Welcome to the March 2018 Refer-to-Pharmacy newsletter.

There's been a lot in the news recently about drug errors causing harm and death and there are certainly lots of challenges facing health professionals. I've had a look at the outcome data from Refer-to-Pharmacy since we started asking the question about medication safety in March 2017.

Since then there have been **137 occasions** where the transfer of care information provided in the referrals from hospital have helped Pennine Lancashire community pharmacists to identify unintentional prescribing errors on GPs' first post-discharge prescriptions.

This highlights how, even though GPs and community pharmacists are getting exactly the same electronic discharge letter at exactly the same time, mistakes still occur; and keeping community pharmacists routinely in the loop (1,760 referrals made in Jan/Feb this year) makes a real difference.

In early February there were two *Hospital Pharmacy Transformation Programme One Year On* meetings (#HPTP1YO). I was asked to speak at the Leeds meeting about our Dedicated Ward Pharmacy project.

Keith Ridge opened proceedings and made special mention that referrals to pharmacy services (not just community pharmacy) will be high on NHS England's agenda in the coming year.

Fulfilling that ethos in East Lancashire Hospitals, we already refer to four distinct groups: community pharmacies, dispensing doctors' practices, domiciliary medicines support teams and a service called IMOT (integrated medicines optimisation team) *and* Refer-to-Pharmacy is future-proofed to allow referrals to GP practice pharmacists and Care Home teams (we just don't have these to refer to in East Lancs).

We've been making referrals for home visits to two domiciliary pharmacy teams for a couple of years now. I thought it would be useful to show how one minute of a hospital pharmacist's time can have a very long reach…

Here's a recent story from the East Lancashire Medicines Support Team's pharmacist:

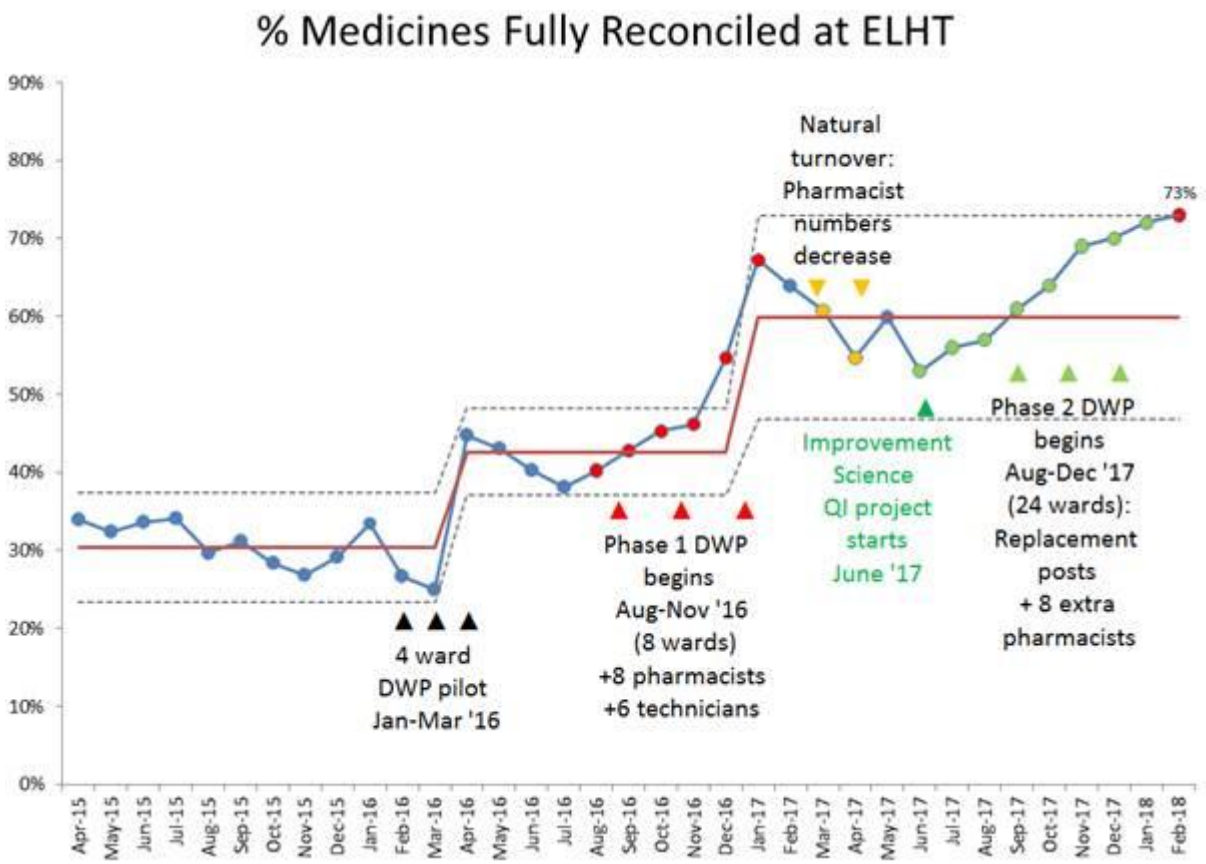
> ***Following receipt of an R2P referral from a ward pharmacist we prepared a care plan and visited the lady at home. The patient had multiple co-morbidities and this had resulted in issues with polypharmacy. Following discussion with the patient we sent nine recommendations to the GP.***
>
> *From these recommendations the GP agreed to:*
> - *a trial discontinuation of quinine, as the patient was not getting any benefit*
> - *reduce the Carbocisteine dose following respiratory review*
> - *stop Corsodyl mouthwash which was prescribed for oral thrush in 2015 and had remained on her repeat prescription!*
> - *stop pholcodine linctus which had been prescribed on repeat prescription for a cough, but has little evidence for use*
> - *stop diclofenac gel as patient is now trialling capsaicin cream instead for the same indication*
>
> ***This review reduced the ladies medication burden by three tablets, three liquid doses and 3 topical applications, each day. It also resulted in her receiving a respiratory review and education on using an inhaler she was struggling to use. Based on drug tariff prices this equated to an annual cost saving of £271.38.***

If there are any Spanish speakers, or readers, out there you may be interested in this article from Spain's professional pharmacy journal *El Farmaceutico* about Refer-to-Pharmacy. I didn't write it in Spanish – they translated it!

And finally… a brief update on #DedicatedWardPharmacy.

Firstly, it the project has been shortlisted for an HSJ Value in Healthcare award in the Medicines Optimisation category. We'll have to wait until June to find out how we have done.

We've been focussing on Medicines Reconciliation and here's the latest data, now as an SPC (or Shewhart) chart.



Until next time…

Many thanks,

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