



■ CATEGORY M MEDICINES

## Excess payments could fund additional services

From Mr A. Lansley, MP

In response to my recent parliamentary questions, ministers have admitted the scale of excess payments for dispensing Category M medicines. My purpose in doing so has been twofold: first, to challenge the competence of the Government in managing the pharmacy contract, and, second, to expose the lack of the additional services which could have been commissioned with those resources.

I have been surprised by the response of some in the industry. They do not want the facts disclosed or discussed. "We cannot do this." The implications are too important. This involves several billion pounds of public spending.

The facts are clear. Large and increasing overpayments in 2005–06 and 2006–07 have led to sharp subsequent cuts in category M prices. This boom and bust is not in pharmacy's interests. Nor have I seen any evidence that the clawback has secured the taxpayer's interest in relation to the £811m overpayments in total, up to the end of March 2007.

I have asked the Pharmaceutical Services Negotiating Committee to publish the quarterly profit margin figures in this financial year (in a letter dated 5 February). I have yet to receive a reply.

It is my job to challenge the Government, in the interests of the public, as patients and taxpayers. So I have challenged its management

of the pharmacy contract. It is why I have championed the commissioning of additional services from pharmacies, especially in delivery of our public health objectives. It is why I hope those who want to see the original purposes of the pharmacy contract achieved, join us in challenging the Government's mismanagement of pharmacy services.

**Andrew Lansley**  
*Shadow Secretary of State for Health*

■ COMMUNITY PHARMACY

## Heavy workload is taking its toll

From Mr A. J. Jukes, MRPharmS

The last sentence of Catherine Watson's letter (*PJ*, 1 March, p244) hits the nail on the head: "We need our leaders to act."

We are reminded as professionals that our primary role is for the well-being of the patient. In recent years I have witnessed and heard of the increasingly adverse conditions and ever increasing workloads that affect the quality of care that pharmacists give patients.

The main themes related to workload seem to centre on low levels of support staff and suitably trained support staff, lack of work breaks and increasing demands that compromise the accuracy and quality of service provision, constituting a risk to patients from both medication errors and the inability of pharmacists to give a high quality, professional service. I know the Pharmacists' Defence

Association has done quality work on related issues, but unless someone enforces change through legislation with teeth or "leaders" actually act on concerns of members then the pharmacy profession will not be "sleeping walking into this state of affairs"; it will be in a coma.

The only other way forward is for professionals to remove themselves from the work premises. But, as Ms Watson rightly suggests, those with mortgages and similar financial commitments cannot do this and it should be a task for the leaders to address. As a locum in the south east of England, I and colleagues in the area now have a list of workplaces that are not considered safe to work in and cover will not be provided to these.

If no one enforces standards and effective methods to manage workload safely and therefore give the public the service they should expect from professionals, I can envisage the same scenario in future years. It is time certain quarters looked up the words

"leader" and "action" in the *Oxford English Dictionary* and supported people at the coalface.

**Andrew Jukes**  
*Brighton*

## We need legal guidelines on workload

From Dr M-L. Truong, MRPharmS

Mike Brunt (*PJ*, 23 February, p212) raised the issue of unreasonable workload. Are there any guidelines about the workload a pharmacist can reasonably accept and how you would set about making a sound judgement about this?

Perhaps we could adopt French practice, where the law requires a minimum number of pharmacists working in a pharmacy, linked to its annual turnover. If we were to adapt such a system, we could link it to the monthly number of items, for example. Alternatively, we could have a guideline to say that a pharmacist can do safely N1 items per day, while a pharmacist, plus a dispenser can do safely N2 items per day, and so on.

**Minh-Loc Truong**  
*Coventry*

**Telephone number**  
All correspondents should supply a daytime telephone number, in case we need to contact them urgently

## Letters to the editor

Letters are welcome from all readers. Letters for publication can be posted, faxed, or sent by e-mail to [letters@pharmj.org.uk](mailto:letters@pharmj.org.uk) and should not normally be of more than 400 words and should cover one topic only. *The Journal* reserves the right to abridge letters and to edit them for clarity and style. Pharmacist and registered pharmacy technician correspondents should supply their membership numbers, and a contact telephone number should always be given.

All letters are considered on their merit and are accepted for publication on the understanding that they have not appeared anywhere, including electronic media, previously. If the issue is of such significance that the correspondent has simultaneously submitted the letter elsewhere, it is the responsibility of the correspondent to inform *The Journal* at the time. Further to a recommendation by the Journal Oversight Board (*PJ*, 1 March 2008, p244), pharmacists and pharmacy technicians whose names appear on the non-practising part of the relevant register are asked to make their status known.

Letters that are critical of individuals, organisations or companies may be sent to the person or body concerned so that they are given a simultaneous right of reply. In these instances, the authors' identities will not be disclosed until publication, and publication will usually be delayed.

Anonymity will only be accepted in exceptional circumstances. These circumstances will be at the discretion of the editor and the decision made in consultation with the correspondent.

■ COMMUNITY PHARMACY

**Do supermarkets do it better?**

From Mr N. Ali, MRPharmS

Lord Mancroft, a Tory peer, sparked a debate on the NHS in the media last week. He made some less than flattering comments about nurses and their lack of professionalism.

What failed to hit the headlines were his comments expressing dissatisfaction with community pharmacy. He remarked how frustrated he becomes when it takes a pharmacy 40 minutes to dispense his medicine when he can see it on the shelf in front of him.

He contrasted pharmacy's inefficiency with the efficiency of British supermarkets. The sad reality is that most of the public equate the profession of pharmacy with retailers selling tins of beans.

Community pharmacy has lost its soul: healing patients has been sidelined and replaced by the drive for commercialism and profits.

**Nadim Ali**  
Pharmacy Lecturer  
Stow College, Glasgow

■ PRIMARY CARE CONTRACTS

**Break the doctors' monopoly**

From Mr Y. K. Tang, MRPharmS

I am amazed that the chairman of the British Medical Association's GPs Committee is advising his members to ignore primary care trust requests for information on practice opening hours and appointments (*HSJ*, 14 February).

GPs must be one of most blessed groups of private contractors on earth. Imagine a car manufacturer having almost the entire UK car industry to itself; able to dictate the price it is paid for products and the opening hours of its showrooms, while blocking and sabotaging attempts by other manufacturers to enter the market; receiving "incentives" to provide a high-quality and efficient service, which it already has the exclusive right to provide; being given taxpayers' money to install a new computer system that is essential to provide its next-generation products — all these while lecturing others that its main concern is its customers, while it threatens to boycott attempts to "privatise" the industry.

It is time GPs admitted that general medical practice needs

serious "restructuring". Two models come to mind: UK community pharmacy and Australian general practice. Both involve local commissioning by centrally appointed agencies and are excellent examples of public-private partnerships.

Patient choice precipitates cost-efficiency and cost-effectiveness. Competition is a powerful motivator, as customers vote with their feet. Having to register with a practice is a major obstacle to health reform, as is the reluctance to allow non-GPs to contract for general medical services.

The argument that GP-patient registration is one of the bedrocks of the UK primary care system is flawed. Patients in Australia are not required to register with a GP or practice. They carry a Medical Benefits Scheme (MBS) card and can use it to see any GP. UK patients are not required to register with a community pharmacy. Yet, most develop a long-term provider-patient relationship with their pharmacists.

The UK general practice system no longer works. It is time people and politicians admitted that GP practices are run as businesses and the most powerful stakeholders are neither patients nor taxpayers.

Multiplicity of service provision means nothing if patients are not allowed to exercise choice. A private enterprise that takes corporate social responsibility seriously can provide as good a service as a GP practice. But would any politician have the courage to take on the most powerful trade union in the NHS to introduce reforms that are long overdue? And, would the public have the insight to support those who do have that courage?

**Jonathan Tang**  
Westcliff-on-Sea, Essex

■ 100-HOUR PHARMACIES

**Holding back the flood**

From Mr M. A. Waldman, MRPharmS

The power of the primary care trust to deal with 100-hour pharmacy applications reminds me of the Dutch boy at the dyke, trying to hold back the flood. It is a farce, as the only outcome after the 45-day consultation period is "yes", otherwise the PCT will be in breach of the law and could face legal penalties.

It is not enough to be offering all the services, as there will not be the funds to pay for them. Every

pharmacy that opens will cost the PCT an average of £20,000 from the service allocation. Some areas have applications in the tens for 100-hour pharmacies. So the only chance that established pharmacies have is to lobby their MP right now to call a halt on regulation 13, which allows exemption under the 100-hour rule. MPs need to put pressure on health minister Dawn Primarolo to do this now and not wait for the Darzi report later this year. The Galbraith report is done but just sitting on a shelf; it needs to be activated.

**Maurice Waldman**  
Director Maurice Anthony Ltd,  
Chelmsford, Essex

■ PCT COMMISSIONING

**PCTs fail to identify local health needs**

From Mr M. James

The recent critical report from the National Audit Office on the new GP contract should draw the detailed attention of pharmacists.

The report notes that when the new GP contract was introduced the Department of Health devolved responsibility for commissioning additional enhanced services to primary care trusts. But the NAO found that some PCTs are commissioning and paying for "enhanced" services that are provided as essential services elsewhere.

The report states that "many PCTs lack the skills to identify and analyse local health needs and to negotiate appropriate services with local providers". The DoH continues to devolve commissioning power to PCTs regardless of whether a PCT has the skills to commission effectively.

The NAO found that 53 per cent of PCTs between 2004 and 2006 had not spent to the minimum level set by the DoH for enhanced GP services.

Although the findings relate to the GP contract they should concern community pharmacy. How can community pharmacy engage effectively with PCTs over local commissioning if PCTs are confused about what they should be commissioning and fail to meet commissioning targets?

The report noted that the new contract failed to meet one of its primary objectives: under-provision in deprived areas.

We know doctors have a heavy workload. We also know that pharmacies open longer than

surgeries, are visited more often by patients and that many are situated in deprived areas. Add to that the fact that people trust pharmacists as healthcare professionals.

So what could be done? GPs need to be incentivised, perhaps through the Quality and Outcomes Framework, to engage with other healthcare professionals, such as local pharmacists, to manage their workload better. GPs should be rewarded, not penalised, for streaming patients into appropriate care pathways. That could be the GP and surgery or a pharmacy, as the recent Pharmaceutical Services Negotiating Committee/Proprietary Association of Great Britain report on minor ailments pointed out.

Pharmacists play an important role in directing patients to GPs when appropriate. In future, GPs should be encouraged and rewarded for directing patients to pharmacies when appropriate. That would benefit GPs, patients and community pharmacy.

**Mark James**  
Group Managing Director,  
AAH Pharmaceuticals

■ PRESCRIPTION CHARGES

**Removing charges will lead to more waste**

From Mr A. R. Korsner, MRPharmS

There cannot be a pharmacist who is not frustrated by wasted medicines. A dozen inhalers, 15 pairs of stockings, 30 insulin pens and 200 colostomy bags are a few that come to mind as I examine my yellow sacks.

To throw away (conservatively) hundreds of pounds of returned medicines and then be told the NHS has insufficient funds for a decent pay award or extended roles, stretches the mind.

There is a maxim that one does not appreciate what one gets for free. Many hard-working people on low pay have to go without medicines, even for illnesses such as cancer, because of the high cost, while some well-heeled people get free medicines because of exemptions. This is a gross abuse of the ethos of the NHS.

When patients pay for medicines they often query the appropriateness or necessity of an item. Patients with private prescriptions for 100 tablets may opt to take half the quantity and come back if they need more.

I have never, in 30-plus years, had a patient ask for half the

quantity on an NHS prescription. Prescriptions should all be paid for, but at a more equitable level for all. A modest £1 or £2 charge would generate less waste and the savings could fund a better service.

Unlike Tessa Jenks (*PJ*, 1 March, p243), I think Scotland and Wales have made a mistake in removing charges and will pay the penalty in higher drug bills and waste disposal costs. If every item attracts the same fee, paperwork is saved; there is an automatic deduction and ETP services would not be compromised.

I have been advocating this for years and cannot understand why it has not been considered. I can only conclude that political expediency has outweighed patient care.

**Adrian Korsner**

*London*

#### ■ MEDICINES USE REVIEWS

### Evidence for extended pharmacy role

From Mr M. W. Beaman, FRPharmS

I congratulate Perry Melnick on his article on medicines use reviews (*PJ*, 8 March 2008, pp281–2). This is the sort of evidence that primary care trusts and local pharmaceutical committees need when promoting the value of the new pharmacy contract to GPs and commissioners. This report is timely in the light of the Darzi review and the forthcoming White Paper on the future of pharmacy.

Many pharmacies provide exemplary levels of service, but we do not always hear of their achievements. The NHS Collaborative on the new pharmacy contract, which ran from 2005 to 2006, published some of these achievements in the National Prescribing Centre report of April 2007. I hope the emergence of pharmacists with special interests will further this work.

**Mike Beaman**

*Rustington, West Sussex*

#### ■ DISPENSING

### Take back work from specialist laboratories

Mr L. J. Cope MRPharmS

The question of extemporaneous dispensing is not difficult to address.

In the early 1990s I worked in a pharmacy where the local GP held a clinic in dermatology at the local hospital. In a single morning we

would be called upon to dispense up to six extemporaneous ointments, creams and lotions. Most of these were compounded on a “slab” which had, in a previous existence, been the side window of a Mini. We made menthol and camphor in white soft paraffin and numerous bottles of sodium bicarbonate ear drops.

Early this century I was still making batches of L-thyroxine 10mg powders for an infant and, until I had to stop working, due to a stroke, I regularly made menthol in aqueous cream.

If the profession took a step back from the desire to be “second tier” doctors, spent more time at the bench, rather than carrying out medicines use reviews while the patients were waiting to have their prescriptions checked, the standing of pharmacy would be enhanced, and the recently qualified computer-literate “whizz-kids” could really practise their art.

I realise that some work will need to be handled by specialist laboratories, but most work carried out by them can safely and efficiently be done in a dispensary, by a competent pharmacist or dispenser. This would benefit the patient, and, in the long run, the cash-strapped NHS.

**Leslie Cope**

*Walsall, West Midlands*

#### ■ MINOR AILMENT SCHEME

### Pharmacists are under pressure

From Dr D. M. McNaughton, MRPharmS

How refreshing to read the letter from Nadim Ali regarding the Minor Ailment Scheme (MAS) in Scotland (*PJ*, 8 March, p273). Prescribing advisers for years have tried to persuade GPs not to prescribe the very items appearing in the MAS formulary.

Pharmacists may see the MAS scheme as a way of supporting GP colleagues in line with the advice from our political and civil servant masters but, surely, the stressful explanation of why we are not prescribing from a patients' shopping list of medicines shows pharmacists in a bad light.

Pharmacy staff can often feel pressured by customers (patients) to ask the pharmacist to prescribe when the presentation is not a minor ailment.

**David M. McNaughton**

*Edinburgh*

## ■ ADRS

**Miconazole oral gel and warfarin**

From Miss S. Baker, MRPharmS

I have become increasingly concerned about the lack of awareness among community pharmacists about the potentiation effect that miconazole oral gel has on warfarin.

I run community based INR clinics in County Durham, and over the past year I have had two cases where miconazole oral gel has been sold to patients taking warfarin. In both cases, the patient's INR increased drastically from their stable 2–3 range, to 15 in the first case and 9.5 in the second case.

The first patient had to be admitted to hospital for vitamin K treatment and the second patient was admitted with haematuria. The risk of bleeding to the patient at this high INR cannot be underestimated. Yellow cards have been completed on the above reactions. A third patient was sold the gel, but checked with the warfarin clinic first and we stopped her using it.

A quick literature search of the interaction shows numerous examples of dangerously high INRs when miconazole oral gel is used with warfarin. This interaction has a black dot in the BNF, yet patients are being placed at high risk of bleeding by being given the oral gel.

Miconazole oral gel should never be used concomitantly with warfarin, whether prescribed by a GP or sold OTC. It may be that extra training is needed for pharmacy staff on warfarin interactions, or that the packaging of miconazole gel should be altered to include a warning on use with warfarin. If the gel cannot be sold safely, then that seems to beg the question, should it revert back to a POM?

**Sonia Baker**

Warfarin Pharmacist  
Intrahealth Ltd, Co Durham

## ■ ASTHMA MANAGEMENT

**Is the proposed strategy smart?**

From Mr J. Knowles, MRPharmS

Anna Murphy provided a useful update on asthma management (*PJ*, 8 March, pp283–6), but pharmacists need to consider whether the so called "SMART strategy" is consistent with the

principles of current guidelines.

The maximum dose of inhaled steroid in adults with persistently poor control is 2,000µg per day of beclometasone equivalent according to the British Thoracic Society/Scottish Intercollegiate Guidelines Network. Patients using the "SMART strategy" could legitimately use 2,400µg of budesonide, putting them at increased risk of steroid adverse effects. I would suggest that until this AstraZeneca marketing strategy has been properly evaluated by SIGN or the National Institute for Health and Clinical Excellence, pharmacists continue to follow the evidence-based guidelines.

**John Knowles**

Lichfield, Staffordshire

**Monitor inhaler technique**

From Mr M. A. Charvonia, MRPharmS

Like Perry Melnick (*PJ*, 8 March, p281), I found asthma problems an excellent focus for medicines use reviews, as poor inhaler technique is one of the biggest barriers to good control. Pharmacists are in a unique position to help people with asthma understand the differences between the myriad of different devices and how to use them correctly.

Breath-activated devices only solve the problem of co-ordination. Although this is a common problem there are many others, such as not shaking first, not holding the device correctly, not breathing in at the optimal rate, not holding the puff in for long enough and not washing the device frequently. The last is rarely mentioned, but in my experience a CFC-free salbutamol inhaler clogs rapidly if not washed frequently and well before it stops completely, it is not giving a full dose. Patients using their inhaler daily probably need to wash it at least twice a week.

**Michael Charvonia**

London

## ■ NON-PRACTISING STATUS

**Title should reflect our professional status**

Mr D. R. Kent, MRPharmS

The declaration for non-practising status was recently amended to

read "...or give any advice whilst acting in the capacity of or holding myself out as a pharmacist". This amendment does not go far enough and should be further amended to read "...or give any advice whilst acting in the capacity of or holding myself out as a practising pharmacist".

I am a pharmacist by degree and a practising pharmacist by virtue of registration. I do not believe a professional qualification can be expunged by failure to pay a fee to a registration body.

The question of continuing professional development is a red herring. In my capacity as chief executive officer of a local pharmaceutical committee my CPD commitment can be more than adequately fulfilled by my non-clinical activities.

So long as a pharmacist makes it clear that he or she is not registered, any information and advice given can be considered in that light by the recipient.

I am a member of the Royal Society; but should I cease to be I will still be proud to call myself a pharmacist, but will make it clear, when appropriate, that I am no longer registered. I already inform, when necessary, that I am largely desk-bound.

I am aware that the title "pharmacist" is restricted; perhaps now is the time to amend the restricted title to "Registered pharmacist" for those registered with the Society and the title "Pharmacist" for those with an appropriate degree and training.

If we do not value our qualification, education and training why should we expect others to?

**David Kent**

Hadley Wood,  
Hertfordshire

## ■ THE SOCIETY

**Worries about costs may be unnecessary**

From Mr J. Ferguson, FRPharmS

In his responses to the letters from Mary Jobling and David McNaughton (*PJ*, 1 March, p246), the Treasurer states that the post of Deputy Registrar "has existed in the Society for many years".

To the best of my knowledge, this post has existed for fewer than 10 years. There was no Deputy Registrar during my time as Secretary and Registrar of the Society (1985–98) or when I was an Assistant Secretary (1967–75). A

post of Deputy Secretary was created about 1975. Perhaps this post was redesignated Deputy Registrar as external pressure grew on the Society to concentrate more on its regulatory rather than its representative role. One would assume, therefore, that the post and the associated costs will, in future, be within the General Pharmaceutical Council. Thus Ms Jobling and Mr McNaughton may be worrying unnecessarily.

Mr McNaughton suggests the sale of both the Lambeth and Edinburgh properties and a move of the Society as a voluntary membership body to serviced offices. Would it not be better to consider the annual income that could be provided, to keep annual subscriptions as low as possible, by renting the significant proportion of 1 Lambeth High Street that will become available when the GPhC staff move out? Funds provided by the members allowed the Society to purchase its original premises in Bloomsbury. The compulsory purchase of those properties by the government so that the National Library could be built opposite the British Museum (a plan later abandoned) provided the funds to build 1 Lambeth High Street, with a considerable additional reserve.

If the new Society is to be "akin to a Royal College" it will need to be appropriately housed. Perhaps my concern about moving to "serviced offices" is coloured by the experience of the National Pharmacy Association. When I joined the staff of the then National Pharmaceutical Union, it was housed in central London at properties it owned in Queen Square. Some years later it was decided to move to rented offices at Southgate in north London. When the original rent became subject to review it apparently became apparent that costs would rise so significantly that it would be better to relocate to premises that could be purchased in St Albans.

To the best of my recollection, the Edinburgh properties are owned by the Benevolent Fund.

**John Ferguson**

Haywards Heath,  
West Sussex

**Broad spectrum**

The Broad Spectrum feature is open to any reader. Contributions of around 1,100 words commenting on topical issues should be sent to [graeme.smith@pharmj.org.uk](mailto:graeme.smith@pharmj.org.uk) for consideration