



Devon Local Pharmaceutical Committee

Keeping you informed of what's going on in your area
Issue No: 42 December 2007

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CONTACT DETAILS FOR DEVON LPC

Officers

Chief Officer: Sue Taylor
Strategic Development Officer: Jonathan Kerr
Project Pharmacist: Mark Stone
Secretary: Kathryn Jones

**Deer Park Business Centre, Haldon Hill,
 Kennford, Exeter EX6 7XX**

Tel: 01392 834022

Fax: 01392 833339

www.devonlpc.org

Email: admin@devonlpc.org

IMPORTANT MESSAGE – The LPC members and Secretariat Team would like to wish you all a very happy Christmas and a peaceful and prosperous new year. We are looking forward to working with you all during 2008 and to integrating community pharmacy into local service development to get the best services possible for patients in the community.

The Secretariat Office will be closed from 12.00 noon on Monday 24th December 2007, and re-open on Monday 31st December 2007

Hellos and Goodbyes

We were sorry to learn that Anna Smith, Vice Chair, was to resign from the LPC after a number of years of membership. We wish her well for the future. Sian Retallick, an independent contractor in Plymouth has been co-opted on to take her place. We also have a new Company Chemist Association representative, Andrew Howitt who works for Lloyds Pharmacy. We look forward to working with Sian and Andrew in the future.

Risky Business? Urgent Action Required?

You probably think this won't affect you. Wrong. It will.

The Department of Health has launched its consultation on the Responsible Pharmacist element of the Health Act 2006. The consultation will finish on January 20th 2008 and all pharmacists and representative bodies are urged to submit their views. The LPC will be considering a number of general points to inform its response to the DH, but would like to have views from pharmacists in Devon. What's clear is that doing nothing is not an option.

More information is available on the PSNC Website and in the December 2007 edition of Community Pharmacy News and a copy of the full consultation document can be viewed on the LPC Website (www.devonlpc.org).

Being responsible – A responsible person is one who is able to act without guidance or supervision, because he or she is accountable and answerable for his or her behaviour. Such a person can be trusted or depended upon to do things on his or her own.

In brief, the consultation is looking at the role of the responsible pharmacist, the records to be kept, and the qualifications and experience necessary for a pharmacist to be eligible to be the responsible pharmacists. The current consultation is not looking at who supervises the sale or supply of medicines, for some bizarre reason only known to the Department of health, supervision will be the subject of a future consultation. What do you think?

Absence from the pharmacy – good for enabling pharmacists to get more involved in primary care. But what about your valuable role as a source of accessible healthcare provision, information and advice. How much time should a pharmacist be

off the premises – one, two or three hours a day; or 50% of the opening hours – 20 hours a week? Should there be a maximum period of absence? What do you think?

Safeguarding patients and members of the public is crucial, a responsible pharmacist will be expected to develop standard operating procedures to do this (if not already done) relating to the sale and supply of medicines and review these each day depending for example on staffing levels or unexpected absence of a member of staff – should this be specified in regulations or guidance and good practice. What do you think?

The burden of **record keeping** will be increased by new requirements to record the identity of the responsible pharmacist for all times that the pharmacy is open and any changes made to SOPs as highlighted above. The consultation is asking what records should be kept. What do you think?

One pharmacy, one responsible pharmacist. Should a pharmacist be able to be the responsible pharmacist for more than one pharmacy at one time? Or should the legislation allow for exceptional situations? The exceptional definitions need to be carefully designed to prevent dilution of the general rule – what would constitute an exceptional circumstance?

Who can be a responsible pharmacist? The government does not intend any additional formal or academic qualification in order to be a responsible pharmacist. But it does not believe that responsible pharmacists should have the relevant experience. It is suggested that there is a minimum period following registration before a pharmacist is eligible. How will this affect recruitment in pharmacy? Will new graduates be prejudiced against by companies?

The way pharmacy contractors conduct their business could be significantly affected by these changes, primary legislation is in place relating to the role of the pharmacist in charge of a community pharmacy and the supervision of the sale, supply, preparation and assembly of medicines. The current consultation is to sort out the details. The LPC will be responding on behalf of our contractors. Community pharmacists need to take an interest in the consultation, you may want to respond on your own behalf. ***If you want us to take account of your views, please use the faxback form attached. If there is enough interest we will put on an evening session to discuss in more detail. Use the faxback form to let us know by the 31st December if you would like to have a local meeting, or 7th January for feedback.***

Category M: 2007/8 Quarter 4 Prices

The 12th Category M price changes have been announced. These prices will apply to prescriptions dispensed in January to March 2008. There are no additions to Category M but the following products will no longer appear in Category M from 1st January 2008:

Clomipramine 25mg capsules (100 pack)	Co-proxamol 32.5/325 tablets (100 pack)
Dipyridamole 25mg tablets (100 pack)	Dosulepin 25mg capsules (100 pack)
Fenbufen 300mg tablets (84 pack)	Ibuprofen 600mg tablets (100 pack)
Metronidazole 400mg tablets (100 pack)	Selegiline 5mg tablets (56 pack)
Selegiline 10mg tablets (28 pack)	

In addition, the DH have confirmed that the reimbursement price for Phenytoin Tablets 100mg (28 pack) will drop to £40 from the 1st January 2008. For more information and to view the list in full see the PSNC website. www.psn.org.uk

The Devon LPC Annual Contractors' meeting and AGM held in November promised to be a lively meeting and we were not disappointed! Over 70 community pharmacists attended the meeting at Sandy Park in Exeter, and heard Peter Colclough Chief Executive Torbay Care Trust, Kevin Snee, Chief Executive Devon PCT and James Short, Director of Primary Care Plymouth PCT talk about their local strategies for developing the NHS and where community pharmacy fits in. The meeting was ably chaired by Dr Michael Dixon, OBE, Chair of the NHS Alliance and a Devon GP. This is what Dr Dixon said in an article published in the November edition of Devon's HealthyLife newsletter.

Because we're worth it!

ONE of the joys of being a GP is never knowing exactly what challenge is going to come through the door next. And this was the case while chairing the recent Devon Local Pharmaceutical Committee (LPC) as the massed company of local pharmacists challenged me and the

Chief Executives of the three Primary Care Trusts with some searching questions.

One of the most passionate was: ***"Why are local community pharmacists being excluded from practice-based commissioning?"***

The easy answer to their question would have been to say that most practice-based commissioning consortia are in their early stages. The honest answer, however, is that practice-based commissioning (PBC) has been largely centred around GPs and GP practices with other clinicians often feeling peripheral.

There is only one tactic when you are being marginalised – prove that you are indispensable. Clearly pharmacists are just that - they simply need to make their case. Throughout Devon there are examples of pharmacists playing a part in reducing unscheduled hospital admissions, of enabling more cost effective care through medicines management and providing extended primary care through screening, treatment of minor injuries and no smoking clinics.

For pharmacists, and all other primary care professionals for that matter, their case will be won by contacting PBC leads (once they are in place) and sowing the seeds in their minds of how they can help redesign better services and save money that can be spent on new services. Every professional group that feels left out of PBC must prepare its case as to how it can help meet the aspirations of the local PBC Consortium.

The LPC meeting also revealed the enormous cultural advances of the past few years. Local pharmacists expressed a wish to become involved in improving local health and reducing inequalities. They want to work with GP practices on clinical governance and be part of joint significant event audit meetings. They also wanted to work with local senior managers in PCTs and put aside the old clinician/managerial rivalries of the past.

It is a credit to these local pharmacists that they want to be involved. The NHS has thrived, as much as it has, largely because people cared, went further than they were paid or contracted to do and because they believed that their main function was to make a difference for patients and the local population. The Devon LPC meeting represented an extension of this great tradition. The integration of local clinicians as commissioners as well as providers may represent the single most important change for the good that we have seen in recent times and have far greater significance than any central target or organisational reform.

For more information about the LPC, to see the annual report and presentations from the meeting look at the Devon LPC website www.devonlpc.org

NPSA Safety Alert 18 Actions that can make anticoagulant therapy safer - March 28th 2007

The NPSA outlined in an alert to all healthcare professionals in March of this year a number of actions that can make anticoagulation therapy safer for patients (**The Pharmaceutical Journal** Vol 278 No 7445 p356, also see A4 Alert card circulated with this issue). These recommendations were produced because it has been recognised that anticoagulants are one of the classes of medicines most frequently identified as causing preventable harm and admissions to hospitals.

Within the alert released were a number of competencies which are required to be in place in any healthcare organisations who are involved in anticoagulant therapy. Pharmacies are required to have the Dispensing oral anticoagulant competence (number 4) in place, this details the following.

Actions for Pharmacy (competency 4)

1. Find out the patients understanding of their therapy, explain what the therapy is for and how any lifestyle factors can impact the treatment.
2. Ensure the patient has the new yellow book which has been explained to them.
3. Ensure there are arrangements in place for measuring the patients INR.
4. Ensure drugs are dispensed with written instructions on what they are for and how to take them.
5. Inform patient of any side effects and what to do if they experience them.
6. Ensure patients understand the potential for interactions with their therapy and the need to consult with a Pharmacist before purchasing OTC medications.
7. Make sure that the use monitored dosage systems for anticoagulant therapy is minimised and that where they are used a risk assessment is carried out.

See (<http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/alerts/anticoagulants>).

The local PCTs all have to ensure that these recommendations are in place before the end of March in 2008. Some have already started communicating with Pharmacies to find out whether the recommendations have been incorporated into the standard operating procedures, if not they will be contacting you shortly. How about using this as a trigger for a Medicines Use Review?

Changes to the sale of Pseudoephedrine or Ephedrine products.

The Medicines and Healthcare products Regulatory Agency (MHRA) issued a statement in August 2007 about the changes to the sale of ephedrine and pseudoephedrine following a consultation.

(http://www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&useSecondary=true&ssDocName=CON2032216&ssTargetNodeId=389)

The MHRA said OTC medication containing these drugs should:

- Have a reduced packsize to 720mg (12 * 60mg or 24 * 30mg)
- Packs should be limited to one per customer
- Sale should be carried out by the pharmacist.
- These products may be reclassified as POM in 24 months if the illicit manufacturer of methylamphetamine is not contained.

In November 2007 the position was clarified through the Commission of Human Medicines (CHM) that the sale of OTC medication containing these drugs should:

- Have a reduced pack size to 720mg (12 * 60mg or 24 * 30mg)
- Packs should be limited to one per customer
- Sale should be carried out by a suitably trained counter assistant.

This would mean that a pharmacy has a Standard Operating Procedure for the sale of Pseudoephedrine or ephedrine indicating when the sale should be referred to the pharmacist and what the counter assistant must do when selling OTC medication containing these drugs. The NPA training guide can be found at the following link. <http://www.npa.co.uk/members/ephedrine.php>.

Electronic Transfer of Prescriptions.... Another burden or an extra pair of hands!

There is no doubt our work-load as practicing community pharmacists has risen steadily over the last two years with the arrival of recording of CPD , MURs and no end of local and national initiatives. The arrival of ETP I am sure has been greeted by many of us with a sigh of “ another job to fit into an already packed day” however ETP may just prove to be the very tool we all need to help free ourselves to deliver current and future pharmacy services.

My own experience began some months ago with the arrival of a scanner and some new software which sat quietly gathering dust for some time. At the end of August a number of prescriptions from our local surgery started to appear bar-coded and in a moment of either curiosity or post holiday motivation I decided to see if I could make the software work. After a few hours of CPD and armed with a smart card and password I decided to give it a go. I had zero expectations of the system and expected to give up soon into the adventure. How wrong I was.....

9.00am put smart card in reader
9.01am signed into professional services
9.02am scanned in script
9.03am prescription detail on my system and ready to print

ABSOLUTELY BRILLIANT!

Rarely have I been so impressed by a “bit of kit”. All ETP scripts are scanned in first thing in the morning and within a few minutes are sitting in my system for me to deal with when I am ready. Acute prescriptions are scanned in and printed out quicker than before with the increased safety of the certainty that the information on the GP prescription has been completely and 100% accurately transferred onto our own clinical system.

Obviously there are some teething problems such as appliances not being “allowed” on ETP prescriptions at this time however I am sure this will be sorted soon. My own experience of ETP has been both enjoyable and professionally rewarding and I would urge all my colleagues in Devon to embrace this excellent new technology.

John Finn
Lloyds Pharmacy, Crediton

The next full LPC Committee meeting will be held on Monday 14th January 2008 (7.30 pm) at the Secretariat Offices, Deer Park, Haldon Hill, Kennford, Exeter. If you are interested in attending as an observer please contact the Secretariat. For a full schedule of LPC meetings for 2008, see the LPC website www.devonlpc.org