

Improving prescribing quality in mental health

Carol Paton is joint clinical lead at the prescribing observatory for mental health (POMH), a unique organisation that allows participating trusts to benchmark their quality of practice against national data. This article describes Mrs Paton's role at POMH and elsewhere. By Shona Kirk.

Carol Paton is chief pharmacist at Oxleas NHS Foundation Trust, a specialist mental health service in South East London. She is seconded from the trust for one day per week to work at the Prescribing Observatory for Mental Health (POMH), where she has worked since its inception in 2005. Mrs Paton is joint clinical lead at POMH alongside Professor Thomas Barnes, a psychiatrist.

POMH helps specialist mental health services improve prescribing practice and runs several quality improvement programmes (see Panel 1). Mrs Paton has had a long standing interest in prescribing quality and the rational, safe and effective use of medicines. She was involved in drafting the initial grant application to the Health Foundation to set up POMH. This enabled membership to be provided free for the first year, after which a subscription fee was introduced.

Quality improvement

The quality improvement programmes run by POMH involve clinical audits, change interventions and the publication

The Prescribing Observatory for Mental Health (POMH) is a quality improvement initiative based within the Centre for Quality Improvement at the Royal College of Psychiatrists. It was originally funded by a grant from the Health Foundation, an independent charity that works to improve the quality of healthcare. POMH is completely independent of the pharmaceutical industry. This year, 48 mental health trusts subscribed to POMH; this represents about two thirds of all mental health trusts.

Panel 1. Organisation of POMH

of benchmarked data, enabling trusts to compare their prescribing practice with other participating trusts. Each trust is defined by a code number, ensuring the reports are anonymous. "This encourages people to be honest," says Mrs Paton. "The data is not released to any external agencies because the main aim of the project is to encourage reflective practice, not to measure performance or produce a league table."

Mrs Paton and Professor Barnes work with trusts to determine which quality improvement programmes they develop. This involves finding out trust priorities and involving expert clinicians in topic groups, which look in detail at individual areas of practice. The topic groups work together to produce project plans, draft data collection tools and help to finalise benchmarked reports, which are sent to participating NHS trusts.

Interventions

When baseline data have been collected performance is compared with national, evidence-based standards, explains Mrs Paton. "If we think that interventions may help clinicians to improve quality, then we work to develop these." She uses the first quality improvement programme run by POMH as an example. This programme looked at the use of high dose and combined antipsychotics in acute adult inpatient settings. "High dose prescribing often results from combining antipsychotics and people often do not realise the contribution that the combination makes to overall dopamine receptor blockade," she says. Results from the baseline audit showed that the standards were not met in a substantial minority of patients; this led to the development of nine quality



Carol Paton

improvement interventions, including a guide called the 'Ready Reckoner'. The Ready Reckoner allows easy calculation of doses of different antipsychotic drugs to find out what the cumulative dose is. "As well as developing the idea for the Ready Reckoner, myself and Professor Barnes decided how it was designed and which drugs were included," Mrs Paton explained. "The Ready Reckoner has been very popular, we have given out thousands of them."

Results from the first re-audit found little difference in prescribing practice following the interventions (*The British Journal of Psychiatry* 2008;192:435-39), however, a second and third re-audit (not yet published) show that practice is now moving further towards the standards. Mrs Paton says: "The major lesson from our first programme was that one year is not long enough to change practice within the NHS. For new audits we now allow 18 months between baseline and re-audit." Other interventions include

working with the National Patient Safety Agency to develop patient information and monitoring packs for lithium. "I was involved in creating the first draft before it went out for consultation. Once finalised the pack will be made available to mental health trusts and primary care," she says.

Data collection tools are developed in-house by POMH and Mrs Paton is involved in deciding which data should be collected in order to effectively interpret the findings. Participating trusts can submit their data electronically using these tools. This allows quick analysis of large data sets. The time from close of data collection to when trusts receive their reports is usually about six weeks. "This means that the data is still very fresh," she explains. Each trust receives a personalised, benchmarked report comprising three sections. The first section shows national data, the second shows performance in the trust compared with the standards and with all other participating trusts and the third shows performance in individual teams within the trust against others in the same trust and compared with the national data. "My role is to give advice on the interpretation of the results and to approve the final reports," explains Mrs Paton.

The POMH team is very small. In addition to the day per week provided by Mrs Paton and Professor Barnes, there is the equivalent of two and a half full time staff, which comprise a project manager and two support staff. However, each trust that participates in the programmes run by the organisation has its own team. These teams normally include a senior pharmacist, a senior psychiatrist, a nurse and someone from the audit/clinical governance department who facilitates local data collection and presents results back to the local clinical team. Mrs Paton says that many pharmacists are involved in POMH and play an important part in data collection and presenting the results back to the organisation. "In many of the trusts that participate, a pharmacist leads the local POMH team," she adds.

Most of the programmes run by POMH involve secondary care. "We are aware that the majority of patients who use mental health services receive much of their care within primary care, however auditing across the interface between primary and secondary care is challenging," acknowledges Mrs Paton. She says that the

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organisation has some links with primary care. "We have recently run a baseline audit investigating the quality of lithium monitoring, and as part of that we looked at Quality and Outcomes Framework data for the trusts that participated," she says. This means that trusts can compare their performance in primary care with national standards as well as with their own local audit data.

The Health Care Commission and Mental Health Act Commission, which are both now part of the Care Quality Commission, have been very supportive of trusts participating in POMH programmes, says Mrs Paton. "Trusts can use the benchmark data that they get from our programmes to provide evidence for Care Quality Commission standards. For example, clinicians participating in clinical audits have a system in place for reflecting on clinical practice and for quality improvement." The POMH programme is very much in line with recommendations from Lord Darzi in his report — High Quality Care for All, she adds.

Mrs Paton has noticed an improvement in prescribing practice in her own trust since the clinical teams started participating in POMH programmes, with practice moving towards the standards. She says that benchmarked data are the most powerful catalyst for change. "If local performance against a standard fares poorly compared with other trusts, the participants want to know why so that they can change their practice," she explains. "There is a real sense of where you are compared with your peers."

Other responsibilities

The National Institute for Health and Clinical Excellence guidelines for mental

health conditions are all prepared by the National Collaborating Centre for Mental Health, which is based at the Royal College of Psychiatrists, and is a partnership between the Royal College of Psychiatrists and the British Psychological Society. The National Collaborating Centre for Mental Health is responsible for organising the group that will undertake work on these guidelines. They have their own systematic reviewers and clinical experts advise the group. Mrs Paton has been on guideline development groups for a number of NICE guidelines and has acted as an expert advisor. Most recently, she chaired the pharmacology topic group for the revision to the depression guideline, which is due to be published later this year. "This involved helping to guide clinical questions that dictate which systematic reviews of the evidence are carried out and then helping to interpret the findings and to develop the recommendations that NICE subsequently make." Mrs Paton carries out this work separately to her work at her trust and POMH. "The trust is very supportive of involvement in projects such as the development of NICE guidelines," she says.

Benefits

Mrs Paton says the most rewarding aspect of her role at POMH is observing change and seeing how enthusiastically many trusts participate in the programmes. She explains: "Each year as we prepare the programme, we run a number of regional workshops and the clinicians who come along to the workshops are always very positive about participating, very honest, and there is a real sense of people sharing problems and working together."

Challenges

Some changes are needed in mental health services, says Mrs Paton. "I do not believe that the management of medicines within mental health services is given a high enough priority," she says. She suggests that better training in the use of medicines for staff of all disciplines and a greater awareness of the benefits and harms that medicines can cause would be a very positive step. Mrs Paton believes that the biggest challenge in the near future will be the probable reductions in NHS resourcing. "Trying to maintain quality will be challenging for everyone," she adds.