

New pharmaceutical care model schemes covering asthma and epilepsy announced for Scotland

Two new pharmaceutical care model schemes (PCMS) are to be introduced in Scotland for asthma and epilepsy.

The Scottish Executive Health Department said this week that £250,000 will be divided between Scotland's 15 health boards for the new PCMS in 2005–06, on top of £1m which will fund the existing schemes for the frail elderly, mental health and palliative care. This money is in addition to the transitional funding arrangements for the community pharmacy contract. Pharmacists will be paid £250 for completing 10 assessments in asthma and epilepsy.

NHS Education Scotland (NES) is coordinating the introduction of the new schemes and pharmacies will receive an implementation pack in June or July. NES has already run training evenings on asthma and epilepsy in preparation, and will be launching self-directed learning packages on these topics shortly.

Annamarie McGregor, PCMS director, said that sign up and implementation of the existing schemes had greatly increased over



Mike Wyndham Picture Library

Scottish asthma patients to get better care through pharmacies

the past year. "All contractors will be able to take part in the epilepsy and asthma PCMS. If they have attended the NES training nights

they can start when they receive the implementation pack or, if they were unable to attend, they can request the NES training support pack," she explained. Ms McGregor added that NHS boards are also focusing on rolling out medication reviews within the frail elderly PCMS. She also said that PCMS for diabetes, hypertension and angina/myocardial infarction will be developed this year.

Frank Owens, chairman of the Scottish Pharmaceutical General Council, said that he is delighted to have secured the funding. "These latest schemes provide an opportunity for community pharmacy to showcase the pharmaceutical contribution to the management of chronic disease," he commented.

□ **Medicines management** Names of the primary care trusts that will be hosting the new community pharmacy framework collaborative that is due to start in England this summer (*PJ*, 16 April, p443) have been announced by the National Prescribing Centre. The list of PCTs is accessible via *PJ Online* (www.pjonline.com/links/pj).

Essential small pharmacies scheme to end

The Essential Small Pharmacies Scheme, which has for many years sustained predominantly rural pharmacies in England and Wales that would otherwise be unviable, is to come to an end.

The arrangements will cease on 31 March 2006. It is expected that a standard local pharmaceutical services (LPS) contract will be introduced for pharmacies that meet criteria similar to those for the ESPS.

Currently, essential small pharmacy status is available to pharmacies that dispense fewer than 26,400 prescription items a year and are at least 1km from any other pharmacy by the shortest practicable route. Such pharmacies — there are 244 of them in England and Wales — have their NHS dispensing income topped up by up to £4,130 a month.

Alastair Buxton, head of NHS services at the Pharmaceutical Services Negotiating Committee, said: "The conversion of the ESPS to an LPS is a move towards simplification, which recognises that ESPS pharmacies achieve one of the objects of LPS by permitting specific local needs for pharmacy services to be met where local conditions make the normal national contract arrangements and funding unsuitable. PSNC will work to ensure that this change does not in any way adversely affect the interests or financial viability of the present ESPS pharmacies."

Call to annotate Register for administrators

The Royal Pharmaceutical Society's Register of pharmacists should include a separate classification for administrative pharmacists, say members of the Association of Independent Multiple Pharmacies (AIMp).

Roy Carrington, chief executive of AIMp, told *The Journal* that AIMp was concerned about having only two categories of pharmacists on the Register — practising and non-practising. "Members of AIMp do not feel that the two classifications go far enough," he said, adding that all AIMp members want to be registered as practising pharmacists and are in favour of continuing professional development. "However, many members think clinical CPD is of no value to them," he said.

"They do not want to register as non-practising since they want to be able to give advice to colleagues, for example, about clinical governance. Our members are happy to say that they will not practise as a hospital or

community pharmacist. They want to be administrators and they want the Register to reflect this."

Mr Carrington added that, as employers, AIMp members want to be sure that a person annotated in the Register as a practising pharmacist is qualified to practise as a locum.

"There needs to be more annotation to the Register and appropriate CPD allocated to the different areas of practice," he said.

Philip Green, the Society's deputy secretary and registrar, and director of education and registration, said: "It is valuable to discuss the central role of the Register and the Society will be looking at specialisation and annotation."

"In relation to continuing professional development it is important for members to remember that CPD should be relevant to their particular area of practice and therefore need not necessarily be clinical."

HRT increases womb cancer

Postmenopausal women taking oestrogen-only hormone replacement therapy or tibolone have a greater risk of endometrial cancer than those taking combination HRT, say researchers. However, they note that since the risk of breast cancer is greater with combination HRT, total cancer incidence remains higher for combined HRT (*Lancet* 2005;365:1543).

New chairman for NPA board

Rajesh (Raj) Patel, a community pharmacist from Cheshire, has this week been elected chairman of the National Pharmaceutical Association for 2005–06. Mr Patel was NPA vice-chairman last year.

The new vice-chairman is Umesh Patel, from Sunderland. Wally Dove has been re-elected treasurer.

Election brings opportunities to promote pharmacy

Key pharmacy bodies have been taking the opportunity to promote the profession during the run-up to the general election.

The Pharmaceutical Services Negotiating Committee is encouraging local pharmaceutical committees to invite prospective parliamentary candidates to visit local pharmacies. It has produced a standard letter for LPCs to send to prospective candidates that outlines the new pharmacy contract and highlights the role of the LPC.

Melanie Woodnick, public affairs officer at the PSNC, commented: "The support of MPs has been valuable in the recent past, most notably during the campaign against the Office of Fair Trading's proposals to remove control of entry. Raising awareness of pharmacy issues with prospective parliamentary candidates provides a good base on which to build further support among those successful in being elected to Parliament on 5 May."

Meanwhile, following the Royal Pharmaceutical Society's general election briefing (*PJ*, 9 April, p433) about 20 candidates from all of the main parties have expressed an interest in visiting a local pharmacy. Beverly



Mo Munir (centre) with Pareshe Kotecha (left), of Beech Pharmacy, and Jim Thornton, a candidate in Nottingham

Parkin, director of public affairs and communications at the Society, said: "We shall be following up our contact after the election with the successful candidates and encouraging them to join the All-Party Pharmacy Group."

Local politicians were also present at Beech Pharmacy, Nottingham, recently



Charles Clarke (right) in Haverfordwest with Steve Ridd, Lloydspharmacy professional development manager

where the pharmacy was officially re-opened by councillor and deputy Lord Mayor, Mo Munir, following its recent renovation.

In Wales, Home Secretary Charles Clarke visited Lloydspharmacy in Haverfordwest, Dyfed, to promote the reduction of prescription charges in the country.

New health Bill in Scotland takes a step forwards

Legislation required for the new community pharmacy contract in Scotland moved closer to reality last week when the Scottish Executive's health committee announced its support for the Smoking, Health and Social Care (Scotland) Bill. The Bill will also result in strengthened disciplinary powers for the NHS over pharmacists who provide pharmaceutical care.

The health committee's stage one report concluded: "The committee supports the Executive's proposals for the provision of planned pharmaceutical care services. The committee believes that, if properly implemented, the proposals could ensure the provision of a wider range of pharmaceutical

services throughout Scotland on the basis of the needs of individual communities."

Pharmacy bodies are supportive of the principles of the Bill (*PJ*, 5 March, p257) but are concerned about the fine detail of the regulations. The Executive has agreed to provide the draft regulations to the committee during the next stage of the Bill's consideration. This second stage — which involves an examination of the details of the Bill — should start in May, provided the Scottish Parliament agrees with the principles of the Bill when it considers the health committee's report on 28 April (after *The Journal* went to press). It is hoped that the second stage will be completed in June.

Changes to generics reimbursement in Scotland

Changes to the reimbursement of drugs in part 7 of the Scottish Drug Tariff were announced this week.

In an NHS circular, the Scottish Executive Health Department explained that the changes are the first stage in a process of transferring money from reimbursement to remuneration. The overall effect on individual contractors will be cost neutral.

A total of £30m will be taken out of part 7 prices in 2005–06 by applying a revised clawback of 27.75 per cent (the existing 13.25 per cent plus 14.5 per cent). However, contractors will receive a "transitional balancing reimbursement payment" calculated as 14.5 per cent of a contractor's gross part 7 payments.

The balancing payment will be made each month from April (paid in June) until the arrangements cease in March 2006. It will be paid through the payment adjustment system and met from health boards' unified budgets.

The tariff prices set in April will remain in place for three months and will only be adjusted if a patent is lost or to address a change in policy. "The new part 7 tariff is intended to deliver a fair aggregate return to contractors and to remove the reimbursement focus away from short-term pricing on individual items," the SEHD said.

Frank Owens, Scottish Pharmaceutical General Council chairman, commented that the arrangements essentially mirror those in England and Wales.

New contract worries for NPA

The National Pharmaceutical Association is worried that pharmacy owners will be confused by a revised monthly reporting form that has been introduced with the new pharmacy contract.

Form FP34, which pharmacists submit to the Prescription Pricing Authority every month along with prescriptions to be priced, asks for details that differ from those set out in the Drug Tariff. For example, contractors are expected to report their dispensing staffing levels excluding pharmacists, although the Drug Tariff says that staffing levels include pharmacists.

Increased fee for flu vaccine

Community pharmacists in Scotland will be paid a two-tier professional fee for supplying influenza vaccines to GPs this year.

The aim of the new fee is to avoid a repeat of the problems that occurred last year following difficulties with the supply chain for flu vaccines. Contractors will be paid a flat rate handling fee of 55p per vaccine plus, subject to certain criteria, a further 55p "risk minimisation fee".

The risk minimisation fee will be paid on submission of a claim form to show that vaccines were ordered from at least three suppliers.

Pharmacists will also have to demonstrate that they processed orders by 20 May, and that they informed health board vaccine coordinators about both orders received from GPs and supply arrangements.

Evidence grows for pharmacist input in diabetes care

Further evidence that pharmacists' interventions improve glycaemic control in patients with type 2 diabetes was presented at the Diabetes UK annual professional conference in Glasgow last week.

A Cochrane systematic review of five trials showed that HbA_{1c} levels were reduced in all studies of interventions designed to improve adherence to medication in which pharmacists saw patients at clinics and addressed specific medication issues. The reductions were principally the result of creative interventions in medicines management and care.

Pharmacists' interventions included measuring adherence with medication event monitoring systems, increasing adherence through improved packaging and reminder systems and initiating insulin treatment and adjusting doses (with patients self-testing their blood glucose). Two interventions involved more comprehensive managed care programmes in which pharmacists delivered patient education.

The role of pharmacists in medication adherence could be more widely exploited, Dr Antje Lindenmeyer, research fellow at the University of Warwick's Centre for Primary

Health Care Studies and one of the review's authors, says.

This could be achieved, she argues, by using education and advice on integrating medication into everyday life to address the problem of nonadherence resulting from either forgetfulness or regimens that are too complex for patients.

"However," Dr Lindenmeyer says, "difficulties arise when attempting to determine the effect of more comprehensive pharmacist interventions on adherence, since adherence is complex and hard to measure".

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EMA completes review of SSRIs and recommends wider product warning

Selective serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors should not be used in children and adolescents except for their approved indications, the European Medicines Agency (EMA) has concluded following its review of the antidepressants.

The review was initiated at the request of the European Commission in December 2004 after safety warnings were issued about the potential risk of suicidal behaviour in children and adolescents treated with these products.

The recommendations, issued earlier this week, are generally in line with those given by the Medicines and Healthcare products Regulatory Agency in 2003 (*PJ*, 13 December 2003, p803), although do not single out fluoxetine as the medicine most suitable for use among children and adolescents.

The EMA concludes that a warning reflecting the increased risk of side effects such as suicide attempt, suicidal thoughts and hostility in young people should be included in the product information of citalopram, duloxetine, escitalopram, fluoxetine, fluvoxamine, mianserine, milnacipran, mirtazapine, paroxetine, reboxetine, sertraline and venlafaxine.

The EMA says that where a decision is made to use these products off-licence for the treatment of depression or anxiety in children and adolescents, the patient should be monitored carefully for the appearance of suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment. The EMA recommendations can be accessed at www.emea.eu.int.

□ **Xigris** The EMA has also recommended changes in the way that drotrecogin alfa activated (Xigris) is used. It suggests that the drug, used in patients with severe sepsis and multiple organ failure, should only be used in high-risk patients, and mainly when therapy can be started within 24 hours of the onset of organ failure.

Booklets for patients with learning disabilities

Three new booklets to help people with learning disabilities make informed decisions about their medicines were launched this week by Medicines Partnership and the Norah Fry Research Centre.

"My medication", "All my medications", and "How to make choices about medication" are booklets designed to help patients record information about what medicines are being taken, why they are being taken and any precautions necessary.

An earlier research project carried out by the Norah Fry Research Centre found that people with learning disabilities who were taking psychotropic medicines did not think they had enough choice about whether they took their medicine or not.

The research found that although the majority of these patients received most of the information about their medicine from their carer, the carers were generally not trained in issues such as why the medicine is needed or what the adverse effects might be.

Jackie Rodgers, senior research fellow at the Norah Fry Research Centre, commented:

"If people with learning difficulties and their families or carers are not in full possession of the information about medication, psychotropic or otherwise, it is questionable whether they can be said to be giving informed consent to treatment."

The booklets, designed for use by patients, their carers and health professionals, are available from the Medicines Partnership website (www.medicines-partnership.org) and can also be accessed via *PJ Online* (www.pjonline.com/links/pj).

□ **Disability toolkit** A toolkit to help assess patients who may need support with their medicines in accordance with the Disability Discrimination Act has been launched by NHS Primary Care Contracting, formerly part of the National Primary and Care Trust development programme. The toolkit is designed to help pharmacists and primary care trusts assess and help people who may have problems taking their medicines or complying with treatment because of a disability. It can be downloaded from *PJ Online* (www.pjonline.com/links/pj).

AAH new contract resource pack and CD-ROM launched

AAH Pharmaceuticals has launched a resource pack to help its customers in England and Wales implement the new community pharmacy contract.

"Navigating the new world" contains action points and templates to help pharmacists deliver the essential and advanced services of the new contract and includes a small section on enhanced services. It also contains guidelines to help pharmacists implement standard operating procedures.

A clinical governance training CD-ROM has also been launched, addressing clinical audit and critical incident analysis, risk management and root cause analysis.

The pack and CD-ROM are available to AAH customers (cost £20 and £25, respectively) and non-customers (price on application) by telephoning 024 7643 2000.



Pack contains templates for delivering essential and advanced services

Modafinil fails to improve fatigue

Modafinil, a drug used to treat daytime sleepiness, does not appear to improve fatigue in patients with multiple sclerosis, a trial has revealed. Aspirin, on the other hand, may reduce the severity of this symptom.

French researchers examined the effects of modafinil in 115 patients with relapsing remitting or progressive MS who were also suffering from chronic fatigue. They found that the drug was no better than placebo at relieving self-reported fatigue symptoms. After 35 days of treatment, both had improved mean scores on a modified fatigue impact scale (63.1 ± 9.3 to 52.3 ± 18.5 for modafinil vs 63.3 ± 10 to 49.2 ± 16.6 for placebo).

Although the researchers conclude that no benefit was detected for modafinil, they say that an unpublished post hoc analysis did reveal an effect related to sleepiness. "Among patients with excessive daytime sleepiness,

modafinil tended to provide more benefit than placebo on the physical component of fatigue," they say (*Neurology* 2005;64:1139).

In a second study (ibid, p1267), researchers observed an improvement in patient scores during treatment with aspirin (1,300mg daily) compared with placebo ($P=0.043$). Patients were treated with both aspirin and placebo in the cross-over trial. Among the 26 patients who completed both phases, 10 (38.5 per cent) preferred aspirin whereas only one (3.9 per cent) preferred placebo ($P=0.012$).

An accompanying editorial warns that the apparent benefit of aspirin and the lack of benefit of modafinil may be related to their effects on other MS symptoms. "It is not clear that patients adequately distinguish effects of fatigue from motor impairment, cognitive impairment and other symptoms," the authors argue (ibid, p1111).

Calcium and vitamin D₃ supplements do not prevent fractures

Supplementation with calcium and vitamin D₃, either alone or in combination, is not effective in the prevention of fractures in elderly people, according to two new UK studies.

The first study involved 5,292 people aged 70 years or older who had had a low-trauma osteoporotic fracture in the previous 10 years. Participants received a daily supplement of either 800 IU vitamin D₃, 1,000mg calcium, a combination of these two, or placebo. Follow up was for between 24 and 62 months.

A total of 698 participants had a new low-trauma fracture but no difference was observed between the treatment or placebo groups in the incidence of fractures. The researchers conclude that policies for secondary prevention of fractures should consider other strategies. They note that the value of supplements for primary

prevention or for those in care homes was not addressed in their study (published online on 28 April in *The Lancet* at www.thelancet.com).

The second study involved 3,314 women in primary care aged 70 years or older with one or more risk factors for hip fracture. Participants received a daily supplement of 1,000mg calcium and 800 IU vitamin D₃ along with a leaflet on dietary calcium intake and falls prevention, or a leaflet alone.

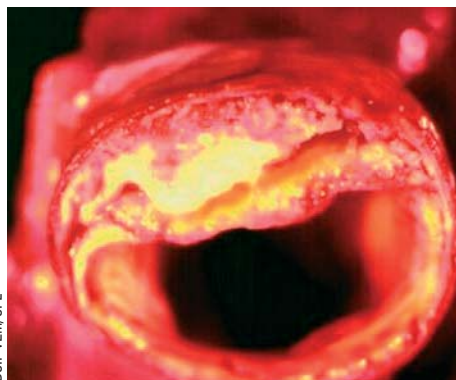
After a median follow up of 25 months, 149 fractures were reported (lower than anticipated) but no difference in rate of all fractures was found between the two groups. The researchers conclude that they found no evidence that supplementation with calcium and vitamin D₃ affects fracture rates in this population (*BMJ* 2005;330:1003).

Rosuvastatin reduces plaque size and changes composition

Impact of rosuvastatin (Crestor) on the size and composition of atherosclerotic plaques in the carotid arteries has been shown by magnetic resonance imaging in the first trial of its kind. Data from the study were presented by AstraZeneca in London last week.

The study involved 35 patients with moderate hypercholesterolaemia and asymptomatic atherosclerosis. Each received either 5mg or 40mg of rosuvastatin daily for two years (the recommended starting dose is 10mg). Low-density lipoprotein cholesterol was reduced by 39 per cent and 58 per cent, respectively.

The MRI showed that rosuvastatin also reduced the proportion of lipid-rich necrotic core in a plaque — a characteristic believed to make plaques vulnerable to rupture, which can result in myocardial infarction and stroke. The 40mg dose of rosuvastatin reduced this necrotic core by 35.5 per cent ($P<0.006$). In



Plaque rupture may lead to MI or stroke

addition, 75 per cent of plaques in the 5mg group and 90 per cent of plaques in the 40mg group showed regression over the two years.

Studies are under way to assess the effect of rosuvastatin on clinical outcomes.