Measuring the quality of pharmacy services: we need to get it right!

By Linda Dodds, joint acting director of clinical pharmacy at East and South East England Specialist Pharmacy Services

Improving the quality of care has always been a priority for the NHS but it has recently become a key driver with the acronym QIPP (quality, innovation, productivity, prevention) becoming the slogan for the next stage of NHS modernisation, which will need to be accomplished under severe financial constraints.

Quality in the NHS has been defined in the context of three domains: safety, effectiveness and patient experience. “High quality care for all” published in July 2008, described an NHS which has “quality at its heart”. In this document Lord Darzi made a number of recommendations around how to ensure quality is embedded in every aspect of the NHS. These included: bringing clarity to quality; measuring quality; publishing quality performance; recognising and recording quality; and raising standards and safeguarding quality.

Many of these recommendations are already being implemented or are in the process of being implemented. The website NHS Evidence is up and running with content growing daily and includes a section on quality and productivity. A National Quality Board has been appointed to oversee the implementation of quality accounts and approve quality observatories are being set up to monitor and drive up clinical quality, and health authorities (SHAs) with a remit to commission services pharmacy teams can offer in the 21st century.

Another challenge is to try to distinguish between a performance indicator, which usually reflects the structure and process underpinning an organisation or service, and a quality metric. For example, a performance indicator might be the average time taken to supply discharge medicines, while the associated quality metric would reflect a patient outcome, for example, the number of patients with discharge medicines who were satisfied with the medicines information they received. In reality, because of the difficulty in constructing metrics that fulfil all of the criteria outlined earlier, and because there may be financial penalties resulting from poor performance (whether through CQUINs or reduced footfall) the difference between a performance indicator and quality metric may be less obvious in practice.

This leads to some uncomfortable questions: once quality accounts and the metrics within them are made nationally available, will it be possible for the data collected to be used to support quality improvement as intended, or will organisations lower levels of quality receive media condemnation and instigation of special measures, as happens now when a CQC or Dr Foster report is published? Will quality account information overcome the seemingly inevitable ranking of organisations despite the argument that performance data can be like comparing apples and oranges because of the different patient populations served by different organisations?

Quality accounts are intended to make providers more accountable, to drive up clinical performance and to provide a framework for commissioner and provider discussions about local priorities for service improvement; however, these statements could also provide the opportunity to give the general public a valuable insight into the contributions of pharmacists to improving the overall quality of clinical care. They could help the profession demonstrate how pharmacy knowledge and skills are used to deliver patient outcomes other than the supply of medicines. This would be valuable not only to patients, but would also help to raise pharmacy’s profile with our fellow health care professionals, some of whom still often have only the sketchiest notion of what services pharmacy teams can offer in the 21st century.

I would suggest that it is, therefore, in our best interest as a profession for pharmacy sectors to work together to try to ensure that appropriate indicators are developed that capture the breadth and depth of pharmacy contributions to patient care, particularly with respect to medicines management. Getting the indicators wrong may also have consequences for pharmacy service providers, leading to customers voting with their feet as a result of what appears to be “poor practice” or to PCTs or acute trusts decommissioning pharmacy services.
Where to start?

Trying to measure the outcomes of pharmacy services by developing meaningful pharmacy performance indicators has challenged senior NHS pharmacists for many years. The difficulty has always been to align the indicators chosen to the delivery of patient outcomes. There is surprisingly little hard evidence to support the added value of clinical pharmacy services, because pharmacists generally work within a multidisciplinary team to deliver patient care and separating out the contributions of pharmacy to overall patient care is complex.

Studies in the US have linked some clinical pharmacy activities to improved patient outcomes. Closer to home, research in Northern Ireland has demonstrated that a comprehensive medicines management service led to reductions in length of stay and readmission rates and a preliminary study in South East England has noted a beneficial association between clinical pharmacy workforce and lower hospital standardised mortality ratios. And, recently, a report from the General Medical Council has highlighted the role of hospital doctors and nurses on pharmacists to identify and correct prescribing errors.

However, the published data to support the benefits of clinical pharmacy contributions to overall patient outcomes in primary care are less robust. Thus, a difficult question must be voiced: will organisations under severe financial pressures on pharmacy find the resources to finance clinical pharmacy or enhanced services, because pharmacists generally work closely with clinical colleagues to deliver collaborative, patient-centred care?

Only well designed research can look at developing a supportive evidence base for pharmacy clinical and enhanced services but, in the meantime, it is vital that the pharmacy community starts to consider which metrics should be recommended for possible inclusion in community pharmacy quality accounts and to support overall outcomes related to safe and effective medicines management in all sectors of care. The work to develop community pharmacy metrics has started with the formation of a steering group that illustrate some of the challenges associated with developing pharmacy quality metrics. The metrics debated were:

- Percentage of patients with a pharmacy-led (Level 2) medicines reconciliation within 24 hours of admission documented in the care notes together with any further actions required.
- Percentage of patients counselled about the side effects of their medicines by pharmacy staff before discharge.
- Percentage of asthmatic patients collecting three or fewer salbutamol (or equivalent) MDIs in the six months after a medicines review.
- Percentage reduction in pharmacy interventions on prescriptions for a penicillin where the patient has a documented allergy.

The criteria the audience were asked to score each metric against were chosen by the clinical directorate as:

- Measures outcome not activity
- Evidence-based benefit
- Pharmacy controls delivery
- Easy to measure
- Easy to see change in performance
- Easily understandable to clinical staff and patients
- Reflects the positive aspects of pharmacy involvement (this was proposed to counter the connotations of performance monitoring, which tends to identify the poorly performing rather than praise achievement)

The vagaries of each metric were soon exposed by the spirited questioning from the audience that followed each presentation. A particular difficulty was assigning the outcome measured to pharmacy deliverables: most would be the result of a variety of inputs from the various members of the healthcare team. In the end it was agreed that none of the metrics was ideal, and that what might appear on the surface to be a suitable metric may only express one aspect of a service, may not actually reflect true quality of care, or could be difficult to measure accurately, thus leading to increased workload which might detract from direct patient care.

An alternative option to a single pharmacy quality metric might be to construct a basket of more simple performance-style measures that might build an overall picture of how a service is delivering a nominated patient outcome. Perhaps the final option is to step back and accept that pharmacy care will be only one of a number of measures that lead to a desired patient outcome. Instead, developing an evidence base for pharmacy interventions should continue to be a priority and pharmacy teams should focus on working more closely with clinical colleagues to deliver collectively agreed patient outcomes for optimal medicines management.

Next steps

As commissioners look to procure defined services from any willing provider, the quality outcomes of service delivery will become the only common denominator to compare services delivered in a variety of different ways and settings. This presents threats and opportunities for pharmacy services. If there are no metrics related to the safe and effective use of medicines it will be hard to establish the need for medicines management criteria to be included in service specifications and harder still to demonstrate the added value of pharmacy involvement.

We know that pharmacy teams can contribute much to the delivery of high quality care through ensuring optimal medicines management, whether it is through enhancing the patient experience by provision of advice or information, assuring effectiveness through the recommendation of cost and clinically effective drug therapies, supporting adherence and reducing medicines waste or ensuring patient safety through effective medicines reconciliation, patient monitoring, structured medication review or supporting the safe procurement and administration of complex medication regimens. Now is the time to work together to ensure these contributions are expressed in quality metrics that are easily understood by patients and our fellow health care professionals, so that medicines management and pharmacy services are viewed as essential to the delivery of high quality health care.

References