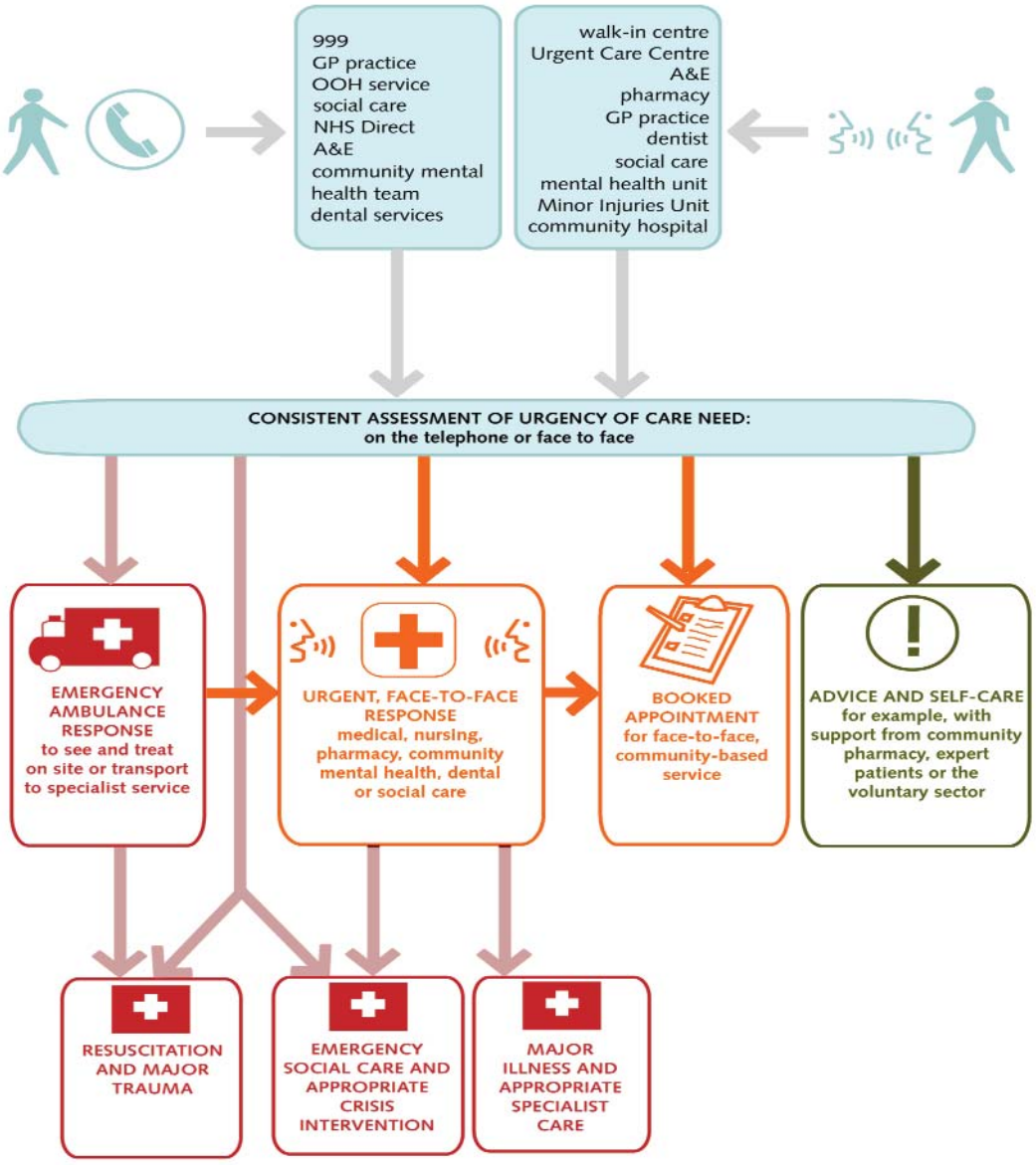
- Start with what you know. Collect the evidence you need, but be selective
- Challenge myths and prejudices but include the views of staff at all levels
- Seek external challenge
- Promote the benefits of openness and honesty - and instigate a 'weaknesses amnesty', allowing people to discuss areas of performance management or performance weakness in a supportive environment

DON'T:

- Ignore the cynics - learn from the past
- Forget how this might feel to those involved – it can be painful and upsetting especially if a stocktake is prompted by a local crisis or critical inspection report. Some people may be in denial. Others may want to do something quickly for reassurance
- Forget to watch out for the things that can go wrong, for example, poor communication and scepticism about earlier changes

b) Conceptual model of effective urgent care[1]

This image of an integrated, high-quality urgent care service takes no account of the particular services which would deliver each part of the model in a particular local health economy. However, in the context of a stocktake or service review, it serves to illustrate the range of possible providers that might be involved locally in the delivery of urgent care.



An alternative single page Care Pathway diagram for Urgent care, if preferred, can be found at:
http://www.isip.nhs.uk/library/care-models/examples/UrgentCarePathw.jpg/view

[1] Direction of travel for urgent care: A discussion document 4 October 2006 Gateway 7071
http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_4139428

2. Diagnose

Diagnosis exercise

1. Define first of all the reference population you are using for the purposes of this exercise e.g. PCT, neighbourhood, population served by an Out-of-Hours Provider.

2. Make a list, using the model(s) above, of every location in your locality where patients are able to (and do) have unplanned consultations, and/or every location where, in your opinion, they might require access to medicines – note for the purpose of this exercise you need to include locations where medicines are not currently available.

3. Make a list, using the model(s) above, of the health professionals/practitioners in your area who are/may be required to supply or administer medicines – again remember to include those professionals who, because of patient flows, ought to be able to supply or administer medicines.

- Cover the whole 24 hour period - if in doubt consider whether access to a particular service varies according to the time of day, site, or clinician
- Some circumstances require medicines to be provided in patients own homes
- Take account of patient's views or preferences if you have previously asked them. Where you have no data, develop your own ways of measuring patients' experience of access to medicines. See ***section 4d*** for more help. If you would like to use the Medicines Management Network survey packs then contact us or visit ***http://www.webstar-health.co.uk***. Also consider CFEP (Client-Focused Evaluations Program) reporting methods and parameters – see ***http://www.cfep.co.uk/about.aspx***
- Factor in decisions arising from previous complaints
- If your organisations aren't coterminous – are there other neighbouring organisations or sites you need to include?

4. For each of the lists you have produced above, consider the statements below and score your service based on the statement which you think most closely reflects the realities of provision. Wherever you are unsure, make a judgement based on the perspective of a patient.

This service delivers modern patient pathways for access to urgent or unplanned medicines, always complies with relevant legislation and allows for further innovative development.	6
This service complies with relevant medicines legislation delivering modern patient pathways for access to urgent or unplanned medicines in the majority of cases. New services are being explored.	5
This service complies with relevant medicines legislation and, in the majority of cases, delivers services to patients at an adequate level with some examples of innovative services available to patients.	4
Structures and functions allow services to be delivered at a basic level , complying with all relevant medicines legislation.	3
This service complies with relevant medicines legislation but, for the majority of patients, does not support equitable access to unplanned or urgent medicines.	2
This service does not support equitable access to unplanned or urgent medicines, nor does it comply with relevant medicines legislation.	1

2. Diagnose

When you have scored each one of your services and activities you should be able to group them in three groups as **your** priorities for development – remember it may be that there are some recurrent themes emerging which can be tackled at the same time.

Score	Suggested action
5 and 6	Celebrate the success and build on these models of care
3 and 4	Look at the services across the geographical area and patient groups – priorities will be to address inequalities, reduce duplication and waste and or add value
2 and 1	Do an immediate risk assessment of the services, develop an action plan for change

If you know that your patient pathways are dysfunctional and will have to change dramatically, there is no point mapping in detail and costing in detail lots of individual steps that you may well eliminate or change completely. When doing the diagnosis exercise think about:

- The processes/ interventions which add value from a patients' or carers' perspective
- Which parts of the journey or pathway adds cost?
- Which parts of the journey or pathway are unreliable and/or create variation or postcode issues?
- Are there any parts of the journey or pathway which do not comply with relevant legislation, limit capacity or reduce flexibility?

For more information on stakeholder / pathway mapping see Value Stream Mapping at:
http://www.idea.gov.uk/idk/aio/6329981

A blank template proforma may be downloaded / printed for the diagnosis exercise or have a look at the example of a completed proforma by clicking on the link: ***http://www.mmnetwork.nhs.uk/***

Need a quick reference source to check out the relevant legislation relating to medicine provision out of hours (including Controlled Drugs) - see Providing Medicines Out-of-Hours, Achieving Safe Practice A guide for PCTs and Organised Providers (Sep 06).
http://www.npa.co.uk/pdf/achieving_safe_practice.pdf

The NHS Institute has created a package (the Lean Simulation Suitcase) which may help or at least provide an alternative approach for your organisation to try. For further information visit ***http://www.institute.nhs.uk/building_capability/general/lean_thinking.html***
Or try looking at: ***Improving Patient Pathways***.

The NHS Institute for Innovation and Improvement's No Delays Priority Programme supports NHS staff in delivering a healthcare system in which no patient waits unnecessarily for anyservice, and which can sustain 18 week pathways. It has developed the No Delays Achiever online service improvement tool which can be found at: ***http://www.nodelaysachiever.nhs.uk/***
If you would like a copy posted to you, please email your details to ***NoDelays@Institute.nhs.uk***
(Please do not reproduce without permission of the NHS Institute).

If you are still having problems and would like the Medicines Management Network NW to help you or do your diagnosis exercise for you then please visit our website for a list of available services and prices – ***www.mmnetwork.nhs.uk***
Or alternatively complete the ***email enquiry*** form and one of our team will call you back to discuss your specific requirements.

3. Check

Towards personalising medicines management (National Prescribing Centre March 2008) describes key learning principles arising from several years of NPC improvement and collaborative programmes with over 200 NHS organisations.

From the work of the ***National Prescribing Centre***, nine concepts have been suggested as a useful way of leading to improvements and creating solutions to medicines management issues.

These concepts are not being suggested here as a specific solution to a problem in the context of urgent care – some of these solutions can be found in ***Section Five***. They are being used here however, to stimulate thinking about ways in which the patient pathway can be improved, using a robust, evidence-based approach.

- There is no blueprint or single right way of providing access to medicines for an unplanned consultation. The most important thing is to ensure that whatever structure you decide upon locally it can actually deliver a world class, legal and safe service – viewed from a patient's perspective
- In many circumstances improved access to routine daytime services in primary care have been shown to have a significant effect on use of urgent care services for example support services to care homes, or supporting improved access to regular repeat medicines during normal hours. *(See section 5 page 23)* ***Warrington Care homes service*** *and* ***Repeat dispensing*** *(see section 14 page 27)*.

a) What does success look like – how are we doing as commissioners

Assess the list of services from the diagnosis exercise against the nine medicines management improvement concepts [2]

On the following pages are a series of checklists which can be used to assess your own fitness for purpose or as a means of identifying specific areas for improvement when commissioning and delivering medicines in unplanned care.

Read the statements next to each of the nine medicines management improvement concepts and tick the relevant box if it applies to **your** service.

Please note: A number of the attributes are relevant to more than one of the nine improvement concepts – they are therefore repeated under each of the relevant headings.

[2] ***http://www.npc.co.uk/pdf/personalising_medicines_management-main.pdf***

3. Check

1. EMPOWER PATIENTS AND CARERS *Enable them to make shared decisions and to self manage medicines and their conditions.*	**✔ Tick here if statement applies**
Patients or carers have been involved in the design and delivery of some or all of our urgent care medicines management services.	
Our organisation has sought the views of our own patients and carers locally about urgent care and/or pharmacy services. Patients / carers know which and where services are available for unplanned or urgent care needs. Our organisation knows how, when, where and who accesses medicines services for unplanned care.	
Support for self care, including access to medicines for minor ailments, are widely and directly accessible to all patients from community pharmacies at times of greatest demand.	
The reasons why medicines have been prescribed are included on repeat prescriptions.	

2. MAKE SERVICES AND MEDICINES MORE ACCESSIBLE *To benefit from improvements in quality of medicines management services, patients must recognise and know how to be able to access services.*	**✔ Tick here if statement applies**
Vulnerable patients are routinely and proactively flagged up with urgent care services.	
Some patients need practical help to be able to access and take their medicines - vulnerable groups are supported within the locality especially for unplanned consultations.	
Emergency Hormonal Contraception is available and women are aware of how and where it can be accessed locally.	
The full range of medicines for palliative/end of life care (including controlled drugs) in appropriate quantities can be accessed in a timely and sensitive way. Patients and their carers are made fully aware of how and where this service can be accessed locally.	
Urgent care medicine supply is supported by commissioning an enhanced Community Pharmacy Service Contract, a 100 hour pharmacy or through Local Pharmaceutical Services.	
Alternative methods of ordering repeat medicines are widely supported.	
Patients have equitable access to repeat dispensing services from pharmacies.	

3. MAKE MORE EFFECTIVE USE OF MEDICINES *It is just as important to support safe and appropriate medicines use in everyday practice as it is to improve the efficiency of medicines management processes.*	**✔ Tick here if statement applies**
Patients always receive a full course of medicine irrespective of where they are seen or who they see – i.e. whomever they see, they complete the episode of care.	
Patients are able to have medicines delivered to their home following an unplanned consultation if their circumstances make this the most appropriate course of action.	
The reasons why medicines have been prescribed are included on repeat prescriptions.	
Support for self care, including access to medicines for minor ailments, are widely and directly accessible to all patients from community pharmacies at times of greatest demand.	
Medicines support services are available in care homes.	
Responsibility for sourcing a medicine supply following an unplanned consultation always rests with the service provider – never the patient or their carer.	

3. Check

4. COMMUNICATE ACCURATELY AND EFFECTIVELY *Ensure that accurate and up-to-date information about medicines is easily available to practitioners, patients and carers.*	**✔ Tick here if statement applies**
GPs are notified by the start of the next working day of any medicines supplied following an unplanned consultation. Patients are not asked to relay messages back to practices; queries are resolved on a professional to professional basis.	
Mental health/crisis teams, social services and the voluntary sector work proactively together and communicate effectively to ensure there are no hospital admissions as a direct result of lack of access to appropriate medicines.	
Patterns and trends of patient usage of urgent care services are fed back to GPs and PCTs to enable changes in practice.	
Medicines usage Out-of-Hours is monitored and regularly reported on, patterns and trends are used to inform changes in practice.	
An electronic discharge system and/or electronic prescription service is available.	

5. DEVELOP THE WORKFORCE *Support the development of new roles, develop and nurture skills across a wide range of professional backgrounds.*	**✔ Tick here if statement applies**
Patients are enabled to self-manage acute exacerbations of long term conditions – i.e. services and practitioners are organised in a way to enable this.	
Locally commissioned enhanced community pharmacy services are specifically commissioned to support access to medicines in unplanned care and access to end of life care medicines.	
The PCT specifies the terms and conditions of 100 hour pharmacies to ensure that their role is maximised in unplanned care e.g. ensuring medicines are available 365 days a year.	
Organisational policies formally recognise medicines management roles and responsibilities and maximum use is made of trained technical and support staff.	
Joint training and learning resources are available for non-NHS carers and for NHS Staff.	
Domiciliary care staff are trained to support patients taking their medicines in the community.	

6. IMPROVE SERVICE EFFICIENCY *Getting the basics right is essential.*	**✔ Tick here if statement applies**
All services and practitioners communicate effectively to ensure admissions to hospital are minimised as a direct result of lack of access to appropriate medicines – there is a recognised forum or process to enable this to happen.	
Local Out-of-Hours medicines usage, including non compliance with the locally adapted, national Out-of-Hours formulary, is monitored and regularly reported on - patterns and trends are used to inform charges in practice. Recognised processes / procedures are in place to do this within the organisation/ health economy.	
Maximum use is made of trained technical and support staff, shared or complementary roles, shared premises and equipment.	
Responsibility for sourcing a medicine supply following an unplanned consultation always rests with the service provider – never the patient or their carer.	
An electronic discharge system and / or electronic prescription service is available.	
Alternative methods of ordering repeat medicines are widely supported.	
Patients have equitable access to repeat dispensing services from pharmacies.	

3. Check

7. MINIMISE RISK AND REDUCE MEDICATION ERRORS *Medicines management services often involve complex interactions or specialised approaches that are inherently risky; Organisations can reduce medication errors by redesigning systems to make it less likely for people in the system to make mistakes.*	**✔ Tick here if statement applies**
All disciplines working with medicines in urgent care are fully aware of, and comply with, all relevant medicines legislation when purchasing, storing and supplying medicines. Relevant training is made available.	
Our Out-of-Hours Providers have access to medicines management support services to deliver robust and safe policies and procedures for medicines supplies.	
Personal responsibilities and processes exist in the urgent care setting for care of the patient to be co-ordinated with other service providers.	
All services set up to specifically improve access to Controlled Drugs (CDs) comply with the legal requirements for safe keeping, recording storage and supply; these are done in a way that does not impede appropriate use to meet patient needs *(Over the last 2-3 years the controls governing the use of CDs have been strengthened in response to the Shipman Inquiry – see **Controlled Drugs: Department of Health - Health care** for up to date information.*	
An audit trail exists for all medicine supplies from stock room to patient. ***The Pharmacy White Paper*** gives a lead role for chief pharmacists in medication safety in PCTs and hospital Trusts.	
All medicines used in an urgent care setting are purchased from licensed suppliers or manufacturing units. If a local provider has insufficient capacity alternative supplies are sourced from a different provider or trust.	
Medicines usage Out-of-Hours is monitored and regularly reported on – patterns and trends are used to inform charges in practice. Recognised processes / procedures are in place to do this.	
Significant events and near misses involving medicines in urgent care are routinely recorded and used to inform and improve future practice. Policies and procedures are in place to ensure this happens.	
Multidisciplinary training and learning resources are easily available to staff in urgent care settingsand they are encouraged, and understand how to access these.	

8. ELIMINATE WASTE *Look for ways of eliminating any activity or resource in the organisation that does not add value to patient care.*	**✔ Tick here if statement applies**
Patients always receive a full course of medicine irrespective of where they are seen or who they see – i.e. whomever they see, they complete the episode of care.	
Maximum use is made of trained technical and support staff, shared or complementary roles, shared premises and equipment. See ***section five*** for examples.	
Use of pharmacy and pharmacist core roles is maximised. Services are proactively commissioned using patient pathway/ flow information.	
Maximum use is made of patient's own medicines, repeat dispensing and 28 day dispensing schemes in hospitals, complemented by access to medicine reviews in the community.	
Use of licensed hospital trust pre-packing/manufacturing units is maximised. Product lines for the Out-of-Hours formulary are rationalised across areas, spare capacity is shared and products may be purchased from other hospital units licensed by the MHRA external to the PCT if necessary. (See individual hospital trust websites for more information on whether they distribute across the UK).	

3. Check

9. FOCUS ON VARIATION *Reducing variation improves the predictability of outcomes and helps reduce the frequency of poor results.*	**✔ Tick here if statement applies**
Medicines usage Out-of-Hours is monitored and regularly reported on to ensure equity – patterns and trends are used to inform charges in practice. Recognised processes / procedures are in place to do this.	
Responsibility for sourcing a medicine supply following an unplanned consultation always rests with the service provider – never the patient or their carer.	
The full range of medicines for palliative/end of life care (including controlled drugs) in appropriate quantities can be accessed in a timely and sensitive way. Exceptions to this are always monitored, recorded and acted upon to ensure the same problem is not repeated elsewhere.	
Significant events and near misses involving medicines in urgent care are routinely recorded and used to inform and improve future practice. Policies and procedures are in place to ensure this happens.	
Use of licensed hospital trust pre-packing/manufacturing units is maximised. Product lines for Out-of-Hours formulary are rationalised across areas, spare capacity is shared and products may be purchased from other licensed hospital units external to the PCT if necessary. (See individual hospital trust websites for more information on whether they distribute across the UK).	

A copy of this checklist with space for notes and evidence can be obtained by clicking on the link: ***www.mmnetwork.nhs.uk.*** Sample documents from other NHS services are also located on our website here under ***Out of Hours – resources***.

If you have specific problems or issues with Controlled Drugs, try looking at the FAQ sheet on ***www.mmnetwork.nhs.uk***. Alternatively visit the Home Office Licensing Information site at ***http://drugs.homeoffice.gov.uk/drugs-laws/licensing/licensing-forms?d-7095067-p=1***. It may help to work through some of the appropriate application processes for holding controlled drugs – this should highlight any weak or problematic issues for you. If in doubt, submit the form – but remember: always liaise with the Home Office in writing in order to preserve an audit trail for your organisation for the future. Specific guidance can be found on ***General security Guidance for controlled drug suppliers***.

Visit the National Prescribing Centre Website ***NPC – Medicines Management*** for more information and resources relating to ***Commissioning for Integrated Medicines Management Programme (CIMM)*** including further examples and evidence to support good practice.

Have a look at the specific examples of service models in ***Section Five*** – give the lead contact a ring or email them for more information - they may have sample documents you could usefully use, updates to their service or useful 'lessons learned'.

Not sure whether anyone else has encountered a similar problem to you? Post a question on the Out of Hours discussion forum: ***http://www.mmnetwork.nhs.uk/forum/?fid=1***. It's easy to ***register*** and use and is open to anyone with an interest in medicines in unplanned care. Also think about uploading some of your own documents to the site to help others – if you're not sure how to do this then ***contact us*** for help.

If you are still having problems and would like the Medicines Management Network NW to help you then please visit our website for a list of available services and prices – ***www.mmnetwork.nhs.uk*** or alternatively complete the ***email enquiry*** form and one of our team will call you back to discuss your specific requirements.

4. Review

Medicine services in urgent care settings are still evolving; there is a great deal of variety of provision according to local environments and settings. Some services (see examples in ***section five***) appear to be very effective, whilst others can often be disjointed, invisible or even unknown to patients and other clinicians alike.

Once you have identified priorities and developed action plans for improving access to medicines following unplanned consultations, you may be unclear as to:

- What tools are now available to measure progress?
- What might be appropriate measures to have in place?
- How might you usefully involve patients?

a) Measuring overall progress

- General tools and tips for assessing your progress and re-evaluating services are available from the Improvement and Development Agency Feb 2008; The performance management Improvement Journey: Keeping on Track.
  http://www.idea.gov.uk/idk/core/page.do?pageId=1292609

- A checklist, designed specifically for this stage has also been developed.
  http://www.idea.gov.uk/idk/aio/1326741

- You might like to use their urgent v important matrix – to revise and update your action or project plan.
  http://www.improvementnetwork.gov.uk/imp/aio/11282

- Remember if it isn't in someone's job description to lead processes and measure performance then it won't happen!

Issues to think through as part of keeping on track, as summarised by the Development and Improvement Agency, include:

DO:

- Allocate time for monitoring and review
- Recognise and reward achievement, and celebrate success
- Concentrate on solving problems rather than blaming individuals

DON'T:

- Get distracted
- Forget to listen actively to people's views on how it's going
- Forget how this might feel to those involved - confidence levels may be high but some people may still feel threatened
- Forget to watch out for the things that can go wrong, for example, changes not being linked together

Review your progress

In the specific context of medicines in unplanned care, use the following questions from the Development and Improvement Agency ***"Issues you might want to ask yourselves"***:

1. In what areas are we on track and meeting milestones?
2. What's working well to support progress?
3. Where is progress not on track?
4. What are the bottlenecks and barriers?
5. What do we need to do differently?
6. What impact are improvements to performance management having on service improvement?

4. Review

b) Measuring overall progress

This section of the toolkit makes some suggestions for suitable methods, processes tools and information which could be captured and used to monitor specific progress with medicines. This list is not prescriptive neither is it exhaustive, but it is here to stimulate thought on what information might be appropriate to collect and indeed available in your locality. It's worth asking your own Out-of-Hours Provider(s) as they may already collect/have a wide range of previously untapped information.

General

- Monitoring of Out-of-Hours prescribing data via Epact – use PCT specific codes plus data capture from FP10PREC forms. See range of available information reports at: ***http://www.ppa.org.uk/ppa/info_sys.htm***
- Cross reference to hospital prescribing data if available - some Trusts have access to Hospital EPACT For more information visit: ***http://www.ppa.org.uk/ppa/hospital_epact.htm***
- Cross reference to formulary data captured by Out-of-Hours provides who use Adastra systems. For more information see: ***http://www.adastra.co.uk/content/Products/applications/AdastraApplication.html***
- Individual follow up from PCT advisers, or Out-of-Hours provider medicines management lead/team where practice differs from recommendations/Out-of-Hours formulary – summary trend or exception reports
- Ensure policy for onward referral is in place where a practice or a provider continues to differ e.g. to Provider or PCT medical, pharmacy lead

Repeat medicines

- All urgent and emergency care providers who initiate repeat medicine supply need to ensure that a report of the supply of medicine is sent to the patient's own GP practice by 08:00 the next working day
- All providers of primary care out-of-hours services currently accept the responsibility to report back to GP practices by 08.00 the next working day. Other Urgent Care providers – e.g. walk-in centres, A&E, Minor Injury Units (MIUs) etc – must accept the same responsibility to report back to the patient's own GP practice
- Out Of Hours Providers should consider reporting quarterly the number and associated trends of such repeat medicine requests to their commissioners (see Expediting the dispensing of an 'urgent' repeat prescription: ***Delivering urgent access to medicines' Nov 2007)***
- On receipt of their data, GP practices should explore what implications (if any) it has for the way in which their patients currently initiate their supply of repeat medicine(s)
- Where it is clear that the problem rests with a particular individual, then the practice would want to explore with that individual why it is that they are using the local urgent care service to access their repeat medicines rather than using the practice's normal methods
- Where a number of patients from a specific practice are accessing repeat medicines from the local urgent care service, the practice may want to explore why this is and look again at their routine procedures to ensure that they do in fact meet the needs of their patients
- Commissioners should also look at the quarterly data and, where this reveals a large number of requests for urgent repeat medicines from the patients of a particular practice, check that the practice has taken steps to resolve the problem and/or work with the practice to modernise the way in which their patients initiate their supply of repeat medicine(s)

c) What might be appropriate measures to have in place?

"People need different information at different levels of the organisation. CEO and Boards need a strategic overview of organisational performance while managers require information that helps them to manage their directorate, service or team. Individuals also need to know how they are performing. There will be a hierarchy of measures reflecting the structure of the organisation and each of these must be owned by an individual – a named person must be accountable for the collection of the information and the performance itself"

Improvement and Development Agency The performance measurement framework; March 2008
http://www.idea.gov.uk/idk/core/page.do?pageId=76209

The same framework also suggests that there is a hierarchy of performance indicators – this is summarised in a diagram which can be found at: ***http://www.idea.gov.uk/idk/aio/4816104***

As there are no national medicines indicators or measures to support unplanned care, localities will need to consider their own local circumstances (including relevant information already collected) when devising their own local performance outcome measures. Consideration should be given to ensuring proposed measures are:

- Relevant
- Attributable and accountable – to organisation or activity
- Clear and well defined so that data can be collected in a timely and consistent way
- Accurate reliable and comparable – able to measure trends and patterns
- Can be validated

Some examples/suggestions for measures for access to appropriate 'Medicines in Unplanned Care' include:

Measure	
Patients admitted to hospital following problems encountered with accessing medicines	Actual number Trend % of a cohort or group e.g. long term condition, mental health , palliative care
Patients or carers who are asked to collect their own medicine	Actual number trend % of overall total % of a cohort or group
Time taken for palliative care patients to access their medicines following assessment Or Patients receive medicines for palliative care within e.g. 2hrs/ 4hrs/other	To make this measure work Providers will need to become more involved in the logistics of the actual medicine supply
Range or number of non medical prescriptions OOH Formulary compliance /exception reports Variance in prescribing by site/ GP/Profession	

Measure	
% of patients who wish to die in their own homes but in fact die in hospital	This is an existing measure. However you could audit/ monitor instances where lack of access to medicines was a major contributory factor
Monitor patterns and trends for premises / sites used most frequently by patients	By time of day/ day of week/ season
OOH providers monitor % of calls which could be dealt with appropriately by another health professional	Monitor trends by time of day/day of week
Use CFEP reporting methods and parameters more widely	See ***http://www.cfep.co.uk/*** for more information
Revisit recent Healthcare Commission "Access to Urgent Medicines" questions; this indicator considered how easy it was to access medication in the out-of-hours period for patients with urgent care needs	***Healthcare Commission***

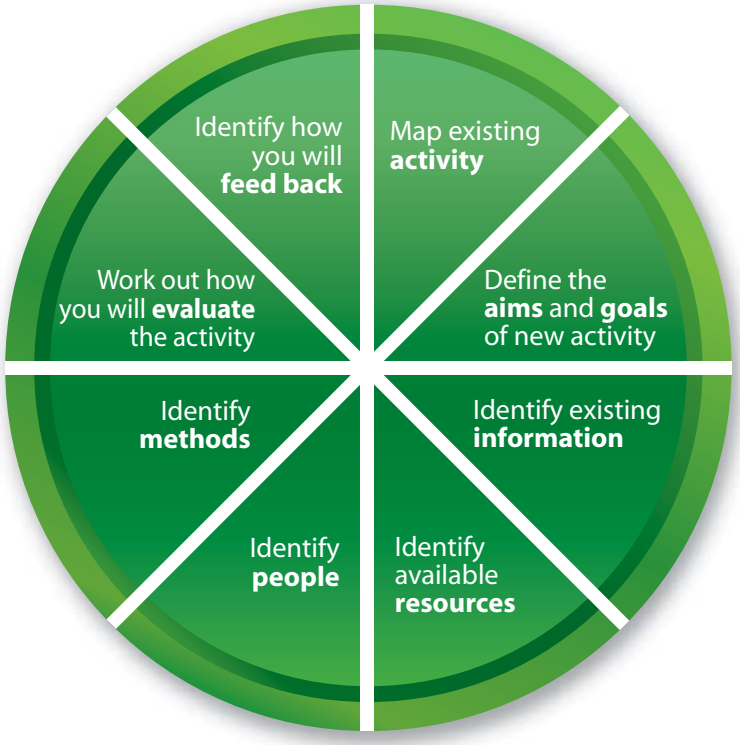
d) How might we involve patients?

I. A Guide to Patient and Public Involvement in Urgent Care has recently been published by the NHS Centre for Involvement and Department of Health (October 2008) It can be found at: ***http://www.nhscentreforinvolvement.nhs.uk/index.cfm?Content=220*** or, ***http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089684***

The Public involvement Guide provides a step by step process to implement an effective system of patient and public involvement in urgent care. It was produced in response to the 2006 consultation on the Direction of Travel for Urgent Care which recognised that urgent or unplanned care provision is very different from other types of NHS care because there is no readily available patient group that can be called upon to get involved. The guide is split into two parts, part one covers:

- ten benefits for involvement,
- who and what the guide is for,
- how to use the guide and
- an excellent 'myth buster' section

Part 2 describes, using a step process, how to go about involving patients and the public specifically in urgent care. Each of the eight steps uses examples to illustrate with the approach organised around a wheel of involvement made up of eight spokes, which is reproduced below:



PPI in Urgent Care Wheel. It is based on the PPI cycle developed by Tritter et al. (Improving Cancer Services through patient Involvement, 2003)

II. To help the NHS respond to the challenge of patient and public involvement, a series of initiatives is being put in place including ***"New statutory guidance to help NHS involve people in healthcare"***. DH 30 October 2008.

Many NHS professionals believe that involving communities in decisions about care and listening to their experiences is an essential step to improving services. However, despite good examples of NHS organisations using involvement, many do not systematically use it as a tool to understand people's care needs. See ***Real involvement: working with people to improve services: Department of Health – Publications*** for specific help on how to approach and plan involvement, how to find the right people or the right involvement methods, how to find people who are easy to overlook.

For further information and resources to help involve service users visit the NHS Centre for Involvement Website at: ***The NHS Centre for Involvement***. Here you will find out about ***Local Involvement Networks***, ***Patient-Citizen Exchange Networks***, and ***The People Bank***.

4. Review

Tips for sucess

Tips for success

The tips can help the NHS engage communities more effectively

- Be clear when you need to involve users of services.
- Involve people at the very start of a process.
- Be clear with people about what can and cannot be influenced.
- Be open, frank and transparent.
- Be prepared to listen to what your community tells you.

Table taken from Involving People and Communities:
A brief Guide to the NHS Duties to Involve and Report on Consultation DH October 2008

Think through carefully which types of people you need to involve and use all available resources for help. A checklist of issues to consider before involving service users is summarised below from both an organisation and a potential users perspective; this has been compiled using suggestions from ***'Real involvement'***:

Organisation's perspective	User's perspective
Why you are involving people – what is the purpose and what are the expected benefits?	*What information people might need – what is their present level of knowledge/understanding, what format will the information need to be made available in?*
What you want to achieve?	*What is expected of these people and what they can expect from you?*
How does/will this work fit with your organisation's overall strategy?	*How will you make sure that everyone understands the discussions, i.e. that health professionals do not use jargon, and that people are 'keeping up' with the debate and have equal opportunities to contribute and ask questions and/or for a further explanation.*
Do you have/need a budget to do this work?	*What is the reimbursement policy.* *Will I get expenses and/or will I be paid for my time?*
How will feedback be used to inform decisions?	*How you will make sure that users' views and opinions are heard and that they are not patronised?*
How will people will be selected or recruited – do they have the skills to do what is being asked of them?	*What skills may people need to have and what training/ongoing support might users' need.* *Who will provide the training/ongoing support?*
Who should be involved?	*Who should I contact if I have problems / issues?* *How can my area of expertise best be used?*

4. Review

III. The Medicines Management Network NW and the DH, through previous opportunistic conversations with service users on visits to urgent care sites have previously identified strong views and a mixture of patient experiences of access to medicines arising from unplanned consultations. In March 2008, we had the opportunity to undertake a small-scale exploration of service users' views using three telephone interviews with volunteers and one focus group in a residential care home in Lancashire which included residents, relatives and staff.[3]
The views expressed were that the system should be:

- **Responsive:** *Many accounts of experiences included avoidable delays resulting from poor inter-professional communication and lack of information about pharmacy services. These delays caused suffering and anxiety for all parties involved. Many of these dealys occurred 'in hours' but impacted during the Out of Hours period.*

- **Reasonable:** *Most users were prepared to receive a prescription for a medicine that they might receive out-of-hours, rather than the perceived luxury of direct supply, but they needed to know where and how they would be able to obtain it. The distance involved had to be reasonable in itself, The concept of 'reasonable' varied according to:*
  - *The ability of the user/carer to travel/leave others*
  - *The time of day/night or weather*
  - *The severity of the illness*

- **Responsible:** *Someone had to be responsible for making palliative care medicines available. Patients hold the NHS responsible for providing mechanisms and for obtaining emergency supplies following major incidents however, participants recognised their own responsibility in playing their part, and expected the same of those who promised the service*

You could do a similar 'focus group' exercise locally yourself. However, if you would prefer to pool resources, we are looking to build on the work described above and extend our understanding of users' views, and to add / compare those of providers and commissioners. We are therefore seeking sites that would be prepared to distribute survey packs to site users. For more information ***contact us***, e mail ***nicola@webstar.co.uk*** or visit ***Webstar Health*** for more information.

IV. Researchers at the University of Sheffield, Medical Care Research Unit, have produced a "Toolkit for monitoring the patient perspective of the emergency and urgent care system". This aims to help those who manage emergency and urgent care services to obtain a patients' perspective of their system in a way which offers valid and reliable data. For more information or a copy of the toolkit and questionnaire visit: ***Policy research programme*** or e mail ***e.l.knowles@sheffield.ac.uk***. In producing their toolkit, the University of Sheffield tested the use of a standard market research company telephone survey versus a 'gold standard 'postal survey. Some useful facts arising from this work include:

- A survey of 1000 people who answered their screening yielded approximately 150 people who had used the urgent and emergency care system in the previous 3 months
- A standard market research company telephone survey using quota sampling was more inclusive and representative than random sampling in a postal survey. It was also more accurate in identifying specific service use
- Patients had a 4 week recall period relating to an urgent care event however answers to satisfaction questions are consistent over a 3 month period
- Using a market research company in this way does not require approval from an NHS ethics committee because no NHS records staff or facilities are used to recruit participants for the survey. The market research company however, must be a member of the ***Market Research Society*** and comply with the Market research Society's code of conduct, see ***MRS Professional Standards: Code of Conduct***
- Need to find a market research agency? Use the ***Research Buyer's Guide*** online
- In 2007, a telephone survey of 1000 people cost approximately £10k including VAT

Decide which approach you are going to take to listen to your own patient and user experiences

[3] Access to medicines out of hours — the views of service users and carers by Nicola Gray, Helen Allanson and Nicholas Reeves (Oct 2008) ***http://www.pjonline.com/news/access_to_medicines_out_of_hours_%E2%80%94_the_views_of_service_users_and_carers***

5. See

a) How others are doing things – Examples of Practical Ways to make this work

A. Urgent Access to Medicines outside normal hours

5. See

Sharing Practice Example 1

Pharmacists working in Out-of-Hours centres

Where: UC 24, Liverpool, Fylde Coast Medical Services

UC24 – Following a demand analysis, employ a sessional pharmacist from the local community on Saturday mornings to manage all medicine related calls via the Adastra system.

Fylde Coast – One of the striking characteristics of the integrated team that works at Fylde Coast is the wide range of staff that makes up the total team. They include; Call handlers (non-clinical);Shift co-coordinator; Pharmacist (7 pm – 10:30 pm weekday evenings, and 9 am – 10 pm at weekends); Dispenser; GP(s);NP(s) Emergency dentist (based on site);Social services Out-of-Hours emergency team (based on site);Twilight nurses (based on site). The team also has easy access to Out-of-Hours Mental health teams; and District Nurses Out-of-Hours teams. The pharmacists have a unique role as full members of the clinical team, thus pharmacists are able to complete episodes of care and manage their own caseload. There are good training and induction modules for new pharmacy staff joining service – jointly run with doctors.
Treatment protocols and access to medicines for common minor ailments- managed by pharmacist.

For Further Details Contact:

UC24; ***Simon.Abrams@uc24-nwest.nhs.uk***; ***John.Caldwell@uc24-nwest.nhs.uk***; ***Julie.Williams@uc24-nwest.nhs.uk***

Fylde; ***Helen.sherrington@fcms.nhs.uk*** Director of Operations for Unscheduled Care or Vicky Storey - Deputy Operations Manager – OOH Service.

FCMS (NW) Ltd.; Tel: 01253 308115, E-mail ***Victoria.storey@fcms.nhs.uk***

Sharing Practice Example 2

Full Time or Sessional PCT Medicines Advice to Out-of-Hours Provider

Where: Walsall PCT , South West Ambulance Trust, UC24 Liverpool

Walsall PCT provides sessional medicines management advice to the Out-of-Hours service in exactly the same way as they would a GP practice.

The adviser is also training to be an independent prescriber and will work sessions in the Out-of-Hours centre.

South West Ambulance have employed a pharmacist (formerly from the PCT) to provide medicines management advice, oversee medicine supplies, provide Standard Operating Procedures for medicines.

UC24 have a dedicated full time medicines management team responsible for all medicine supply processes and procedures at all sites (including cars).

For Further Details Contact:
Walsall; Dr Albert Benjamin Albert Benjamin, Medical Director, Waldoc (Out-of–Hours) Community Benefits Society.
E-mail: ***albert.benjamin@walsall.nhs.uk***; Tel: 01922 858000.
Tel: 0845 8904710 (Waldoc) or Lesley Woakes, Primary Care Development Manager, Walsall PCT; ***Lesley.woakes@walsall.nhs.uk***, Tel: 01922 444185.
Other contacts Bharat Patel – Pharmaceutical Adviser, NHS Walsall , ***Bharat.Patel@walsall.nhs.uk*** or Jas Johal, WALDOC Pharmaceutical Adviser ***js_johal@yahoo.co.uk***; Mobile: +44 (0)7976 980208.

SW Ambulance Trust; Sue Oakley, Pharmacy Adviser South West Ambulance Trust, Tel: 07867 926928, ***Sue.oakley@swabt.nhs.uk***

UC24; Dr Simon Abrams, Director of Clinical Services Urgent Care 24
And Medical Director of Urgent Health UK; Email: ***simonabrams@dsl.pipex.com***
Tel: 0151 230 5565 or ***Julie.Williams@uc24-nwest.nhs.uk***

5. See

Sharing Practice Example 3

Car Computers

Where: Fylde Coast Medical Services Whitegate Drive, Blackpool, Lancashire

If a GP, District Nurse, ECP or NP is on a visit, their cars (spoke) are fitted with a fixed computer that is linked via mobile phone technology to the Fylde OOH Centre (hub). When they have completed their visit, they download their clinical intervention notes, including their concern proforma, to the hub. Every 20 minutes the hub computer 'pulls' any new information from all the spokes into the main computer as back up.

In the same way, any urgent calls that come into the Fylde Out-of-Hours centre that result in an urgent visit by a health professional, can be downloaded to the car computer within seconds. The health professional in the car gets an information printout from an integrated printer next to the computer (also fixed in the car).

Innovative extended roles for drivers – they are also involved in re-stocking provider bags and cars and work in dispensary.

For Further Details Contact:
FCMS (NW) Ltd.; ***Helen.sherrington@fcms.nhs.uk*** Director of Operations for Unscheduled Care or Vicky Storey – Deputy Operations Manager – Out-of-Hours Service. Tel: 01253 308115, E-mail ***Victoria.storey@fcms.nhs.uk***

Sharing Practice Example 4

Co-location of medicines services with A/E

Where: Warwickshire PCT, Salford Hospitals NHS Trust, UC24 Liverpool

Warwick Hospital – Out-of-Hours service not just co-located with A & E but the two clinical teams are highly integrated with some staff working in both Out-of-Hours and A & E. This truly integrated service was driven by primary and secondary care clinicians working in close partnership, with clear support from CEOs of both the PCT and the Hospital Trust.

There is Immediate access to mental health crisis team and a good planned network of community pharmacy cover with plans to have pharmacist input on specific Out-of-Hours shifts.

Ticket machine planned for collection of charges. Costs and profits to be shared jointly between A/E and Out-of-Hours
Salford – Out-of-Hours Pharmacy co-located as part of A/E staffed on a rota basis by hospital and community pharmacists. Site also has a community pharmacy as part of the hospital (registered with the RPSGB)
UC24- Every consultation room at each site has a medicines cupboard providing full courses of out-of-hours formulary items. Sites include co-location with A/E and Walk in Centre.

For Further Details Contact:

Warwick; Amin Mitha, Head of Medicines Management NHS Warwickshire. ***Amin.mitha@ warwickshirepct.nhs.uk***

Salford; Ambreena Asghar, Manager, Salford Royal Hospital Outpatient Pharmacy. Tel: 0161 206-4211; ***ambreena.asghar@srht.nhs.uk***

UC24; Dr Simon Abrams, Director of Clinical Services Urgent Care 24
And Medical Director of Urgent Health UK; Email: ***simonabrams@dsl.pipex.com***
Tel: 0151 230 5565 or ***Julie.Williams@uc24-nwest.nhs.uk***

5. See

Sharing Practice Example 5

Proactive service commissioning/income generation/innovation

Where: Warrington Out-of-Hours Service / Warrington PCT

Close collaboration between the medicines management team, the Out-of-Hours manager and the community pharmacy provides a service which has been positively and proactively commissioned by PCT. This relationship has allowed the service to develop in response to service and patient needs.

Innovative services include:

- Innovative and flexible partnership with community pharmacy partner (Co-op) who provides pharmacists, medicines and services co-located in Out-of-Hours centre. Over the counter medicines and advice are available
- In hours team of nurses providing advice , visits and access to medicines in nursing homes
- Excellent and innovative income generation schemes to sustain service e.g. proactive scheme IV Drugs scheme for hospital admission avoidance
- Nurses keep palliative care and complex patient details up to date weekly

For Further Details Contact:

Matthew Cockcroft Pharmacy Manger/PEC pharmacist Warrington Co-op, ***matthew.cockroft@coop.co.uk***

Melissa Burgess, Head of Medicines Management, Warrington PCT, Tel: 01925 843785, ***Melissa.burgess@warrington-pct.nhs.uk***

Sheila Williamson – Interim Project Support Unscheduled Care, Warrington PCT, ***Sheila.williamson@warrington-pct.nhs.uk***

Sharing Practice Example 6

Regular Communication / Patient Involvement

Where: Warrington Out-of-Hours Service

Regular proactive dissemination of data to commissioners on Out-of-Hours service use. The Out-of-Hours manager has regular dialogue and proactive links with wide range of local groups and decision-makers.

Regular publicity campaign – including repeat medicines.

Local PPI forum were invited to inspect service, reports in local press.

For Further Details Contact:

Matthew Cockcroft Pharmacy Manger/PEC pharmacist Warrington Co-op ***matthew.cockroft@coop.co.uk***

Melissa Burgess, Head of Medicines Management, Warrington PCT, Tel: 01925 843785; ***Melissa.burgess@warrington-pct.nhs.uk***

5. See

Sharing Practice Example 7

Emergency Repeat medication –Patient Group Direction

Where: Cornwall and Isles of Scilly PCT

Rurality prompted Cornwall and Isles of Scilly PCT to devise emergency supplies plan whereby medicines are available from selected pharmacies in Cornwall under a patient group direction. This scheme involves the Out-of-Hours supply of medicines to patients who have had the items on repeat prescription in the past.

See also original ***NHS Scotland scheme*** which began at the end of 2005 PJ, 3 December 2005, p682.

For Further Details Contact:

Cathy Noakes, Community Pharmacy Lead; ***Cathy.Noakes@CIOSPCT.cornwall.nhs.uk***

Sharing Practice Example 8

Pharmacist Network

Where: Palliative Care Pharmacist Network

Pharmacists who would like to join the Palliative Care Pharmacists Network can e-mail Anne Garley at Help the Hospices ***a.garley@helpthehospices.org.uk*** or Margaret Gibbs ***m.gibbs@stchristophers.org.uk*** for more information or an application form.

The website for the PCPN can be accessed by clicking ***http://www.pcpn.org.uk***

Interested pharmacists can register for the forum but certain parts of the website will only be available to members.

5. See

Sharing Practice Example 9

Community Pharmacist supporting a hospice; Community Pharmacy Enhanced Service

Where: Bristol Palliative Care Pharmacy Network

Uses an NHS Community Pharmacy Enhanced Service to deliver the following:

- **Locally agreed Specialist Palliative Care Drugs**
- **Available during normal working hours**
- **Pharmacist prescribing**
- **Pharmaceutical assessment prior to admission , interventions, disability assessment**

Working with local specialists Consultants, Pharmacists, GP representatives, Nurses, PCT Medicines management team. Mapping the opening hours including 100 hour pharmacies to ensure ease of access across the area.

Aims and intended service outcome

1.1 This service is aimed at the supply of specialist palliative care drugs, some of which may not be standard stock for community pharmacies, during normal working hours

1.2 The pharmacy contractor will stock a locally agreed range of palliative care medicines and will make a commitment to enable prompt access to these medicines during normal working hours

1.3 The pharmacy will provide information and advice to the user, carer and clinician. They may also signpost to specialist centres e.g. local hospices, support groups or other health and social care professionals where appropriate.

1.4 The pharmacy will inform the PCT promptly if there are significant supply issues in obtaining any of the medicines on the palliative care drugs list

For Further Details Contact:

Margaret Hook , Principal Pharmacist St Peters Hospice Bristol ***MHookPharm@aol.com***, Mobile: 0710285958

Sharing Practice Example 10

Medicine Supplies in Rural Areas/Ambulance Trust led

Where: South West Ambulance Trust

Service co-ordinated and run by the ambulance trust with robust processes forstock control, top up and supply of medicines. Excellent medicines stock and protocols on vehicles – these vehicles are strategically placed across counties.

Innovative extended roles for drivers – they are also involved in re-stocking provider bags and cars.

For Further Details Contact:

SW Ambulance Trust Sue Oakley, Pharmacy Adviser South West Ambulance Trust, Tel: 07867 926928, ***Sue.oakley@swabt.nhs.uk***

5. See

Sharing Practice Example 11

Re tendering Out-of -hours services

Where: Sefton PCT / Sefton Provider Services

In 2007, decision was taken by PCT Board to respecify a whole Sefton service covering medical services, triage, call handling and interaction with walk in services.

Provider response was to establish a small tender team, used a project approach to the tender response dividing areas up into workstreams. Largest element was the clinical model and governance arrangements.

Integrated delivery structure utilises first contact practitioners, and has seamless pathways that deliver Unscheduled Care with the Out-of-Hours Service being a single point of access. The whole team is exclusively dedicated to Sefton and the needs of its patients.

For Further Details Contact:

E-mail: ***Alison.Shaw@sefton.nhs.uk***; Director, NHS Sefton Provider Services.

Sharing Practice Example 12

Pharmacist managing patients within A/E department

Where: Pharmacy Dept / A&E St Thomas' Hospital, London

Developed explicit criteria to identify accident and emergency patients suitable for management solely by a pharmacist. Conclusion of their study showed that a pharmacist could treat at least 2% of adults presenting at the study hospital A&E department. This excludes 3% of patients with minor ailments currently well managed by nurses in the study hospital. A pharmacist working in this A&E department could treat an estimated 5,854 patients annually. Incorporating a pharmacist within the team may alleviate the workload of emergency staff and could potentially reduce waiting times.

For Further Details Contact:

Ms Collignon at Pharmacy Department, St Thomas' Hospital, Lambeth Palace Road, London SE1 7EH
E-mail: ***ursula.collignon@gstt.nhs.uk***

5. See

Sharing Practice Example 13

Collaborative ownership of central extended hours pharmacy

Where: Sheffield

29 local pharmacies are shareholders in a central, extended hours pharmacy. Services provided include: evening deliveries, emergency supplies, palliative care medicines, emergency planning support, EHC, minor ailments. Uses a hub and spoke model to share stock and resources

For Further Details Contact:

Martin Bennett, Managing Director Associated Chemists (Wicker) Ltd
E-mail: ***martin@wicker.co.uk***

Sharing Practice Example 14

Innovative ways to reorder repeat medicines

Where: Worthing, Digi TV – Kirklees Council

Improving access to repeat medicines during day time hours can have a significantly positive impact on requests subsequently made to out of hours services. The following represent some innovative ideas to improve daytime services.

My Repeats have won the business innovation award from the Pharmacy Business Award. Myrepeats.com is operated by Coombe Care Ltd. It a service available to pharmacies to enable their patients to order their prescriptions online. Their objective is to improve prescription services for all patients by making them more accessible, timely and patient friendly.

DigiTV is a not-for-profit service run by local government for local government, so if you are investigating digital interactive TV or mobile phone services for your organisation, then you have found the right site. DigiTV can help you further understand, pilot, launch and successfully run citizen-focused services on these new channels.

If you need additional assistance please contact the DigiTV helpdesk on 0845 434 8540 or investigate the ***DigiTV Wiki***, which has a range of useful documents about the project.

For more information about Repeat Dispensing visit:
http://www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Prescriptions/DH_4000157

For Further Details Contact:

My Repeats.com ***http://blog.myrepeats.com/***
Digi TV: Guy Giles Operations Manger DigiTV, Tel: 07973 909 663 or visit:
http://www.digitv.gov.uk/site/component/option,com_contact/catid,12/Itemid,70/

5. See

B. Palliative Care Practice examples Index

5. See

Palliative Care Practice Example 1

'Concern' Proformas

Where: Fylde Coast Medical Services Whitegate Drive, Blackpool, Lancashire

Provision of seamless information between the Out-of-Hours service and all other health professionals involved in their in-hours care on any patients causing concern.
Any member of the Out-of-Hours team who sees patients who give cause for concern (particularly palliative care patients) fills in a simple proforma (half A4). The proforma, which contains details of the patient's own GP and surgery address, is faxed or downloaded directly to the Fylde Out-of-Hours office, where it is entered on the Adastra system (This software programme is able to keep a record of every patient, phone call, clinical interventions etc that the Out-of-Hours service deals with). At 8 am every morning, a fax is sent to every GP surgery named on any of the proformas collected that night, with details of any interventions, why the health professional is concerned, and any instructions that have been left with the patient or carer – e.g. to contact the GP in the morning.

For Further Details Contact:
FCMS (NW) Ltd.; ***Helen.sherrington@fcms.nhs.uk*** Director of Operations for Unscheduled Care or Vicky Storey – Deputy Operations Manager – Out-of-Hours Service. Tel: 01253 308115, E-mail ***Victoria.storey@fcms.nhs.uk***

Palliative Care Practice Example 2

Multidisciplinary Palliative Care Training for all OOH staff

Where: North Durham Out-of-Hours Service and Peterlee Community Hospital/Urgent Care Centre, Easington

For Easington PCT, the lead GP (Robin Armstrong) initially provided a series of teaching sessions to GPs who worked in the Out-of-Hours period. These sessions focused on;
• How the Out-of-Hours service operated
• What the service expects
• Out-of-Hours interaction with the walk in centre
• Drug information (categories of drugs used, doses, method of administration etc); and
• End of life care pathway in palliative care.
These teaching sessions have now been delivered to all GPs in the PCT and all GPs working for Primecare (the contracted Out-of-Hours provider). It was subsequently extended to all DNs, palliative care teams and any other health professionals who deal in palliative care. Each member of the team attending the course receives a training booklet on palliative care. This booklet is also provided in every Out-of-Hours car undertaking visits in the community, any new GP packs and in the urgent care centres.

In Durham, Dr Lindsay Crack (Palliative Care Consultant at Durham District Hospital, the local hospice and Marie Curie), pioneered a training course for palliative care for GPs and other health professionals, who deal with dying patients Out-of-Hours. The course was developed because GPs expressed concern at their lack of knowledge and understanding of palliative care, particularly when they were responsible for the medical cover for these patients. The area had no funding for consultant cover at the hospice, PCTs were in the process of re-organisation and there had been some clinical incidents. Thus the GPs themselves asked for extra training. The course is now being rolled out to all health professionals who deal with palliative care patients and there is a waiting list.

For Further Details Contact:

Durham: Berenice Molloy, Head of Non Elective Care, County Durham PCT, Tel: (0191) 301 1300: ***Berenice.Molloy@durhamclspct.nhs.uk***
Easington: Sandra Sah, Service Manager Out of Hours and Urgent Care.
Tel: 0191 5876036, e-mail ***Sandra.sah@cdpct.nhs.uk***

The Palliative Care Team led by Kay Macalindan, Tel: 0191 586 2426, and
Margaret Tennant, Tel: 07766 901168 (mob), E-mail ***Margaret.tenant@cdpct.nhs.uk***

Palliative Care Practice Example 3

Proactive updating of vulnerable patient records/Dedicated Phone number for carers

Where: Huddersfield PCTs & Local Care Direct, Longbow Close, Dyson Wood, Huddersfield, Yorkshire, Warrington Out-of-Hours Service

There is a real drive and commitment by Huddersfield PCTs to ensure that any palliative patient is identified as soon as they are diagnosed, and that GPs, district nurses or specialist nurses etc have their contact details and needs recorded on a detailed proforma, a copy of which goes to the Out-of-Hours Centre where it is stored in a both paper file and on computer. A specially employed member of staff checks and updates this information weekly, liaising with GPs and primary care teams.

Involvement of the Local Practice Managers network was instrumental in the initiation of the service.

All health professionals give the patient and carer the same, dedicated telephone number, reinforced at every visit, for them to ring if they need help. Should the patient or the carer ring the number, it goes through to the Local Care Direct call centre and flashes red on the screen. All call staff have all undergone a training course on dealing with palliative call patients and understand that these calls must be passed quickly to the nurse or doctor, who is always on duty.

The standard of just 5 minutes to answer, pass and have the qualified health professional answer is regularly audited and anyone failing this target is retrained until they comply. Should the patient or carer need a visit, the visiting teams aim to reach the patient's home within 20 minutes. All the visiting cars have a secure controlled drug box in the boot of the car, which contains all palliative care medication from a standard formulary.

Warrington: Proactive scheme whereby nurses keep palliative care and complex patient details up to date weekly.

For Further Details Contact:

Rebecca Kilburn, Operations Manager Additional Services, Tel: 01484 487267 or Mobile: 07717 677095

Warrington: Matthew Cockcroft Pharmacy Manger/PEC pharmacist Warrington Co-op, ***matthew.cockroft@coop.co.uk***

Melissa Burgess, Head of Medicines Management, Warrington PCT, Tel: 01925 843785, ***Melissa.burgess@warrington-pct.nhs.uk***

Sheila Williamson – Interim Project Support Unscheduled Care, Warrington PCT, ***Sheila.williamson@warrington-pct.nhs.uk***

Palliative Care Practice Example 4

On Demand Availability of Palliative Care Drugs – Pharmacy Local Enhanced Service

Where: Calderdale PCT

The pharmacies participating in the service will stock a locally agreed list of medicines and will make a commitment to ensure that the users of the service have prompt access to these medicines, in response to the presentation of an NHS prescription, during all the pharmacies contracted opening hours.

The pharmacist ensures that in date minimum stocks of all the drugs are available at all times. This stock is held separately or distinct from normal dispensing stock and a system devised to identify the medicines as needed for the palliative care drug service.

For Further Details Contact:

Ruth Buchan ***ruth.buchan@calderdale-pct.nhs.uk*** Medicines Management, Calderdale PCT, 4th Floor, F Mill, Dean Clough, Halifax HX3 5AX, Tel: 01422 281300

5. See

Palliative Care Practice Example 5

Palliative Care Drug Stocks in Pharmacies

Where: Birmingham North & East, Heart of Birmingham, South Birmingham, Solihull, Sandwell Worcestershire , PCTs

Pan Birmingham network of 63 pharmacies holding an agreed list of palliative care medicines for out of hours and in hours supply. OOH services also hold palliative care medicines stocks.

Community Pharmacy Palliative Care Network

- Sixty five community pharmacies guarantee holding the listed drugs. Pharmacies involved include those open until 11pm seven days a week.

Out-of-hours providers

- Out-of-Hours providers guarantee holding stocks of drugs included in the national Out-of-Hours formulary.

Acute hospitals

- Two hospitals will dispense urgent primary care prescriptions for palliative and end of life prescriptions 24 hours a day, seven days a week.

The Badger Out-of-Hours Service: Badger encourages GP practices to send notification of patients requiring palliative care so doctors handling their calls are aware of their needs. For more information about Badger see: ***www.badgermedical.org.uk***

For Further Details Contact:
Abi Jenkins, Network Palliative Care Pharmacist, Birmingham, Tel: 0121 507 4481, Tel: 07766 221983, E-mail: ***abi.jenkins@nhs.net***

Palliative Care Practice Example 6

Access to pre filled Syringe Drivers and Diamorphine/Using 100 hour pharmacies

Where: Manor Pharmacy Aseptic Dispensing Unit; Bristol PCT

Manor Pharmacy Aseptic Dispensing Unit winner of ABPI Pharmacy Awards 2007. British Pharmaceutical Conference. Provide aseptically prepared pre-filled syringes for palliative care, succeeds in integration of community pharmacy into the palliative care team.

Additional list of palliative care drugs that only 100 hour pharmacies stock – Bristol PCT.

For Further Details Contact:
linda.ferguson@manorpharmacy.co.uk Business development manager or David Evans W R Evans Chemist, Tel: 0115 951 2110.
Bristol PCT Medicines Management Team, Tel: 01179 003416.

5. See

Palliative Care Practice Example 7

Anticipatory Care and Just in Case Boxes

Where: Staffordshire; The Peace Hospice, Mount Vernon Cancer Network; Durham PCT

Staffordshire: Pharmacies and dispensing practices linked to GP practices participating in the Gold standards framework supply a pack of palliative care medicines to patients at a time identified by the practice. Packs are refilled by the pharmacy and the scheme is closely audited. There is also a clinical pharmacy scheme provided to the local hospice and Out-of-Hours service.

Pharmacy rota service linked to scheme in Shropshire County.

There is also a clinical pharmacy scheme provided to the local hospice and Out-of-Hours service in Stoke on Trent.

The Peace Hospice, Mount Vernon Cancer Network: They have: Standard documentation: Best Practice Guidelines for anticipatory care; MVCN Symptom control guidelines; standard patient information leaflet;

Evaluation of Just in case boxes (2007) showed that they enabled no hospital admissions, 11 patients to stay at home (tyheir preferred place of care) used 22 times by nurses and twice by a GP.

Durham: Urgent access to diamorphine and syringe drivers Out-of-Hours keeps patients from having to be admitted to acute care. Any patient, who has a 'Just in case' drug box, also has a syringe driver (with the equipment to set it up) provided in their home. Spare syringe drivers are also provided in the urgent care centre and from the palliative care team. (Cost: £1000 per syringe driver, re usable and only required in small numbers per year).

As an interim solution, a stock of diamorphine is held at Durham acute hospital. **Licensed by the Home Office to hold stocks of diamorphine.**

For Further Details Contact:

Mark Seaton, Head of Medicines Management South Staffordshire PCT; ***mark.seaton@southstaffspct.nhs.uk*** Tel: 01889 571700

Sue Plummer, Director of Patient Services, The Peace Hospice
Mount Vernon Cancer Network, ***splummer@peacehospice.org.uk***

Durham Berenice Molloy, Head of Non Elective Care, County Durham PCT, Tel: (0191) 301 1300: ***Berenice.Molloy@durhamclspct.nhs.uk***

Palliative Care Practice Example 8

New role for Palliative carers

Where: Peterlee Community Hospital/Urgent Care Centre, Easington

Development of Band 4 carers to support the palliative care team.
The carers complete a course in palliative care and are seconded to a Macmillan nurse for 6 months. They provide personal, hands-on care to palliative care patients, and emotional support to the family. They are seen as an integral part of the Macmillan team, but also give support to the DN teams. They have had a great deal of positive feedback from carers and already constitute an experienced community of support workers.

For Further Details Contact:

Sandra Sah, Service Manager Out of Hours and Urgent Care, Tel: 0191 5876036, e-mail ***Sandra.sah@cdpct.nhs.uk***

The Palliative Care Team led by Kay Macalindan, Tel: 0191 586 2426, and Margaret Tennant, Tel: 07766 901168 (mob),
E-mail ***Margaret.tenant@cdpct.nhs.uk***

5. See

Palliative Care Practice Example 9

Joint working between PCT and local Pharmacists

Where: Walsall PCT

Scheme developed jointly between PCT in close collaboration with local Pharmaceutical Committee (LPC).
A number of community pharmacies keep an agreed stock list, participate in a rota scheme and provide advice on palliative care medicines.

For Further Details Contact:

Walsall Walsall; Dr Albert Benjamin Albert Benjamin, Medical Director, Waldoc (Out-of-Hours) Community Benefits Society.
Email: ***albert.benjamin@walsall.nhs.uk***; Tel: 01922 858000.
Telephone: 0845 8904710 (Waldoc) or Lesley Woakes, Primary Care Development Manager, Walsall PCT;
Lesley.woakes@walsall.nhs.uk, Tel: 01922 444185.

Sue Crabtree – Head of Palliative and End of Life Care, Walsall Community health ***sue.crabtree@cht.walsallch-tr.wmids.nhs.uk***

Palliative Care Practice Example 10

Macmillan knowledge Sharing Project and Out-of-Hours Toolkit

Where: We are Macmillan Cancer Support *www.macmillan.org.uk*

Macmillan Out-of-Hours Toolkit has four sections supported by examples good practice references and downloadable resources :
• Communication and co-ordination of care
• Integrated working and access to medicines
• Education resources for Out of Hours care
• Resuscitation guidance and policies

For Further Details Contact:

Lorraine Sloan@macmillan.org.uk; Dr Rosie Loftus, ***rloftus@macmillan.org.uk***; secretary, Kay Cannon, Tel: 01634 223109;
kay.cannon@nhs.net

Palliative Care Practice Example 11

Non medical prescriber support to palliative care

Where: Pan Birmingham Palliative Care Network

Out-of-Hours provider and local hospice have several non medical prescribers that cover palliative care.
Out-of-Hours Provider keeps agreed list of palliative care medicines as well as 100 hour pharmacy that supports Out-of-Hours service.
Local hospice supported well through informal arrangement with local pharmacy.

For Further Details Contact:

Melanie Young, Pan Birmingham Palliative Care Network Manager, Tel: 0121 414 8253, Mobile: 07773 774412
E-mail: ***melanie.young@westmidlands.nhs.uk***
Zoeta Brown, Deputy Manager/Service Improvement Facilitator, Tel: 0121 414 8253, Mobile: 07973 411756
E-mail: ***zoeta.brown@westmidlands.nhs.uk***

6. Useful information sources and links

a) Where can I Go for Help

Follow the links highlighted in this toolkit for more information. If you have used another tool, web site or resource during this process that was particularly helpful or useful – tell us about it and we will add to the website and toolkit for others to use

Visit the Medicines Management Network NW website for more information ***www.mmnetwork.nhs.uk*** – here you will be able to find all the websites, background documents listed, shared practice, documents for downloading and sharing blank template proformas

Can't find what you are looking for?

Ask a question on the Medicines Management Network Urgent Care Medicines Forum ***http://www.mmnetwork.nhs.uk/forum/?fid=1*** or make contact with one of the leads highlighted in a shared practice example for more information or help

Having trouble getting in touch with someone, want some help finding other examples or want to share your own experiences? Then Contact Julie or Hannah at the Medicines Management Team – Tel 01772 647016
julie.feeney@northwest.nhs.uk; ***Hannah.dirania@northwest.nhs.uk***

Would like specific help with patient involvement

Contact the Centre for Involvement for bespoke help if you are having difficulty finding a local PPI representative to help you with patient involvement: ***Jayne.Taylor@warwick.ac.uk***

That hasn't helped

If you are still having problems we may be able to provide face to face discussions, site visits, conflict resolution, expert advice specifically tailored to your own organisation or locality. If you would like the Medicines Management Network NW to help you or do your diagnosis exercise for you then please visit our website for a list of available services and prices – ***www.mmnetwork.nhs.uk***. Or alternatively complete the email ***enquiry form*** and one of our team will call you back to discuss your specific requirements

And finally two important tips for success …

- Involve lay people in the process of diagnosing the problems and at any and every opportunity draw on data about patient experience
- Don't be afraid to commission the service to look exactly the way you want it too – challenge current boundaries and use the flexibilities of health professionals' skills and contracting methods to contribute positively to a quality service rather than have them define the processes for you

Appendix One

Medicines Context and Policy

1. The original ***Carson review (2000)*** recommended that all providers of out-of-hours services should ensure that, where the individual needed to start a course of medicine without delay (whether because delay would compromise care or for pain relief), they should provide the full course of the relevant medicine at the same time and the same place as the consultation. This recommendation was developed fully in ***Securing Proper Access to Medicines in the Out-of-hours period***, guidance which was published at the end of 2004.

2. In essence, the later policy guidance and associated legal directions set out a new principle in respect of the supply of urgent medicines to patients in the out-of-hours period, namely that responsibility for ensuring that patients are supplied with the medicines they need rests with the provider and not the patient (or their carer). In practice, this means that at all those times when the local community pharmacy is closed, the service provider should make alternative arrangements to supply the medicines at the same time as the consultation – regardless of whether that consultation takes place in a centre or in the patient's own home.

3. Moreover the guidance emphasised that exactly the same principle should be applied in meeting the needs of those patients who had chosen to die at home, where problems in accessing medicines (especially controlled drugs) had historically been one of the key factors that led to inappropriate and unwelcome admissions to hospital.

4. In 2003, ***NHS24*** in Scotland found that 5% of all their calls related specifically to medicines and that a further 6% of all calls involved the nurse providing medicines advice. When this audit was repeated in April 2005 – the new figures estimated that 15% of calls related specifically to medicines and 30% of calls involved the nurse providing medicines advice.

5. The sense of 'unfinished business' was reinforced in a number of surveys of patient experience of out-of-hours services, where patients invariably report ongoing difficulties in securing the medicines they need. In 2006 the ***National Audit Office*** and ***Which?*** reports on out-of-hours services for the first time demonstrated evidence of variations in the quality of service provision which was subsequently, re-enforced by three large providers using a new Out-of-Hours patient experience questionnaire – they reported that access to medicines was the single most important shortcoming in current service provision.

6. In November 2007 access to medicines was one of the key areas highlighted for further work in the ***DH 'Urgent care update'*** Key areas highlighted by the Direction of Travel consultation and other work. Though existing guidance was already available, the evidence was that there were three issues that continued to be a concern: prompt and easy access to medicines when needed; the ability of other practitioners to supply medicines and/or administer drugs; and securing access to urgent repeat medicines. Further specific advice and information on access to medicines was therefore made available in November 2007 – ***Delivering urgent access to medicines outside 'normal' hours Notes for Commissioners and Providers***

7. Most recently, in September 2008, a service review of urgent and emergency care by the Healthcare Commission – '***Not just a matter of time'*** A review of urgent and emergency care services in England found that only 29% PCTs scored well in all respects of commissioning services which ensure the range of drugs available meets local needs and reflects good prescribing practice. One example was that 39% of areas were not able to supply all the items listed in the National out-of-hours formulary set by the Department of Health.

Appendix One

Familiarise yourself with the key messages outlined in the list of relevant medicines policy below

1. Raising standards for patients. New partnerships in out-of-hours care, Department of Health, October 2000.

   http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007133

2. Delivering the Out-of-Hours Review. A practical guide to Securing Proper Access to Medicines in the Out-of-Hours Period, Department of Health, December 2004.

   http://www.mmnetwork.nhs.uk/med-out-resources.php

3. The Provision of Out-of-Hours Care in England, National Audit Office 2006

   http://www.nao.org.uk/publications/nao_reports/05-06/05061041.pdf

4. Which Way? Negotiating the out-of-hours maze. Campaign Report, Which?, London, 2006

   http://www.which.co.uk/press/press_topics/campaign_news/health/out_hours_care_july_06_571_89195.jsp

5. Urgent care update Key areas highlighted by the Direction of Travel consultation and other work". November 2007

   http://www.dh.gov.uk/en/Healthcare/Urgentcare/index.htm

6. Delivering urgent access to medicines outside 'normal' hours. Notes for Commissioners and Providers, November 2007

   http://www.mmnetwork.nhs.uk/Delivering_urgent_access_to_medicines_outside_normal_hours.pdf

7. Not just a matter of time A review of urgent and emergency care services in England

   http://www.healthcarecommission.org.uk/_db/_documents/Not_just_a_matter_of_time_-_A_review_of_urgent_and_emergency_care_services_in_England.pdf

Appendix Two

Case Studies – Whole system Urgent Care Services

Case Studies – Whole system Urgent Care Services

The following case studies are all real events and people. They can be used as part of a service review, redesign, problem solving or training event. To obtain printable versions of these case studies ***click here***.

A workshop programme timetable and plan is also available to download on: ***www.mmnetwork.nhs.uk***

For each case study discuss in groups and describe:

1. The general faults in the system
2. What general improvements could be made in the system in terms of access, assessment and response?
3. What are the specific roles and services that pharmacists, and community pharmacies, could play in your locality to improve urgent care services? Use the following headings to group:

1. Case Study – Jane

Jane, a young 15 year old, and her 17-year-old boyfriend made a 20-minute bus journey to the local A&E department to try to get the morning after pill. They had a two-hour wait in A&E to be told that they should go to the local pharmacist.

Not wanting to go back into their own locality, they walked from the A&E department to a pharmacist, which was a quarter-of-an-hour away, only to be told that they should contact their own local GP.

Not having her GP practice telephone number with her, they then returned home by bus to find out the telephone number of her GP. She phoned her GP to be told on an answer machine that the surgery was closed and, that if she still required to speak with a GP, she should ring the Out-of-Hours service that was operating for their GP service. She diligently rang the Out-of-Hours GP service and was told to come down to the Primary Care Centre where she would be seen by a GP.

She returned to the bus stop and got on the same bus that she had travelled back home on. She got off at the same bus stop that she had done before to go to the A&E department. She arrived at the Primary Care Centre and was seen within 10 Minutes by a GP and given a prescription for the morning-after pill. She took the prescription to the Pharmacy and was served by the same pharmacist who had spoken to her two-and-a-half hours earlier.

This whole experience had taken the whole of the bank holiday Sunday from 10.30 in the morning to 5.0 pm in the afternoon.

The GP who saw her at the Primary Care Centre said that it was a good job that the young woman had the determination and peace of mind to work through the services and not be put off by it. Had she not done this, the end result could have been a teenage pregnancy.

Appendix Two

2. Emily's story

Emily was diagnosed with a brain tumour in August 2002 aged 24. She was a chiropodist who managed her medication herself for many weeks, except when she had severe relapse in symptoms or when a syringe driver was needed. This happened three times between September 2002 and February 2003, at which times she was entirely dependant on her mother and father as carers. This is the story of the weekend when things went wrong.

Friday Afternoon – syringe driver set up by district nurses attached to Emily's GP practice.

Saturday morning – dose of analgesia increased; dexamethasone started as per chart by Macmillan Nurses. Saturday midday – Emily's condition worsened, OOH on-call centre phoned. No record of Emily, her condition and no notes available. On-call centre phoned hospital ward for more information – skeleton staff no information available. On-call duty doctor visited, by which time Emily had settled a little, so no action was taken; doctor asked for a report at 6pm.

Saturday 2 pm – Emily becomes very distressed, doctor contacted again who visited at 6pm and gave an injection of midazolam and left a prescription for one vial (prescription unused). No information given to parents about Emily's condition. No repeat visit or follow up arranged; doctor said he would leave message with twilight nurses.

Saturday 10pm – Emily's condition had again deteriorated and she was in much distress. On-call centre phoned – parents asked to phone back as doctor's shift was changing– delay. Decision taken that more midazolam needed.

Saturday 12pm – New on-call doctor still trying to locate midazolam. Some found at a local hospice. Father was asked to drive there to collect supply. He was left alone in a dark corridor where he could hear staff discussing Emily. After 30 minutes, he was told he was not authorised to carry drugs so was asked to return home. Emily still very distressed.

Sunday 1am – doctor arrives with drugs, having driven to the hospice to collect them himself.

Sunday 2am – Emily settled

Sunday 10am – Carers planned for needing more midazolam over Sunday into Monday morning. They phoned the on-call centre and the doctor arranged a prescription. Carers drove to collect the prescription and & also contacted several pharmacies to make sure that they were open and had stocks available (no one had enough to fulfil whole prescription) Back in time for the week-end duty district nurses to administer an injection and recharge the syringe driver. Emily now needed more pain relief. Nurses reluctant to increase dose without authorisation, said: *'Let's see how she goes until tomorrow morning'*, Nurses left.

Sunday midday – Carers phoned on-call doctor who wrote prescription for increased pain relief dose. Carers drove to collect the prescription and then to a different pharmacy to collect medicine (full amount not available). Father returned home and telephoned on-call centre for someone to administer pain relief. Sunday 2 pm – duty doctor and district nurse returned to administer increased dose of pain relief. Emily remained comfortable from this time until Monday morning when her GP practice resumed care.

Comments from Emily's parents

"I am sure you will appreciate that as Emily's parents we found her condition absolutely heartbreaking, especially as we were helpless, unable to comfort her, let alone make her more comfortable. We relied totally on the medical system to provide relief from pain & sickness etc. We want to let people know what happened to us, so that we can help prevent it happening to others".

Appendix Two

3. Case Study – John and Mary

John and Mary are both in their 80s. John suffers from Alzheimer's and depends on Mary for all his personal care. Both take a wide range of medicines. The extended family has tried, without success, to persuade John & Mary to have some help in the home.

At 09.15 on a Saturday morning the duty GP contacted the Social Services OOH Duty Manager seeking assistance. He had visited John and Mary following a call from a neighbour. Mary had collapsed with chest pains and he was making arrangements to admit her to hospital. There was nobody able to provide immediate care for John. OOH Duty manager agreed to arrange a community care assessment, but had to advise that there would be some delay as his only worker on duty who was trained in this area was currently committed to another matter at the local custody suite.

At 11.30 the duty social worker attended the home to be greeted by angry neighbours and find that John had apparently wandered off. She spent the next 45 minutes looking for John before calling the police & reporting him as a missing person. The duty manager withdrew the social worker to deal with another urgent call at 14.00. The police located John at 15.30 in a local shop after he had sought to obtain goods without having the money to pay for them. They returned John home and again relied upon the diminishing goodwill of the neighbour to look after him until the social worker returned at 18.00.

Once the social worker was able to assess John she arranged for him to have an emergency placement at a residential home, although there were delays because of the non-availability of the home manager who had to confirm funding arrangements. John eventually arrived at the residential home at 20.30, more than 11 hours after the GP had advised Social Services of his urgent need for alternative care.

4. Dorothy

Dorothy is 84; she lives alone in her own home with no close family. She has lots of professional support: GP, Consultant, Community Psychiatric Nurse, Support worker, plus daily care from social services. She is private & independent and generally in good health except for chronic severe anxiety which has responded well to antidepressants. Medicines are currently the main support to enable her to be in her own home; if she stops taking her medication she does not eat or take care of herself.

At 09.15 on a Saturday morning the duty GP contacted the Social Services OOH duty manager seeking assistance. He had visited Dorothy following a call from a neighbour. As there was nobody able to provide immediate care for Dorothy, the OOH duty manager agreed to arrange a psychiatric assessment but had to advise that there would be some delay as the CPN on duty was currently committed. At 11.30 the duty social worker attended the home to be greeted by angry neighbours and to find that Dorothy had wandered off. Her condition had deteriorated so badly that she had to be sectioned and admitted to the psychiatric unit.

Despite all the professional support, no one was actually sure whether she was taking her medicines or not (in fact she was not). No one took responsibility for this. A local pharmacist provided a monitored dose system to try to help her comply. After 2 months in-patient stay on regular medication she became much better and was discharged home to her GP with a care package. A medicine reminder chart was set up whereby carers come to the flat every day to prompt Dorothy to take her medicine.

Three months later, at 10.30 on a Sunday evening, a neighbour contacted the OOH centre because she was concerned about Dorothy's behaviour. A duty doctor visited and found that Dorothy's condition had again deteriorated to such an extent that she was again sectioned and admitted to hospital.

On further investigation into the reasons for this admission, it was discovered that when the carers came into the flat to remind Dorothy to take her medicines this prompt took the form of - 'Have you taken your tablets Dot?' 'Yes Love', she would reply, and they recorded in their book that the medicine had been taken. If these episodes continue Dorothy may no longer be able to live in her own home and may be forced to live in residential care.

Appendix Two

5. Interview B April 2008

We had a lady who had terminal cancer and she was in horrific pain through the cancer in her bones, and she was bedridden, and we needed these drugs to make her comfortable.

The palliative care doctor came out and she said we needed these drugs. We had to contact her local GP who didn't help us at all, and actually said it wasn't his problem. He said that we should have gone back to the consultant, and had a prescription from her, which I thought was really wrong when we're dealing with someone who is in severe pain. This person was given 24 hours to live, and we wanted to make her as comfortable as possible and pain-free.

So we were given this prescription and myself and a carer went in my own car, we went all the way round [town] to see if we could get these end of life drugs…The doctor had just visited, and he gave us this prescription…We said "Where would we get these kind of drugs?", because they were quite high power drugs that are really not the norm of the medication that we get for our residents. So we went round [area], and this was about five o'clock.

We visited all the local chemists and none of them stocked this drug. Then we were in a position where I was concerned that the patient was in severe pain. So we went to the local hospital at the [hospital] and they had to get a consultant to rewrite the prescription so they could dispense it at their hospital…This was up till, I think, nine o'clock at night…And this person had been in pain for, what, four to five hours or more. Screaming out, and I don't think that was correct.

I think the procedure was correct that the doctor should have actually given her something. Then we had a problem with the twilight nurses came out, and they weren't comfortable about giving this medication…They're the district nurses who actually support the home…And what happened there was they weren't comfortable about giving the drug because the doctor hadn't signed something…It was very high dose morphine, and because it was the dosage that was of concern that we were giving this patient, the nurses weren't comfortable about this…

We tried to contact the out-of-hours doctor, who also wouldn't help us. He felt that it was the doctor before, who had prescribed the medication. But as we tried to explain, that doctor had gone home. So someone has to take responsibility, so then he came out and he had to also come out and see everything and look at the drugs and all our notes and then he decided that it was okay, and then he wrote on the nurses' form, you know, this is the protocol to follow…

People don't want – people are all about covering their backs, and making sure this patient was comfortable, and to me, it failed in that line…At the end of it, after all that, after many hours – I can't remember, I think it must have been five, six hours, seven hours at the most – we finally gave this patient her medication and she was comfortable. And sadly she passed away the next day.

Account from stakeholder (Interview B) at a Care Home

Appendix Three

Helen Allanson – Director Medicines Management NW
BSc (Hons), Registered Pharmacist -MRPharm S, Diploma in Prescribing Science

Helen is a qualified pharmacist with over 20 year's experience of working in the NHS in strategic roles with a variety of organisations and partners. She is an enthusiastic and determined professional with the ability to think and work strategically. She has effective listening and communication skills with the ability to negotiate successfully without causing confrontation. Gaining the support and commitment from clinicians and managers is one of the most important factors in improving quality of care - Helen has achieved much through building good relationships, and encouraging others to do the same. She is very experienced at communicating with people at all levels within and outside the NHS and has built up and maintained an extensive network of contacts.

Since 2000, Helen has been the National Lead on Medicines Supply Out-of-Hours, She led the development process and authored the formulation, publication and enabling of National Policy and associated Legal Directions for "Securing Proper Access to Medicines in the out-of-hours Period;" DH December 2004 and co-authored "Delivering urgent access to medicines outside 'normal' hours: Notes for Commissioners and Providers" (as highlighted in DH Urgent care update November 2007).

Helen is currently the Director of the Medicines Management Network North West (***www.mmnetwork.nhs.uk***) which provides leadership, assistance, advice on all aspects of medicines management, connecting together policy themes to facilitate service improvement, development and system reform across health communities and networks (NHS and external).