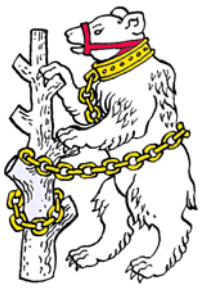
Programme
and
Conference Proceedings

UKMi
UK Medicines Information

34th UKMi Practice Development Seminar
Warwick 18th-19th September 2008



Contents – Conference Proceedings

Programme…… i

Welcome to the 34th UKMi Practice Development Seminar…… iii

Conference Organising Committee…… iv

The Ragged Bear …… v

Contents – Conference Proceedings…….. 1

Opening session …… 4

Welcome to Warwick …….. 4

Annual report of UKMi ……... 4

Plenary Session 1 – Health service refiorms – Imperative for change …… 5

Health service reforms and Pharmacy – an overview …….. 5

Health service reforms – impact on Medicines Information…….. 6

Plenary Session 2 – Approving new drugs…….. 7

NICE and the national processes for approving new drugs ……. 7

NHS resources and patients' rights - PCT processes for approving new drugs ……. 8

Plenary Session 3 – Hospital acquired infection…… 14

Overview of hospital acquired infection ..…… 14

Introducing antibiotics into hospitals …… 15

Plenary Session 4 – IT developments in MI …… 17

NeLM ……. 17

MiDatabank – New and future develpments ……... 18

Plenary Session 5 – Patient safety issues and MI ……. 19

Patient safety challenges …..……. 19

Medicine Information promoting patient safety …….. 20

Hospitals responding to the Safer Patient Initiative ……... 21

Parallel Sessions …… 22

Critical appraisal for new drugs (for D&TCs) ……..... 22

Current issues in rheumatology …… 23

Preparing for advanced practice ……... 24

Research in MI…….. 25

Patient helplines …….. 26

Writing skills surgery…… 27

Drugs in psychiatry …… 28

Payment by Results …… 29

MI technicians and skill mix in MI …… 30

Poster Presentations…….. 31

1 Improving information governance for pharmacists working out of hours: involvement of a MI service…….. 32

2 Does documenting when a MI service receives telephone calls help to plan service provision? …….. 33

3 The Mystery Shopper Project: A useful additional tool for Quality Assurance of MI services? …… 34

4 User Survey: Survey Of NHS Medicines Information (MI) Centres By PIPA ... 35

5 Does Medicines Information have an impact on patient care?..... 36

6 Research into the value of a medicines information service: Part 2 – piloting a questionnaire …….. 37

7 Research into the value of a medicines information service: Part 1 - where to start? …… 38

8 Does enquiry answering make a difference to patient outcomes ? ……... 39

9 Joint regional MI/specialist clinical pharmacist posts – do they work? ……. 40

10 Factors that influence the length of time it takes to handle medicines information enquiries ……. 41

11 Medicines Q&As on NeLM: Are they useful and accessible to UK medicines information pharmacists? …….. 42

12 Information resources for hospital pharmacies: Managing the risk ……..... 43

13 Internet based Database for management and documentation of drug information in German hospital pharmacies …….. 44

14 Crystal ball gazing – do predictions come true? ……... 45

15 How do community pharmacists answer questions about medicines 24/7? … 46

16 Medicine-related calls handled by community pharmacists: A preliminary study …… 47

17 NHS Direct call referrals regarding complementary therapies ……... 48

18 The public, the media and medicines information …… 49

19 Developing The “Drug Use In Liver Disease” Service ……. 50

20 Into the Future, The UK Drugs in Lactation Advisory Service …… 51

21 Analysis of paternal exposure enquiries made to the National Teratology Information Service …… 52

22 MI Boot Camp - using NVQ Unit 3 to prepare our student pharmacy technicians for their future career …… 53

23 Level 1 enquiries - identifying the medicines information training needs of hospital pharmacists …….. 54

24 One-to-one training for clinical pharmacists: Sharpening skills…….. 55

25 Which factors influence spontaneous reporting of adverse reactions to varenicline in Northern and Yorkshire? …….. 56

26 Storage of medicines and medicinal products in Automated Dispensing Systems (robots) when ‘Store Upright’ is a requirement……... 57

27 Contribution of clinical & non-clinical groups to support adherence to highly active antiretroviral therapy (HAART) for patients attending a regional HIV centre in Northern Ireland…….. 58

28 Analysis of poisons enquiries from hospital pharmacists to the National Poisons Information Service ……. 59

Conference Sponsors…… 61

Conference Professional Exhibitors…….. 62

NOTES – pages for delegate notes…… 63

Map of University of Warwick campus…….. **Back cover**

Opening session

Welcome to Warwick

Professor Ray Fitzpatrick, *Clinical Director of Pharmacy at Royal Wolverhampton Hospitals, Chairman of the Hospital Pharmacists Group Committee of the RPSGB*

Ray Fitzpatrick is Clinical Director of Pharmacy at Royal Wolverhampton Hospitals and has almost 30 years hospital pharmacy experience, 17 as a chief pharmacist. He is also Professor of Pharmacy at Wolverhampton University, and was instrumental in establishing the undergraduate MPharm course at the University. Ray has a special interest in Medicines Management and pharmacy practice research, and has over 80 publications and conferences abstracts to his name. He is external examiner to several universities and has advised NHS and government bodies on medicines management and prescribing issues. He is Chairman of the Hospital Pharmacists Group Committee of the Royal Pharmaceutical Society of Great Britain, he is a member of the steering committee of the European Academy of Hospital Pharmacy and is Consultant Editor to The Journal Hospital Pharmacy Europe. In 2007 Ray was made a Fellow of the Royal Pharmaceutical Society of Great Britain for distinction in the profession of pharmacy.

Annual report of UKMi

Eilish Smith, *Principal Pharmacist - Northern Ireland Regional Medicine and Poisons Information Service and Chairman UKMi Executive*

Eilish graduated from Queens University, Belfast in 1973 with an honours degree in Pharmacy and later graduated with an MSc in Hospital Pharmacy. Her initial career was in community pharmacy. She then moved into hospital pharmacy practice when medicines information centres were being established throughout the UK. She has spent many years developing and providing medicines information services and in representing Northern Ireland at UKMI. She is currently Chair of the UKMi Executive

Abstract

A report of the activities and developments of the UK Medicines Information network (UKMi) during 2007/8

Plenary Session 1 –
Health Service Reform – Imperative for Change

Chair: Professor Ray Fitzpatrick,

Health service reforms and pharmacy – an overview

***Professor Peter Noyce CBE**, Professor of Pharmacy Practice, University of Manchester*

Peter Noyce is Professor of Pharmacy Practice, and Directory of The Workforce Academy at the University of Manchester (1991-present). Currently he is professional adviser to the DH Pharmacy Regulatory and Leadership Oversight Group (PRLOG) (2007-2009); Practice Chair, BPC 2009; Deputy Chair, Pharmacy sub-panel, and RAE (Research Assessment Exercise) 2008; Formerly Peter was Medicines Commissioner (2002-2005 and Deputy Chief Pharmacist, Department of Health (1986-1990). He was awarded the CBE for services to healthcare in 2008 , He has also been made FFIP (Fellow of International Pharmacy Federation – FIP) for services to pharmacy internationally, 2008 and the RPSGB Charter Gold Medal, 2002.

Abstract

The background landscape to this presentation is "Quality and Safety", particularly in relation to medicines use. Of particular interest to the medicines information specialist are the frameworks and processes for "Safe Products, Safe Systems and Safe Professionals." For 40 years the Medicines Act has provided a legal framework for ensuring safe and effective medicines. In the last 10 years, a systems-based approach has evolved to reduce medicines-related errors, and now the emphasis has turned to ensuring safe professionals.

Much of this presentation will concentrate on the implementation of the 2007 White Paper "Trust, Assurance and Safety – the Regulation of Healthcare Professionals in the 21st Century" This provides a broad agenda which seeks to modernise and harmonize the regulation of all health professionals and includes education, specialist and advanced practice, and revalidation. Consideration will also be given to the Darzi paper, "A High Quality Workforce: NHS Next Stage Review."

The functions and processes for establishing the new pharmacy regulator, the General Pharmaceutical Council, will be addressed and some reflections offered on the need for a new professional body for pharmacy.

Utilisation is the fourth stage of a knowledge service with the education of clinicians, patients and managers on how to use the information. Our expectations of patients will change but perhaps the greatest change is faced by clinicians who will have to learn that the three most important words of the 21st century are "I don't know".

The final stage is a feedback group, a question answering service from the user to the supplier via the procurer to ensure that unanswered questions are clearly classified into those for which an answer exists, if only it can be found, and those uncertainties for which there is no answer. In this latter group the question answering service will ensure that an answer is produced. This, of course, is a familiar function to pharmacists who have led the way in question answering services.

Health service reforms – impact on Medicines Information

Richard Cattell, *President of the Guild of Healthcare Pharmacists (GHP) and Head of Pharmacy, Dudley Group of Hospitals*

Abstract

Not available at time of printing

Plenary Session 2 – *Approving New Drugs*

***Chair:* Ron Pate**, *Pharmaceutical Adviser Secondary Care, Department of Medicines Management, Keele University*

Ron Pate is currently Secondary Care Pharmaceutical Adviser to the Department of Medicines Management at Keele University. Formerly he was Secondary Care Pharmaceutical Adviser to the West Midlands Strategic Health Authority (NHS West Midlands) and prior to this Clinical Director Pharmacy and Medicine Management Services for the Dudley Group of Hospitals. Ron is a past President of the Guild of Healthcare Pharmacists (1992-94) and was former Honorary Secretary to the European Association of Hospital Pharmacists (1996-2000). Ron supports NHS West Midlands in the performance management of former regional pharmacy specialist services, including Medicines Information

NICE and the national processes for approving new drugs

Professor Andrew Stevens
Head of Department of Public Health & Epidemiology, University of Birmingham

Andrew Stevens is Professor of Public Health at the University of Birmingham. He chairs one of the NICE appraisal committees. He was the first director of the National co-ordinating centre for Health Technology Assessment (at Southampton) and he co-directs the National Horizon Scanning Centre (at Birmingham). He is a founder member of EuroScan (the international collaboration for early warning in new health care technologies). Currently he is also vice-chairman of the Royal Orthopaedic Hospital Foundation Trust.

Abstract

There are different perspectives on the purpose and value of regulation from the pharmaceutical industry, government, clinicians, patient organisations and the media, and the regulators themselves. The two principal regulatory hurdles in Britain are (1) safety and efficacy exercised by the MHRA and EMEA, and (2) the National Institute for Health and Clinical Excellence, the Scottish Medicines Consortium and the All Wales Medicines Strategy Group with their responsibility for clinical and cost effectiveness. Their remits, coverage and clout differ somewhat. The tensions between the different perspectives on regulation are at their most public and severe in the decision making at NICE. The background to elements of NICE's decision making are explored with examples.

NHS resources and patients' rights - PCT processes for approving new drugs

Professor Chris Newdick, *Professor of Health Law, University of Reading and Member of the South Central Health Priorities Forum*

Chris Newdick is a barrister and the Professor of Health Law at the University of Reading. He has served on the Department of Health's Medicines Commission, is an Honorary Consultant to Berkshire West PCT and a member of the Berkshire Priorities Committee. He is currently on the BMA's Working Party on NHS Rationing and is the author of Who Should We Treat? – Rights, Rationing and Resources in the NHS.

Presentation

NHS RESOURCES AND PATIENTS' RIGHTS –
PCT PROCESSES FOR APPROVING NEW DRUGS

1. NHS RESOURCE ALLOCATION – WHOSE DUTY?

The Secretary of State must continue the promotion in England of a comprehensive health service.

The services so provided shall be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed. (s 1(1) and (3), National Health Service Act 2006).

R v N and E Devon HA, ex p Coughlan (1999)

> …as long as he pays due regard to that duty, the fact that the service will not be comprehensive does not mean that he is necessarily contravening [the Act]…a comprehensive health service may never, for human, financial and other resource reasons, be achievable…

NHS (Functions of StHAs and PCTs and Admin Arrangements) Regs 2002

It is the duty of every Primary Care Trust in respect of each financial year, to perform its functions so as to secure that the expenditure of the trust...does not exceed [its income] (s 229, National Health Service Act 2006).

2. IMPACT OF N.I.C.E.

A. NICE *Technology Appraisal Guidance*

A Health Authority shall, unless directed otherwise by the Secretary of State, apply such of the sums paid to it under the Act as may be required so as to ensure that a health care intervention that is recommended by [NICE] in a Technology Appraisal Guidance is, from a date not later than three months from the date of the Technology Appraisal Guidance, normally available… (NICE Directions, 2003)

NICE does not override [clinical] responsibility… even the best clinical guideline is unlikely to be able to accommodate more than 80% of patients for whom it has been developed (NICE, 2002).

B. NICE (and other NHS) *Guidelines*

R v N. Derbyshire HA, ex p Fisher (1997)

> If the circular provided no more than guidance… then the only duty placed upon the health authority was to take it into account… They were not obliged to follow the policy, but if they decided to depart from it, they had to give clear reasons for doing so.

3. SECONDARY CARE DUTIES OUTSIDE NICE

R v N Lancashire HA, ex p A, D &G (1999)

Reasonable PCT Discretion

The precise allocation and weighting of priorities is clearly a matter of judgement [for] each authority … It makes sense to have a policy for the purpose - indeed, it might well be irrational not to have one – and it makes sense that an Authority would normally place treatment of transsexualism lower in its scale of priorities than, say, cancer or heart disease or kidney failure. Authorities might reasonably differ as to precisely where in the scale transsexualism should be placed and as to the criteria for determining the appropriateness and need for treatment.

Consistent Priorities Framework

… in establishing priorities - it is vital: for (1) an authority accurately to assess the nature and seriousness of each type of illness, (2) to determine the effectiveness of various forms of treatment for it and (3) to give proper effect to that assessment and that determination in the application of its policy.

No RCT?

…the mere fact that a body of medical opinion supports the procedure does not put the health authority under any legal obligation to provide the procedure… However, where such a body of opinion exists, it is…not open to a rational health authority simply to determine that the procedure has no proven clinical benefit while giving no indication of why it considers that is so.

Blanket Bans Unreasonable

… the more important the interests of the citizen that the decision effects, the greater will be the degree of consideration that is required of the decision-maker. A decision that, as is the evidence in this case, seriously affects the citizen's health will require substantial consideration, and be subject to careful scrutiny by the court as to its rationality.

4. EXCEPTIONAL CASE REVIEW

A. Rationality in Exceptional Cases

Rogers v Swindon PCT (2006)

Otley v Barking and Dagenham PCT (2007)

First, Dr Sharma's query about the ratio in which Avastin had been prescribed by comparison with other components of the cocktail was an irrelevant query. Secondly, there were no other treatments in practice available to Ms Otley amongst those that could be prescribed within normal National Health Service standards which were likely to have any benefit for her. Thirdly, the Panel did not take into account the slim but important chance that treatment including Avastin could prolong Ms Otley's life by more than a few months. Fourthly, on any fair minded view of the exceptionality criteria identified in the critical analysis document, her case was exceptional.

B. Are *Personal* Circumstances Legitimate Differentiators?

Rogers v Swindon PCT

… could properly involve a decision by a trust which was subject to financial constraints and which decided that it could not fund all the patients who applied for funding for Herceptin treatment, to make the difficult choice to fund treatment for a woman with, say, a disabled child and not for a woman in different personal circumstances.

R (Gordon) v Bromley PCT (2006)

… where short-term prolongation of survival mattered [eg] someone who needed to make care arrangements for young children. There may be circumstances in which survival for very short periods may constitute particular circumstances.

But: (1) should patients with distressing *personal* circumstances merit *clinical* priority? Or should patients be treated similarly according to the *clinical* evidence? (2) What personal circumstances should qualify? *Rogers* mentioned a *disabled* child; *Gordon* mentions "children." Would a carer for an *elderly* relative qualify? Patients who are not carers may say this is discriminatory.

C. EU Law

Watts v Bedfordshire PCT (2006)

> where the delay arising from such waiting lists appears to exceed in the individual case concerned an acceptable period having regard to an objective medical assessment of all the circumstances of the situation and the clinical needs of the person concerned, the competent institution may not refuse the authorisation sought on the grounds of the existence of those waiting lists, [or] an alleged distortion of the normal order of priorities linked to the relative urgency of the cases to be treated.

5. PRIMARY CARE PRESCRIBING DUTIES

The members of a practice shall seek to secure that, except with the consent of the PCT or for good cause, the orders for drugs, medicines and listed appliances given by them... in any financial year does not exceed the indicative amount notified for the practice... (s 18, NHS and Community Care Act 1990).

The contractor shall not prescribe drugs and appliances whose cost or quantity, in relation to any patient is, by reason of the character of the drug or appliance in question in excess of that which was reasonably necessary for the proper treatment of the patient (GMS Regs, sched 6, para 46).

Incentives and Sanctions

QOF, practice-based commissioning.
Strategies to Achieve Cost-Effective Prescribing (DoH Interim Guidance, 2007).

The contractor shall carry out its obligations under the contract with reasonable care and skill (GMS Regs, sched 6, para 67).

…a prescriber shall order any drugs, medicines and appliances which are needed for the treatment of any patient who is receiving treatment under the contract by issuing to that patient a prescription form (GMS Regs, sched 6, para 39).

Patients will continue to be guaranteed the drugs, investigations and treatments they need… There will be no question of anyone being denied the drugs they need because the GP or Primary Care Group have run out of cash. GPs' participation in a primary care group will not affect their ability to fulfil their terms of service obligation always to prescribe and refer in the best interest of their patients. PCGs will be expected to live within their budgets. *Developing Primary Care Groups,* (DoH, 1998) HSC 1998/139, paras. 52-53.

R v Secretary of State, ex p Pfizer (1999))

> The doctor must give such treatment as he, exercising the professional judgment to be expected from a GP, considers necessary and appropriate.

Black/Grey Listed Drugs

THAMES VALLEY ETHICAL FRAMEWORK:

Berkshire Priorities Committee (BPC)
Oxfordshire Priorities Forum (OxPF)
Milton Keynes PCT
South Bucks and Chiltern PCT
Vale of Aylesbury PCT
Wycombe PCT
Thames Valley Cancer Network
Thames Valley Local Specialised Commissioning Group (LSCG)

Background

The Berkshire Priorities Committee and Oxfordshire Priorities Forum are both committees of representatives of the NHS organisations in each county and include lay members as well as clinicians and managers. The purpose of the BPC and OxPF (the 'Priorities Committees') is to advise the local NHS as to the health care interventions and policies that should be given high or low priority. Primary Care Trusts (PCTs) are under a statutory duty to promote the health of the local community. They are also under a duty not to exceed their annual financial allocation. This inevitably means that, from time to time, hard choices have to be made. The Priorities Committees help PCTs choose how to allocate their resources to promote the health of the local community. Individual cases are considered by the respective PCT.

Purpose of the Ethical Framework

An ethics subgroup was set up to review the existing ethical frameworks of Berkshire and Oxfordshire and to develop a Thames Valley wide ethical framework to support decision making across all three counties both within the established Priorities Committees and also within the LSCG/networks or individual PCTs. For the purposes of this document, all the above organisations will be referred to collectively as the 'Committees'. The purpose of the ethical framework is to:

• Provide a coherent structure for discussion, ensuring all important aspects of each issue are considered
• Promote fairness and consistency in decision making from meeting to meeting and with regard to different clinical topics
• Provide a means of expressing the reasons behind the decisions made.

Many of the decisions will involve the exercise of judgment and discretion and there will be room for disagreement both within and outwith the Committees. Although there is no objective or infallible measure by which such decisions can be based, the Ethical Framework enables decisions to be made within a consistent setting which respects the needs of individuals and the community. The Committees recognise that their discretion may be affected by National Service Frameworks, National Institute for Health and Clinical Excellence(NICE) technology appraisal guidance and Secretary of State Directions to the NHS.

Equity

The Committees believe that people have equal rights of access to health care on the basis of need. There may also be times when some categories of care are given priority in order to address health inequalities in the community. However, the Committees will not discriminate on grounds of personal characteristics, such as age, gender, sexual orientation, gender identity, race, religion,

lifestyle, social position, family or financial status, intelligence, disability, physical or cognitive functioning. Health care should be allocated justly and fairly on the basis of need and capacity to benefit, so as to maximise the welfare of patients within the budget available. The Committees will assess health needs according to patients' capacity to benefit from health care. In the absence of evidence of health need, treatment will not generally be given solely because a patient requests it. Similarly, a treatment of very little benefit will not be provided simply because it is the only treatment available. This is necessary to ensure that resources are used to provide the greatest health benefit.

The Ethical Framework is especially concerned with the following:

1. EVIDENCE OF CLINICAL AND COST EFFECTIVENESS

The Committees will seek to obtain the best available evidence of clinical and cost effectiveness. It will promote treatments for which there is good evidence of clinical effectiveness in improving the health status of patients. It will not normally recommend treatment that is shown to be ineffective. When assessing evidence of clinical effectiveness the outcome measures that will be given greatest importance are those considered important to patients' health status. Patient satisfaction will not necessarily be taken as evidence of clinical effectiveness. Trials of longer duration and clinically relevant outcomes data may be considered more reliable than those of shorter duration with surrogate outcomes. Reliable evidence will often be available from good quality, rigorously appraised studies. Evidence may also be available from other sources and this will also be considered. Patients' evidence of significant clinical benefit is also relevant. The Committees will also compare the cost of a new treatment to the existing care provided and will also compare the cost of the treatment to its overall benefit, both to the individual and the community. They will consider technical cost-benefit calculations (e.g. QALYs), but these will not by themselves be decisive.

2. COST OF TREATMENT

Because each PCT is duty-bound not to exceed its budget, the cost of treatment must be considered. The cost of treatment is significant because investing in one area of health care inevitably diverts resources from other uses. A single episode of treatment may be very expensive, or the cost of treating a whole community may be high.

3. INDIVIDUAL NEED FOR HEALTH CARE

The Committees will consider the health needs of individual patients according to their capacity to benefit from health care. So far as possible, it will respect the rights of patients to choose between different treatment options, subject to the support of the clinical evidence. Urgent and life-saving treatment will be given a high priority, as will treatment which effectively treats "life time", or chronic conditions such as arthritis, mental illness, or sensory impairment. When evidence of clinical effectiveness is equivocal, options for treatment will be given particular attention. There will be no total bans on treatment since there may be cases in which a particular patient has special circumstances which present an exceptional need for treatment. Each case of this sort will be considered on its own merits in the light of all the clinical evidence. PCTs have procedures to consider such exceptional cases on their merits.

4. NEEDS OF THE COMMUNITY

Public health is an important concern of the Committees and they will seek to make decisions which promote the health of the entire community. Some of these decisions are promoted by the Department of Health (such as the guidance from NICE and National Service Frameworks). Others are produced locally. The Committees also support effective policies to promote preventive medicine which help stop people becoming ill in the first place. Sometimes the needs of the community may conflict with the needs of individuals. Decisions are difficult when expensive treatment produces very little clinical benefit. For example, it may do little to improve the patient's condition, or to stop, or slow the progression of disease. Where it has been decided that a treatment has a low priority and cannot generally be supported, a patient's doctor may seek to persuade the PCT that there are exceptional circumstances which mean that the patient should receive the treatment within procedures established by the PCT.

5. NATIONAL STANDARDS

The Department of Health issues guidance and directions to NHS bodies which may give priority to some categories of patient, or treatment. These may affect the way in which health service resources are allocated. The Committees operate with these factors in mind and recognise that their discretion may be affected by National Service Frameworks, NICE technology appraisal guidance, Secretary of State Directions to the NHS and performance and planning guidance.

Plenary Session 3 – *Hospital Acquired Infection*

***Chair:* Craig Rore**, *Lead Pharmacist, Grampian Medicines Information Centre, Aberdeen*

Craig Rore is Lead Pharmacist for the Grampian Medicines Information Centre at Aberdeen, Secretary to the Association of Scottish Medicines Information Pharmacists, and a member of the UKMi Executive. He is also member of the New Drugs Committee of the Scottish Medicines Consortium. Craig teaches Medicines Information and Evidence Based Medicine to the 3rd year and 4th year Pharmacy MSc students at the Robert Gordon University. Previously, Craig was Drug Information Manager at Great Ormond Street Hospital, London.

Overview of hospital acquired inection

***Dr David Jenkins**, Head of Infection Control and Clinical Microbiologist, University of Leicester Hospitals NHS Trust*

Abstract

Not available at time of printing

Introducing antibiotics into hospitals

Professor Jonathan Cooke, *Director of Research & Development; Clinical Director for Medicines Management & Pharmacy, University Hospital of South Manchester NHS Foundation Trust*

Jonathan Cooke is Director of Research and Development and Clinical Director of Pharmacy and Medicines Management, University Hospital of South Manchester NHS Foundation Trust. He is also Professor, School of Pharmacy and Pharmaceutical Sciences, University of Manchester. He has previously held positions in Bradford and Leeds Hospitals. Jonathan is a member of UK Medicines and Healthcare Products Regulatory Agency (MHRA) Persons Appointed Panel; Department of Health Specialist Advisory Committee on Antimicrobial Resistance (SACAR)., Department of Health Advisory Board for Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) ; DH/HPA Joint Working Group on Clostridium difficile Infection, Prevention and Management; Steering Group for the NHS Centre for Reviews and Dissemination Economic Evaluation Database at the University of York ; and Board Member and Trustee for the British Society for Antimicrobial Chemotherapy. He is also rapporteur to the European Commission. His research interests are in antimicrobial usage, medication safety, health economics.

Abstract

Healthcare associated infections (HCAI) are a Government and an NHS priority.

Antimicrobial resistance constitutes a significant part of this and MRSA and Clostridium difficile infection rates and screening have become national targets.

The Department of Health is firmly committed to reducing HCAIs. It has produced a number of guidance documents:

Getting Ahead of the Curve, Winning Ways: Working together to reduce Healthcare Associated Infection in England, Towards cleaner hospitals and lower rates of infection: a summary of action, Clean, Safe Care – reducing infections and saving lives, Saving Lives: A delivery programme to reduce healthcare associated infection including MRSA, Essential steps to safe clean care: Reducing healthcare-associated infections provide guidance on moving towards compliance with these policies, best practice and evidenced based care.

The Health Act 2006 makes provision for the Secretary of State to issue a code of practice relating to the prevention and control of HCAIs in connection with healthcare provided by or for the following NHS bodies.

The Government has just launched a national campaign to remind doctors of the problem of antibiotic resistance and make clear to patients that antibiotics will not get rid of the common cold. This follows on from recommendations for initiatives that will ensure UK collaboration on defining learning outcomes for prudent antibiotic use for all health professionals.

The move towards evidence-based medicine has gained momentum this last decade. The publication of the CONSORT (Consolidated Standards of Reporting Trials) statement in 1996, its revision in 2001 and extension in 2004, which sought to improve the quality of reports of randomized controlled trials (RCTs), has contributed to this. Through its insistence on complete transparency of reporting, the statement has enabled editors and readers to understand exactly why and how an individual RCT was designed, conducted and analysed, and to assess the threats to the validity of its results.

The recent publication of the TREND statement (Transparent Reporting of Evaluations of Nonrandomized Designs) sought to do for public health interventions, most of which are described in non-randomized studies, what CONSORT has achieved for the RCT. It adapted the CONSORT statement, its checklist of descriptors and its flow diagram, but with revisions relevant Hospital interventions to control the rising levels of antimicrobial resistance (AMR) and healthcare-associated (nosocomial) infections form a large body of non-randomized studies. Systematic reviews of isolation policies in the hospital management of MRSA and of interventions to improve antibiotic prescribing to hospital inpatients have revealed major methodological weaknesses and inadequate reporting in published research. These included lack of details on study design, as others have noted, the timing and nature of interventions, failure to consider threats to validity of inference in the form of potential confounders and biases, and inappropriate statistical analyses. Studies were largely quasi-experimental and often basic information such as the number of isolation beds, criteria to diagnose infection, culture and typing of organisms, or the timing of interventions were missing. Guidelines for the publication of future outbreak reports and intervention studies were produced, informed by theoretical considerations but, although available on-line (www.hta.nhsweb.nhs.uk), these refer primarily to MRSA and are not as user-friendly as the revised CONSORT statement with its 22 item checklist and flow diagram.

The quality of research in hospital epidemiology (infection control) must be improved to be robust enough to influence policy and practice. In order to raise the standards of research and publication, a CONSORT equivalent for these largely quasi-experimental studies has been prepared by the authors of two relevant systematic reviews, following consultation with learned societies, editors of journals and researchers. The ORION statement: guidelines for transparent reporting of Outbreak Reports and Intervention studies Of Nosocomial infection consists of a 22 item checklist, and a summary table. The emphasis is on transparency to improve the quality of reporting and on the use of appropriate statistical techniques. The statement has been endorsed by a number of professional special interest groups and societies. Like CONSORT, ORION should be considered a ‘work in progress’, which requires ongoing dialogue for successful promotion and dissemination. The statement is therefore offered for further public discussion. Journals and research councils are strongly recommended to incorporate it into their submission and reviewing processes.

Plenary Session 4 – *IT Developments in MI*

Chair: ***Peter Sharrott***, *Pharmaceutical Adviser, London Specialised Commissioning Group*

Peter Sharott has recently retired as Pharmaceutical Adviser to the London Specialised Commissioning Group and Strategic Lead to the Pharmacy & Medicines Management, London Procurement Programme. Heis a member of National Pharmaceutical Supplies Group, the DoH Medicines Management in Mental Health Advisory Group and the London HIV Drugs & Treatments Group. His special interests include pharmaceutical procurement, benchmarking pharmacy services, workforce planning and mental health pharmacy services. Previously, Peter worked in Nottingham, Derby, King's College Hospital London, before becoming District Pharmacist at Charing Cross Hospital, followed by Pharmacy Services Manager, Chelsea & Westminster NHS Trust and Pharmaceutical Adviser to London Regional Office and then DHSC. Peter retired from full-time NHS work in August 2008.

NeLM

David Erskine, *Director, London & South East Medicines Information Service*

David Erskine has been Director of the London & South East Medicines Information Service for 3 months (having previously acted up for 4 years). He has worked at the Regional Centre at Guys for 12 years and prior to his promotion was responsible for developing the service for commissioners. David has been involved with the development of NeLM since its beginning as DrugInfoZone in 1998 and has been Project Lead for the development of the new platform since the project started in 2005. He has also been closely involved with the London New Drugs Groups throughout his time in post and the staff at this centre write the evaluations used by the London Cancer New Drugs Group to formulate their guidance.

Abstract

In this session the progress made so far with the development of the website will be reviewed briefly and the developments expected to be launched over the next 6 months will be highlighted. Key developments to be covered include:

- the launch of a battery of web-based tools for communities of practice to enable them to share material within the umbrella of NeLM
- the launch of a Medicines A-Z feature which will enable users to access key information about specific medicines (including information from sources like Datapharm and the BNF)
- the launch of a facility to allow NHS organisations to use NeLM as a platform for their formulary

MiDatabank – New and future develpments

***Steve Moss**, Managing Director, CoAcS Ltd, University of Bath*

Steve Moss is a pharmacist who after an initial time in the family community pharmacy joined the School of Pharmacy in Bath as a lecturer and has over the years taught pharmacy practice, pharmaceutics and pharmaceutical microbiology. His research interests have included repair of radiation induced DNA damage, drug targeting, gene delivery and the formulation of poorly soluble drugs.

Throughout his academic career Steve has always been involved in the development and use of computer software in relation to pharmaceutical applications. In 1992 he lead the group of academics that founded PCCAL (The Pharmacy Consortium for Computer Aided Learning) which has been responsible for the production of more than 30 CAL packages used in over 400 universities worldwide with pharmacy undergraduate students.

In addition to his academic career Steve has always been closely involved with the pharmaceutical industry and commerce. He is currently managing director of CoAcS Ltd which produces and markets pharmaceutical software. Examples of software projects include Capex and Lipidex, commissioned by Pfizer and widely used in the formulation of powder and lipid filled capsules, and training packages for AstraZeneca and the Department of Health. Most recently CoAcS has been responsible for implementation of the RPSGB computer based CPD recording system.

In the context of the UKMI meeting, Steve, through CoAcS, has worked with the UKMI to produce MiDatabank which is designed to be a national database application to record and process MI enquiries.

Abstract

Not available at time of printing

Plenary Session 5 – *Patient Safety Issues and MI*

Chair*: *Peter Sharott

Patient safety challenges

Steve Browne, *Director of Pharmacy, University ob Bristol Hospitals NHS Trust and Associate Director, Medicines Management, NHS South West*

Steve Brown is Director of Pharmacy for University Hospitals Bristol NHS Foundation Trust (formerly United Bristol Healthcare NHS Trust), and Associate Director of Medicines Management for NHS South West Strategic Health Authority. UHBristol is an Acute Teaching Trust comprising eight hospitals in central and south Bristol, and provides numerous tertiary care services including cancer, paediatrics and cardiac surgery. Three regional Pharmacy services also operate through the Trust. Steve has worked in Hospital Pharmacy in South Wales and Oxford before moving to the Bristol Royal Infirmary. He has been Director of Pharmacy in UBHT since 1997 and has varied professional interests including clinical governance, patient safety, technical services, research ethics, critical care, NICE implementation and the cost-effective use of medicines. He has contributed to numerous national strategic developments including being a member of the Modernising Manufacturing Board (South), a member of the advisory group for the Healthcare Commission review 'The Best Medicine' (2007) and a member of the Pharmacy Reference Group supporting work for the 'NHS Next Stage Review'. Currently he is also member of the 'NHS Casemix High Cost Drugs Steering Group'. At present his focus on patient safety includes leading the Medicines Management workstream in a second wave Trust in the Healthcare Foundation 'Safer Patients Initiative', and being the Pharmacist member of the core campaign team for the 'Patient Safety First' national campaign for England.

Abstract

The presentation will consider the challenge of ensuring patient safety with regard to medicines; can we reduce the level of avoidable harm to zero?

The following issues will be addressed:

- What is the scale of the problem? What are the key medication risks?
- The strategic direction of the White Paper 'Pharmacy in England – building on strengths, delivering the future' with regard to patient safety; the responsibilities of Chief Pharmacists with regard to Patient Safety.
- The medicines management agenda of the 'Patient Safety First' national campaign; managing high risk medicines; links to the NPSA work programme
- Examples of improving patient safety; the Toft report; regional projects

Medicine Information promoting patient safety

Ben Rehman, *Director, London Medicines Information Service*

Ben Rehman graduated from the London School of Pharmacy in 1997. His recent roles include:

- *Staff Editor, British National Formulary*
- *Medicines Information Manager, North West London Hospitals*
- *Director, London Medicines Information Service*

Abstract

The presentation will focus on the ways in which medicines information services can support the growing patient safety agenda within the NHS, with particular focus on the NPSA. A brief overview of the NPSA work programme will be given, including discussion of forthcoming rapid response reports. The talk will then focus on how medicines information can support patient safety with discussion of previous NPSA alerts and the likely information needs arising from forthcoming rapid response reports.

Hospitals responding to the Safer Patient Initiative

Don Hughes, *Director of Pharmacy, North Wales NHS Trust (Central)*

Don Hughes spent most of his career based at Wirral Hospital NHS Trust where he was clinical lead pharmacist from 1987 to 2001. There he gained extensive experience of in-patient electronic prescribing and latterly with the early use of automation of dispensing. He gained his Masters degree there by utilising multidisciplinary error data to identify system improvements. He moved to the Countess of Chester in late 2001 as Director of Pharmacy, where he initiated a novel automation of medication system within their accident and emergency department. He became Director of Pharmacy at Conwy & Denbighshire NHS Trust in early 2005. Conwy & Denbighshire was a first wave site for the Safer Patient Initiative where Don was the lead for the medicines management component of the initiative, which focussed on using novel techniques to improve the safety of high risk drugs and high risk processes. He retains a keen research interest in system improvements and the use of IM&T to support the safer clinical use of medicines.

Abstract

The presentation will provide a brief overview of the UK national Safer Patient Initiative (SPI).

The initiative was sponsored by the Healthcare Commission and involved four UK Trusts working in partnership with the Institute of Healthcare Improvement (IHI) from Boston USA. The speaker will provide a brief resume of the novel techniques used with the campaign to reduce risk of harm with high risk drugs and improve the safety of high risk systems. Medication errors and severe adverse events occur repeatedly with ‘high risk’ medicines. Clearly much awareness has been raised with the advent of the NPSA, the national safety alerts and the rapid responses. However, the techniques used within the SPI are markedly different in that they focus on a bottom approach by fostering small tests of change by staff who actually work within existing systems rather than a top/down process. The primary focus of the presentation will be on the IHI model of improvement using PDSA cycles and continual measurement as a method of sustained safety improvement.

Parallel sessions

Critical appraisal for new drugs (for D&TCs)

David Erskine, *Director and* ***Satpal Soor****, Principle Pharmacist, London & South East Medicines Information Service*

For personal details, see page 17

Abstract/Objectives

An opportunity to work through the assessment of a new drug for a formulary committee focussing on a consideration of the wider NHS perspective and in particular the use of ethical frameworks, the implications of Payment by Results and Lord Darzi's report "High quality care for all: NHS Next Stage Review". Workshop delegates will be expected to undertake some pre-course reading and find out some additional information prior to the workshop. The key aims for workshop attendees will be to gain:

- A better knowledge of common measures of risk and benefit when assessing a new drug and the limitations of those
- An understanding of the issues involved in determining the local role of a new drug in the context of existing national guidance
- An understanding of how changes in NHS funding may influence the uptake on new therapies and where they are prescribed and administered.

Current issues in rheumatology

Sarah Zareian, *Lead Pharmacist for Trauma, Orthopaedics & Rheumatology*
Dr. Ash Samanta, *Consultant Rheumatologist*
University Hospitals of Leicester NHS Trust, Leicester Royal Infirmary

Sarah Zareian currently works as the Lead Pharmacist for Trauma Orthopaedics and Rheumatology at the University Hospitals of Leicester. She is a supplementary prescriber for osteoporosis and is working towards gaining her independent prescribing qualification this year (2008). Sarah is the RPSGB representative on the National Audit of Falls and Bone health steering group. Prior to this Sarah has worked in other areas of pharmacy including phase one clinical trials.

Ash Samanta is a consultant rheumatologist at University Hospitals of Leicester NHS Trust and was appointed to this post in 1990. Before becoming a consultant he worked in several different areas in the country in junior posts including SHO's, registrars and senior registrars and gained a wide range of experience in general medicine and all the specialities. As a consultant he has seen many changes in the management of rheumatoid arthritis culminating in the use of anti-TNF therapy. He has a busy NHS practice and is responsible for under graduate and post graduate teaching. He is actively involved in clinical audit and is Head of Service for rheumatology. In addition to his medical work Ash has a law degree and is a part time lecturer in Law at the DeMontfort university Leicester. He teaches in the medical ethics in law programme and has published widely.

Abstract/Objectives

Rheumatology consultant and lead pharmacist tag team duo, Dr Ash Samanta and Sarah Zareian will challenge you in this workshop by discussing various approaches on how you should manage a variety of rheumatological disorders.

The workshop will begin by providing everyone with an introduction to some of the more common rheumatological disorders with a significant focus on Rheumatoid Arthritis, Psoriatic Arthritis and Ankylosing Spondylitis.

NICE and BSR recommendations will be considered in parallel with what you will experience in practice through a valuable set of real life case scenarios.

To ensure this workshop encourages feelings of greater awareness and excitement around rheumatology the workshop will come to a close by providing attendees with an update on future drug therapies and models of service with particular reference to Universities Hospitals of Leicester .

Preparing for advanced practice

Catherine Duggan, *Associate Director of Clinical Pharmacy for London, South East and Eastern and Senior Clinical Lecturer at the School of Pharmacy, University of London*

Catherine is an Associate Director of Clinical Pharmacy for London, South East and Eastern and a Senior Clinical Lecturer at the School of Pharmacy, University of London. In her post, Catherine is leading the development of programmes to support Advanced Practice across all sectors of the profession with the Joint Programmes Board (London East and South Eastern Regions). Additionally, she is involved in developing an evaluation culture within pharmacy practice, including the evaluation of clinical guidance on drug use patterns, the use of new drugs in small patient populations and adoption of evidence-based practice. Catherine is the current Chair of the United Kingdom Clinical Pharmacy Association and is an elected member of the Council of the Royal Pharmaceutical Society.

Abstract/Objectives

Pharmacy is the profession with expertise in the safe, appropriate and effective use of medicines for patients and the public. For years now, evidence has suggested that, as part of the healthcare team, clinical pharmacy demonstrably reduces costs, improve the quality of prescribing and increases safe management of medicines across all levels of practice, alongside the established roles of technical, procurement and medicines information pharmacists.

Most recently, political and professional drivers have increased demands for our profession to meet current and future health and social challenges with innovative evidence based services. In the UK, these visions have culminated in the publication of the White Paper (Building on Strengths- delivering the future) with the clear vision that pharmacy meet current and future health and social challenges with innovative evidence based services. There is a demand for increased clinical services across all sectors and specialisms in pharmacy, starting with integrating clinical practice into the undergraduate degree to support newly qualified pharmacists to apply pharmacy science into practice of pharmacy at the point of registering.

The White Paper “Trust Assurance and Safety” sets out the need for a separate regulator and leadership body to ensure maximum benefit to profession and public alike. In 2010, we will see a new body, the General Pharmaceutical Council, to regulate the profession, together with the opportunity to create a separate single leadership body for all sectors of pharmacy. This will benefit patients by making it easier for pharmacists to keep up to date with the latest advances in practice and ensure patients receive the best care related to medicines wherever they live. Following these two White Papers, we see the need to appropriately recognise different levels of practice regardless of specialism and sector of practice and to ensure that advanced practice is regulated across the profession.

The presentation will present the developments to date: the academic support seeks to build the knowledge required to practice at an advanced level around leadership, management, research and education. We have also focussed on codifying the experience required to gain advanced skills in practice relevant to all areas of specialism, by identifying core skills and more focussed specialist skills.

The workshop will describe how the pharmacy specialist groups across the UK have informed the development of Expert Practice and will share experiences and models for discussion- including how to build a portfolio that demonstrates your level of practice .

Research in Medicines Information

Paul Rutter, *Principle Lecturer, Pharmacy Department, Wolverhampton University*

Paul qualified in 1992 and worked as a community pharmacist for two years before becoming a teacher practitioner for Boots, working at Bradford and Portsmouth Universities. He then became a research practitioner, gaining his PhD in 2000 before becoming a full-time academic in 2001. He worked in pharmacy practice department at Portsmouth University until 2004 where wanderlust struck and went travelling in South America. On returning home he joined the new pharmacy department at Wolverhampton University in 2006 as Principle Lecturer in Pharmacy Practice. His research areas include self-care and he has written books on diagnosis for pharmacists.

Abstract/Objectives

Learning Outcomes

- Understand the purpose of the National UKMI Research Strategy
- Explain the role of the Research working group
- Know why research is important
- Be aware of the draft R&D standard
- Be able to take an idea & turn it into a project plan

Plan for the session

- Overview of MI research strategy and draft standards
- Activity one: project plan
- Group people in to areas ‘common interests’. This will be done prior to attendance by people completing pre-workshop questions
- Ask groups to draw up what steps they have to do to get the idea from a piece of paper to fruition and rank in order of importance
- Facilitators to go around the groups and to help
- Groups to display answers on flip charts
- Groups to use resource packs and session material to help
- Feedback
- Summary

Patient helplines

Trevor Beswick, *Director – South West Medicines Information & Training*
Sangita Kapur*, Senior Medicines Information Pharmacist, Northwick Park Hospital*

Trevor Beswick has spent most of his career in hospital pharmacy and Medicines Information and Training. After a six year spell working in Primary Care Trust, initially in Medicines Management and then in Primary Care Management and Commissioning, he moved back into MI and Training about 12 months ago.

Sangita Kapur is Senior Medicines Information Pharmacist at Northwick Park Hospital.

Abstract/Objectives

The workshop will examine the case for establishing patient helplines. It will then look at the barriers and problems in setting up such a service before focusing on the key elements to include in developing a business case to set up a patient helpline service.

Workshop objectives for the Patient Helplines workshop

- To review the case for establishing patient helplines.
- To identify barriers and risks to setting up such services.
- To share experience in setting up a patient helpline in MI.
- To consider points to include within a business case.

Writing skills surgery

Tim Albert, *Writer and writing skills trainer*

Tim Albert trained as a journalist and worked on local, national and medical publications as writer, subeditor and editor. In 1990 he recycled himself as a trainer, specialising in writing and editing courses for health professionals. He has run many courses for medicines information pharmacists (with some participants coming back several times!) and is a member of the PJ's journal oversight board. His latest book Write Effectively a Quick Course for Health Professionals, was published last month by Radcliffe Press.

Abstract/Objectives

Learning objectives for the Writing Surgery:

At the end of this session participants will have

- heard about the writing and communication problems faced by their colleagues,
- reflected on their own writing and communication problems
- discussed various solutions and strategies for coping with these problems,
- identified at least three action points that they can use to improve their own writing/communication skills.

Drugs in psychiatry

Anne Connolly, *Principle Pharmacist Medicines Information, Maudsley Hospital*

Anne Covvolly currently m anages the National Centre for Psychiatric Medicines Information based at the Maudsley Hospital. Her research activities include examining prescribing quality in different ethnic groups and using novel treatments in rapid tranquillisation. Anne is module leader for the pharmacotherapy course for the MSc Mental Health Studies at Kings College London.

Objectives:

The workshop will be an interactive session discussing new advances and current treatments for depression and schizophrenia.

Payment by Results

Rajesh Chauhan, *Market Access Solutions Manager, Roche Products Limited*

Rajesh Chauhan originally qualified as a pharmacist at Greenwich District hospital before moving into the community and setting up his own company - an independent pharmacy business. Several years later Raj decided to change his career and returned to further education to undertake an MBA. Raj subsequently joined the Department of Health and specifically the Payment by Results team. Whilst there he was responsible for development of the tariff, the currencies to support it (predominantly HRG4) and liaised with a wide range of clinicians to ensure it was fit for purpose. Raj joined Roche just over two years ago, firstly as a Healthcare Development Manager and then as a Market Access Solutions Manager. Part of his role is the creation, training and delivery of appropriate market access materials to overcome funding and capacity hurdles. The remainder of Raj's role is to develop and drive the overall strategy within Roche with regards to PbR.

Abstract/Objectives

PbR is an important development within the NHS and therefore it is increasingly important to understand the structure of PbR and the tools that underpin it. This session's objectives are, therefore, to understand:

- The principles of PbR and how the tariff operates
- How hospitals code and get payment from Primary Care Trusts under PbR
- The implications for providers and commissioners

Part of the session is interactive and will enable the audience to obtain a very practical understanding of how a tariff is generated from clinical diagnosis through to payment.

MI Technicians and skill mix in MI

Vivienne Rose, *Principal Technician, Medicines Information/Formulary, Northampton General Hospital and Director- UKMi Accredited Medicines Information Technicians Training Scheme (AMITTS)*

Vivienne Rose is currently Principal Technician, Medicines Information and Formulary at Northampton General Hospital and has been in this post since 1999 but has been employed at NGH since 1989. In 2003 Vivienne was one of the first technicians to gain accreditation on the UKMi Accredited MI Technician Training Scheme (AMITTS) and subsequently became a member of the AMITTS Board of Management. For the past two years she has been Course Director for the scheme. She has recently become a member of the UKMi Education & Training Working Group.

Abstract/Objectives

This workshop is designed to be 'about' technicians rather than specifically 'for' technicians.

Since 2003, the UKMi Accredited Medicines Information Technician Training Scheme (AMITTS) has accredited 34 MI technicians and there are a further nine technicians who have almost completed the accreditation process. There are technicians in a number of other centres who are not accredited.

The scheme currently concentrates on the enquiry answering process but Medicines Information departments undertake many more roles than solely enquiry answering. In this workshop the aim is to look at the skill mix in MI and identify roles that MI technicians can undertake and the skills and knowledge that is required for them to develop into these roles, such as training, critical appraisal etc.

The session will also include an overview of the UKMi Accreditation Scheme for Technicians and information on plans for the 4th cohort.

Poster Presentations

Best posters prize

Prizes for the two best posters will be awarded at the closing session (Plenary 5)

Previous winners of the best poster prizes:

2007
Sarah Rimmer, Lindsay Harkness and Prof Graham Davies
The use of advice provided by a Medicines Information enquiry answering service and its impact on patient outcome

2006
Elizabeth Pridgeon
Information provided by pharmacists contacting NTIS for advice about drug/chemical exposures in pregnancy

Lisa Britton, Jeremy Liew and Vibha Teli
Implementation of standard answers in medicines information for frequently asked questions of a specialist nature.

2005
Anne Lee, Sheena Kerr et al
Complexity indicators for medicines information enquiries

Adam Hocking
What is the effect of a peer review system on the standard of enquiry answering in medicines information

Oral presentations
There will be no oral presentations at the seminar. Previous winners of the best oral presentation are:

2006: Sarah Cavanagh.
Medicines information to the developing world. Whose need is the greatest?

2005: Janet West
Assessment of the impact of pharmacist dose adjustment of aminoglycosides and vancomycin in the intensive care unit

Poster 1

User Survey: Survey of NHS Medicines Information (MI) Centres by PIPA

PIPA Standards Working Party

This was the first full survey by PIPA members of the interaction between Industry Medical Information Departments and NHS Medicines Information Staff conducted during Q2, 2008 using an online survey tool. A total of 208 calls were assessed from approximately 140 different Hospitals.

Results

The majority (89.9%) of enquirers were Medicines Information Pharmacists. The most common enquiry topics were storage/stability (21.2%), off-label (unlicensed) use (13.5%) and adverse effects (12%). The most common reason for the enquiry related to patient treatment (specific patient 46.6%; future patient treatment 20.2%), 9.1% were for guidelines etc and 25% for other reasons (storage/stability the most common).

Quality of Interaction

Clarity of caller introduction was good or excellent in 90.4% of calls and poor/very poor in 9.6%.

Telephone manner was good or excellent in 93.3% of calls and poor in 6.7%.

In 93.8 % of calls, the enquiry was considered appropriate to be answered by the Medical Information Department and in 6.2% it was felt it was not.

In 94.7% of cases it was felt that the enquirer had provided sufficient background information to enable the question to be answered. In 5.3% it was not.

In 71% of cases where it might have been appropriate for the enquirer to try and answer the question themselves prior to calling, it was felt that sufficient effort had been made, but in 29% of cases it was not.

In 95.7% of calls, the deadline was considered to be easy or fair.

In 96.9% of cases where it was necessary to get back in contact, it was easy or fair.

For 88.5% of enquiries, it was felt that the enquirer could not have done more to enable their enquiry to be successfully answered.

Conclusions

The interaction of NHS Medicines Information Staff with Industry Medical Information Centres is generally good and appropriate. Areas identified for consideration by PIPA and UKMi for improving the interaction between the enquirer and the Industry include: clarity of introduction, effort made to try and answer an enquiry before calling, adverse event enquiries, enquiries relating to information in the SPC, and requests for information outside the SPC.

Poster 2

Improving information governance for pharmacists working out of hours: involvement of a MI service

Mark Cheeseman, *Regional MI Pharmacist – Training & Secondary Care Support East Anglia Medicines Information Service*

Abstract

Medicines information/advice out of hours is provided by the on-call pharmacists at the Ipswich Hospital NHS Trust. The on-call pharmacists record the advice/information they have given on paper which is then reviewed by the lead on-call pharmacist. Any necessary action is then taken by the lead on-call pharmacist where upon the paper record is then destroyed. Therefore there is no easy or reliable way of retrieving this information at a later date if needed.

It was identified by the EAMIS that the information/advice documented by the on-call pharmacists was very limited with no or little reference to the source(s) used to provide the information. In addition, there was no clear, robust audit trail of the information provided out of hours which meant that it could not be checked at a later date if needed for legal reasons.

An Emergency Duty Drug and Medicines Information (EDDi) Pack based on the UKMi Enquiry Answering guidelines and UKMi Quick Question Guide, was developed to support on-call pharmacists providing advice/information out of hours at the Ipswich Hospital NHS Trust.

This document guides the on-call pharmacists to record the minimum amount of information which should be recorded when taking in an enquiry. It also sign posts the on-call pharmacist to the resources available to them and where these can be found, i.e. the MI centre, dispensary, Internet.

The EDDi pack provides a dedicated form for those enquiry types received out of hours. Once completed by the on-call pharmacist, the form is given to the MI centre to retrospectively enter onto MiDatabank. The enquiry is categorised to Ipswich Hospital out of hours to enable better retrieval of the information/advice given. It also allows monthly reports to be given to the lead on-call pharmacist showing the types of enquiries received out of hours and the information/advice provided.

The EDDi Pack is now in use by the on-call pharmacists at Ipswich Hospital. After 3 months, the on-call pharmacists will be surveyed and the EDDi Pack evaluated to identify its usefulness.

Poster 3

Does documenting when a MI service receives telephone calls help to plan service provision?

Mark Cheeseman, *Regional MI Pharmacist – Training & Secondary Care Support East Anglia Medicines Information Service*

The East Anglia MI Service (EAMIS) introduced a rota in mid 2007 for medicines information (MI) pharmacists answering the phone, processing enquiries and undertaking 'active' time. This utilised a MI pharmacist answering the telephone and another processing enquiries. However, it was recognised that there are some days and certain times of day when relatively more enquiries are received compared to others. Identifying when these time periods occur might enable better planning, more efficient use of staff and potentially greater 'active' output.

The aim of this service evaluation was to find out if there are any patterns with regards to the day and/or time of day when the MI centre receives telephone enquiries.

A simple 'Telephone Record Form' was produced which enabled the MI pharmacist to document the type of call, i.e. enquiry or other (this was for all other calls which were not enquiries), and the day and time it was received Monday to Friday. Telephone calls received by the MI centre were recorded every other month for 8 months (4 months data collected).

A total of 1398 telephone calls were documented during this 16 week period. A total of 772 (55%) were enquiries and 626 (45%) were classified as "other" calls. The median numbers of enquiries received each working day over the 16 week period showed that in descending order of frequency, most telephoned enquiries were received on Thursdays, Wednesdays, Tuesdays, Monday and Fridays. The highest number of enquiries received by the MI centre each day was between 11am and 12pm, and 2pm and 4pm.

As a consequence of this work, the rota used by the EAMIS has been adjusted to ensure that a full complement of staff is available to receive enquiries on Wednesdays and Thursdays, in particular between 11am and 12pm and 2pm and 4pm. For all other days, except between 11am and 12pm and 2pm and 4pm, only one MI pharmacist is on the rota to answer telephones & process enquiries which enables more staff to undertake 'active' work.

Poster 4

The Mystery Shopper Project: A useful additional tool for Quality Assurance of MI services?

Alison Innes, Caroline Taylor, Satpal Soor and Davina Wraight,
London & SE Medicines Information Services, Northwick Park Hospital and Guy's Hospital, London

Background

The current UK Medicines Information (UKMi) Standards for Quality Assurance (QA) of enquiry answering by Medicines Information (MI) services rely upon retrospective analysis of a sample of enquiries based on the enquiry records. Mystery shopping has been used in health service evaluation (1) and has been proposed as an additional tool for assessment of the quality of the UKMi enquiry answering service.

Aims

To determine whether the mystery shopper approach is feasible in MI.

To assess whether the mystery shopper approach provides any additional information to the current methods for assessing the quality of the enquiry answering service.

Method

In the first phase a clinical pharmacist in each participating Trust asked their local MI centre the same question, and recorded details of the enquiry intake, communication of the answer, and accuracy of the MI documentation. The MI staff were asked if they answered as if it was a genuine enquiry. In the second phase the senior pharmacy manager asked for a review to test whether this method is useful to assess literature searching skills. An experienced UKMi assessor assessed all the available data.

Results & Conclusion

The mystery shopper approach was found to be a feasible approach for assessing certain elements of the quality of the MI enquiry answering service, and can provide some additional and complementary information to the current UKMi QA methods. The use of staff within the same department as a mystery shopper presents problems, and an external or non-pharmacy mystery shopper may be more successful. Consideration should also be given to using a single mystery shopper for all centres to avoid bias.

References:

1. Moriaty H, Macleod D, Dowell A. Mystery shopping in health service evaluation. *British Journal of General Practice.* 2003; 497: 942-946.

Poster 5

Does enquiry answering make a difference to patient outcomes?

Gill Stead *and* ***Peter Golightly****, Trent Medicines Information Service, Leicester Royal Infirmary*

Introduction

In September 2007 UKMI published a strategy for “Effective Information for Managing Medicines” to facilitate the NHS medicines management agenda locally and nationally.

In order to measure how successful UKMI is in supporting the key issues underpinning organisational change within the NHS, it is essential to develop a tool that enables assessment of the impact of enquiry answering.

Aim

•Design and validate a questionnaire.

•Analyse the data.

Method

A survey form was designed listing all possible end outcomes of enquiry answering. A total of 249 surveys were mailed from five MI centres (Trent, Lincoln, West Midlands, Solihull and Birmingham City) for the pilot survey.Results

An adequate overall response rate was seen (55%) with most healthcare professional groups responding.•The results show that 95 % of the information and advice given in response to enquiries by a wide range of health professionals result in resolving prescribing and medicine management problems.

- •66% enquirers indicated they thought the information enhanced patient safety.
- •The results show that the MI service is used by the health community to assist with the acute daily problems that it encounters and not an educational resource for literature searching alone.
- •Hospital pharmacists are the biggest enquiry user group of MI and so it is important to measure the outcome of their enquiries. Our survey showed these enquiries do result in a positive

Conclusion

Although MIDatabank captures enquiry category and the nationally used “user survey” is a useful indicator of customer satisfaction, they do not capture what actually happens to that information and the impact that it has. If adopted nationally, this survey, with minor adjustments, would provide the basis of a useful tool on perhaps an annual basis. It would be appropriate to use this in addition to the existing user survey to measure the outcome of the information and advice given by MI pharmacists. This would enable MI departments to assess and be assessed nationally in a detailed manner in line with the strategic aims of UKMI and the NHS. Future developments could include adding a rating scale and a financial element.

Poster 6

Does Medicines Information have an Impact on Patient Care?

Diane Bramley, David Erskine, Champa Mohandas, Alice Oborne, Satpal Soor, *Pharmacy Department, Guy's and St Thomas' NHS Foundation Trust, London*

There is little published work evaluating the direct impact of Medicines Information enquiry answering services on patient care[1]

Objectives

To assess if MI advice to healthcare professionals in response to their enquiry is used

To assess whether MI advice impacts on patient care

Method

Two weeks prospective data collection from MI centres at two teaching hospitals

Patient-specific enquiries from health professionals

1) Taking in initial enquiry: callers asked if they are waiting for reply before proceeding with any further treatment or action and what is the expected patient outcome.

2) Follow up: Semi-structured interviews 7 – 28 days later to obtain details of the patient outcome and see if and how the caller used the advice provided.

Results

40 enquiries included, 32 callers followed up, 8 unavailable after four attempts

Status of enquirers: 16 doctors, 17 pharmacists, 6 nurses, 1 dentist

Waiting for reply before action: 31 waiting for reply, 7 already had plan of action or already treating patient, 1 unsure of how to proceed, 1 patient had already died.

30 (94%) of the enquirers followed up used the MI advice, 2 (6%) did not use because no additional information provided, or they wanted the information for future reference

Discussion

MI advice was used by the majority of enquirers and was reported to impact on patient care. Information on actual patient outcomes was limited to enquirer's opinion of immediate patient outcome, with no independent confirmation. Future studies could utilise an independent panel to reduce bias or subjectivity[2]

References:

1) D Hands, M Stephens, D Brown. A systematic review of the clinical and economic impact of drug information services on patient outcome. Pharm World Science 2002;24: 132 – 138.

2) A Spinewine, B Dean. Measuring the impact of medicines information services on patient care: methodological considerations. Pharm World Science 2002; 24: 177 - 181

Poster 7

Research into the value of a medicines information service: Part 2 – piloting a questionnaire

***Helen Davis, Simone Henderson, Joanne McEntee**, and **Jill Rutter**, North West Medicines Information Centre, Liverpool and **Paul Rutter**, University of Wolverhampton.*

Background

The UK Medicines Information (UKMi) national research strategy highlights the limited published research on the impact of MI services on patient care. The aim of the study was find out how the advice we provide to enquirers is used and what it is used for.

Methods

A questionnaire was designed based on the findings of a literature search, examples of existing questionnaires and writing guides. All healthcare professionals who contacted the North West MI centre with an MI enquiry over a five day period were eligible for receipt of a questionnaire, except NHS Direct staff and patients. The questionnaire consisted of questions on user satisfaction and how the advice provided was used. As this was a pilot study, enquirers were asked to comment on the format of the questionnaire and ease of completion.

Results

Of 53 questionnaires sent out, 51% were returned. Non-responders received a single telephone follow-up call after three weeks; the response rate then increased to 75%. All enquirers were happy with the quality of the service provided. 95% of enquirers used the information provided and 85% of these used the information for the management of a patient. Of the latter, 91% said that the information provided had a beneficial impact on patient care. Other uses of the information were to advise others, for CPD or for teaching purposes. 84% of respondents completed the questionnaire in five minutes or less. 97% stated that they understood the questions, were given adequate explanation and the questionnaire length was acceptable. 89% said the questions flowed well yet our analysis revealed that only 20% worked correctly through the questionnaire.

Conclusion

The results indicate a high level of satisfaction with the NWMI service. Nearly all enquirers used the information provided and a high proportion of these felt the information was useful for the care of their patient. The results from the pilot allowed us to revise and improve the questionnaire and make changes to the processes for issue and receipt. The questionnaire will be used to conduct a larger study and is intended to be used as an audit tool in the NWMI centre in the future.

Poster 8

Research into the value of a medicines information service: Part 1 - where to start?

Simone Henderson *and* ***Joanne McEntee,*** *North West Medicines Information Centre, Liverpool.*

Background

The national user survey used by UK Medicines Information (UKMi) centres to assess the quality of their enquiry answering service does not currently gather data on the impact of the service on patient care. This has been identified as an essential UKMi research topic[1]. How should this deficit be addressed? As novice researchers, how do we start?

Objective

To design a study to find out if and how medicines information and/or advice given to healthcare professionals is used in the care of patients.

Methods

- **Getting advice.** We found extensive information on research methods on the UKMi website. Support was available from MI colleagues and UKMi research leads, schools of pharmacy and local trust research and development departments.
- **Defining the research question.** We conducted a literature search and prepared a research protocol to clearly set out the aims and proposed methods of the project.
- **Designing a questionnaire.** Using information gathered from the published literature, guides to survey methods and questionnaire design, and examples of questionnaires used within the UKMi network, we prepared a draft questionnaire. We sought comments from colleagues and experts in pharmacy practice research on its content and layout.
- **Calculating sample size.** We estimated the required sample size using a calculator available on the internet.
- **Doing a pilot.** We conducted a pilot to ensure that the questionnaire was suitable for purpose, and our processes for issuing and receiving questionnaires were robust. Computer software was used to assist in data analysis.

Findings

Conducting a research project is challenging and time consuming. Support is available from within the UKMi network and from external sources such as universities and healthcare trusts. A clear focus on the aims of the project is essential and a pilot is necessary to ensure that nothing has been overlooked.

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Poster 9

Joint regional MI/specialist clinical pharmacist posts – do they work?

Fontane Lok *and* ***Kerstin Weber,*** *East Anglia Medicines Information Service, The Ipswich Hospital NHS Trust, Ipswich*

Background

At Ipswich Hospital, two new roles have been implemented recently. These involve working as both regional medicines information (MI) and specialist clinical pharmacists. There is one clinical pharmacist for critical care, theatres and anaesthetics, and another for ophthalmology, ENT and urology. These full-time roles involve spending three afternoons each week in MI and the remainder within the clinical area.

Some of the advantages and disadvantages to these innovative roles are provided below:

Advantages

1. Developing the clinical pharmacy service provided by utilising MI skills:
    - Enquiry answering skills: retrieving relevant information from enquirers, awareness of the resources to use, able to interpret information, and provide complex information in response to enquiries.
    - Theoretical knowledge gained in MI can be applied into clinical practice.
    - Communication skills acquired in MI are essential for collaboration with other healthcare professionals and patients on the ward.
2. Developing the MI service provided by utilising clinical pharmacy skills:
    - In MI, a link with hospital pharmacy practice is important so that information can be interpreted using clinical background knowledge.
    - Pharmacist's knowledge and practical experience in specialist area can be used as a resource in MI.
    - Understanding patients' views and concerns can be taken into account when providing advice in MI, especially for NHS Direct enquiries.

Disadvantages

Less flexibility, for example it is not always possible to attend meetings.

Summary

In summary, the benefits of working as both MI and specialist clinical pharmacists far outweigh the disadvantages. It is the authors' belief that the time spent in each area is optimal. Working in MI in the afternoons enables the provision of a pharmacy service to the clinical areas when it is most urgently required (i.e. in the mornings).

Poster 10

Factors that influence the length of time it takes to handle medicines information enquiries

William Horsley, Elizabeth Mallett, Gillian Masters, *RDTC, Newcastle*

Introduction

Research on MI enquiries often focuses on the quality and quantity of information received and dispatched. [1] The aim of this research was to investigate the factors that influence the length of time it takes to handle MI enquiries.

Method

Enquiries received between January and December 2007 were identified. The time spent on each enquiry was analysed to relate it to the time that the call was received, the enquirer type, and the enquiry category. As this value is recorded as a non-linear categorical value it was adjusted to ordinal data to permit statistical investigation. [2] Ordinal logistic regression was performed using Minitab® software. [2,3]

Results

The time spent on most enquiries was 0 -15 minutes (513, 36%). Only 7 enquiries took over 24 hours. Statistically significant categories ($P \leq 0.05$) were identified for each of the three factors investigated. Enquiries from GP's, hospital medics, PCT advisers, and practice pharmacists took significantly longer to complete. Enquiries about adverse reactions, alternative medicines, and drug selection took significantly longer to complete, and those about identification and references took significantly less time than other types of enquiries. It was also found that enquiries received later in the day were completed significantly quicker than those from earlier in the day.

Discussion

The main weakness in the data is that the time taken is subjectively assessed by staff. The duration recorded for each enquiry could also be affected by users relying on the default value of 1 - 4 hours rather than selecting a specific value. However as this selection accounted for < 10% of enquiries this is not believed to be the case. There is no rational explanation for the difference in time taken to complete an enquiry based upon the hour of the day that it was received. This relationship might reflect the personal attributes of MI staff. Some of the statistical tests were compromised by the large number of variables which resulted in poor fitting of the data to the assumed models and this is a weakness in the analysis.

Conclusion

This information can be used by MI managers to help with planning of their service. The data suggest that enquiries from earlier in the day, those from GP's, hospital medics, and primary care pharmacists, and which are about adverse reactions, alternative medicines, or drug selection take longer to answer than other enquiries. Enquiries about drug identification or requests for references take the least time. These conclusions should be verified using a larger data set.

References

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2. McCullagh P. Regression models for ordinal data. Journal of the Royal Statistical Society. Series B (Methodological) 1980;42(2):109-42
3. www.minitab.com

Poster 11

Medicines Q&As on NeLM: Are they useful and accessible to UK medicines information pharmacists?

Marc Miell *and* ***Kate Picket.*** *Wessex Drug and Medicines Information Centre, Southampton University Hospitals Trust.*

Aim

To establish if UKMi pharmacists find Medicines Q&As useful and accessible in answering patient-centred clinical enquiries.

Method

Based on the findings of a small pilot project, a questionnaire of open and closed questions was developed, to be administered through a structured telephone interview. 50 potential partcipants were randomly selected from the UKMi Directory and approached for interview between December 2007 and June 2008; 24 agreed to participate. Quantitative data on the total number of visits to the Medicines Q&As was also obtained from the National Electronic Library for Medicines (NeLM) for the 12 month period from 29th November 2006 – 29th November 2007.

Results

23 questionnaires were available for analysis. In an average week all 23 respondents (100%) accessed Medicines Q&As at least once, with 91% (n=21) stating that Medicines Q&As helped them to answer between 1 and 5 enquiries during this time.

The Medicines Q&As that were used most often and/or were most useful were those which addressed the use of drugs in pregnancy and breastfeeding and those relating to central nervous system medicines.

The majority of users (96%, n=22) were able to find Medicines Q&A documents easily. A variety of methods were used to access Q&As and some users used more than one method.

During the 12 month period from 29th November 2006 – 29th November 2007, 129 Q&As were available on NeLM (54 of which were added or updated during this year). The total number of visits to Medicines Q&As during this time was 262,950.

Conclusion

Overall, the results demonstrate that the content and accessibility of Medicines Q&As is appropriate for UKMi pharmacists and that they are a popular resource.

Poster 12

Information resources for hospital pharmacies: managing the risk

Sahera Uddin, Louise Nolan *and* ***Gillian Stead,*** *Trent Medicines Information Service, Leicester*

Introduction

Information has the most value when it is accurate, up to date and accessible at the point of need. Access to current medical information is a necessity for pharmacy staff in order to support patient care and safety and to fulfil their role as guardians of medicine. The risk management policy for the NHS UKMI Medicines Information services has outlined that out of date resources are a risk.

Aim

- To establish the essential resources required in pharmacy departments
- To audit the hard copy resources kept at each pharmacy site and evaluate this against the essential resources to highlight any deficits
- Generate a resource management system to ensure that pharmacy departments always have access to the most up to date essential resources.

Method

- Stage 1 Data collection- audit of resources at all three pharmacy sites
- Stage 2 Data Entry- a database was designed on Microsoft Access to capture data
- Stage 3 Development of the ‘essential resource list’ by MI pharmacists
- Stage 4 Generation of reports from the database to highlight any deficits
- Stage 5 Development of a guideline for the management of resources across UHL pharmacies.

Results

The only formal requirements for resources required in pharmacy came from the RPSGB for pre-registration sites. This together with MI recommendations, formed the essential resource list. Reports were generated from the database and showed that most of the essential resources were either out of date or unavailable and therefore potentially posing a risk.

Conclusion

Results show that hospital pharmacy departments are not necessarily adequately resourced to answer clinical enquiries and resources are often out of date. This shows that all pharmacy departments need surveillance of their information resources. Review by MI resulted in purchase of new editions of books and also an electronic Medicines Complete package making a saving of £220.00 ensuring up to date information accessible at the point of need. Tracking and purchase of new editions will be managed by MI thereby minimising the risk of out of date information being used to aid clinical decision making.

Poster 13

Internet based Database for management and documentation of drug information in German hospital pharmacies

S. Amann [1], G. Kirsch [2], J. Menchini [1], C. Mildner [1], U. Mühlhäuser [2], C. Querbach [2], C. Schuhmacher [1], D. Strobach [1], C. Vetter-Kerkhoff [1,]

[1] Committee for Drug Information & Communication, [2] Working Group FAQ, German Society of Hospital Pharmacists (ADKA), Germany Technischen Universität München, Germany

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Background

According to a survey, commissioned by the German Society of Hospital Pharmacists (ADKA) in 2002, members showed great interest in having their own documentation system for drug information (DI). Providing drug information on a professional basis is a growing topic in clinical pharmacy services.

Objectives

To do this service efficiently, the internet based ADKA-Aminfo-Datenbank was established in 2003 as a helpful tool for the organising and documenting of DI in German hospital pharmacies.

Methods [1]

- Technical requirements: Internet access, internet browser, JavaScript activation
- Data security: Password protected area (user: autorized staff, hospital pharmacies)
- Usage fee per hospital pharmacy: € 250 per year
- Login to database: no installation, worldwide access (www.adka-aminfo.de)

Results [1]

- The Database (D) consists of the following main sections/menu:
- Management of questions: contains recording questions, typing answers, attaching sources used and classification (e.g. ATC, ADR, category of queries).
- Menu Documentation: enables additional documentation relevant for statistics (e.g. consultation time, quality assurance aspects, potential cost saving) and printing standardized answer sheet.
- Search features: offers access to complete details of stored enquiries.
- FAQ-module: Unlike local FAQs that are available to any user in the hospital pharmacy, ADKA-FAQs revised by a brains trust are provided for all users of the D.
- Administration: User, literature, text elements are included to support data entry.
- Statistics: statistical evaluation of stored questions according to e.g. category, urgency of enquiry, sources of information, enquirer.

Discussion [1]

Currently, 84 German hospital pharmacies utilise the D. The D can be used as an activity confirmation

- for physicians and nurses: Quality improvement, saving of time and labour, improved cooperation physician/pharmacist, or pharmacist/ward respectively
- for the pharmacy director: Structured approach guarantees quality standards, optimisation of operations in the area of DI, insight into time and effort used
- for the clinic director: Documentation of quantity and quality work performed, quality improvement, drug safety, transparency of activity “DI”, justification of financial and human resources

Conclusion

DI is a growing challenge for hospital pharmacists. The quality of DI has a substantial influence on the success of drug therapy. This internet based D represents a practical choice to ensure a high standard of quality of management and documentation of DI. It provides cooperate identity, information exchange via FAQ´s, extensive search features and timesaving presentation of the service.

References

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Poster 14

Crystal ball gazing - do predictions come true?

Lindsay Banks *and* ***Helen Davis,*** *North West medicines Information centre, Liverpool*

Background

Prescribing Outlook – New Medicines (PO-NM) aims to anticipate UK drug launches or licence extensions in the next 12-18 months that are likely to have a significant impact in the NHS. It has been published annually in September since 2003. Horizon scanning is by nature intuitive but systems have been developed to support the process. UKMi has refined the processes for deciding content of PO-NM over recent years but their effectiveness is unknown.

Aim

To evaluate the accuracy of predictions of new product launches as stated in PO-NM and identify factors contributing to unintended omissions.

Method

The date of UK marketing for new products or significant licence extensions for all drugs over the period Sept 03 to Aug 07 were obtained. Each product was categorised as: 'on target' if listed in PO-NM and launched within 6 months of predicted date, 'off target' - launch > 6 months of predicted/not launched/withdrawn from the licensing process, or 'missed' – not included in PO-NM. A proportion of drugs were included in more than one year of publication as licensing progressed. Two experts in horizon scanning assessed whether any missed drugs should have been included, with hindsight. These were categorised as 'unintended omissions (UOs)'.

Results

Publication year	No. included	'On target'	'Off target'	No. missed	No. UOs	% UOs of total launches
03-04	43	51%	49%	17	6	10%
04-05	37	49%	51%	16	3	5.6%
05-06	47	70%	30%	21	5	7.3%
06-07	41	56%	44%	19	3	5%

Of the 17 UOs 8 (47%) were new chemical entities, 8 (47%) licence extensions and 1 was a new formulation. 11 (65%) of the UOs were launched in the summer months.

Discussion

PO-NM coverage is not intended to be comprehensive but focus on those thought to have the largest impact. Although the processes for deciding content have been refined over time the relative proportion of drugs 'on target' has remained reasonably constant. Regarding UOs, it is known that data on licence extensions is more difficult to obtain than that for new chemical entities and the time from filing to licensing is shorter. It appears that UOs are more likely to occur when the filing of drugs for licensing occurs whilst PO-NM is being compiled.

Poster 15

How do community pharmacists answer questions about medicines 24/7?

David Brown and Muriel Eggbeer-Linde *School of Pharmacy, University of Portsmouth and* ***Angela Emerson,*** *Wessex Drug and Medicines Information Centre, Southampton University Hospitals NHS Trust.*

Background

The changing roles of community pharmacists require them to have reliable, up-to-date access to information about medicines around the clock[1-4]. However previous work has demonstrated that they are often not able to answer questions about medicines from the information resources available to them[1]. This may simply be due to insufficient information resources in the pharmacy, but could be due to a lack of awareness of the resources available or restricted information support outside office hours. UKMi needs to know how community pharmacists handle questions about medicines 24/7 and whether these practitioners require further support.

Method

Cross-sectional survey of community pharmacists working in Southampton and Portsmouth using a postal questionnaire.

Results

Of the 120 pharmacists surveyed, 31 usable returns were received (26%).

Most respondents indicated that they had not experienced barriers to finding information about medicines during office hours (84%, n=26). All used paper-based resources in the pharmacy (100%, n=31), but this mainly related to use of the BNF (100%, n=31); only 55% (n=17) used key resources such as 'Stockley's' and product data sheets. In addition, as only 71% (n=22) of respondents had internet access, with the majority (95%, n=21) of these having restricted access, only 45% (n=14) used electronic resources to answer questions about medicines. Respondents indicated that they most commonly needed to find information about side effects, and pregnancy and breast-feeding (84%, n=26). 87% (n=27) of respondents indicated that they worked outside office hours, and the majority found it more difficult to find information about medicines during this time (61%, n=19)*. Barriers listed included lack of resources in the pharmacy and lack of support services. When asked to respond to several within and out-of-hour patient-specific medicines information enquiries, although respondents were able to formulate questions well, they often could not respond to the request appropriately because of these and other barriers, sometimes resulting in delayed action or sub-optimal advice being given.

Conclusions

UKMi have the opportunity to work with relevant stakeholders to improve the access to medicines-related information resources in community pharmacies, to provide training on efficient searching appropriate to a busy community setting, and to develop appropriate outputs targeted to primary care topics (e.g. Medicines Q&As).

(* Only 27 participants responded to this question)

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Poster 16

Medicine-related calls handled by community pharmacists: A preliminary study

Paul Rutter, *University of Wolverhampton, Pharmacy Dept, School of Applied Sciences*

Aim

This study aims to determine what type of enquiries community pharmacists handle on a day-to-day basis.

Background

The community pharmacist is often regarded as the most accessible health care professional. However, little or no research has been conducted to determine the types of enquiry community pharmacists handle.

Method

Community pharmacies from Blackwater Valley & Hart, Mid and North Hampshire Primary Care Trusts (PCTs) were recruited to the study. Pharmacists were asked to complete a pre-piloted data collection form that captured details on the enquirer, the nature of the enquiry and the answer the pharmacist gave (only data relating to the first two parts of the survey are reported here). The study was designed to last one week. All forms were analysed using Excel.

Results

Sixty-six completed data collection forms were received from eleven pharmacists. Twice as many enquiries were from women, and enquiries were primarily from people aged over sixty or under twenty. Further analysis shows that all enquiries (n=10) involving people under twenty were initiated by parents. Health care professionals, doctors and nurses, only accounted for 18% (n=12) of the enquiries. Enquiries were fielded and handled primarily in a face-to-face manner (63.6%, n=42), although most enquiries from doctors (n=7/9) and nurses (n=2/3) were via telephone.

Information relating to interactions of medicines (n=17, 26%) were the most frequently handled. Other commonly asked enquiries centred on how to take medicines (n=13, 20%), side effects (n=11, 17%) and choice of therapy (n=11, 17%). Doctors (n=4/9) asked about choice of therapy more than patients/carers and parents (n=7/52), and was found to be significant (Chi-squared test, p=0.026).

The median time to answer the enquiries was between 3 and 6 minutes, although fifteen enquiries took longer than 7 minutes. No relationship was found between enquirer status or type of enquiry versus length of time to answer. Participants were asked their opinion on the completeness of the answer provided (where 1 = complete and 5 = incomplete). Overwhelmingly, they believed they had answered the enquiry completely, with 54 from 64 replies assigning a score of 1 or 2, compared to just 3 replies which were scored as a four.

Conclusion

Community pharmacists frequently field medicine information-type enquiries. The majority of enquiries are generated by people who are not healthcare practitioners and centre on problems associated with medicine taking.

Poster 17

NHS Direct call referrals regarding complementary therapies

Andreas Muenstedt, Gillian Stead, *Trent Medicines Information Centre*
Elizabeth McKechnie*, Glenfield Hospital*

Introduction

A substantial number of calls are received from members of the public regarding the use of complementary therapies. The available information on complementary therapies is limited, post-marketing surveillance is unreliable, and their quality is not well controlled as most products used as complementary therapies are unlicensed. Previously unreported side effects and drug interactions may therefore occur. Giving a definite answer is often impossible. It was therefore felt that a disproportionate amount of time was spent on each of these enquiries.

Aim

To rationalise and standardise the approach to enquiries regarding complementary therapies; in particular the number of resources used, and what advice was to be given to patients regarding the unlicensed status of complementary therapies.

Method

One hundred NHS Direct call referrals regarding complementary therapies were analysed, and the following data captured: resources used, resources providing the necessary information, time spent per enquiry, what grade evidence answers were based on, and advice given to the patient regarding the regulation and quality of complementary medicines. Based on the findings, guidelines were developed, including a suggested search strategy and advice regarding the unlicensed status of complementary therapies which was to be included in every answer. A subsequent sample of 50 enquiries was analysed to measure the outcome.

Results

90% of enquiries were regarding the safety and potential drug interactions of herbal products. In 99% of cases the enquiry could have been answered using the information from the Natural Medicines Database alone. Other resources did not add further information.

Before / after implementation: the average time per enquiry was 44.7 and 40.2 minutes respectively; the average number of resources 3.2 and 2.5; 7% and 78% of enquirers, respectively, were advised about the unlicensed status of complementary therapies.

Conclusion

The reduction in the number of resources after implementation of the guidelines was statistically significant, while the impact of the guidelines on research time was not. However, a change in practice at NHS Direct resulted in longer consultations of MI pharmacists with enquirers, which may have been a confounding factor. The main benefit was a marked improvement in the quality of the advice given to patients: the number of cases where it was documented that the patient had been advised regarding the unlicensed status of complementary therapies and the associated risks was significantly increased, enabling more patients to make a fully informed decision.

Poster 18

The public, the media and medicines information

***Christine Proudlove**, Director, North West Medicines Information Centre, Pharmacy Practice Unit, Liverpool*

Introduction

Medicines-related questions from the public have a range of triggers. One stimulus is information that has been broadcast or published by in the media. This survey of medicines information (MI) centres explored services provided directly to the public and how the media influenced the questions received.

Methods

An electronic questionnaire survey was conducted for two weeks in September 2007. UK MI centres were informed of the survey via the UKMi e-discussion group.

Results

Responses were received from 63 centres (around 30% of the total and included 55 local and 8 regional centres). Only four centres did not take calls from the public; 24 (38%) had an established patient helpline and the remainder took calls on an ad-hoc basis, or supported NHS Direct through a formal agreement. In the past year, almost 80% of centres that took calls from the public received over 20 such enquiries and 16 centres (27%) received over 100.

The most challenging aspects of answering these enquiries were: dealing with people who wanted a black-and-white answer (93%), trying to put risk into an understandable context (71%) and controlling the interaction with a talkative patient (69%). Media stories (mainly in tabloid newspapers or TV/radio news items) were an occasional trigger for these questions. Respondents perceived that media-related questions were most commonly about newly highlighted adverse effects (73%) and complementary medicines (71%). Of 48 responses to the request to give details of the last media-related question received, the majority (25) concerned adverse effects. They included 7 questions about switching statins and 5 about cardiac effects of glitazones.

Discussion

There are challenges to answering MI questions from the public that differ from those of providing a service to healthcare professionals. They include problems in conveying difficult messages around uncertainty and risk, areas that may be avoided or misrepresented by the media.

The Healthcare Commission has identified the need for more patient helplines and this is an aim of the UKMi strategy (*Effective Information for Managing Medicines, 2007*). Support material is being developed to help centres establish helplines. The survey also highlighted the need for training in this area, e.g. on communicating risk and dealing with difficult callers.

Poster 19

Into the Future: The UK Drugs in Lactation Advisory Service

Kelly Broad, Peter Golightly *and* ***Louise Nolan****, Trent Regional Medicines Information Service, Leicester Royal Infirmary, Leicester*

Introduction

The UK Drugs in Lactation Advisory Service (UKDILAS) is delivered jointly by Trent Regional MI and West Midlands Regional MI. A total of 943 enquiries, from healthcare professionals and members of the public were answered by the service in 2007. To support the provision of information on drugs in breast milk several resources are developed and maintained by UKDILAS including UKMICentral website, in-house UKDILAS monographs and NELM Q&As.

Method

A two part audit was designed to identify UKDILAS service users, what medicines information was requested and what sources were used prior to contacting UKDILAS, at the Trent Regional MI. **Part 1** retrospectively analysed the service user and the specific medications enquired about. In addition to this, **Part 2** prospectively looked at what resources were used prior to calling UKDILAS.

Results

- The top 5 users were hospital / medicines information pharmacist (61%), GPs (12%), primary care nurses / midwives (7%), Members of the public (7%) and community pharmacists (3%). Other hospital staff and external bodies, for example La Leche League, contributed to the other 10%.
- The top five frequently asked categories were: antidepressants, opioid analgesics, antihistamines, antipsychotics & drugs used for nausea and vomiting.
- Of the 203 enquiries analysed there was no specialist UKDILAS resource available for 65 enquiries

Conclusions

- Callers frequently contacted UKDILAS for clarity of information found on UKMICentral. This suggests that traffic light status is not perceived to be sufficient for some enquiries and further detailed information is required.
- Of the top 5 BNF categories frequently enquired about a NELM Q&A / UKDILAS resource was available for all.
- Enquiries received from Medicines Information centres did not suggest that all enquirers were using the basic resources available before contacting UKDILAS.

Poster 20

Developing The "Drug Use In Liver Disease" Service

Smita Bhikha, *Medicines Information Centre, Leeds General Infirmary, Leeds*

Introduction

The Leeds Medicines Information Centre provides a specialist advisory service on the use of drugs in patients with liver disease. This role involves answering enquiries concerning adult or paediatric patients with acute or chronic liver dysfunction, and patients who have undergone a liver transplant. The most frequently asked questions relate to the choice of drug (and appropriate dosage) in patients with liver disease.

Aim

- To improve information kept within the centre.
- To improve the speed of the enquiry answering service.
- To ensure that adequate information is gathered from the enquirer to answer the enquiry fully.
- To adequately train other staff working within the centre to handle these enquiries.
- To improve the way that the answer is communicated.

Method

"Liver Disease Maps" have been drawn to aid understanding of the disease state. A series of monographs are being written to improve knowledge held within the centre, and aid enquiry answering. Staff are being trained to handle the enquiries, and a generic search strategy has been written to aid them.

Conclusion

The liver disease maps and monographs have been well received within the centre. Enquiry answering has become much quicker, and past enquiries (with the help of MIDatabank) have become a much more valuable resource. At present, monographs have been written for various antibiotics, and it is intended to extend these across a wide range of drug therapies.

All staff "manning" phones receive basic training regarding information needed from the enquirer. Those staff members that are newly "liver" trained still find undertaking the enquiries difficult. However, resources such as the liver maps, monographs and the search strategy should make thinking around the subject easier, and discussion with senior colleagues with regard to each enquiry is encouraged.

Poster 21

Analysis of paternal exposure enquiries made to the National Teratology Information Service

Elizabeth Mallett, *Regional Drug and Therapeutics Centre, Newcastle*

Introduction

2-3% of enquiries to NTIS each year relate to paternal exposures. As the outcome data are limited in this area, it can be difficult to assess the risks to the foetus.

Aims

To investigate the number of paternal enquiries to NTIS over 5 years.

To identify the most common classes of drugs which were the subject of enquiries over the last 3 years and to highlight a “top ten” list of drugs and determine whether these would be expected to affect male reproductive function or increase the risk to the foetus. To provide guidance on assessing paternal exposure enquiries.

Methods

Relevant enquiries over the last 5 years were identified and those from the last 3 years further analysed. Known and predicted risks relating to paternal exposures were used to determine whether the drugs in question were likely to affect male reproductive function or increase the risk to the foetus.

Results

The number of enquiries was fairly constant over 5 years. Over 3 years, the most common agent involved was methotrexate. The majority of enquiries were about immunosuppressant drugs, antineoplastic agents and drugs affecting male hormones.

Discussion

The mechanisms by which paternal exposures might affect male reproductive function are: effects on sexual function e.g. erectile dysfunction; effects on spermatogenesis leading to impaired fertility and adverse chromosomal effects in the germ cells (1). Additionally, some agents are excreted in the semen and the foetus might be exposed by this route (2).

The agents which generated the most enquiries are those which, using this information, could be predicted to have adverse effects. However, a proportion of enquiries (9%) were about drugs for which an adverse effect would not be expected.

A search strategy is suggested to help enquirers assess the risks relating to paternal exposures.

NTIS advise generally, that at present there is insufficient evidence to justify termination following paternal exposures. There is inconsistent advice as to whether or not chromosome analysis should be performed after exposure to cytotoxic or mutagenic substances.

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Poster 22

MI Boot Camp: Student Pharmacy Technicians in the Medicines Information Centre

Helen Brittain, *Medicines Information Centre, Leeds Teaching Hospitals NHS Trust*

Background

Leeds Teaching Hospitals NHS Trust traditionally provided training for three student pharmacy technicians annually, who worked toward the City and Guilds National Vocational Qualification (NVQ) Level 3 in Pharmacy Services[1] whilst rotating through various pharmacy departments within the Trust. Service demands and the enhanced roles undertaken by pharmacy technicians in the Trust resulted in the student cohort for 2007/8 being increased by 500%. Feedback from students and the peripatetic assessor indicated that the assessment tools previously used were inefficient and time-consuming. The appointment of a qualified assessor to the permanent MI team offered an opportunity to improve training and assessment of competence.

Objectives

- Student pharmacy technicians receive relevant and meaningful training in basic MI skills and the use of resources.
- Assessment is carried out using realistic methods and demonstrate that skills and knowledge gained is used for patient benefit.
- Patients continue to receive high quality information and advice from the MI centre.

Outcome

- Development of a specific training workbook based upon an abridged version of the UKMi Training Workbook and in-house training for new resident pharmacists, incorporating written questions to assess knowledge.
- Holistic assessment practice using simulation and direct observation of work on actual enquiries provides evidence for several units of the award.
- Quality of information and advice provided to enquirers is maintained by the use of an accuracy check by a qualified pharmacist.
- Assessment results and positive feedback from students, line managers and the internal verifier demonstrate that the new workbook and training programme are producing a positive outcome for students undertaking unit 3, with most students completing the unit within six weeks.

References:

1. NVQ Pharmacy Services Level 3 (7355-03); City and Guilds, London. Available from http://www.cityandguilds.com/documents/ind_health-science-tech_pharmacy/7355-l3-pharmacy.pdf

Poster 23

Level 1 enquiries - identifying the medicines information training needs of hospital pharmacists

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A previous in-house service evaluation had identified that hospital pharmacists were the most common users of the Medicines Information (MI) service. The aim of this audit was to identify the MI training needs of hospital pharmacists by reviewing the enquiries recorded on MiDatabank from this user group.

A data collection form was initially piloted using 20 hospital pharmacist enquiries received by the MI centre. This recorded the enquiry type, complexity of enquiry, time the enquiry was received, length of time taken to complete the enquiry and the resources used to answer the enquiry. These indicators were used to identify any possible training needs.

Enquiries received during the period June to August 2007 from hospital pharmacists were retrospectively analysed. 781 enquiries were received during the study period of which 22% (n=171) were from hospital pharmacists. The most common categories of enquiry received from hospital pharmacists were, in descending order of frequency: administration/dosage, choice of therapy/indication/contraindication, drug interactions and pharmaceutical.

A total of 83 (48%) of the enquiries received from hospital pharmacists were categorised as level 1. The MI service answered 25% of these enquiries in their entirety using resources available outside of MI/at ward level. It was identified that if clinical pharmacists had access to Medicines Complete (Martindale, Stockley's Drug Interactions), an additional 20% of level 1 enquiries could have been completed by the hospital pharmacist.

Enquiries received from hospital pharmacists peaked between 11am and 1pm, and between 3pm and 4pm. The median time taken for the MI service to complete a level 1 enquiry was 12 minutes

In response to these results, a MI reference guide was developed to signpost the pharmacists to appropriate Internet resources enabling them to answer their level 1 enquiries. At the same time, pharmacists were also given access to Medicines Complete and MiDatabank was installed on more computers within the Pharmacy. The MI service continues to monitor level 1 enquiries each month to identify any further training needs.

Poster 24

One-to-one training for clinical pharmacists: Sharpening skills

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Aims

In January 2006, the Trent Medicines Information department offered one-to-one training MI sessions for pharmacy staff across University Hospitals of Leicester (UHL). The aim of the one-to-one session was to address individual or directorate MI-related concerns that come about in day to day clinical pharmacy work. Possible topics suggested were: Database searching, critical appraisal, navigation and interpretation of websites, orientation to local UHL resources, advice on how to approach directorate–related information requests. Attendees were asked to specify learning outcomes for the training session in advance.

MethodThe sessions lasted 1 hour each, were held in MI (away from ward and dispensary distractions) and were conducted by an experienced MI pharmacist (band 8A). Attendees were emailed a survey to assess the usefulness and relevance of their MI one-to-one training session. In total 10 individual and 2 directorate sessions were conducted between January 2006 and July 2007 with most sessions involving refreshing literature searching and finding journals, navigating useful internal and external websites.

Results

- Of the 10 individual sessions attended: one pharmacist was AFC band 7, six pharmacists were AfC band 8A and three pharmacists were AFC band 8B.
- The sessions were rated as 4.3 out of 5 for usefulness.
- All respondents said their objectives were met**.**
- Respondents stated that the most helpful aspects of session included: information on accessing local and specialised resources, useful websites, understanding the differences between databases, handouts, answering specific questions, short duration, meeting MI staff, having time away from wards and bleep to concentrate properly.

ConclusionsThe 1:1 sessions which support the UKMI strategy for education and training sessions were well received by pharmacy staff with sessions generally attended by more senior pharmacists. This may be as they have less recent experience of MI, answer more of their own MI queries, or because junior pharmacists were less aware of the availability of the training sessions.

The feedback indicates the individualised nature of the session and time out from their usual workplace was valued and highlight that there is a need for regularly updating medicine information skills in clinical pharmacists.

Poster 25

Which factors influence spontaneous reporting of adverse reactions to varenicline in Northern and Yorkshire?

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Dr G Masters, Dr S White*, Regional Drug and Therapeutics Centre, Newcastle*

Introduction

Varenicline an aid to smoking cessation was launched in December 2006. Following spontaneous reports of depression and suicidal ideation via post-marketing surveillance, a Europe-wide review of safety data was initiated. Adverse drug reactions (ADRs) can be reported via the Yellow Card scheme, which collects information on suspected ADRs, contributing significantly to patient safety by monitoring the risk-benefit ratio of medicines.

Method

The number of Yellow Cards submitted and types of reactions reported in the geographical area covered by the Yellow Card Centre Northern and Yorkshire (YCCNY) were requested from the Medicines and Healthcare products Regulatory Agency (MHRA). Primary care prescribing data for varenicline, for the same area, were obtained from ePACT.net (Prescription Pricing Division).

Results

The number of suspected varenicline ADRs reported via the Yellow Card scheme in YCCNY is proportional to the varenicline prescribing rates (correlation = 0.85 [$p<0.0005$]). The number of suspected varenicline ADRs reported in YCCNY peaked between November 2007 and January 2008, following warnings about severe changes in mood and behaviour from the US Food and Drug Administration and the MHRA.[1,2] Gastrointestinal reactions were the most frequently reported reactions, nausea and vomiting were the most common and are well recognised from clinical trials.[3] Reports of psychiatric reactions increased in November 2007 and although levels have declined they remain higher than previously.

Discussion

Varenicline, as with all new drugs is closely monitored by the MHRA. It is generally accepted there is considerable under-reporting of ADRs for new drugs and reporting tails off over time.[4] It is therefore reasonable to conclude that under-reporting of varenicline ADRs in YCCNY is likely. The evidence from YCCNY demonstrates that the volume of ADRs reported can be influenced by prescribing rates and by raising awareness about specific ADRs.

Conclusion

Yellow Card reporting rates for varenicline ADRs may be related to the volume of items prescribed and the amount of publicity concerning ADRs. There is under-reporting and rates are likely to reduce further unless safety messages are repeatedly reinforced amongst the healthcare community. Varenicline is a timely reminder that reporting of suspected ADRs is a crucial factor in helping to maintain patient safety.

References

1. US Food and Drug Administration. Early communication about ongoing safety review: varenicline November 2007
2. Medicines and Healthcare products Regulatory Agency. Safety warnings and messages for medicines. 14 December 2007
3. Regional Drug and Therapeutics Centre (Newcastle). Varenicline New Drug Evaluation No. 81(update); January 2008
4. Martin RM et al. Underreporting of suspected adverse drug reactions to newly marketed (black triangle) drugs BMJ 1998;317:119-20

Poster 26

Storage of medicines and medicinal products in Automated Dispensing Systems (robots) when 'Store Upright' is a requirement

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Introduction

The Audit Commission report 'A Spoonful of Sugar' recommended the introduction of automated dispensing systems to all trusts[1]. Many hospital pharmacies, including those within WUTH, now have robots to automate the storage and dispensing of medicines and medicinal products, releasing staff for patient-centred services. Robots measure the dimensions of each pack and then place that pack in the most suitable position within the unit for size and positional stability[2]. This may not always be upright.

It was observed that some items have the direction 'Store Upright' on the packaging. All products with this requirement needed to be identified, and systems annotated, to ensure compliance with these specific storage requirements to maintain quality.

Method

Internet and product literature searches were performed to identify any items which needed to be stored upright.

Results

23 medicines and medicinal products with the direction on the pack and/or on the product literature to 'Store Upright' were found. Of these, 12 were currently being stored in the robots within WUTH pharmacies, and 5 others had previously been stocked.

Recommendations

- Remove the 12 products identified and store on open shelves.
- Change the shelf location on the pharmacy stock control system
- Add 'Store Upright' as a special consideration to the entry on the pharmacy stock control system for all 17 products.
- Remain alert when any new product, or new packaging for an existing product, is received, incorporating this check in the WUTH Pharmacy Purchasing Safety Risk for New Drugs.

References

1. Audit Commission, A Spoonful of Sugar – Improving Medicines Management in Hospitals, Audit Commission, 2001
2. Derek Swanson, Automated dispensing – an overview of the types of the systems available, Hospital Pharmacist 2004; 11(2): 66-68
3. Quality Control North West, Purchasing for Safety, A resource document for Trusts to facilitate compliance with safety Alert 20 (NPSA 20) www.qcnw.nhs.uk

Poster 27

Contribution of Clinical & Non-Clinical groups to support adherence to highly active antiretroviral therapy (HAART) for patients attending a regional HIV centre in Northern Ireland

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Background

British HIV Association (BHIVA) guidelines recommend adherence support should be part of the routine clinical care provided by all healthcare professionals. We evaluated patients perception of those groups who provided support to their adherence to HAART and which had the most beneficial contribution.

Method

A questionnaire was distributed to patients (≥ 18years) on HAART attending routine appointment within the HIV clinic. The questionnaires were self-reported and anonymous.

Results

There are a number of groups and organisations that can support patients' adherence to HAART. The HIV clinic was perceived as the most important source of adherence support. With patients indicating that all members of the multidisciplinary clinic team had contributed to supporting adherence at to HAART at some stage (range 5 - 90%). However support from family, friends & external organisations were notably less (range 8 - 21%). The groups that patients reported as having the most beneficial contribution to supporting adherence were HIV doctors, HIV nurses & the HIV pharmacist (31%, 31% & 22% respectively). Only 9% reported family as being the most important to supporting their adherence to HAART.

Conclusion

The life-long commitment to taking HAART requires a multidisciplinary approach between all stakeholders to provide personalised information & education as a part of a framework for self-management and supporting shared-care decision-making. Patients may find it difficult to seek that support from family and friends. Nurse specialists & pharmacists can have a role in coordinating adherence services.

Poster 28

Analysis of poisons enquiries from hospital pharmacists to the National Poisons Information Service (NPIS)

Paula Russell, *Regional Drug and Therapeutics Centre, Newcastle.*

Introduction

Approximately 1% of enquiries to NPIS each year are from hospital pharmacists. The quality of the information gathered is important in determining the quality and appropriate of the response.

Aims

To investigate the types of poisons enquiries from hospital pharmacists to NPIS over a one year period. To investigate the proportion of hospital pharmacist enquiries that did not provide the essential data for a risk assessment over six months within that year.

Methods

Hospital pharmacist enquiries taken from Medinfosys® between 1st July 2006 and 30th June 2007 were analysed on the basis of call reason. Circumstance and location were noted for the patient specific cases. Patient specific enquiries for 1st Oct 2006 – 31st March 2007 were further analysed. The presence or absence of data was noted and the percentage of this for each category of missing information was calculated.

Results

There were 16,631 calls to Newcastle NPIS from 1st July 2006 to 30th June 2007 of which 175 calls (1%) were from hospital pharmacists. Of the patient specific enquiries (n=99), 18 out of the 29 'medication error' calls occurred in hospital.

Further analysis showed no indication of age was given in 12% of enquiries while 37.7% were noted only in terms of 'adult' and 'child'. Agent name and circumstances were not available for 1.7% of cases.

Discussion

While the percentage of total poisons enquiries from hospital pharmacists remained constant over the 4 years to July 2007, the absolute number increased from 88 to 579. Medication error was the reason for 29% of the hospital pharmacist enquiries and 62% of those occurred in hospital. Hospital pharmacists are increasingly involved in A&E, ITU/HDU and MAU. Thus they are well placed to pursue this type of enquiry provided the appropriate information has been gathered before contacting NPIS.

Conclusion

Poor provision of data means that we are unable to provide appropriate timely advice. The enquiry can be unnecessarily prolonged as further necessary information is gathered, thus potentially delaying patient treatment. The UKMI Enquiry Answering Guidelines on Poisoning and Overdose should provide a useful training and support tool to improve the handling of poisons enquiries by hospital pharmacists.

References:

(1) UK Medicines Information. Medicines Information Enquiry Answering Guidelines. January 2007. http://www.ukmi.nhs.uk/filestore/ukmiacg/Enquiryansweringguidelines2007.doc (accessed 20/08/2008)

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