

# review of circulars and OFFICIAL PUBLICATIONS

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Our regular monthly review includes a discussion of the health service circular on "intermediate care" and its possible effects on hospital pharmacy services. Some recently released NICE guidelines are also considered

The subject of health service circular (HSC) 2001/001, issued on January 19, was "Intermediate care", defined as services which:

- Are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing National Health Service inpatient care
- Are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery
- Have a planned outcome of maximising independence and typically enabling patients/users to resume living at home
- Are time-limited, normally no longer than six weeks and frequently lasting one to two weeks or less
- Involve cross-professional working, with a single assessment framework, single professional records and shared protocols

The processes of assessment, patient selection and care planning are crucial to the appropriate application of intermediate care services.

Intermediate care encompasses the following service models:

- Rapid response. This prevents acute admissions by providing rapid assessment and diagnosis, and, if necessary, rapid access on a 24-hour basis to short term nursing or therapy support and personal care in a patient's own home
- Hospital at home. Intensive support in a patient's own home to avoid acute admission or to enable early discharge

- Residential rehabilitation. Short term therapy in a residential setting such as a community hospital, rehabilitation centre, nursing home or residential care home for medically stable patients, before returning home. This may be a "step down", following a stay in an acute hospital or a "step up", following referral by, for example, a general practitioner, social services or a rapid response team
- Supported discharge. Short term nursing and/or therapeutic support in a patient's home
- Day rehabilitation. Short term therapeutic support provided at a day hospital or day centre

Hospital pharmacists will recognise that various components of intermediate care, as defined above, already operate. However, the extent to which this occurs will vary depending on the local situation.

The circular emphasises the need to develop the existing structures further, and indicates that they will be supported with additional resources. Intermediate care is focused on preventing avoidable admissions to hospital and, once admitted, ensuring that patients are discharged with appropriate care arrangements as soon as practical.

The development of intermediate care will have a profound effect on the way health care is delivered in the future, and will have a significant impact on acute services, particularly early discharge arrangements. The need to respond to changing demands for discharge medication is an obvious effect on hospital pharmacy.

Shorter hospital stays may have other impacts, such as a greater input to patient counselling before discharge, planning medication needs at the time of admission, and greater use of patient's own medication during and/or after their stay in hospital.

The potential also exists for hospital pharmacists to become involved in care planning and schemes to prevent admission where this

might be linked to current medication that the patient is taking.

"Guidance on the use of donepezil, rivastigmine and galantamine for the treatment of Alzheimer's disease" was the title of **Technology Appraisal Guidance** number 19, issued by the National Institute for Clinical Excellence (NICE) in January. The guidance advises that the drugs should be made available in the NHS for people with mild and moderate Alzheimer's disease whose Mini Mental State Examination (MMSE) score is above 12 points (maximum 30) and who meet specified criteria. The criteria include a requirement that only specialists, such as old age psychiatrists and care of the elderly physicians, should initiate treatment. If GPs are to take over prescribing, it should be done under a shared care protocol. The drug should only be continued if an assessment made two to four months after reaching the maintenance dose, shows clinical improvement in the patient. The annual cost per patient of drug treatment varies from £821 for rivastigmine up to £1,248 for donepezil at the higher (10mg daily) dose. The assessment estimates the drug costs to the NHS at £42m per year.

NICE's **Technology Appraisal Guidance** number 20, also released in January, was entitled "Guidance on the use of riluzole (Rilutek) for the treatment of motor neurone disease". The guidance recommended the use of the drug for the treatment of individuals with the amyotrophic lateral sclerosis form of the disease. The drug should be initiated by specialists but can be prescribed by GPs under a shared care protocol. Treatment with riluzole amounts to an annual cost of £3,718 per patient, the potential impact on the NHS drug bill being £7.5m per annum. Currently, the estimated funding of riluzole treatment is £2m per annum.

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