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NHS Somerset

Minutes of the **Somerset ICS Medicines Optimisation Committee** held via Microsoft Teams, on **Wednesday, 12th October 2022.**

Present:	Dr Andrew Tresidder (AT)	Chair, ICB GP Patient Safety Lead
	Anne Cole (AC)	Somerset LPC
	Steve Du Bois (SDB)	Chief Pharmacist, Somerset NHSFT
	Shaun Green (SG)	Deputy Director of Clinical Effectiveness and Medicines Management, ICB
	Katie Heard (KH)	Consultant Pharmacist, Antimicrobial Stewardship (SomersetFT)
	Jonathan Higman (JH)	Chief Executive (ICB)
	Sam Morris (SM)	Medicines Manager, ICB
	Michael Lennox (ML)	LPC Representative
	Andrew Prowse (AP)	Chief Pharmacist and Controlled Drugs Accountable Officer, YDH NHS FT
	Helen Spry (HS)	Medicines Manger (ICB)
	Helen Stapleton (HSt)	Workforce Programme Manager
	Fivos Valagiannopoulos (FV)	PCN Clinical Pharmacist representative, South Somerset West PCN & Tone Valley PCN (LPC rep for independent pharm)
	Zoe Talbot-White (ZTW)	Prescribing Technician, ICB

1 INTRODUCTIONS & APOLOGIES FOR ABSENCE

AT welcomed everyone to the Somerset ICS Medicines Optimisation Committee.
The following attendees were welcomed as guest speakers:
Jonathan Higman, Chief Executive (ICB)
Anne Cole, Somerset LPC
Katie Heard, Consultant Pharmacist, Antimicrobial Stewardship (SomersetFT)
Helen Spry, Medicines Manger (ICB)
Helen Stapleton, Workforce Programme Manager Somerset Integrated Care System (ICS)

2 REGISTER OF MEMBERS' INTERESTS

The Somerset ICS Medicines Optimisation Committee received the Register of Members' Interests relevant to its membership.
There were no amendments to the Register.
The Somerset ICS Medicines Optimisation Committee noted the Register of Members' Interests.

3 DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA

3.1 Under the ICB's arrangements for managing conflicts of interest, any member making a declaration of interest is able to participate in the discussion of the particular agenda item concerned, where appropriate, but is excluded from the decision-making and voting process if a vote is required. In these circumstances, there must be confirmation that the meeting remains quorate in order for voting to proceed. If a conflict of interest is declared by the Chairman, the agenda item in question would be

chaired by a nominated member of the Somerset ICS Medicines Optimisation Committee.

There were no declarations of interest relating to items on the agenda.

4 MINUTES OF THE MEETING HELD ON 15th June 2022

4.1 The Minutes of the meeting held on 15th June were agreed as a correct record.

4.2 **Review of action points**

Most items were either complete or, on the agenda.

5 Matters Arising

5.1 Hospital at Home and medicines oversight

The Hospital at Home programme was lacking pharmacy and medicines engagement however this has now been resolved. AP is on the board and is enabling this workstream.

Initially starting with the frailty and respiratory teams, extending into heart failure and surgical patients. The number of patients on virtual wards currently around 5 or 6 per month this could increase to around 50 by March.

Teams will be based in 4 hubs across Somerset with 9 medication hubs based in community hospital locations. Medicine supply will primarily be on FP10 or a grab bag to take to a patient's home. Specialist drugs will come from YDH.

6 System Medicines Optimisation Work Stream Focus Area

6.1 Workforce update

HSt gave an update on workforce.

Much has been achieved in the year since the first summit:

- Agreed ambitious plan and workstreams needing longer term commitment and additional capacity.
- Secured one off funding from HEE and local people board.
- Established governance & workforce leadership.
- Workforce forum supported across the system and represented regionally and nationally.
- Expansion of cross-sector community/ hospital foundation trainee places. If all post filled will triple number of pharmacist trainees previously in system.
- Most PCNs involved in cross-sector PTPT training.
- 12 months funding for appointed lead pharmacist and lead technician to support the infrastructure.
- Flexible Teach & Treat IP pilot model based in primary care with funding for 2 years.

Focus for the next 6 months and beyond:

- Mobilise IP training clinics to develop services.
- Organise domestic and international attraction campaigns to stabilise vacancies.
- Agree funding for March 23 workforce programme to maintain momentum.

Comments from SIMO:

- Thanked HSt for her achievement.
- Acknowledged how much has been done but still lots to do.

- Thanked everyone involved for their collaboration on supporting this.
- The workforce coming through the pipeline has stabilised a position which can be built on
- Thanked AP for input with trainees.
- Pharmacy is the third largest registered workforce in healthcare.
- Focus going forward in next 6-18 months is supporting the frontline. Pharmacy is part of the front line in all its functions.

The programme receives full endorsement from SIMO.

Helen to meet with Johnathan to discuss how the ICB can support the programme.

Action: HSt

6.2 Antimicrobials update

KH gave an update on Antimicrobial stewardship:

- Focus on making antimicrobial stewardship a system wide approach with everyone working together.
- Stewardship works at individual, system, and population level. All three need to work in unison.
    1. Individual – Improve outcomes, prevent infection, improve diagnosis, optimise treatment, and reduce adverse events.
    2. System – Reduce associated costs, prevent admissions, increase patient flow, optimise resources, reduce antimicrobial spend.
    3. Population - Reduce antimicrobial resistance, prevent use of broad-spectrum antimicrobials, increased surveillance, optimise pathways and access, reduce inappropriate antimicrobial seeking.
- Working with AP on Hospital at Home and with GPs for early diagnosis.
- Putting patient onto orals from IV as soon as possible to optimise resources.
- Many national and local drivers for antimicrobial stewardship (DoH, NICE etc.).
- Previous measures focused mainly on consumption, however stewardship not just about consumption. Patient outcomes also need to be measured; this is being done through audits and will be the focus from now on.
- KH has been identifying staff involved in stewardship and collaborating on priorities to ensure joint working.
- Total consumption in Somerset slightly higher than average. Narrow spectrum use very low.
- Have been struggling with YDH since outpatient pharmacy took over from Boots, but this is being looked in to.
- Target for 22/23 to reduce use of watch and reserve antimicrobials. This is unlikely to be met so may need to be added to the risk register.
- Will be working closer with community mental health hospitals as consumption is high.
- Historically YDH and MHP site have run separate audits, the aim is to bring them together so it can be presented to the board and ownership demanded.
- Increasing MDTs. In 4 weeks identified 170 patients, saw 140 at least once on the wards, led to 113 interventions.
- Due to covid 80% of guidelines were out of date. All guidelines have been reviewed and screened for safety issues and extended as appropriate.

- New guidelines are being developed to promote IV-PO switch, 48-72hour review, clear course lengths
- Confusion in community hospitals as to which guidelines they should be following so this will be made clearer.
- Somerset is Benchmarking high with increasing rates compared to regional and national data. Trying to find out why this is happening
- Somerset Antimicrobial Steering Group meeting for the first-time next week since being disbanded in 2020.

HS gave an update on prescribing antimicrobials:

- There are two national prescribing indicators for Antimicrobial stewardship in primary care. 1. Number of prescriptions for antibiotics 2. Percentage antibiotics prescribed as co-amoxiclav, cephs or quinolones. Somerset compares well with other ICBs and subintegrated ICBs (SIBICBs) on both of these indicators.
- Somerset is 1 of 25 to meet both national AMR primary care prescribing targets.
- ICBs are having difficulty meeting the number of prescription items target and this is getting worse month on month, however the co-amoxiclav cephs and quinolones indicator is improving month on month.
- All SIBCLs in the South West met the two targets in 12 months to June. We achieved this through our ongoing work with GP practices and our Somerset Infection Management Guidance. Most of the guidance is national with some local adjustments made in collaboration with secondary care and microbiology.
- Made some amendments to national recommendations in response to local resistance rates and safety concerns: Pivmecillinam as an option for UTIs to reduce Trimethoprim resistance. Methenamine as an option for prevention of UTIs rather than antibiotic prophylaxis.
- We compare well on the national indicators, so have also been working on other quality improvement areas: -Reducing the repeat prescribing of nitrofurantoin because of the long term safety implications (over 30% reduction in the last year).-Reducing repeat prescriptions for trimethoprim and looking at trimethoprim use in the over 70s. -Reducing topical fusidic acid topical mupirocin. -Monitoring the use of unusual or non-formulary antibiotics. - Looking at treatment duration although this is difficult as we don't have the diagnostic coding information,
- We also work closely with secondary care. For example – Gentamicin ear drops are non-formulary but lab reports lead to prescriptions instead of neomycin. - Pouchitis antibiotics, many patients take these antibiotics for the longer term and antibiotic choices do seem to be variable.

Comments from SIMO:

- Thanked KH and HS for their presentations.
- Pleased KH has joined Somerset as the first consultant pharmacist.
- The work we do on antimicrobial stewardship is vital to keeping the system running and patients safe.
- Somerset in a good position, however highlighted areas need improvement. Overall pleased with achievement.

- Growing number of treatment resistant fungi a growing risk.
- Have shown that a collaborative pharmacy workforce can improve patient outcomes.
- Confusion around different pathology laboratory sensitivities has been flagged at a national level

6.3 SFT discharge audit and transformational programme

AT presented the SFT discharge audit and transformational programme:

- Merger of the two trusts to take place in April 2023.
- An approved pharmacy strategy document is in place to integrate pharmacy services across Somerset over the next three years.
- Currently three disparate pharmacy teams (YDH, MPH & MH) with limited collaboration.
- MPH currently the leanest pharmacy service in England & Wales. YDH close to the mean although they stopped contributing to bench marking 3 years ago.

Clinical pharmacy service

- Plans to transform the clinical pharmacy service at MPH, as currently pharmacists have limited presence on the wards, and no technicians. There is also no pharmacy involvement on patient discharge. Prescriptions go directly to primary care without any checks, this is very unusual (YDH heavily involved and manage around 8,000 discharge errors per year). When AP became aware of this, he decided to do an audit to assess the risk for patient safety.
- The discharge audit reviewed a total of 550 patient discharge summaries over one week. 66% of the discharge prescriptions required pharmacy intervention. Over a third of the discharge summaries with errors were risk assessed as medium to high risk of having the potential to cause harm.
  Examples of high-risk errors include omission of acute ABX, anticoagulants, inhalers, insulin, immunosuppressants etc. Wrong drug or dose prescribed.
  If the data was to be extrapolated, it would equate to an average of 50 errors per day with an average of 17 having moderate to high risk of causing patient harm. Total number of errors would equate to around 70,000 per year. The trust had recognised the issue but not the size of it
- Community hospital mental health wards also completed the audit. 11/37 had at least one error and most were low risk.
- The risk has now been added as a high risk to the corporate risk register for SFT.
- A business case has been proposed to mirror the model adopted at YDH which works well. It will establish 9 discharge teams across the trust, pharmacist will screen discharge prescriptions, and technicians and assistants will dispense medicines bedside. The main implementation issue will be workforce, recruiting will be in three phases starting this year for a start date in spring. Assuming funding is given the full service won't be in place until end of 2024.

Operational Delivery

- MPH is larger than YDH but has less operational hours. Looking to extend the weekday hours and introduce a clinical service at the weekends at MPH.

Pharmacy workforce development

- Working in partnership across the system to support workforce development and increase the pipeline of trainees.
- Currently only 1 preregistration pharmacist in MPH and 1 in community services, whereas YDH have 4. Next year hope to have 4 at MPH and 8 the following year. They also hope to have 5-6 preregistration technicians training at any given time.
- Supporting cross sector foundation trainee pharmacist posts between the trusts and community pharmacy. 12 joint roles for 2023 aiming for 24 in 2024. Doing similar with cross sector preregistration technicians.

Service developments

- MPH pharmacy robot is around 16 years old, usual lifespan 8-12 years. Needs replacing, a refurbishment will be needed to accommodate the new robot. Been through tender process waiting for consideration by the trust. Planned installation Spring 23.
- MPH aseptic dual isolator units need to be replaced with 3-4 individual units. A business case is being prepared.

Digital medicines

- Currently significant fragmentation in the way medicines are prescribed across the system. YDH paper charts, MPH Better ePMA, community hospitals & MH Rio ePMA. Strategy is to align to Better ePMA across Somerset.
- Development of interface between Better ePMA (secondary care) and EMIS (Primary care) for seamless transfer of patient records.
- Adopt single stock control system for MPH & YDH.

Comments from SIMO

- Sobering presentation on the discharge prescription errors and issues it creates. Congratulated AP for uncovering all of the issues and developing a plan to sort it out.
- Digital offers a lot of potential solutions. We want to get it right. Long journey around digital programme but doing at right pace with digital team's support.
- JH asked how this plan would benefit the system in a measurable way.
  -Length of stay.
  -The system is running at 115% patients rather than 100% due to readmissions. Better discharges should reduce that by a % which will be measurable.
- ML offered to discuss PCNs supporting admissions with Jess Brown in the digital team.
- Reduction of thousands of errors will free up thousands of pharmacist / GP hours.
- A community pharmacy would be shut down if they had that level of errors. Will have caused real patient harm and real workload.
- PCNs need to unify the way they deal with discharge prescriptions this would allow for better collaboration with the trusts.

- 60% of community hospital admissions are from MPH so the nursing and pharmacy teams are being impacted by the errors. Resolving this will free up resources without additional funding.
- MPH discharge prescription errors is already on the ICB risk register.

AP to share information with SG. SG to share information with quality committee.

Action: AP & SG

7 Other Issues for Discussion

7.1 Community pharmacy contract changes and emergency closures

ML updated SIMO:

- Community pharmacies are not immune to closures and are being driven by the lack of workforce.
- LPC as a leadership body are trying to help pharmacies reduce the number of closures and the impact they have.
- A toolkit has been shared by national leadership to minimise disruption of closures.
- There is a process pharmacies need to follow if they close. It includes reporting the closure and managing business obligations. LPC will support pharmacies that are doing their best to minimise and manage closures. They will also challenge the senior leadership/ ownership teams if they are not doing their best for the patients.
- NHS regional team are working on a closure policy.
- Flat funding over a 7 year deal, high inflation, medication availability issues and lack of workforce has made pharmacy a very difficult business to maintain.
- A new funding settlement needed. Payment is currently 90% prescription and 10% services. This needs to be more like Scotland and Wales with a 50% split.
- The expansion of community pharmacy through 111 online has been welcomed.
- Towards the end of winter, the two trust A&Es will be able to implement a pharmacist consultation service. This will help transfer appropriate patients from A&E back to a pharmacist.
- Community pharmacy will deploy oral contraception service from early Spring.
- Drive upskill community pharmacists as independent prescribers, to be able to provide additional services.
- In the process of recruiting a pharmacy integration lead. They will act as an enabler between the ICB and community pharmacy.
- SIMO can help by pushing for digitalisation of the medicine's agenda and continuing work on DMS and workforce.

Comments from SIMO:

- Important that we look after our community pharmacies and pharmacists.
- Face to face pharmacy contact is important in solving patient issues.
- Quality is always the cheaper option in the long run.
- Over 100 community pharmacy in Somerset across rural county high level in high deprivation levels. Continue to work together as we have done.

- Move by 2026 for all newly qualified pharmacists as Independent Prescribers (IP). The profession needs to handle this appropriately to prevent all IPs being seen as higher level. It will likely create a two-tier pharmacy profession. Many senior pharmacists won't want to do the IP course for their remaining years in pharmacy.

7.2 Digital referral to pharmacy (smoking & discharges)
-Noted

8 Other Issues for Noting

8.1 **Carbon Strategy – Standing item**

- ICB update – ICS Pharmacy Green Plans
- Trust update
- Community pharmacy update

Currently one of best in county. Everything we do has a carbon footprint. There is a lot more we can do to deprescribe and prevent harm.
-Noted

9 **Workforce**

9.1 See 6.1

10 Regional Medicines Value Work Stream

10.1 Regional Medicines Optimisation Committee Southwest– Last meeting 12/09/22

10.2 Medicines Value Steering Group (South West) – Next meeting TBC
Discussed CGM. Somerset are already NICE compliant within budget.

10.3 South West Medicines & Pharmacy Senior Leadership Group – Next meeting TBC

10.4 Somerset Antimicrobial Stewardship Committee – Next meeting 19/10/22

10.5 South West Pharmacy Governance Meeting – Next meeting TBC

11 Risks Review and Management

11.1 Medicines availability
September data showed nearly 150 generic medications in short supply so had thier price renumeration increased. Potentially additional £3 million on budget
Increasing:

- Costs and workload in community pharmacy trying to source.
- GP workload when stock not found and having to change prescriptions
- Patient harm if they haven't got their medication.

Discuss as teams to risk access, if no improvement add to register. **Action: All**

12 Any other business

12.1 Work stream proposal for the next meeting
Send ideas to SG. **Action: All**

12.2 Partners – Medicine Optimisation updates and Priorities for 2022

ICB – Priorities to March
JH outlined the plan on a page:

- A lot needs to be done over the next 6 months. Winter will be really challenging. Need to deliver the best possible outcomes over a tough winter.
- Plan on a page is to create realist deliverables and define focuses for the executives.
- Can't dominate everything we do as other areas also need to progress, especially developing capability to work as a system.
- Somerset NHS and Somerset County Council have made an agreement to move forward on simplicity. Don't want to create extra meetings. Going to use health and well-being board together with the ICB to create the integrated care partnerships.

Comments from SIMO:

- Medicines optimisation team is constantly working to improve outcomes contributing to reduction in GP and A&E attendance and readmissions while balancing the budget. Important for other member of the pharmacy family to be aware of this plan.
- Community pharmacy feel included in the new Somerset ICB, other regions have been struggling with this.

Highlight on the plan on a page where pharmacy sits most strongly and were it works in parallel, then send to SG to collate. **Action: All**

DATE OF NEXT MEETINGS
14th December 2022
22nd February 2023
26th April 2023
28th June 2023
25th October 2023