



In this Issue

	Page		Page
Chief Officers News and Views	1	How to check the expiry date of your SMART card	3
Enhanced Service Developments	2	Devon PCT Strategic Review	3
Quick Fixes	2	New prescribing arrangements for dermatology	3
NPSA Safety Alert for coagulant dispensing	3	Supply of Controlled Drugs	4

CHIEF OFFICER'S NEWS AND VIEWS

Most of the calls and contacts to the LPC Secretariat recently have been from contractors worried and concerned about the reduction in Category M pricing that has impacted heavily on the profession. Opening the annual LPC conference last week PSNC Chairman Dr Chris Hodges spoke of financial attrition as "the most serious and current factor directly relating to pharmacy" and PSNC Chief Executive Sue Sharpe spoke of the two main pressure points affecting community pharmacy – control of entry and purchase profit income. Locally, we are seeing the reality of those statements. The ongoing delay in the adjustment of drug prices to calculate purchase profit income has been demonstrated to be a real flaw in the mechanics of funding the pharmacy contractual framework and while it could be (and has been!) argued that this is a rebalancing of over-funding through Category M in the first half of the financial year, who would have foreseen such a significant swing with such little notice?

Coupled with the ongoing inefficiencies at the NHS Business Services Authority that has meant some contractors regularly not receiving payment for prescriptions submitted and the piecemeal commissioning of local enhanced services through pharmacy we are experiencing the lowest morale in the profession we have seen for a long time.

How acceptable is it that a profession receiving 80% or more of its income from the NHS does not know from month to month what it will be paid for one prescription dispensed, or when, or has to wait three or more months to be paid for the work they have done on behalf of the NHS? We need to have a system that works for pharmacy, that is, a system that enables pharmacy contractors to know exactly what they will be paid for their NHS services and when; a system that allows them to accurately budget their financial flow over the next year and beyond, within an environment that truly recognises the contribution community pharmacy can make towards the local health needs of local populations.

When the current community pharmacy contractual framework was put in place, we truly believed that

community pharmacy would be enabled to become more service driven than supply led. Unfortunately, the commissioning of new pharmacy based services has only occurred on a small scale, certainly not to the extent of shifting services from the existing dominant medical model. Might this change? If it doesn't, the existing model of pharmacy provision will continue to be undermined and destabilized. In her speech at the conference last week, Dawn Primarolo MP said that she wanted the White Paper to address some key issues, i.e. how to best strengthen pharmacy's focus to one which promotes health and wellbeing? what changes are needed to help pharmacy make its mark in tackling the major health inequalities which exist today? How do we ensure that pharmaceutical care is both more personalised for patients and consumers and integrated with other providers? What should we be going to improve the quality of pharmaceutical care?

The crucial element of her speech was - how do we support this contribution through better commissioning of pharmaceutical services? Pharmacy often gets a bad press in terms of its management of paperwork and variability in quality. Let's move towards the commissioning of bundles or "baskets" of services from pharmacy in the same way that services are commissioned from other sectors of primary care, so that these services become integrated into the heart of pharmacy and the funding is there to support them.

So while we are waiting for the White Paper, what can you do in

the meantime? **Let's Build Bridges - take up the Chemist and Druggist's "Building Bridges" campaign that shows local MPs at first hand the work undertaken by a dedicated pharmacy team. Contact the C&D to find out how to get involved**

<http://www.chemistanddruggist.co.uk/buildingbridges> or contact the LPC for advice and support

How acceptable is it that a profession receiving 80% or more of its income from the NHS does not know from month to month what it will be paid

What do you want from the White paper?
Pharmacy as Public Health Promoters?
Pharmacy tackling health inequalities?
Personalised pharmaceutical care?
Quality improvement
Range of commissioned services?

Enhanced Service Developments

The LPC Secretariat has been busy with PCTs negotiating on local service development; for 2008-09 supervised dispensing in substance misuse, needle exchange schemes and the provision of EHC under a patient group direction continues across all three PCTs.

In Torbay, the PGD for EHC has been extended to include young women up to the age of 24. A copy of the new PGD just gone out, please contact Siobhan Grady (01803 210549) at the PCT if you are accredited but not yet received a copy – also make sure you keep the signed copy handy in your pharmacy. Torbay are also commissioning compliance support for those patients who do not meet the DDA criteria for support under the essential services component of the contractual framework; pharmacy advice to care homes and smoking cessation.

Devon are continuing the smoking cessation LES for 2008-09 with a more robust support programme for contractors. Unfortunately the pharmacy advice to care homes is not a commissioning priority for Devon PCT for 2008-09.

Plymouth are commissioning the pharmacy advice to care homes scheme and will be piloting a community pharmacy weight management service in a number of pharmacies across Plymouth based on the successful Coventry model that has demonstrated the community pharmacy model as an effective way of supporting people to lose weight and increase their levels of physical activity. This is an exciting move forward for us to start involving pharmacy in meeting local PCT targets and to integrate pharmacy into local care pathways.

Sexual Health Services: Chlamydia screening is currently being piloted in just over 50 pharmacies in Devon PCT, and we are working with them to develop a PGD for treatment. Torbay are also working with us to develop a Chlamydia screening and treatment service in pharmacy, hopefully to start later in the summer.

Quick fixes

Medicines Use Review – congratulations to the first two pharmacies in Devon that achieved their target of 400 MURs!! What's happened to the rest?? Think about the comments in the leading article, funding is available in the Advanced Services component of the pharmacy contract, MURs are intended to improve patient outcomes, so don't delay any more. The LPC continues to support contractors in the delivery of the Advanced Service, don't forget the two forthcoming workshops – support your LPC and patients, come along and learn how to "Magic a MUR!" Details on the events page of the LPC website (http://www.lpc-online.org.uk/devon_lpc/forthcoming_events.html); feedback from the first two workshops has been really positive. The LPC has also produced a further resource highlighting some quick wins for MURs, see the paper attached to this newsletter (http://www.lpc-online.org.uk/bkpage/files/115/mur/current_issues_for_mur_targeting.pdf) or log onto our website.

Asthma MURs - Some of you will have had the chance to try out a Aerosol Inhalation Monitor (AIM) at the recent COPD meeting in Plymouth. Teva UK have offered to loan AIMs to a number of pharmacies across Devon. The objective is to ensure that patients are using their inhalers correctly and receiving the best education to enable them to do so. It is intended that each pharmacy wanting to take up this offer will have the use of a machine for one month, and then it will be loaned to another pharmacy. The AIMs machine can be used to help contractors provide MURs for asthma patients. There is no cost to the pharmacies, AIMs and the component parts will be supplied and training to use the AIM provided in house. **Please faxback the attached form to let us know if you would like to have use of the AIM and we will do the rest.**

Pharmacy Forums – Devon PCT has recently started a new programme of Pharmacy Forums. Both the PCT and LPC view these forums as a key element in local communication and engagement strategies, and provide an excellent opportunity to meet local colleagues and start sharing best practice. As said earlier in the newsletter, It has never been so important for community pharmacy to work together at a local level, details of future meetings and local contacts are available on the LPC website events page. **Don't forget to bring the staff so they can get involved in the public health campaigns.**

NHS Choices – www.nhs.uk – this is a public website and the information is used by the public, NHS Direct and potential new contract applications. Check your details are correct, if not, contact your local PCT and ask them to update them. Remember, this is the way that patients will be aware of the pharmacy they can nominate for EPT Release 2 prescriptions.

Public Health Campaigns – The local public health campaigns will shortly be announced in each PCT. Pharmacy has always asserted that it is best placed to provide advice and access to the population and so improve healthcare and reduce inequalities. Public health campaigns provide a focus and are linked to PCT targets or key local concerns, and the evidence from such campaigns will inform future service needs and redesign. For pharmacy to be considered in the future, it is important to support these campaigns, don't forget they are after all an essential service and therefore a contractual obligation.

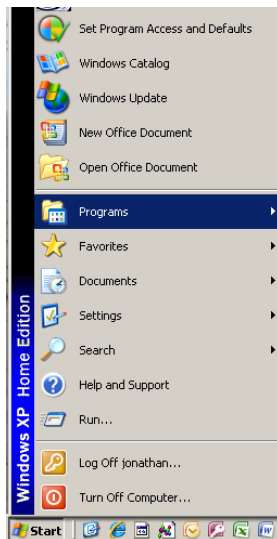



NPSA Safety Alert for anticoagulant dispensing- don't forget the dispensing checks required from the 1st April - as part of our programme of ongoing support to contractors in Devon, the LPC have developed a training brief to help you ensure you are ready for the NPSA safety requirements for anticoagulant dispensing effective from the 1st April 2008. Check out our website . http://www.lpc-online.org.uk/devon_lpc/es1.html

How to check the expiry date of your Smartcard certificate

As from June 2008 there is due to be a system upgrade to the spine that will *force* smartcard certificates to be renewed within the pharmacy before they expire; however until this upgrade, a few smartcards will need to be renewed by the PCT, or at a terminal that can renew the certificate. This may be your local GP practice. If the smartcard is not renewed before the expiry date then the card cannot be used until revalidated.

The PCT will try to contact pharmacists whose card is due to expire, but you can check your own card by following the instructions below. (Not all pharmacy systems can provide this information on screen).



1. Log in to the system with your smartcard.
 2. Click on the start button in the bottom left and corner of the screen 
 3. Select "Programmes" or "All Programmes" from the menu
 4. Select the "Gemplus" programme
 5. Select the "Gemsafe Toolbox"
 6. Select "Certificates"
 7. Select the latest red certificate on the right hand side
 8. Click on "Show Details"
 9. You will then see "Valid from" date.
 10. If this date is within the next 3 months then you should arrange for the certificate to be renewed. Contact your PCT ETP lead to see how this can be done, possibly at your local GP surgery.
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Devon PCT strategic review

– the PCT is presenting its findings from their Strategic Review at the pharmacy forums. If you are working in Devon and you think pharmacy has a lot more to offer than being recognised at the moment, now is the time to have your say.

Highlights of the review can be seen on our website at www.devonlpc.org.

An example of the PCTs stated intentions is;

Staying Healthy

"Make health checks and advice more accessible in local venues such as GP practices, pharmacies and in local community hospitals as their role develops"

Are you carrying out health checks already?

If so, tell us.

Do you have evidence that they work?

If so tell the PCT or tell us – we need to know what's out there.

New prescribing arrangements for dermatology treatment in Devon

Further to a recent meeting of Devon PCT and Royal Devon and Exeter Foundation Trust, there has been a recent announcement of new arrangements for dermatology outpatient prescribing:

From 1st April 2008, medication required for immediate treatment will be prescribed for patients attending dermatology outpatient clinics. Hospital FP10HNC prescriptions will replace the dermatology 'flimsies' that have been used for a number of years. In the majority of cases, medication will be required immediately, due

to the nature of referrals for moderate to severe conditions. The direction of the FP10HNC will generally be 28 days, contact details of the prescribing clinician will be included on the prescription in case of queries. The patient will need to make an appointment to see their GP to obtain a prescription for further supply of ongoing treatment. **Community pharmacists may wish to review stock levels of medication listed in the Dermatology section of the Joint Formulary. The only exception to the new arrangement is isotretinoin (Roaccutane®),**

Issues in Current Practice

Don't know where they live? Don't know who they are? Do know they need that controlled drug item – Do you supply?

A recent issue was brought to the attention of the LPC office concerning the supply of controlled drugs and what is expected from a pharmacist when supplying items on a prescription.

As we all are aware of the changes that were brought in at the start of February 2008, the supply of controlled drugs has become yet more onerous on pharmacists.

(see LPC January newsletter 08- http://www.lpc-online.org.uk/devon_lpc/lpc_newsletter.html)

However some of the regulatory items brought in are open to the professional discretion of the pharmacists concerned or are general good practice recommendations. For instance, take the newly introduced requirement that the pharmacist must now ask for verification of the identity of the patient or their representative. This is a legal requirement but in order to allow patients access to drugs that they require a pharmacist is able to supply a schedule 2 controlled drug without proof of identity-**it will not be a criminal offence to make such a supply**. But equally if it is felt that by the pharmacist the supply is inappropriate they are fully justified in refusing to supply to a patient or representative with no ID or with ID (see pg8 <http://www.rpsgb.org.uk/pdfs/cdmanagechguid.pdf>).

The address of a patient as we know must be placed on a prescription for a controlled drug, but some might not be aware that it is deemed acceptable for the prescription to have the address written as **N.F.A** or no fixed abode (see pg13 <http://www.rpsgb.org.uk/pdfs/factsheet1.pdf>).

Below are some more requirements that are not mandatory and are open to the discretion of the pharmacist.

1) Patients or representatives should have their identity verified by one of the following when collecting a schedule 2 controlled drug-

a. Driving license, Official photo ID, Passport, Cheque/debit/credit card, utility bills, recent bank statement, birth/marriage certificate, council rent book, Professional registration card.

NOT MANDATORY TO HAVE SEEN THE EVIDENCE FOR A SUPPLY TO BE MADE, PHARMACISTS' DISCRETION.

2) Patient or representative must sign on the reverse side of a prescription to indicate they have collected the item on a schedule 2 or 3 item-

NOT MANDATORY TO HAVE IT SIGNED (GOOD PRACTICE/ PHARMACISTS' DISCRETION)

3) Patient should have a 'Patient identifier'-(NHS number) on prescription

NOT MANDATORY TO BE PRESENT (GOOD PRACTICE-WILL BE LEGAL REQUIREMENT IN FUTURE)

CONTACT DETAILS FOR DEVON LPC

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Return of Paperwork ... is always a difficult one!

Make sure all paperwork for the multi-disciplinary audits, health promotion campaigns and LES's is returned in a timely way. If you don't want continual reminders or phone call, make a diary note of when evaluations and returns are necessary.