

Controlled Drug supply under PGD set to expand

Proposals to expand the range of Controlled Drugs that can be supplied or administered by pharmacists and nurses working under patient group directions (PGDs) have been published by the Medicines and Healthcare products Regulatory Agency.

The consultation also contains proposals on changing the locations and circumstances in which CDs can be supplied or administered for the purposes of pain relief and on clarifying the position concerning the sale, as well as supply, of products under PGDs.

Currently pharmacists can supply and administer all drugs in schedules 4 and 5 under a PGD. Nurses can, in addition, supply and administer diamorphine (schedule 2) for cardiac pain in coronary care units and accident and emergency departments.

The shortage of diamorphine and development of patient services away from hospitals are cited as reasons for the proposals to allow nurses and pharmacists to supply and administer morphine under PGDs. The con-

sultation also says that pharmacists are increasingly taking on new roles and their knowledge of therapeutics supports the case for them being able to use some schedule 2 CDs for pain relief in areas where there is a clinical need but no immediate access to an independent prescriber. "Continuing the current inconsistency between nurses' and pharmacists' ability to provide pain relief under a PGD can no longer be justified and is a barrier to improving patient services," it says.

The MHRA is also seeking to amend an error in the 2003 amendments to the POM Order that does not explicitly permit sale as well as free supply under a PGD.

The consultation document makes it clear that neither the Home Office, the Department of Health, nor the MHRA expects that the proposals will lead to drug misuse or diversion.

The proposed changes would have effect in England, Scotland and Wales. The consultation document is available on the MHRA



Diamorphine shortages have prompted the proposal for morphine supply by PGD

website at www.mhra.gov.uk and via *PJ Online* (www.pjonline.com/links/pj).

Consultation begins on pharmacist independent prescribing of CDs

Whether pharmacist independent prescribers should be allowed to prescribe Controlled Drugs is the subject of a Home Office consultation that aims to increase access to medicines for patients, improving care in areas such as palliative care, substance misuse, post-operative care and pain relief.

The consultation, launched last week, also seeks views on whether the range of CDs that independent nurse prescribers are able to prescribe should be expanded. In addition it addresses whether pharmacist and nurse prescribers should be able to prescribe specific schedule 2 CDs to addicts for the management of their addiction.

The Government believes that prescribing by pharmacist and nurse prescribers should

be considered in the same way as prescribing by doctors. "The current inability of pharmacist independent prescribers to prescribe independently any CD and nurse independent prescribers to prescribe a very limited range independently is at odds with this, and is seen as a potential barrier to patient choice and local innovation in providing services for patients," the consultation states.

The document emphasises that, if the proposal is adopted, pharmacist and nurse independent prescribers would still not be able to prescribe cocaine, diamorphine or dipipanone for the management of drug addiction. It adds that the Home Office would welcome views on this matter so that it can give further consideration to the feasibility of such a change.

David Pruce, director of practice and quality improvement at the Royal Pharmaceutical Society, said: "Extending prescribing powers to include Controlled Drugs will give patients improved access to the care they need and make full use of pharmacists' skills. Pharmacists will only prescribe within their own competencies and the Society has developed a clinical governance framework for prescribers to ensure that standards are maintained."

The proposed changes would have effect in England, Scotland and Wales.

The consultation is available on the Home Office website at www.homeoffice.gov.uk and via *PJ Online* (www.pjonline.com/links/pj).

PSNC and DoH publish details of community pharmacy patient questionnaire requirements

Details of the community pharmacy patient questionnaire (formerly referred to as the patient satisfaction questionnaire) were published last week by the Pharmaceutical Services Negotiating Committee and the Department of Health.

Conducting an annual patient survey is a requirement for all contractors in England and Wales as part of the clinical governance arrangements of the community pharmacy contract (*PJ*, 24 March, p338). From April, contractors must carry out an annual patient survey based on a national template questionnaire. Contractors may add additional questions provided they are related to the provision of health care services. A minimum return rate is specified depending on dispensing volume.

The requirements state that the questionnaire must be free from advertisements and must be accompanied by an explanation as to what it is for and how to complete it, at least two options for it to be returned, and details of what will be done with the responses. They also stipulate that questionnaires must be given to a range of patients to reflect the different services and opening hours of the pharmacy.

Alastair Buxton, head of NHS services at the PSNC, said: "The questionnaire provides an invaluable opportunity for pharmacy contractors to learn more about how their patients view the service they provide. The results will help them to develop their business and will, I am sure, demonstrate how much local people value the service that community pharmacies provide every day."

Gianpiero Celino, director at Webstar Health, which is providing a patient survey support service to community pharmacy, said that pharmacists can be apprehensive about running surveys with patients. "However, based on our experience of surveying over 10,000 patients in community pharmacy, we know that by taking time to plan and by delegating to their staff pharmacists should find the experience rewarding and informative. It is important not to underestimate how much time will be needed. . . . Making an early start is a must," he said.

The PSNC will send details of the questionnaire to every pharmacy contractor with the next issue of *PSNC Community Pharmacy News*. The survey can also be downloaded from the PSNC website (www.psn.org.uk) and via *PJ Online* (www.pjonline.com/links/pj).

Pharmacists need to see anticoagulation test results

Before dispensing repeat prescriptions for anticoagulants, community pharmacists should ask to see patients' latest international normalised ratio results, the National Patient Safety Agency has recommended.

As part of a work programme and set of patient safety alerts and materials to support implementation, which cover five areas of medicines management, the NPSA recommends that pharmacists should not assume that prescribers have undertaken safety checks when prescribing anticoagulants.

"Reviewing the patient-held record, which includes the date of the last clinic appointment, the latest INR test result and current dose, and confirming this information with the patient, is recommended as safe practice," the NPSA says.

The NPSA outlines a number of other actions that can make anticoagulation safer, including that patients are not required to split tablets, use alternate dosing or take more tablets than necessary, and that the NHS adopt a standardised 1,000 units in 1ml infu-

sion of sodium heparin and minimise the use of concentrated heparin products. The NPSA and the British Society for Haematology have also redesigned the patient-held "yellow" information booklet.

The other areas covered by the NPSA's work programme and alerts are: liquid medicine administered via oral and other enteral routes; injectable medicines; epidural injections and infusions; and paediatric intravenous infusions.

Senior pharmacists are being asked to take a lead on implementing the guidance, Keith Ridge, chief pharmaceutical officer for England, said at the launch of the work programme.

"Pharmacists, with their knowledge and skills in medicines, are in a position to take an overview of safe systems and how medicines are used in practice. Those pharmacists will need to have the full managerial support of chief executives, medical directors, nursing directors and others to get these important things done," he said.



The redesigned "yellow" booklet

All the recommendations should be implemented by 31 March 2008 and each of the alerts includes a recommended time frame for implementation. Further information is available from the NPSA website (www.npsa.nhs.uk).

Superintendents must live in UK, say company chemists

Superintendent pharmacists of pharmacy companies should have to live in the UK, the Company Chemists Association has said.

Responding to a Royal Pharmaceutical Society consultation on guidance notes on the new Code of Ethics, the CCA told the Society that it should seek amendment of the Medicines Act 1968 to make UK residence a requirement.

The CCA also took the view that comments in the planned guidance notes in relation to patient confidentiality did not go far enough. It said that unnecessary access to patient specific data should be prevented, not merely minimised, and that patients should be told that information might be shared with other health professionals.

Pharmacies in information prescription plan

Pharmacies are to be involved in two pilot schemes to test ways of improving the information patients receive about their illnesses and treatment.

Steve Tomlin, children's services consultant pharmacist at Evelina Children's Hospital, London, said that staff would complete a proforma with parents and children at the hospital to identify their information needs and preferences. Details would then be sent electronically to NHS Direct, which would deliver the type of information requested according to the preferences expressed. Possibilities include post, e-mail and mobile telephone text messages.

The same service is also to be piloted through one Boots, one Tesco and one Co-op community pharmacy.

"There often isn't good information for parents or children," Mr Tomlin said. "Often drugs are used off-licence and even information on licensed medicines is not always good."

The Royal College of Paediatrics and Child Health and the Neonatal Pharmacists Group will be just two of a number of organisations contributing information for the project, which will focus on asthma and epilepsy, together with cardiac and renal conditions.

A second pilot, based at Hammersmith and Fulham Primary Care Trust, aims to deliver information through GPs' surgeries and community pharmacies to help diabetes, asthma and arthritis patients understand their illness and its treatment.

Pharmacies might have to print out a quarter of EPS prescriptions

Paper tokens might need to be generated for over a quarter of prescriptions when release 2 of the electronic prescription service is introduced later this year. But local pharmaceutical committee representatives objected to this at their annual conference last week.

They approved a resolution that the Pharmaceutical Services Negotiating Committee should reject the plan to ask community pharmacists to print tokens from electronically generated and transmitted FP10s so that patients who have nominated a pharmacy but are exempt from paying prescription charges and are not age exempt can sign the back to claim their exemption from payment.

Lindsay McClure, head of information services at the PSNC, said that printing tokens was an interim solution agreed between the PSNC and the DoH in 2004.

"The PSNC continues to view pharmacy printing the paper token as an interim solution until a more efficient arrangement can be put in place," she said.

Ms McClure said that, if every patient in England who is taking repeat medicines chooses to nominate a pharmacy, paper tokens would need to be printed for 27 per cent of prescriptions.

Malcolm Goldie (Gateshead and Tyneside LPC), who proposed the motion, said that

signing the back of prescriptions to claim an exemption was first introduced some 40 years ago as an interim measure.

"If this is introduced, it will last until we are in our boxes," he said. He suggested that, if the Government genuinely wants to prevent, rather than pay lip service to preventing fraud it should introduce a signable electronic device, as has been done by some delivery firms.

Applications are now being sought by the Department of Health from primary care trusts for release 2 initial implementer sites (see p359).

Meeting report p378

Agreement backed by 18 pharmacy organisations says that royal college should be all-encompassing

Basic agreement on how a professional leadership body for pharmacy should be set up was reached at a meeting held in Waterloo, London, earlier this month. The Royal Pharmaceutical Society was not invited to participate.

The so-called "Waterloo agreement", backed by 18 pharmacy organisations, supports an all-encompassing royal college, with categories for practising, non-practising, retired and overseas pharmacists as well as pharmacy technicians and others involved in the science and practice of pharmacy.

The meeting was convened by the College of Pharmacy Practice with the aim of contributing to the dialogue about setting

up a royal college-type body and making sure the views of small organisations are taken into account. Some of the supporting organisations will wish to be an integral part of the royal college and others will give their support while retaining their independence.

CPP chief executive Ian Simpson stresses that the CPP is not in any way setting itself up in opposition to the Royal Pharmaceutical Society. "Indeed the meeting was geared towards reaching an agreement to work together with the Society," he said. In fact, this is the first of 10 points on which the organisations agree.

The organisations also agree that the royal college should have a faculty system and that

it should recognise different levels of education, expertise and specialisation by means of peer group accreditation. "This should take account of work that some organisations, such as the College of Mental Health Pharmacists and the CPP, have already done," said Mr Simpson.

He estimates that the organisations represent about 15,000 pharmacists and technicians, although he acknowledged that this does not take account of people belonging to more than one organisation.

The Waterloo agreement was presented at a private seminar last week, which was run by the King's Fund on behalf of the Department of Health to help inform Lord Carter and his working party on implementation of the White Paper. Mr Simpson told *The Journal* that the agreement came in for some criticism at the seminar for not having enough community pharmacy representation. He acknowledged that many of the organisations represent secondary and primary care pharmacists but pointed out that 75 per cent of the members of the Institute of Pharmacy Management are community pharmacists.

The Waterloo agreement is available on the CPP website at www.collpharm.org and via *PJ Online* (www.pjonline.com/links/pj).

Organisations that support the agreement

Organisations that support the agreement are: the Association of Pharmacy Technicians UK, the British Oncology Pharmacy Association, the College of Mental Health Pharmacists, the College of Pharmacy Practice, including its Faculty of Neonatal and Paediatric Pharmacy and Faculty of Prescribing and Medicines Management, the Guild of Healthcare Pharmacists, the Institute of Pharmacy Management, the Neonatal and Paediatric Pharmacists' Group, the Primary and Community Care Pharmacy Network, the Primary Care Pharmacists' Association, the Pharmacy Law and Ethics Association, the UK Clinical Pharmacy Association, UK Medicines Information, the UK Psychiatric Pharmacy Group, the NHS Pharmaceutical Aseptic Services Group, the NHS Pharmaceutical Production Committee, the NHS Pharmaceutical QA Committee, the Technical Specialists Education and Training Committee and the UK Radiopharmacy Group.

Still no terms of reference for the Carter working party

With only one more meeting of the working party set up to advise Lord Carter on the establishment of the General Pharmaceutical Council and a royal college-type body, its terms of reference are still under discussion. Lord Carter, who chairs the working party, is due to write his paper and present it to Government ministers for consideration before Easter.

As far as the establishment of the two bodies is concerned, Hemant Patel, President of the Royal Pharmaceutical Society, said: "I would like to see a clear timetable from the Department of Health and we should agree that timetable. I would like to see resources identified and a commitment from ministers that they will stick to it."

The President believes that the Bill to change regulation across the health professions is already being drafted and that it currently has 200 clauses. "I understand the pharmacy clauses are still to be inserted and I would like to work with the department to make sure all the relevant issues are covered."

Health minister Lord Hunt is expecting to read the report over Easter and the President expects an announcement shortly afterwards.

Interview p369

Professional leadership body should not have a monopoly on education and training

To guard against complacency and inefficiency, the new professional leadership body for pharmacy should not have a monopoly on accrediting undergraduate courses and revalidating practitioners, according to the Council of University Heads of Pharmacy (CUHOP).

In a letter to the Department of Health, the CUHOP says that the General Pharmaceutical Council, which it assumes will be responsible for the accreditation of undergraduate education and training and the revalidation of both pharmacists and pharmacy technicians, might choose to delegate or subcontract the undertaking of these functions to one or more bodies. The CUHOP proposes that the professional leadership body should not be guaranteed to carry out these functions.

The letter also emphasises that the professional body should be a learned organisation that promotes, facilitates and celebrates excellence. It says that it should be at liberty to criticise Government or NHS policies and performance in the areas of education and health care, as well as other areas relevant to medicines research, development and use.

The CUHOP believes that membership of the leadership body should be voluntary. However, if membership is made compulsory, the cost should be benchmarked against similar bodies, such as the Association of British Dispensing Opticians (annual fee £225) and membership should be open to appropriately qualified non-pharmacists and people from overseas. The council suggests that the organisation will have a faculty structure with entry being by portfolio of evidence, most often including a postgraduate diploma or postgraduate master's qualification. There should be different classes of membership, including member, student, associate and fellow, it adds.

The CUHOP believes that the council of the leadership body should exclusively or overwhelmingly be elected by and from its membership, with guaranteed representation from each of the faculties and from each of the membership categories.

Finally, the CUHOP says that it might be willing to come under the umbrella of the professional leadership body, but, given its unique managerial responsibilities, only if it could retain an independent and potentially dissenting voice.

Mixed views on success of Pfizer distribution scheme

Some four weeks into Pfizer's direct-to-pharmacy distribution arrangement through UniChem views on the success of the scheme are mixed. Rival wholesaler AAH Pharmaceuticals has accused UniChem of providing a two-tiered service in its delivery of Pfizer prescription medicines — offering preferential service to its existing customers over those also dealing with other wholesalers.

UniChem has rejected this suggestion. A spokeswoman told *The Journal*: "As a business it is not in our interest to offer any preferential treatment to any customers."

AAH has put forward the testimonies of a number of pharmacists who say they are being denied a timed delivery slot and believe that their cut-off times for orders are unacceptable — some are as early as 10am. "As a result they were finding it harder to meet patient needs and felt they were being deliberately pressured to move all of their business to UniChem," an AAH statement said.

UniChem explained that existing customers have retained their cut-off and delivery times for all orders. For new Pfizer accounts, cut-off times are determined by the location of the dispensary in relation to the distribution centre from which it is served. "Therefore, some people have better cut-offs than others — that happens across the board with all wholesalers. As the routes settle down and as ordering patterns become more standardised, people will start to see a regular delivery slot," the spokeswoman said, stressing that there have been few complaints to the company's distribution centres.

David Watson, Pfizer's head of trade, added: "I don't minimise the issue, because we are keen to understand on an individual basis if we can do anything to improve cut-off times. If people say it is an issue — whether it be pharmacists or dispensing doctors — we will try to resolve it."

Neal Patel, head of communications, National Pharmacy Association, told *The*

Journal that it is too soon to tell whether Pfizer's model will work. "We are monitoring the situation closely," he said. "Because there is still stock and parallel imports within the supply chain it is probably too early for some of the problems we envisage to become apparent."

Phoenix streamlines ordering

Phoenix's first-line wholesale customers can elect to continue placing orders for Pfizer products with Phoenix as usual and the wholesaler will pass the orders on to UniChem. David Coles, deputy chairman, Phoenix, told *The Journal* that, although the wholesaler cannot do anything about the emerging direct-to-pharmacy models, it can keep the ordering process as simple as possible for its customers. Customers still need to open a Pfizer/UniChem account but for those who request the service Phoenix sends the Pfizer order on immediately using the Pfizer account number.

Scottish industry manifesto

The Scottish branch of the Association of the British Pharmaceutical Industry has published a manifesto to call on election candidates to recognise the pharmaceutical industry's contribution to the health and wealth of the nation. It calls for an end to postcode prescribing, tax changes to make Scotland a more attractive place to invest, and a reversal in the trend of budget cuts for medicines.



Plan the NHS workforce, MPs tell the DoH

Workforce planning must become a priority for the health service, the House of Commons Health Committee says in a report that calls the Government's approach "a disastrous failure".

The committee concludes that the NHS has gone from boom to bust with a period of dramatic recruitment and pay rises now being followed by widespread job cuts, sweeping training cuts and severe pay restrictions as a result of NHS organisations recruiting more staff than they could afford to pay.

The committee criticises a lack of integration between financial and workforce planning. "The expansion of the workforce was reckless and uncontrolled and increases in funding were often seen as a blank cheque for recruiting new staff," it says.

The committee also criticises pay rises for medical consultants, saying: "Large pay in-

creases were granted without adequate steps being taken to ensure increases in productivity in return."

Recommendations made by the committee include:

- n End constant reorganisation of workforce planning
- n Improve integration between workforce and financial planning
- n Improve productivity
- n Stop considering staff groups separately

Responding to the report, Sian Thomas, deputy director of NHS Employers, said: "Workforce planning has always been a huge challenge in health care. It isn't an exact science and the time it takes to train a health care professional means that the way services are provided may have changed in the meantime."

CCA blames primary care trusts for lack of new pharmacy services

Insufficient creative thinking among commissioners and a lack of appropriate incentives for GP support is holding back the delivery of patient-centred services by pharmacies, according to the Company Chemists Association.

In evidence to Anne Galbraith's review of the arrangements for pharmacy contracting, the CCA said that not all primary care trusts had taken seriously their responsibility to fund advanced pharmacy services. The association called for the development of advanced services under the national pharmacy contract to support smoking ces-

sation, sexual health improvement, obesity reduction and a national minor ailments scheme.

The association would also like to see incentives in the GPs' quality and outcomes framework to encourage use of the repeat dispensing service and other forms of collaboration between GPs and pharmacies.

To support better service commissioning, the CCA suggested that PCTs should map the market of willing providers of new services and better articulate the business case for new services in order to increase the level of interest from potential providers.

The submission also contains a clear warning against any major change of direction from the current contract. It said that companies had invested in good faith and that the Department of Health must recognise that the environment and drivers conducive to private sector business investment are very different to those of the NHS.

"Constant reviews do not make for confidence and certainty," the CCA said. "Community pharmacy makes decisions for long-term investment, so there needs to be a reasonable expectation of a sustainable service in order for the case to be made."

All change for top positions at key pharmacy bodies

Lawyer Christopher Hodges has been appointed to chair the Pharmaceutical Services Negotiating Committee when Barry Andrews's term of office runs out at the end of August. The appointment comes as the National Pharmacy Association named its acting chief executive as Colette McCreedy, currently director of pharmacy practice at the NPA, and as the Royal Pharmaceutical Society started its search for a new chief executive.

The new PSNC chairman, Dr Hodges, is a consultant to CMS Cameron McKenna, where he advises, among other areas, on product liability and health care law. He has more than 16 years' experience of a range of issues involving the pharmacy sector, including commerce, regulation and ethics. PSNC chief executive Sue Sharpe said: "Christopher

Hodges has a sound understanding of community pharmacy, as well as a grasp of the wider health care environment derived both from his legal practice and his involvement with the Association of British Healthcare Industries and the [Government's] Health Industries Task Force."

Dr Hodges added: "Community pharmacists have very high standards of service and there are significant opportunities under the contract to deliver even better and more extensive care as the health care environment changes."

At the NPA, Ms McCreedy will take on the role of acting chief executive when current chief executive John D'Arcy departs. Ms McCreedy said: "It is a great privilege to take the reigns of the NPA at a time of considerable change. With the support of the NPA

board and executive team I will be ensuring the NPA continues to deliver for members over the coming months."

Umesh Patel, NPA chairman, added: "The board had no hesitation in making the appointment . . . Colette has a track record that speaks for itself."

Before joining the NPA, Ms McCreedy worked as a community pharmacist in both the UK and Switzerland.

Meanwhile, the Society has started its search for a chief executive to lead it through the structural change expected following the Government's recent proposals for the future regulation of health care professionals (see **Society** p381).

An advertisement has been placed in this week's *Journal* (see pA19) with another appearing in *The Sunday Times* last weekend.

Pharmacy developments have only just started, minister says

Developments in pharmacy services have only just begun to scratch the surface of what can be achieved, health minister Andy Burnham said at last week's Pharmaceutical Services Negotiating Committee annual dinner. "I am personally convinced the next decade will see community pharmacy having a much bigger role," he said.

Referring to plans to make better use of the whole pharmacy workforce, Mr Burnham gave an undertaking that patient safety would be at the forefront. That was why extensive consultation was taking place on the new role of responsible pharmacist in community pharmacy. "We will do nothing to jeopardise patient safety in implementing this measure," the minister stated.

Mr Burnham said that he had heard the concerns of pharmacists arising from the introduction of practice-based commissioning.

He was sure that the expertise and contribution of pharmacists needed to be brought to bear on the commissioning process and a project was being funded this year to support better integration of pharmacy with PBC.

"We hope this will stimulate greater pharmacy involvement to make a full contribution as we move forward in shaping service delivery for the future," Mr Burnham said.

But there will be further change, the minister warned, saying: "The commitment is there to help you deliver and make sure you are in the best possible place to contribute to the NHS of the future. I want pharmacy to feel it is on the front foot at all times — leading the way in transforming future service provision."

Meeting report p378



Craig Strong

Andy Burnham: commitment is there

Bids sought for EPS release 2 initial implementer sites

Expressions of interest are being sought from primary care trusts in England to be initial implementer sites for release 2 of the electronic prescription service, health minister Andy Burnham announced at the Pharmaceutical Services Negotiating Committee dinner held in London last week.

Release 2, which will include doctors being able to add digital signatures to electronic prescriptions and patients being able to nominate a pharmacy to dispense their medicines, is due to start later this year. NHS Connecting for Health is seeking to recruit initial implementer sites to use release 2 functions so that it can ensure interoperability and data integrity outside a test environment.

PCTs are invited to apply and to nominate GP practices and pharmacies that may be willing and suitable to take part. Pharmacies

must have some experience of dispensing repeat prescriptions and have business continuity plans (data back-up arrangements) in place.

Proposals should be received in writing or electronically by 17 May and sites are expected to be chosen by the end of June. There is no limit to the number of sites that PCTs can propose and NHS CfH is encouraging proposals from users of a broad range of systems, such as multiple and independent pharmacies, internet pharmacies, appliance contractors and dispensing doctors.

A letter and application form have been sent to PCTs and can be downloaded from the Department of Health website at www.dh.gov.uk and via *PJ Online* (www.pjonline.com/links/pj).

News in brief

SPGC to be renamed

Community Pharmacy Scotland is to be the new name of the Scottish Pharmaceutical General Council, Harry McQuillan, SPGC's chief executive officer, confirmed this week. "We wanted a name that was more representative of what we do," he said. The decision to change SPGC's name was made last November.

Medway seeks new head

The universities of Greenwich and Kent are seeking a new head of school for the Medway School of Pharmacy following the promotion of the current head, Clare Mackie, to pro-vice chancellor (see pA18).

Smoking ban helps people to quit

Scotland's ban on smoking in enclosed public places is inspiring people to quit the habit, health minister Andy Kerr claimed this week. He was speaking on 26 March: the first anniversary of the ban's introduction. "Latest statistics show a smoking rate of 24.6 per cent for the first three quarters of 2006, down from 26.2 per cent in 2005 — a greater decrease than in previous years," Mr Kerr said.

The statistics, published this week by ISD Scotland, show that 46,466 people in Scotland consulted NHS smoking cessation services in 2006. Numbers were highest between January and April, peaking in March. Nearly 5 per cent of smokers made an attempt to quit in 2006. Of those, 34 per cent were successful at one month, 34 per cent were smoking and 32 per cent were lost to follow-up.

The report notes wide variations in cessation services across NHS boards. "Areas with a large pharmacy scheme (which will tend to see large numbers of clients), such as Grampian and Greater Glasgow, have among



Decision to quit is being inspired by ban

the highest annual service uptake rates," it says. But it adds that, because pharmacy schemes are less intensive than smaller specialist services, quit rates tend to be lower.

□ **Prescribing statistics** ISD Scotland also released annual prescribing statistics this week. While prescribing of non-steroidal anti-inflammatory drugs fell, prescribing of anti-obesity drugs was up 16 per cent on the previous year.

Consider role pharmacy can play helping smokers quit after ban in England and Wales

Pharmacy should play a key role in supporting the increased demand on smoking cessation schemes that will be generated by the smoking bans in England and Wales, the Royal Pharmaceutical Society has declared.

Paul Gimson, the Society's lead for long-term conditions and public health, spoke at a conference organised by the Welsh Assembly Government last week, ahead of the introduction of the Welsh ban on smoking in public places on 2 April. He explained how smokers benefit from pharmacy-based services because of their accessibility and the opportunistic nature in which they can be accessed.

Speaking after the conference, Mr Gimson said: "There are many examples of pharmacists providing a smoking cessation service that adds considerable value to existing service provision. Unfortunately, despite the compelling argument and results, these services are not provided consistently across the country and their role is not effectively integrated into the wider health service. The demand for smoking cessation services doubled in Scotland after their ban and we would urge those preparing for the bans in Wales and England to consider the role that pharmacy can play in meeting this demand."

NICE advice on interventions to reduce substance misuse

Anyone who works with young people should be prepared to identify those who are vulnerable to drug problems and to step in and help them access the right support and services, says the National Institute for Health and Clinical Excellence.

NICE's guidance makes recommendations on community-based interventions to reduce substance misuse among vulnerable and disadvantaged young people. It is aimed at NHS practitioners, including those who are trained in motivational interviewing or group-based behavioural therapy, as well as, among others, teachers, school nurses and those working in social care and the criminal justice sector.

The guidance is available from the NICE website (www.nice.org.uk) and via *PJ Online* (www.pjonline.com/links/pj).

Oxygen headset fees agreed

Decommissioning fees for oxygen headsets have been agreed by the Pharmaceutical Services Negotiating Committee and the Department of Health.

Contractors will receive £50 for oxygen headsets purchased after 1 July 2004 and £25 for headsets bought before then. Payments will be subject to contractors' claims, which had to be submitted by 31 December 2006. Further information is available from the PSNC website (www.psn.org.uk) and via *PJ Online* (www.pjonline.com/links/pj).

The DoH has also announced that legislative changes to block the prescribing of oxygen on NHS prescription forms in England are expected shortly, although no date has yet been set for their implementation.

In addition, the Welsh Assembly Government has confirmed that claims for payment for oxygen supplied against a prescription up to 31 March may be submitted to the pricing authority until 5 April.

MURs will help make best use of free scripts Support for NHS prescription charge reform

Pharmacists in Wales can help patients make the best use of free prescriptions by offering medicines use reviews, says Community Pharmacy Wales. Speaking to *The Journal*, Peter Haydn Jones, chief executive of CPW, said: "What is important is that contractors embrace the MUR service to ensure medicines are being put to best use by patients, particularly as prescriptions become free of charge to all patients in Wales from 1 April."

Welsh First Minister Rhodri Morgan stressed that free prescriptions could lead to cost reductions as a result of savings in hospital care. "Many people are deterred from taking regular medication that would help them live healthier lives because of the cost of paying for regular prescriptions," he said. "If patients cannot afford the medicines they need to treat their condition, the long-term costs to the NHS could be far greater in terms of avoidable hospital treatment."

National Assembly for Wales statistics issued this week reveal that the number of prescriptions dispensed in the community increased from 56.6 million in 2005 to 58.9 million in 2006. However, the net ingredient cost per item decreased by 15p to £9.74.

Widespread support for reform of NHS prescription charges exists in Scotland, according to the findings of a Scottish Executive consultation. A report on the consultation, published last week, concludes: "Virtually all participants felt that the existing flat rate charge is too high and a significant proportion, particularly older people with a chronic condition and those on a lower income, felt strongly that charges should be abolished entirely."

According to the Scottish Executive's analysis of responses, there was general agreement that ability to pay should be the key consideration in any changes to the charging system. Public support for an exemption on the basis of long-term medical conditions was widespread, but this was not reflected among health boards and medical bodies.

There was also agreement that prepayment certificates should be better publicised and available to purchase in instalments.

Speaking after the report's publication, Lewis Macdonald, deputy health minister, said: "The findings of the Scottish Executive's review of NHS prescription charges are being given careful consideration."

Low-dose aspirin as effective as higher dose after percutaneous coronary intervention — and safer

Patients with acute coronary syndromes (ACS) undergoing percutaneous coronary intervention (PCI) experience similarly low rates of cardiovascular events with low-dose aspirin as those treated with higher doses, but with less risk of major bleeding, according to results from a major study.

A sub-analysis of the PCI-CURE study compared the safety and efficacy of low (≤ 100 mg), intermediate (101–199mg) and high (≥ 200 mg) doses of aspirin in 2,658 patients with ACS undergoing PCI.

Data presented earlier this week at the American College of Cardiology 56th

Annual Scientific Session, held in New Orleans, Louisiana, reveal similar rates of cardiovascular death, myocardial infarction or stroke in all of the aspirin dose groups at 30 days and at eight months (4.1 per cent with ≤ 100 mg aspirin versus 4.0 per cent with ≥ 200 mg at 30 days).

The incidence of major bleeding was not significantly different between the groups at 30 days (1.5 per cent with ≤ 100 mg aspirin versus 2.1 per cent with ≥ 200 mg), but was noticeably reduced with low-dose aspirin after eight months (1.9 per cent with ≤ 100 mg aspirin versus 3.9 per cent with ≥ 200 mg; haz-

ard ratio 2.21, 95 per cent confidence interval 1.25–3.89).

Shamir Mehta, associate professor of medicine at McMaster University, Canada, and one of the study investigators, said that the data warranted further investigation, particularly since higher doses of aspirin tend to be used routinely in the US, while lower doses are prescribed in post-PCI patients in Europe.

Dr Mehta has started a large randomised trial, known as CURRENT-OASIS 7, recruiting 16,000 patients from more than 40 countries to answer definitively the question of optimal aspirin dose.

Smokers miss out on advice on how to quit

Two out of three smokers are not being told by their doctor about the range of methods available to help them stop, warns a survey which highlights the need for improved provision of information on smoking cessation.

The survey of 3,760 adult smokers (aged 25 years and over) from 15 countries, including the UK, found that only 33 per cent said their doctor had explained the various methods of quitting smoking. In contrast, 66 per cent of nearly 3,000 doctors taking part in a related survey claimed that they had given their patients who smoke information about cessation methods.

Hayden McRobbie, research fellow at the clinical trials research unit at the University of Auckland, New Zealand, and programme director of the UK National Smoking Cessation Conference, said that advice from a health care professional, even when brief, is known to increase the success of smokers wanting to quit. Despite this, the surveys showed a major gap, with 41 per cent of doctors saying they discuss smoking with

their patients at every visit, compared with only 9 per cent of smokers reporting that this happened.

These surveys show the need for improved communication between smokers and health professionals, suggested Dr McRobbie. “Although smokers know that quitting smoking is the single biggest step to improving their health, the results show that patients often do not believe they are receiving the support and advice from their doctor that is vital to successfully quit smoking.” He argued that smoking should be managed as a chronic, relapsing medical condition that involves physical and psychological addiction to nicotine.

“Pharmacists are in an ideal position to talk to people about smoking cessation, including the range of methods available to help them quit,” he added.

The survey results were presented at the American College of Cardiology 56th Annual Scientific Session held in New Orleans, Louisiana, earlier this week.

Illicit drug classification does not reflect harm assessment

The framework used by the UK's Advisory Council on the Misuse of Drugs to assess the risks associated with illicit drugs is discussed in a *Lancet* article published last week (2007;369:1047).

The authors used the framework to rank a range of drugs, including those currently categorised into groups A, B and C within schedule 2 of the Misuse of Drugs Act as well as unclassified substances including alcohol, solvents and tobacco. They found a “surprisingly poor correlation” between drugs' harm ranking and their Misuse of Drugs Act classification, although class-A drugs heroin and cocaine were still ranked highest in terms of harm. The authors say that the method now used to assess harm is evidence based, but they are critical of the system used to classify drugs under the Misuse of Drugs Act. “The current classification system,” the authors say, “has evolved in an unsystematic way from somewhat arbitrary foundations with seemingly little scientific basis.”

Testosterone patch may address low libido in women with surgically induced menopause

A transdermal testosterone patch to treat loss of female sexual desire resulting from surgically induced menopause has been launched. Marketed by Procter & Gamble Pharmaceuticals as Intrinsa, the patch is licensed for the treatment of hypoactive sexual desire disorder in women who have undergone bilateral oophorectomy and hysterectomy and who are receiving oestrogen therapy.

The patch delivers 300mg of the hormone over 24 hours. This can be achieved by applying a new patch every three to four days. Each patch should be applied to a clean, dry area of skin on the lower abdomen below the waist — application sites should be rotated and

treatment should be appraised every six months.

All patients should be monitored for, and advised to self-assess, potential androgenic adverse effects, such as acne, changes in hair growth and hair loss.

In addition, the summary of product characteristics advises that, although signs of virilisation such as voice deepening, hirsutism or clitoromegaly were reversible in clinical trials, they may be irreversible in some cases and discontinuation of treatment should be considered if these symptoms occur.

Mild erythema and itching at the patch site is the most common adverse effect.

Notice-board p362



Intrinsa was made available this week