Royal Pharmaceutical Society of Great Britain

Community Pharmacist

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FOREWORD

Dear Reader

The reality of practice-based commissioning will soon be upon us bringing challenges and opportunities. There is little time to waste and, as the saying goes, to fail to plan is to plan to fail. The Community Pharmacists Group is at the forefront and would urge you to follow the advice in our last newsletter (summary in this edition).

The roll-out of the new electronic prescription service is also looming. The opportunities are going to be there for the early adopters and woe betide the ones who do not keep up. They will be left behind and lose their market share.

Another unknown is the way the new boards for pharmacy will operate and how they will source their information. The Practice Committee, into which the CPG feeds, is closing down, ready for the new boards to take over its duties, but our work at the CPG continues unabated. There is a great deal for us to feed into the policy-making forum.

The Department of Health recently approached the Royal Pharmaceutical Society with a request for help with its "Early detection of cancer" project; the CPG immediately fielded two players. Community pharmacists will often be the first health care professionals to encounter early signs of cancer, eg, a persistent, untreatable cough. The earlier treatment begins, the better the outcome.

We are all aware of the risks associated with the sales of certain chemicals, particularly strong oxidising agents, but what about terrorism? Many purchasable products can be used to this end. Any suspicious requests for reagents should be referred to the police without delay. It is better to be thought over-cautious than to delay the detention of a terrorist.

Jeremy Clitheroe
CPG chairman

Pharmacists need to report instances of violence in the NHS

Cynthia Ludford, head of primary care for the NHS Security Management Service (in England), describes how and why pharmacists should be reporting any incidents of violence to the service

The NHS SMS has overall responsibility for all policy and operational matters related to the management of security across all NHS services, whether delivered by employed staff or contracted practitioners.

Although the remit covers all security-related matters, the first priority of the NHS SMS is to tackle violence against staff. In order to deliver this priority it is necessary to ensure that physical assaults on NHS staff are reported to the NHS SMS. The growing networks of local security management specialists (LSMSs) are responsible for this function and work related to it has been progressing for some time in trusts. The NHS SMS has published figures of assaults in all NHS trusts (see www.cfsms.nhs.uk). The figures for 2005–06 will be released in the near future.

It should be noted that the figures for primary care trusts reflect assaults on directly employed staff with few contractor professionals and staff yet reporting.

Violence against staff

The Physical Assault Reporting System (PARS) is in place and is designed to be used by all PCT staff and contractors, although not all PCTs are yet fully implementing this system for contractors. Some reports have been received from directly employed PCT staff but physical assaults are also experienced by those providing primary NHS care in such places as pharmacies, GP surgeries, opticians, walk-in clinics, dental practices and prisons. Unfortunately few of these physical assaults are reported to the PCT and therefore are unable to be recorded on the PARS system.

It is crucial to report physical assaults in these areas, so that the true nature and extent of the violence can be understood. Measures can then be developed to address these problems so as to ensure a more secure environment for all staff who deliver NHS care. As 90 per cent of interactions between patients and the NHS occur in these settings, it is essential to ensure the security of all professionals and staff who provide services.

The PARS reporting form can be made available to victims of physical assault by the PCT LSMS or can be downloaded direct from the NHS "Counter fraud and security management service" website (see www.cfsms.nhs.uk). When completed, the form should be sent to the LSMS.

The NHS SMS appreciates that not all PCTs have yet considered asking their LSMSs to look outwards to primary care practitioners and their staff and it is acknowledged that, in this early stage of PCT reconfiguration, it is not always clear who the LSMS or security management directorate is. However, where PCTs have already engaged closely with their primary care and community health care practitioners and staff, to tackle security-related incidents and breaches, it has shown dividends for both parties and greatly enhanced the working relationships.

Conflict resolution training

The NHS SMS has been tasked by the Secretary of State with ensuring the delivery

of conflict resolution training (CRT) (see "Conflict resolution training, implementing the national syllabus — 1 April" at www.cfsms.nhs.uk) to all those at the frontline of patient care, some 800,000 people in all, by 2008. This is progressing well. Discussions are under way with several professional and academic bodies to identify the most effective ways to deliver this syllabus to pharmacists and their staff.

In many PCTs, LSMSs are proactively raising the pro-security profile with their primary care colleagues by presenting at local professional committee or locality management meetings.

They are also pointing practitioners and staff to the wealth of important guidance, press releases, frameworks, newsletters and shared good practice from health bodies, which appears on the document area of the NHS CFSMS website. These include "Not alone — a guide for the better protection of lone workers in the NHS" and "Non-physical assault explanatory notes". Everyone who works in the NHS has the potential to be a lone worker at some time.

Reporting violence

Finally it is important to stress once more that all incidents of physical assault should initially be reported to the police. It is also essential that all incidents of physical assault on NHS staff are reported to NHS SMS through the LSMS using a PARS form, even if the incident is not pursued by the police.

The NHS SMS Legal Protection Unit can give legal advice to NHS bodies and individuals, and can consider taking forward cases on behalf of the victim in partnership with the appropriate trust or employing body when they have not been taken forward by the police or Crown Prosecution Service. There have been some successful outcomes and these will act as a deterrent to those who may be minded to be violent in the future. Case histories can be found on the NHS CFSMS website in the security management section.

For the purposes of reporting to the NHS SMS, a physical assault is defined as "the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort".

Together, we can tackle the problem of violence against staff, but the NHS SMS needs to know about incidents so that it can give direct support, guidance and information to prevent recurrence. You can greatly assist this process and help to improve security for yourselves and your colleagues who are working to deliver high-quality health care if you report the violence to the police and NHS SMS. Because of the central collation of information, your report may help to prevent a similar or worse incident occurring elsewhere in the NHS.

Queries should be directed to securitymanagement@cfsms.nhs.uk. Further information can be found on the website www.cfsms.nhs.uk.

Note that the NHS Security Management Service is an England-only organisation.

Long-term conditions: integrating the role of community pharmacy

Paul Gimson, lead for long-term conditions and public health at the Royal Pharmaceutical Society, reports on how the Society is working to integrate the role of pharmacy into the management of long-term conditions

The successful management of long-term conditions in the community is a key objective for the NHS. We all know, in theory, that community pharmacy is an under-utilised resource that should have a role to play, but how? This has always been a difficult question. The first stage of this work has been to develop a resource that brings together evidence for the community pharmacist's contribution to the management of long-term conditions, as well as options for mainstreaming these services. Alison Blenkinsopp, of Keele University, and Gianpiero Celino, of Webstar Health, were commissioned to carry out this work.

Three particular conditions were reviewed — asthma, coronary heart disease and diabetes — although the lessons learnt probably apply to most other long-term conditions also. Overall, the review findings indicate that the evidence base for effectiveness of community pharmacy services for people with the three reviewed conditions is as convincing as that which supports primary care nursing input. This is a valuable message to take to commissioners.

Where services add value, there is generally found one or more of the following key activities, which are listed in order of complexity. It is recommended that future services are based around these activities:

- Case finding
- Monitoring and information review

- Structured education
- Medication review
- Therapy management and prescribing

A brief summary of the findings is listed below. Specific practice examples are described in more detail within the original project.

Asthma

- The average community pharmacy serves around 450 people with asthma each year
- The project found and reviewed 10 intervention trials of community pharmacy-based asthma services
- Seven of the 10 trials showed positive effects on asthma control
- The most effective use of community pharmacy resources will be to focus on those whose asthma is less well controlled, or could become uncontrolled
- Several models of community pharmacy based asthma care are offered in the UK, usually on a pilot basis
- Community pharmacists have identified asthma as an area in which they would like to offer a more clinical service
- Other countries are sufficiently convinced by the evidence that they are funding a pharmacy-based asthma service

Coronary heart disease

- The average community pharmacy serves 122 people with angina and has 24 people each year needing treatment following a heart attack
- The published literature includes several trials of community pharmacy-based services which aim to reduce risk factors for coronary heart disease
- There is good evidence that community pharmacy-based services result in improved lipid levels and more patients reaching lipid targets
- There is some evidence that pharmacy services can improve blood pressure control
- Point-of-care testing for blood pressure and lipids is increasingly offered in community pharmacies but connectivity of the service with the wider NHS is unclear
- The project found one point-of-care testing service that could serve as a model for future developments
- Community pharmacists identified CHD

as an area in which they would like to offer a more clinical service

Diabetes

- The average community pharmacy serves 156 people with diabetes, 133 of whom have type 2 diabetes
- The average pharmacy can expect to have nine newly diagnosed patients with type 2 diabetes each year
- The published literature includes several trials of community pharmacy-based diabetes services
- Four out of five studies that measured diabetes control using a comparison with a control group showed a significant improvement
- The project found one pharmacy-based diabetes care service in the UK with a robust evaluation
- Both the trial results and the service evaluation indicate that the most effective use of community pharmacy resources will be to focus on people whose diabetes is less well controlled
- Community pharmacists identified diabetes as an area in which they would like to offer a more clinical service
- Other countries are sufficiently convinced by the evidence that they are funding a pharmacy-based diabetes service

Based on these results, eight key criteria of any good pharmacist-integrated supported service for people with long-term conditions were identified. These are:

- The pharmacist assesses the patient's readiness to change and adjusts the start date for the intervention where necessary
- The pharmacist provides education on the disease, helps identify key issues (eg, triggers in asthma) and works with the patient to develop an action plan for self management
- The patient participates in all decisions (eg, where the pharmacist intends to make a recommendation about a change in treatment)
- Therapy is monitored by the patient together with the pharmacist
- The pharmacist takes responsibility for outcomes and promotes evidence-based care. Outcomes are measured across a range of indicators (patient acceptability, hospital admissions, etc)
- The pharmacist-patient interaction is based on an appointment and occurs in a private consultation area
- The patient's GP is informed or consulted about all test results and interventions

In order for one of these services to happen, it was found certain enabling measures needed to be in place:

- Multidisciplinary involvement
- Externally recognised certification of programme
- Acceptance by referring doctors
- Effective marketing to doctors and patients
- Reimbursement of pharmacist

How services could be better integrated into the NHS

Barriers	Suggested solutions
Clarity and credibility	
GPs not aware of our potential	We need local champions to lead local engagement with GPs
Our leadership can appear fragmented and confusing to others	United leadership that develops and promotes the evidence base for clinical practice
We are not proactive in selling benefits of pharmacy to patients	Take the message to the public, harness their support to lobby others
Collaboration and competition	
Progress for pharmacy can be perceived to be a risk to GPs	Effective local engagement — familiarity diminishes the threat
Trust is dependent on positive personal experiences	Create time, opportunity and incentives for GPs and pharmacists to work together
GPs doubtful of community pharmacy's ability	Address concerns, develop the evidence base
Ability and willingness	
Access to information hinders progress	Make the case for access, demonstrate our potential
Turnover of pharmacists undermines relationships	Recognise value in relationships between pharmacists and GPs and patients
Pharmacists are not homogeneous — their aspirations differ	Avoid a one-size-fits-all approach

Mainstreaming of pharmacy

Despite the compelling evidence, few services are actually commissioned from community pharmacy. Through a number of stakeholder interviews and focus groups, the project found that the barriers to the integration of community pharmacy could be divided into clarity and credibility, collaboration and competition, and ability and willingness (see Panel).

Influencing change locally

It is not possible to be prescriptive about how to achieve a good pharmacy-supported service for people with long-term conditions. By definition, circumstances differ across Great Britain. However, the project made the following recommendations:

- Immediate involvement of pharmacy at the local level in discussions on commissioning
- Increased publicity to raise awareness of what pharmacists can do, based on evidence
- An accessible evidence base to demonstrate community pharmacy contribution, explaining links to key NHS targets
- Identifying service brokers, mentors and facilitators to link up providers and commissioners
- Skilling up, and providing tools for, local community pharmacy champions
- Developing model service specifications for long-term conditions, including patient care pathway and outcome measures that clearly demonstrate the value that pharmacy can bring

What can the Society do?

The Society is keen to take these findings forward, and is developing ways it can by:

- Actively disseminating the findings of the long-term conditions project
- Promoting pharmacy involvement in discussions on commissioning, both at a local and strategic level
- Using this work in its ongoing role of raising the profile of pharmacy
- Identifying pharmacy champions, and explore ways of supporting them
- Developing model service specifications

The full results of the project are now available on the Society's website (www.rpsgb.org) and can be used as a tool by those wishing to integrate community pharmacy into the management of long-term conditions.

What can you do?

The Society would welcome suggestions about how this work can be taken forward, but also urges individual pharmacists to think about what they could be doing. What are the local opportunities that you could harness? What is happening locally with commissioning? Who are the local pharmacy champions? Who are the movers and shakers? What can you do to influence the views of individual GPs and health planners?

Changes to Controlled Drug requirements

There have recently been a number of changes to the monitoring and inspection, prescribing, supply and record keeping requirements for Controlled Drugs. The changes, which are a mixture of legislative and good practice requirements, have led to a number of changes in day-to-day practice for pharmacists.

The Royal Pharmaceutical Society has created a special webpage that will help keep community pharmacists up to date. The page outlines the changes, clarifies whether they are legislative or a matter of good practice and provides links to further information (see www.rpsgb.org/worldofpharmacy).

Pharmacies are key to smoking cessation

As all pharmacists will no doubt be aware, bans on smoking in public places are in force in both Scotland and Wales, and come into force in England on 2 July. This inevitably has, and will lead to, an increased demand for smoking cessation services.

The role of pharmacists in smoking cessation is well established, with services ranging from the sale of over-the-counter medicines to full counselling sessions and supply via patient group directions. Pharmacies can be particularly effective, based on their location in the community and their accessibility. In spite of this case for pharmacy, and the bans, the level of additional services commissioned from pharmacy is low.

In order to support the development of pharmacy services, the Royal Pharmaceutical Society will be producing a number of fact sheets and signposting documents that are designed to support the pharmacist in developing pharmacy services and inform stakeholders about pharmacy's potential.

Community pharmacists should consider approaching their local health organisation and finding out what their plans are with regard to smoking cessation services.

If no services through pharmacy are planned, then ask why not?

PBC — what can you do at a local level?

Those wanting to find out more about practice-based commissioning should refer to last month's newsletter. The Community Pharmacists Group believes it is worth emphasising the points about what community pharmacists in England should be doing to get involved, mainly:

- Contacting PBC locality groups
- Talking to primary care trust commissioners about providing pharmacy advice to commissioning groups
- Ensuring that there is pharmacy representation on professional executive committees
- Talking to local GPs about their plans for PBC
- Finding out what the required format is for bids and tenders
- Finding out what local health care priorities are and what they can offer

HAG breaks barriers for enhanced services

Community pharmacists providing enhanced services will be well aware of the problem of not being able to provide that service in another area.

Until now, pharmacists wishing to move into another primary care trust were faced with the prospect of being deemed unqualified to work in that area, despite any previous experience and accreditation elsewhere.

The Harmonisation Accreditation Group (HAG), under the chairmanship of Gail Thomas and with Clive Moss-Barclay as its project director, have come up with the solution and have secured the written support of over 80 per cent of local PCTs in the north west. They are now looking to roll-out the project nationally.

At a recent presentation to the Royal Pharmaceutical Society's Practice Committee, Mr Moss-Barclay outlined the scheme. The aim of the group is to reduce the obstacles to the continuity and timely provision of enhanced community pharmacy services, thereby improving patient access to the services. This is being achieved by standardising accreditation requirements for community pharmacists across all PCTs in the north-west. PCTs have established reciprocal agreements for accepting pharmacists who have been accredited for an enhanced service in another PCT.

The HAG will define the core competencies required for a service and endorse suitable frameworks of training which can deliver these competencies. This will include identifying suitable learning programmes, for example, a Centre for Pharmacy Postgraduate Education training package. Once pharmacists are accredited they receive a HAG endorsed certificate and are qualified to provide the accredited service in any of the participating PCTs.

Further information can be found on the Primary Care Contracting website (www.primarycarecontracting.nhs.uk). The CPG warmly congratulates the Manchester-based Harmonisation Accreditation Group on its work and success in tackling and solving the tricky issue of cross-border accreditation for enhanced services within the NHS and hopes that this service becomes standardised across the whole country.

Professional executive committees — guiding PCTs

The Department of Health has recently published its guidance on the structure of primary care trust professional executive committees. This is potentially good news for pharmacy since the Government expects the professional executive committees fully to reflect the range of clinical professions and the wealth of experience this brings.

The exact purpose of a professional executive committee depends on the PCT, but in general they will be expected to support the PCT in developing its vision and strategic direction, commission services and support practice-based commissioning, advise on clinical effectiveness and clinical governance and lead on clinical communications with partners and stakeholders.

As with everything else, you need to find out what is happening at your PCT if you want to be involved and considered for membership. Those wishing to find out more can access the document at (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance).