

Is there a future for community pharmacy in public health?

From Mr H. R. Patel, FRPharmS

Your report of the 10th UK Public Health Association Forum by Dr Jill Jesson (P7, 16 November, p725) exposes a lack of appreciation by pharmacists and their representatives on national pharmacy bodies of the urgent need to develop a wider understanding of public health and public health pharmacy.

Dr Jesson laments the fact that there was no community pharmacy input to the conference. At the same time she urges community pharmacy to have a presence at such meetings if it wants to be seen as a major player in public health.

Relying on the traditional role of dispensing and acting as traders will not make our contribution to health care relevant to others. Dr Jesson is right to urge pharmacy to think more widely if

it wants a future that is appreciative of community pharmacists' role in improving health.

What "Our healthier nation" made clear was that there is a need for well-trained public health professionals from all disciplines to promote work on reducing health inequalities and to provide the necessary skills to understand the health needs of different commu-

nities. It was also recognised that a cadre of public health practitioners was needed, as was the promotion of public health approaches in all health professions, senior management, local authorities and communities.

Pharmacy has an undoubted contribution to make as acknowledged by the activities of the National Pharmaceutical Associ-

ation, which has got itself involved in many schemes around the country. It is the NPA's belief that community pharmacists are a major resource for public health but their potential has to be activated.

Whom should community pharmacists look to for support in order to take their rightful place in delivering growing public health service? Serving, protecting and promoting community pharmacy's role in public health has to be some organisation's responsibility if there is to be a future in the local health economies. When will pharmacy learn that three levels of practice — specialists, practitioners and those with a role in health improvement — are needed to play an integrated role in primary care? Dr Jesson's point is that to be irreplaceable and effective, we have to be seen by local planners as an integral and valuable part of the public health network. Thus, damaging pharmacy would damage the planners' own interests and enhancing pharmacy would enhance their own interests.

Hemant Patel
Brentwood, Essex

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Engaging community pharmacy in NHS planning

From Mr A. B. McCoig,
MRPharmS

Hemant Patel's thought provoking article (*PJ*, 16 November, p714) and Dr Jill Jesson's report on the UK Public Health Association's Forum (*ibid*, p725) serve to reinforce the current state of National Health Service planning culture.

The simple truth is that senior and lead NHS executives consistently fail to factor community pharmacy into any broad plans for the future of health services nationally. This in turn means that we are all faced with different and disparate debates and negotiations for the involvement and procurement of additional pharmaceutical services locally.

The latest attempt by the Department of Health to impose its wishes on local primary care trusts came in the form of the new three-year plan. Mr Patel is right to alert us all to the pitfalls in this and puts us on notice to act promptly to safeguard and promote our rightful engagement and interests. The publication of the three-year plan provides us yet again with opportunities to put pharmacy into the PCT frame when they consider how best to achieve the proposed targets laid out in the document. Our continued exclusion in name is lamentable and is not only disappointing but intellectually irresponsible from an NHS viewpoint.

Blindness towards the pharmacy constituency is an affliction peculiar to the DoH when considering how best to manage expanding capacity and access in the NHS. We also have an important role to play in public health; this is one of the most glaring areas of omission that occurs with monotonous regularity. Dr Jesson's criticism, however, of the lack of pharmacist presence at the most recent UKPHA conference is unworthy. Attendance at such an event lasting three days would cost the participant at least £1,500 in hotel bills, conference fees and locum cover.

As a result of the continuing exclusion of pharmacy involve-

ment and representation from all major NHS planning teams, is it any wonder that pharmacists fail both to register a presence and to obtain funding for such gatherings? I belong to both the London Public Health Taskforce on Inequalities and the London Modernisation Board as a representative of almost 2,000 community pharmacists who deliver services in the capital. My inclusion on these bodies was not automatic; the London Pharmacy Forum had to make forceful representations through various routes and contacts to gain entry and claim a seat at these tables. There is no central funding for me to attend such gatherings; neither is there any mechanism to reimburse my expenses from the regional office.

PCTs are now charged with being "radical" in order to achieve targets and milestones set within the plan. In my view, based on information received from the various pan-London committees, there is no chance of ever achieving the targets set for employing more GPs and consultants in the three-year plan. The term "wishful thinking" springs to mind when one considers that the London region is currently trying to attract 71 doctors from Europe at a cost of £20-£30,000 per doctor in recruitment expenses alone. Armed with this information and given the position of GP retirements nationally, one would conclude that PCTs should be in some meaningful dialogue about health care provision with local pharmaceutical committee representatives around the country. Sadly, I doubt that many of us are engaged in such discussions.

However, let us be optimistic. We should allow some time for PCTs to digest the enormity of the challenge that has been set before we ask for an audience. PCTs have been sent Plan A. There is no Plan B except to note that local organisations will have to modify the original plan in order to meet their collective responsibilities. Pharmacy must be included in these arrangements to allow for the best chance of targets being achieved on a broad front.

Andrew McCoig
Chairman, London Pharmacy
Forum
Secretary, Croydon Local
Pharmaceutical Committee

PSNC advice on NHS three-year plans

From Mr M. J. King,
MRPharmS

Although the latest announcement on planning services for the National Health Service (*PJ*, 16 November, p698) may have "passed *The Journal* by", it did not escape the notice of the Pharmaceutical Services Negotiating Committee.

The PSNC ran a series of seminars for local pharmaceutical committees from 4 to 18 October on developing additional pharmaceutical services at which we explained to the 120 delegates who attended the arrangements for the new three-year NHS planning cycle.

The seminar highlighted the opportunities and guided local pharmaceutical committees on how to become involved.

Furthermore the latest edition of the PSNC *Community Pharmacy News*, published in early November, featured an article on the new cycle.

A briefing paper for LPCs, expanding on the arrangements and providing action points for LPCs, was published by the PSNC on 15 November and is available on the PSNC website (www.psnc.org.uk).

Michael King
Head of Professional Development
and Local Pharmaceutical
Committee Services
Pharmaceutical Services
Negotiating Committee

Endorsing prescriptions for dressings

From Ms C. A. Watson,
MRPharmS

Clinical governance and continuing professional development are concepts that we should willingly embrace to enhance the image of our profession.

However, in return, I look forward to the day when a pharmacist will be trusted to endorse prescriptions for dressings with missing information without having to send them back to the prescriber for initialling.

Carol Watson
Derby

How should dispensed insulin preparations be labelled?

From Mr N. A. Caldwell,
MRPharmS

How should insulin preparations ideally be labelled? For example, is it better to label soluble insulin, "Inject 14 units twice daily subcutaneously before meals, as directed", or simply, "Inject subcutaneously as directed"?

Within our hospital trust we supply inpatient insulin to wards without dosing instruction. We wait for the insulin dose to be "stabilised" and a discharge prescription order requested, before we retrieve the supply from the ward and relabel it with "full instructions," or supply a second lot of insulin with "full instructions." The accuracy of "full instructions" is, however, a moot point.

Insulin requirements for individual patients vary depending on diet, physical activity and general health. So while a patient normally takes 14 units twice daily, for a large meal at a restaurant they may increase their short acting preprandial boost to 20 units. Is there, therefore, any point labelling the insulin with the number of units to be injected if dosing varies?

In addition, when patients go home, the insulin dose required to achieve normoglycaemia may be quite different in the home setting compared with that required in the hospital. Again, why then label with dose?

Although I am sympathetic to the call for good professional practice where we avoid ambiguous labelling, eg, "Take as directed", with insulin therapy is there any other way to communicate dosing information? Why fool ourselves into thinking we are providing an accurate service, when patients may ignore what is on the label, and do what the diabetes specialist team has trained them to do?

I would welcome comments from colleagues as to how they tackle this dilemma.

Neil Caldwell
Deputy Chief Pharmacist, Clinical
Services,
Wirral Hospital NHS Trust
e-mail neil.caldwell@wbnt.nhs.uk

Need for rational and realistic fees

From Mrs T. C. Jenns,
MRPharmS

While browsing through my Drug Tariff recently, I had a look at the section that deals with the extra fee of 40p that is paid when a threshold quantity is exceeded.

The quantities and entries appear to be entirely random, for example:

- 1 Aprinox 2.5mg 53; Aprinox 5mg 56; bendroflumethiazide 2.5mg 63; bendroflumethiazide 5mg 62
- 1 Lipostat 10mg 60; no other strengths listed
- 1 Zocor 10mg 61; Zocor 20mg 67; simvastatin 20mg 67; no other strengths listed
- 1 Lipitor not listed
- 1 Losec capsules 20mg 70; no other strengths or tablets or generics listed
- 1 Zoton not listed
- 1 Zirtek tablets 45; generic not listed

- 1 Thyroxine 25µg 95; thyroxine 50µg 115; thyroxine 100µg 85; Eltroxin 50µg 107; Eltroxin 100µg 80

Who is responsible for updating this list and how are the quantities decided? Should it be based on an excess of two months supply, eg, 57 for a once daily dose? If so why are all the quantities different? The list needs a radical overhaul to reflect modern prescribing and all drugs (and dressings and appliance) should have a threshold quantity set. This could be put next to the relevant entry in parts VIII and IX. If a proprietary product, eg, Zantac was prescribed, the same level as the generic entry for ranitidine could apply. Drugs not appearing in the tariff, eg, propranolol SR 80mg, would have to be listed elsewhere.

It is in our interest to get this looked into so that we receive rational and realistic fees.

Tessa Jenns
Wimbourne, Dorset

Dr GORDON GEDDES, head of information and technical services, Pharmaceutical Services

Negotiating Committee, replies: Fees related to threshold quantities were introduced with effect from 1 September 1987 to offset the discontinuation of differential on-cost. At that time, the PSNC became increasingly aware of the tendency of medical practices in some areas to issue repeat prescriptions for longer treatment periods up to six months in some cases. This practice was not uniform throughout England and Wales. Before the introduction of a flat on-cost rate (and its eventual disappearance) a switch to longer term prescribing had been partially offset by a higher on-cost rate. Thus a fee related to the treatment period became a PSNC objective.

ADR REPORTING

Certainty is not necessary

From Mr C. Anton

Louise Hughes and colleagues deserve praise for researching into the poorly understood area of recognising symptoms or

adverse drug reactions (P7, 16 November, p719). However, there was one important omission in the paper. The Committee on Safety of Medicines now asks that all drugs used in children should be treated as "black triangle" drugs and all suspected adverse reactions should be reported.

Therefore, I would add to their useful advice to community pharmacists that they should encourage parents to inform them of any ADRs experienced by their children.

It was also interesting to read some of the comments, particularly the pharmacist who began "We must make sure . . .". The CSM does not require certainty before reporting only a suspicion. So pharmacists should use their clinical judgement and experience to decide the facts, but they should not be put off reporting because they cannot be sure.

Christopher Anton
Administrative Co-ordinator,
West Midlands Centre for Adverse
Drug Reaction Reporting,
City Hospital,
Birmingham

Established routines must be maintained

From Mrs S. Davis, MRPharmS

I am the carer of a sufferer of Parkinson's disease. I am also a member of the Parkinson's Disease Society. This organisation produces a quarterly magazine for its members as well as a large number of informative leaflets for sufferers and their carers.

Over the years, I have been embarrassed to read correspondence from readers regarding the mismanagement of their medication while they have been in hospital, often for reasons unrelated to their Parkinson's disease.

Parkinson's disease is a variable condition. No two patients experience the same pattern of symptoms or response to medication. Patients and their carers learn to devise a timetable for administering their medicines, which gives the optimum benefits for their particular situation. Having established a regimen that suits the patient's needs, it is a cause of distress to find that control of their medicines is taken out of their hands as soon as they enter hospital. The consequences of disturbing these administration patterns can be painful and unpleasant.

My understanding is that in recent years medicines administration in hospital has been directed towards consulting and informing patients and giving them more control over their medicines. The slavish observance of precisely timed drug rounds with the medicines trolley was, I believed, becoming a thing of the past. The fact that letters describing bad experiences in hospital keep appearing seems to indicate that this is not happening everywhere.

May I make a plea to ward pharmacists that they take the time (which I know is at a premium) to listen to Parkinson's disease sufferers and ensure that they continue to receive their medicines at times that suit them best? We, as a profession, must educate other health professionals, such as nurses, about the importance of recognising and observing established drug regimens in order to maintain what is often hard-won disease control.

Susan Davis
Stroud, Gloucestershire

Other funding factors may be limiting access

From Dr R. Prettyman

As an old age psychiatrist involved in the treatment of people with Alzheimer's disease and the prescription of cholinesterase inhibitor drugs I was interested to read the paper by Shubhra Mace and David Taylor (*PJ*, 9 November, p680) describing, among other things, the current pattern of funding for these drugs in England and Wales. I was, however, slightly surprised to note that there appeared to be a limited budget for these drugs in only 11 health authorities.

In my discussions with colleagues in different parts of the country I cannot recall hearing of anywhere where funding for this treatment is entirely unrestricted. The other issues which need consideration in relation to funding are the associated non-drug costs (medical and other manpower costs, administration costs, pharmacy costs, etc). If these are under-resourced they may well constitute the main factor limiting access to treatment.

Richard Prettyman
Senior Lecturer in Psychiatry for
the Elderly
University of Leicester

Unhindered by pharmaceutical knowledge

From Dr B. Wells, MRPharmS

I was interested to read the letter from Dorothy Drury (*PJ*, 19 October, p565) which quite correctly drew attention to the need for all who sell medicines to be properly trained. I suppose that this should include newsagents, grocers, supermarket staff or even slot machines. She also singled out those who may sell medicines to our President at car boot sales.

However, I would hope that, as an eminent pharmacist, Marshall Davies would be aware of the properties of any medicines obtained from such a source, especially as some of the products identified by Mrs Drury are on

special offer at his previous place of employment.

Mrs Drury, however, does highlight the fact that pharmaceutical distribution to consumers is becoming an increasingly diverse activity involving many members of the public, who are able to operate in a whole range of fields, unhindered by pharmaceutical knowledge, professional restrictions or disciplinary procedures. It would be useful if the Royal Pharmaceutical Society could tap into the rich veins of experience and expertise available in this group and possibly even seek to appoint representatives from it to the Council, with a view to better regulating pharmacists. It would be interesting to see if there is any support for the adoption of such an idea, as the benefits are self-evident.

Brian Wells
Aldbrough, East Yorkshire

Unambiguous instructions are needed

From Mr G. J. Weaver,
MRPharmS

Pharmaceutical suppliers are against photocopying patient information leaflets (*PJ*, 9 November, p666). Prescribers vigorously defend their right to prescribe part packs. Pharmacists are required to include PILs with dispensed medicines. We need an immediate and unambiguous instructions from the Royal Pharmaceutical Society law department on how dispensers can comply with their obligations.

To make my question more specific I include this example: Buccastem 3mg is available in packs of 50 which include one PIL with clear diagrams. I find it not uncommon to dispense three or four times from this pack.

G. J. Weaver
Bath

STEPHEN LUTENER, head of professional conduct, Royal Pharmaceutical Society, states: The Medicines Control Agency has recently consulted the Royal Pharmaceutical Society and others on its proposals to introduce legislation which would permit the photocopying or downloading of patient information

It would be helpful if all letters contributors would supply a daytime telephone number.

leaflets. This was one of a number of measures considered, which would aid compliance with the requirement that all supplies of medicines are accompanied by a PIL. Other measures being considered include encouraging prescribers to adopt patient pack quantities when writing prescriptions, and permitting "rounding" by pharmacists where amounts prescribed do not correspond with patient packs.

The Society does not believe that photocopying leaflets is a solution to the problems facing pharmacists because of professional and practical difficulties. In making our response, we have repeated our offer to the Department of Health and the Medicines Control Agency to meet to discuss ways forward, since we are all in agreement that it is necessary to provide a PIL with every medicine supplied, in order to fully inform, and therefore protect the patient.

Give equal weighting to hospital and community

From Mr J. Harris and
Mr N. Sewak

As preregistration trainees, we read with some incredulity the article on preregistration cross-sector training (*PJ*, 9 November, p682). We believe that cross-sector training is a vital part of the process of helping pharmacists in the future to be well rounded, and promote better links between the hospital and community sectors. What we struggle to understand is how the article contributors can believe that two weeks is sufficient time, in a different area, to gain useful insight with regard to potential future careers.

The University of Bradford sandwich degree allows a full six months to be allocated each to community and hospital pharmacy. This provides the chance for preregistration trainees to see the complete spectrum of pharmacy, including things like pharmacist-led clinics and consultant ward

rounds in hospital pharmacy, and nursing home and domiciliary oxygen services in community pharmacy. This simply is not possible in a two-week period, and can only produce a distorted image of what pharmacy is today. This is typified by the Sainsbury's employees saying that they spent too much time in the hospital dispensary. Any hospital pharmacist will tell you that they do not spend the majority of their time there, yet there was the potential for the Sainsbury's students to leave with that impression.

We believe that the only way that true cross-sector training can be achieved is to give equal weighting to both hospital and community placements. Each area teaches different skills. Let us give people the chance to gain the full experience of both, and then decide on a future career.

James Harris
Preregistration Trainee
C&A Brack Pharmacy
York

Navin Sewak
Preregistration Trainee
Nu-Pharm Chemists Ltd
Hyde, Manchester

CPD

What is being done to increase relevance to industry?

From Mr A. F. Pleuvry,
MRPharmS

Mike How's letter (*PJ*, November 16, p713) makes sorry reading. However, I am pleased to note that Nigel Graham believes that the Royal Pharmaceutical Society's practice division devotes a considerable amount of time and resource solely to industrial pharmacy. Perhaps he would like to elaborate on that statement. What is being done to support industrial pharmacists apart from the Qualified Persons' scheme? For example, what is being done to make the continuing professional development scheme more relevant to industry, or is this part of a plot to disenfranchise those of us who may be perceived as not being "proper" pharmacists? If so, then perhaps it should be confirmed quickly before the annual

retention fees become payable, since most industrial pharmacists do not need to remain on the register for legal reasons.

Alex Pleuvry
Stockport,
Cheshire

Help with legal and ethical issues

From Professor J. Wingfield,
FRPharmS

Pharmacists seeking professional development through sound techniques for defensible decision making will have been helped by Ruth McGuire's article (*PJ*, 2 November, p647). Those seeking specifically to juggle complex and sometimes conflicting legal and ethical issues in decision making may also find help in the series of articles published five years ago in *The Pharmaceutical Journal* (1997, vol 259, p94, p129, p256, p290, p375, p548). These articles are supplemented and updated in the second edition of 'Practical exercises in pharmacy law and ethics' pub-

lished earlier this year by the Pharmaceutical Press.

Joy Wingfield
Nottingham

Responsibility

From Mrs C. Cooke, MRPharmS

How can any pharmacist who remains involved in pharmacy practice, either directly or indirectly, not be continually developing their expertise? What kind of pharmacist would I be if I had stopped learning when I graduated 27 years ago?

Continuing professional development is not just about learning new skills to move into different roles. It is regularly questioning ones current knowledge and practices, updating them and addressing any shortfalls. This takes place for me at work and in my own time and I would not expect it to be any different. This is, in my view, one of the responsibilities of belonging to a profession.

Catherine Cooke
Kingston bridge, Somerset

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CPD

We need special provisions to be made

From Mr G. Dilley, FRPharmS

Like Professor Edward Shellard (*PJ*, 9 November, p676), I have been a pharmacist for more than 60 years. I no longer work and shall not be able to participate in continuing professional development, but I want to remain a member of the Royal Pharmaceutical Society whenever CPD becomes compulsory.

Being a pharmacist has enriched my life and has been useful in that part of my work that has been outside pharmacy. I enjoy reading *The Pharmaceutical Journal* and struggle to keep abreast of developments.

For the number of pharmacists, myself included, who find themselves in the same position as Professor Shellard regarding CPD, special provision must be made.

Gordon Dilley
Exeter

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Academic achievements should be recognised

From Mr J. B. Morris,
MRPharmS

I have been following, with considerable interest, the concerns expressed by many members of the Royal Pharmaceutical Society who are either retired or currently working outside community or hospital pharmacy. Until my retirement I spent over 30 years working in the cosmetics industry but remained on the register.

My pharmaceutical knowledge was in constant demand and my qualification was both recognised and accepted by other professions around the commercial world.

Now it seems that I may be on a compulsory fast-track to non-membership because I have no intention or desire to comply with continuing professional development requirements. I appreciate the need for CPD but why apply it in such a blind and

inflexible manner? Those who are retired or working outside pharmacy have the right to have their academic achievements recognised and I would respectfully suggest that if MRPharmS is no longer available to them then PhC would do nicely.

John Morris
Northampton

One pharmacy register should be retained

From Mr D. A. Hancox,
MRPharmS

May I please clear up an apparent misunderstanding with Doreen Fine (*PJ*, 9 November, p676)?

I recently expressed the view that continuing professional development applied to all pharmacists and that any appraisal system had to recognise the individual nature of every pharmacist's practice (*PJ*, 26 October, p607).

We are therefore in agreement that different specialists will undertake different CPD. In pharmacy the CPD record of a pharmacist responsible for the provision of sterile pharmaceuticals will differ substantially from that of a pharmacist responsible for the provision of pharmacy services in a community pharmacy. Similarly, the CPD record of an academic pharmacist will differ from that of a pharmaceutical adviser to a health authority.

I also agree with her that a pharmacist whose expertise was entirely that of an industrial pharmacist should not undertake a locum in community pharmacy without he or she being able to demonstrate fitness to practise within community pharmacy.

Where we might disagree is in the need for separate registers of "practising" and "non-practising" pharmacists. To create such registers we have to define "practice" and we have to determine how a pharmacist can move from the "non-practising" register to the "practising" register.

Even if the definition of practice is restricted to one embracing community and hospital practice (and I do not believe it should be) there are problems. There may be a common core of knowledge, skill and

competence for community and hospital pharmacists. However there is also knowledge, skill and competence that is specific to specialties within these areas of practice. CPD cannot be restricted to the common core.

Why not keep it simple and retain one register together with a professional responsibility for every pharmacist to undertake, and maintain a record of, CPD that is consistent with continued ability to meet his or her specific responsibilities?

By this means we would all be able to demonstrate to our professional body at any time that we are taking appropriate steps to maintain our ability to meet those responsibilities. Furthermore, the Royal Pharmaceutical Society would have a system that gave reassurance to other health professionals, the general public and the Government that all pharmacists take appropriate steps to retain their individual fitness to practise.

Where does this leave Professor Edward Shellard (*PJ*, 9 November, p676), Doreen Fine (a primary school teacher) and others in similar positions? Such pharmacists would remain on the register but, in the absence of any supporting CPD, they would have no evidence to support their immediate engagement in any area of pharmacy practice.

Douglas Hancox
Auckland,
New Zealand

ONLOOKER

Excalibur was not pulled from a stone

From Mr S. J. Jones,
MRPharmS

I read with interest Onlooker's comments on the sword Excalibur (*PJ*, 16 November, p697). Although one could debate at length the historical basis for the Arthurian myth, and here I speak from experience, there is no basis for linking the sword pulled from the stone with Excalibur itself. The two weapons are distinct, both in the legends and in the nature of their potential origins in earlier mythology.

Stephen Jones
Newark,
Nottinghamshire