PUBLIC AUDIT COMMITTEE

Wednesday 6 May 2009

Session 3

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PUBLIC AUDIT COMMITTEE
9th Meeting 2009, Session 3

CONVENER

*Hugh Henry (Paisley South) (Lab)

DEPUTY CONVENER

Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Willie Coffey (Kilmarnock and Loudoun) (SNP)
*Cathie Craigie (Cumbernauld and Kilsyth) (Lab)
*George Foulkes (Lothians) (Lab)
*Anne McLaughlin (Glasgow) (SNP)
Nicol Stephen (Aberdeen South) (LD)
Andrew Welsh (Angus) (SNP)

COMMITTEE SUBSTITUTES

Derek Brownlee (South of Scotland) (Con)
*Linda Fabiani (Central Scotland) (SNP)
James Kelly (Glasgow Rutherglen) (Lab)
John Farquhar Munro (Ross, Skye and Inverness West) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Angela Canning (Audit Scotland)
Barbara Hurst (Audit Scotland)
Tricia Meldrum (Audit Scotland)
Carolyn Smith (Audit Scotland)

CLERK TO THE COMMITTEE

David McGill

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Jason Nairn

LOCATION

Committee Room 1

Scottish Parliament

Public Audit Committee

Wednesday 6 May 2009

[THE CONVENER *opened the meeting at 10:00*]

Interests

The Convener (Hugh Henry): Good morning and welcome to the ninth meeting in 2009 of the Public Audit Committee. I welcome Audit Scotland staff to the meeting, and I ask everyone to ensure that their mobile phones and other electronic devices are switched off.

We have received apologies for absence from Nicol Stephen, Murdo Fraser and Andrew Welsh. I welcome Linda Fabiani to the meeting in place of Andrew Welsh. Do you have any interests to declare?

Linda Fabiani (Central Scotland) (SNP): No.

Decision on Taking Business in Private

10:01

The Convener: The first item on our agenda is to ask members whether they agree that we should take items 4, 5 and 6 in private.

Members *indicated agreement*.

Section 23 Report

"Managing the use of medicines in hospitals—A follow-up review"

10:01

The Convener: The second item on our agenda is a briefing from the Auditor General for Scotland on a section 23 report on managing the use of medicines in hospitals.

Mr Robert Black (Auditor General for Scotland): I invite Angela Canning, the assistant director who led the project, to introduce our study briefly.

Angela Canning (Audit Scotland): The Auditor General's report, "Managing the use of medicines in hospitals: A follow-up review", was published on 16 April 2009. As part of their hospital treatment, almost all patients receive medicines, which costs the national health service more than £220 million a year. In order to maximise the benefit of medicines, they need to be used safely, appropriately and cost effectively.

Our report follows up on the progress that has been made against key recommendations in our 2005 baseline report, and it gives an overview of national developments since then. We would like to bring four main findings to the committee's attention. The first is that hospital medicines are an area of significant expenditure for the NHS. In 2007-08, the NHS spent around £220 million on hospital medicines, which represents about 6 per cent of overall hospital running costs. We considered the costs of four high-cost medicines in particular and found that they accounted for 12 per cent of the expenditure on hospital medicines in 2007-08. They put particular pressure on hospital budgets, as is highlighted in exhibit 2 on page 7 of the main report.

The NHS has made good progress in budgeting for new medicines. That work has been led by the Scottish Medicines Consortium, which was set up in 2001 to provide the NHS in Scotland with a single source of advice on new medicines. The SMC now produces annual reports that include information on the budget impact of new medicines that are expected to become available in the coming year and are expected to cost the NHS at least an additional £500,000 annually.

NHS Quality Improvement Scotland develops clinical guidelines for the NHS, but still does not routinely assess the impact of those guidelines on budgets. However, there was a recent pilot on five of the guidelines, and NHS QIS is expected to decide later this year whether it will extend the process to cover future guidelines.

Our second finding was that boards need better information to ensure that medicines are used safely and appropriately in order to achieve the greatest benefit for patients. Progress has been slow in developing a national hospital electronic prescribing and medicines administration system. A HEPMA system can provide staff with instant information on the medicines that are prescribed and administered for each patient, thus reducing the potential for mistakes. It can also provide monitoring information on the medicines that are used in hospitals. In our 2005 report, we recommended that a national system be developed and implemented, but Ayrshire and Arran NHS Board remains the only health board with a system like the HEPMA system. Case study 1 on page 8 of our report covers the Ayrshire and Arran experience and illustrates some of the significant benefits of its system. It looks unlikely that a national system will be put in place in the next few years, and the new e-health strategy does not set out clear plans or timescales to ensure that such a system will be in place in all hospitals.

Our third main finding was that the NHS is making progress in promoting safe and cost-effective use of medicines. All acute hospitals in Scotland are taking part in a national patient safety programme, which was launched in January 2008. One aim of the programme is to reduce the risk to patients from adverse drug events and near misses. There has also been good progress in developing local and national guidance on prescribing.

Progress has been slower in developing a national approach to incident reporting. All boards have their own systems in place, but there is still no national approach. NHS Quality Improvement Scotland is working with boards on the feasibility of developing a national approach, but it is still to decide on the way forward.

Our fourth main finding is that increasingly, although hospital pharmacy staff work directly with patients and staff, workforce planning is still not well developed. Although there have been changes to the way in which services are delivered, workforce planning has not kept pace. There is still no national framework for recognising or accrediting extended roles for pharmacy technicians, apart from two extended roles that need a formal qualification. There is variation among boards as regards whether some tasks are carried out as part of standard or extended roles. We have recommended that a national framework be developed to improve consistency among boards and to provide assurance on staff competency for extended roles.

Most boards are still experiencing problems recruiting and retaining hospital pharmacy staff, and identified agenda for change as the difficulty. By December 2008, only 10 boards had assimilated all hospital pharmacy staff into agenda for change. Since agenda for change was introduced, there has also been less national information available on hospital pharmacy staff—for example, no vacancy data are available.

In December 2008, the Minister for Public Health asked the chief pharmaceutical officer for Scotland to develop an action plan for pharmacy and medicines covering both hospitals and primary care. The action plan is due in September 2009 and it is expected to focus on several issues, including workforce planning, patient safety, information technology support for hospital prescribing, performance management and integration between hospitals and primary care. It is a welcome development because there has been no national pharmaceutical strategy in place since the first strategy ended in 2005. As ever, we are happy to answer questions.

The Convener: Thank you very much. A couple of things in the report struck me. The first is that four drugs account for something like 12 per cent of the total medicine expenditure, which is staggering. When you look at exhibit 1 in the follow-up report, the percentage of total expenditure that hospital drug expenditure represents has not changed that much, but it is clear that there are major pressures, so I am interested in their implications.

Secondly, there seems to have been a successful pilot in NHS Ayrshire and Arran that has not been rolled out across Scotland, which seems to be a bit perverse, to say the least.

Mr Black: I offer a thought or two—both those points are absolutely vital. I am sure that Angela Canning and the team can give the committee more detailed information about the pressures and trends in prescribing in acute hospitals. However, looking to the future—this is borne out by work that we have done in the past—there is absolutely no doubt that the theme of pressure on drug budgets will re-emerge. As Angela Canning described, in the past few years since our baseline report, the NHS has been successful in controlling drug expenditure and has taken several initiatives to achieve that. Exhibit 2 on page 7 of the follow-up report refers to the four high-cost medicines, to which the convener referred, that now account for 12 per cent of expenditure on hospital medicines. That indicates a trend into the future.

I suggest that a related question is about the choice between medicines and hospitals. Some years ago we did a report on general practitioner prescribing in hospitals and identified tens of millions of pounds that could be released for redeployment in the NHS by doctors prescribing

generic as opposed to branded drugs. We have revisited that three times—or was it twice?

Barbara Hurst (Audit Scotland): It was twice.

Mr Black: We have seen the benefits coming through from that measure. We have found a similar issue in this report in the sense that the NHS needs to get good information systems about the patterns of prescribing and it needs a good knowledge of costs to ensure that budgets are being used well. However, cost pressures must be viewed alongside patient safety, which is one of the themes that runs through the report—a bit like the writing that runs through a stick of rock.

I will take a moment to describe what strikes me about the report in that regard. Angela Canning and the convener have mentioned the HEPMA system—the medical management system—that NHS Ayrshire and Arran has developed. We have included that as a case study because, on the basis of our evidence, the system works and has benefits for patient safety and management of medicines.

I encourage the committee to take a quick look at case study 1 on page 8 of the report, in which we say that the system gives NHS Ayrshire and Arran "reporting at ward level" about

"the medicines staff need to administer to each patient"

and about the timing of delivery of those medicines in the ward. It gives information about the risk of "adverse drug events" because of the interaction between different drugs, and about choices between drugs. Those seem to me, as a layman, to be very important strengths of the system.

It is worth noting, with regard to patient safety benefits, that it is reasonable to ask the NHS why it is not appropriate to roll out that system to other boards. There may be robust and entirely appropriate answers to do with the longer-term plans for the NHS as a whole. However, in the meantime, a number of boards do not have such a system, and there is a shortage of dedicated pharmacists, which is a point that is made later in the report.

Exhibit 8, on page 21 of the report, shows the wide variation in the percentage of beds that are covered by clinical pharmacy services. A number of the large boards do not have in-hours clinical pharmacy services that cover all their beds. If we view that alongside the underdeveloped nature of systems, we begin to see a pattern emerging in which clinical safety is linked to budget constraints—we need to make sure that the prescribing is going on there.

A second risk issue that emerges from the report is the fact that there is not really a national approach to analysing the pattern of unfortunate incidents in hospitals. A reasonable question to ask the NHS is how, at Scotland level, it learns from things that go wrong, and how it ensures that the information gets through the system to other parts of the NHS.

As Angela Canning and I have mentioned, there are issues around the standards of training for pharmacy technicians in particular, and around the availability of pharmacist expertise in hospitals. A lot of progress has been made on that, but we would expect more to be happening by now.

Willie Coffey (Kilmarnock and Loudoun) (SNP): Picking up on the point that the report makes about the HEPMA system, I would like some clarification about paragraph 13 on page 8 of the report. It seems to suggest that the HEPMA principle is being somehow integrated within a wider management plan. I hope that it has not been discarded, but is still being considered as a wider part of medicines management in hospitals.

With regard to the case study report on NHS Ayrshire and Arran that you mentioned, I have seen for myself the pharmacy robotics system at Crosshouse hospital—it is amazing what that can do and the time that it saves. It is encouraging that NHS Ayrshire and Arran intends to connect that system with the HEPMA system.

Lessons appear to have been learned in Ayrshire and Arran, and I would be interested in finding out in the future other boards' views of the system, and whether the principle is being enshrined within a wider medicines management policy. Can you clarify whether that is the case?

Angela Canning: I think you are right—the plans are to introduce HEPMA along with a wider patient management system. Perhaps Tricia Meldrum can give more history on why the system was piloted in Ayrshire and Arran, and an update on where the Government's thinking is now.

Tricia Meldrum (Audit Scotland): The system in Ayrshire and Arran was introduced more than 10 years ago. It is very much driven by staff at local level, who took the initiative as they wanted to develop something that was fit for purpose and that would work with their local systems. They have worked very closely with their IT providers to develop a system that works with their drug control and pharmacy systems and can take information from their patient management systems. It has been developed piece by piece over the past 10 or 12 years. A couple of years ago, the Government examined what was needed to implement a system across the country. What is in Ayrshire is fit for purpose in Ayrshire, but would not necessarily work with IT systems in other hospitals.

10:15

A group was put together to examine the principles that would be needed for a national HEPMA system. That group recommended against a stand-alone system because there is a need to link in to other patient systems to get demographic information, lab results and other such information. What is needed is for it to be part of an integrated patient management system. That is what is being taken forward through the e-health strategy. However, we are concerned that it includes HEPMA only as an optional module. When will it happen? When it does, will the boards be able to choose not to take on board the optional module component of it? The principles have been signed up to: that is the national approach but it may be that not all boards will necessarily implement that model. We do not have clear timescales.

Willie Coffey: That is quite encouraging. It sounds like a systems integration issue rather than an abandonment of the principle of managing the medicines. We still want to press for progress on that, at some point.

Tricia Meldrum: Our idea of timescales is getting a bit clearer. We see it as something that should be put in place sooner rather than later, in order that we can get the benefits.

George Foulkes (Lothians) (Lab): In passing, it is encouraging that the health secretary has agreed to give a £3 million loan to the Western Isles NHS Board. That obviously follows up from the work that Audit Scotland did and that we did in producing our recommendations. That was very encouraging.

However, less encouraging is the progress that has been made. Audit Scotland will know that I have a bee in my bonnet about following up of their reports. The reports are excellent, but I am very sceptical as to whether they are always followed up by the officials in the Scottish Executive, the health boards and other bodies around the country.