



U.K. Psychiatric Pharmacy Group

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August 3, 2005

By email: robert.clayton@rpsgb.org

Dear Robert

Re: Discharge planning – moving patients, moving medicines, moving safely

Thank you for your letter of 13th July 2005 inviting comments from the United Kingdom Psychiatric Pharmacy Group on the above document. Unfortunately the document arrived very late and consequently our response is rather limited.

1. We would like to congratulate the working party on producing such a comprehensive report
 - a. The examples of good practice in appendix 7 and the templates in Annexe A through H could be especially useful if made available in an electronic format
2. The report is very long and detailed. We would hope that a useful summary document can be produced to highlight simply and effective multi-disciplinary solutions. The current document summary does not achieve this. We believe the Quick Reference Guides produced by SIGN could be a more effective model for this report.
3. As the policy context highlights, there is much written about the need for good discharge planning and communication. We would strongly encourage that the Society to use this report to produce a meaningful change. This will require a true multi-disciplinary effort otherwise the risk remains that a similar report in 10 years time will uncover a similar picture.

"Promoting better pharmaceutical care for people with mental health needs"

4. Despite the policy context and much good work nationally, we note that there are very few examples of mental health issues or good practice (see point 15, below) from the mental health field in the report. The National Service Framework (NSF) for Mental Health is not described at all. In this NSF:
 - a. while few specific mentions are made of medication at discharge the themes of discharge planning and the need for effective medicines management are recurrent through the report
 - b. the specific risks associated with discharge of mental health service users are described
5. Patients using mental health services generally have much longer stays on psychiatric units. This leads to more changes in the medication regimen increasing the need for good communication. This lends itself less well to one-stop dispensing practices.
6. The use of pre-discharge leave at the end of the admission further complicates matters. Patients may attempt to obtain medication from primary care whilst still, in name at least, an in-patient. At this stage GPs are unlikely to have detailed information further compounding the errors that can arise.
7. Anecdotally, a source of error in GP surgeries may be the inappropriate delegation, for example to unqualified secretarial staff, of some tasks, including reading and transcribing discharge letters & their advice to the practice computer system. Some novel approaches have been considered where these staff groups are given training in understanding discharge letters to improve the accuracy of the changes they make to patients' prescriptions on the practice computer system.
8. There is confusion when secondary care continues the supplies of some medications, for example atypical antipsychotics, anti-dementia medications and some antidepressants. This is further compounded when a variety of secondary care mental health services can support a patient, for example day hospitals, intensive home treatment teams, assertive outreach. The results can be that
 - a. patients access duplicate supplies of their medication from primary and secondary care
 - b. patients may not be able to access monitored dosage (MDS) systems when their mental health and physical medications are separately dispensed by secondary and primary care respectively. An example of a medication restricted to secondary care could be clozapine and in some areas atypical antipsychotics or anti-dementia medications.

These levels of complexity confirm the need for effective and simple communication.

9. Key message, page 36: Many trusts, but particularly mental health trusts, do lack the resources to institute pharmacist led discharge and other pharmacy lead schemes described in this report.

- a. It is a key theme of this report & it's recommendations is that pharmacists should unilaterally handle the majority of tasks relating to discharge and effective communication.
 - b. The working party needs to consider if this proposal is realistic recognising the current pharmacy workforce, recruitment & retention problems. It is unclear what the impact of Agenda for Change will be.
 - c. The working party should consider widening the recommendations to at least include suitably qualified clinical technicians and members of the wider pharmacy team, and preferably make the responsibilities multi-disciplinary.
10. Action plan, page 40 - point 5: Patients Own Drugs (PODs) are not always appropriate in mental health particularly as failure to comply is a common cause of admission.
 11. Action plan, page 40 - point 6: Self-administration needs to be carefully considered and would be inappropriate in certain cases.
 12. Supplying patients with large quantities of medication may be outside the DOH - National Suicide Prevention Strategy which recommends patients with a history of self-harm in the last 3 months receive no more than 2/52 supply of medication.
 13. Action point 7, page 40: Evidence from a Canadian study suggests that community pharmacists may lack the necessary skills to engage clients with mental health issues.
 14. Action point 9, page 41: There may be a need for different approaches for acute and mental health trusts when planning publicity for patients and practitioners.
 15. Within appendix 7, Good Practice examples, we are aware of
 - a. the Gloucestershire Royal NHS Trust, an acute hospital supplying the local mental health trust. Pharmacists on some wards complete the discharge prescriptions electronically which are then sent to pharmacy for dispensing. The electronic record of the patients' stay also has the doctor discharge and patient discharge information. These electronic records are faxed to the patients' GP within 24 hours of discharge. Consequently: patient information arrives within 24hrs of discharge; the patient record is updated; medication discrepancies are prevented. Contact is the clinical pharmacy manager, Mr Nick Butler.
 - b. the work of Diane Harris and colleagues
http://www.pjonline.com/ijpp/bpc2001/ijpp_bpc2001_r67.pdf
 - c. work funded through the Changing Workforce Programme and NIMHE on redeveloping the delivery of pharmacy services in mental health. Steve Manders has coordinated this SPREAD funding and would be able to give you some examples of good practice from these projects.

We hope that these comments are of use to you in finalising this report. We would be glad to contribute to further discussion if that would help you.

Yours sincerely

A handwritten signature in black ink that reads "Graham Newton". The signature is written in a cursive style and is underlined with a single horizontal line.

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Chairman, United Kingdom Psychiatric Pharmacy Group