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Job profiles for hospital pharmacists are published

National profiles for five hospital pharmacist roles under "Agenda for change" were published this week. It is expected that the majority of pharmacists' jobs will be able to be matched to these five profiles.

Ron Pate, chairman of the Guild of Healthcare Pharmacists terms and conditions committee, told *The Journal*: "I am cautiously optimistic that this is a good step forward for pharmacists."

The job profiles that have been agreed are: post-registration pharmacist, clinical pharmacist, specialist clinical pharmacist, highly specialist clinical pharmacist and principal clinical pharmacist/clinical pharmacy services manager. The guild says that posts in primary care, technical services, medicines information and mental health can be matched to these profiles.

Although the profiles have been agreed by the guild, it has some concerns. Mr Pate comments: "A number of significant issues remain unresolved. We need to test the profiles in the job matching process in the early implementer sites. This will identify the degree of success we have achieved and, almost certainly, areas that need further work."

In particular, he highlighted the areas of unsocial hours and on-call pay. "As with many other professional groups, the reimbursement is likely to be significantly below other national and local agreements being replaced including the emergency duty commitment allowance," he said. Another area of concern is recruitment and retention premiums.

Full descriptions of the job profiles, including job statements and detailed job information, can be found at both the Department of Health and guild websites (see *PJ Online*, www.pjonline.com/links/pj).

Cautious optimism over new pay deal

Post-registration pharmacists are described as being part of a structured rotational training programme while the clinical pharmacist role includes provision of clinical pharmacy services and supervision of staff.

The specialist clinical pharmacist's job description includes delivering a clinical pharmacy service to a clinical area, and teaching and supervision of other pharmacists, technicians and students. The role of the highly specialist clinical pharmacist includes responsibility for leading and delivering specialist pharmacy services to a directorate as well as providing expert advice and undertaking research. The role of the principal clinical pharmacist/clinical pharmacy services manager is to deliver, manage and develop clinical pharmacy services to the trust.

The next step is for the early implementer sites to test the job profiles. A final ballot on the full roll out is expected in the spring or summer.

Pay bands for the five hospital pharmacist job profiles

Job profile	Band	Pay scale
Post-registration pharmacist	Band 6	£20,955–£28,387 (transitional pay* from £18,322)
Clinical pharmacist	Band 6	£20,955–£28,387 (transitional pay* from £18,322)
Specialist clinical pharmacist	Band 7	£25,290–£33,342 (transitional pay* from £21,368)
Highly specialist clinical pharmacist	Band 8a/b	a £32,258–£38,709 (transitional pay* from £29,213) b £37,574–£46,451 (transitional pay* from £33,342)
Principal clinical pharmacist/ clinical pharmacy services manager	Band 8b/c	b £37,574–£46,451 (transitional pay* from £33,342) c £45,213–£55,742 (transitional pay* from £38,709)

**If a pharmacist's current pay level falls well below the allocated pay scale, salary will be initiated on the transitional scale and be increased over a couple of years until it reaches the band level.*

Control of entry changes report due shortly

The report of the group set up to advise the Government on how changes to the regulations governing control of entry can be implemented in England is expected shortly.

Sue Sharpe, chief executive of the Pharmaceutical Services Negotiating Committee and a member of the advisory group, confirmed to *The Journal* that the group held its last meeting in December. Final comments had been made by the end of the year and the report is now being drafted.

Edited minutes of the first four of the group's five meetings have been posted on the Department of Health website (see *PJ Online*, www.pjonline.com/links/pj). The minutes show that considerable discussion took place about how the new tests of choice and competition might be applied and how the four exemption categories might be defined. The advisory group had a remit to discuss implementation of changes to the regulations, but members noted that this did not preclude them from offering views on whether any of the exemptions should be introduced.

One topic of discussion was the need for primary care trusts to assess the adequacy of existing pharmaceutical services in their areas before any new contract applications are considered or invited.

The advisory group heard from Peter Magirr about a pharmacy assessment scheme in Sheffield designed to ensure that valuable pharmacy services are not adversely affected by primary care developments under the Local Improvement Finance Trust scheme. Such an assessment tool could help consistent decision making by primary care trusts. Dr Magirr is pharmaceutical adviser to South East Sheffield PCT and represented the NHS Confederation on the advisory group.

The group also heard that an agreement on rural dispensing arrangements has been reached between pharmacy and medical representatives, but full details of this have not been made public.

New rural dispensing rules could be introduced alongside any changes to control of entry.

Drug injecting centre pilot

Medically supervised injecting centres should be piloted in the UK to allow illicit drug users to inject safely in a clinical environment, say the authors of an article in this week's *BMJ*. They suggest that trained staff could offer injecting advice, including advice to move away from intravenous drug use (2004;328:100).

The Society

Retention fees

The Society's new online service for paying retention fees has been well received by members and is working well (p35).

Staff structure

The Society has created several new senior staff posts with the aim of strengthening its integrated roles as a modern regulatory body and professional organisation for pharmacy (p36).

No evidence for practice of alternating doses of paracetamol and ibuprofen in children with fever

The practice of alternating doses of paracetamol with ibuprofen to help control fever cannot be safely recommended, say researchers.

The practice originated in the 1970s when alternating doses of paracetamol and aspirin were used to produce a more rapid and sustained reduction in fever. When aspirin use was associated with the development of Reye's syndrome in children, practitioners began to recommend alternating ibuprofen with paracetamol instead.

The researchers say that this change was made without sufficient evidence, and that parents instructed to use the combined regimen may become confused, potentially leading to overdose. In addition, the authors say, renal toxicity can occur as a result of ibuprofen inhibiting glutathione production, which is needed to prevent accumulation of paracetamol in the renal medulla.

Catrin Barker, principal pharmacist, medicines information, Alder Hey Hospital, Liverpool, told *The Journal*; "We do not recommend [alternating paracetamol with ibuprofen] as routine practice because of a lack of evidence. However, there may be individual patients in whom it is necessary."

Current guidelines produced at Alder Hey hospital recommend using paracetamol as first line and changing to ibuprofen if paracetamol is ineffective. The guidelines state: "Once you have switched to ibuprofen – stick with it. Do not restart paracetamol."

The researchers recommend that nurses and other health care providers only use one single antipyretic medication in febrile children, and ensure that the child is receiving an age-appropriate therapeutic dose. If the use of either paracetamol or ibuprofen and additional non-pharmacological methods of fever reduction have failed, the practitioner is encouraged to proceed with caution when recommending alternating antipyretic therapy (*Pediatric Nursing* 2003;29:379).

Children with fever should be treated with one antipyretic medicine

■ **Research proposals** The Department of Health has recently called for research proposals on the use of paracetamol and ibuprofen for treating fever in children. The call forms part of the NHS Health Technology Assessment programme.

Spending rates for dementia drugs still vary

Spending on anti-dementia drugs continues to vary across the UK despite national guidance on the use of these medicines.

A survey conducted by Pfizer, which co-markets Aricept (donepezil), has revealed that some areas of the UK are spending £8 or more per head of the local population aged over 65 years while others are spending less than £2.

Statisticians looked at how much money was spent on three anti-Alzheimer's drugs — donepezil, rivastigmine (Exelon) and galantamine (Reminyl) — in 1999 and in 2002–03. They found that although overall spending rose, there were wide variations in spending among different geographical areas.

In 2002–03, total spending on these three drugs by Thames Valley Strategic Health Authority (population over 65 years 311,085) was £484,819. This was almost half that for similar sized West Yorkshire SHA (population over 65 years 312,697) which spent £878,651.

The researchers acknowledge that looking at prescribing data, rather than the amounts spent on these drugs, would more accurately reflect usage and access.

Pfizer says that the SHAs and health boards whose primary care trusts are spending least on these drugs are Thames Valley, Birmingham and the Black Country, Shropshire and Staffordshire, Leicestershire, Northampton and Rutland, County Durham and Tees Valley, Lothian, Bro Taf and Icheyd Morgannwg.

A spokesman for Lothian NHS Board said he had reservations about the methodology used in the study which called into question the validity of the findings.

Data from the survey were presented at the National Institute for Clinical Excellence annual conference held in Birmingham last month.

Guidance on the use of anti-dementia drugs was issued to the NHS in England and Wales by NICE in January 2001.

US warning on oseltamivir

Oseltamivir (Tamiflu) should not be administered to children younger than one year, according to a new warning issued by the Food and Drug Administration in the US.

The FDA and Roche Laboratories, manufacturer of Tamiflu, have notified US health care professionals of safety data that raise concerns about the use of oseltamivir in young infants. They suggest that clinicians may be tempted to use the drug off-licence during the influenza season.

Preclinical research has shown that a high dose of oseltamivir results in drug levels in the brains of juvenile rats approximately 1,500 times those seen in adult animals. The high exposure, which the FDA suggests is related to immature blood brain barriers, was associated with deaths among the seven-day old rats.

Roche and the FDA say they do not know what the clinical significance of the research may be but stress that oseltamivir should not be prescribed outside its licensed indications. Tamiflu is not licensed for use in children under one year in the US or the UK.

Pharmacists urged to study opportunities in the new GP contract

Pharmacists working in community and primary care settings are being urged to study the details of the new general medical services contract, published by the Department of Health at the end of last year.

The DoH published on its website details for primary care trusts on how to implement the new GP contract. In addition, draft regulations for the contract's legal framework, a draft standard contract and the statement of financial entitlements showing what GP practices will receive were also published.

Sue Carter, head of prescribing and pharmacy at Adur, Arun and Worthing Teaching PCT, told *The Journal*: "It is in pharmacists' interests to read these documents, and supporting information available from the British Medical Association, and familiarise themselves with the opportunities. There are many situations in which pharmacists could gain from offering their services to GPs who will be keen to gain the most from their contract. In addition, it is likely that the new pharmacy contract will be structured in a similar way."

Aspirin linked to greater risk of pancreatic cancer

The risk of pancreatic cancer in women is increased with long-term, regular aspirin use, according to US researchers. Their finding is at odds with evidence that non-steroidal anti-inflammatory drugs reduce the risk of several cancers and pre-cancerous lesions.

Eva Schernhammer, of the Brigham and Women's Hospital and Harvard Medical School in Boston, and her colleagues examined the association between aspirin use and risk of pancreatic cancer among 88,378 women participating in the US Nurses' Health Study. They documented 161 cases of pancreatic cancer over 18 years of follow-up.

Overall, there was no significant difference in risk of pancreatic cancer between regular aspirin users (those who took two or more 325mg aspirin tablets per week) and nonusers (defined as those who took less than two tablets per week). However, when the researchers looked at duration of aspirin use, they found that women who reported more than 20 years of regular aspirin use had a 58 per cent increased risk of pancreatic cancer compared with women who never regularly consumed more than two aspirin tablets per week (P=0.01).

Furthermore, risk of pancreatic cancer increased with increasing aspirin dose for women who reported consistent, regular use. Compared with non-users, women who took 14 or more aspirin tablets per week had an 86 per cent increased risk of pancreatic cancer (P=0.02).

Long-term use of aspirin will need to be assessed carefully, researchers say

The researchers point out that the positive association between aspirin use and the risk of pancreatic cancer could reflect analgesic use for pain from occult or preclinical malignancies. "However, the increasing risk of pancreatic cancer with increasing duration of use, particularly after more than 20 years, makes this explanation unlikely." Moreover, the findings remained largely unchanged after the researchers excluded the first two years of follow-up from their analysis.

"Our findings do not support a protective effect of analgesics use on the risk of pancreatic cancer. Rather, aspirin appears to increase the risk of pancreatic cancer after extended periods of use," the researchers say. "Risks and benefits associated with the use of aspirin have to be weighed carefully in any recommendations made by health care providers."

The study is published in the *Journal of the National Cancer Institute* (2004;96:22).

The author of an accompanying editorial (ibid, p4) comments: "There are no easy answers to the question of what aspirin and other non-steroidal anti-inflammatory drugs do to pancreatic carcinogenesis.

"The findings by Schernhammer et al, are provocative and force us to think carefully about the actions of aspirin and other NSAIDs and the mechanisms underlying pancreatic cancer."

Seven generics companies sued by NHS over allegation of price-fixing cartel for penicillins

Seven generics manufacturers are being sued by the National Health Service in England over allegations that the companies organised a cartel to fix the prices of penicillin-based medicines in 1998 and 1999.

Proceedings were issued in the High Court last month against Norton Healthcare, Norton Pharmaceuticals, Regent-GM Laboratories, Kent Pharmaceuticals, Generics (UK), Ranbaxy UK and DDSA Pharmaceuticals. The case has been brought by the Secretary of State for Health, the Prescription Pricing Authority and the 28 strategic health authorities. Damages of £30.5m plus interest and costs are being sought in respect of anticompetitive actions to restrict supplies and fix prices which the companies are said to have colluded in.

Documents presented to the court allege that the companies held meetings to discuss fixing prices and maximum volumes of specific products and that some companies were paid to stay out of the market for penicillin-based products. The action comes a year after a £28m-claim against Norton, Regent-GM and Goldshield Group in relation to warfarin by the NHS. This has not yet been resolved.

Companies *The Journal* spoke to denied the allegations. Norton said that it made a loss on some of the products in question.

Fraud office unfair in handing over seized generics papers

The Serious Fraud Office acted unfairly in handing over papers seized from Kent Pharmaceuticals to the Department of Health, the High Court has ruled.

The documents were seized during raids on the offices of Kent Pharmaceuticals and the homes of some of its executives in April 2002. The raids were part of an investigation by the SFO into suspected fraud related to the pricing of generic warfarin and penicillin products (*PJ*, 13 April 2002, p487). The investigation, which involves five other companies, is still continuing but no charges have yet been brought.

Mr Justice Maurice Kay and Mr Justice Mackay ruled on 17 December 2003 that the raids themselves were lawful. However, the SFO was unfair to Kent by failing to give advance notice of its intention to hand over some of the documents to the DoH or to give a reasonable time to take court action, if the company wanted. After the ruling, Kent said that the action against it appeared to have been "motivated by political expediency".

Specials extension to supplementary prescribing

Plans are being made to extend the prescribing rights of supplementary prescribers to include unlicensed medicines supplied as specials and extemporaneously dispensed medicines. Supplementary prescribers are currently only allowed to prescribe licensed medicines and reformulated medicines where tablets or capsules have to be crushed or opened and prepared as liquids.

Consultation letter MLX 298 (see *PJ Online,* www.pjonline.com/links/pj), issued by the Medicines and Healthcare products Regulatory Agency at the end of last year, seeks views on the plans.

Legislative changes under the Medicines Act 1968 will apply throughout the UK as far as supplementary prescribing in general is concerned. The consultation letter says that NHS supplementary prescribers in England should have the extended right, but that it will be for the devolved administrations in Wales, Scotland and Northern Ireland to make their own decisions on its application within the NHS in their localities.

The proposals include a provision to prevent supplementary prescribers receiving specials from manufacturers or wholesalers for direct supply to patients. The rationale for this is that supplementary prescribers are advised not to be involved in the formulation, preparation and supply of medicines they have themselves prescribed.

Conflict resolution training offered to pharmacy staff

Community pharmacists and their staff are among frontline NHS workers who are in line for conflict resolution training to be organised by the NHS Security Management Service (SMS).

Speaking at a briefing held at the end of last year, Jim Gee, chief executive of the NHS SMS, said that as many as 730,000 frontline staff would be eligible for the one-day training course. The course will cover ways of recognising and resolving conflicts and breakdowns in communication that might occur during dealings with the public. Spotting warning signs and the use of verbal and non-verbal communication will be covered, but the course will not extend to self-defence.

Training will be offered by primary care and hospital trusts, external trainers or the SMS itself. The first courses should start in April.

The training forms part of a new security strategy for the NHS in England, designed to protect assets and property, as well as those who work in or use the NHS. Key parts of the strategy include the nomination of trust directors with responsibility for security and the appointment of local security managers at each trust. A new reporting system for incidents of physical assault on staff will be set up, together with common definitions that should allow a better chance of prosecution. Security managers will have a national manual to work from and the support of a legal protection unit to work with the police and the Crown Prosecution Service.

Ways of avoiding conflict will be covered by new training

In addition, trials of a remote alarm device are to be undertaken. This will be of similar size to an identity badge but will incorporate an alarm button using mobile telephone technology. The location at the time of activation will be recorded as evidence.

Bill Darling, chairman of the SMS and a past-president of the Royal Pharmaceutical Society, said: "We believe that the strategy will result in resources, lost due to violence, theft or damage, being freed for the continuing improvement of frontline services while maintaining an environment where patients and staff feel safe and secure."

Police inaction angers Essex pharmacist

Brian Conn, a community pharmacist from Romford, Essex, has expressed his anger at what he sees as the reluctance of the police to take action on information he supplied to them following an assault in his pharmacy.

Mr Conn is manager of Barry Shooter Pharmacy in Chadwell Heath, Romford. He told *The Journal* that on 17 December 2003 he was assaulted and momentarily knocked unconscious by a young man while in the dispensary.

Just before the attack, Mr Conn had taken photographs of the man and his companions who were causing a disturbance in the pharmacy. He used these photographs to identify the man and his address.

"I offered this information to the police, but they told me that, in effect, it was privileged information covered by data protection rules. They seemed really reluctant to take it," Mr Conn said.

The Society's Code of Ethics puts a duty of confidentiality on pharmacists and their staff with respect to patient information, including personal details held in the pharmacy. However, police officers can make written requests for information to be disclosed without patients' consent where this is deemed necessary "to assist in the prevention, detection or prosecution of serious crime" ('Medicines, Ethics and Practice' July 2003, p87).

Pharmacies to have complaints managers

All community pharmacy and local pharmaceutical services contractors in England will have to appoint complaints managers under a new NHS complaints system. They will also have tell patients who that manager is and submit annual reports to their primary care trusts and the Commission for Healthcare Audit and Inspection.

Shortly before Christmas, the Department of Health issued draft regulations for consultation until the end of March. The proposed regulations will apply to all NHS contractors and service providers.

The draft regulations mean that dissatisfied patients will be able to complain about services or treatment up to 12 months after the event. Complaints can be made verbally or in writing to any member of staff and will be subject to the regulations unless complainants agree that simple and quick resolution is possible.

In the absence of such agreement, complaints will have to be logged and acknowledged in writing by complaints managers within two working days. Complaints must then be investigated and detailed written responses prepared.

Complainants who are not satisfied with such responses will be able to ask for investigation by CHAI. The commission will then be able to decide whether further investigation is necessary, and can carry it out, or can refer the matter to another body, such as a professional regulatory authority.

The draft regulations are available via *PJ Online* (www.pjonline.com/links/pj).

News in brief

BNF collection record

The collection of outdated copies of the British National Formulary for the Commonwealth Pharmaceutical Association has set a new record with nearly 10,000 collected. The books were collected from community and hospital pharmacies by AAH Pharmaceuticals and will be sent to developing countries.

NHS Direct television

Health information from NHS Direct is to be offered through digital television from the summer. The channel will not broadcast programmes but will offer interactive services and could, in time, allow repeat prescriptions to be ordered.

Pravastatin for diabetes with CHD

Pravastatin prevents cardiovascular events in patients with coronary heart disease and diabetes. A sub-group analysis of the LIPID trial showed that pravastatin 40mg daily reduced the risk of cardiovascular events by 21 per cent ($P<0.008$) in patients with diabetes (*Diabetes Care* 2003:26:2713).

Novartis offers free TB drugs

Novartis is to supply free tuberculosis drugs under an agreement with the World Health Organization. The company will donate the drugs over five years to the Global Drug Facility, which will supply countries trying to improve TB control.

Alternative CPR treatment strategy is more effective

Vasopressin followed by adrenaline may be a more effective treatment strategy for refractory cardiac arrest than adrenaline alone, say European researchers. Their finding, published in *The New England Journal of Medicine* (2004;350:105) has led to a call for a revision of cardiopulmonary resuscitation guidelines.

Researchers from Austria, Germany and Switzerland randomly assigned 1,186 patients who had suffered a cardiac arrest outside hospital to receive either vasopressin or adrenaline (epinephrine), followed by additional treatment with adrenaline if needed.

They found that among patients with asystole, spontaneous circulation was restored more often in those treated with vasopressin. These patients were also more likely still to be alive at admission to hospital (29.0 per cent of patients given vasopressin survived compared with 20.3 per cent given adrenaline, P=0.02). Furthermore, survival until hospital admission after additional therapy with adrenaline was higher among patients who were initially treated with vasopressin than among those initially treated with adrenaline (25.7 per cent of patients given vasopressin then adrenaline survived compared with 16.4 per cent given adrenaline alone, P=0.002).

In an accompanying editorial (ibid, p179), Kevin McIntyre of Harvard Medical School, Boston says: "This is a remarkable outcome, given that patients in this subgroup could have been deemed to be beyond hope of resuscitation." Medical policymakers should do whatever is necessary to facilitate the orderly implementation of new guidelines based on this new information, he adds.

Pharmacy adopts NHS branding

Greater use of the NHS logo is encouraged in the pharmacy vision document

Associated Chemists (Wicker) in Sheffield has installed NHS branding on the fascia of its late-night pharmacy.

Martin Bennett, managing director of Associated Chemists, told *The Journal* that the NHS logo replaced a green cross logo, at a cost of £77. "We took our authority to do this from the pharmacy vision document published last year which said that community pharmacies should be identified as an integral part of the NHS and should use the NHS logo," he said.

The pharmacy was open for two hours on Christmas Day and dispensed around 90 items. Mr Bennett said that although prescription numbers were around the same as the year before, sales of non-prescription medicines had been much higher, particularly on Christmas Eve and Boxing Day.

Vision for pharmacy, p19

PJ Online

Network News

Network News, a new part of the Society section, will carry details of Society branch and regional meetings. It will also carry features (such as "How the Norwich and Norfolk branch was revived"). Branch committee members who want to tell others about local successes can send in their suggestions (e-mail network.news@pharmj.org.uk).
www.pjonline.com/networknews
www.pjonline.com/diary

Health events for 2004

The calendar of health promotion events has been updated to include events in 2004 publicised by the Department of Health and Health Wales. Further events will be added to the listing as they are publicised. Event organisers can submit details of their plans for inclusion in our listings to editor@pharmj.org.uk.
www.pjonline.com/diary

Vision for pharmacy

A new series will profile pharmacists who have developed services that match the Government's view for the future of the profession. The first profile considers a community pharmacist in Middlesex and his aim for a more patient focused pharmacy service.
www.pjonline.com/vision

Teaching extemporaneous preparation is still important

Teaching extemporaneous preparation to pharmacy students is viewed as important within all schools of pharmacy, say the authors of a new study. This is despite their being little need for it in community practice.

Tanbira Chowdhury, School of Pharmacy, University of London, and colleagues collected information about pharmacy undergraduate courses in extemporaneous preparation and dispensing from all 16 schools of pharmacy operating in 2002–03.

They suggest that the importance given to extemporaneous preparation is due to additional skills being learnt. "Practical exercises in this area provide students with opportunities to perform pharmaceutical calculations and solve problems, emphasise the importance of accurate and systematic working practices and develop the concept of self-audit," they say. The authors note that the Boots peppermint water case led most schools to changes extemporaneous preparation courses (*Pharmacy Education* 2003;3:229).