

Chief pharmaceutical officer for England appointed at DoH



New CPO Keith Ridge

Keith Ridge, currently director of pharmacy at University Hospital Birmingham NHS Foundation Trust, has been appointed chief pharmaceutical officer at the Department of Health.

Dr Ridge is expected to take up his new post at the beginning of March 2006. His first tasks will be to drive forward work on independent prescribing by pharmacists and the DoH pharmaceutical public health strategy. He will also be responsible for overseeing changes to the management of Controlled Drugs in the wake of the Shipman Inquiry.

Dr Ridge said: "Over the past few years, patients have demanded change to how health services are delivered, including pharmacy. The Government and the pharmacy profession have listened and are responding, putting pharmacy practitioners right at the front line of patient care. Prescribing of medicines by pharmacists and the new community pharmacy contract will increase access to health care. I intend to help make sure patients benefit from these and other initiatives."

Dr Ridge has been chief pharmacist at North Glasgow University Hospitals NHS Trust and an adviser to the Scottish chief pharmaceutical officer. He has previous experience of work at the DoH and worked in community, industrial and academic pharmacy.

Hemant Patel, President of the Royal Pharmaceutical Society, said: "I look forward to meeting Dr Ridge at the earliest opportunity to discuss how we can continue to maximise the contribution that pharmacists make to the health of the nation."

Dr Ridge succeeds Jim Smith, who left the DoH at the end of August to become professor of pharmacy practice and policy at Sunderland University.

Implementation plan announced for new contract in Scotland

Implementation of the new community pharmacy contract in Scotland is to take a bottom-up approach, with a key role given to local pharmacy practitioner champions.

A Scottish Executive Health Department letter issued this week describes how practitioner champions will be trained to become experts in the new contract. They will then use this knowledge to train and support other local pharmacists. The practitioner champions must be wholly or mainly employed in community pharmacy and they will be remunerated for their role from ring-fenced funding totalling £250,000. This sum is being divided between NHS boards and is for the implementation of the public health and minor ailment services only; details of the implementation of the other two core services will follow.

The SEHD stresses that the implementation programme must benefit all community pharmacists so the practitioner champion will support every pharmacist in one geographical area including individual contractors, those working for multiples and regular locums. The practitioner champions themselves will be supported by implementation groups at NHS boards. Nationally, an implementation

management group, which will be part of the SEHD, will co-ordinate implementation of the new contract.

Alison Strath, principal pharmaceutical officer at the Scottish Executive, told *The Journal*: "This programme and the role of the practitioner champion is about supporting all community pharmacists in understanding, implementing and living the new community pharmacy contract in Scotland. It is also an exciting opportunity for all community pharmacists to play their part."

Commenting on the role of the practitioner champion, Frank Owens, chairman of the Scottish Pharmaceutical General Council, said: "It is important to the success of implementation that community pharmacy contractors feel real ownership of the new contract process. The commitment and enthusiasm of contractors, along with the energy required in successful delivery, lies in securing that ownership."

He added that the SPGC is extremely supportive of the initiative and will be writing to all pharmacy contractor committee members later this week about identifying suitable local nominees.

Scottish contract 2006 p694

National patient group direction allows urgent supplies of repeat medicines

Pharmacists in Scotland are to be authorised to provide emergency supplies of a full cycle of patients' regular medicines instead of being limited to a five-day supply.

The mechanism that will allow such supplies is a national patient group direction (PGD) that operates in the out-of-hours period. Pharmacists who have signed up to the PGD will be able to make a supply of nearly everything in the British National Formulary, providing the patient has had a repeat prescription for the medicines before from an NHS doctor in Scotland.

Overall responsibility for the PGD lies with NHS24 and local implementation will be carried out by NHS boards. Harry McQuillan, national pharmaceutical adviser at NHS24, said: "This initiative allows pharmacy to build upon the already significant contribution it makes to patient care within the out-of-hours period and during public holidays."

A new prescription form — a community pharmacy urgent supply or CP(US) form — will be used to record the details of supplies made using the PGD. It will be sent to GPs to alert them of the supply and be submitted to Practitioner Services for payment.

In addition to this reimbursement, every community pharmacy contractor is to be paid a £300 fee for the period from Christmas to the end of February.

This is intended to recognise the additional workload resulting from a reduction in GP surgery hours and the Scottish Executive's winter campaign. It takes into account the findings of the SPGC inquiry into the impact of the new GP contract on pharmacy workload in the out-of-hours period.

Frank Owens, chairman of the SPGC, said that the introduction of the new GP out-of-hours arrangements had brought fresh challenges for community pharmacy.

"With GP surgeries closed for eight days over the coming festive fortnight, there will be further pressures," he predicted. "The beauty of this new arrangement is that it will allow community pharmacists the opportunity to exercise their professional judgement and provide, where appropriate, a full repeat supply in a single transaction."

The new PGD will be revised by the Scottish Executive Health Department and the SPGC in March.

News feature p682

APPG writes to Hewitt on care outside hospitals

Community pharmacists' accessibility and trusted status, along with the new community pharmacy contract, will enable them to be used as the principal means of delivering improvements in primary care, says Howard Stoaite, chairman of the All-Party Pharmacy Group, in a letter to the Department of Health about its forthcoming White Paper on out-of-hospital care.

Dr Stoaite sets out key recommendations formulated by the APPG after meeting with relevant stakeholders and collecting information on developments already taking place in community pharmacy.

Dr Stoaite says that providing the public with choices of services and provider is important as a means of improving access. "However, people need good quality information so that they can make informed choices," he argues. He recommends that pharmacists' role in information and advice, including signposting, should be recognised in the White Paper as a means of developing and promoting choice.

Dr Stoaite stresses that a better balance between treating illness and maintaining good health needs to be achieved. He highlights the role that pharmacists have in health promotion and treating minor ailments and says that the White Paper should recognise that the role of health promotion "sits naturally" with community pharmacies.

He also believes that the White Paper should encourage primary care trust managers and other health professions to make full use of pharmacists when commissioning local services. The development of these services requires the commitment of NHS funding, he says. "Community pharmacies and other service providers need to know that the investment they are required to make is for the long term and that primary care funding is put in place on this basis," he adds.

He highlights that reorganisation of PCTs remains a concern. He is worried that progress made in getting PCT managers to recognise how pharmacists can help deliver



Pharmacies are easily accessible

improvements for patients, largely through pharmacy representation on professional executive committees, will be disrupted.

Lastly, Dr Stoaite emphasises the need for pharmacies and GP practices to have IT connectivity and for pharmacists to have access to the national care record system.

Providing services from pharmacies will relieve pressure on GPs

Providing diagnostic tests and other services in pharmacies will reduce the number of visits patients need to make to other health professionals and will mean GPs' time can be used more effectively, according to the NHS Confederation.

In a paper written for the Government to consider in its consultation on out-of-hospital care — "Your health, your care, your say" — the confederation outlines the key principles it believes should underlie the de-

velopment of out-of-hospital care. These include integrating services and improving continuity of service across providers, as well as encouraging self-care, visits for groups of patients with similar conditions and consultations via e-mail and telephone.

The confederation argues that a much higher proportion of patients should be seeing health professionals other than GPs, including patients with minor conditions and those who need more specialist advice. "Services in phar-

macies may also enable GP time to be better used," it adds. The paper also emphasises the importance of considering the cost of health care in terms of patients' time. "Patients should be able to have all their needs met in the minimum number of encounters, including imaging and blood tests. This means more one-stop services, using larger and more comprehensive facilities, as well as using non-NHS settings, such as providing some basic testing in pharmacies or supermarkets," it says.

News in brief

Healthy Start scheme begins

Roll-out of the Healthy Start scheme, which replaces the Welfare Food Scheme, has started in Devon and Cornwall. The new scheme will be extended throughout Great Britain during 2006. Under the new scheme, vouchers can be exchanged for milk, fresh fruit and vegetables and infant formula at any registered retailer, including pharmacies.

Sexual health campaign

A sexual health awareness campaign run by the Society was a great success, it has announced (p705).

Retention fees for 2006

The 2006 pharmacists' retention fee collection process begins shortly. The Society answers common questions about the exercise (p706).

The Society

Ethics code could fetter discretion, NPA warns

Professional discretion will be fettered if the Royal Pharmaceutical Society's new Code of Ethics follows the prescriptive form of its current version.

That is the view of the National Pharmacy Association set out in its response to the Society's recent consultation (*PJ*, 8 October, p466).

The NPA says that a new approach is needed. An ethical framework should be set out, rather than comprehensive guidance that is intended to cover all eventualities.

The NPA takes issue particularly with the way the current code sets out service specifications. This, it suggests, is generally unnecessary since the new pharmacy contract sets out service specifications that pharmacy contractors are obliged to meet. Instead, any new code should simply refer to recognised professional standards wherever they exist.

Guidance should be developed when there are no existing standards, but this should be separate from the Code of Ethics itself.

Follow NICE guidelines on hypertension, says *MeReC Extra*

Prescribers should follow the current National Institute for Health and Clinical Excellence guideline on managing hypertension until any changes are announced, the November issue of *MeReC Extra* concludes.

The advice is issued as part of a review of the blood pressure lowering arm of ASCOT

(anglo-scandinavian cardiac outcomes trial). *MeReC Extra* also considers the value of three-day courses of trimethoprim for simple urinary tract infections in women.

The publication is available online at www.npc.co.uk and via NHSnet at www.npc.nhs.uk.

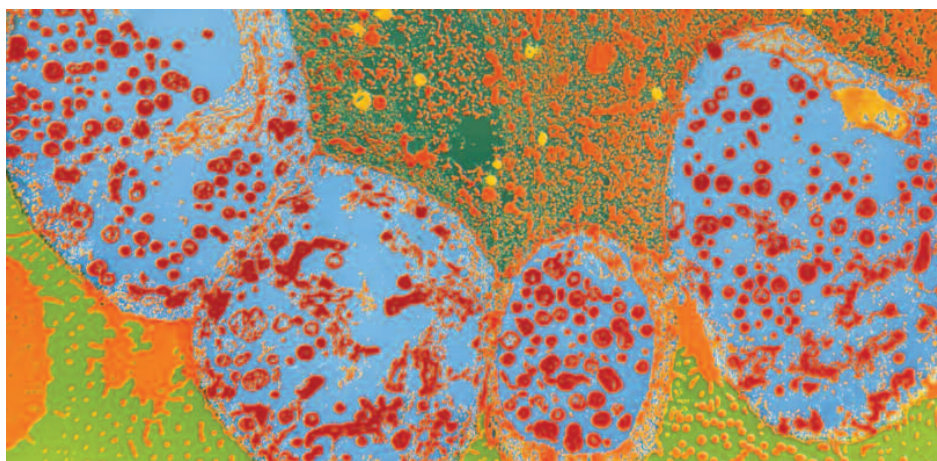
Manchester pharmacies in chlamydia/EHC study

Young women asking for emergency contraception at about 30 pharmacies in the Greater Manchester Primary Care Trust area are to be offered chlamydia screening in a University of Manchester study.

They will be given a purple box containing a bottle for a urine sample and a confidential questionnaire offering them a variety of ways they can be sent the results. Postage is prepaid for the samples to be sent for testing with results returned within three working days. Women who test positive, and their partners, will be referred to a genitourinary clinic for full sexual health screening and treatment. The process from test to treatment is expected to be completed in two weeks.

The study, funded by the BUPA Foundation, is being carried out as a response to the Department of Health drive for primary care trusts to offer chlamydia screening to those under 25 years in non-genitourinary clinic settings by April 2006. Starting from 3 January 2006, researchers hope to screen 2,000 women through pharmacies. Chlamydia screening will be offered to a further 1,000 women asking for emergency contraception at family planning clinics and 400 asking for it at the Manchester Brook Advisory Service.

Loretta Brabin, of the division of human development and reproduction at the university's medical school, who is leading the study



Dr R. Dourmashkin/SPL

False-colour transmission electron micrograph of a human fallopian tube infected with *Chlamydia trachomatis* (red spots)

said: "This could identify and treat a potentially huge unknown population at risk of untreated chlamydia. . . . The study will not add to the workload of pharmacies because pharmacists are supposed to advise women asking for emergency contraception about sexually transmitted infection. Now they can give them a direct offer of help."

The researchers will also gather information on the previous STI treatment of clients attending various outlets for emergency hormonal contraception, and their risk of being

infected. They will find out how many women going to pharmacies take the test kit home and how many post it back and thus they will discover whether this is an effective screening system.

Research nurse Grace Thomas, who is running the study, added: "Looking at the number of young women going to pharmacies, there is huge potential there for people at risk of STIs who are not tapping into the more traditional health care services available."

Judge contract applications on essential services only, say pharmacists in Wales

Applications for NHS pharmacy contracts in Wales should not be decided on the basis of ability to provide either advanced or enhanced pharmaceutical services, Community Pharmacy Wales has told the Welsh Assembly Government.

Responding to a WAG consultation on reforming the rules governing contract applications, CPW takes the view that only an ability to deliver essential services is relevant to the contract application process. However, it concedes that local health boards (LHBs) could "give due regard" to any potential contractor's ability to deliver advanced services or to participate in locally commissioned enhanced services.

CPW also opposes the provision of innovative services as a criterion for deciding contract applications. Such services might not be in line with patient needs and could lead to inconsistencies, it says. If innovative services were needed, they would be identified by LHBs and commissioned as enhanced services. CPW opposes the inclusion of improving choice as a determining factor for the same reason. However, it adds that any offers by contract applicants to provide specific services should be binding if the contract is subsequently awarded.

On patient needs, CPW suggests that LHBs should be required to carry out annual pharmaceutical needs assessments.

New funding for IT upgrades for Scotland pharmacies

Pharmacy contractors in Scotland are to receive additional funding towards upgrading their computer software in preparation for the new contract.

The Scottish Executive announced this week that every contractor will receive £500 towards the cost of installing software to run the electronic minor ailment service. Payment is conditional on the provision of evidence to show that the software has been installed and works.

Frank Owens, chairman of the Scottish Pharmaceutical General Council, said that upgrades need to start now.

"Clearly software suppliers cannot upgrade every pharmacy on 31 March 2006 — it will take time for software engineers to visit pharmacies and to carry out the necessary work," he said. Contractors should contact their system suppliers as soon as possible to arrange upgrades.

This week's funding is in addition to the £450 paid earlier this year for upgrading patient medication records systems and other investment not paid to contractors but from which they benefit. This includes (per contractor) £500 for N3 connection, £1,350 each year for N3 running costs and £300 for the eMAS software development.

Financial concerns over abolishing prescription charges

Abolishing NHS prescription charges got the thumbs down from the Scottish Parliament's finance committee last week.

It examined the financial consequences of a Bill that proposes the abolition of charges (PJ, 29 January, p105). The committee concluded that removing charges would lead to increased uptake of prescriptions and higher

health service costs. It was not convinced that costs would be offset by fewer hospital admissions due to greater compliance.

"The committee is concerned that the costs of this Bill will result in a sizeable shortfall in the NHS budget and that it remains unclear as to how this shortfall will be addressed," the report concludes.

Conventional antipsychotics as likely as atypicals to increase risk of death in elderly, study suggests

Conventional antipsychotic drugs are at least as likely as atypical antipsychotics to increase the risk of death among elderly people, according to the authors of a study published in *The New England Journal of Medicine* this week (2005;353:2335).

The US Food and Drug Administration issued a public health advisory in April that warned that, compared with placebo, the use of atypical antipsychotics almost doubled the risk of death in elderly patients with dementia.

Philip Wang, department of psychiatry, Brigham and Women's Hospital, Boston, Massachusetts, and colleagues conducted an observational study with the aim of defining the risk of death among elderly patients starting treatment with conventional antipsychotics compared with those starting atypicals.

They analysed data from 22,890 patients aged 65 years and over who had begun receiving a conventional or an atypical antipsychotic drug and compared risk of death within 180 days, less than 40 days, 40 to 79 days and 80 to 180 days of initiation of therapy.

Analyses that adjusted for a number of confounders showed that conventional antipsychotics were associated with a higher risk of death than atypical antipsychotics at all intervals (≤ 180 days: relative risk 1.37, 95 per cent confidence interval 1.27–1.49; <40 days: RR 1.56, 1.37–1.78; 40–79 days: RR 1.37, 1.19–1.59; 80 to 180 days: RR 1.27, 1.14–1.41). The greatest increase in risk occurred with higher doses and during the first 40 days after initiation of therapy, say the researchers.

They also looked at subgroups of patients, defined by the presence or absence of dementia and residency in a nursing home, and found that the risk of death within 180 days was higher with conventional antipsychotics in all subgroups.

"On average, for every 100 patients treated with a conventional antipsychotic drug instead of an atypical agent, there would be seven additional deaths," they say. "If confirmed, our results suggest that conventional antipsychotic medications may not be safer than atypical agents and should not simply replace atypical drugs that are stopped in response to recent FDA warnings, as may be happening." They suggest that well defined studies specifically involving the elderly are needed to define optimal care.

Call for global action to improve patient safety

Global action is necessary to improve patient safety, said Patricia Hewitt, Secretary of State for Health, at the opening of a patient safety summit in London this week.

The summit concludes a programme of health-focused events that have run throughout the UK's six-month presidency of the EU and was attended by patient safety experts from across EU member states and the rest of the world.

It looked at ways of bringing together information and best practice from across the EU to make health care services and products safer for patients.

At the summit the UK pledged to provide £5m a year for the next five years to the World Alliance for Patient Safety, which was

established by the World Health Organization in October 2004. The alliance was formed to raise awareness and political commitment to improve the safety of patients and facilitate the development of patient safety policy and practice in all WHO member states.

Discussion at the conference focused on the need for action at national and international levels, learning from "high risk" industries and the importance of systems' design to reduce errors, and how education and training can influence future thinking in patient safety.

The summit took place in London from 28–30 November and is expected to inform policy development work of the European Commission as well as EU member states.

PJ Online

Access to *PJ Online* is free to all

Christmas page

This contains details of company closures over Christmas/New Year and links to past Christmas miscellany articles in *The Pharmaceutical Journal*. www.pjonline.com/xmas

Scottish contract 2006

A new series on the Scottish community pharmacy contract that starts in April 2006. www.pjonline.com/contract

Linking to *PJ Online*

The links section has a page to assist people wanting to link to *PJ Online*. It lists URL shortcuts to popular sections. www.pjonline.com/links

News in brief

Almus safety award

Jonathan Burton, of Danderhall Pharmacy, Danderhall, Midlothian, has won the first Almus patient safety award, which was launched earlier this year (*PJ*, 13 August, p191). Mr Burton's entry, entitled "Making patient safety a priority", was a work programme designed to motivate and train staff in safe pharmacy practice.

Calprofen reclassification

Pfizer Consumer Healthcare has applied to the Medicines and Healthcare products Regulatory Agency to have Calprofen 100mg/5ml oral suspension (ibuprofen) reclassified as a general sale list medicine.

Regular salbutamol may increase risk of airflow obstruction

Regular inhaled short-acting beta agonists may increase the risk of future moderate or severe asthma attacks, authors of a letter published in *Nature* predict (2005;438:667).

Urs Frey, University Hospital of Berne, Switzerland, and colleagues analysed data from a published double-blind crossover trial that compared the effects of regular inhaled salbutamol (400µg four times daily) with those of a regular long-acting beta agonist, salmeterol (50µg twice daily), and placebo. All trial participants were taking similar doses of inhaled corticosteroids throughout.

By looking at a series of 300 consecutive, twice daily peak expiratory flow (PEF) measurements, the researchers predicted the risk of worsening airflow obstruction.

This was done by calculating the conditional probability that, given the current air-

way condition, a severe obstruction will occur within 30 days.

The researchers found that, for any value of PEF, regular salmeterol decreased the probability that moderate or severe airflow obstruction would occur within one month compared with placebo ($P < 0.004$) and salbutamol ($P < 0.02$). However, salbutamol increased the risk of future moderate or severe airflow obstruction beyond that seen with placebo, especially for near normal values of PEF, they say. "Our results suggest that the short-acting agonist treatment leads to significantly increased variability and loss of predictability of airway function," they conclude.

British Thoracic Society/Scottish Intercollegiate Guidelines Network asthma treatment guidelines only recommend the use of short-acting beta-agonists as required.

Flavours for dispensed medicines to be marketed

Flavorx, a US company that markets flavourings for dispensed medicines, is to try to expand its business into the UK.

The company is to meet several community pharmacy companies this month with a view to its flavourings being available in this country early next year for addition to medicines by pharmacists when they dispense them.

Flavorx says that market research has indicated demand in the UK for a solution to the problem of patients not taking medicines as prescribed because of their taste or smell.

In the US, the company markets 42 different flavours which it says are sugar-free, non-allergenic, dye-free, it is alcohol-free, sodium-free and so concentrated that only a few drops

need to be added to any bottle of liquid medicine.

Kenny Kramm, president, Flavorx, said that none of the flavourings tastes like sweets so children cannot become confused over what is a sweet and what is a medicine.

However, some questions remain to be answered before the flavours can be used in the UK. Lynsey Balmer, head of professional ethics at the Royal Pharmaceutical Society, said: "The Society recognises the importance of initiatives to improve patient compliance. However, the implications for patients of adding flavours to medicines is something that will need careful consideration."

A Medicines and Healthcare products Regulatory Agency spokesman added: "You

can't just add something to a medicine to change its flavour without approval from the MHRA. Flavour is part of the licensing agreement and you don't know what chemicals are in the flavour mixture and how they will interact with the medicine."

But the company does not see this as an absolute obstacle.

Ashton Maaraba, a Flavorx senior vice-president, said: "Prior to our initial launch, we will certainly be in full compliance with all UK regulatory bodies, such as the National Health Service and Royal Pharmaceutical Society. We think that this is of the utmost importance to stick to each country's regulations and adapt the programme to meet the country's guidelines."

Welsh solution to MDS dilemma sought

Health and social care professionals in Wales are hoping to find a way of providing monitored dosage systems (MDSs) for patients who would benefit from them but who do not qualify for them under the new NHS pharmacy contract.

A meeting to this end is to be held by the Welsh Assembly for Community Pharmacy Wales, the General Practitioners Committee (Wales), local health boards and local authorities to discuss alternative funding for MDSs.

The new contract requires pharmacists to dispense medicines in MDSs for patients who need them after an assessment by the pharmacist has found that they have disabilities that make normal dispensing containers unsuitable. No extra payment is available to meet the cost of any MDSs provided.



Monitored dosage systems can benefit people other than those who are considered to have disabilities

In the meantime, Community Pharmacy Wales and the General Practitioners Committee (Wales) have written jointly to all community pharmacies and GPs in Wales to explain the situation. The letter makes it clear that MDSs are not available from the NHS on request.

Intramuscular injections may not always be successful

As much as 68 per cent of patients may not be successfully receiving drugs delivered by intramuscular injection into the buttocks, a study presented at the annual meeting of the Radiological Society of North America in Chicago, Illinois, this week suggests.

Researchers added an air bubble to the injections of 50 patients scheduled to receive an intramuscular medicine and to undergo computed tomography. Injections were into the upper outer quadrant of the buttocks. Analysis of the bubbles' location on the scans showed that only 32 per cent of the patients received a successful intramuscular injection. And, although the success rate among men was 56 per cent, among women it was 8 per cent.

"Our study has demonstrated that a majority of people, especially women, are not getting the proper dosage from injections to the buttocks," said lead author Victoria Chan, Adelaide and Meath Hospital in Dublin. "We have identified a new problem related, in part, to the increasing amount of fat in patients' buttocks," she added. "There is no question that obesity is the underlying cause."

TNF inhibitors appear to induce remission in rheumatoid arthritis

More than half of patients with rheumatoid arthritis who go into remission after treatment with a tumour necrosis factor inhibitor may remain well once the treatment is withdrawn, according to data presented at the American College of Rheumatology annual meeting held in San Diego, California, last month.

The study compared four commonly used treatment strategies for very early rheumatoid arthritis in 508 patients: standard disease modifying antirheumatic drug (DMARD) therapy starting with methotrexate; step-combination therapy starting with

methotrexate and adding in other DMARDs; an initial intensive combination of methotrexate, sulfasalazine and prednisone; and a combination of methotrexate and infliximab.

The researchers found that the last two combination strategies were the most effective at inducing remission, although longer-term data will be needed to see which of the two was most effective.

Ferdinand Breedveld, professor of rheumatology at the University of Leiden, the Netherlands, said one of the most exciting new pieces of data involves 77 patients who were taken off infliximab after six

months' remission. "What we found raises the possibility that anti-TNF therapies are remission-inducing drugs, because in a year and a half of follow up only 10 had flare ups and had to go back onto therapy," he said.

He added that as a whole the study shows that, if the disease is diagnosed and treated early enough, combination therapies used initially are far better than sequential monotherapy or a stepped-up approach.

"What it also shows us clearly is that if you don't reach treatment goals with methotrexate then just switching to another DMARD is a waste of time," he added.