

Nearly half want pharmacists to stay in pharmacies

Nearly half the people and organisations that commented on the Government's plans to allow pharmacists to leave pharmacy premises while they are open for business were against the proposal.

The Department of Health's summary of responses to the consultation on the responsible pharmacist regulations records the fact that 41 per cent of the 311 responses opposed the plan.

A further 10 per cent said that they could not comment on the plans until proposals were published on how requirements for the supervision of dispensing and medicine sales might change (this is to be the subject of a separate consultation later this year).

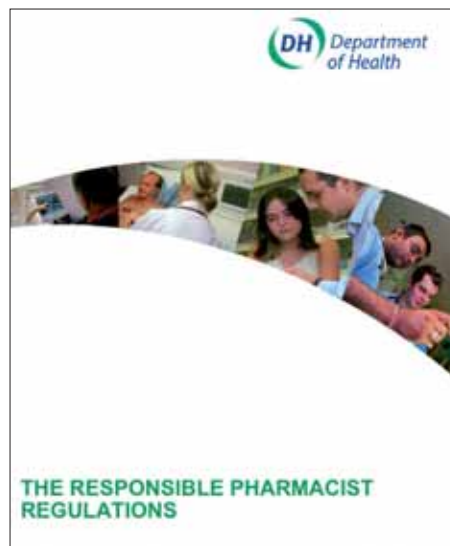
A smaller proportion of respondents (35 per cent) accepted that absences could be allowed, but that responsible pharmacists should spend most of their time on-site.

The majority of responses that addressed the question of pharmacy procedures said that clarity was needed on the specific statutory responsibilities of company superintendent pharmacists, responsible pharmacists and pharmacy owners. However, many of them said that it was impractical to expect responsible pharmacists to sign acceptance of the procedures every time responsibility passed from one pharmacist to another.

The report notes that 49 of the 311 responses, from both individuals and organisations, were the same and had apparently been written by one person.

The DoH has also published its response to the results of the consultation. The document is available at www.dh.gov.uk and via *PJ Online* (www.pjonline.com/pjlinks).

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Pandemic flu legislation changes supported

Most of the Government's proposals to amend medicines legislation in the event of an influenza pandemic are supported by those who responded to its initial consultation on the subject (*PJ*, 1 December 2007, p617). Respondents supported the idea that emergency supply should be extended to 28 days and suggested that this should be implemented at the earliest opportunity, rather than waiting for a pandemic. In its response, the Government confirms its commitment to consider this and indicates that it will be part of a further consultation.

The suggestion that expired and unused medicines should be supplied to patients was opposed by a significant minority and those that did support it wanted there to be explicit conditions specified and guidance produced. Some respondents opposed suggested

changes around Controlled Drugs but most supported the proposals, subject to conditions, clear guidance and protocols.

Most respondents did not agree that emergency legislation should be stopped immediately after the pandemic and suggested that a period of recovery, lasting two to six months, would be needed to allow for a return to normality in the production of medicines and the pharmacy supply chain; the Government accepted this suggestion.

The Government says that many of the possible changes will now be taken forward for further consideration in the required technical statutory consultations, led by the Medicines and Healthcare products Regulatory Agency and the Home Office. The summary of responses is available at www.dh.gov.uk and via *PJ Online* (www.pjonline.com/pjlinks).

Nigel Clarke chosen to chair Transitional Committee

Nigel Clarke has been appointed chairman of the Transitional Committee that will help with the development of a new professional body for pharmacy.

Mr Clarke — whose independent inquiry into the new body recommended that a transitional committee be set up — was selected for the role by the Royal Pharmaceutical Society's Council.

The Society's Vice-President Martin Astbury said that Mr Clarke had "already demonstrated to the profession through his independent report that he is able to work across pharmacy and to reflect the views and needs of pharmacists".

The committee, to be known as Transcom, will produce a prospectus for the new professional body by the end of 2008.

On-call payments adjustment postponed

The current structure by which hospital pharmacists receive payment for on-call duties will continue until 31 March 2010, the NHS Staff Council has agreed. The structure, originally agreed under the previous Whitley grading system, pays pharmacists approximately £2,500 per year to contribute to the on-call service.

Under the terms and conditions of Agenda for Change, the on-call arrangements are due to be adjusted, but the current structure was protected until the end of September 2008. This protection period has now been extended until March 2010, during which a sub-group of the council will be convened to examine several aspects of on-call work and develop a new payment structure.

Dave Thornton, chairman of the terms and conditions committee, Guild of Healthcare Pharmacists, believes that this is good news for hospital pharmacists. The only structure of payment that is currently proposed to replace the Whitley model would result in a reduction in salary for most pharmacists who provide an on-call service, he said.

"We are aware of several trusts that [were planning to] revert to these payments in October," he added. "The extension will prevent this from happening."

The guild will work with the health sector of union Unite to ensure the views of its members are considered during further negotiations. Any proposals that are developed will be subjected to a ballot of union members.

Search for RX Factor

The search is on for pharmacists who have the knowledge and charisma to be the faces of pharmacy. The Royal Pharmaceutical Society launched its "Pharmacy RX Factor" competition this week, with the aim of selecting four individuals to represent pharmacy in England, Wales, Scotland and Great Britain. The winners will receive professional media training and have the chance to take part in national and regional media campaigns in 2009.

Anyone who thinks they have what it takes is invited to send a colour, passport-size photograph, a copy of their CV and 300 words about why they think they have the RX Factor to Kate Thatcher, public relations and membership assistant, 1 Lambeth High Street, London SE1 7JN, by 1 July.

NICE advocates diabetes education

Every patient with type 2 diabetes should be offered structured education when he or she is diagnosed, the National Institute for Health and Clinical Excellence suggests in updated guidance, published this week.

The new guideline on managing type 2 diabetes recommends that people with the condition, and their carers, should be made aware that structured education is an integral part of diabetes care, and this should take the form of a group education programme, provided locally.

NICE also provides advice on clinical matters, such as assessment of blood glucose control, blood-glucose-lowering therapy, blood pressure and cholesterol management, and neuropathic complications.

Self-monitoring of blood glucose should be offered to newly diagnosed patients only as part of a self-management education programme, NICE recommends.

Launch of the guideline coincides with a call from the charity Diabetes UK for better communication between healthcare professionals and people with type 2 diabetes.

The charity believes that some 650,000 people with type 2 diabetes are not taking the medicines prescribed to treat the condition. Many such patients do not understand why oral hypoglycaemic medicines have been pre-

scribed or the long-term consequences of not taking them, Diabetes UK said this week.

New NICE guidelines are available on the institute's website (www.nice.org.uk) and via *PJ Online* (www.pjonline.com/pjlinks).

□ **NICE on cholesterol** Guidance on identifying people most at risk of cardiovascular disease (CVD) and who should be treated with statins has been published this week by NICE. People should be prioritised on the basis of an estimate of their CVD risk before a full formal risk assessment, NICE recommends.

Before offering lipid modification therapy for primary prevention of CVD, other modifiable risk factors — such as smoking status, alcohol consumption, blood pressure and obesity — should be identified and managed if possible, NICE recommends.

For primary prevention, NICE says that simvastatin 40mg (or a statin of similar efficacy or acquisition cost) should be offered to adults over 40 years of age who have a 20 per cent or greater 10-year risk of developing CVD. Higher intensity statin therapy or treatment with fibrates or anion exchange resins should not be offered routinely.

Lipid modification therapy with simvastatin 40mg (or equivalent) should be offered as soon as possible in the presence of CVD (secondary prevention), the institute suggests.

NICE appraisal of drugs for ankylosing spondylitis and anaemia

This week NICE accepted adalimumab and etanercept, but not infliximab, for treatment of adults with severe active ankylosing spondylitis. The treatments are approved for patients with sustained active spinal disease (confirmed on two occasions at least 12 weeks apart) who have not benefited from therapy with two or more non-steroidal anti-inflammatory drugs taken at the maximum recommended dose for four weeks.

In a separate technology appraisal NICE has stipulated that erythropoietin analogues (epoetin alfa, epoetin beta and darbepoetin alfa) should not be used routinely for managing anaemia induced by cancer treatment. NICE says that erythropoietins can be used in combination with intravenous iron as an option for women receiving platinum-based chemotherapy for ovarian cancer who have symptomatic anaemia (haemoglobin 8g/100ml or lower), or for people who cannot be given blood transfusions and who have profound chemotherapy-related anaemia that is likely to impact on their survival.

Both appraisals are available from www.nice.org.uk and via *PJ Online* (www.pjonline.com/pjlinks).

Early insulin in type 2 diabetes beneficial

Further evidence that early intensive insulin therapy for newly diagnosed type 2 diabetes patients can help the body's β -cells recover and restore blood glucose control emerged this week (*The Lancet* 2008;371:1753).

In a trial of 382 patients in China, aged 25–70 years with type 2 diabetes, participants were randomised to receive a continuous subcutaneous insulin infusion, multiple daily insulin injections or standard oral hypoglycaemic medicines. Treatment was stopped after normoglycaemia was restored for two weeks and patients were followed up on diet and exercise alone for one year.

The researchers found that 97.1 per cent of patients in the infusion group achieved normoglycaemia within 4.0 days and 95.2 per

cent in the injection group achieved it within 5.6 days. This compared with 83.5 per cent of patients in the oral hypoglycaemics group achieving normoglycaemia within 9.3 days.

After one year, more patients in the insulin groups maintained blood glucose control than in the oral medication group (51.1 per cent and 44.9 per cent versus 26.7 per cent; $P=0.0012$). The researchers propose several mechanisms to explain the difference in remission rates, such as insulin affecting the metabolic memory and impeding the progression from metabolic abnormalities to irreversible cellular and epigenetic changes.

“Our findings support the initiation of early transient intensive insulin treatment in those patients,” they conclude.

Tailored care package fails to improve glycaemic control



Ian Hooton/Science Photo Library

Blood pressure was lowered in the intervention group

Some cardiovascular benefits are achieved with an enhanced diabetes care package for UK residents of South Asian origin, but improving glycaemic control remains a major challenge, according to a study published in a diabetes special issue of *The Lancet* (2008;371:1769).

A total of 1,486 newly diagnosed type 2 diabetes patients of South Asian origin from 21 inner city practices in the UK were randomised to receive enhanced care — including additional time with a practice nurse, support from an Asian link worker and input from a diabetes specialist nurse — or standard care. Primary outcomes were changes in blood pressure, total cholesterol and glycaemic control after two years.

The researchers recorded a reduction in diastolic blood pressure ($P=0.0001$) and arterial pressure ($P=0.0180$) in the intervention group compared with the placebo group but no difference in total cholesterol, systolic blood pressure or HbA_{1c}.

Over the study population as a whole, the researchers recorded improvements in blood pressure and total cholesterol (but not in HbA_{1c}). These improvements were associated with increased prescribing of antihypertensives and statins and are consistent with those reported by other investigators after the introduction of the Quality and Outcomes Framework (which started during the course of the study), they say.

“In view of the healthcare resources provided, we find it disappointing that neither the QOF incentives nor our culturally sensitive enhanced care package significantly effected glycaemic control,” say the researchers.

The authors of an accompanying editorial (*ibid* p1728) suggest that a substantial structured patient-education component seemed to be missing from the study.

Alia Gilani, a bilingual prescribing support pharmacist for NHS Glasgow, believes that pharmacists are ideally placed in the community to support South Asian diabetes patients and help reduce inequalities. Pharmacist independent prescribers can allow patients quicker access to medicines and are able to monitor adherence, she added.

Trusts' safety alert responses variable, study shows

Huge variation exists across trusts in adopting safety alerts, researchers from York and Cardiff universities have shown.

They were commissioned to carry out an evaluation of the Safety Alert Broadcast System (SABS) in 20 acute trusts, 15 primary care trusts, four ambulance and two mental health trusts in England for one year to June 2007.

The team also assessed the role of SABS liaison officers whose responsibility it is to disseminate safety alerts, and if they are relevant to their trust, to ensure action is taken by their organisation.

The researchers examined 12 alerts. They found that 22 per cent of survey respondents said that their trust did not have a policy or procedure for managing alerts and, in some cases, old medical devices were still being used. Front-line staff awareness of what alerts actually said was also patchy, the findings showed.

Some alerts are straightforward but many require cultural changes, which trusts did not seem to account for. "Trusts did not look at

an alert and say, 'What does that mean for us as an organisation?'," said Karin Lowson, a health economist at York University and lead author. "Some are a lot more complicated than others but trusts did not seem to take that on board."

The researchers have devised a series of steps that trusts could use to consider each alert as it comes out. These include questions such as how many patients does it affect, what are the funding implications, is it an ongoing alert, what are the organisational issues, and which groups of patients and staff does it affect.

When the researchers evaluated the roles of SABS officers they found that they had variable levels of responsibility and authority. People with 216 different job titles were given the role — some administration staff and some in senior posts. Many spent little time on SABS.

"They often did not report up to the board, had a wide portfolio and that part of their role was quite small so there were a lot

of issues around empowering that person," said Ms Lowson at the Patient Safety Congress 2008, held in London last week.

Whether they have the right set of skills was another factor; non-clinical staff were often given the role although many of the alerts involved clinical issues.

The study, carried out for the Patient Safety Research Programme, recommended that staff working as SABS liaison officers should be given extra support. It also recommended that trusts rigorously audit alerts that have significant impact on their organisation and ensure they are implemented instead of focusing on the process of sending them out across departments.

Examples of alerts examined included reducing harm from misplaced nasogastric feeding tubes, avoidance of latex allergy in patients and staff, and reducing harm from oral methotrexate.

A report of the meeting will be published in next week's *Journal*.

Society offers award for medicines safety

A new award that recognises significant contributions to improving medicines safety in Britain is to be offered by The Royal Pharmaceutical Society.

Speaking at the Society's annual general meeting on 21 May, the outgoing President, Hemant Patel, said that the Council had given the award the go-ahead earlier in the day. It was an important step towards achieving his ambition, expressed when he was re-elected President in June 2007, that Britain should become the safest place in the world to receive medicines.

Applications for the award would be invited later in the year and the first award would be made in 2009.

Pilot study demonstrates reduction in medication-related events through pharmacists' and technicians' interventions

Pharmacists and pharmacy technicians have been shown to make a significant contribution to preventing medication-related events during a one-week pilot study at a busy London hospital.

The pharmacy-led study, presented at the Patient Safety Congress 2008 in London last week, was conducted at the Royal Brompton and Harefield NHS Trust during August 2006.

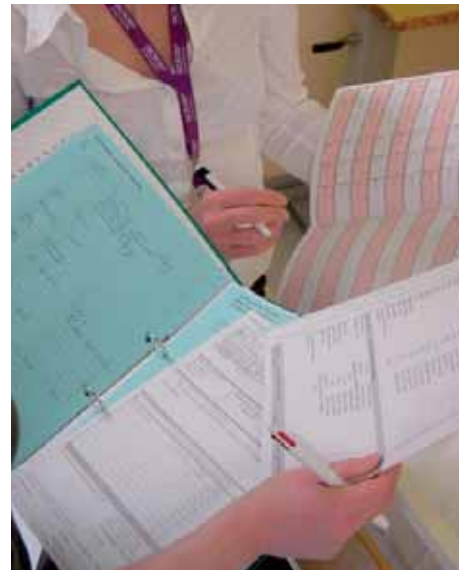
The study picked up 298 medication-related events. Of these, 96 per cent (286) were prescribing errors, 3 per cent (9) were administration errors and 1 per cent were (3) pharmacy errors. No internal or external dispensing errors were reported.

Of the prescribing errors reported, 30 adverse incidents occurred. The other 256 events were near misses and were prevented through corrections by 24 pharmacists and two pharmacy technicians.

There was an even spread of events during the working week — with an average of 43 per day. This highlights the increased risk of medication-related adverse events occurring at weekends due to lack of pharmacy monitoring, say the researchers.

Jeremy Liew, senior principal pharmacist for clinical governance and research at the trust, told *The Journal*: "Before this we did not know how many errors pharmacists were picking up and the errors were not graded for potential to harm patients. The study shows that pharmacists are doing a good job at stopping medication-related errors before they translate to real harm."

The researchers found that a significant proportion of the reported prescribing errors



Pharmacy team shown to reduce medication errors

related to doses that needed amending according to patients' renal status. "Pharmacists are skilled in tailoring doses according to blood results, particularly for drugs with a narrow therapeutic index," Mr Liew pointed out.

The researchers say that, since the study is a pilot, it is difficult to extrapolate or generalise using these data. However, they now intend to pilot a new database to capture data over a longer period. They also hope to have input from a multidisciplinary panel on grading near misses and their potential to harm patients.

PJ Online

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Prescribing and medicines management (P&MM)

Articles on prescribing and medicines management; the latest concerns patients taking warfarin and problems revealed by medicines use reviews. Also links to back issues (2002–2007) of the *P&MM* bulletin.
www.pjonline.com/pmm

Parallel trade

A three-part series on parallel imports. It looks at the history, recent challenges to the legality, and rules governing the sale of parallel-imported products.
www.pjonline.com/series

Opposition to EU plan to ban medicines repackaging

An EC proposal to ban the repackaging of medicines to help stamp out drug counterfeiting has attracted widespread opposition.

The Medicines and Healthcare products Regulatory Agency, the Guild of Healthcare Pharmacists and the Pharmaceutical Group of the European Union all share concerns about the proposal, which is part of a wider consultation package.

The MHRA, on behalf of the Government, says the ban would prevent importers from elsewhere in the EU meeting UK regulations requiring that all medicines should have labels and patient leaflets in English in both primary and secondary containers. It also believes that sealing the outer packaging of products would have little effect in combating counterfeiting because seals can easily be copied.

The guild says that pharmacists must retain their legal right to open packs to maintain patient safety. A proposal to restrict the opening of the end package to the end-user fails to define a pharmacist in that capacity.

Banning pharmacists from opening packs could, for example, affect the supply of medicines in small doses to suicidal patients, the guild says, adding: "The pharmaceutical industry is unlikely ever to be able to produce

the number and range of packs required for specialist work." A ban would also prevent pharmacists checking the contents of a medicine's container in the interest of patient safety.

The PGEU, which represents community pharmacists from 30 European countries, says that a repackaging ban would discourage parallel trade in medicines. It also warns that a ban on opening sealed products could mean patient information leaflets have to be attached to the outside of medicine containers, which patients could find unacceptable.

Patient safety could also be put at risk if they have to deal with multilevel packaging and more than one patient leaflet, it says.

The comments come in response to a suite of proposals, published in March, which the EC Directorate-General for Enterprise and Industry believes will help identify counterfeit medicines circulating in the EU and stamp out the fraud (*PJ*, 29 March, p356).

Seizures of counterfeit goods at EU borders rose to over 43,000 in 2007, a nearly 17 per cent increase on the previous year, statistics released by the EU last week reveal. Over 2,000 of the seizures were counterfeit



Nikolaos Sourmelakis/Stockphoto

medicines, corresponding to more than four million items — a 51 per cent increase on 2006.

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DoH reminded of pharmacists' role in helping minority ethnic groups

The Department of Health is being reminded of the key role community pharmacists can play in helping to meet the needs of black and minority ethnic (BME) patients in England.

The Royal Pharmaceutical Society has written to remind ministers that the pharmacy White Paper urges commissioners to create innovative and imaginative solutions to improve patients' access to and choice of services.

The letter is in response to two reports from the department that look to GPs to improve BME services in primary care.

Paul Bennett, chairman of the Society's English Pharmacy Board, commented: "Addi-

tional GP services will have a positive effect on the health of all groups within affected communities, but an intelligent commissioning process can enhance existing services with a smaller drain on NHS funds. Diverting larger sums of money to develop GP practices simply to duplicate services would waste valuable resources. The Government has recognised that it is important to provide alternative sources of healthcare provision that appeal to hard-to-reach social groups — such as [in] a less formal health setting."

He pointed out that pharmacists, based in every community, are an obvious but under-used resource in improving primary care

services for BME groups. Pharmacies are open at convenient times without the need for an appointment and often when GP surgeries are closed, he said. Some 99 per cent of the public are within 20 minutes of a pharmacy and almost three-quarters of pharmacies have private consultation areas where patients can discuss health issues."

He also reminded the DoH that pharmacists can provide expert advice and treatment for a wide range of minor ailments and are increasingly taking on new roles such as checking for cardiovascular problems and diabetes — conditions with a higher incidence in BME groups than in other groups.

PGEU promotes pharmacists' help with adherence problems

Including community pharmacists in multidisciplinary care teams can help patients who have problems adhering to therapy, according to a new policy document from the Pharmaceutical Group of the European Union.

The document, presented to the European Parliament earlier this month, says: "Pharmacists' direct and frequent contact with the patient, their easy availability and their unique expertise in medicines put them in a key position . . . to provide an effective contribution to any intervention intended to promote patients' adherence to therapies with the ultimate goal of improving patient health outcomes."

On long-term conditions, the document points out that pharmacists need to be able to present the benefits and risks of medicines in such a way that patients can make informed decisions and be encouraged to take their medicines appropriately. It adds that appropriate training of pharmacists is needed to ensure that pharmacy specialised services are implemented to their full potential.

"Targeting adherence: improving patient outcomes in Europe through community pharmacists' intervention" can be downloaded from the PGEU website (www.pgeu.eu).

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Melatonin is launched as a POM for short-term insomnia

Pharmacists may be asked to dispense melatonin on prescription for patients with short-term insomnia, following the launch of Circadin melatonin tablets as a prescription-only medicine next week.

Circadin 2mg prolonged-release tablets are indicated for short-term monotherapy of patients 55 years or older with primary insomnia. One tablet should be taken once daily, one to two hours before bedtime, after food, and continued for three weeks.

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