



Pharmacists are key players in the management of chronic disease

Dr Peter Hammond, consultant endocrinologist, Harrogate District Hospital, presented the Bristol-Myers Squibb keynote address and asked if pharmacists were key to management of chronic disease. He immediately answered emphatically 'Yes'!

Dr Hammond started by looking at deliverers of medical care in the past and the present, where a number of professionals now contribute to quality patient care. The introduction of the prescribing qualification enables this role and further supports pharmacists' key position in the multidisciplinary team.

Dr Hammond outlined a number of ways pharmacists could become involved in delivering the targets outlined in the General Medical Services (GMS) contract including cardiology, diabetes epilepsy and mental health. GPs will be keen to reach targets thus pharmacists should be looking for opportunities to become involved in delivering them!

He then turned to the diabetic theme of the weekend and emphasised the challenge of treating blood pressure to the target level of

<140/80 mmHg (and lower for patients with microalbuminuria) and reducing lipid levels to target levels of 5.0 mmol/l. Data from the UK Prospective Diabetes Study (UKPDS) in type II diabetics suggest that each 10mmHg drop in systolic blood pressure leads to a 12% risk reduction for any complication related to diabetes. Hypertension in diabetic patients may be more resistant to treatment than in the general population, presenting a challenge to prescribers. The majority of diabetics will require two or more antihypertensive drugs.

Dr Hammond then went on to describe the pharmacist-led diabetic cardiac risk and hyper-

tension management clinic established in secondary care in Harrogate. This clinic aims to reduce blood pressure and lipid levels to target. It also seeks to help patients to self-manage via education and hand-held records. A nine-month audit demonstrated the impact of this intensive management approach: 47 patients who had been seen in the clinic for a mean of 20 weeks had a systolic blood pressure reduction from a mean of 166 to 146mmHg, a reduction of total serum cholesterol from 5.2 to 4.4 mmol/l and low-density lipoprotein from 2.8 to 2.0mmol/L. The results demonstrate the value of pharmacist team-members in an area with complex medication, drug interactions and detailed monitoring.

Dr Hammond's presentation was really encouraging to pharmacists wanting to take forward a pro-active role in delivering care and looking to become supplementary prescribers. It demonstrated what pharmacists can achieve for patient care and how they have a major role in delivering chronic disease management.

Candy Norris

Harrogate General Hospital

(Insert: Dr Peter Hammond)



In this issue:

- Chronic disease management
- Chairman's news
- Professional Secretary's news
- From the practice interest groups
- Autumn 2003 Award winners

The deadline for contributions for the next issue is 27 February 2004

Write to:

The Editor, *In Practice*
United Kingdom Clinical Pharmacy
Association
FREEPOST (LE 6333), Wigston,
Leicestershire, LE18 1AZ

Leadership and management development group launch

This first joint specialist interest group between the Guild of Health-system Pharmacists and UKCPA was launched at the UKCPA autumn 2003 Symposium. Whilst management is in the title, this group is not just for managers! The Leadership and Management development interest group (LMDPIG) aims to offer something for all levels and areas of leadership: individual to strategic, and build networks in and without pharmacy for support, coaching and mentoring.

The launch was well attended and celebrated with champagne. Gillian Hawsworth, RPSGB President opened the launch and offered her personal support. Pippa Roberts, chief pharmacist Chelsea and Westminster NHS Trust, David Webb, director of clinical pharmacy for London and Eastern and Duncan McRobbie, principal pharmacist Clinical Services, Guy's and St Thomas's Trust shared their Leadership experiences in clinical and management settings. Speakers' presentations will be available on GHP and UKCPA websites.

For the group to be successful, we need your involvement. Join via the Guild or UKCPA: <http://www.ghp.org.uk/> or <http://www.ukcpa.org/>.

The next session of the LMDPIG will be at the Guild 2004 National Conference 26-28 March: How to be a positive leader - achieving excellence in practice. We hope you will join us!

(Insert: Leadership and management development group steering group: Graeme Hall, Cathy Mooney, Richard Cattell, Suzanne Khalid, Philip Howard).



Care of the elderly group news

Three workshops were held at the autumn 2003 symposium.

1. Osteoporosis. This workshop was run by Nuttan Tanna, specialist pharmacist menopause and osteoporosis, Hillingdon PCT. It aimed to identify methods of osteoporosis screening to assess and monitor progression, and to evaluate current prevention and treatment strategies. Nuttan also discussed risk factors for developing osteoporosis, the role of evidence-based guidelines and areas of potential pharmaceutical input into screening, management and prevention of osteoporosis.

2. NSF For older people: the story so far for medicines management. The aim of this workshop by Brendan Prescott, Community Healthcare Medicines Manager, South Sefton PCT, was to identify areas of progress, both locally and nationally, towards implementation of medicines management services (MMS) for older people. Brendan highlighted his experience with a first-wave pilot site for the MMS Collaborative and the basis of this service in the NSF for older people. Group discussion focused on the problems associated with identifying patients with increased pharmaceutical needs, levels of medication review (levels 0 to 3) and different staff that could do reviews.

3. Dysphagia: a hard pill to swallow? This workshop, run by myself, outlined the stages of normal swallowing and classification of dysphagia. The roles of different assessment and treatment methods, texture-modified diets and different methods of enteral feeding were also highlighted. Group discussion involved devising a pharmaceutical care plan for dysphagic patients. This highlighted the multidisciplinary nature of dysphagia management.

Wound care study day October 2003

Many thanks to those who attended this study day in Edinburgh. Lectures and workshops were lead by pharmacists and tissue viability nurses, with the following objectives:

- Outline the different types of wounds
- Describe wound assessment and healing
- Identify appropriate wound care products.

Handouts for all these sessions and copies of replies to questions in the last edition of *In Practice* can be obtained from Derek (below).

Electronic newsgroup. This group aims to encourage networking and distribution of information and models of care. If you wish to join, please send me your email and postal address, job title and telephone number.

Care of the elderly PIG welcome pack 2003

Copies are available from me. A lot more information has been added to this edition.

Derek Taylor
Chair, Care of the elderly PIG
Pharmacy, Broadgreen Hospital
Thomas Drive, Liverpool, L14 3LB
(0151) 282 6446, dataylor@tinyworld.co.uk

Chairman's news

Happy New Year to you all. This time of year is often when we make New Year's resolutions and plans for the rest of the year. One of our tasks within UKCPA this year is to tackle the issue of consultant pharmacists. We need to find a method of identifying when a pharmacist is practicing at a consultant level in his or her clinical speciality. We plan to use the London and South East Clinical Pharmacy Competency Framework as a template for this. We hope to have an early draft by the May symposium to share with you all.

On the Practice Interest Group front, we plan to launch an Emergency Care group in May to address some of the issues around acute admissions to hospitals. We also have launched a newsgroup for Gastroenterology. See <http://uk.groups.yahoo.com/group/UKCPA-Gastroenterology-PIG/>, for details on how to join and previous messages. Good luck in meeting your resolutions for the year.

Philip Howard
Chairman



Clinical comments: Oxygen and Errors

Columns are taken from past *Pharmacy Magazine* editorials written by UKCPA members.

Oxygen therapy service changes

The Royal College of Physicians 1999 oxygen therapy guidelines indicate that in many conditions oxygen therapy improves morbidity but not mortality. In COPD associated with chronic hypoxia, however, long term oxygen therapy (LTOT) used for over 15 hours daily dramatically improves survival and exercise tolerance.

The Department of Health proposes transferring responsibility for LTOT prescribing from GPs to hospital consultants. Long-term oxygen therapy will be provided via specialist oxygen contractors in a similar way that the oxygen concentrator service is organised.

GPs will retain prescribing responsibility for short-term therapy patients, and it is assumed that will be supplied via community pharmacies. This raises issues around maintenance of skills for oxygen provision in community pharmacy and continuity of easy access to short-term therapy. Other logistics issues for the proposals include the capacity of hospitals to deal with the volume of patients requiring oxygen therapy and acceptable waiting times, particularly in areas experiencing difficulties filling respiratory consultant posts. Who will monitor patients on LTOT and how would this be organised?

At this stage it is uncertain what role, if any, community or hospital pharmacists will play in the provision of LTOT.

Sonia Sanghani, community pharmacist
Chair, public relations committee

We need more writers: contact Sonia Sanghani via the office. Topics covered to date are chronic pain, angina, CHD, COX II's, errors, combination inhalers, oxygen, methotrexate. Columns will be available on <http://www.pharmacymag.co.uk/>

Medication errors in primary care

With the advent of clinical governance and the National Patient Safety Agency (NPSA), establishing processes to address medication errors is key. The concept of safe systems of work is not new; indeed the whole dispensing checking process is based on this. This can be expanded to include training staff on differences in drug packaging, awareness of electronic errors, extra vigilance with high-risk drugs.

The NPSA recently announced measures to prevent methotrexate errors including patient treatment diaries, revised methotrexate packaging and improvement in pharmacy and GP computer systems. But why not take this safety lesson one step further and draw up a list of the top ten high-risk drugs you supply. Then consider what measures you could take to ensure these prescriptions are handled safely. Oral cytotoxics, immunosuppressants, insulin, warfarin, digoxin and steroids are examples.

Accurate drug-history taking on hospital admission and provision of appropriate discharge advice are time-consuming but important issues. The recent NSF for Children highlighted the interface as a particular area of risk: errors in strengths of liquid formulations still occur with serious consequences. Whilst electronic developments will assist in tackling some drug-safety issues in the future, pharmacists should also discuss medication with patients, GP's and secondary care staff. Patients can often be key sources of information to prevent errors, e.g. types of insulin used.

The challenge for all of pharmacy is to embrace a blame-free culture and be prepared to review, adapt and reflect, to ensure safe systems of work. How often do you review dispensing errors and identify causes and effects?

Kevin Purser, Ipswich Hospital
Chair, Quality and risk management PIG

Critical care group news

1. Benchmarking Critical Care Services

A benchmarking document has been developed by the Glasgow and West of Scotland Critical Care Practice Interest Group. It deals with both organisational standards and key activities in critical care and has been piloted in Scotland. The Critical care group (CCG) invite all interested parties to complete this document so that we have an idea how services across the country compare. The document is available electronically and can be requested from ruth.forrest@sgh.scot.nhs.uk. Results will be available to all participants.

2. Allied Health Profession and Health Care Scientist Advisory Board

New guidelines have been produced by this group on behalf of the Intensive Care Society. They include a statement on critical care pharmacy. The article was written by Cathy McKenzie, John Dade, and Mark Tomlin. The document can be accessed at www.modern.nhs.uk, fast link to Critical Care and you will find it under 'Documents for Sharing'.

3 Educational Events 2004

On the 11th February 2004 the CCG is running a beginners day aimed at pharmacists less experienced in critical care. Book early to avoid disappointment. The CCG may host another event in 2004 for specialist critical care pharmacists.

4. The CCG e-network

To clarify the position regarding the electronic network. There are two groups to join, this will be rationalised shortly:- www.yahoo.co.uk, www.smartgroups.com
Firstly, you are required to register with Yahoo or Smartgroups. This gives you a password and user name and enables you to submit your

name for membership of the various groups available. You then ask to join their groups, and complete details. They then email you back with a number to enter to confirm you are who you say you are. You are then a member and you can search the databases of groups. You then ask to join the groups (search UK-CPA - no punctuation). They will contact John Dade who will approve your membership if you are a member of the UKCPA.

*Cathy McKenzie, Guys & St Thomas' Hospital
Critical care group committee*

Surgery and theatres PIG news

1. National stilboestrol shortage

A manufacturer's problem has led to a stilboestrol tablet shortage which is likely to continue until spring 2004. Hospitals are using a variety of solutions: some are using the manufacturer's recommendation of 1mg stilboestrol being equivalent to 150mcg-1.5mg of ethinylestradiol tablets and titrating dose to response. Others are using results from two small trials claiming castrate testosterone levels to decide therapy. Ethinylestradiol 50mcg daily is suggested by Langeveld JW et al *Br J Urol* 1989; 63: 76-79. Ethinylestradiol 7.5mg patches (progynova) two patches weekly (unlicensed indication) is advocated by Ochrim JL et al *J Urol* 2003; 169: 1735-1737. It is essential irrespective of which option you advocate that your urologists have the final say and staff are appropriately informed.

2. Botulinum toxin for anal fissures

Rachel Westwood, Northampton hospital wrote having been asked to write a formulary application for botulinum toxin for anal fissures. She asked which brand was used, frequency of administration and place in therapy. Nicholas Boyt from York provided really useful response

1999; 22:163-6, *NEJM* 1998; 338: 217-220, *Dis Colon Rectum* 1999; 42: 1016-1021, *Am J Surg* 2000;179:46-50, *Dis Colon Rectum* 1997;40:1029-1032, *Digest Surgery* 1999;16: 515-518, *Annals Surg* 1998; 228: 664-9, *NEJM* 1999; 341: 65-9, *Gut* 2001; 48(2): 221-4, *Digest Dis Sci* 1999; 44: 1588-9.

Botox has been approved at York hospital for anal fissures, third line after GTN ointment +/- diltiazem ointment. Botulinum toxin is injected in the anal sphincter, either side of the fissure (see references for dose). It causes internal sphincter muscle weakness which can last 3-4 months. Faecal incontinence affects 7% patients. Healing rates for botulinum toxin are greater than GTN ointment, but the cost difference is huge especially if one vial is used per patient. The anticipated annual usage is six patients per year. To date patients who have received the treatment have not required additional doses, however a small number of patients may in the future. Basingstoke was the only other hospital using this treatment.

3. Controlled drug (CD) destruction

How is ward destruction of the remains of CD solutions from epidurals and syringes no longer required by patients done nationally and is this waste recorded? John Dade from Leeds highlighted that destruction is not a statutory requirement because CDs become the property of patients once booked out. However from the point of good practice and accountability for CDs several hospitals (Leeds, Winchester, North Cumbria) have introduced or are looking at introducing a separate ward CD destruction register. It is essential that it is a separate register, as the ward CD book must be retained for records required by law only.

4. Alternative to etamsylate injection

Prior to the discontinuation of etamsylate injection the ear, nose, throat doctors at Wrexham hospital applied etamsylate injection on gauze swabs to areas that bleed profusely during procedures. Now that etamsylate is no longer available Elaine Sturman wrote asking if anyone had looked at alternatives or had tried tranexamic acid? Replies to the news group indicated that no other hospitals were using etamsylate in this way. However several centres were using tranexamic acid mouthwash successfully for similar indications at 250-500mg/5ml either purchased as a special or mixed in-house from the injection.

5. Antibiotic prophylaxis in prostate biopsy

Elizabeth Beechey, Senior Clinical Pharmacist for Surgery at Gloucester Royal Hospital requested comment on local antibiotic prophylaxis for prostate biopsy. Replies were: Alan Timmins, Queen Margaret Hospital, Dunfermline: ciprofloxacin 500mg with metronidazole 400mg orally 30-60 mins pre-procedure. Priya Mistry Basingstoke: ciprofloxacin 500mg dose before and 500mg BD for two days afterwards. Sharron Millen, Southampton: As Basingstoke.

*Sharron Millen
Southampton Hospital*

Clinical comment 3: Inhaled steroid and long-acting β -agonists

The new British asthma guidelines promote early use of long acting beta-2-agonists (LABA) and inhaled corticosteroids (ICS). The evidence for both drugs in asthma is overwhelmingly convincing at guidelines step 3 and the prescribing of one inhaler instead of two may have advantages for certain patients.

A primary goal of chronic obstructive pulmonary disease (COPD) therapy is to improve patients' health status, facilitating daily activities. A fifth or less of all patients with COPD respond to steroid challenge and these are probably patients with mixed asthma and COPD, or asthmatics that have been misdiagnosed. In view of the financial pressure on the NHS, indiscriminate ICS prescribing, including combination inhalers, to COPD patients poses a substantial, unnecessary economic burden.

A recent meta-analysis of six trials found the rate of FEV1 decline in COPD did not differ

between placebo or ICS. The authors concluded that ICS probably do not affect long-term decline in lung function in COPD. However, ICS may be used in patients with severe COPD and frequent exacerbations as ICS may improve symptoms, quality of life and reduce hospitalisations.

The community pharmacist is ideally placed to actively manage COPD patients by monitoring the appropriateness and effectiveness of therapy. Remember, many COPD patients are treated as asthmatics. Appropriate prescription of combination therapies will help ensure better patient outcomes and more cost-effective use of drug budgets. By asking whether a new ICS has made a difference to breathing, daily activities or sleeping, it is possible to ascertain whether patients should be referred back to their GP.

*Anna Murphy, respiratory pharmacist
Glenfield Hospital Leicester*

Quality and risk management news

Are patients any safer? How well are risk reduction strategies working?

Patient safety has been high on the agenda for several years now, but how much change has occurred at grass roots level? Most speakers at this study day in September were from primary care, reflecting the increasing interest in patient safety from these groups of pharmacists. But just how far have we come in achieving a "no blame" or "open and fair" culture?

Steve Eastham from Boots the Chemist, has been active in promoting safe systems of work in Boots branches. He talked about 'danger times', where concentration might be less than ideal. The period immediately after a break can be a problem – post-break dipping out. His recommendation to counter this was to have a warm up period, where perhaps a dispensed prescription is left on one side to be checked after an interval of 10 minutes. Relating this to how a sportsman would approach a training session or games is a good way of helping apply this across the whole team, from staff putting goods away, to dispensing, checking etc. Errors can occur at any point in the chain and have consequence.

Steve has been able to promote report completion, including reports of near misses amongst staff who are already hard pressed, by pointing out that it takes 90 minutes to complete a dispensing error report, generally at an inconvenient time (as it must be dealt with immediately), whereas a near miss takes 10 minutes. A near miss is a free lesson.

Bruce Warner and Ruth Goldstein reported work from five Derbyshire PCTs. Initially pharmacists were reluctant to get involved and it seemed unfair that GP's were incentivised. However, some pharmacies now collect data consistently and although there are variations between pharmacies, baseline data exist that can be used in the future. Pharmacies receive feedback on a quarterly basis.

Wendy Harris from the NPSA detailed how community pharmacists will be encouraged to input medication errors. She also discussed ways in which individual pharmacists can take steps to maximise patient safety by looking at products purchased. These should have clear labels, be well differentiated (from other strengths/drugs), have appropriate warning labels, be ready to administer and have adequate information for practitioners and patients. Several hospital procurement sites now apply risk assessment criteria when purchasing, this can be relevant in community pharmacy too.

*Amanda McLean
Quality and risk management PIG*

Cardiac PIG news

Pharmacists must improve their consultation skills

Pharmacists should ensure they have effective consultation skills in order to provide pharmaceutical care, claims Dr Graham Davies, Director of Academic Studies at Brighton University. Speaking at the Merck UKCPA Cardiac Study day held in London on 30 September, Dr Davies described a process to the consultation that is essential to ensuring the drug knowledge that pharmacists have can be effectively applied in the patient setting.

This consultation process should be structured rather than random and should include elements of relationship building, problem identification, problem resolution and consultation closure. Pharmacists spend a lot of time focusing on medicines and communicating with other health professionals, and patient consultation skills are often overlooked, claimed Dr Davies.

These sentiments were echoed by Prof John Weinman, Professor of Health Psychology, Guy's, Kings and St Thomas' Medical School. He described the emphasis now being placed on consultation skills by physician, especially the Royal College of General Practice. He went on to describe the system of beliefs about illness and treatment that patients develop during their illness. Understanding these issues for individual patients is essential

in overcoming the barriers that patients have around medication taking. Patients require an understanding of the cause, consequences, timeline and actions they can take relating to their illness. They also have concerns regarding the taking of medicines that need to be explored and addressed in order to ensure patients are making informed choices when it comes to taking medicines.

Other topics covered on the day, which was focused around pharmacists who at some stage wished to become supplementary prescribers included a review of the NICE Heart Failure Guidance (Helen Williams, Cardiac Team Leader, Kings College Hospital, London) and understanding risks and benefits of cardiac medicines (Duncan McRobbie, Principal Clinical Pharmacist, Guy's and St Thomas' Hospital, London).

Candy Norris (Principal Clinical Pharmacist, Harrogate) described various models of delivering pharmaceutical care to patients. These included models for delivering outpatient care in hypertension and heart failure, outreach care for cardiac medication review, and inpatient care. This provided some interesting debate regarding the application of different models according to the patient and service need. The Cardiac Practice interest group will shortly be producing a toolkit to support the development of new models of care.

*Duncan McRobbie
Chair, Cardiac PIG*

Models of care package

UKCPA has produced a new resource pack for pharmacists wishing to set up cardiology clinics. It contains eight models of care covering hypertension, heart failure and general cardiac medication review. The models are the protocols, prescribing monographs and referral systems for clinics throughout the UK. This excellent resource should help pharmacists establishing models within their own area.

It is intended that the pack will be updated with new models and that packs from other therapeutic areas will be produced in the future.

We acknowledge contribution from: Janet Lock, Richard Lowrie, Duncan McRobbie, Sara Moore, Fiona Reid, Val Reilly, Dawn Wilson.

Packs can be obtained from the UKCPA office

Cost to UKCPA members is £10 plus £4.50 (p&p), non-members is £15 plus £4.50 (p&p)

*Candy Norris
Cardiology Practice Interest Group*

New practice interest groups

UKCPA aims to expand its practice interest group base to include more therapeutic areas, particularly areas linked to NSFs. To this end, UKCPA launched a cardiology PIG last year, respiratory this year and now a diabetes PIG. The aim of the diabetes PIG is to provide support to pharmacists working in the diabetes field and to foster links which will lead to pharmacists providing higher quality patient care. In particular we aim to consider the pharmacist-prescriber role and the knowledge and skills needed for this. The Group is aimed at anyone with an interest in diabetes, and it is hoped that the membership will include pharmacists from all branches of the profession. The first meeting will be in April 2004.

Candy Norris

A Rheumatology PIG is in formative stages. A study day is in the pipeline and musculoskeletal disease featured at the autumn 2003 symposium. The complexity of recently marketed and imminent drugs, the logistics of monitoring and supplying these, and an increasing evidence base in rheumatology mean that there is a real need for such a PIG. The first committee meeting is planned for early in the new year.

Chris Green

Professional secretary news

The UKPCA office has received a steady stream of consultation documents from the Medicines and Healthcare Products Regulatory Agency (MHRA), Department of Health and the Pharmaceutical Society. Over 20 have been received since May 2003.

These ranged from reclassification of products from prescription-only to pharmacy medicines or general sales list medicines to EU directives on good clinical practice in research clinical trials. We also provided a response to consultations on competencies of the future pharmacy workforce and supply of medicines under patient group directives. We are grateful of responses to consultations, especially those received well in advance of the deadline!

Graeme Hall, Professional secretary



Infection management PIG news

1. Antibiotic resistance study day

To really see natural selection in action, Charles Darwin should have been around now instead of in the 19th century, stated Dr David Livermore, director of the Antibiotic Resistance Monitoring and Reference Laboratory at the Central Public Health Laboratory at the Infection management group study day in October. Dr Livermore stressed the importance of pharmacists being able to interpret resistance data.

A wide range of denominators is used in published reports, making it almost impossible to compare data. One such pitfall was the way in which different studies deal with multiple samples from the same patient. If all samples are included, the incidence of resistance may appear artificially high. This is because sicker patients, who are more likely to be infected with resistant organisms, are likely to have multiple samples sent for culture and sensitivity testing. Some studies therefore included only one sample per patient per week, others included only one per patient per month.

Concluding, Dr Livermore commented on the irony that it has taken us 30 years to work out that it is better to give gentamicin once daily; we have also spent 40 years telling patients how important it is to 'complete the course', but now use three-day courses in many situations. It will be interesting to see what we are doing differently in another 40 years!

Hayley Wickens, microbiology pharmacist St Mary's Hospital, London, gave delegates a virtual tour of a hospital microbiology lab, explaining what happens to samples sent to the lab. She encouraged pharmacists to find out how samples are processed in their local lab, to help them interpret microbiology reports. Participants also heard presentations on surgical prophylaxis, highlighting the lack of evidence on which to base practice. The study day was over-subscribed and it was very clear that study day participants really wanted to grasp the opportunity to get involved!

*Bryony Dean Franklin
Hammersmith Hospital*

2. DoH funding for antimicrobial initiatives

In June this year, the Department of Health (DoH) announced that it was making almost £12M available over the next three years, to enable hospital pharmacists to develop clinical services that promote prudent use of antimicrobials. This is the first time that hospital phar-

macists have been given DoH money to focus on a specific clinical area. However, pharmacist will need to rise to the occasion and show that money is well spent. Here we discuss the background to this development and its implications, and suggest some initiatives that pharmacists could consider putting into place with this additional funding.

The Chief Medical Officer's (CMO) letter announcing the funding highlighted the important role that clinical pharmacists play in improving patient care and promoting effective use of medicines. The letter also explained that the aim of the additional funding was to build on existing good practice, by pump-priming clinical pharmacy activities that focus on antimicrobial prescribing, particularly targeting clinical areas with high antibiotic use or other specific needs that have been identified locally.

As a result, funds were allocated to primary care trusts (PCTs) based on the number of beds in local hospitals, with some weighting towards medium-sized trusts. PCTs then distributed the funding to local hospital trusts. What kind of initiatives should we be looking at?

DoH suggests funding be used to address :

- intravenous to oral switch programmes for antimicrobial agents;
- promotion of the appropriate use of narrow-spectrum agents;
- policies used for surgical prophylaxis;
- infection control;
- choice of antibiotics for both prevention and treatment of infection.

Other examples of good practice suggested by the Infection Management PIG include:

- Attendance on ward rounds for specialities with high antibiotic use, advising on antibiotic choice, combinations, durations, routes
- Education of nursing, pharmacy, medical and laboratory staff on dosing and monitoring of aminoglycosides and glycopeptides
- Evidence-based review of antibiotic-related protocols in all clinical specialities, including surgical prophylaxis and treatment of specific infections
- Linking prescribing guidelines with local resistance patterns
- Increasing feedback to prescribers about quality of antimicrobial prescribing

- Investigating potential use of automatic stop orders for antibiotics
- Exploring the potential role of antibiotic team ward rounds for patients on complex antibiotic regimens
- Accompanied visits with junior pharmacists to provide education and support relating to antibiotic use.

While the ideal approach for many trusts may be to create a new antibiotic specialist pharmacist post, the funding may not be sufficient for a whole post. Some trusts are therefore advertising for part-time positions; others are combining the funding with existing moneys to create a post that combines antimicrobial support and other duties. There are likely to be many other models. What is just as important is that all pharmacists are encouraged to take responsibility for encouraging the appropriate use of antimicrobials, so that we can help to slow down the current spread of resistance.

What happens next?

Strategic Health Authorities will monitor the use of the funds, and the initiative will be overseen by the specialist advisory committee on antimicrobial resistance (SACAR). This committee advises the government on its strategy to minimise infections caused by resistant organisms and maintain antimicrobial effectiveness. Trusts will therefore need to draw up action plans and reports showing how the money is being used, and how initiatives link in with local priorities.

Work is also reported to be under way at the DoH to identify models of good practice for pharmacists. This is expected to be available on the DoH website and is likely to include job descriptions, business cases, examples of multi-disciplinary working, standards for antibiotic formulary committees, criteria and standards for intravenous to oral switches, policies for automatic stop dates and audit examples.

The Infection Management group aims to support developments such as this by providing a network, educational events, and a forum for exchanging examples of good practice. We are in the process of planning further educational events for 2004.

3. Infection management PIG newsgroup

The address is barbdean@tiscali.co.uk

*Bryony Dean Franklin, Barbara Dean, Wendy Lawson, Catherine McLaughlin, Hayley Wickens
UKCPA Infection Management Group*

Newsgroup addresses

If you would like to join the practice interest group electronic newsgroups, please email the group address below, giving information on your:

- Email address
- Job title
- Postal address
- Contact telephone number

UKCPA-CriticalCare-PIG-
subscribe@yahoogroups.co.uk

UKCPA-EducationTraining-PIG-
subscribe@yahoogroups.co.uk

UKCPA-ElderlyCare-PIG-
subscribe@yahoogroups.co.uk

UKCPA-InfectionManagement-PIG-
subscribe@yahoogroups.
co.uk

UKCPA-PrimaryCare-PIG-
subscribe@yahoogroups.co.uk

UKCPA-QualityAssurance-PIG-
subscribe@yahoogroups.co.uk

UKCPA-Surgery-Theatres-PIG-
subscribe@yahoogroups.co.uk

UKCPACardiologyPIG-
subscribe@yahoogroups.co.uk

UKCPA-RespiratoryPIG-
subscribe@yahoogroups.co.uk

UKCPA-Rheumatology-
OsteoporosisPIG-subscribe@ ya-
hoogroups.co.uk

UKCPA-PalliativeCare-ChronicPain-
subscribe@yahoogroups.co.uk

UKCPA-DiabetesPIG-subscribe@
yahoogroups.co.uk

New newsgroups

The following practice interest groups are under consideration for development into full PIGs. Newsgroups are a useful way to see if PIGs are viable. The addresses are:

UKCPAAccidentEmergencyPI-Group-
subscribe@yahoogroups.co.uk

If you wish to get involved in setting up either group, contact :
Philip.howard27@ntlworld.com

This abstract was omitted from the autumn symposium abstract book **The Development of the Southern Derbyshire Medicines Support Service.** Diane Harris, Project Pharmacist, across 5 PCTs in Southern Derbyshire.

Background. Older people frequently have complicated medication regimes and can have difficulty managing medicines. Many are housebound and have no contact with a pharmacist. The NSF for Older People highlighted that up to 50% of older people may not take medicines as intended and 5 to 17% hospital admissions may be due to adverse reactions or interactions.

Aim. To provide a pharmaceutical care domiciliary service, by trained community pharmacists to people of all ages and with all illnesses having problems taking or managing drugs.

Objectives: To: 1. identify patients having difficulty managing medication in primary and secondary care, 2. provide a comprehensive pharmaceutical care package, including full medication review and concordance solutions in a domiciliary setting, 3. ensure patients receive appropriate, effective and consistent support to improve medicine adherence, 4. facilitate transition of patients with potential medicine problems, across the secondary-primary care interface.

Method. Twenty community pharmacists completed extensive training including an MSc module (equivalent to 150 hours) on pharmaceutical care of older people. Referral forms were received from any health professional in hospital or community or social services. The assessing pharmacist contacted the regular dispensing pharmacist and GP for details of medication, test results and major medical history.

A domiciliary visit was made to patients, including the carer or referrer if appropriate. Joint visits were made with key workers for mental health patients and with learning disability nurses. Visits include a full medication review (including over-the-counter medicines), assessment of patients' needs and discussion of medicines based upon principles of concordance, to develop individual, tailored pharmaceutical care plans. Clinical interventions were suggested to prescribers and compliance issues addressed, including medication reminder/tick charts or compliance aids. Copies of care plans were given to patients, referrers and dispensing pharmacists and a letter sent to the GP.

Results. There were 600 referrals in the first year. The number of medicines ranged from 2 to 19 on referral and 2 to 15 after assessment. Items were reduced for 23% patients. 18% had doses changed and 2.5% had medicines increased (e.g. aspirin and statins started for CHD). Compliance aids were arranged for 69% and hoarded medicines removed from 23% patients. Problems affecting compliance included memory problems, vision problems and polypharmacy.

Safety issues identified included delirium due to continued, unnecessary oxybutynin prescription; hypoglycaemic attacks due to high-dose glibenclamide;

patient discontinued antiepileptic (thought it was a hypnotic); accidental overdose despite using a medidos box; falling due to benzodiazepines; patient stabilised on lithium and diclofenac but diclofenac suddenly withdrawn.

Impact on patient outcomes. Evaluation forms were sent to all referrers four months after the pharmacists' visit. To date, 130 (77%) forms have been returned. Ninety-five percent of referrers felt the service benefited patients/carers and 99% patients/carers and 88% of referrers had not encountered any problems with the service. The main problem was a delay from the referral to the pharmacist's visit during a very busy period. 87% referrers felt patients were not having problems taking medication but patients still having problems had included confusion, dementia and psychosis. 73% patients/carers were better at remembering to take drugs. Stock levels were better controlled in 78% cases.

Impact on professionals: Visiting pharmacists described networking, job satisfaction, personal rewards, improved relationships with doctors and increased professional standing. Professionals value the service and comments include "I have used this service for many clients and have always had positive results." - Social Worker. "The pharmacist has provided an excellent service and has always been eager to help." District Nurse

A preliminary analysis of 116 patients found that for 49 (42%) patients, 478 visits (mainly by district nurses) have been saved over a 3-month period. This is estimated to have saved £23,360 over one year. A conservative extrapolation for 600 patients would give a potential saving of £121,000 over one year and this offsets the costs of the service.

A novel initiative is a minimum data set - a tailored report produced by GP computer systems sent to the assessing pharmacist in advance. It contains patients' medical history, drugs, allergies and recent tests. Another development is hospital pharmacists assessing inpatients and liaising with the dispensing community pharmacist. If needed, medications are dispensed into the most appropriate compliance aid and used for self medication before discharge. This service is planned to be integrated with the 'single assessment process'.

All five PCTs have now funded a permanent service. It supports the NSF for Older People and assists PCTs to meet targets for medication reviews.

References. Department of Health. 'Medicines and Older People'. Implementing medicines related aspects of the National Service Framework for Older People. 2001.

Acknowledgements. Prescribing advisors at Southern Derbyshire PCTs and pharmacists. University of Derby, Dr J Lacey and Dr RGoldstein

Community pharmacy palliative care network

The Napp award was won by Shirley Kelly, Victoria Hospital, Dundee. Palliative care aims to achieve the best possible quality of life for patients and those close to them through a holistic approach incorporating psychological, spiritual, social and medical issues. Palliative care pharmacy networks have existed in Scotland since 1992 but were set up due to user demand, not specifically designed to ensure continuity of care and clinical governance. The Tayside network aimed to establish a core of well-trained community pharmacists to provide high quality pharmaceutical care and support other healthcare professionals. Fifteen pharmacies were included in the network. A multi-disciplinary steering group meets twice a year. Service level agreements

outline community pharmacists responsibilities including provision of essential drugs and information and documentation of contacts. Pharmacists were trained using distance learning and face-to-face methods where real-life case studies were discussed. Patient care has improved and patients no longer face multiple trips to successive pharmacies to obtain drugs. Confidence in the service both from a user and provider point of view has increased, but out-of-hours supply still needs to be dealt with. The scheme's success is due to the multi-disciplinary approach at all levels. Ms Kelly concluded by recommending a stepwise approach to service implementation.

Medicines management in primary care group news

1. Changes to the committee

Dawn Wilson is the new chair, Irene Gummerson has been co-opted as community pharmacy representative, Laraine Tuplin remains as secretary, Alison Wilson is our EPC representative and Steve Mennear is our e-news group and website co-ordinator.

Contact e-mail addresses are below but Dawn is out of action due to maternity leave!

irenegumm.wake@virgin.net

Laraine.Tuplin@centralderby-pct.nhs.uk

alison.wilson@whpct.nhs.uk

steve.mennear@nhpct.nhs.uk

DwnWil@aol.com

We are delighted to have Irene on board to put community pharmacists' perspective. She has written this article on what the NSF for diabetes may mean to community pharmacy.

2. National Service Framework for Diabetes Standards (December 01):

1. Prevention of Type II diabetes
2. Identification of people with diabetes
3. Empowering people with diabetes
4. Clinical care of adults with diabetes
- 5 & 6. Clinical care of children and young people with diabetes
7. Management of diabetic emergencies
8. Care of people with diabetes during hospital admission
9. Diabetes and pregnancy
- 10, 11 & 12. Detection and management of long-term complications

The **Delivery strategy** came in January 2003, for implementation from April 2003.

There is no ring-fenced money except for retinopathy screening but my hope is with the new Pharmacy Contract, due out next year.

The PSNC have mentioned the following potential 'essential services' by community pharmacists, so think of them in relation to your diabetics:

- * giving patients advice about medicines
- * advising on possible adverse effects (hypos?)
- * repeat dispensing
- * signposting patients to other professional services (diabetes nurse, dietitian, podiatrist?)
- * public health: pharmacists appear well-placed to identify new cases for screening

The 'enhanced services', to be provided by trained accredited pharmacists, start with medicines use reviews.

The 'additional services' could include smoking cessation, medicines management ('NSF: Delivery' specifically mentions pharmacists regarding this) and care home services. The specification and value of services would be agreed nationally but commissioned locally and could become essential or enhanced services.

The NSF: Delivery does mention pharmacists'

potential as supplementary prescribers, but hurdles need to be addressed, not least finding GP mentors and paid 'backfill' locums whilst you attend courses or sit in with the doctor.

There is a long way to go with the new contract: consultations, negotiation, acceptance, implementation, but I'm hopeful that at last it will enable more pharmacists to be involved in helping patients, including those with diabetes.

Irene Gummerson

3. Medication reviews

This is a burning issue for PCTs at the moment as it features in the NSF for Older People and in the new GMS contract.

In Southern Derbyshire we have used the 'Room for Review' document from the Medicines Partnership as a starting point for a strategy presented to our Older Persons Partnership Groups. We are now putting an action plan together looking at existing resources and deciding future needs to achieve the goals.

We already have money allocated to community pharmacists who undertake medication reviews in residential and nursing homes. Pharmacists also undertake home visits for patients identified with difficulties with drugs.

Another important issue is to ensure reviews undertaken are recorded on GP computers using standard read codes.

We will use secondary care links to capture medication reviews done in hospital, ensuring that these are also recorded. Community and hospital pharmacists all have a part to play.

Medicines Partnership Website:
www.medicines-partnership.org

Laraine Tuplin

4. Spring symposium 2003 workshop: Concordance

Dr Fiona Stevenson works in inpatients' health beliefs and the Medicines Partnership Task Force. She gave a brief overview of the difference between compliance and concordance.

The report that started it all, "From compliance to concordance" was published in 1997 as a result of a working group which recognised that about 50% patients on long term drugs do not take fully therapeutic doses. Reasons identified were many, centred around beliefs about medicines which are not shared within consultations. These beliefs lead to misunderstandings, which are compounded with a lack of information given in one-sided consultations, plus information and experiences gleaned from friends, family and the media.

Concordance aims to identify and bring out into the open what is actually going on, in order to arrive at a successful partnership in prescribing and medicine taking. We spent the whole of the workshop discussing areas around concordance.

Thank you to corporate members

UKCPA thanks corporate members and sponsors for their ongoing support:

- AstraZeneca Plc
- Aventis Pharmaceutical Ltd
- Baxter Healthcare Ltd
- Bayer Plc
- Boehringer Ingelheim Ltd
- Bristol-Myers Squibb Pharmaceutical Ltd
- Celltech Pharmaceutical Ltd
- Clinovia Ltd
- GlaxoSmithKline
- IMS Hospital Group
- MacoPharma (UK) Ltd
- Manderville Medicines
- Martindale Pharmaceuticals/Arum Pharmaceuticals
- Merck Pharmaceuticals
- Napp Pharmaceuticals Ltd
- Pfizer Ltd
- Phoenix PharmaPlc
- Servier Laboratories Ltd
- Sintek Ltd
- Unichem Ltd
- Wyeth Laboratories

Letters to the editors in *In Practice*: Have your say!

What do you think about the new look for *In Practice*? What articles would you like to read? Is there enough from the PIGs?

Do you have any information that should be shared with other clinical pharmacists? We have not had any letters for this issue of *In Practice*.

Autumn 2003 winners: Emergency hormonal contraception and Standards

Ten excellent oral communications at the autumn symposium demonstrated the breadth and quality of work currently undertaken by clinical pharmacists across the UK

The **GlaxoSmithKline Best First Time Presenter Award** went to **Caroline Hollingshead** from Pharmacy Alliance who presented patients' views and information needs regarding emergency hormonal contraception (EHC). Over 750 patients who had obtained EHC in 250 community pharmacies nationally were surveyed. Around 44% patients chose to purchase EHC rather than get it on prescription, as it was accessible and convenient. Respondents overwhelmingly agreed that pharmacies were a suitable place to obtain EHC, pharmacists provided appropriate advice and they would recommend the pharmacist to others. The need to improve pharmacists' provision of information regarding sexually transmitted diseases was highlighted.

Mohammed Rahman and colleagues from the Royal Liverpool University Hospital won the **GlaxoSmithKline Best Oral Presentation** for work evaluating pharmacist-written discharge prescriptions from general surgical wards. They demonstrated that compared to junior doctors, discharge prescriptions written by junior pharmacists contained fewer errors, omissions and required less interpretation. Dispensary pharmacists evaluated interventions by comparing discharge prescriptions to inpatient charts. A total of 755 interventions were required on 128 discharge prescriptions written by junior doctors compared to 76 interventions on 133 pharmacists' discharge prescriptions.

Alison Dale from City Hospitals Sunderland NHS Trust presented the 2003 **Merck Pharmaceuticals Medicines Management Award**. Work from Sunderland demonstrated that re-designing pharmacy services improved attain-

ment of patient-centered Audit Commission targets. Standards set included availability of discharge medicines within 4 hours, reuse of patients own drugs, provision of patient reminder cards and drug history taking. These were measured before the start of the project and at regular periods after service redesign. Stepwise improvement was demonstrated and all targets were met after 9 months. This was all



Agenda for Change: an update from an early implementer site

Agenda for Change, the Department of Health's initiative to harmonise and modernise pay and terms and conditions across the health service will affect all pharmacists.

Delivering the opening address at the autumn Symposium, Duncan McRobbie, Principal Clinical Pharmacist, Guy's and St Thomas' Hospital NHS Trust, described what the early implementer sites (EI) were doing to facilitate this for pharmacists.

Agenda for Change (AfC) aims to ensure all NHS staff are valued equally, thus all staff (except for doctors and very senior managers) will have their individual jobs matched against nationally agreed "job profiles" and will then be assimilated on to a common pay spine. The pay spine is divided into bands 1-7 and bands 8 a,b,c and d. Slightly different terms and conditions apply between these two groupings.

Pharmacists in secondary care EI sites have recently gone through a job analysis process.

This information is being used to create job profiles describing expected performance and allocate bands for "families" of jobs. These are currently being agreed in collaboration between the Guild of Healthcare Pharmacists and the Department of Health. A similar process for technicians is being led by the Association of Pharmacy Technicians.

Once nationally agreed job profiles have been published, pharmacy staff will then undergo a process of matching, where individual jobs will be compared to the job profiles. In EI sites this process is required to be completed by March 2004 and the planned roll-out expected to be completed by autumn 2005.

Pay progression within bands will be on the basis of performance and this will be dictated by a Knowledge and Skills Framework for each job. At the end of the first year in a job, individuals will be required to demonstrate they meet competencies described in "gateways".

Apart from pay, other issues which will affect

pharmacists include a decrease in the contracted hours (from 39 to 37.5 per week) and a change in when these can be delivered (for bands 1-7: 7am-7pm Monday to Friday, for band 8: 7am-10pm Monday to Fridays and 7am to 1pm on Saturdays and Sundays). There are also changes to overtime, unsocial hours payments and on call arrangements.

Recruitment and retention premiums may be paid for jobs where there is direct competition outside the NHS. Pharmacists have been identified as one of these groups. Pay protection will exist for 5 years individuals whose salary is adversely affected in the restructure.

Duncan said EI should be seen as pilot sites, to get bugs out of the system before roll-out. He also stressed that non-EI sites should not be doing their own thing before the processes have been agreed. Anybody being asked to do anything by their Trusts for AfC should contact GHP for advice.

Future events: awards

Napp Palliative Care Award, Merck Medicines Management Award: closing date 1 June 2004.

Study days and symposia

Uncharted territory in respiratory therapeutics, 10 February 2004

Starting out in critical care, 11 February 2004

Developing clinical practice skills, 2-4 April 2004

Keep the circulation going, 15 April 2004

Spring symposium 7-9 May 2004

Closing date for abstracts: 1 March. Register by 23 April. Corporate members dinner is on 6 May

Autumn symposium 19-21 November

Material included in *In Practice* is based on information available from resources at our disposal at the time of issue.

Opinions expressed herein do not necessarily represent those of UKCPA or individual members. The inclusion of any information does not imply any endorsement by the UKCPA.

Articles, editorials and any other information published in *In Practice* may not be reproduced for any form of advertising, sales or publicity, nor be reproduced without written permission.

In Practice is edited by Alice Osborne and Duncan McRobbie on behalf of the UKCPA public relations committee.



United Kingdom Clinical Pharmacy Association

**UKCPA, 2nd Floor, Alpha House
Countesthorpe Road
South Wigston
Leicestershire LE18 4PJ
Tel: 0116 2776999
Fax: 0116 2776272
Email: admin@ukcpa.com
Website: www.ukcpa.org**