

Community contract poses challenges

Issues that have emerged since the implementation of the new community pharmacy contract were discussed at the annual conference of the British Association of Pharmaceutical Wholesalers last week. **Gemma Cleveland** reports

John D'Arcy, chairman of the National Pharmacy Association, highlighted some of the issues that have arisen from the new contract, particularly in terms of its impact on patients and GPs. He started by talking about medicine use reviews: "The problem with MURs is that nobody knows what they are. Patients are unaware of them, and, in a general sense, patients are unaware of the contract." The contract needs to be promoted gradually so that pharmacists can get their head around it, he said. The NPA has introduced an advertising campaign, but more needs to be done to make consumers aware, particularly of MURs. For the first time pharmacists have to go out and sell their services and the concept of MURs, said Mr D'Arcy.

The second area of low awareness lies with GPs. Currently GPs are reimbursed for full medication reviews, which are a step up from MURs. The GPs do not see how pharmacy MURs fit within their contract and they do not see why they should have to receive loads of additional paperwork. GPs need to be encouraged to understand the importance of MURs, where they fit in and how they can be of benefit, eg, perhaps as a precursor to them carrying out a full medication review.

Another challenge for community pharmacists relates to them having to provide a consultation area: one that is signposted, comfortable and confidential, so that the consultation cannot be overheard. Achieving this is not easy in a community pharmacy.

With regard to information systems, a lot of the services under the new contract are

predicated on record keeping and sharing information. A written record of an MUR, for example, is sent off to the GP. However, the GPs are coming back and saying that they do not want any more information and certainly do not want information on a form written by hand. "To me this cries out that we need some kind of electronic link," Mr D'Arcy said. "So in terms of pharmacy and IT, it has got to go further than just the proposed electronic prescribing service," he added. Mr D'Arcy said that he believes a system needs to be developed where pharmacists are able to interact with the electronic patient record kept by the GPs.

"SOPitis" is hitting pharmacy at the moment," Mr D'Arcy said regarding the clinical governance aspect of the new contract. Pharmacists historically are not good at writing things down, he said. Some standard operating procedures are clearly sensible and fairly easy to do, but how do you write an SOP for a self-medication service, or health promotion? This is clearly not as easy and pharmacists are finding this part of the contract challenging, he said.

Waste is also an issue. Mr D'Arcy explained that as part of the contract's essential services, pharmacists are now required to take back and manage waste. However, a conflict exists in that it is against environmental health regulations to do so. Pharmacists can collect waste from a residential home, but they are breaking the environmental health law if they collect it without a licence. A lot of pharmacies are losing care home business because of

their inability to collect waste. There is also the issue of pharmacists being required to take back sharps, needles and syringes. Again, it is a breach of regulations to take these back when the pharmacist is not part of a proper needle exchange scheme, he said.

There also seems to be an issue emerging over the services provided by pharmacists under the Disability Discrimination Act. As part of the new contract, a small agreed sum has been added to each prescription item to cover the pharmacist making a reasonable adjustment in the case of a disabled person, eg, creating a Braille label or putting together a monitored dosage system. However, some primary care trusts and GPs, believing that costs are covered (GPs especially, who have been writing seven-day prescriptions so that pharmacists get four fees a month rather than one fee) are encouraging patients to demand MDSs as a right. This is something that needs to be factored into the cost of service model, said Mr D'Arcy.

On a national level, Mr D'Arcy said that devolution was becoming a challenge, with each of the four countries of the UK becoming more and more different to each other. "Each country is looking to do something bigger, better and 'whizzier'," he said. There are four different health care approaches and four different contracts for pharmacy. However, here lies an opportunity to take examples of successful initiatives throughout the UK and encourage other governments that are not incorporating them yet to take them on board, he said.

Improving drug safety: consider the human factor

Patient safety is an important issue for the NHS, said David Cousins, head of safe medication practice at the National Patient Safety Agency. Information from NHS bodies shows that between February and November 2005, 35,000 medicines incidents were reported. "A lot of these incidents have not actually led to harm this time. However, this does not mean there will be no consequences," he said.

There are a couple of myths regarding human error, explained Professor Cousins. The first is the "perfection" myth, instilled at schools, where, if people try hard enough, they will not make mistakes that pose a threat to safety, ie, you are a bad professional if an error or incident occurs, he said. The other is

the "punishment" myth. The thought that those who make mistakes should not be allowed to continue; "if there are some bad apples, get rid of them and make them go away," he said.

Professor Cousins also said it is a myth that if a medicine has a EU marketing authorisation it will be safe in use. "Marketing authorisations do not take into account human factor considerations," he said. There is no "user testing" of the final product before it is shipped to patients. Clinical trials do not look at the final product.

Professor Cousins said that the NPSA is recommending the NHS not just to take trial data into account when appending drugs to formularies, but also to look at the product's appearance and the label, and assess possible causes for a mix up.

The NPSA is encouraging appropriate secondary warning labels, barcodes and solu-

tion concentrates that do not need complex calculations to make up. Professor Cousins spoke about the publication "Information design for patient safety" that the NPSA has produced with the Royal College of Art, which provides guidelines for packaging design (ideal colour combinations and fonts) to avoid confusion and mistakes being made due to packaging. "Patients get confused when everything looks the same," he said.

Patients are also telling the NPSA that they are receiving generic medicines from different manufacturers every single month. They are asking their pharmacists for greater brand continuity but the pharmacists are saying that it is the wholesalers who send the stock and that they cannot do anything about the system. For the sake of these patients and their safety maybe pharmacists should be working with the wholesalers to create some kind of continuity, said Professor Cousins.

The British Association of Pharmaceutical Wholesalers annual conference was held in Ware, Hertfordshire, on 7 June