# Programme
## and
# Conference
# Proceedings

**UKMi**

UK Medicines Information

*35th UKMi Practice Development Seminar*

*Edinburgh 17th-18th September 2009*

# Contents – Conference Proceedings

# Opening session

## Welcome to Edinburgh

*John Cromarty*, *Director of Pharmacy NHS Highland*

*Background of joint academic appointments in clinical pharmacy and post-qualification education and training, including Specialist Principal Pharmacist/Senior Lecturer in Clinical Pharmacy (North West Thames RHA/University of London, 1981-1989); first National Specialist/Senior Lecturer in Post-Qualification Education and Training for Pharmacists in Scotland (University of Strathclyde, 1989-1993); National Specialist in Clinical Pharmacy for Scotland (The Robert Gordon University, 1993-2000). Currently Director of Pharmacy, NHS Highland (since 2006) and was first Chairman of NHS Scotland Directors of Pharmacy (2006-2008).*

*Formerly a Member of the RPSGB BPC Practice Research Adjudication Panel (2001-2008) and currently a Member of the RPSGB Task & Finish Group on Advanced and Specialist Practice in Pharmacy.*

*Awarded the RPSGB Charter Gold Medal in 2007.*

*Visiting Professor at the School of Pharmacy, University of Strathclyde.*

# Plenary Session 1 – *Professional Development and Competence*

***Chair: John Cromarty***, *Director of Pharmacy, NHS Highland*

## The change in professional leadership and regulation

***Steve Churton***, *President Royal Pharmaceutical Society of Great Britain*

*Steve has been President of Royal Pharmaceutical Society of Great Britain since June 2008.  Prior to this he was Head of Professional Practice and Pharmacy Superintendent with Boots the Chemist with responsibility for the management, professional and commercial activities of 5000 pharmacists (across 2500 UK wide locations).  His recent achievements include:*

- *Commissioning an independent enquiry and an extensive 18 month consultation with the membership to understand their needs of a new professional leadership body – this culminated in the publication of a Prospectus for the new organisation.*

- *Directing a major change management programme to demerge the current organisation into separate regulatory and professional leadership bodies, and to create a professional body with the capability and capacity to deliver the products and services heralded in the Prospectus.*

- *Successfully launching member-centric campaigns to address the important issues of workplace pressure and legislative reform to decriminalise single dispensing errors.*

## Abstract

An opportunity to for a question and answer session with the president of the Royal Pharmaceutical Society about the progress to date and the future development of the new professional leadership body for Pharmacy.

# Development of the new professional body – Implications for advanced practice

*Graeme Hall, Assistant Chief Pharmacist, University Hospitals of Leicester, member of TansCom & RPSGB Council*

*I have been a hospital pharmacist for 20 years including 2 years as clinical services manager at The Gold Coast Hospital in Queensland, Australia. Currently I work at the University Hospitals of Leicester as Assistant Chief Pharmacist Clinical services, a post I have held for 8 years.*

*I sat on the Transitional Committee, the body that drafted the prospectus for the new professional body.  I was professional secretary for UKCPA for 7 years and now hold the office of Vice Chair. In May I was elected to Council of the RPSGB*

## Abstract

Advanced practice is extremely important to the profession, it drives innovation in patient care and results in new services being developed.  The White paper for England (and similar documents in Scotland and Wales) are aspirational and require vibrant advanced practice to meet the aims set out.

In the past advanced practice has arisen mainly through specialist groups.  Groups have developed disparately with little co-ordination and no cohesive voice.  This has happened in part because the profession's leadership body was focussed on regulation, and to a large degree - community pharmacy, when a lot of advanced practice was being developed in secondary care.

The Transitional Committee, drafting the prospectus for the new professional body, was clear that this advanced practice and specialist groups needed to be either within the infrastructure of the new professional body or at least working closely together.  It was suggested the main nucleus of advanced practice would be a "specialist curriculum committee" that would ensure the knowledge set and experience required for different levels of practice across specialities was consistent, a quality assurance process.

The formation of the new professional offers a new environment for advanced practice to flourish in a co-ordinated way, developing clear career pathways for pharmacists. Alongside this a united voice of advocacy for the profession with all it's complexity and diversity.

# Plenary Session 2a – *Using Evidence in Practice*

## Beyond RCTs

***Professor Sir Michael Rawlins,*** *Chairman of the National Institute of Health & Clinical Excellence (NICE)*

*Sir Michael Rawlins has been chairman of the National Institute of Health & Clinical Excellence (NICE) since its formation in 1999. He is also chairman of the Advisory Council on the Misuse of Drugs (since 1998). He is an Honorary Professor at the London School of Hygiene and Tropical Medicine, University of London, and Emeritus Professor at the University of Newcastle upon Tyne.*

*He was the Ruth and Lionel Jacobson Professor of Clinical Pharmacology at the University of Newcastle upon Tyne from 1973 to 2006. At the same time he held the position of consultant physician and consultant clinical pharmacologist to the Newcastle Hospitals NHS Trust. He was vice-chairman (1987-1992) and chairman (1993-1998) of the Committee on Safety of Medicines.*

## Abstract

The nature of the evidence to support the routine use of intervention causes from various sauces. Although randomized controlled trials have an important place, other designs have and important role. The notion of "hierarchies" is inappropriate.

# Plenary Session 2b – *Using Evidence in Practice/ Medicines Information Update*

## Session dedicated to Dot Anderson

*Chair: Pat Murray*, Director of NHS Lothian Pharmacy Service

*Pat Murray has worked in NHS Lothian across all hospital, primary and community pharmacy settings over a period of 34 years.  She was appointed as Director of NHS Lothian Pharmacy Service in 2006.  In April 2009 Pat was appointed visiting Professor of the University of Strathclyde. As Chair of the NHS Lothian Area Clinical Forum, where all seven Professional Advisory Committees and the Healthcare Scientists Forum are represented.  Pat is a Non-Executive member of the NHS Lothian Board.  One of the Board Committees which Pat sits on and has chaired since March 2008 is the Healthcare Governance and Risk Management Committee.*

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## Evidence, engagement and judgement – the approach at SMC

*Angela Timoney,* Vice chair Scottish Medicines Consortium

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*Angela Timoney is Director of Pharmacy NHS Tayside, and Chair of Directors of Pharmacy NHS Scotland.  She is Vice Chairman of the Scottish Medicines Consortium (SMC) and has been involved with SMC since its formation in 2001.  She has chaired a number of short-life working groups on behalf of SMC - one to increase access to medicines for children, and is currently Chair of the Biosimilars Working Group.*

*Angela has worked for NHS Tayside since 1995, initially as Chief Pharmaceutical Adviser, and until 2006 as Consultant in Pharmaceutical Public Health.  She has been involved in the assessment of pharmaceutical products for the NHS for most of her professional career and is particularly interested in how to ensure that the complex assessments and judgements of a product's value are understood and trusted by all stakeholders.*

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### Abstract

SMC evaluates medicines at an early stage in the life cycle of the product.  At that time the manufacturers will hold almost all evidence and they are required to provide a case to persuade the NHS in Scotland that this agent is cost-effective for use in the indication.

There are challenges in interpreting this case and the evidence supporting it; do the clinical trials match the Marketing Authorisation and the perceived place in treatment?  Does this accord with the view of clinicians and patients who wish to access it?  How should we ensure that we use evidence wisely and that stakeholders in the process have a voice which contributes to better judgements?

# Mi DataBank – What's new in 2009

*Steve Moss, Keith Brown,* CoAcS 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

# Annual report of UKMi

***David Erskine,*** *Chair - UKMi Executive*

*David Erskine has been Director (or Acting Director) of the London & South East Medicines Information Service for the last 5 years but has worked at the centre since 1996. He began his 2 year tenure of the Chair of UKMI Executive in September 2008. David has been closely involved with the development of NeLM since it was originally launched as DrugInfoZone in 1998 and has been project lead for the development of the new platform since 2005. He also teaches critical appraisal to pharmacists in London and the South East on behalf of the London Pharmacy Education & Training and also teaches on post-graduate courses at the School of Pharmacy, Kings College, and the Medway School of Pharmacy.*

## Abstract

***UKMI annual update***

A report of the activities and developments of the UK Medicines Information network (UKMI) during 2008/9.

# Plenary Session 3 – Data Security and Protection

**Chair: Howard McNulty,** *General Secretary Institute of Pharmacy Management*

*__Currently__ General Secretary, Institute of Pharmacy Management (2004 - ) &Professor, Institute of Pharmacy & Biomedical Science, University of Strathclyde (1997- ).*

*Pharmacy Management Consultant 1997–2008, was the first*

*Pharmaceutical Advisor Scottish Prison Service 2000–2 and*

*External Verifier for the Scottish Qualifications Authority for Technician Pharmaceutical Services 1995 – 2008.*

*__Worked__ for 22 years in the NHS, initially as Principal Pharmacist ( Drug Information) for the then SW Region (setting the Regional Centre in Bristol Royal Infirmary)  from 1975 – 1983.  Founder Chairman of the then Drug Information Pharmacists Group 1975 – 79 and organised the Bristol DI Conference in 1977.  Took on Regional Education & Training in 1980.*

*Moved to Glasgow into pharmacy management in 1983 becoming Chief Pharmacist for Greater Glasgow (1989 – 1997) set up pharmacy & medicines management systems, established new posts for pharmacy specialists in audit, drug misuse, education, prescribing support, public health and new services in supervised methadone and health promoting pharmacy services.*

### Professionally

*Founder Member of RPSGB Scottish Pharmacy Board 2007 – 8 and Member of the Transitional Committee to establish the new professional body.*

### Personally

*Played cricket (badly) at Scottish County level from 1983–7. Married with three children and 6 grandsons. Enjoy most sports and a Burnley FC armchair supporter!*

# Copyright – Issues for MI Pharmacists

*Jim MacNeilage*, *Copy Licensing Agency*

*Police officer with City of Glasgow police for 17 years, leaving in 1986 to join the Performing Right Society as a Licensing Inspector in west of Scotland. Promoted to Manager of PRS Scottish office in 1989 responsible for licensing of all public performances of music in Scotland and N Ireland.*

*Joined CLA in 1998 as Business Development Manager for Scotland, responsible for all CLA activities in Scotland. Was responsible for first negotiated NHS licence with NHS Scotland, then licensed NHS Wales and N.Ireland, and most recently Isle Of Man.*

*Has dealt with all subsequent re-negotiations with those areas and the successful introduction of the new licence enabling digital re-use.*

*Also deals with negotiations on schools licence for Scottish schools, including the GLOW project and acts as CLA liaison with all Scottish and N.Ireland HE and FE institutions.*

*Currently manager of the CLA licensing team for all UK business and Government activities.*

## Abstract

Presentation will cover the permissions granted under the CLA licences for the NHS throughout the UK, highlighting the differences between the regions

The new permission for re-use of digital materials will be covered.

## Data Security & Freedom of Information legislation

*Laurence Bebbington, Law Librarian, Hallward Library, University of Nottingham*

*Laurence Bebbington is currently Faculty Team Leader at the University of Nottingham with responsibility for the subject areas of Law, Social Sciences, Business and Education. He is also the University's Copyright Officer. He has also worked at the universities of Glasgow, Strathclyde, Cambridge and Birmingham, and at the Royal College of Physicians and Surgeons of Glasgow. He is a regular conference speaker on legal issues such as copyright, freedom of information, data protection and disability discrimination, and on other legal issues affecting information work. He has published various articles on these subjects and is a joint editor of, and contributor to, Staying Legal: A Handbook for Information Professionals, 2003 for FACET Publishing*

## Abstract

Data protection, data security and freedom of information are subjects which increasingly surface in the news – often as a result of serious breaches of the relevant legal frameworks. An informed and responsible approach to these issues is no longer something which organisations or individuals who use data and information can consider as subjects to be relegated to the "back burner" but must be actively addressed. This session will outline the main elements of the legal regimes for data protection and freedom of information, and will discuss how they interact. Issues of particular relevance to pharmacists, health workers and the NHS will be addressed. The session will also focus on appropriate and relevant compliance strategies to ensure compliance with the legal regimes.

# Plenary Session 4 – Renal Therapeutics

*Chair: Trevor Beswick, Director, South West Medicines Information Service*

## Renal therapeutics – An update

*Caroline Ashley, Lead Pharmacist Renal Services, Royal Free Hospital, London*

*Caroline Ashley graduated from the School of Pharmacy, University of London in 1986. After working at Guys Hospital for 4 years, during which time she undertook an MSc degree in Pharmacology, she moved to the Royal Free Hospital in 1991 to work in the field of renal medicine. She is now the Lead Specialist Pharmacist for Renal Services at the Royal Free, with some 18 years renal experience, and her major areas of interest are transplantation and auto-immune renal disease. Caroline was involved in the evolution of the Renal NSF, as well as the NICE guidance on Immunosuppression in Renal Transplantation, and the use of Cinacalcet for the Treatment of Renal Bone Disease. She is the co-editor of both the Renal Drug Handbook and the Introduction to Renal Therapeutics, and has been the Chair of the UK Renal Pharmacy Group for several years.*

## Abstract

With the introduction of eGFR reporting, the diagnosed incidence of chronic kidney disease has increased markedly.

In 2008, the National Institute for Health and Clinical Excellence published their guidance on the Early Identification and Management of Chronic Kidney Disease in Adults in Primary and Secondary Care.

This presentation will look at the key points of this report, including

- Stages of CKD
- Albumen-Creatinine ratios
- Risk factors
- Hypertension
- Hyperlipidaemia
- Renal Bone Disease
- Renal Anaemia

It will also cover topics such as

- Causes of chronic kidney disease
- Monitoring renal function (Cockcroft & Gault versus MDRD estimations)
- Drug handling in renal disease
- The 3rd edition of the Renal Drug Handbook.

# Renal replacement therapy

*Dr Paddy Gibson*, *Consultant Renal Physician, NHS Lothian*

*Consultant Renal Physician in Edinburgh and West Lothian whose practice is mainly in the management of end-stage renal failure using multiple different techniques.*

## Abstract

The presentation aims to inform on the problems encountered in pharmacology and prescribing as a results of patients need for renal replacement therapy.

As a result of insurmountable physiological and unfathomable technical difficulties complicated by an ever-changing field, there is very little useful data that the practicing professional can use to guide their actions.

The presenter will review this paucity of data.

An attempt will be made to address the physiological and technical barriers mentioned. An overview of the renal replacement therapies offered to patients is given. How these therapies interfere in pharmacokinetics will be discussed.

No easy solution is offered.

# Plenary Session 5 – Communicating with Patients

*Chair:  **Anne Lee**, Acting Chief Pharmaceutical Advisor, Scottish Medicines Consortium*

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*Anne Lee graduated in 1984 from Heriot Watt University in Edinburgh and went on to do her pre-registration year at the Royal Infirmary of Edinburgh.  In 1986 she took up a post at the Regional Drug Information Centre in Newcastle upon Tyne which marked the beginning of almost 20 years working in Medicines Information, latterly in Glasgow Royal Infirmary.  In 2005 she moved to a Principal Pharmacist post with the Scottish Medicines Consortium, where she is the lead for the Horizon Scanning programme.  Anne has a particular interest in the safety of medicines and has edited a textbook on adverse drug reactions.*

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## The Role of the patient representative on SMC

***Sheila Tunstall James,*** *Chair, Patient Advisory Group, SMC*

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*I started my working life in the pathology lab of a district general hospital. The next stage came when I qualified as a teacher, spending several years teaching in Birmingham Schools. From there I moved on into the pharmaceutical industry where I spent thirty years; starting as a representative; rising to Clinical Liaison for Northern Europe and finally as Training Manager. Since retiring I have been involved in various roles as a Public Partner with NHS Scotland.*

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## Abstract

The presentation aims to describe the role of the patient interest group representatives on the Scottish Medicines Consortium and some of the challenges for those carrying out this role. Some insight into how the patient representatives input may impact on the final decision of SMC is given.

# Patient information for exceptional medicine requests

*David Pfleger,* Consultant in Pharmaceutical Public Health, NHS Grampian

*Qualified in 1989 and initially worked in community pharmacy. In 1996 I became a Teacher – Practitioner with the University of Nottingham where I completed a Masters in Public Health and my Academic Practice Certificate. In 2001 I moved to Robert Gordon University, as a Senior Lecturer in Pharmaceutical Public Health, working half the week in academia and the remainder for NHS Grampian in the Public Health Unit.*

*As well as working around the redesign of medicine management structures in NHS Grampian I have led our work around prioritisation of investment in new medicines and the development and coordination of our process to access medicines in exceptional circumstances.*

*Outside of medicines management my main NHS work is around pharmaceutical needs assessment and emergency planning.*

## Abstract

Technological advance means that the range of new medicines and conditions that we are able to treat continue to expand. In a financially restrained NHS there is a need to target available resources to best effect. In support of this the importance of the role of health technology assessment bodies, such as the National Institute for Health and Clinical Excellence and the Scottish Medicines Consortium, has grown. Whilst there is limited attention given when medicines are approved for use in the NHS there has been significant attention given to situations where medicines have been turned down or restricted.

Since the late 1990s the right of care organisations in the UK to prioritise investment in certain health interventions and restrict others has been demonstrated through a number of judicial reviews. These reviews have also made it clear that blanket bans of particular medicines will not stand up to review and that care organisations must have decision making processes in place to review the provision of a medicine, not normally funded, for use on an individual patient basis.

In NHS Grampian our process for making these types of decisions was first formalised in 2003. Today NHS Grampian aims to engage the patient in the decision making process as early as possible. This presentation will describe our experiences of this patient involvement and reflect on lessons learned.

## Critical appraisal I: Teaching basic principles

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

*For personal details, see page 3*

### Abstract/Objectives

The workshop will be an interactive session which will provide the opportunity for participants to discuss the rationale for critical appraisal and then work in groups to explain the importance of some of the key concepts to the other workshop participants.

Key issues to be covered include:

- Why the RCT is so important.

- When is the rate of loss to follow up too high?

- Why we prefer intention to treat analyses.

- How can we explain results in more understandable ways.

- Why we prefer the 95% confidence interval to the p-value

- Issues to consider before extrapolating results to the wider population

# Health economics

***Ailsa Brown,*** *Health Economist, SMC*

*Ailsa Brown has worked as the principal health economist for the Scottish Medicines Consortium since 2006. The Scottish Medicines Consortium provides rapid health technology advice on all new drugs to NHS Scotland, focussing on the clinical and cost-effectiveness of treatments. Prior to working for SMC, Ailsa worked as a health economist for NHS Greater Glasgow and Clyde for 10 years where she undertook a range of health economic analyses, such as priority setting exercises for regional service developments, appraisals of public health interventions and decision-support work for the local medicines resource management group.*

## Abstract/Objectives

The aim of the workshop is to give an overview of the principles of health economic assessment as applied to new drug developments. The various types of economic evaluations will be outlined before focussing on cost-utility analysis, the preferred methodology for organisations such as NICE and SMC. Discussion will be given on QALYs as an outcome measure and interpretation of cost-effectiveness ratios.

# Drugs in pregnancy

***Dacia Jones,*** *National Teratology Information Service, Newcastle-upon-Tyne*

*Dacia has worked as a Medicines Information Scientist at the Regional Drug & Therapeutics Centre in Newcastle-Upon-Tyne since 2001. She moved to her current position as a Senior Medicines Information Scientist specialising in teratology in October 2008. Her current post involves taking part in the enquiry answering service, writing summaries on the use of drugs in pregnancy, and training new staff members.*

## Abstract/Objectives

This is an interactive session covering aspects of drugs in pregnancy and the potential effects on the foetus.

This workshop will enable participants to:

- Recognise the factors determining risk to the foetus
- Gather background information required to answer an enquiry on drug use in pregnancy
- Interpret the available information
- Formulate an answer

# CPD for MI Dummies

## Bridget Rankin and members of the UKMi Education & Training Working Group

**Bridget Rankin,** Principal Pharmacist - Medicines Information. Maidstone & Tunbridge Wells NHS *Trust*

*I qualified in 1982 and for 14 years worked as a community pharmacist and community pharmacy manager. In 1996 switched to hospital pharmacy practice and after 4 years moved into Medicines Information.*

*I have always had a special interest in Education and Training and as a member of The UKMI Education and Training Workgroup contribute to various work streams including the National Medicines Information Training Course and the development of an advanced practice programme.*

**Trevor Beswick,** *Director – South West Medicines Information & Training University Hospitals Bristol NHS Foundation Trust*

*Most of my career has been spent in MI and Training I have also worked for a PCT in the areas of Medicines Management, Primary Care management and Commissioning.*

**Selwa Elrouby,** *Medicines Information Manager, Central Manchester Hospitals NHS Foundation Trust*

*After qualifying in 2000 I worked as a rotational pharmacist at Central Manchester Hospitals NHS Foundation Trust. A year spent on a secondment t South Manchester hospitals NHS Foundation Trust developed my interest in Medicines Information (MI) and project work during that year resulted in publications examining information needs of GPs and community pharmacists as well as examining the expansion of MI service provision to primary care. After working in MI and cardiothoracic surgery, I now manage the MI service at Central Manchester University Hospitals NHS Trust and support the information needs of the Trusts medicines management committee. I have a keen interest in education and training and teach MI skills to both undergraduates and pharmacy diploma students at The University of Manchester. I joined the UKMi education and training group in Jan 2008 and will be organising the Jan 2010 UKMi National Course.*

## Abstract/Objectives

As MI pharmacists and technicians we are constantly learning. Recording our Continuous Professional Development is not a new concept for us but there may be barriers to incorporating it into our practice. Now that CPD is mandatory and each record must comply with RPSGB requirements it is essential that we overcome the barriers and understand the key elements that make a good CPD record.

During this workshop we will explore the barriers to recording CPD and consider the types of activity within our day-to-day work in Medicines Information that can be used to complete a CPD record.

We will examine the RPSBG format for plan & record and identify what makes a good record.

There will be an opportunity to share 'top tips' for completing good quality records and keeping the momentum going.

## Aim

To help MI pharmacists to plan their learning and to record significant experiences as CPD records.

**Learning Outcomes**

- To recognise & list the barriers to recording CPD

- To identify events that develop our professional practice and can be recorded in an RSPBG approved format

- To locate resources for presenting significant learning points as CPD records

- To list key aspects of completing a CPD record correctly

## Pain management – current developments

***Dr Beverly Collett,*** *Consultant in Pain Management University Hospitals of Leicester*

*Dr. Beverly Collett is a Consultant in Pain Medicine at University Hospitals of Leicester NHS Trust, UK.*

*She is Treasurer and Council member of the International Association for the Study of Pain (IASP), and was the facilitator for IASP's Global Year against Pain for 2007/8 'Pain in Women'. She is Chair of the SIG 'Pain of Urogenital Origin' (PUGO).*

*She is a Past-President of the British Pain Society and of the International Pelvic Pain Society and previously Honorary Secretary of the European Federation of IASP Chapters. She was a member of the Founding Board of the Faculty of Pain Medicine of the Royal College of Anaesthetists. She is Chair of the Chronic Pain Policy Coalition (CPPC) – a group facilitating patients, parliamentarians and health care professionals to improve pain management in the UK.*

*She has been a Consultant in Pain Medicine since 1986, running general pain clinics and she also has a specific interest in paediatric pain, pelvic pain in women and pain in patients with drug dependency problems. Currently, she is the clinical advisor for the MUR plus project in Leicesterershire.*

## Abstract/Objectives

7.8 million people in the UK suffer from chronic pain. Pain has a significant humanitarian and economic cost. Patients suffer not only from their symptoms, but they can also become depressed and anxious and can go on to lose their jobs, miss school or college and their societal and family role can be affected.

Often early management of pain takes second place to investigations of the cause. Sometimes, pain will persist even when the cause is treated.

This workshop aims to educate about the pathophysiology of pain and to explain what happens at the level of the spinal cord and brain when pain persists. Management strategies, both medication and holistic, will be discussed in detail.

The importance of the role of the pharmacist in the management of patients with chronic pain will be highlighted, especially in view of MURPlus currently being introduced nationally.

## Critical Appraisal II: Assessing a non-inferiority study
*David Erskin,* *London & South East Medicines Information Service*

*For personal details, see page 3*

### Abstract/Objectives

The workshop will provide the opportunity for participants to learn about how non-inferiority studies are designed and the additional factors that should be borne in mind when critically appraising this type of study. Participants will then work in groups using a checklist to critically appraise a study that they have been sent as pre-course reading using these criteria.

# Effective writing skills

**Tim Albert,** *Writer & 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

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.

# Preparing for an MI audit

**Fiona Woods, Mark Cheeseman,** *UKMI Clinical Governance Working Group*

## Fiona Woods

*Fiona Woods is the Director of the Welsh Medicines Information Centre (WMIC) in Cardiff.*

*Fiona Woods is an experienced Medicines Information Pharmacist who has been Director of the WMIC for over 20 years and has spent nearly all her post-registration experience working in Medicines Information.*

*Fiona Woods is currently the convenor of the UKMi Clinical Governance Working Group Which has recently revised the MI standards and audit toolkit.*

## Mark Cheeseman

*Mark graduated from the University of Portsmouth in 1999 and completed his pre-registration year at Portsmouth Hospitals. He then continued working at Portsmouth as a rotational pharmacist before joining the Wessex MI centre (Southampton) in 2001. After nearly 3 years, he decided to move to Suffolk and take up a post at Ipswich Hospital involving critical care, anaesthetics, microbiology and formulary. About 3 years later an opportunity came up to work in the East Anglia MI service based at Ipswich Hospital where he's been since 2007. Mark is currently an active member of the UKMi Clinical Governance Working Group.*

*Mark holds a Masters' degree in Infection Management from Imperial College, London.*

## Abstract/Objectives

Learning outcomes:

- To understand the principles underpinning the UKMi audit scheme
- To be familiar with the responsibilities of the auditor, the MI manager and the Senior Pharmacy manager in the audit process
- To be familiar with the audit process
- To identify means of deriving maximum benefit from the audit process

# Risk assessment of unlicensed medicines

***Ben Rehman,*** *Director, London Medicines Information Service*
***Tim Root,*** *Specialist Pharmacist, Clinical Governance & Technical Services*

## Tim Root

*I registered in 1977. In April, 2003, after 18 years as Chief Pharmacist at the Royal Marsden. I moved to my current post as Specialist Pharmacist, Clinical Governance and Technical Services, South East England Specialist Pharmacy Services. I have also worked as a project manager for the NPSA and as a pharmacy adviser to the DH Cancer Action Team. I am joint professional secretary to the National Advisory Board for Modernisation of NHS Medicines Manufacturing and Preparation Services. I have been a member of the HPG Committee since 2005. My interests lie particularly in intravenous therapy, patient safety and governance of pharmacy services in general, and medicines manufacturing and compounding services in particular.*

## Ben Rehman

*I registered as a pharmacist in 1998 and since then have worked in varied branches of the profession included community, hospital, and industrial pharmacy; as well as medical writing for the BNF.  My current role is as Director for London Medicines Information Service—my particular interest is in ensuring MI's continued relevance in responding to the needs of PCT commissioners; better reflecting the needs of patients, and the patient safety agenda; and in continuing to support and evolve Trust-based medicines information services.*

## Abstract/Objectives

Assessing unlicensed medicines is a task often undertaken by medicines information pharmacists and is vital both in encouraging the rational use of medicines and in ensuring patient safety.  The interactive workshop will introduce some basic concepts concerning the regulatory framework for medicines in the UK and the potentially inherent differences in risk that may result.  We will then move on to discuss elements likely to be essential in assessing risk for unlicensed medicines. Participants will be expected to apply a risk based approach to a variety of example scenarios and to report back to the group as a whole.

# Diabetes – Management and current issues

***Steve Williams,*** *Consultant Pharmacist in Medicine & Medication Safety*

*Steve sees his consultant pharmacist role as a privilege and believes he is working as an ambassador for pharmacy as a "drug expert". He works clinically as a pharmacist independent prescriber in the medical admissions unit and diabetes outpatients, and is the hospital lead for medication safety. He also works as an honorary clinical lecturer at the University of Manchester and is currently undertaking an MPhil investigating the attitudes of hospital pharmacists to reporting medication errors.*

*He has worked specifically with Diabetics for the last 12 years, independently seeing patients and prescribing for the last 4 years in a hospital multidisciplinary diabetic clinic.*

*He believes that all pharmacists should be aiming to work as non-medical prescribers, in particular for the benefit of patients with long term conditions such as diabetes and cardiovascular diseases.*

## Abstract/Objectives

Type 2 Diabetes really is going to be the disease of the 21st Century if the worldwide "obesity epidemic" continues to rise.
With two new exciting classes of Incretin related hypoglycaemic drugs that seem "weight friendly" the new NICE guidance appears, at first glance, to give the "green light" to prescribe any combination of licensed drugs if a patient has poor glycaemic control.
New trials however suggest that perhaps we should not be so aggressive about HbA1c targets and consistently trials tell us that we must pay more attention to blood pressure and general cardiovascular risk factors.
So this session will consider the current pharmacotherapy controversies and most importantly how holistic therapeutic decisions should be made in practice for individual type 2 diabetic patients.

# 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:**
**2008**
Sahera Uddin, Louise Nolan and Gillian Stead
*Information resources for hospital pharmacies: managing the risk*

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

**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*

# An evaluation of medicines information provision in NHS Forth Valley

*Gail Healey, Senior Pharmacist, Medicines Information, Stirling Royal Infirmary, Stirling*

Aim

To evaluate service user opinion regarding current and future medicines information (MI) provision in NHS Forth Valley and propose a model for future service provision within NHS Forth Valley.

Setting

The research was set in the Medicines Information Department at NHS Forth Valley. The population under study were previous enquirers who had used MI services in the past and enquirers who use both of the centres were included in this research.

Method

The participants of the study were identified from the master enquiry log which is held within the MI department, by the study pharmacist. A quantitative questionnaire was developed in order to obtain the required information. The research participants were required to complete a postal questionnaire and mail it back using a reply paid envelope to the study pharmacist. Non-responders were identified and re-targeted with a mailing at the end of the data collection period.

Key Findings

There was an overall response rate of 42%. The most common resource used by healthcare professionals when answering medicines related enquiries personally is the BNF, which was favoured by 94% of respondents. 59% of respondents felt that the electronic resource they had the most training to use was Google. 54% of users would prefer to keep the same service available to them at the present; a local MI centre with an on call service for urgent out of hours advice, and quickness of answer was the most important component of MI services. 70% of service users would utilise medicines information related training if it were available and would like information tools to be made available to them.

Conclusion

The MI service at NHS Forth Valley is well regarded by its users, who do not wish for the current way of accessing the service to change. The results show that information resources available to the healthcare professionals within NHS Scotland are poorly utilised by the respondents which presents opportunities through training events to improve their knowledge of the range of resources at their disposal, and how use them in order to gain and act appropriately upon the information they contain. The service needs to evolve and keep pace with the changing face of the NHS and evolving professional roles whilst ensuring that it meets the needs and expectations of its users and UKMi standards at all times.

# Description of the medicines information service workload

*Diane Bramley, Mohammed Dambha*, *and Davina Wright, Medicines Information, Guy's and St Thomas' Hospital and Kings College London.*

Aim

To describe the workload of Medicines Information.

Background

Medicines Information centres (MIC) have collected data on their workload for approximately 30 years but have not published this data outside of MI.

Method

National workload data from 2006/07 was analysed.  MI centres from two UKMi regions were asked to complete a survey with a 4 months workload data retrieved from MiDatabank.  Only centres with MiDatabank were asked to participate due to limitations of retrieval of other systems. Each centre generated a workload report with the total number of enquiries, enquirer types, contact methods and enquiry category.  The centres with MiDatabank v2 were asked to cross match enquiry types with enquirers but this was not possible for centres still using an earlier version of the database.

Results

The National workload data collection 2006/07:  There was an 83% response rate (n= 177 / 214). 208 465 enquiries were answered during the 1 year period; an average of 98 enquiries per centre per month.  There was a strong correlation between the number of beds and the number of enquiries with local centres handling 129 enquiries per 100 beds.  MI trained 2450 trainees spending 10300 days delivering this tutoring.  For the two region data collection there was a response rate of 72% (n = 28/39) with data from 26 local MIC and 2 regional MIC.  All respondents completed a workload report and 22 centres submitted extra data on enquirer vs. enquiry type.  A total of 10256 enquiries had been answered during the 4 month period; an average of 92 enquiries per centre per month.  The most common enquiry type was administration / dosage followed by choice of therapy / contraindications, adverse effects and interactions.  Between 85 – 93% of enquiries were patient-specific.

Conclusion

Medicines Information services answer a large volume of enquiries with the vast majority of enquiries relating to patient-specific treatment.  Collection of workload statistics has become easier with the introduction of MiDatabank and also enabled further analysis of the MI workload.

References

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# What is the impact of a Regional Medicines Information Centre on the pharmacy department in its host Trust?

*Helen Jones, Jessica Burnup and Simon Wills, Wessex Drug and Medicines Information Centre*

## Aim

To explore and develop how the Wessex Drug and Medicines Information Centre impacts upon the pharmacy department in its host trust

## Background

The NHS Medicines Information (MI) Service is delivered by departments ranging from local through to regional centres. Wessex Drug and Medicines Information Centre (WDMIC) is a regional centre based at Southampton University Hospitals NHS Trust and is strongly linked both geographically and functionally with the pharmacy department, which also provides significant funding to the unit. We wanted to acknowledge, review and develop how the MI centre supports the pharmacy department.

## Method

A focus group, consisting of a cross section of 9 pharmacy staff, was conducted to establish what people perceived as the implications of having a regional MI centre in the pharmacy department, and how MI could support individuals and the department.

## Results

The group felt that the WDMIC had prestige in the wider pharmacy community but, due to a lack of awareness, had less in the host trust itself. The WDMIC was considered to benefit the development and retention of pre-registration pharmacists and rotational pharmacists, in addition to improving patient care. The enquiry answering service was the role most frequently cited in appreciative terms by the focus group – it was used to answer questions that pharmacy staff did not have the time/resources/expertise to tackle. People valued an opinion more than simple evidence. Suggested areas for increased support by WDMIC included: increased awareness and support to technicians, training on referring enquiries, developing a patient helpline, an MI Continuing Professional Development (CPD) pack for pharmacists, and audit and research help. Participants felt that there would always be a need for an MI service and highlighted the potential for MI to be involved in future pharmacy developments such as electronic prescribing.

## Conclusion

The results of this study showed a lack of awareness within the pharmacy department (particularly among non-pharmacist staff) about the services provided by WDMIC. The focus group felt that there was prestige in having a regional MI centre within the pharmacy department. The service was considered to improve patient care on a day-to-day basis. Further ways in which WDMIC could support the pharmacy department were discussed and other areas for research were highlighted.

# Just what do medicines information pharmacists do all day?

***Craig Rore***, *Lead Pharmacist, Grampian Medicines Information Centre, Aberdeen Royal Infirmary, Foresterhill, Aberdeen.*

Background

Time analyses are often used in commercial organisations to bill clients for the time spent on individual projects. We felt it would be useful to quantify the length of time the Medicines Information team spends on different activities such as staff training and clinical work.

Methods

A clock was purchased which chimed every 15 minutes. Every third working day for 6 months (January – June 2009), staff within the Grampian Medicines Information Centre documented their activity on hearing the chime. Data was analysed using an Excel spreadsheet.

Results

Unsurprisingly, enquiry answering was the most significant activity, occupying 46.7% of total staff time. Formulary work took 12.6% of time, and 11.9% of staff time was spent either training or being trained.

Exceptionality requests are a relatively recent addition to the MI workload, and it is potentially useful to be able to quantify the time spent on these. These requests occupied more than 5% of the Lead Pharmacist's time during the study period.

A similar study was carried out in the Centre in 2003. The staffing of the centre has changed since 2003, so direct broad comparisons are not appropriate. However, it is interesting to see how individual roles have changed over this time. For example, the Lead Pharmacist has additional responsibilities and now spends much less time on enquiry answering (35% compared with 52%).

Discussion

Although this study in isolation is interesting, the results are more useful when the study is repeated to see how the workload of the centre evolves over time. This could be used to justify a request for additional funding, or to demonstrate improved efficiency with paperless working, for example. It would also be interesting for two comparable centres to carry out the study and compare the results. This could then be a useful tool to compare practice and share ideas to improve efficiency.

# Do medicines information services make a difference?

*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 that published research on the impact of MI services on patient care is limited. The aim of this study was to find out how advice on patient management provided by the North West MI service to healthcare professionals 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, survey writing guides and a pilot. This was sent to all enquirers who contacted the North West MI centre with an enquiry over a six month period (September 08 to March 09), except NHS Direct staff and patients. The questionnaire consisted of three sections focusing on satisfaction with the service, how the advice provided was used and its usefulness to patient care.

Results

Of 672 questionnaires sent out, 459 (68%) were returned. Almost all respondents (95% [435/457]) stated that they used the advice provided; 80% (350/434) used the advice for the management of a current patient and 29% (125/434) for future patients. Most common uses were to check if current or proposed management was appropriate (51% [186/366]) and to manage adverse effects or drug interactions (25% [93/366]). Other uses included continuous professional development (24%) and training or teaching (16%). 96% (422/440) of respondents said that the advice provided answered the question asked and 95% (376/396) considered it to be useful for the care of their patient. 5% of enquirers did not use the information as it was no longer required, or they obtained the information elsewhere and 1% (5/455) of enquirers said the advice was not supplied in time to be useful. Overall, 99% of enquirers were satisfied with how the MI service was provided. Many respondents made additional comments on the good or excellent quality of the service and helpfulness of staff, and over a third were regular users of the service or commented that would use the service again or recommend it to their colleagues.

Conclusion

This large survey shows that users of the North West MI Service value the service provided; they follow the advice given and consider it useful in the care of their patients. However, proving that the service makes a real difference to patients' health and well-being is challenging as measurable outcomes are difficult to define.

# Patient impact:  Analysing growth of the clinical role for medicines information

*Simon Wills, Wessex Drug & Medicines Information Centre, Southampton University Hospitals NHS Trust*

The most complex enquiries are those in which the MI pharmacist adopts an overtly clinical role – acting as an adviser on the management of a specific patient. This requires clinical judgement and is different from (a) providing information alone and (b) answering non-patient-specific enquiries.

In this study, a random selection of 225 enquiries from 1999 and from 2009 was analysed to determine if the clinical role of Wessex MI in enquiry answering had increased over ten years. Two measures were targeted:

(1) The number of patient-specific enquiries.

(2) A ranking of enquiries according to clinical complexity.

The ranking according to complexity was based on the system in UKMi National Audit Standards. However, after piloting, it was clear that the existing system was too subjective for the purpose of this research and so it was modified to reduce researcher bias.

Compared to ten years ago, the Wessex MI Centre now answers significantly more patient-specific enquiries (93% vs. 59%), more enquiries where overt professional judgement is required (52% vs. 24%), and provides more bespoke written answers (21% vs. 4%).

The welcome growth in all these areas underlines the importance of Wessex MI in the care of individual patients in primary and secondary care.

Proactive efforts to reduce the numbers of more straightforward enquiries received have been successful, and have been greatly aided by the wider availability of e-technology within the NHS as a whole. Reducing the numbers of these enquiries has enabled the MI centre to focus its efforts on more clinically complex enquiries. So whilst overall enquiry numbers have not increased, the proportion that are most clinically complex is much greater – this makes better use of the clinical expertise in MI.

MI centres need to promote their clinical role more actively.

## The East Anglia Medicines Information out of hours project – results from a pilot study

**Mark Cheeseman**, *East Anglia Medicines Information Service, The Ipswich Hospital NHS Trust, Ipswich on behalf of the East Anglia Medicines Information Network*

Background

A pilot study to identify the types of medicines information (MI) enquiries handled out of hours by pharmacists was undertaken by the East Anglia MI network.  Secondary aims were to identify if:

- the process used to collate enquiry titles from local MI centres worked in practice

- the data could allow Medicines Q&As to be identified which would then be written to support the types of enquiries received out of hours

- the data could allow the local MI network to identify the resources that on-call pharmacists should be able to access out of hours

- a bespoke training pack could be developed which could be used by MI pharmacists for their local on-call pharmacists.

Titles of enquiries handled out of hours during the period January to March 2009 by each hospital in the East Anglia area were collated by the regional MI centre.

Results

During the first 3 months, an average of 72% of MI centres within the region responded. A total of 189 enquiries were received from local hospitals. The types of enquiries handled by pharmacists working out of hours during this period were identified, with injectable medicines accounting for nearly two thirds of these. In addition the medicines most commonly involved in enquiries handled by pharmacists out of hours were identified.

Conclusion

The primary aim of this pilot study was achieved. Such was the response rate from local MI centres that the process for reporting the types of enquiries handled out of hours by local hospitals was felt to be practical. The data collated during the pilot period has enabled specific Medicines Q&As to be identified which could be written to support the types of enquiries received out of hours. The data will be reviewed after a further 3 months before work begins on identifying the resources that on-call pharmacists should be able to access out of hours and the development of a bespoke training pack.

# Investigating the impact of medicines information on patient care and patient outcomes:  Part 1

*Diane Bramley* and *Alison Innes. Medicines Information, Guy's and St Thomas' Hospital, Northwick Park Hospital/School of Pharmacy, London.*

Aim

To Investigate the impact of the Medicines Information (MI) enquiry answering service on patient care and patient outcomes.

Background

A pilot study carried out last year concluded that in the opinions of enquirers the MI service had a positive impact on patient care[1].  Further study was needed to improve the survey methods to obtain more detailed results.

Method

Thirty five MI centres across three UKMi regions took part in a one or two week prospective data collection.  A two-part electronic questionnaire was developed and teaching sessions were given at the regional MI meetings.  Health-care professionals asking patient-specific enquiries were asked how they intended to use the advice from MI.  The enquirers completed a second electronic survey approx. 2 weeks later asking what happened to the patient and how they used the advice from MI. Results were analysed with a statistics package and an expert panel assessed a sample of the data for an independent evaluation of the results (see poster part 2).

Results

There was a 57% response rate for obtaining a dual set of questionnaires. 11% of enquirers hoped to resolve their patient's therapeutic problem, 13% to improve their symptoms or slow the disease process, 31% to avoid or prevent a disease, symptoms, adverse effects or drug interaction (including checking safety of a choice of therapy), 14% were managing the risks of therapy that had already been given and 27% hoped to optimise the administration of a drug.  In 22% of enquiries MI identified and advised on an additional drug therapy issue.  84% of enquirers thought MI had a positive impact on patients care or outcome.  76% of these thought MI improved patient care but not the immediate outcome and 24% thought MI improved patient outcome.  Further analysis will follow.

Conclusion

A high proportion of enquirers thought MI had a positive impact on patient care or outcome.  Most enquirers were not seeking MI's help to improve the patient's outcome and were hoping to reduce risk to the patient.  Findings from this study suggest future studies may be more appropriately focussed on investigating the affect of MI on reducing risk to patients.

References

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# Investigating the impact of medicines information on patient care and patient outcomes: Part 2

*Diane Bramley and **Alison Innes**. Medicines Information, Guy's and St Thomas' Hospital, and Northwick Park Hospital/School of Pharmacy, London.*

## Aim

The specific aims of this study (Part 2) were: to obtain an independent rating of the impact of MI on patient care, patient outcomes and risk for a sample of MI enquiries (from data collected in Part 1 of the study); and, to develop an MI-specific rating scale for ranking the impact of MI advice on patient care, outcomes and risk for wider use.

## Background

A pilot study concluded that enquirers found that MI had a positive effect on patient care.[1] Further development and data collection followed (see Part 1 poster). An independent rating of the impact of MI was proposed as a possible method of obtaining a valuable external view on the impact of MI, and of testing the reliability of enquirer-reported outcomes, thereby further exploring the data and extending the understanding of the impact of MI.

## Method

A consensus panel of 3 consultants and 3 senior clinical pharmacists rated the impact of a purposive sample of 24 data sets (enquiry forms and questionnaires from Part 1) on a six-point rating scale. Qualitative and quantitative analysis were used to assess the data. The principles of ranking used by the panel were then applied to the full data set to obtain an 'independent' ranking of a large, representative data set.

## Results

The panel reached a consensus rating of the impact of MI for all enquiries using the rating scale. 19 ratings were considered valid. The panel rating of the impact of MI agreed with the enquirers' rating in 12/19 cases, was less positive than the enquirers rating in 5/19 cases, and more positive in 2/19 cases. The panel rated 18/19 enquiries as having a positive impact and in most cases this was based on risk (13/18) either alone (5/19) or on both patient care and risk (8/19), and on patient care (9/18) alone (1/19). Only one enquiry had an impact on patient outcomes, and one a negative impact. Rating of impact for the full data set and further analysis will follow.

## Conclusions

The consensus panel provided an invaluable and rarely sought independent rating of the impact of MI on patient care & outcomes providing insight that allowed a large data set to be rated using the same principles. Enquirer-rating of impact is more positive than an independent rating. This study showed that MI's impact often depends on risk factors, usually on risk reduction. Patient outcomes are rarely affected by MI which is to be expected given MI's role. Risk reduction may be a more meaningful outcome to measure the impact of MI than patient outcomes.

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# Improving access to the Medicines Information Helpline.

*Caroline Burgess, Thomas Ferguson and Marcus Warner, Medicines Information Centre, King's College Hospital, Denmark Hill, London*

UKMi aim to improve patient accessibility to medicines related information in line with the Healthcare Commission Best Medicine Report.[1] In 2007, King's College Hospital Medicines Information (KCH MI) started advertising its patient helpline using a leaflet placed in the TTA bag, however the number of calls received via the helpline remained low in 2008.  This project aimed to explore usage of the MI helpline by members of the public (MOPs) and assess whether accessibility could be improved.

Data were collected by MI pharmacists about all calls to the MI helpline in December 2008.  A structured questionnaire was also developed and delivered to 50 outpatients.

During December 2008, KCH MI received 17 calls from MOPs.  MI pharmacists were able to answer all the calls received. Only 6 calls were from discharged patients who obtained the number from the leaflet. Other patients were transferred to MI after contacting switchboard or using the Trust website.  No patients were given the helpline number by other healthcare professionals (including pharmacists) at KCH.

Of the 50 outpatients questioned, 38 said they would call the helpline if they had medicine related issues.  50% of questioned outpatients strongly agreed that labels on bags and appointment/clinic cards were the best places on which to advertise a helpline number.  However, use of appointment/clinic cards is likely to be impractical and increase the proportion of inappropriate calls. Posters in waiting areas, word of mouth from clinicians, hospital switchboard and the website were other popular choices.  Leaflets and business cards were the least popular options, with 50% of patients disagreeing or strongly disagreeing that business cards were effective for advertising an MI helpline.

The current advertising strategy for the MI helpline appears to be relatively ineffective.  Prominent advertising of the MI helpline details on the Trust website and with switchboard should improve access to the helpline.  Re-launching the helpline to staff involved in discharge counselling patients is warranted.  Stickers on bags and posters in waiting areas may be more effective advertising strategies at KCH than business cards and leaflets. It is essential to assess the impact of these proposed changes on MI workload and appropriateness of calls once the helpline has been re-launched.

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# Patient Help Lines: what is the current picture in South East England?

*Mark Cheeseman, East Anglia Medicines Information Service, The Ipswich Hospital NHS Trust, Ipswich*

A study published in 2000 identified 82 hospital pharmacy based patient help lines in the UK. A more recent review of UK acute hospitals found that 64% had a patient help line.  The aim of this study was to ascertain the current provision of patient help lines in the South East of England.

Medicines information (MI) centres in South East England were asked to complete an online survey in early 2009 consisting of 15 questions.

A total of 44 MI centres (48% of MI centres in South East England) completed the survey. In addition to the number of hospitals that operate a patient help line, the following data was collated from the survey:

- Number of enquiries received and the enquiry types

- Advertised hours, routes of communication used and patient groups excluded from accessing the help line

- Number of departments that:

    o   received funding to set up their help line

    o   have written procedures for operating their help line

    o   provide additional training to their staff

    o   follow-up patients

    o   pro-actively identify risks/potential risks as a result of help line enquiries.

The information from this study provides a snapshot of how patient help lines are provided in the South East of England.  Data from this survey has also been used to inform a MI research project for pharmacy undergraduates from the University of East Anglia.

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# Outcomes of information provision to callers to a psychiatric medication helpline

*Anne Connolly, David Taylor and **Olubanke Olofinjana**, Medicines Information Department, The Maudsley Hospital, Denmark Hill, London, SE5 8AZ*

## Aims and Method

To examine outcomes of information received by callers to a psychiatric medication helpline. A questionnaire was completed over the telephone with 123 callers. Data on the reason for contacting the helpline, frequency of self-referral to a health care professional, action taken as a result of information received & satisfaction with the service & quality of information received were collected.

## Results

Almost half (47%) of callers reported changes (stopping, starting, switching or dose adjustment) to their medication after consulting a psychiatric medication helpline. However a small majority (53%) of callers reported no quantifiable changes in their medication apart from reassurance, referral, review and monitoring. Well over half (59%) of callers contacted a healthcare professional, most commonly a doctor, after contacting the helpline. Overall satisfaction with the quality of information and service provided by the helpline was very high.

## Clinical Implications

Information provided by a psychiatric medication helpline can result in changes to callers treatment and increase contact with other health care professionals. Use of information provided by the helpline are numerous and often go beyond a need for mere factual information.

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> **Poster 13**

## What really happens to a Drug Alert following cascade from MI?

***Helen Brittain**, Pharmacy Technician, Medicines Information Operations Manager, Leeds Teaching Hospitals NHS Trust*

Background

The Medicines and Healthcare products Regulatory Agency (MHRA) cascades reports of actual or suspected defects in medicines using the Drug Alert tree cascade system.[1] Drug Alerts play a vital and integral role in assuring quality for patients from the medicines supply chain.  The Medicines Information Centre (MIC) at Leeds receives Drug Alerts from the MHRA by fax or telephone and by email. The MIC then cascades further to 17 local areas.

Feedback following a Class One Drug Alert received out of hours resulted in the local cascade process being reviewed. An audit cycle was created and the first audit was undertaken in July 2009.

Method

After consultation with relevant stakeholders, a standard operating procedure was developed, encompassing a step-by-step guide to assessing the impact of a drug alert and ensuring all affected medicines were recalled, including areas such as homecare, patient's own medicines and emergency/'crash' boxes and ambulance transfer bags.  The new process includes a feedback form for each local area to return to the MIC; this would then be used to assess the impact of alerts on stockholding across the Trust, assist in planning for future incidents and provide quality assurance of the cascade process. Assessment of the feedback forms at the end of the first year will provide data regarding the impact of each alert and assess the effectiveness of the cascade process. Documentary evidence from dispensaries and stores was gathered and used to provide accompanying data.

Results

Not yet published: results will be available August 2009.

References:

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# Article request – How much time is spent on this activity?

*Clare Nelson and Denise Stevens, Office Administrators, Trent Medicines Information Service, Leicester Royal Infirmary, Leicester.*

Introduction

Evidence based medicine underpins clinical activity within the NHS and is facilitated by UKMI in many ways. One function of most regional medicines information (MI) centres is the provision of a journal article request facility, from journals to which it subscribes, offered to its service users and managed within copyright laws. At Trent MI this activity has traditionally involved supplying copies of articles to which the department and or our hospital libraries subscribe. More recently this has also included finding and supplying free full text articles which are available electronically. These activities are managed by the administration team using an in-house acquisition procedure. This can be time consuming.  It can also incur an additional expense if a British Library loan is required to support requests from staff within the department.

Aim

To identify factors which affect the processes of reference acquisitions and ways in which those processes can be made more efficient.  These factors include: who requests articles from Trent MI; the number of requests received; how much time is spent obtaining articles; the purpose of the request; the expense incurred of articles ordered from the British Library; and the variety of practices within UKMi regarding article retrieval.

Method

Data were collected on all article requests received over nine months and collated on a spreadsheet. A questionnaire was sent to 14 regional centres to establish their request procedure.

Results

During the period of the audit we received 125 requests of which 65% were successfully acquired without incurring costs and 14% were obtained via the British Library at a cost to the department of £84.23. On average 3.5 hours was spent searching for references each month, with each search taking an average of 14 minutes range from 5-40 minutes. Trent MI were the highest users with 63% of requests.  The second highest users of the service were pharmacists from the host Trust. Of these 56% of articles could have been obtained by the pharmacists themselves from our hospital libraries. Local MI centres were the third highest users. The results of the questionnaire sent to the regional MI centres shows most follow an in-house acquisition procedure for obtaining articles, and the majority do not record the time taken on MiDatabank.

Conclusion

The time taken to search and obtain articles can be considerable especially when more than one article is needed to answer an enquiry. None of this time is recorded on MiDatabank. Use of a national UKMI Standard Operating Procedure (SOP) for article acquisition could affect the number of article requests, decrease the time taken, increase awareness of and compliance with copyright law and be used as a training tool to assist pharmacists to find their own articles for non MI enquiries.

Future Recommendations

A discussion should take place to determine if the time taken in obtaining articles for enquiry answering and other MI activities should be recorded on MiDatabank.

Other regional MI centres to carry out their own or similar audits to compare results so that a national UKMI SOP for article acquisition can be produced. Re run the audit to determine if training UHL pharmacists and secretaries has reduced the number of article requests received for non-MI enquires

## Users and stakeholders of UKMi – What matters to them about the enquiry answering service? Methodology for designing a new survey.

*Angela Badiani, **Jo Oswald**, and Simon Wills. Wessex Drug and Medicines Information Centre, Southampton University Hospitals NHS Trust.*

An important tool to evaluate and quality assure the UK Medicines Information enquiry answering service is a satisfaction survey. This should regularly be sent out to a random selection of enquirers. The current national user survey design is based on a study performed in 1999, the results of which were not published [1]. This study did not consult enquirers about the choice of questions in the user survey: they were developed by the investigators themselves.

The aim is to ask users and stakeholders what aspects of the UKMi enquiry answering service are most important to them, and use this to redesign the user survey.

Phase 1 will involve a series of qualitative interviews. Purposive sampling will be used to select a variety of individuals representing key stakeholders and users. They will then be invited to take part in a one-to-one interview to determine what aspects of the UKMi enquiry answering service they consider most important.

This interview will be semi-structured and will be recorded and subsequently transcribed verbatim. The data will then be coded and analysed for key themes.

The topics from phase 1 which were rated as important most often, or of particular importance by the stakeholders will, along with the results of a literature review, be developed into a prototype quantitative questionnaire. This prototype will be shared with participants using a Delphi technique and modified according to their responses.

For phase 2, this questionnaire will be piloted on a much larger, random sample of enquirers from a wider geographical area. Respondents will be asked to complete the questionnaire as well as rate the questions in terms of importance. The questionnaire will also allow respondents to describe any other issues which they feel are important but which have not been included in the questionnaire.

The results from phase 2 will be analysed and the data presented to the UKMI Research And Development Working Group for translation into a validated user survey.

This is the initial research proposal; any feedback would be most welcome.

Reference

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## The Mystery Shopper Approach: does it work in East Anglia?

*Mark Cheeseman*, *East Anglia Medicines Information Service, The Ipswich Hospital NHS Trust, Ipswich*

Background

A mystery shopper project was undertaken in the London regions and previously reported on [1]. One of the conclusions from this study was that the use of a senior clinical pharmacist as a mystery shopper affected the way the enquiry was handled and answered in many cases. With the authors' permission, the same methodology was used in the East Anglia medicines information (MI) region but a 'junior' clinical pharmacist was employed as the mystery shopper.

The primary aim of this study was to determine if the methodology used in the London regions could work in a different geographical area. Additional aims included whether the use of a junior clinical pharmacist would affect the enquiry answering process; and, whether the mystery shopper approach provided any additional information to the current methods for assessing the quality of the enquiry answering process.

Method

A junior clinical pharmacist in each participating Trust asked their local MI centre the same enquiry and documented details of its intake, communication of the answer and accuracy of the documentation. An experienced UKMi pharmacist assessed all the available data.

Results

Like the London project, the approach was found to be a feasible method for assessing certain elements of the enquiry answering service. In particular the approach provided useful information about the enquiry intake and answer (communication skills) which are not currently assessed by any UKMi quality assurance methods. The use of a junior clinical pharmacist highlighted some issues and confirmed that an external or non-pharmacy mystery shopper maybe more appropriate.

Future

A telephone/communication skills training package and assessment toolkit is to be developed by UKMi for MI centres to use as a result of these two studies.

References

1.    Innes A, Taylor C, Soor S, Wraight D. The Mystery Shopper Project: A useful additional tool for quality assurance of MI services? Poster publication presented at the 34th UKMi Practice Development Seminar 2008.

## The role of an expert user group to evaluate e-learning about injectable medicine compatibility

*Simon Wills, Wessex Drug & Medicines Information Centre, Southampton University Hospitals NHS Trust; Alison Wright, E-learning Programme Manager, NHS Education South Central; Eleanor Woodford Guegan, Chair of Peripheral IV Line Training Group, NHS Education South Central.*

South Central SHA commissioned the regional MI centre at Southampton to create an e-learning module about compatibility of injectable medicines for nurses.

In order to ensure that content was relevant to the end-users, the SHA's Peripheral IV Training Group was asked to act as an expert user group to test a prototype version. These senior nurses from different trusts were asked to:

(a) assess the module for its general approach and usefulness;

(b) evaluate content critically;

(c) advise on how this e-learning would best be used in practice;

(d) consider whether there were other topics for e-learning that ought to be addressed in the future.

The User Group's overall assessment of the module was very favourable and some of the reasons for this are described. However, the members of the group gave practical advice and suggestions to improve the content, and their recommendations concerning the application of this e-learning in practice were used to help implement the module. Several injection-related topics for future e-learning were identified and these will hopefully become the basis for a suite of injectable medicine modules.

The value of incorporating an expert review of e-learning prior to launch is stressed. This ought to form a basic element of any e-learning project plan.

**Poster 18**

## Is training remotely beneficial?  Comparing face-to-face and 'remote' delivery of MI training.

*Karoline Brennan*, *North West Medicines Information Centre, Liverpool.*

The North West Medicines Information Centre provides training for primary care pharmacy staff across the North West on the use of internet resources to find relevant information about medicines. This training has traditionally been provided face-to-face in full-day meetings and is well received. Some staff have difficulty accessing this training so we decided to explore the possibility of 'remote' training sessions.

Training was offered for staff in the North West on how to use the recently launched website NHS Evidence. Three types of training sessions were delivered:

1. A traditional face-to-face training session;

2. 'Remote' training using Web Presenter, an online application allowing participants to view the presentation online while listening to the presenter by phone;

3. 'Remote' training using a telephone conferencing facility. Participants received a copy of the presentation in advance. The presenter directed users by phone to navigate the presentation on their own computers rather than online.

All participants in the 'remote' sessions responded with their views on the training compared with traditional training.  The advantages and disadvantages of 'remote' training are described in the poster.

Their overall response: training remotely is beneficial!

# NHS Direct referred enquiries: is there a training need for UKMi?

*Mark Cheeseman, Abigail Scott, Kerstin Weber, East Anglia Medicines Information Service, The Ipswich Hospital NHS Trust, Ipswich*

'Complex' medication-related enquiries received by NHS Direct call centres are referred to participating UKMi centres by Health Information Advisors (HIAs) and Nurse Advisors (NAs). Based on the rota used by UKMi, the East Anglia Medicines Information Service (EAMIS) potentially handles the most NHS Direct referrals per week in England and Wales. Enquiries received by the EAMIS from NHS Direct are documented using MiDatabank.

The primary aims of this project were to:

- identify the most common enquiry types received by the EAMIS from NHS Direct

- identify the most common drug classes/clinical areas involved for each of the above

- develop the EAMIS in-house training programme for MI pharmacists

The five most commonly referred enquiry types over a one-year period were identified using data from MiDatabank. These were (in descending order of frequency): interactions, administration/dosage, choice of therapy/indications/contra-indications, adverse effects and drugs in pregnancy. The titles of enquiries in each category were reviewed and due to the large numbers, only the three most common drug classes/clinical areas were identified.

In each of the five enquiry types, it was found that a limited number of drug classes/clinical areas contributed to the majority of enquiries referred to EAMIS by NHS Direct. The EAMIS in-house training programme will target these areas to improve the knowledge of MI pharmacists and the quality of their answers to patients. This information may be useful to other UKMi centres that handle referred NHS Direct enquiries as it is believed that the enquiries received by EAMIS are generally representative for the UK.

## Poster 20

## Medicated patches and the MRI scan – a burning issue?

*David Anderton and **Philppa Cory**, Medicines Information Centre, The Royal Derby Hospital, Derby DE22 3NE.*

The use of transdermal medicated patches has increased considerably in recent years, such that there are currently 38 on the UK market. Some patches are formulated with an aluminium foil backing which could potentially cause injury if worn during an MRI procedure. A literature search revealed limited information regarding this issue; a single published case report described second-degree burns in a patient wearing a nicotine patch during an MRI scan [1]. The FDA are aware of at least two other anecdotal cases of patients experiencing burns after wearing a nicotine patch during an MRI scan [2]. In the UK the only information we were able to find was from an MHRA "One Liner" bulletin (May 2009) highlighting the risk [3]. A search of the eMC data-base revealed just one of the 38 whose SPC/PIL (Neupro - rotigotine patch) gave any sort of warning regarding use during an MRI [4].

This poster will examine the risks associated with the use of transdermal patches in this setting, will examine the composition of patches on the UK market, and will offer guidance as to an appropriate course of action for patients and radiographers.

References:

1. Karch AM. Don't get burnt by the MRI. Am J Nurs 2004;104:31

2. Burns in MRI patients wearing transdermal patches. ISMP Medication Safety Alert!

http://www.ismp.org/Newsletters/acutecare/articles/20040408.asp

3. One Liners issuie 68 – May 2009. http://www.mhra.gov.uk/Publications/Safetyguidance/OneLiners/CON049158

4. Neupro Transdermal patch

http://emc.medicines.org.uk/medicine/21963/SPC/Neupro+1+mg+24+h%2c+2+mg+24+h%2c+3+mg+24+h%2c+4+mg+24+h%2c+6+mg+24+h%2c+8+mg+24+h+Transdermal+Patch+%26+Parkinson%e2%80%99s+disease+Treatment+Initiation+Pack/

## Rationalising the use of dipyridamole suspension

*David Anderton*, Medicines Information Centre, The Royal Derby Hospital, Derby DE22 3NE.

The NHS spends around £11 billion per year on medicines, amounting to 18% of its operating budget. It is imperative that this money is invested wisely to maximise cost-effective outcomes. Locally, inappropriate use of medicines, waste and failure to maximise prescription income has placed increasing pressures on Trust drug budgets.

In order to address local overspends and reduce the cost of prescribing, a medicines management workstream was identified to contribute recurrent savings to the Trust target. Early and sustained engagement in the workstream was required of senior clinical medical staff, including the medical director and chairman of D&T, as well as other key nominated medical, nursing and pharmacy leads staff with a key aim of improving the safe, clinical and cost effective use of medicines to safeguard patient care and realise recurrent savings. Medicines Information played a key role in supporting this workstream.

Trust expenditure on dipyridamole suspension in 2007/8 was £39 K. The suspension is licensed for use as an adjunct to oral anticoagulation for prophylaxis of thromboembolism associated with prosthetic heart valves. It was noted that all usage locally was in patients with swallowing problems following an acute stroke. A paper was prepared by the MI centre describing the evidence base for dipyridamole post –stroke. It concluded that the use of dipyridamole in suspension form in this setting was not evidence based, and thus was not a good use of scarce NHS resources. A proposal to place an embargo on the prescribing of dipyridamole suspension was supported by D&T and endorsed by stroke physicians within the Trust. A FAQ document was prepared explaining the background to the issues and providing advice as to how patients with swallowing difficulties should be managed. A start date of 1 July 2008 was agreed.

This poster will present the background to the dipyridamole initiative, how MI was involved in its introduction, and will look at the cost savings made possible in the local Trust and surrounding PCTs.

# Risk management role of medicines information – development of lepirudin dosage and monitoring guidelines

*Ana Bastos, **Sandra Wood** and Valerie Linn, Medicines Information, Pharmacy Department, Monklands Hospital, Airdrie, Scotland.*

Aim

To develop evidence-based Lepirudin Dosage and Monitoring Guidelines (DMG) for the treatment of Heparin induced thrombocytopenia (HIT) with focus on the dosing, monitoring and preparation specificities of this drug.

Background

Lepirudin is used as an anticoagulant in patients with HIT and is administered intravenously.[1] Therapy with lepirudin is complex and requires careful multidisciplinary effort to minimise potential errors in its use. In addition, the infrequent occurrence of HIT and hence the uncommon use of lepirudin leaves pharmacists with insufficient experience about the specificities of this drug. The reduction of drug errors is a government health target in the United Kingdom[2] and Medicines Information (MI) is well placed to tackle high risk drugs aiming to make their use safer.  A recent dosing error with lepirudin occurred in Monklands hospital. As a risk management strategy MI proactively developed a lepirudin DMG aiming to provide an effective tool to guide in the optimal and timely management of patients prescribed with lepirudin.

Method

The Lepirudin DMG was developed using an evidence-based review of the literature. Clinical pharmacists and haematologists most likely to use or already using lepirudin were involved in providing user-feedback during the development and validation of the final tool.

Results

The Lepirudin DMG included 6 sections: baseline information, initial dosage (with emphasis on dose adjustments in patients with impaired renal function), monitoring, dosage adjustment and instructions for therapy discontinuation and transition.

Conclusion

A Lepirudin treatment tool for HIT was developed and validated in a tertiary care hospital in an effort to improve the management of patients requiring lepirudin and reducing the risk associated with the dosing and administration of this drug.

References:

1. Refludan Summary of Product Characteristics, via http://emc.medicines.org.uk, accessed on 29/07/09, last update on eMC on 04/09/09.
2. Safety in doses: medication safety incidents in the NHS. National Patient Agency 2007.

# A poisoning & prescribing data analysis examining mefenamic acid.

*James DA* *National Poisons Information Service; Newcastle / Regional Drug & Therapeutic Centre Newcastle.*

Objective

To identify the incidence of poison centre enquiry's regarding Mefenamic acid and describe the epidemiology of associated poisonings.

To highlight the self harm risk group, the drugs known toxicity compared to other Nonsteroidal anti-inflammatory drugs (NSAIDs).

To emphasise the efficacy of other NSAIDs drugs in the treatment of women with dysmenorrhoea.

Method

Data analysis of national poison information enquiries and regression analysis of national Prescription Prescribing Authority data.

Discussion

Commonly used NSAIDs are of relative low toxicity, with mefenamic acid being an exception. Mefenamic acid has tonic-clonic (grand mal) convulsion inducing potential in overdose usually preceded by muscle twitching accounting for the predominant consequential clinical effect in overdose, reported in 38% of cases[1]. Convulsions generally manifest within 12 hours and peak concentration can take this long post ingestion[1]. The lowest dose to cause coma and seizures in an adult was 3.5 grams[2] (e.g. 7 x 500mg tablets).

Mefenamic acid is predominantly used in the treatment of primary dysmenorrhea and menorrhagia (500mg 3 times daily[3]). It has been reported as many as 90% of women aged 18-45 years suffer from dysmenorrhoea[4].

NSAIDs reduce the production of prostaglandins thus reducing pain and are frequently prescribed for this indication. Ibuprofen, naproxen, and mefenamic acid are the first line NSAIDs indicated in primary dysmenorrhea[5]. There is no evidence of the superiority of any individual NSAID with regard to efficacy[6]. Mefenamic acid is specifically licensed for menorrhagia[3].

It has been demonstrated that prescribing trends reflect patterns of self-poisoning[7]. Although there is no data available on the epidemiology of mefenamic acid poisoning, it is likely that it is associated with the female adolescent section of the population. A fifteen-year prospective study[8] of adult deliberate self-poisonings documents a dramatic increase in NSAID overdoses, reflecting prevailing prescribing developments. The numbers of mefenamic acid overdoses were disproportionately increased, prompting the authors to conclude that availability is not the only determinant and thus suggesting that Mefenamic acid may be being prescribed to those in high-risk groups.

Conclusion

The above points demonstrate the importance of considering the potential toxic profile of a drug and weighing this up against potential benefit when prescribing medication. Hence, the potential toxic profile of certain drugs such as Mefenamic acid must be taken in to account when prescribing for high-risk groups such as 15-19 year old females[9].

## References:

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4 Jamieson DJ, Steege JF. The prevalence of dysmenorrhea, dyspareunia, pelvic pain, and irritable bowel syndrome in primary care practices. Obstet Gynecol. Jan 1996;87(1):55-8
5 NHS Clinical Knowledge Summaries accessed 24/7/09 Via cks.nhs.uk
6 Marjoribanks J, Proctor M, Farquhar C, Sangkomkamhang US, Derks RS.
Nonsteroidal anti-inflammatory drugs for primary dysmenorrhoea. Cochrane Database of Systematic Reviews 2003, Issue 4
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8 McMurray J. Trends in analgesic self-poisoning. British Journal of Clinical    Pharmacology; Jan 1988; 25: 120P – 121P
9 Bialas MC, Reid PG, Beckj P, Lazarus P, Smith PM, Scorer RC, Routledge P. Changing patterns of self-poisoning in a UK health district.  Aug 1996; Q Med 1996; 89: 893-901

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# Medicines use evaluation of intravenous paracetamol

*Alison Campbell, **Cristina Coelho**, Jenny Stirton and Leanne Hunter - Pharmacy and Prescribing Support Unit, NHS Greater Glasgow and Clyde*

Background

Use of intravenous (IV) paracetamol in NHS Greater Glasgow and Clyde has increased during 2007-2008 with an associated increase in expenditure of 59%. This medicines use evaluation aimed to determine the appropriateness of IV paracetamol prescribing within the Surgical and Anaesthetics Directorate.

Methods

Data were collected prospectively in surgical wards, high dependency and intensive care units in each acute hospital across the Health Board for one day only.  This included 1350 beds. All patients prescribed IV paracetamol on the day of the audit were included.

Results

Ninety-nine patients were included in this study (7% of audited beds). The majority (n=65, 66%) were prescribed IV paracetamol as one of several optional routes of administration. In this subgroup, the actual route used was unknown in 59 patients (91%). Thirty-four patients (34%) were prescribed paracetamol exclusively by the IV route, of which thirteen (38%) did not appear to have an appropriate reason for this on the day of the audit. Of the 28 patients weighing less or close to 50kg (±5kg), only eight (29%) were weighed. Of the seven cases where dose adjustments were appropriate due to low body weight, only one patient (14%) was prescribed a reduced dose. A regular clinical pharmacy service was associated with a higher proportion of correct doses prescribed.

Discussion

IV paracetamol is prescribed in a minority of patients at surgical ward level. Widespread practice of prescribing paracetamol IV/oral was identified. Data suggest that over one-third of patients prescribed IV paracetamol may not have an appropriate reason for this route. Results highlight the lack of awareness regarding dose adjustments in low body weight and the role of pharmacy in promoting clinical and cost effective prescribing.

Conclusions

Data suggest that the use of IV paracetamol could be further rationalised and early review of IV route should be encouraged.  Low body weight may often be overlooked as a relevant factor for dose adjustments, increasing the risk of paracetamol toxicity.

Educational initiatives: Following the results of the project, an educational package was produced to facilitate dissemination of information to pharmacy, nursing and medical staff. Oral presentations have been delivered across the Health Board, targeting junior and senior staff, including medical and non-medical prescribers. Data from this audit have also been used in a medicines education bulletin.

# Medicines utilisation data: A vital commodity in today's NHS

*Roy Foot, **Yvonne Semple** and Peter Mulholland, Area Medicines Information Centre, Glasgow Royal Infirmary, 2Southern General Hospital, Glasgow*

Background

It is well recognised that the NHS faces pressure to deliver high standards of healthcare in the wake of increasing cost pressures.  Costs related to medicines account for almost 15% of the total NHS budget.  Accurate and timely information regarding medicines utilisation is vital.  Within NHS Greater Glasgow and Clyde (NHSGGC), there are two main prescribing groups that report directly to the Board; the Prescribing Management Group which is considered the financial arm of the advisory structure, and the Area Drug and Therapeutics Committee which advises on all matters relating to medicines.  There are several Subcommittees which feed into these groups. Medicines Information is widely represented at these committees.  The Medicines Utilisation and Prescriber Education (MU&PE) Subcommittee particularly focus on prescribing trends, adherence to Formulary and proactive educational materials.

Objective

Provision of medicines utilisation data to MU&PE Subcommittee.

Methodology

There are two main sources used for medicines utilisation data within NHSGGC.  Prescribing data from primary care is obtained from PRISMS and data from the acute sector is obtained from the Ascribe pharmacy computer system.  PRISMS is a national web-based application including data from all NHS prescriptions issued or dispensed in community pharmacies.  Information can be analysed down to individual prescribers.

Data from the Ascribe pharmacy system used across acute NHSGGC sites is exported quarterly into a medicines utilisation Access database.  Queries have been designed in this database to produce standard reports.  Data can be analysed down to ward level.  Using these two sources of information, routine reports are generated and discussed at MU&PE meetings.  Prescribing trends can be compared within and across sectors.  Reports are used to guide resource, highlight the need for educational initiatives, inform medicines planning and provide a signal for further medicines evaluation work.

Conclusion

The current processes in place to produce medicines utilisation data within NHSGGC are well established.  Future developments including electronic prescribing and the progression of a national medicines database to track prescribing in the acute sector will improve and increase the medicines utilisation data available.

# 'NICE Bites' prescribing bulletin

***Lindsay Banks**, North West Medicines Information Centre, Pharmacy Practice Unit, 70 Pembroke Place, Liverpool L69 3GF.*

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Objectives

To provide healthcare professionals with a clear, concise summary of key prescribing points taken from NICE1 guidance.

To facilitate implementation of NICE guidance and promote best practice by providing easily accessible information at the point of prescribing.

Background

This project originated from a request by a local senior commissioning pharmacist for assistance in incorporation of key prescribing points from NICE guidance into their local Health Economy formulary. It was recognised that this might be useful across the North West Strategic Health Authority. The suggested format was an electronic bulletin consisting of two sides of A4, to be published monthly for distribution to healthcare professionals. It would include key prescribing recommendations and signpost readers to full NICE guidance. This bulletin would be cascaded to prescribers within primary and secondary care in PDF and Word to enable incorporation into local formularies.

Method

1) An initial draft bulletin entitled 'NICE Bites' was compiled and circulated to Heads of Medicines Management for comment.

2) To ensure accuracy, clarity and consistency a writing guide was compiled and standard operating procedures set up in accordance with UKMi recommendations for clinical governance.

3) A proposed work schedule was developed to include NICE Clinical Guidelines and Technology Appraisals for inclusion in 'NICE Bites' within one month after publication.

4) In January 2009 the first edition of 'NICE Bites' was published and circulated to the following groups: chief pharmacists, local and regional medicines information pharmacists, PCT pharmacists, senior medicines management pharmacists, community pharmacists and NICE implementation pharmacists.

5) In March 2009 'NICE Bites' became available online at www.nelm.nhs.uk.

Monitoring and evaluation

'NICE Bites' is being used locally and nationally to facilitate NICE implementation. It is difficult to assess the impact on practice at this stage so a questionnaire survey is planned for 2010 to evaluate the usefulness of this publication and any impact on prescribing. Anecdotally: a local PCT is including it in their prescribing newsletter, others are cascading it to prescribing leads and one GP was prompted to start an audit on prescribing of glucosamine, attendance at a local committee of Prescribing Leads led to the agreement to use this publication to disseminate information to prescribers and facilitate monthly appraisals of local implementation of NICE guidance.

Ref: (1) National Institute for Health and Clinical Excellence. Full guidance accessible at www.nice.org.uk.

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## An e-learning and assessment package to support the implementation of medicines reconciliation.

*Trevor Beswick (South West Medicines Information and Training), Ellen Bidwell (South West Medicines Information and Training), Keith Brown (COACS), Andrew Davies (North Bristol NHS Trust), Jill Loader (NHS South West), Steve Moss (COACS),*

Medicines reconciliation is a key step in improving patient safety as people move between care sectors e.g. from home to acute care. NICE has published guidance on medicines reconciliation and many NHS organisations are implementing strategies to improve the quality and comprehensiveness of this intervention. Whilst in many acute hospitals pharmacists and pharmacy technicians are able to provide the main resource for carrying out medicines reconciliation, community and mental health trusts rely on other staff groups. This web based e-learning and assessment package has been developed, with funding from NHS South West as part of a strategy to improve patient safety, to meet the training needs of a wide range of staff groups who are involved in medicines reconciliation.

The package has been piloted in four NHS organisations. It provides organisations with a means to manage the learning and assessment of their staff through the identification of a hierarchy of organisation leads, assessors and learners together with the ability to maintain records of training and assessment.

The package is currently available to NHS organisations in the South West and plans are being developed to make it more widely available in 2010.

# The Scottish Medicines Consortium – horizon scanning for new medicines to support financial planning in NHS Scotland

*Anne Lee, Laura McIver, Joanne Andrew, Susan Donnelly, David Carson, Alex Robertson, Pauline O'Connor. Scottish Medicines Consortium, Delta House, West Nile Street, Glasgow*

The Scottish Medicines Consortium (SMC) undertakes rapid appraisal of new medicines and advises NHS Scotland on their clinical and cost-effectiveness.  In 2005 SMC introduced a horizon scanning (HS) initiative, aimed at improving financial planning through the provision of early intelligence on new medicines in development.

The horizon scanning team of pharmacists and management accountants gathers intelligence on new medicines through a process involving engagement with clinical specialists across Scotland as well as the pharmaceutical industry. An annual horizon scanning report, entitled Forward Look, is issued to Health Boards each October.

Three 'Forward Look' reports have been produced, featuring medicines expected to become available for use in the following 12 to 18 months. Reports are focused on medicines expected to have a moderate to high net impact on the drug budget and/or significant implications for service delivery. In addition, all medicines designated as orphan drugs are included in the reports irrespective of their anticipated budget impact.  For all these medicines, the report includes an estimate of uptake in the Scottish population and the corresponding potential budget impact in years 1 and 5 after the medicine is introduced. The budget impact estimates take account of the anticipated costs and savings associated with the new medicine; for example, this might involve offsetting the costs of a displaced medicine or adding the costs of any additional treatment monitoring required.

The poster will outline the SMC horizon scanning methodology and provide an overview of the outputs to date.

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