

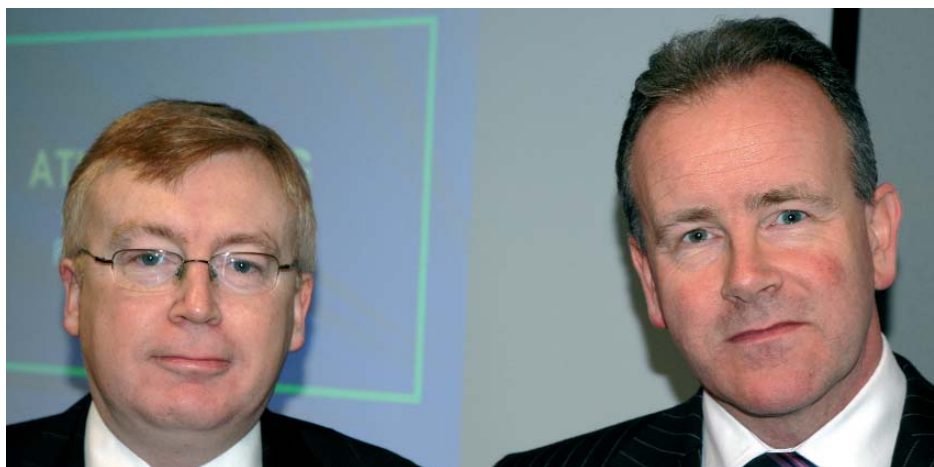
Pharmacy family must confront reforms

Alison Ewing reports on presentations given by the chief pharmacist for England and the chief executive of the National Pharmacy Association

As a result of the White Paper “Our Health, Our Care, Our Say”, there will be a shift of significant resources from secondary to primary care and this will be a potential driver for involving new health providers and competition into the market for health services, said Keith Ridge, chief pharmacist for England. For pharmacy, this offers an opportunity to transform processes to improve the quality of care and reforms must be confronted by the pharmacy family, taking patients and the public with them, Dr Ridge continued. For example, primary care trusts will have to involve the public more.

Dr Ridge also predicted increased information needs for the commissioning cycle in the newly structured NHS. Pharmaceutical care assessments have been carried out in community pharmacy, but not many hospitals have done this, and Dr Ridge suggested that the needs assessment process might be better done for pharmacy on a local health economy basis, through a joined up approach. Reforms, such as independent prescribing, the new community contract and the Health Act 2006, may open up opportunities for referral between members of the pharmacy family but they will need training for it to work, he added.

So how should pharmacy respond? “It is all about professionalism,” Dr Ridge claimed. The medical profession, through the Royal College of Physicians and in the aftermath of Shipman, published a framework for modern medical professionalism. Dr Ridge believes that this approach is equally applicable to pharmacy and should involve a system of collaborative leadership. This could be helpful for the pharmacy family, particularly when the Foster review has cast doubt on the Royal Pharmaceutical Society’s dual role, he noted. Dr Ridge cited an example of good collaborative working in Sheffield where 109 community pharmacies have worked with 72 GP



Keith Ridge (left) and John D’Arcy: pharmacy should respond to changes with collaboration and professionalism

practices to provide services, including minor ailments schemes, to 72,000 patients. The city’s community pharmacies also carry out high level medicines use reviews, and are successful in smoking cessation and sexual health services. One reason for the success is that hospital pharmacy had input into the scheme, Dr Ridge said.

John D’Arcy, chief executive of the National Pharmacy Association, said that the multitude of recent changes has caused mounting professional frustration and uncertainty — pharmacy had political recognition, but post-contract euphoria is wearing off. The contract has resulted in roles and responsibilities on top of existing roles. MURs are included in the core funding element but are still problematic. Enhanced services are seen by primary care organisations as a solution to meeting health targets. Emphasis has shifted from supply to clinical services, but it is essential that input to supply is maintained, he said.

In terms of the pharmacy family, Mr D’Arcy commented that there is a great deal

of fragmentation within the profession: “there is a plethora of community pharmacy bodies — NPA, the Pharmaceutical Services Negotiating Committee, the Scottish Pharmaceutical General Council, Community Pharmacy Wales, Primary Care Contracting, the Company Chemists Association and the Independent Pharmacy Federation, to name but a few, — with further fragmentation between community, hospital, primary care and industry.” However, it is not the number of bodies but their collective efficacy that is important. “It is essential to work together to add value. Pharmacy is a small lobby so must do everything possible to punch above its weight, having one voice on key issues. A divided voice is no voice at all,” Mr D’Arcy explained, before using the cohesive working of the All Party Pharmacy Group as an example. The opportunity exists for greater coalescence. To develop pharmacy’s clinical role in this exciting time, pharmacy must work smarter and more collaboratively, Mr D’Arcy concluded.

ADRs impact on Payment by Results

Almost one in six inpatients experience an adverse drug reaction (ADR) after admission to hospital, the initial analysis of a study has shown. Associated factors include increasing age, being female and increased length of stay. Little research has been published in this area, but previous research had shown that around 6.5 per cent of hospital admissions were due to ADRs and the equivalent of seven 800-bed hospitals are occupied by ADR patients, costing £446m per annum.

Emma Davies, pharmacist at the Royal Liverpool and Broadgreen University Hospitals NHS Trust, is assessing the burden of ADRs on in-patients in a UK hospital, as

her PhD research. “Prolongation of hospital stay was politically relevant given the new Payment by Results system for funding secondary care,” she explained. Despite the huge range of medicines used in hospitals, commonly used drugs with predictable ADRs are the commonest causes of an adverse reaction and most reactions are potentially preventable, Ms Davies said. Further study is being done to see if there are predictability indicators that can help prevent ADRs.



The Association of Teaching Hospital Pharmacists meeting took place in Runcorn on 23 November

Electronic prescribing

Many challenges must be overcome to make e-prescribing systems fit for purpose in an NHS environment, said Brian Power, lead IT pharmacist at Wirral Hospitals NHS Trust. While e-prescribing offers advantages, pharmacists need to ensure that the systems being offered to the NHS deliver without compromising patient safety (eg, they should include basic prescribing safety features). These systems also need to support local formulary control and it must not be assumed that they can work in all areas regardless of their complexity. There needs to be flexibility to adapt to high risk areas, such as paediatrics, Mr Power said.