



# Community Pharmacist

July 2006

## Dear Reader

Welcome to the latest issue of *Community Pharmacist*, the newsletter of the Royal Pharmaceutical Society's Community Pharmacists Group. Since our last issue we have seen several changes in personnel at Lambeth, but your CPG committee continues to go from strength to strength. There is insufficient space here to tell you all our plans. However, I will briefly cover some topics close to every community pharmacist's heart.

The ever-changing rules on waste will give us plenty to do. We have seen the practical results arising from the adverse ruling on the difference between medicinal waste from nursing and residential homes and cannot help but attribute the anomaly to income generation. There are the issues involved in sorting out medicinal waste within the pharmacy and with the VAT implications associated with dispensers doing the work rather than pharmacists.

The new CD Regulations will cause a multitude of problems for us all. The CPG committee will be there at the forefront to bring its collective wisdom and specialised experience to bear. Our advice will be positive and constructive, rather than negative.

Safety for NHS personnel is a high profile subject at the moment. Many of our members work long hours, frequently in isolation in deprived inner-city areas. Add "drugs and money" to the equation and you have a prescription for disaster. However, a solution may be on the horizon as I have been able to discuss this with Dr Cynthia Ludford, head of primary care, NHS Security Management Service. She is supportive of our cause and kindly agreed to attend the last CPG meeting.

Finally, we shall continue to monitor home oxygen therapy actively. It is not going away and neither are we.

**Jeremy Clitherow**

*CPG chairman*

## Cascade warning systems have come a long way since the 1980s

In this article, **Jeremy Clitherow**, CPG chairman, looks back at the use of early warning systems and how they have moved on over the years. He also provides his three top tips on the subject

**D**o you recall the wisdom in the old saying that those who fail to learn the lessons of history are doomed to repeat the mistakes of the past? This came back to me so clearly while I was musing over the subject of tips for early warning systems.

Back in the 1980s, I recall both myself, as a much younger local pharmaceutical committee secretary, and the then district pharmaceutical officer on our knees on the floor of the boardroom at the Liverpool Children's Hospital setting up the first pyramid early warning system using Kardex filecards. The system was tested some time later when a truly life-threatening crisis developed.

### Three top tips for cascade warning systems

- **First tip:** Reverting to the lessons of history, the first tip is to establish the house rules from the start. The EWS is for life-or-death alerts — Class 1 and above — and not for stolen prescription forms. It also requires the pharmacist on duty to carry the responsibility. In the days of telephone messages, the obligation was to write the message down, sign and date it, put it on display in the dispensary and pass the message on. The pharmacist in each new shift had to read and sign the sheet to signify that he or she had read it and would comply. Nowadays, the house rules would include a dedicated standard operating procedure.
- **Second tip:** The second tip is to appoint a controller/discriminator. Without such an appointee you will find that the system becomes clogged with low-level messages that would be better either sent by mail or not at all.
- **Third tip:** The third tip is to set up a multi-pyramid system with a reporting system from the bases back up to the controller. Single pyramids are not safe.

The message was that a batch of a well-known baby food might have become contaminated by salmonella. Given the product and the vulnerability of the user group, all community pharmacists needed to be alerted immediately.

In those days there were 133 pharmacies in the city and from the top of the pyramid to the base and back to the controller took exactly eight minutes. This demonstrates the value of an effective cascade system.

### New technology

We have come a long way since those early days when we set up our first early warning system, which, oddly enough, worked perfectly.

The original telephone system was overtaken by multi-faxes which was all well and good up to a point. That was until you found that half of the recipients were so fed up with coming into work in the morning and finding 20 feet of faxed generic manufacturers' price lists, no paper left in the tray and no toner left in the cassette that they lost interest.

Cold-printed faxes tend to fade quickly when filed edge on in a suspension file because of poor bonding of the ink, and hot-printed ones use much more expensive toner. Even if the machine had not run out of the consumables, many an alert message would be hidden in the middle of a string of other price lists and trade messages.

No doubt some enterprising pharmaceutical guru will come up with an e-solution to the mechanism of message transmission — one which runs in Windows, allows a "ping" message to be heard even if the pages are not on display, will not allow staff members to overwrite or delete the message and can be sent simultaneously to all pharmacies on a patch. As a fail-safe, it should identify those sites that have not actively acknowledged the receipt of the alert.

So the time has now come for one of you gurus to show us how to move early warning systems into the e-world.



## Changes to CD regulations: the impact on community pharmacy

A number of changes to the monitoring and inspection, prescribing, dispensing, record keeping and destruction of Controlled Drugs have been introduced as part of the ongoing programme to implement the recommendations of the Shipman Inquiry. These are a mixture of legislative requirements and professional good practice guidance. The changes to the legislation will apply to England, Scotland and Wales. However, the arrangements for meeting the new requirements may differ between them.

As of 7 July, there have been a number of changes in the management of CDs that will have impacted on the day-to-day practice of the community pharmacist. These include:

- Community pharmacists are not able to dispense a private prescription for a Schedule 2 or 3 CD issued by a prescriber in England or Scotland for human use unless it is on the standardised private prescription form. The private prescription must also contain the prescriber's identification number. These regulations do not come into force in Wales until 1 January 2007.
- Community pharmacists are required to send these standardised private prescription forms to the relevant NHS agency, eg, NHS Business Services Authority (formerly the Prescription Pricing Authority), at the end of each month.



- Community pharmacists are also required to ascertain the identity of anyone collecting a Schedule 2 CD issued against a prescription, to determine if the person is the patient, the patient's representative or a health care professional acting in his or her capacity as such.
- The validity of all prescriptions for Schedule 2, 3 and 4 CDs has been reduced to 28 days from the date of signing or other start date as indicated by the prescriber.

Pharmacists are reminded that, as a matter of good practice, they should keep a running balance within the CD register.

Detailed guidance to help pharmacists cope with the changes has been published by the Royal Pharmaceutical Society (see [www.rpsgb.org](http://www.rpsgb.org)). Information has also been published in *The Pharmaceutical Journal* (1 July, p25). — Heidi Wright, head of quality improvement, Royal Pharmaceutical Society.

## What a new LPC chairman thinks about an LPC's role

Having been a member of many local pharmaceutical committees over the past 10 years, I was elected chairman of East Sussex LPC in April this year. This led me to develop a different perspective on the role of an LPC. Our first major task has been the development of a robust governance strategy. This was in response to recent events in North East London and the Nolan principles for public bodies. Having got these procedural and control mechanisms out of the way, the committee has turned its attention to the shifting primary care agenda.

I see the priorities of my LPC over the coming year as being further development of our strategy to suit the changes in primary care, talking to contractors to ensure they become engaged with LPC activities, engaging with new PCTs at all levels and influencing the decision makers involved with practice-based commissioning.

I hope the results of this will be increased contractor involvement with East Sussex LPC, increased uptake of advanced service by contractors to exceed the national average, the development of new PCT enhanced services to provide opportunities to increase income, and opportunities to provide pharmacy-led services through practice-based commissioning.

These should be the activities to which contractors hold us to account. — Howard Duff, invited CPG committee observer.

## MURs are a chance for pharmacists to show what they are worth

What do we hear these days about medicines use reviews?

I suppose we hear the usual grumbles: "I don't have time", "I'm too busy", "I can't get a locum", "I haven't got any cover" and "the doctors don't value them when we do them and don't take any notice of them when we send them in". These are pharmacists' excuses for not getting them done.

MURs are a great chance for us to show our worth and we must not let it slip by. We still have to gain acceptance by demonstrating that MURs have value to GPs themselves and that it will be much easier when they can be sent to practices electronically. But remember that they are designed to help patients to understand their medicines in addition to suggesting to the GP possible problems or alterations. Medicines use reviews give us a



great opportunity to spend time with our regular patients and to be able to influence their medicine taking. We can often use the time to increase patients' understanding and compliance, or even to suggest modifications to their drug regimens to the benefit of both them and the NHS.

This is the time for us to show that our rhetoric about being experts in medicines is true and that we can influence people's health through advising on the sensible use of their medicines.

Finally, MURs are our chance to cement our relationship with our patients. Patients value the time we spend with them. Grasp this opportunity while it is here and remember, if nothing else, patients love MURs. — John Hind, CPG committee member.

# Have you applied for your EPS smart card yet?

With the introduction of Release 1 of the NHS Electronic Prescription Service, **Lindsay McClure**, head of information services at the Pharmaceutical Services Negotiating Committee, describes how pharmacists can register for a smart card to enable access to the system

**R**elease 1 of the NHS Electronic Prescription Service (EPS) has started. All community pharmacists working in England, including locums, will require a smart card to access the system. No other pharmacy staff are required to register for smart cards at present.

Smart cards are one of a number of security measures being taken to protect the confidentiality of patient information on the new NHS IT systems in England.

Since Release 1 of EPS does not provide access to the NHS Care Records Service, NHS Connecting for Health has put in place a simplified application form and process. Pharmacists are not currently subject to the same user policies as other staff who can access care records. Arrangements for Release 2 are under review, but it is likely to involve pharmacists registering again for additional access rights.

Pharmacists can choose to register to receive a smart card in the primary care trust area either where they live or where they work. The cards are not pharmacy- or PCT area-specific. Since only pharmacists may currently apply for a card, other pharmacy staff will initially share the pharmacist's card to access EPS. It is recommended that pharmacists keep a log of individuals who use their cards on a particular day.



PCT "registration authorities" are responsible for issuing smart cards. In some areas PCT representatives are visiting pharmacies. In other areas, pharmacists can register for smart cards at local events, such as local pharmaceutical committee and Royal Pharmaceutical Society local branch meetings. In yet other areas, pharmacists may be required to visit the PCT.

In each case, it involves a face-to-face meeting and provision of proof of identity and a completed registration form. There is also a set of associated conditions that pharmacists must agree to comply with.

The registration form should be provided by the primary care trust, or a copy can be accessed via the website of the Pharmaceutical Services Negotiating Committee's ([www.psn.org.uk](http://www.psn.org.uk)). Since the process requires a face-to-face meeting, pharmacists should not post the registration form to the

primary care trust unless this has been requested locally.

For further information on how smart cards will be distributed in particular areas, pharmacists should contact their local PCT or local pharmaceutical committee.

Detailed information on EPS and the issuing of smart cards is available in the pharmacy IT section of the PSNC website.

## A pharmacist's experiences of smart card supply in East Sussex

An update on how smart cards are being distributed, by pharmacist and CPG committee member **Vanessa Taylor**

It became apparent in January that the biggest stumbling block regarding the issuing of smart cards would be communication between all the parties involved. So in March, East Sussex local pharmaceutical committee organised a conference — funded by systems suppliers and supported by pharmacy IT leads from the regional IT cluster, the SHA and all PCTs. This set the scene for good working relationships and a platform to discuss the best way forward with decision makers.

The LPC worked with all the PCTs. This culminated in two mechanisms for action, with one lead appointed for East Sussex and one for Brighton and Hove City Teaching PCT. It was decided at the outset that one smart card would be issued to each practising pharmacist. Update and information meetings were held between all stakeholders. These are ongoing and will hopefully stand

us in good stead for the implementation of phase 2 — more of which later.

So how are things going now? A database of all pharmacists is in the process of formation; this can only be a good thing as previously there has been no knowledge of the number and roles of all the pharmacists who are working in community pharmacy in East Sussex. Brighton and Hove has held one issuing meeting at which all attendees had their photographs taken and papers reviewed; 36 pharmacists attended. A further meeting was held in June. In the remainder of East Sussex the PCTs have employed an IT person to visit all pharmacies and take photographs of pharmacists. The latest figures I have show that about 100 photographs have been taken and 170 pharmacists have been identified. The next step will be to arrange to view all pharmacists' documentation and issue the cards.

Then we only need systems to be enabled and everything will be in place to allow pharmacy contractors to claim their payments. This is, however, only phase 1, where no confidential information will be available to community pharmacy from the NHS spine.

Phase 2 is a different ball game and all those smart cards issued in East Sussex will have to be withdrawn and new, more secure ones issued for each person working in the pharmacy, with different levels of access. If we thought phase 1 was difficult, how will we cope with the introduction of phase 2 smart cards? At least in East Sussex we have a foundation on which to build that starts and ends with good communications.

Anyone in East Sussex who has a problem obtaining a smart card they can contact me, by e-mail at [vanessam.taylor@btopenworld.com](mailto:vanessam.taylor@btopenworld.com).



## A new world of out-of-hours service provision

Community pharmacist and CPG committee member **Vanessa Taylor** gives her thoughts on rota services and the brave new world of out-of-hours service provision

It was Boxing Day 1970 and sleeting slightly. I turned the corner to open the pharmacy for my first bank holiday rota and was faced with three-deep rows of queuing customers. Flu had struck. This was "rota old style" in a market town. The pharmacy had a monopoly on customers because no one else was open. We were generally happy to provide a service for poor remuneration because the number of customers and over-the-counter sales made the whole operation viable and provided a service to the public. At the end of a hard two-hour rota (having been only paid for one hour) we finally closed the doors on the last customer knowing that we had made a difference.

Over the years, I have undertaken rotas in almost every community pharmacy setting you can imagine. From large multiples, where it was a nightmare to make sure all the locking arrangements were completed, to small village pharmacies, where the surgery telephoned when the last patient had been seen and we knew if we waited five minutes and nobody had arrived we could close the shop.

Thirty-six years later and we are in a different working environment. The old rota has disappeared and, although it had served us well, it was definitely time for a rethink. The rota service finished in April and primary care trusts have been busy looking at their pharmaceutical needs assessments to see where they need a rota service, if at all. It is also a great opportunity to look at negotiating a better deal. So what sort of service do we have now? We have large supermarkets in almost every location providing pharmacy services for long hours. We have pharmacies in health centres, 100-hour contract pharmacies and internet pharmacies. We have competition in the high street with multiples opening ever more hours and small independents fighting for survival because opening longer means more opportunity to fill prescriptions. And, make no mistake, even with the new contract, it is still about numbers.

Surprisingly, considering the above, there is still a need — even in my area of high population and in many towns — for a selective

rota service. Most PCTs have taken proposals to their LPCs for the new enhanced out-of-hours service. Generally, these have been agreed with increased funding to at least cover the costs of providing a service. However, one PCT that I know of has decided it would be a good idea to link a palliative care service to the out-of-hours service and make it mandatory. This has been pushed through by sending an agreement to contractors who naively thought they were agreeing just to provide an old rota style service.

The palliative care element has to be provided with no additional payment. However, the PCT has generously agreed to pay in arrears at the end of the year for the initial cost of the drugs to be kept in stock, with no payment for stock that goes out of date. Unfortunately, this was carried out without recourse to the LPC. Let us hope that, after further discussion with the LPC, common sense prevails. If the above scenario is replicated in other areas around England, I really do despair for the future of negotiating with some of our more difficult PCTs.

## Minor ailment schemes reduce GP workload

Pharmacists have been treating minor ailments for many years. However, one group of patients has for many years avoided coming direct to the pharmacy for minor ailments: people who do not pay prescription charges. The incentive of free prescriptions means that they prefer to visit their GP first. This is widely recognised as being a waste of GPs' time, with up to 40 per cent of consultations being for minor ailments.

Pharmacy minor ailment schemes are seen as the way of avoiding this and hence reducing GP workload. Instead, pharmacists use vouchers or prescriptions to supply medicines on the NHS.

These schemes have been successfully tried out throughout the country. Foremost among them are the "Care at the chemist" scheme run in Bootle, Merseyside, in 1999, and the "Direct care at the chemist" scheme which started off in pharmacies in Tayside in 2001.

The latter scheme was gradually expanded across Tayside and then Ayrshire and Arran health boards. Starting as a paper-based system, using CP1 prescription forms, it has now become the national minor ailment service — one of four core services under the new pharmaceutical care contract in Scotland. Prescribing and patient registration

have moved from paper forms to a central database and electronic payments.

Pioneering pharmacist OTC prescribing schemes in Newcastle, Sunderland and Nottingham should also be noted. Several of these schemes involved the supply of treatments for head lice.

A national directed minor ailment service is also being considered for Wales and a similar scheme has been under way in Northern Ireland for some time. This brings us to the question of whether there should be a national scheme for England. It could be introduced as an advanced service, one to which all pharmacists could opt in, with a single scale of payment and co-ordinated paperwork (ahead of any electronic payment system coming into existence). The current situation with prescription charges means that there is a place for such a service if we want to reduce inappropriate use of the NHS.

There is plenty of evidence that these schemes work, that they do not increase prescribing costs (because prescribing is simply transferred from GPs to pharmacists), and that patients are happy to use them. Is the only thing holding us back that we do not want our oldest and most established service nationalised? — *Vanessa Taylor, CPG committee member.*

### IN BRIEF

#### Health and Social Care Awards

The Department of Health is inviting applications for its annual Health and Social Care awards. The awards, now in their sixth year, recognise and reward excellence in the provision of care at the frontline as well as offering NHS and social care staff the chance to highlight all that is best about the work they are doing every day.

Further information about the awards and how to enter can be found at [www.healthandsocialcareawards.org](http://www.healthandsocialcareawards.org).

The deadline for entries is 31 August.

#### POM-to P-switches

Pharmacists are reminded that Royal Pharmaceutical Society practice guidance on POM to P switches for the following medicines is available via the Society's website ([www.rpsgb.org](http://www.rpsgb.org)): sumatriptan 50mg tablets (June 2006); amorphine 5 per cent nail lacquer (May 2006); chloramphenicol 0.5 per cent eye drops (June 2005); simvastatin 10mg (July 2004); and omeprazole 10mg (May 2004).