

Pharmacists should ask LPCs about smartcards

Community pharmacists should find out when their primary care trust will issue them with the smartcard essential for them to take part in the electronic prescription service (EPS) before they commit themselves to paying for the costs of the computer connection, pharmacy negotiators warned this week.

Community pharmacists are entitled to £200 a month — to pay for broadband and connection to N3, the national NHS network — as part of the EPS agreement with the Department of Health.

But to date only a handful of community pharmacists have been issued with the smartcard which acts like a security key enabling them to draw down the electronic prescription. The delay by PCTs means that pharmacists could find themselves paying for the electronic connection costs even though they cannot take part in the EPS.

Pharmaceutical Services Negotiating Committee chief executive Sue Sharpe said this week: "Pharmacists will be unable to get the £200 connection allowance unless they have a smartcard from their PCT. If PCTs have no time scale for being able to issue the smartcards we don't want pharmacists to get the connections up and running but then not be able to get reimbursed for the costs."

The PSNC is baffled by the delay in issuing smartcards, although it has acknowledged

that PCTs are under "immense budgetary pressures".

Sue Sharpe said: "I don't know what's holding it up and I don't want to speculate. Pharmacists should contact their local pharmaceutical committee to discover what their PCT timetable is on this."

Failure of PCTs to issue smartcards is also hampering the provision of electronic medicine use reviews (MURs), she said. Although a lack of smartcards does not prevent pharmacists from carrying out MURs, it does mean they have to be carried out on paper which "limited their value" to GP practices which were moving towards paperless systems.

The need for pharmacists to be linked to the NHS was highlighted earlier this month by Labour MP Howard Stoate, chairman of the parliamentary All Party Pharmacy Group, in a letter to health secretary Patricia Hewitt.

He warned her: "Access by community pharmacists to the national care record system is essential if services such as medicines use review and independent prescribing are to operate to optimum success. Specifically, pharmacies and GP practices must have IT connectivity. Failure to achieve IT connectivity will hamper service improvements."

A spokesman for NHS Connecting for Health said PCTs had been given guidance about issuing smartcards to community phar-



Sue Sharpe: pharmacists will not get connection allowance without smartcard

macists. "Further detailed guidance will be available on this shortly. It is then anticipated that PCTs will begin the smartcard registration process."

He said: "Guidance for community pharmacy contractors on what they need to do in order to be in a position to operate EPS will also be issued shortly. This will include sections on both smartcard registration and connectivity."

Pharmacist projects win national awards

Two medicines management projects involving pharmacists were among the winners of the inaugural general medical services and personal medical services Awards of Excellence, presented at the NHS Alliance Conference in Harrogate, North Yorkshire, this week.

Every patient receiving a repeat prescription at Phoenix Medical Practice in Doncaster, which was awarded the GP practice medicines management award, had a medicines check in the past year.

When the "review due" date on each patient's repeat prescription came round, GPs at the practice carried out a paper-based medication review, comparing the patient's repeat prescriptions with the medical records. The reviews also assessed whether all necessary diagnostic and screening tests had been carried out. If they had not, the patient was tele-

phoned and a face-to-face review of the patient's medicines, conducted by either the GP or by the practice pharmacist, was arranged.

The primary care organisations medicines management award was won by the medicines management team at Rugby PCT. In all but two of the practices in the PCT, more than 90 per cent of patients has received medicines reviews.

The PCT has had a team of medication review pharmacists since August 2002 and it also now employs medicines management technicians.

The awards, jointly sponsored by Novartis Pharmaceuticals and Schering Plough, were open to GP practices and primary care organisations across the UK which had gained the maximum points available under the quality and outcomes framework.

Review limit raised to 250

The maximum number of medicines use reviews that can be carried out during the first year of the new community pharmacy contract has been increased from 200 to 250, the Department of Health has confirmed.

The DoH says that the new limit only applies to pharmacies in England that begin providing MURs before 1 January 2006.

Commenting on the announcement, Sue Sharpe, chief executive of the Pharmaceutical Services Negotiating Committee, said: "We would have liked a higher limit than this to encourage those pharmacists who have been quick to take up this new service."

She adds that, to date, 4,700 pharmacists are accredited to provide the service, and at the end of October, more than 20,000 MURs had been carried out. "They will continue to increase and we will shortly be discussing with the Department of Health the numbers of reviews that can be undertaken in 2006-07."

Leaflet for patients on drug side effects developed by MHRA

A patient leaflet that contains questions and answers on the side effects of medicines has been produced by the Medicines and Healthcare products Regulatory Agency.

The leaflet will be distributed to pharmacies and GP surgeries as well as being sent to patients who report side effects via the yellow

card scheme. It can also be downloaded from the MHRA website (www.mhra.gov.uk) and via *PJ Online* (www.pjonline.com/links/pj).

Patients are told to ask their pharmacist for a patient information leaflet if they do not receive one with their medicines.

Society

- **New guidance on supervision**
New guidance on supervision may allow supply while the pharmacist is in a private consultation (p755).
- **National pharmacy boards**
A protocol has been agreed for the relationships between the Society's devolved pharmacy boards (p757).

Social-value judgements not relevant to health care

Treatment should not be denied to patients with conditions that may be self-inflicted, the National Institute for Health and Clinical Excellence says in a report published last week. The report, "Social value judgements: principles for the development of NICE guidance", describes the institute's approach to incorporating social value judgements into the processes used to develop NICE guidance. It will be used only to help those developing NICE guidance and is not intended as guidance for the wider NHS.

There are two reasons why NICE should not take into account whether a condition is self-inflicted, says the report. First, it is often impossible to decide whether someone's condition is self-inflicted or due to other factors, and secondly, it does not accept the principle of "deservedness" in priority setting within the NHS. However, if self-inflicted causes of the condition influence the clinical or cost-



Treatment should not be denied when conditions may be self-inflicted

effectiveness of the intervention, it may be appropriate to take this into account, it adds.

A spokeswoman for NICE gave the example of a patient with chronic obstructive pulmonary disease who needs oxygen therapy and is a smoker. "The effect of the smoking means that oxygen therapy is dangerous and can lead to an explosion," she says.

The report also emphasises that socioeconomic status, gender and sexual orientation should not influence access to treatment. It adds that age and race should only influence access when there is clear evidence that these cause differences in the clinical effectiveness of an intervention.

Patient choice is also addressed: "While respect for autonomy and individual choice are important for the NHS and its users, this should not have the consequence of disadvantaging NHS users as a whole by having an unacceptable opportunity cost or promoting the use of interventions that are clinically and/or cost ineffective."

Implementing NICE guidance

Practical advice on implementing National Institute for Health and Clinical Excellence guidance was published by NICE in the form of a "How to" guide last week.

The guide, aimed at organisations responsible for implementing NICE guidance as well as commissioning organisations, addresses the role of a "NICE manager" supported by a multidisciplinary team. It details implementation steps and sets out advice for those commissioning services from independent contractors.

The guide will be sent to all NHS organisations in England and Wales.

Lack of NICE guidance cannot be sole reason for withholding treatment from NHS patients

It is not acceptable for NHS organisations to cite a lack of National Institute for Health and Clinical Excellence guidance as the sole reason for not providing a treatment, according to health minister Jane Kennedy.

Speaking at last week's NICE conference in Birmingham, she said: "NICE does not exist to 'kite mark' all the drugs that are licensed for use in the UK. Therefore, the NHS will have to continue to make informed decisions about the use of these drugs."

She explained that NICE was established to make recommendations on drugs where there were questions about the effectiveness of their use.

"For everything else, the NHS must make decisions with clinical and cost effectiveness first in mind," she said.

Ms Kennedy added that the Department of Health in England would shortly be consulting on proposals to revise the topic selection process for NICE appraisals.

SMC issues guidance on six more drugs

The Scottish Medicines Consortium this week accepted five drugs for use within NHS Scotland and rejected one.

Adalimumab (Humira) is recommended for the treatment of adults with active and progressive psoriatic arthritis when response to previous disease-modifying antirheumatic drugs has been inadequate. A topical treatment, calcipotriol/betamethasone dipropionate ointment (Dovobet) for stable plaque psoriasis, has also been approved. However, its use is restricted to a maximum of four weeks by doctors experienced in treating inflammatory skin conditions.

A pivotal study that shows carmustine implants (Giladel) were associated with an increase in median survival time of 2.3 months has resulted in them being recommended by the SMC as an adjunct to surgery and radiation for the treatment of patients with newly diagnosed high-grade malignant glioma.

The SMC has also accepted zonisamide (Zonegran) for the treatment of adult patients

with partial seizures, with or without secondary generalised seizures. It should be restricted to those patients who have not benefited from older anticonvulsants, such as carbamazepine and sodium valproate, or who do not tolerate them. Treatment should only be initiated by doctors with appropriate experience in the management of epilepsy.

A further drug accepted for restricted use is iloprost trometamol nebuliser solution (Ventavis) for patients with New York Heart Association Class III primary pulmonary hypertension. It should only be used as second-line treatment where bosentan is ineffective or not tolerated. In addition, it is not recommended for patients who would otherwise not have received prostacyclin treatment. Its use is restricted to specialists working in the Scottish Pulmonary Vascular Unit.

Finally, the SMC has not recommended the use of erlotinib (Tarceva) for locally advanced or metastatic non-small cell lung cancer after failure of at least one prior treatment.

News in brief

NHS complaints

Complaints about the NHS in Scotland fell by 3.2 per cent in the financial year 2004–05 compared with the previous year. According to a report published last week, the most common complaints were about staff attitudes, behaviour and communication.

Scotland's obesity problem

Obesity among children in Scotland has increased over the past five years, statistics released by NHS Scotland this week show. The problem is worse in older children, although the proportion of children of all ages who are overweight is above the UK expected rate. In the 2004–05 school year, 34 per cent of 12-year-olds were overweight, 19 per cent were obese and 11 per cent were severely obese.

Society criticised despite High Court appeal failure

Manchester pharmacist Allan Stuart Black was rightly struck off by the Royal Pharmaceutical Society's Statutory Committee earlier this year, a High Court judge has ruled (*PJ*, 16 April, p468). However, the judge criticised the Society for treating him unfairly despite dismissing Mr Black's appeal.

Mr Black, who was superintendent pharmacist of Formans (Chemists) Ltd, over-claimed £52,000 from the Prescription Pricing Authority after getting in a muddle when his marriage broke down. Formans has fully repaid the over-payment. Mr Black was never accused of dishonesty, but Mr Justice Collins said that his conduct remained too serious to be dealt with by only a reprimand despite unfairness in the way he had been dealt with by the Society.

The mother of the patient who was prescribed the drug was to have given evidence

in Mr Black's support at a Statutory Committee hearing in January. But she had told the Society by fax two days before the hearing that she could not attend. Mr Black and his legal team were not informed she could not attend until the day of the hearing.

Mr Justice Collins observed: "The manner in which the respondent (the Society) dealt with the problem caused by Mrs J's inability to attend merits severe criticism."

The judge said that the absence of dishonesty on Mr Black's part, his previously flawless reputation and the fact that his error did not put any patient at risk would normally have made suspension from the Register, rather than erasure, the appropriate sanction. However, the judge said that the Society had no power to suspend pharmacists.

The judge said: "Serious though his misconduct was, I think that he should be given

the opportunity to seek reinstatement before the usual three-year period has elapsed. I would recommend that favourable consideration should be given to an application for reinstatement made once 12 months have elapsed."

Mandie Lavin, the Society's director of fitness to practise and legal affairs, said: "We are pleased the judge has upheld the decision to remove the appellant from the Register. We are also pleased the judge has recognised the current limitations to our legislation and we have been working hard to formulate legislation to enable us to discharge our duties as a modern regulator. We will be reviewing our arrangements for summoning witnesses in the light of the judge's comments. We are currently reviewing all our procedures in preparation for our new Section 60 requirements."

Prevention in NHS reforms

Health Secretary Patricia Hewitt has pledged that the next raft of reforms in the NHS will move away from acute care to prevention, and health and social care in the community.

Delivering the London School of Economics annual health and social care lecture, she said that the Government was also determined to tackle health inequality and promised that more money would be targeted to deprived areas. She calculated that over the next two years this would mean people living in poor areas would receive £1,700 per head of NHS funding compared with £1,200 per head for people in more affluent areas.

Ms Hewitt also repeated the Government's commitment to its patient choice agenda, having more diverse NHS providers — including those in the private sector — and the principle of money following the patient.

She did not rule out further reorganisation and said that the current consultations about mergers and restructuring of primary care trusts were essential if they were to have the "weight and expertise" they needed to influence health providers.

Union issues lobbying call over health service reform

Amicus is urging its members to lobby their members of Parliament over Government proposals to reform health services. The trade union wants its members to meet MPs at the House of Commons on 10 January 2006. Amicus head of health Gail Cartmail said: "We are campaigning against plans in 'Commissioning a patient-led NHS', which we know will fragment the delivery of services currently provided by PCTs to the serious detriment of clients, patients and staff."

NHS efficiency savings ahead of schedule

Efficiency savings in the NHS in England are ahead of schedule, the Secretary of State for Health, Patricia Hewitt, has said.

Steps to save £6.5bn between 2004 and 2008 are said to be £200m ahead of target, with £1.7bn having been saved already.

The single biggest contribution to the savings to date has been achieved by forcing down the cost of medicines to the NHS. Price reductions achieved by renegotiating the Pharmaceutical Price Regulation Scheme and introducing new controls on generic drug prices have saved £697m since 2004 and are expected to save £975m annually by March 2006.

The cash savings were set out in a Department of Health report last week. The report also says that time savings are expected



Drug savings reach £697m in two years

to be made by introducing the electronic transfer of prescriptions from GPs to pharmacies and from pharmacies to the Prescription Pricing Authority.

Hospital pharmacists migrate to primary care

Pharmacists who work exclusively in primary care are more likely to have come from the hospital than the community sector, a paper in this month's *International Journal of Pharmacy Practice* reveals (2005;13:281).

Rachel Mullen, research associate at Central Liverpool Primary Care Trust, and colleagues carried out a survey of primary care pharmacists in England in 2001.

Of 432 pharmacists, 52 per cent worked only in primary care and had migrated largely from the hospital sector (28 per cent from hospital, 19 per cent from community and 5.3 per cent from other sectors). Almost half (48 per cent) worked in other sectors, mainly community, alongside their primary care post (31.5 per cent in community, 9.3 per cent in hospital and 6.9 per cent in other sectors). The most common reason for leaving hospi-

tal pharmacy was to increase autonomy and responsibility. Community pharmacists moved to make better use of their knowledge and do more interesting work.

The researchers suggest that concerns about the impact of primary care on hospital, rather than community, pharmacy are warranted. They point out that around three-and-a-half times more pharmacists work in community pharmacy than hospital pharmacy, so it is likely that the community sector will be able to absorb losses more easily.

"It is important to continue to monitor the migratory and practice patterns of primary care pharmacists to help inform whether the primary care employment sector is continuing to draw pharmacists mainly from the hospital sector," they conclude.

Article p753

Switch to aromatase inhibitor improves survival

Replacing tamoxifen with anastrozole (Arimidex) improves survival of patients with early breast cancer compared with continuing on tamoxifen for five years, according to results from the first study to show a survival benefit of changing hormonal therapy.

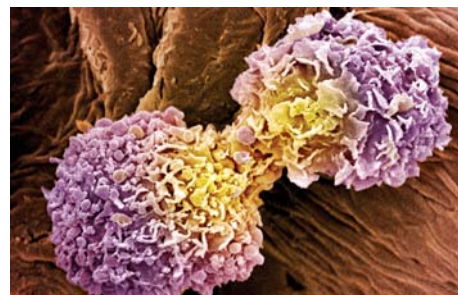
The meta-analysis of three trials with similar design included 4,006 women with hormone-sensitive early breast cancer who were randomised to switch to anastrozole after two to three years of tamoxifen or to remain on tamoxifen for five years.

The results showed that women changing to anastrozole gained a 29 per cent improvement in survival compared with those remaining on tamoxifen (hazard ratio 0.71, 95 per cent confidence interval 0.52–0.98; $P=0.0377$). The risk of disease recurrence was

reduced by 45 per cent and risk of distant recurrence fell by 39 per cent.

Reporting the findings at the San Antonio breast cancer symposium last week, Walter Jonat, of University of Kiel, Germany, said: "Results from a previous study — the ATAC trial — showed that survival is improved if patients start treatment with an aromatase inhibitor rather than tamoxifen. This meta-analysis shows that survival is also increased if patients already on tamoxifen are switched to anastrozole."

Geoff Saunders, Macmillan cancer network pharmacist for Greater Manchester and Cheshire, commented: "These findings are encouraging us towards using aromatase inhibitors at an earlier stage in the treatment of breast cancer. The evidence indicates that we



Steve Gschmeissner/SPL

Cancer cells: recurrence is reduced

should start women with oestrogen receptor-positive early breast cancer with an aromatase inhibitor at diagnosis. Those already on tamoxifen should be switched early, rather than remaining on tamoxifen for five years."

COX-2 inhibitor launched by Novartis

A new selective cyclo-oxygenase-2 (COX-2) inhibitor has been launched by Novartis. Lumiracoxib (Prexige) is indicated for symptomatic relief of osteoarthritis and for the short-term relief of moderate to severe acute pain associated with primary dysmenorrhoea and dental and orthopaedic surgery.

Its summary of product characteristics states that, since COX-2 inhibitors have been associated with an increased risk of cardiovascular risks, the shortest duration and the lowest effective daily dose should be used. In addition, it warns that lumiracoxib should be used with caution in patients with a history of cardiac failure, left ventricular dysfunction or hypertension, and that patients with significant risk factors for cardiovascular events, such as hypertension, hyperlipidaemia, diabetes mellitus and smoking, should only be treated with lumiracoxib after careful consideration.

Notice-board p741

Adding trastuzumab increases survival

Treatment with trastuzumab (Herceptin) at the same time as, or following, chemotherapy increased disease-free survival in a trial of 3,222 women with human epidermal growth factor receptor 2 (HER2)-positive early breast cancer.

Patients randomised to receive doxorubicin and cyclophosphamide followed by docetaxel plus trastuzumab showed a 51 per cent reduction in the risk of recurrence compared with the control group of women treated with chemotherapy without trastuzumab (95 per cent confidence interval 35–63 per cent; $P<0.001$). Those treated with docetaxel, carboplatin and trastuzumab showed a 39 per cent reduction in recurrence (21–53 per cent; $P<0.001$). Preclinical research indicating that using a non-anthracycline-containing regimen was better tolerated was also confirmed by the study results.

Data were presented at the San Antonio breast cancer symposium last week.

Pharmacists consulted on paediatric formulations

Pharmacists are being consulted on their views about the formulation of children's medicines, which might bring about new European guidelines for the pharmaceutical industry.

A European Medicines Agency (EMA) working party, chaired by Tony Nunn, clinical director of pharmacy at the Royal Liverpool Children's NHS Trust, has produced the consultation paper, "Reflection paper on formulations of choice for the paediatric population".

It is aimed at the industry to highlight the issues around the formulation of medicines for children including liquids, their taste and texture, as well as the size of ampoules, the concentration of the medicines, and transdermal patches.

Mr Nunn said: "We are trying to alert people to the current state of knowledge

about formulations for children and to reflect on that.

"Do we, for example, need guidelines on the taste in children's medicines because we know that children's perceptions of taste are different from adults'? Often when we test for taste we use adult testing panels, which seems a bit silly.

"It also includes a plea to the pharmaceutical industry to provide more information to allow us to [administer] children's medicines more safely and effectively."

The results of the consultation may lead to new guidelines around the formulation of children's medicines but that, according to Mr Nunn, will depend on comments received. "It will be up to the EMA to decide where to go next," he said.

The deadline for comments on the consultation paper, which is available on the



Children's medicines under consultation

EMA website (www.ema.eu.int) and via *PJ Online* (www.pjonline.com/links/pj), is 31 December.

More licensed child medicines a step closer

Having more medicines licensed for use in children came a step closer last week with approval of a research incentive scheme by the EU Council of Ministers (*PJ*, 12 February, p168).

Companies that test medicines for their suitability for paediatric use are to be given an extra six months' patent protection regardless of the outcome of the tests.

Draft EU legislation on the matter has been progressing through European legisla-

tive procedures since September 2004 despite vigorous opposition from generics manufacturers. They say that the proposal will delay the launch of generic competitors to proprietary medicines and inflate the cost of health care.

The proposal now has to pass a second reading in the European Parliament and is expected to be implemented next year. Four years will have passed since it was first mooted in 2002.

Toxic herbal medicines alert

Consumers are warned by the Medicines and Healthcare products Regulatory Agency not to purchase or use two African herbal remedies — M2 and Energy 2000.

The MHRA says that the products may contain *Strophanthus sarmentosus* or *Aristolochia* species. *Aristolochia* species, which can cause kidney failure and cancer, are banned in unlicensed herbal remedies in the UK. *Strophanthus* species can result in heart problems including abnormal heart rate and heart failure.

ACE inhibitors and ARBs not always best in kidney disease

Angiotensin-converting enzyme inhibitors and angiotensin-II receptor blockers are not necessarily better than other antihypertensives in preventing kidney disease, a review of evidence suggests (*Lancet* 2005;366:2026).

Researchers from University College London looked at data from 127 randomised controlled trials to investigate whether there is evidence to support national and international guidelines which endorse the first-line use of these agents in patients with diabetic and non-diabetic nephropathy.

The researchers say that benefits of ACE inhibitors and ARBs on renal outcomes in placebo-controlled trials probably result from a blood-pressure lowering effect. In trials that compared the drugs with other antihypertensives there appeared to be "no significant salutary effect" on renal outcomes, they add.

"Treatment decisions for hypertension in renal disease should be based on the blood-pressure lowering effect, comparative tolerability, and cost of antihypertensive treatment," the researchers conclude.

100th Nucare PLUS store

Nucare has opened its 100th Nucare PLUS store — part of the upgrade scheme for Nucare pharmacies — in Tyldesley, Manchester. The company has also unveiled a new corporate structure. Nucare Health and Nucare Pharmaceuticals will continue to provide retail and wholesale services, respectively. A third division, Nucare Services, will be responsible for all marketing and support activities.

News in brief

Study questions routine prophylaxis against thromboembolism after fracture below the knee

Fractures below the knee do not warrant routine prophylaxis against venous thromboembolism, concludes a Canadian prospective cohort study presented at the 47th annual meeting of the American Society of Hematology in Atlanta, Georgia, this week.

Between August 2002 and June 2005, 2,446 consecutive patients with fractures of the patella, fibula, foot and tibia were followed prospectively for three months, with thromboprophylaxis not allowed. Education regarding

symptoms of deep vein thrombosis and pulmonary embolism was provided at study entry.

Presenting the results, Rita Selby, from the University of Toronto, said that by three months only seven of 1,174 patients (0.6 per cent) sustained a symptomatic, objectively confirmed venous thromboembolism.

"It is clear from these results that the side effects of thromboprophylaxis, such as gastrointestinal bleeds, outweigh any benefits and it is unlikely to be cost effective," she said.

She added that many centres in Europe offer routine thromboprophylaxis for fractures below the knee and that the study should make them reconsider this practice. The study, however, does not have any implications for thromboprophylaxis after fractures above the knee, where the benefits outweigh risks.

The National Institute for Health and Clinical Excellence is expected to publish safety guidance on prophylaxis against venous thromboembolism in May 2007.

Pharmacy IT must evolve for future contract needs

Key to finding the most appropriate IT system to support the new community pharmacy contract is identifying one that will evolve over time to meet both current and future needs, according to Nick Strong, managing director of Systems Solutions.

"It is important that your IT supplier has a roadmap of ideas and features that will be added to your IT system over time," he says. "This roadmap should be reviewed regularly, with new features being added to the system at least once a year."

Systems Solutions has carried out a survey of 400 UK pharmacists that identifies repeat dispensing, smoking cessation, minor ailments

schemes, prescription intervention services, medication disposal and medicines use reviews as the services pharmacists are most interested in providing.

Mr Strong believes that there are a number of minimum features that a pharmacy IT system should have in order to provide these services.

The repeat dispensing functions should be capable of keeping track of multiple repeats and, in order to assist scheduling, be able to link repeat management to the prescription collection service.

The software should also prompt the user to ask patients whether their medicines are

still required and record if any changes are made.

To enable pharmacists to identify patient groups to whom they can provide enhanced services, the system should be able to record patients' lifestyle information, Mr Strong says. This function is also useful for running a minor ailments scheme.

The system will need to be able to register patients and be capable of storing and printing registration forms, pre-printed prescriptions and support minor ailments scheme reporting. In addition, it should contain endorsement software that is able to recognise drugs for minor ailments, he adds.

Pharmacist wins "Leader for change" award

Joel Hirst, a pharmacist and quality improvement facilitator in medicines and pharmacy at Bristol North Primary Care Trust, has won a "Leaders for change" award for a project that focuses on increasing the role of community pharmacists in the provision of local health services.

The project, one of 12 recognised by the charity The Health Foundation, involves a minor ailments scheme, innovative use of community pharmacists to provide enhanced services in public health and an increase in the number of pharmacists involved in the management of long-term conditions.

Mr Hirst told *The Journal* that he hopes the third strand will be achieved by getting more community pharmacists engaged in medicines use reviews as well as commissioning specialist clinical services from suitably trained pharmacists. The first three long-term conditions to be targeted are epilepsy, mental health and asthma.

The 14-month award scheme is work-based and provides a place on a structured learning programme in change management



Joel Hirst: quality improvement facilitator

at Lancaster University management school, funding for a mentor and £3,000 for training and development needs.

Mr Hirst commented: "This award and the change management programme provide me with a great opportunity to position community pharmacy at the heart of the local medical and public health services."

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System implemented to aid rational clinically led drug selection in Northern Ireland

Pharmacists in Northern Ireland and the Netherlands have collaborated to develop and implement an evidence-based, transparent process for drug selection. The process has been used since January to decide which angiotensin-converting enzyme inhibitors should be selected for use throughout primary and secondary care in one health board in Northern Ireland.

Evaluation of the system was completed last month at one health board trust.

A list of three ACE inhibitors has been identified to replace the previous 11 products, with a target prescribing rate of 70 per cent (to allow some flexibility for treatments outside the selected list). Potential savings of up to £1m per annum are projected as a result of this approach. The system, known as

STEPS (safe, therapeutic and economic pharmaceutical selection) has been developed from the SOJA (system of objectified judgement analysis) process.

The SOJA process involves the construction of a matrix in which the criteria for drug selection, such as clinical efficacy, tolerability and interactions, are listed and are assigned weighting points. The drugs or products under consideration are then adjudicated and given a percentage score for each criterion. The matrix is then completed for each product by multiplying the percentage score by the weighting. An overall ranking for the products then emerges.

The main strength of SOJA is that clinicians can be invited to determine the selection criteria and the weightings. In this way drug

selection can be seen to be both rational and clinically led. In practice, the choices that clinicians make are highly predictable and it is almost always possible to achieve consensus, says Rob Janknegt, CZ, Sittard, the Netherlands.

Consultants and GPs both liked the STEPS method, as it provided an objectified approach to drug selection, commented Michael Scott, chief pharmacist, United Hospitals Trust, Antrim. The standardisation of products, such as ACE inhibitors, will improve patient safety by eliminating much of the confusion that can be caused by the use of different agents and brands, including parallel imports, Dr Scott added. The next step is for the process to be extended and used to select the most appropriate statins and proton pump inhibitors for use in the region.