

HOSPITAL PHARMACY

£20m saved by medicines management

Medicines management, NICE guidance, medication error research, continuing professional development and the Commission for Health Improvement were among the topics discussed at hospital pharmacy practice sessions on 16 September. Gareth Jones, editor of Hospital Pharmacist, reports

Introducing a medicines management service involving a pharmacist and a technician on each ward could save a trust £20m, said Dr Michael Scott, chief pharmacist at United Hospitals Trust in Antrim, Northern Ireland. The running costs of the additional service have been estimated to be around £1m. Savings can be achieved through more efficient use of junior doctors' time, improving bed use through reduced length of stay and reducing readmission rates.



Michael Scott: medicines management can reduce length of hospital stay

Dr Scott introduced a medicines management service on five wards across hospitals in the trust in May 2001. Patients on these wards were allocated to either an intervention or control group. Patients allo-

cated to the control group received standard care, and a junior doctor took their medical histories without pharmacist intervention. The intervention group patients received a full medicines management service from the pharmacist and technician. This included an assessment of appropriateness of medication at admission, inpatient monitoring, pre-discharge preparation, and communication with primary care health professionals at discharge. Community pharmacists received a faxed discharge letter. Over 1,000 patients were reviewed as part of the research.

The length of hospital stay of patients in the intervention group was significantly lower than that for the control group. Hos-

pital stay reduced from 17 days to 13 days. Hospital readmission at 12 months was also significantly reduced in patients in the intervention group. A saving in drug costs was achieved in patients in the intervention group due to reuse of patients own drugs. Dr Scott described an example where the nursing time spent on drug administration had been reduced by a third in the intervention group.

The time that patients waited for their discharge prescriptions was also reduced. The average waiting time was 35 minutes in the intervention group and 135 minutes in the control group.

Questionnaires returned from patients, general practitioners and community pharmacists showed wide support for the new service.

Savings would be achieved through better use of drugs, and through reducing nursing time. Dr Scott said that an expansion in the service may need to be funded from the current nursing budget.

Collaboration to allocate funds for NICE guidance

To deal with the allocation of funds needed to implement NICE guidance, Bristol, North Somerset and South Gloucestershire primary care trusts (PCTs) have formed a "National Institute for Clinical Excellence college", said Trevor Beswick, head of medicines management at Bristol South and West PCT.

The previous approach to funding NICE guidance followed by the former health authority involved a funding estimate being made, followed by a transfer of funds to the provider trusts. There was no follow-up or monitoring of how the money had been spent or whether it had been spent on the appropriate appraisal. There were mismatches between what the trusts said they were spending and what NICE had said they should be spending, and there was a recog-

nition that there were huge potential cost pressures from NICE guidance if the previous approach was continued.

The NICE college was established to provide a common approach to NICE guidance in the region, reduce duplication of work across PCTs, co-ordinate local implementation work and establish processes for making allocations. Technology appraisal guideline are identified by the NICE manager. Costs are then calculated to include resources required for monitoring therapy. Estimates are also made about the proportion of the funds that



Trevor Beswick: collaborative approach

will be given to primary and secondary providers. The college, which meets monthly, consists of a manager, two representatives from the PCTs, two representatives from the local NHS health care provider trusts, a finance lead and representation from out-of-area trusts as required.

Four PCTs, three acute providers, one mental health partnership trust and two out-of-area trusts provide care for 900,000 patients who live in the area covered by the college.

Setting a prescribing policy before the issue of new NICE guidance, the shifting timetable of NICE and reconciling cost estimates with final expenditure are some of the challenges that still face the NICE college.

According to Mr Beswick, in the 18 months since it became established, the NICE college has achieved its aims of providing clarity to working processes, strengthening working relationships between the trusts and PCTs, and among the PCTs, and tightening financial control. It is hoped that, in the future, financial estimates, planning, audit and follow-up will improve further.

Lessons from roll-out of CPD

Different approaches to supporting continuing professional development have been pursued in three regions where roll-out of the Royal Pharmaceutical Society's CPD programme has happened, said Lynne Bollington, All-Wales Principal Pharmacist, Training and Personal Development.

Ms Bollington summarised the lessons learnt. The biggest barrier to acceptance of CPD is understanding what it is. Peer review meetings are a time-effective method

of sharing records and building confidence, whereas one-to-one mentoring is not feasible. Someone should be identified at regional and trust level to take the lead, and support networks should be built to enable sharing of experiences and develop confidence. There are unresolved issues with CPD, and Ms Bollington wondered how CPD could develop measured outcomes, and how it would fit with the knowledge and skills framework and wider NHS agenda.

Pharmacists should contribute to medication error research by submitting ideas, says PSRP director

Pharmacists should send ideas for medication error research to the Patient Safety Research Programme (PSRP). This was the request made to participants at the conference by the director of the programme, Richard Lilford, professor of clinical research at the University of Birmingham.

The PSRP was set up by the chief medical officer (CMO) for England, Sir Liam Donaldson. Professor Lilford reports directly to the CMO, who set the policy imperatives of the programme as birth asphyxia, intrathecal vincristine, suicide in hospitals for acute mental illness and medication error.

"Medication error is the single greatest cause of human suffering resulting from error," said Professor Lilford. He also said that 4 per cent of all hospital admissions are caused by error in medication and 1.5 per cent of all hospital prescriptions have an error that leads to harm.

Professor Lilford believes that the use of clinical pharmacists and the use of computer systems can contribute to a reduction in error. The area for research is therefore to find out in what way these interventions could be used to cut down error.

Dr Jim Smith, the chief pharmaceutical officer for England, is about to publish a list of interventions which could help to reduce

errors and will be used by the PSRP in planning research, according to Professor Lilford. The PSRP will review the error rates in hospitals where computer systems have already, or are soon to have, a system implemented, as well as looking at systems in other countries.

The interface between hospital and community is an area currently missing from the research plans. Professor Lilford would therefore be particularly interested in receiving suggestions from pharmacists for research in this area. Further information about the PSRP can be found on the research programme's website at: www.publichealth.bham.ac.uk/psrp

CHI and CHAI – implications for pharmacy

Pharmacists were encouraged to get involved with becoming CHI (Commission for Health Improvement) reviewers by David Stead, chief pharmacist at the Royal Bournemouth Hospital. "We deal with such a plethora of people within the organisation on a day-to-day basis that we are ideally suited to talking and listening to a whole range of health professionals," Mr Stead said, based on his experience as a reviewer.

Mr Stead offered some advice on how to survive a CHI review. "Look at the pillars of clinical governance and make sure that you have got the evidence to support what you are going to say," he said. "If you have got something to say, you have got to make sure that you say it – it does not matter what they ask you."

Mr Stead pointed out that although there may be a pharmacist in the team, interviews are likely to be carried out by a non-pharmacist.

In four years, among other things, CHI has done 300 clinical governance reviews. It is due to be replaced in April 2004 by the Commission for Healthcare Audit and Inspection (CHAI), subject to the current legislation being passed by Parliament. The chairman and commissioners will be appointed by the NHS Appointments Commission and they will make an annual report to Parliament. The closing date for applications for the post of chief executive has passed, and an appointment must therefore be imminent.

CHAI will develop new criteria for star ratings, with the emphasis being on what affects the patients assessment of quality. Mr Stead emphasised that as the new CHAI organisation does not currently exist, his comments were based on "crystal-ball gazing". The aim of the new organisation will be the same as that of the old organisation, and that is to bring about an improvement in the quality of the service.

He questioned how much of the current data collected provide us with a systematic approach to understanding and improving

quality, saying: "At the moment we have data but not intelligence." Mr Stead then gave an example of how this differs. "It is not about the number of adverse events that you report; that is data. But the intelligence we want is how organisations use that data to improve their error reporting systems or improve their risk management processes." There will be a drive to obtain information on the quality of care that patients are receiving. There will be unannounced random visits, with severe penalties for false or inaccurate reporting.

What impact will CHAI inspections have on pharmacy? CHAI may check on



David Stead: make sure you have the evidence to support your case

implementation of NICE (National Institute for Clinical Excellence) reviews and national service frameworks. It is critical for pharmacists and pharmacy organisations to tell CHAI what data to use to generate the information. Self-assessment will become more of a norm, as well, possibly, a greater number of visits that are focused on key areas of the service that we deliver commented Mr Stead. These inspections may focus on coronary heart disease, treatment of older people, children's services and value for money.

Case study: what happens during a CHI review

Mark Donaghy, clinical governance facilitator for community pharmacy for Bradford South and West Primary Care Trust described what happened when the Commission for Health Improvement visited Bradford in March 2003.

The visit involved all four PCTs in the city and the team sent many questions to be answered in advance. A PCT review manager was identified who would co-ordinate the visit so that it would be a positive experience for those taking part. The local pharmaceutical committee was also involved and newsletters and posters were sent out to encourage pharmacists to come forward to participate. It was emphasised that the PCT as a whole was being inspected — not individuals — and that the review team wanted to see patients and practitioners doing good work. The team visited

three different pharmacies: one had long opening hours, another offered an anticoagulation service and the third worked closely with a GP practice. Mr Donaghy was also interviewed and was asked how a pharmacist would alert the PCT about dangerous prescribing.

When it came to the report being published two months later CHI was positive about pharmacy services, although it did pick up the fact that prescribing errors are not currently reported to the PCT. Dispensing processes, on the other hand, were not an issue. The report also applauded South and West Bradford PCT for funding pharmacists to the tune of £200/day for locum fees in order to enable them to participate in daytime training with nurses and GPs.

According to Mr Donaghy, the review process was positive for pharmacy.