

12th August 2010

‘A REVIEW OF MEDICINES MANAGEMENT FOR HEART OF ENGLAND NHS FOUNDATION TRUST’

A review commissioned by Heart of England NHS Foundation Trust director of safety and governance Sarah Woolley, and group 4 director of operations Gloria Cooke.

As part of the Trust’s governance programme all clinical incidents are reported and investigated with the most serious being the subject of Serious Untoward Incident reports (SUIs). These are examined as a top priority to determine the root cause of the incident so that recommendations can be made, and lessons learned as soon as possible. Where a Coroner’s Inquest is held, the findings of that investigation are also examined so that additional changes can be made, and further learning can take place.

Two high profile, fatal medicine-related cases have occurred recently at Heart of England NHS Foundation Trust which prompted a review of all serious incidents over the last 6 years, in addition to a regular 6 monthly review of medication incidents by the pharmacy department to identify any trends. As a result of these incidents and the consequent findings from root cause analysis, the external review was commissioned with the specific aim to provide assurance to the Board and the wider Trust and (where appropriate) stakeholders, in relation to the systems currently in place in the Trust for the procurement, storage and safe management of medicines, the actions taken to address the root causes identified in the previous untoward incidents and to identify any concerns or further areas for improvement in clinical practice, managerial arrangements or governance that would contribute to the continued aspiration to deliver world class pharmacy services at the Trust and thereby safer patient care.

This review was undertaken by Bob Timson and John Gilby, two pharmacists from Bob Timson Associates Pharmaceutical Consultancy (BTA) with experience as former NHS Trust chief pharmacists, and latterly as independent reviewers of medicines management services in NHS Trusts over the last 10 years. The review was undertaken between April and June 2010 against a background of three key issues: the project brief, recent guidance from the NHS relating to the provision of pharmacy services, and from the National Patient safety Agency (NPSA) and the Trust’s strategic requirements, as outlined in the corporate business plan.

Semi-structured interviews were held with the pharmacy managers, pharmacy staff (a selection of pharmacists and technical and support staff) involved in the provision of services from Heartlands, Solihull and Good Hope pharmacy departments and non-pharmacy staff (a selection of senior executives, directors and managers, nurses and clinicians in the Trust). In addition, meetings were held with relatives of three patients affected by recent untoward incidents to gain their views on how medicines management arrangements might be improved. Results of these interviews and key judgements were then discussed with the director of medical safety and Trust’s group 4 operations director. Many of these issues were then explored in greater depth. A final report was produced which included a number of recommendations.

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Their report was submitted to the Trust in June 2010. Senior officers within the Trust received and considered the report and recommendations and since that time an action plan has been developed identifying key responsibilities, timescales and processes or audits for on-going monitoring. The report has also been shared with the Care Quality Commission, WM Strategic Health Authority and other key stakeholders such as the local Commissioners. It is now being shared with the families who contributed their views.

The chief pharmacists’ findings concluded that ‘with regards to the management of medicines across the Trust as a whole, our overall assessment indicates that the process for overseeing medicines management within the Trust is now well structured and resourced, and is supported by a comprehensive Medicines Policy’.

The Trust has set up the ‘medicines management steering group’ to work through the action plan developed on the back of the recommendations. A number of work streams have been identified which will report to the medicines management steering group with progress against the action plan being reported to the Trust’s Governance and Safety Committee.

The details of the recommendations will be available in the review document itself, downloadable from www.heartofengland.nhs.uk following consultation with the families.

The Trust is determined to learn from the review and to deliver enhancements to the medicines management services that it provides to its patients. A number of early actions have been taken in direct response to the review and the Trust has now set itself a challenging timescale to engage staff in delivering the remaining recommendations. It is anticipated that most required actions will conclude by the spring 2011, and that any longer term initiatives will have been fully scoped and initiated by that time.

The Board wishes to thank everyone who contributed to the review and the project teams which are taking forward the recommendations.

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