

Consultation started on reform of NHS final-salary pension

NHS staff are likely to need to work until the age of 65 to be entitled to a full pension, if proposed changes to the NHS pension scheme are implemented. The Department of Health commissioned the NHS Confederation to review the scheme in 2003 on behalf of NHS employers and the proposed changes are now the subject of consultation.

Currently, NHS staff retiring from the age of 60 are entitled to the full pension which is linked to their final salary and number of years worked. The proposed new scheme will raise that age to 65. Staff retiring between the ages of 55 and 65 will be able to claim a pension but at a reduced rate. Another significant change proposed is to calculate the pension based on average, rather than final, salary.

The terms and conditions committee of the Guild of Healthcare Pharmacists was due to meet on 9 February, after *Hospital Pharmacist* had gone to press, to discuss a response to the proposals. The committee's chair, David Miller, told *Hospital Pharmacist* that there is



Pension payments will still not "rely on the vagaries of the stock market"

no immediate cause for concern as those existing staff who intend to retire before 2013 will be able to do so without any loss of existing rights. He welcomed

the fact that the scheme will retain its defined benefits status (rather than being a defined contribution scheme) which, he said, "guarantees the payment rather than relying on the vagaries of the stock market".

The panel below outlines some of the significant differences between the current and proposed NHS pension scheme. The closing date for the consultation, which started on 10 January, is 11 April and more details are available from the following website www.nhsemployers.org

□ An article on pensions for NHS employees is set to appear in next month's issue of *Hospital Pharmacist*.

Summary of current and new pension scheme

	Current NHS pension scheme	Proposed new NHS pension scheme
Normal pension age	60	65
Membership age limits	16 to 70	16 to 75
Accrual rate	1/80	1/60
Lump sum	3/80	Only available by reducing pension
Salary reference period	Best of last 3 years	Average pay over up to 13 years

Admissions increased by "at home" reviews

Emergency admissions to hospitals are increased by medication reviews carried out by pharmacists in patients' homes, according to research published last month in the *BMJ* (available via www.bmj.com).

Researchers randomised 872 elderly patients who were discharged from hospital after an emergency admission with two or more prescribed drugs to receive two home visits by a pharmacist (intervention group) or their usual care (control group). Those in the intervention group went on to have 30 per cent more admissions to hospital and 43 per cent more home visits by GPs than those in the control group. Quality of life measures

also decreased less in the control than the intervention group.

The researchers suggest three explanations. First, pharmacists may have enabled patients to understand their condition better, leading to patients being able to recognise warning signs earlier and seek help. This theory is supported by the smaller number (albeit not significantly) of deaths in the intervention group than the control group that was noted. Second, pharmacists might have encouraged patients to adhere to their medication regimens more than they otherwise would, thereby precipitating side-effects or drug interactions. Another possibility was that having pharmacists visit patients at

home simply added to the complexity of care, increasing the confusion and anxiety of patients.

It is not clear from the paper whether the patients in either group received any advice about their medicines from hospital pharmacists during their emergency admissions.

The researchers conclude that: "... a growing body of evidence suggests that further research is necessary to elucidate the most effective form and detailed effects of medication review. The recommendation in the national service framework for older people that this should be widely introduced in primary care seems to lack a clear evidence base."

brief

■ Pharmacists should be involved in drafting policies aimed at producing smoke-free hospital trusts, according to guidance sent out by the Health Protection Agency. One reason for this is the interaction between antipsychotic medication and stopping smoking. Another is the effect on drugs budgets, with the guidance recommending that nicotine replacement therapy and bupropion should be included in hospital formularies. The guidance is available via www.pjonline/links/hp

■ Re-organisation of the NHS Purchasing and Supply Agency is to take place. More details are at www.pasa.nhs.uk

■ A new poster campaign aims to raise awareness of the latest drive to reduce violence against NHS staff. It also highlights the role staff can play in tackling violence, including knowing how to defuse and report incidents. Further information is available at www.cfsms.nhs.uk

■ "The Breckenridge report revisited" is the topic of a meeting at the Royal Pharmaceutical Society on Thursday 14 April. The guest speaker will be Professor Sir Alasdair Breckenridge who will speak about the preparation of injectable medicines — 30 years on. The meeting is being jointly organised by the Pharmaceutical Aseptic Services Group and the Society's Hospital Pharmacists' Group. Further details are available from the advertisement on p74.

■ The British Pharmaceutical Conference Committee is calling for abstracts of posters and talks in pharmacy practice. The deadline is 15 April. E-mail bpccpractice@rpsgb.org for more details.

Patients to report suspected ADRs

Patients, along with parents or carers of patients, are now able to report suspected adverse drug reactions (ADRs) directly to the Medicines and Healthcare products Regulatory Agency. This is one of the changes introduced in response to recommendations made in the MHRA's "Report of the independent review of access to the yellow card scheme". Patients can submit information online (www.yellowcard.gov.uk) or on forms that have been made available at 4,000 GP surgeries across the UK.

Anthony Cox, ADR pharmacist at Sandwell and West Birmingham Hospitals NHS Trust said: "Public access to the scheme's data is indicative of the general move towards transparency in society." He pointed out, however, that people should be aware of the limitations of the data held by the MHRA. Mr Cox continued: "Patient reporting of ADRs will allow individual patients to play their role in drug safety, and also give a real opportunity to evaluate the usefulness of such

The image shows a yellow form titled 'SUSPECTED ADVERSE DRUG REACTIONS' from the Medicines Control Agency (MCA). The form is partially filled out. In the 'PATIENT DETAILS' section, 'Patient Initials' are 'AB', 'Sex' is 'M', and 'Weight if known (kg)' is blank. In the 'SUSPECTED DRUGS' section, 'Give brand name of drug and batch number if known' is blank, and 'Route', 'Dosage', 'Date started', 'Date stopped', and 'Prescribed for' are also blank. In the 'SUSPECTED REACTION(S)' section, 'Please describe the reaction(s) and any treatment given:' is blank. There are checkboxes for 'Recovered', 'Recovering', 'Continuing', and 'Other' under the 'Outcome' section. A blue pen is resting on the form.

Yellow card scheme is to be extended to patients, with wider access to data for independent researchers as well

reports ... Reports from health professionals will continue to be of the utmost importance to drug safety in the UK, and the start of patient reporting does not reduce the professional responsibility on pharmacists, nursing staff and doctors to report to the scheme any qualifying reactions they observe."

Other changes to the yellow card scheme announced include wider access to data.

Anonymised data about suspected ADRs will be published on the MHRA website and will therefore be available to the general public. Researchers will be able to access more detailed data. Safeguards will be in place, with each request to do so being reviewed by an independent committee, to make sure that it is ethically and scientifically sound and protects patient confidentiality.

First hospital pharmacy technicians register

Pharmacy technicians have started registering with the Royal Pharmaceutical Society, in a process which will lead to mandatory registration by 2007. When *Hospital Pharmacist* went to press, 139 technicians had been registered.

Clair Moore, pharmacy technician at the Warwickshire Nuffield Hospital was one of the first to have her name on the register. She has been a pharmacy technician for 16 years and described the process of registering as straightforward.

"I wanted to register at the earliest opportunity," said Ms Moore. "Being registered gives pharmacy technicians proper recognition of our knowledge, skills and professional role in the eyes of our employer and patients," she added.

Registered pharmacy technicians will receive their own weekly copy of *The Pharmaceutical Journal* and be eligible to vote in the election of two of their number to the new Council of the Society. The new Council, in addition to the two

technicians, will include 18 pharmacists and 10 privy council appointees. Further information on this election process is included in an article in this issue of

Hospital Pharmacist (pp75-6). *Hospital Pharmacist* is now available to registered pharmacy technicians for the reduced rate of £40 per year. Further details of this offer and an application form are available from the website www.pjonline.com/Hospital/CurrentContents.html.

Trusts set monthly Agenda for Change targets

NHS trusts have been set a timetable of targets to ensure that Agenda for Change will be fully implemented by the end of September. By the end of February, 20 per cent of staff

should have a Knowledge and Skills Framework outline and by the end of March, 60 per cent of staff should have been matched to Agenda for Change bands. These milestones should ensure

that 50 per cent of staff are assimilated (ie, paid in line with Agenda-for-Change-based terms and conditions) by the end of April and 100 per cent by the end of September.

Do not restrict emollient choice, skin group says

Patients should be given the opportunity to choose the emollient products that suit them from the widest possible selection, according to members of the Skin Care Campaign (SCC), an umbrella group that represents the interests of all people with skin diseases in the UK.

In a letter to all hospital pharmacies in December 2004, Peter Lapsley, the chief executive of the SCC, expressed concern about reports that some hospital pharmacies were restricting the choice of emollients available in an effort to reduce costs. The majority of treatments for skin diseases are applied topically and are therefore “worn” like cosmetics, rather than taken internally. For this reason, the smell, texture and feel of a product can have a big influence on whether or not it is used and, therefore, on its clinical effectiveness. A product that is not used can undermine a treatment regimen, producing a poor clinical outcome and is



MIKE WENDHAM

A patient with eczema: sensitive skin means that some emollient products are better tolerated than others and therefore choice should not be restricted

wasteful of NHS resources, Mr Lapsley argued.

Many people will need a selection of products — for example, heavier emollients for use on limbs than for the face, richer (ie, greasier) emollients for night time use compared with those used during the day

and different products for use in the winter compared with the summer. Moreover, people with eczema and related conditions tend to have sensitive skin and find some products more tolerable than others.

Taking into account these factors, staff at some hospital

pharmacy departments now provide kits of six or seven emollients, with a sufficient amount of each product for a two- or three-day trial. Similarly, practice at some dermatology departments is to allow patients to test a dab of a large number of products before choosing the emollient(s) they wish to take home with them.

We are regularly asked, “Which is the best emollient?” said Allan Melzack, a community pharmacist at Tesco stores in Handforth, South Manchester with a special interest in eczema. “There is no universal best emollient. Patients need the opportunity to work out which is best for them by trying a range of products,” he explained – *Contributed*

Further SCC information

More details about the Skin Care Campaign are available by visiting www.skincarecampaign.org

Medicines information error and near miss database set up

A database of medication errors and near misses occurring within medicines information services in NHS hospital pharmacy departments across the UK has been launched by the clinical governance working group of UK Medicines Information (UKMI). The database, known as IRMIS (Incident Reporting in Medicines Information Scheme), covers incidents in medicines information practice only — and not those relating to, for example, the prescribing and administration of drugs, because there are existing systems to capture this data. Passwords and user names are required to gain access to IRMIS and data are anonymised. The database is also secured on the NHSnet and the National Patient Safety Agency is aware of the scheme.

According to Julie Horwood, Elena Grant and Fiona Woods, from the clinical governance working group of UKMI, information about any incidents that occur in medicines information practice should be submitted to hospital trust reporting systems in the same way as dispensing errors, but should also be reported to IRMIS. The idea is that by collecting data about incidents happening within the medicines information field in a central database it will be possible to determine trends, share learning, and inform training programmes, risk management strategies and national standards. All this should help reduce the likelihood of similar incidents re-occurring, they said.

Further details are available at www.ukmi.nhs.uk

Patient opt outs from NPfIT records database are clarified

Conditions under which patients may opt out of various aspects of the National Programme for IT (NPfIT) electronic records database have recently been clarified by the Department of Health.

A spokesman for NPfIT explained that, in extreme circumstances, a person may opt out of having their information held on the database providing they can demonstrate that the holding of information would cause unwarranted damage or distress to themselves or somebody else.

Patients can also opt not to have electronic data held about them shared. Here, their data would still be recorded locally and sent to the national database but it would be “locked” so that no one (except possibly in the future, the patient) could see it.

Local records will also have more access controls, so that data could be accessible only to those who generate it and the organisations for which they work, but not to clinicians in other local NHS organisations. Should patients change their minds, national records can be activated for sharing immediately and additional access controls around local records can be removed. Patients do not have to prove harm to opt out of having their records shared, but steps will be taken to ensure that they understand the possible implications for their health care, the spokesman said.

Finally, patients will be able to select certain information about their health to go in a “patient sealed envelope”, enabling them to restrict access to selected data to certain clinicians.