

Pharmacy Flyer

Focusing on pharmacy in the new NHS



More than medicines

In this edition of the Pharmacy Flyer we look at the potential for community pharmacy to save the NHS money whilst improving patient care.

We consider the New Medicine Service and targeted Medicines Use Reviews (pages 2-3). These have been implemented in community pharmacy from 1st October and fit firmly within the Quality, Innovation, Productivity and Prevention (QIPP) agenda.

Community pharmacy's contribution to QIPP is

explored on (pages 4-6).

The Health and Social Care Bill is making its way through Parliament. We highlight some of the risks to pharmacy of the changes which are already happening and how PCTs can mitigate against them when transferring responsibilities to local authorities (pages 7-8).

If you would like more information or have any comments then please contact the editor Margaret Peycke m.peycke@npa.co.uk

Stop Press...

Community pharmacy alcohol brief interventions save money in primary and secondary care referrals as a result of at risk drinkers reducing their alcohol consumption¹.

Evaluation of the Royal Borough of Windsor and Maidenhead community safety partnership

project showed: demonstrable outcomes, demonstrable financial gain, sustainability and diffusion. The project is being taken forward as a QIPP initiative.

Reference

¹ SE Alcohol intervention programme evaluation report available from the Centre for Public Innovation www.publicinnovation.org.uk

What's happening in Ask Your Pharmacist Week

AYP Week – More than Medicines (7-13 November) is part of the NPA's ongoing work to showcase community pharmacy as an expert clinical and public health resource, as well as an effective medicines supply service.

Evaluation of last year's AYP Week showed a marked rise in awareness. For example, it halved the number of people who believed that no community pharmacies offered NHS stop smoking services.

AYP Week is a great platform for a concentrated and concerted public awareness drive. So we encourage NPA members, local pharmacy representatives and NHS bodies across the UK to get involved.

This year we want AYP to be bigger and better – and this

requires the active involvement of the local NHS in the initiative. We have updated and re-launched the Ask Your Pharmacist website www.askyourpharmacist.co.uk. This includes video content about medicines use and pharmacy.

If you have comments about the website, or wish to link your own website to any of the AYP content then please contact Sarah White, NPA Press Officer on 01727 795901 / s.white@npa.co.uk.

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The New Medicine Service and targeted Medicines Use Reviews

October 1st saw the launch of the advanced pharmacy service, the New Medicine Service (NMS) and targeted Medicines Use Reviews (MURs). Both of these services support the Quality, Innovation, Productivity and Prevention (QIPP) agenda. Pharmacists and their representative bodies, Local Pharmaceutical Committees (LPCs) need to be supported to ensure all prescribers understand the value of these services, how they can improve patient care and reduce costs.

The aim of the NMS is to provide support to patients when they first start taking a new medicine for a long term condition, so that they can obtain maximum benefits from their medication.

The NPA has produced a pack to support pharmacists implement the NMS. This pack, along with other supporting materials such as FAQs, are available to all on the NPA website; <http://www.npa.co.uk/nms/> To obtain a free hard copy email Simon Wills: s.wills@npa.co.uk

Background to the service

NMS is an evidence based service based on proof of concept research by the London School Pharmacy¹. It is estimated that 30% to 50% of people with long term conditions do not take their medication as intended by the prescriber. This not only leads to poor disease management with increased morbidity, the possible need for additional medication and unplanned hospital admissions but also the costs associated with the waste medication such as the collection and destruction over and above the cost of the medicines.

Earlier research² had shown that 33% of patients, ten days after the initiation of a new medicine, were not fully compliant with their treatment regime, as intended by the prescriber, and of this sample 45% were intentionally non compliant and 55% were unintentionally non compliant. 66% of the patients had medicine related problems and concerns and 61% wanted further information about their medicines.

The proof of concept research¹ then demonstrated that pharmacist intervention at ten to fourteen days after a prescription for a new medicine was issued improved compliance or identified occasions when the medication had been or should be stopped and the patient should see their prescriber.

The results showed that non adherence was significantly decreased in the intervention group, 9% were non adherent compared to 16% in the control group and that those in the intervention group had fewer medicine related problems

or concerns (23% as opposed to 34% of those in the control group).

Overview of Service

The NMS³ has been developed initially for patients with Asthma/COPD, Diabetes (type 2), on Antiplatelet / anticoagulant therapy or have hypertension. These patients also have to be on medicines in specific BNF categories.

The service takes place in three stages:

1. Identification of patient and enrolment includes gaining consent to information sharing
2. The intervention - a semi structured interview carried out at seven to fourteen days after treatment has commenced. This can be carried out face to face or over the telephone.
3. Follow up, again face to face or by phone 14 to 21 days after the intervention.

Data will be captured at all stages of the process so that the service can be evaluated. The money for the service is only available to April 2013. The results from the evaluation, by the Department of Health, will determine the future of the service. Community pharmacists can provide the NMS service if:

- The pharmacy has a consultation room which meets the specifications laid down for MURs
- The pharmacist is accredited to provide MURs
- The pharmacist has completed the NMS self – assessment form declaring that they have the necessary skills and knowledge to deliver the NMS.

Service outcomes

This service supports the QIPP agenda of saving money whilst improving patient care. It should:

- improve patient adherence
- increase patient engagement with their condition and medicines
- reduce medicines wastage
- reduce hospital admissions due to adverse events from medicines
- lead to increased Yellow Card reporting
- receive positive assessment from patients
- improve the evidence base on the effectiveness of the service
- support the development of outcome and/or quality measures for community pharmacy and also improve pharmacist and GP working.

What can PCTs do to maximise the potential savings from the NMS?

Identification and enrolment of patients is going to be key to the success of the service. Whilst pharmacists can and will use their PMR data to identify potential service users, we know from experience with MURs, that if GPs refer patients to the service, it (the NMS) is given a kudos that means patients are more likely to take up the offer of the intervention. We are also aware that if GPs have not understood the benefits, to their patients and themselves, of the service, they will not refer their patients. GPs also need to be reassured that they will not be inundated with paperwork they do not know what to do with and patients being referred back to them, in their eyes, unnecessarily. Pharmaceutical Services Negotiating Committee (PSNC) and the British Medical Association (BMA) have produced an information sheet⁴ for GPs and also a joint letter for LPCs and LMCs⁵. The NPA has also produced a FAQ sheet for GPs and GP staff⁶.

PCTs can facilitate GP/ pharmacist working to enable efficient and effective delivery of the service either by initiating learning events or supporting those run by LPCs and LMCs, this may involve encouraging LMCs and GPs to attend. Topics for discussion could include:

- What the service entails and the benefits for patients and the practice
- When GPs prescribe a new medication for an eligible patient why and how they should refer them to the new service
- Reassuring GPs that they will not receive paperwork every time a patient enrolls in the NMS. Patients will only be referred when a prescriber review is required.
- Agreeing referral criteria including prioritisation and how patients are referred back to a GP. This will have the additional benefit of patients seeing how the joined up working improves their care.

Changes to the Medicine Use Review (MUR) service⁷

These also come into force on the 1st October and include targeted MURs for:

- Patients taking high risk medicines (specified in service specification)
- Patients recently discharged from hospital who had changes made to their medicines while they were in hospital. Ideally patients discharged from hospital will receive an MUR within four weeks of discharge but in certain circumstances the MUR can take place within eight weeks of discharge
- Patients with respiratory disease.

From October 50% of MURs that pharmacists carry out have to be for patients in the target groups. Targeting MURs will not only ensure that patients most likely to benefit from MURs will receive one but will also enable commissioners



and clinicians to realise more value from the service. PCTs should work with GPs and secondary care to develop a method of alerting pharmacists to patients who have been recently discharged from hospital and also work with hospital discharge pharmacists and nurses to ensure that patients are aware of the service.

There are also some changes to the clinical governance elements of the contractual framework which are documented on the PSNC website www.psn.org.uk.

References

¹ Patients' problems with new medication for chronic conditions Barber N, Parsons J, Clifford S, Darracott R, Horne R Quality and Safety in Health Care, 13 (3): 172-175 (2004)

² Patient-centred advice is effective in improving adherence to medicines. Clifford S, Barber N, Elliott R, Hartley E, Horne R. Pharmacy World and Science, 28: 165-170. (2006)

³ Full details are available on the PSNC website <http://www.psn.org.uk/pages/nms.html>

⁴ Community Pharmacy services – a briefing for GP practices NHSE, PSNC and BMA August 2011 http://www.psn.org.uk/data/files/PharmacyContract/Contract_changes_2011/GP_guide_to_contract_changes_Aug_2011.pdf

⁵ Joint letter to LMCs and LPCs http://www.psn.org.uk/data/files/PharmacyContract/Contract_changes_2011/IMP028_06_Letter_to_LMCs_and_LPCs.pdf

⁶ NMS FAQs for GPs and GP staff www.npa.co.uk/nms

⁷ Changes to MUR service PSNC <http://www.psn.org.uk/pages/mur.html>

Quality, Innovation, Productivity and Prevention framework

Background

In the Spring 2010 *Pharmacy Flyer*¹, we described key features of the Department of Health's Quality, Innovation, Productivity and Prevention framework (QIPP)². QIPP is a large scale transformational programme, which aims to improve quality of care whilst making up to £20 billion of efficiency savings by 2014-15.

Each SHA has developed an integrated QIPP plan of its own. There are a number of national work streams producing tools and programmes to support local change leaders. Work streams include long-term conditions, delivering the right care at the right time, or Improvement of productivity by making better use of workforce skills and capacity. There is a national work stream specifically focusing on medicines use and procurement which is being led by Peter Rowe, who is a pharmacist by background.

The medicines use and procurement work stream aims to offer:

- Clear guidance on the efficient use of medicines in primary care, through the National Prescribing Centre and review / expansion of existing Better Care Better Value indicators
- A best practice tool on medicines management and additional support for Primary Care Trust Prescribing advisers
- Greater transparency and clarity to commissioners and prescribers on the cost of treatments such as 'Specials'
- Additional proposals to reduce medicines waste and improve concordance.

At a recent meeting, Peter Rowe rejected claims that the medicines QIPP agenda was primarily about cutting the drugs bill.

"Transformation is changing the way the system and the people within it work, and because we have to release cash there will be tough decisions made. If people want to call these "cuts" then fine, but I think they're efficiency savings."

He said that there was no evidence that current medicines-related QIPP activities were inconsistent with National Prescribing Centre Guidance or that they were not in patients' best interests.

In the rest of this article, we identify some of the strategies that may be implemented by community pharmacists to support the implementation of the QIPP agenda. PCTs should maximise the potential of community pharmacy by engaging with Local Pharmaceutical Committees (LPC)

and local contractors, supporting the delivery of advanced and essential services and by commissioning appropriate enhanced services.

Targeted Medicines Use Review (MUR) and the New Medicine Service (NMS) (see page 2)

MURs offer an ideal opportunity to explore what patients know and don't know about their medicines and to fill the information gaps. Targeted MURs help community pharmacists to focus MURs on those groups where improved adherence is likely to have the most marked impact. Likewise the NMS is initially targeted at those groups where benefits to both patients and the NHS are likely to be greatest.

Transfer of Care

Transfer of care, especially when patients are discharged from hospital is an important area where community pharmacists may have an input.

An MUR after discharge should identify unintentional as well as planned changes to treatment and help to optimise adherence to and benefits achieved by new treatment. To capitalise fully on this opportunity, hospital pharmacists will need to liaise closely with their colleagues in the community to identify patients who are about to be discharged or have recently been discharged, and to encourage patients to visit the community pharmacy of their choice and ask for an MUR.

The Royal Pharmaceutical Society has recently published *Keeping patients safe when they transfer between care providers –getting the medicines right*³, professional guidance on good practice for medicines management during transfer of care between sectors. Empowering patients to be active partners in managing their medicines is crucial to more efficient and effective transfer of care. Working with hospital colleagues, community pharmacists have a key role to play, offering patients verbal and written information about their medicines and targeted MURs.

Medicines waste

The 2010 DH report *Evaluation of the Scale, Causes and Costs of Waste Medicines* estimated the annual cost of avoidable medicines waste in NHS primary and community care in England at less than £500K for an average PCT. The authors comment that reducing this is financially and politically desirable. They go on to say that there is an opportunity for significantly greater returns (£500m

per year) in improved health outcomes from better use of medicines, further development of pharmacist-managed repeat dispensing coupled with a check to confirm the need for every re-supply is recommended. Those who over or under order could be targeted for an MUR to identify the cause.

Whilst reducing waste is not a primary end point for either MURs or NMS this may be a secondary outcome.

Integrated care pathways

Care pathways should provide the backbone of patient care, integrating all aspects of primary and secondary care. Once developed, PCTs should look at each step along the care pathway and identify who will provide each element of the service – this needs to be done in a structured way, identifying the professional(s) with the necessary skills at each stage. In addition, consideration should be given to ease of access for the patient.

For example pharmacists should undertake the medicines management aspects of the pathway and could free up GP time by undertaking routine monitoring of, for example, HbA1c for those with diabetes. *Integrating community pharmacy into the care of people with diabetes*⁴ written in conjunction with the DH diabetes team provides practical examples of the types of services pharmacists and their teams could provide.

Healthy Living Pharmacies (HLP)⁵

Developed and implemented by NHS Portsmouth followed by launches in the Isle of Wight, Southampton and Birmingham, HLPs have shown they can make a real difference to the health and wellbeing of their local communities through high quality services on alcohol consumption, contraception, sexual health, smoking cessation and weight loss.

Examples of outcomes come from the respiratory targeted MURs.

Out of 1123 patients:

355 had not seen a healthcare professional in the previous twelve months

- 70% were uncontrolled
- 74% had adherence issues
- 27% were smokers of whom
- 75% were recruited to stop smoking schemes
- 42% quit

Of the 1123 patients 48% have been seen for a second time and their condition has improved.

Twenty HLP pathfinder sites representing 30 PCTs were announced in August. The pathfinder sites represent a range of communities across England and aim to address health inequalities.

Better care better value indicators

Several of the QIPP Medicines use efficiency schemes in provider setting¹ initiatives relate to the Better Care Better Value (BCBV) indicators. For example: *A joined up approach to decision making, managing and monitoring medicines use across primary and secondary care*. The advanced pharmacy services Medicines Use Reviews (MURs) and the New Medicine Service (see above) will help in the effective delivery of the medicines optimisation agenda.

These services will enable patients to understand the need for their medication and how to take their medicines most effectively, leading to improved adherence.

NICE cost saving Guidance

NICE has published estimated savings which they claim could be achieved if certain of their guidelines were followed. <http://www.nice.org.uk/usingguidance/benefitsofimplementation/costsavingsguidance.jsp> Savings, per £100,000 spend, are cited.

Hypertension; CG34: implementing this guideline can save £446,627. The increased costs in drugs are outweighed by the reduction in heart attacks and strokes. Pharmacists can target existing patients for MURs and for newly diagnosed or patients whose medication has been changed in line with guidance the NMS.

Long-acting reversible contraception CG30: the cost of these agents is more than offset by the reduction in costs associated with unplanned pregnancies saving £214,681 One PCT in London has commissioned a community pharmacist to provide depot injections thereby improving access to this service.

Nutrition support in adults CG32: cost savings, £28,472 from identifying and managing malnourished patients. Community pharmacists are ideally placed to identify those who may be malnourished.

PCTs could commission an enhanced service whereby pharmacists screen patients using a recognised tool such as MUST⁶, developed by the British Association for Parenteral and Enteral Nutrition. Findings from the screen would determine next steps, such as advice on healthy eating and enriching diets to referral to the local dietetic service or the appropriate supply of nutritional supplements.

Supply of gluten free foods

Another initiative which supports the QIPP agenda is the Supply of Gluten Free Foods. The NHS could save five to eleven million pounds a year by reviewing the supply of gluten free foods. In order to support NHS commissioners Coeliac UK, NPA and PSNC have launched a toolkit⁷ to support a review of the supply of gluten free foods.

Pharmacy-led supply schemes offer flexibility to the

patient and remove the need for them to make frequent visits to their GP, whilst monitoring the amount of products supplied to ensure they are within the Coeliac Society guidelines.

A review of schemes operating in Northamptonshire and Cumbria showed savings of between 20% and 40%

Specials

NHS expenditure on Specials has risen rapidly albeit from a low baseline.

Prescribing is often but not always initiated in hospital by doctors who do not realise the impact on primary care prescribing budgets and GPs are reluctant to change prescriptions issued in the hospital setting.

Another cost centre for specials arises in Care Homes where patients often require special (liquid) formulations for example when they are dysphagic.

Prices vary widely between suppliers and pharmacists are encouraged to purchase wisely.

In Croydon a scheme developed between the PCT and the LPC paid pharmacists 10% of the savings made on specials.

PCTs need to consider solutions with the LPC and not dictate possibly unworkable schemes which will alienate local contractors. A new Tariff for Specials came into effect with the November 2011 Drug Tariff⁸.

Things NOT to do in the face of financial pressures

Health Ministers and officials have been explicit that the NHS should not rush to cut valuable and proven services.

This would have the effect of fracturing continuity of care and, as far as independent contractors to the NHS are concerned, undermining confidence of contractors to invest for the future.

On the contrary, straightened NHS finances should act as a spur to investment in those services that have the potential for accruing significant cost savings elsewhere in the system as well as delivering improved patient care.

Collect evidence of benefit and be able to demonstrate benefits to patients

In the current cash strapped NHS it is vitally important to demonstrate value for money in terms of patient outcomes.

Audits can be used to demonstrate how pharmacists as the experts in medicines add value to the supply of medicines by their professional input into dispensing by measures such as the number of apparent prescribing errors and anomalies challenged and corrected.

When commissioning enhanced services PCTs should build evidence gathering into the service specification focussing on data which can be easily be collected by pharmacists. Information will be easier to gather, collate and analyse by PCTs if software systems such as Pharmabase, Webstar or Sonar are used.

Direct evidence such as a reduction in hospital admissions may be difficult to gather but surrogate markers such as the number of patients with COPD who have stopped smoking or the number of women who requested EHC and who had a chlamydia test and were treated, can be used. The number of unregistered patients accessing a service could be an indicator for reducing health inequalities.

References

- ¹ Pharmacy Flyer NPA Spring 2010 www.npa.co.uk/resources
- ² QIPP, Department of Health <http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm>
- ³ Keeping patients safe when they transfer between care providers –getting the medicines right Royal Pharmaceutical Society 2011 www.rpharms.com/current-campaigns-pdfs/1303---rps---transfer-of-care-10pp-professional-guidance---final-final.pdf
- ⁴ Integrating community pharmacy into the care of people with diabetes RPS and NPA 2010 http://www.npa.co.uk/Documents/Docstore/PCO_LPCs/Integrating_community_pharmacy_into_the_care_of_people_with_diabetes.pdf
- ⁵ Healthy Living Pharmacy website, NHS Portsmouth <http://www.portsmouth.nhs.uk/Services/Guide-to-services/Healthy-Living-Pharmacy.htm>
- ⁶ MUST screening tool British Association for Parenteral and Enteral Nutrition http://www.bapen.org.uk/must_tool.html
- ⁷ Community pharmacy supply of Gluten-free food – a toolkit for commissioners http://www.npa.co.uk/Documents/Docstore/Press-Releases/About-the-Association/Gluten_free_supply_toolkit%5b1%5d.pdf
- ⁸ Drug tariff NHS BSA <http://www.nhsbsa.nhs.uk/3473.aspx>



Transfer of responsibilities from Primary Care Trusts to Local Authority organisations

Changes proposed in the Health and Social Care Bill need recording in both Primary Care Trusts (PCTs) and Local Authority organisations (LAs) risk registers. Pharmacy is an area where the transfer of roles and responsibilities, if not properly managed, has the potential to reduce patient care.

PCT clusters need to ensure that they have the appropriate skills to manage community pharmacy during the transition period. We are aware that with the clustering of PCTs some experience is being lost. In most PCTs responsibility for community pharmacy sits within one or more of medicines management, public health and commissioning / contracting teams. PCTs must also develop a robust transition plan for managing the handover of responsibilities to other organisations including the National Commissioning Board and local authorities.

Current PCT responsibilities for pharmacy include:

- Contract applications
- Contract monitoring
- Pharmaceutical Needs Assessments (PNAs)
- Commissioning of enhanced services
- Pharmacy public health campaigns (6 per year)

In addition:

- There is a statutory requirement for PCTs to appoint an Accountable Officer who is responsible for the use and management of controlled drugs in the area.
- PCTs have a responsibility for Patient Group Directions (PGD) where they are used within enhanced services to supply prescription only medicines such as emergency hormonal contraception. Responsibility lies with the PCT who set up PGD.

It is still not clear where all responsibilities and lines of accountability will lie. Broadly we know that:

- Responsibility for PNAs will be transferred to Health and Wellbeing Boards
- The National Commissioning Board will directly commission a range of services including primary care which includes pharmacy contracts
- Pharmacy public health services are likely to fall under the remit of directors of public health and be determined by Health and Wellbeing Boards (HWB)
- Other pharmacy-based services may be commissioned by Clinical Commissioning Groups (CCGs)
- The new structures will include clinical senates and Local Professional Networks (for pharmacy, optometry

and dentistry) which will support CCGs and HWBs.

PCTs and local authorities, through the Directors of Public Health and Health and Wellbeing Boards, must work together to manage the transfer of responsibilities. In some areas transition groups have been set up. These may consist of PCT/ SHA pharmacy teams and local authorities and DsPH and Local Pharmaceutical Committees (LPCs). In addition councillors and officers with responsibility for adult social care may be involved.

Pharmaceutical Needs Assessments

A good PNA will sit alongside the Joint Strategic Needs Assessment (JSNA). The JSNA will include the health needs of the population whilst the PNA reviews the pharmaceutical provision and the pharmaceutical needs. Pharmaceutical services are defined in legislation.

Community pharmacies may deliver additional services commissioned by the PCT, the need for which is determined by the PNA. Whilst some of these services are clinical the majority support the public health agenda. It is also likely that in future the current Control of Entry system for deciding pharmacy applications (see below) will change and that the PNA will be used to determine applications.

Not only is it important that PNAs are robust and kept up to date by the PCT clusters but also that systems are put in place for the transfer of the PNA to Health and Well Being Boards. Primary Care Commissioning has produced Ten Top Tips for managing the transition of PNAs to Health and Wellbeing Boards which include:

- Ensure the PNA process is noted in the PCT risk register
- Prepare a project plan identifying the roles and responsibilities for the transition
- Maintain the PNA
- Identify the health and well being lead at the local authority
- Brief the LA
- Involve the LA in the PNA management process before transition
- Ensure the LA stakeholders understand the role of the PNA in market entry and commissioning

It is essential that if communities are to get the pharmaceutical services they need that there is a robust PNA as this will be used by the National Commissioning Board to award pharmacy contracts as well as for commissioning enhanced services.

A quick guide to pharmacy for local authority officials and councillors

Community pharmacies, like most GP practices, are privately owned yet are an important part of the NHS family. For the average community pharmacy over 90% of their income comes from delivering NHS services.

Community pharmacy services are paid for out of a nationally agreed sum. This is ring fenced but cannot be exceeded. Pharmacists are the experts in medicines, highly qualified with a four year degree course in pharmacy followed by a pre-registration training year.

Non pharmacist staff in pharmacies have to have a minimum NVQ level 2 training to be a medicines counter assistant and pharmacy technicians (usually in the dispensary) are trained to NVQ level 3.

Community pharmacy provides services which support local authorities' agendas for:

- Supporting independent living
- Reducing health inequalities and
- Public health

Market Entry

Currently the awarding of community pharmacy contracts (Control of Entry, it is not a free market) is the responsibility of PCTs and applications are divided into 'standard' 40 hour contracts and 'exempt' applications.

Standard contracts are subject to the 'necessary and expedient test' whilst exempt applications are those which are open for 100 hours, some shopping centre and health centre pharmacies and internet pharmacies.

The system is currently under review.

For information on the control of entry regulations visit the Department of Health website <http://www.dh.gov.uk/en/Healthcare/Primarycare/Communitypharmacy/NHSpharmaceuticalregulations/Controlofentry/index.htm>

Pharmaceutical contractual framework

The pharmacy contract has three service levels all of which include public health elements.

Essential services – all pharmacies have to provide the essential services which include:

- Dispensing of medicines

- Repeat dispensing
- Waste management
- Public health including:
 - Lifestyle interventions
 - Sign posting
- Self care
- Clinical governance
- Supply of appliances

Advanced services are commissioned centrally. There are now three.

- Medicine Use Reviews (MURs) are provided by the majority of pharmacies. Changes to the contractual framework, which came into force on the 1st October 2011, mean that 50% of MURs have to be targeted at patients suffering from Asthma or COPD or have been recently discharged from hospital or are taking a medicine on list of commonly taken medicines more likely to cause unintended consequences if not taken as intended.
- New Medicine Service (NMS) is a new advanced service for people with the following conditions or therapies: diabetes (type 2), asthma /COPD, anti-platelet – anticoagulation therapy or hypertension. For more details see the section on NMS page 2.
- Appliance Use Reviews for patients using specified appliances

Enhanced services - these are commissioned by PCTs to meet local need, determined by the PNA, and whilst some are clinical the majority support the public health agenda. The most commonly commissioned services are: stop smoking, needle exchange, supervised consumption for substance misusers, supply of emergency hormonal contraception and chlamydia testing and possibly easy access to treatment for self limiting conditions rather than having to visit the GP.

Pharmacy and public health

Community pharmacy has an impressive track record in public health. A guide specifically produced for councillors and council officers. *What can pharmacy do for your local community?* is available by contacting Simon Wills s.wills@npa.co.uk