



# Community *Pharmacist*

November 2007

## FOREWORD

### Dear Reader

I write with great pleasure that the Manchester-based Harmonisation of Accreditation Group, affectionately known as the "HAG", has won the NHS Alliance Acorn award and was short-listed for a Pharma award. All credit has to go to Gail Thomas, who chairs the group, and project director Clive Moss-Barclay.

In my other life as a local pharmaceutical committee secretary, I have plenty of reasons to be grateful to the HAG. Enhanced services under the NHS contract are nationally specified (as agreed between the Department of Health and the Pharmaceutical Services Negotiating Committee) and locally commissioned. So far, so good. That is, until you have people wanting to rewrite specifications. This is where the LPC office is involved. The telephone caller (mostly on Saturday mornings or bank holidays) is usually a locum who finds that the pharmacy he or she is providing cover for is contracted to provide enhanced services and wants to know if his or her training (usually undertaken miles away) satisfies local requirements. At present, all I can say is "maybe". HAG accreditation kitemarking will solve this. And with over 90 per cent of all primary care trusts already signed up to the scheme, I shall soon be able to assure enquirers that if they are HAG-kitemarked, they have a passport to practise freely across PCTs.

A final word on pseudoephedrine. The decision has been made. We are to have reduced pack sizes and products could soon be reformulated or become prescription only. Let us show that we are capable of acting as the safe custodians of P products which, while safe and efficacious, may be misused.

**Jeremy Clitherow**  
CPG chairman

## Enhanced services providers will need evidence of patient success

Andrew McCoig, member of the CPG committee and an independent contractor, discusses the need to start documenting interventions to reap the rewards of new commissioned services



For decades, community pharmacists and their assistants have done what they always do — respond to symptoms, advise on anything asked, diagnose minor and some not so minor illnesses and provide a remedy. Occasionally, the customer is referred to the doctor or an accident and emergency department. However, we have never documented our daily list of contacts and how we have dealt with each person who presents in a pharmacy for help and advice.

What a chore, you may scream. After all, we are not paid to document this activity; it is too numerous, sometimes complex and difficult to pin down when staff are busy. The only record of activity is the daily prescription item count, the number of enhanced service contacts (or we do not get paid) and the cash taken at

the end of the day. Job done, you might think. Think again. If we wish to progress down the enhanced service road and become providers of new commissioned services, we have to work smarter. We will need to document activity and collect evidence that we possess reasonable clinical skills which we are putting to effective use. More importantly, these skills could be set to work providing NHS patients with reasons to stay away from GPs and hospitals.

Collecting data and recording activity can be difficult and tedious. We have never had to prove ourselves to anyone except our customers and the Department of Health, with accurate prescription supplies. As night follows day, if you do not gain the respect of customers with your professional know-how, you will fail in



your pharmacy business. There is, however, an increasing need to prove to primary care organisations that what we do is effective, and cost-effective, if we want to develop enhanced services and expand the role of the pharmacist. Without hard evidence and clear audit to support our claims, we are relying on the anecdotal "this-is-what-we-do" statement.

## Evidence of clinical activity

One way of collecting evidence of clinical activity, apart from walking round with a clipboard all day long, is to look at the sales of certain categories of P products. For example, the two OTC brands of chloramphenicol eye drops would provide us with evidence of the kind of activity the primary care organisations are looking for. Optrex Infected Eyes and Broclor may only be sold with a pharmacist present and have to be stored in a refrigerator. Therefore, any customer presenting with an eye infection is bound to seek advice from the pharmacist. The sale, if appropriate,

would take place by the pharmacist (or a staff member) retrieving the product from the fridge, which cannot be accessed or viewed by the customer. It therefore cannot be a simple demand sale or impulse purchase. So there is always a clinical assessment and diagnosis leading to the supply of appropriate medication. Box ticked.

If the companies owning the brands would give us a breakdown of the numbers of eye-drop packs sold in each postal area, we would be able reasonably to claim that pharmacists have met X number of legitimate calls for help with infected eyes and have, therefore, prevented the same number of GP contacts.

## Work smarter and reap rewards

The pharmacy team at Croydon Primary Care Trust has decided to assemble evidence by audit to press the case for more involvement of local pharmacies in the delivery of primary health care. Even the Prime Minister is advocating that pharmacists do more to de-

flect patients from the traditional "run to the doctor for every illness and test". Croydon may not be the first to do this — I have done no research to see if this activity has been initiated in other parts of the UK. However, it is clearly an important part of proving the worth of the pharmacist and pharmacies, which are located conveniently and highly accessible.

Few services are kick-started without evidence to demonstrate that the exercise will be worthwhile, used by the target audience and be better value than the existing service or able to reach more people. We know there is spare capacity in pharmacy today. We could work smarter and more effectively doing additional primary care services (diagnostics, minor ailments and injuries) but at present we rely on customers to pay for these if we provide them. The NHS seems to be waking up to the opportunities within pharmacy, so be prepared to get out your clipboard and audit your clinical activity. It will yield dividends.

# The role of community pharmacy in the treatment of diabetes

Paul Gimson, lead pharmacist for long-term conditions at the Royal Pharmaceutical Society, reports on a recent meeting that took place at the Society headquarters in London, discussing the role of the pharmacist in managing diabetes

The Royal Pharmaceutical Society and the National Pharmacy Association are undertaking a project to support integration of community pharmacy into local diabetes care pathways. The aim is to initiate community pharmacy services that help people with diabetes to manage the condition better. The project will produce a toolkit to help pharmacists and local primary care organisations to implement such services.

On 24 September the Society hosted a workshop attended by those with an interest in diabetes, including GPs, nurses, practice managers, patients and members of Diabetes UK.

This work forms part of the Society's programme aimed at integrating the role of pharmacists into the management of long-term conditions, as well as being part of Practice-based Commissioning week. Integration is not just about pharmacy services replacing existing services, it is about identifying areas where inclusion of pharmacy can add value to patient care. Previous work by the Society (see panel) summarises evidence showing that integrating the role of pharmacy benefits patients, although there are few examples of truly integrated services.

A workshop at the meeting aimed to examine where pharmacy could and should be contributing to the care of people with diabetes and how this role should be communicated to commissioners. It was chaired by Shailen Rao, a consultant with Soar Beyond and the pharmacist responsible for setting up the Hillingdon Scheme.

## Long-term conditions — integrating community pharmacy

- 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
- Community pharmacists said diabetes is an area in which they would like to offer a more clinical service
- Other countries have been convinced by the evidence to fund a pharmacy-based diabetes service

Community pharmacists in Hillingdon PCT are commissioned to provide a diabetes service that is integrated with other local services. Evaluation showed that diabetes control improved in almost all patients receiving the pharmacy service. In patients whose diabetes was uncontrolled at baseline, target levels were reached in half of them during the first year. Positive effects were also seen on blood pressure control and total cholesterol.

A number of themes emerged from the meeting. Participants said that before talking to commissioners about additional services, pharmacists should ensure they have got the basics of their services in order, are engaged with local practitioners and aware of local health services, care pathways and priorities.

The message was that pharmacies not able to demonstrate essential and advanced services offered to the highest standard need not apply. It was thought that for many enhanced roles to work the pharmacist would need closer links with primary care services.

The importance of multidisciplinary working was emphasised. It was thought this could be started at the educational level by pharmacists attending local multidisciplinary training events. The difficulty of attending training during a normal working day was raised. If this problem is not addressed, it will severely hamper the chances of pharmacists being included in integrated services.

There was enthusiasm for expanding the role of pharmacy in the management of diabetes. It was believed that pharmacists could add value by enhancing their medicines management role (through targeted medicines use reviews or enhanced services) or offering support services such as weight management. The group offered real support for the role of pharmacists in insulin initiation and titration.

All those present concluded it had been a useful meeting. It highlighted the areas on which pharmacists should focus efforts. Early in 2008 the Society and NPA hope to have produced a toolkit that will support pharmacists and commissioners in that effort.

# The ethics of working with pharmaceutical companies

What is the relevance of the Association of the British Pharmaceutical Industry code of practice to community pharmacists?

Heather Simmonds, director of the Prescription Medicines Code of Practice Authority, discusses the key issues

As pharmacists take on new prescribing responsibilities, it is important to be aware of how relationships with pharmaceutical companies should be managed. Two sets of rules are at issue: the Association of the British Pharmaceutical Industry Code of Practice for the Pharmaceutical Industry and the Royal Pharmaceutical Society Code of Ethics and Standards. So what do you need to know?

**What is the ABPI code?** The ABPI code covers the promotion of medicines for prescribing to health professionals and the provision of information to the public about prescription-only medicines in the UK. Most pharmaceutical companies in the UK have agreed to comply with the ABPI code, which reflects, and extends beyond, UK law.

The ABPI code includes many requirements about the content of promotional material, including the need for all claims in writing or by representatives to be capable of substantiation. It places restrictions on the provision of samples, promotional aids, meetings, hospitality, travel and accommodation. Detailed reports of all cases are published on the Prescription Medicines Code of Practice Authority's website (the PMCPA was established by the ABPI to administer the ABPI code at arm's length from the ABPI). Brief details of serious cases are advertised in the medical and pharmaceutical press.

**How does the ABPI code fit with the Society code of ethics?** Before the anticipated revision of the code the Society Code of Ethics and Standards stated that pharmacists must "act in the interests of patients and other members of the public" at all times and must ensure they "adhere to accepted standards of personal and professional conduct and do not engage in any behaviour or activity likely to bring the profession into disrepute or to undermine public confidence in the profession".

Therefore, when considering whether to work with or accept support from a pharmaceutical company, you should ask yourself "would I be willing to have these arrangements generally known?". If the answer is "no" then you probably should not proceed.

**What about promotion of over-the-counter medicines to pharmacists?** The ABPI code does not apply to the promotion of over-the-counter medicines to pharmacists or health professionals when the object is to encourage purchase by the public. This is covered by one of the Proprietary Association of Great Britain (PAGB) codes.



Advertisements to encourage prescribing do come within the scope of the ABPI code.

**What are the ABPI code requirements for representatives?** The ABPI code applies to what representatives say and the materials they use. Representatives must not offer inducements or use subterfuge to gain an interview and no fee should be offered or paid for the grant of an interview.

**What does it say about meetings and hospitality?** Pharmaceutical companies may sponsor meetings, but sponsorship must be disclosed in all papers relating to the meeting and any published proceedings. Payment may not be made to doctors or other prescribers, directly or indirectly.

It must be the scientific or educational content that attracts delegates to a meeting. Lavish or deluxe venues must not be used and companies should avoid using venues renowned for their entertainment facilities. Meetings wholly or mainly of a social or sporting nature are unacceptable.

Hospitality can only be provided in association with scientific meetings, promotional meetings, scientific congresses and other such meetings. Subsistence must be limited to the main purpose of the event and secondary to it. Hospitality cannot be offered to spouses or other such people unless they qualify as a delegate in their own right. Companies can only provide economy air travel to delegates sponsored to attend meetings.

Pharmaceutical companies can sponsor a branch meeting if the sponsorship is declared

up front, the primary purpose is educational, the venue and hospitality are appropriate and the content is suitable for the audience.

## What restrictions are there on gifts?

No gift, benefit in kind or pecuniary advantage should be offered or given as an inducement to prescribe, supply, administer, recommend, buy or sell any medicine. Items must not be offered for personal benefit. Promotional aids must be inexpensive — the limit is £6, excluding VAT — and of a similar perceived value to you as well as being relevant to the practice of pharmacy.

So, for example, stationary items, such as pens, pads, diaries and calendars and clinical items, such as nail brushes, surgical gloves, tongue depressors, tissues and peak-flow meters, are acceptable. However, items for use in the car or home are unacceptable, such as coasters, clocks, rugs, umbrellas and road atlases.

## What about medical and educational goods and services?

Companies are permitted to provide medical and educational goods and services that will enhance patient care or benefit the NHS and maintain patient care, but not in such a way as to be an inducement to prescribe, supply, administer, recommend, buy or sell any medicine.

They must not bear a product name, but may bear a company name and the involvement of the pharmaceutical company must be made clear. Therapy review programmes, which aim to ensure a patient receives optimal treatment following a clinical assessment, are permitted and can be a productive way to work together to improve patient care.

However, it is unacceptable for a pharmaceutical company to assist with a switch programme where all patients on medicine A are simply switched to medicine B without clinical assessment. Companies could promote a switch from one product to another, but must not assist in carrying it out.

## What should I do if I have concerns?

Complaints about the promotion of medicines for prescribing or the provision of information about prescription-only medicines to the public should be sent to the Director of the Prescription Medicines Code of Practice Authority, 12 Whitehall, London SW1A 2DY (or by e-mail to [complaints@pmcpa.org.uk](mailto:complaints@pmcpa.org.uk)).

Heather Simmonds chairs the Code of Practice Panel, which considers complaints submitted under the ABPI code in the first instance, and is responsible for running the PMCPA



## Pharmacy 2020: have your say

The Pharmacy 2020 consultation was launched on 6 October. Each member has a stake in the future of the profession, so take part in the consultation to ensure that you have your say on your future and the future of younger generations and to ensure that pharmacy is at the forefront of health care for patients in 2020 and beyond. The consultation is available on the Royal Pharmaceutical Society's website ([www.rpsgb.org](http://www.rpsgb.org)) where it will remain for 12-weeks.

The Society is involving members every step of the way and aims to develop a vision of



the future that the profession owns. We can then work together to make the vision reality. The Society has recruited 19 Pharmacy 2020 champions who will support the branches in

England, Scotland and Wales to encourage members to shape the future of pharmacy.

The Society has also bound the background papers and consultation to make it easier for members to consider the issues that may affect the profession in ten to 15 year's time. To receive copies contact [pharmacy2020@rpsgb.org](mailto:pharmacy2020@rpsgb.org). Please let the Society have your views by 28 December 2007.

### IN BRIEF

#### Clinical governance resource for community pharmacists

The Royal Pharmaceutical Society in conjunction with the NHS Clinical Governance Support Team, has developed a free online resource for community pharmacists. Seven interactive modules will help you get to grips with the clinical governance requirements of the community pharmacy contract. The modules include: a background to clinical governance and its components, audit, patient, public and carer involvement, patient safety, good practice, clinical effectiveness and professional standards. The course is available at [www.cg4cp.org.uk](http://www.cg4cp.org.uk)

#### Lung cancer awareness

The CPG has been pleased to be part of a campaign that aims to raise awareness of lung cancer and, in particular, of the fact the disease, if caught early, can often be treated. As a result of this campaign, the Society in conjunction with *The Pharmaceutical Journal* has issued practice guidance to coincide with a special article in the *PJ*. The guidance urges pharmacists to be alert to lung cancer symptoms, such as worsening of a longstanding cough, especially in high-risk patients; increase public awareness of the signs and symptoms of lung cancer and the importance of early detection and take all opportunities to advise on smoking cessation.

#### North West Harmonisation of Accreditation

The North West Harmonisation of Accreditation scheme allows pharmacists accredited in one primary care trust to transfer their accreditation to another, thus removing the need to undergo training in different geographical areas for the same service. The CPG was keen to see this roll-out across the whole of England, and it looks like its efforts are bearing fruit. The English Pharmacy Board has taken on the case and agreed to support the transition of the harmonisation of accreditation group from a regional agreement to a national one. Work on a similar scheme is also ongoing in Wales.

## Resource tools for a Society inspection

The Royal Pharmaceutical Society's inspectors routinely visit all retail pharmacy premises to ensure that legal requirements and professional standards are observed. To support the visits, the Society produces resources to guide pharmacists.

The CPG had the opportunity at its recent meeting to discuss and comment on these tools and decided they were a useful resource that pharmacists should be made more aware of. As well as the inspectors' checklist for a routine monitoring visit, the tools include advice and guidance on:

- Keeping a near miss error log
- The destruction of Controlled Drugs
- Refrigerator temperature monitoring and using the refrigerator thermometer
- The management of products with a short shelf life
- Recommended procedures for date checking of pharmacy stock
- Records of supplies of unlicensed medicinal products
- Reducing risk and improving quality
- Risk minimisation with regard to dispensing and checking

- The standards required for registered pharmacy premises
- Dealing with dispensing errors

The tools are available to download at [www.rpsgb.org/protectingthepublic/inspectorate](http://www.rpsgb.org/protectingthepublic/inspectorate).

## Report of the CPG Council September 2007 meeting

The most recent CPG meeting was held on 18 September, when Jeremy Clitherow was re-elected as chairman and Mr John Hind as vice-chairman. The committee discussed the ongoing debate about the future of the Royal Pharmaceutical Society. It was noted that the Society's Council agreed at its July 2007 meeting to undertake an independent inquiry on the principles, structure and functions of a future professional body for pharmacy. The Council has since appointed Nigel Clarke, chairman of the General Osteopathic Council, to conduct the review.

It was thought by the committee that since community pharmacy would be likely to form the largest constituency of any such professional body then it was important that the CPGs' views formed part of this inquiry. It was agreed that the CPG would provide a submission to the review.

Concerns were discussed at the meeting about the devolution of the global sum to

primary care trusts. Although it was acknowledged that, in theory at least, this should present no issues to contractors, concerns were expressed about PCTs' abilities to manage the extra pressure this would pose (the handling of change in oxygen supply was cited as an example) and also the possibility that PCTs might try to use this as a method of controlling how the pharmacy contract money was spent. The CPG urged pharmacists to make any issues known to their local pharmaceutical committee.

On other matters, the group expressed its concern at the proposed increase in Society retention fees, and the effect this could have on the community pharmacy workforce. It was agreed that a response to this effect would be submitted to the fees consultation.

The CPG committee wants to ensure the group is serving its members. Please e-mail any suggestions on how it should develop to [cpg@rpsgb.org](mailto:cpg@rpsgb.org).