

Using non-clinical staff to improve medicines management services

A scheme in Cumbria uses non-clinical “practice medicines managers” to improve medicines management services. **Dawn Connelly** reports

The demands of a changing health service, an increasingly elderly population and the current financial climate within the NHS mean that it is essential to develop efficient and cost-effective ways of working. A scheme in Cumbria is using non-clinical staff to improve medicines management in general practice. The two-year pilot scheme achieved a year-on-year substantial reduction in prescribing costs growth, improved patient safety and quality of medicines management services, reduced waste, and enhanced satisfaction for patients and practice staff. It has now been extended to neighbouring primary care trusts.

The scheme involves appointing a dedicated non-clinical member of staff — called a practice medicines manager (PMM) — to take on administrative tasks and systems management activities. The initial pilot involved all 21 practices in West Cumbria PCT, each of which recruited and employed a PMM using PCT funding equivalent to 1 per cent of the annual drug budget (£200,000). The scheme allows practice pharmacists, who are in short supply in Cumbria, to delegate tasks to the PMMs leaving them free to concentrate on more clinical and strategic work.

“We already had a prescribing network of pharmacists and GP prescribing leads in the practices but we wanted to increase the medicines management activity and we could not get enough pharmacists or pharmacy technicians,” explains Mel Bradley, prescribing adviser at what is now Cumbria PCT. “We also recognised that a lot of the jobs did not need a clinical pharmacist to do them — it was not a good use of pharmacists’ time.”

A training programme was developed and delivered by the PCT prescribing team, which



The practice medicines managers at a group training session

comprises Jeff Rudman, PCT GP prescribing lead, Lynn McFarlane, PMM facilitator, and Mrs Bradley. The training programme started with a two-day residential course, followed by monthly half-day training sessions. The course has gained accreditation from the Open College Network as a diploma in medicine management — it is the first qualification of its kind in the UK and is equivalent to NVQ level 3. The modules include: medicines management and prescribing quality; waste management and stock control; medicines, patients and the law; therapeutics; repeat prescribing and medication review; prescription process and analysis; and management.

“It is a generic qualification but the teaching is designed so that we can pull in local issues,” Dr Rudman explains. “The PCT has a prescribing agenda and the idea is that we tackle the same issues with the PMMs, the prescribing lead GPs and practice pharmacists,” he says. The emphasis is on a collaborative learning style to encourage sharing of good practice. At the monthly sessions the PMMs present their practice projects (see Panel) and discuss any problems and potential solutions.

The PMMs have taken on day-to-day tasks, such as managing the repeat prescribing system (including staff training), being a point of contact for medicines-related queries within the practice team and between practices and outside agencies, dealing with hospital discharge information and interventions from community pharmacists, and managing care home orders.

Most of the PMMs were recruited from within existing staff, mainly senior receptionists. Mrs McFarlane provided them with essential on-the-ground support. “Part of the

success [of the scheme], however, is the ownership. We wanted the practices to own this person and for them to be part of the health care team. We did not want them to be seen as someone parachuted in from the PCT to interfere with the practice,” says Dr Rudman.

“Initially the pharmacists may have felt the PMMs were encroaching on their territory,” Mrs Bradley admits. However, she says that they now appreciate that by delegating non-clinical tasks to the PMM they have time for more clinical and strategic work. Dr Rudman adds: “They can see something to do strategically and then delegate, which magnifies their power and effectiveness.” Mrs Bradley emphasises the efficiency of the system. “In the past it might have taken months to get through projects. It has revolutionised the amount of medicines management work practices can now do.”

Results

The PCT previously had one of the highest expenditures per head and the highest costs growth on medicines. Four years into the scheme, it had the lowest costs growth in the strategic health authority (−6 per cent). The reduction in costs growth over the two-year pilot was equivalent to £714,000.

The scheme also demonstrated universal improvement in the repeat prescribing measures of the medicines management service collaborative. For example, prescription items out of synchronisation fell from 65 per cent to 32 per cent, prescriptions without dosage instructions fell from 15 per cent to 2 per cent and generic prescribing rose from 3.1 per cent to 83.1 per cent.

Prescribing quality indicators improved in seven of the 13 areas measured and were better than the national average in eight out of 13 areas, including volume of benzodiazepine prescribing, cost of drugs prescribed of limited clinical value, cost of ulcer healing drugs and cost of modified release cardiovascular drugs.

The PMMs resurrected a previously unsuccessful intervention scheme whereby community pharmacists are paid for recommending changes to repeat prescriptions. These changes are now implemented via the PMM. In one year, 3,148 suggestions were made, of which 88 per cent were implemented, generating savings of £64,798.

The PCT now funds the scheme on a permanent basis. In addition, it has been extended to two neighbouring PCTs and now operates in 53 practices across Cumbria and 50 across Northumbria. The scheme has proved universally popular with PCTs, clinicians, practice staff and patients.

Practice projects

The PMMs took on a number of individual practice projects, including:

- A structured approach to medication review
- Prioritising patients for medication review
- Medication and systems review in residential and nursing homes
- Structured review and stock control of the contents of doctors bags
- Formulary implementation
- Dose optimisation
- Patient information and education around medicines
- Concordance monitoring
- Elderly care medication review clinics