



New Chair for UKCPA

In Practice gets to know Dr Chris Green, new Chair of UKCPA, a little better...

My day job is Director of Pharmacy and Medicines Management at the Countess of Chester Hospitals NHS Foundation Trust.

UKCPA means meeting other people who are passionate about improving themselves and their services to patients, who are prepared to push boundaries and who are real leaders in clinical pharmacy. It also means fun and friendship – part of the enjoyment of conferences is meeting up with colleagues who are also friends. UKCPA members take their work seriously but very few take themselves too seriously.

The best thing about being a pharmacist is that it has consistently kept me interested and given me opportunities to learn almost every day. You know you are making an actual difference to patient care. It can be challenging, but in a positive way.

I take my inspiration from people who deliver above and beyond what is expected, because it reminds you that you can do it too. Those who think outside the box and are passionate about their interests also inspire me.

My top three priorities as Chair of UKCPA are to work with the rest of

the team to guide us through the changes in the GPhC and RPSGB and maintain UKCPA as a leader in clinical pharmacy, to ensure that we build on our successful partnership with the GHP and other like minded organisations, and to work towards some nationally recognised standards for clinical pharmacy services.

We've got a real opportunity to build on the success of UKCPA with the increase in full time office staff and the appointment of a General Secretary. Credentialing, the Pharmapedia project, CPD, and working more closely with other specialist groups and the RPSGB all have exciting potential.

The biggest challenge facing the profession currently is probably the financial meltdown. I believe pharmacy really needs to show how valuable its role is. Also, I think the undergraduate curriculum needs a radical overhaul so that graduates are better equipped for the job that they will do.

My advice to aspiring pharmacists is to be observant and recognise who is good and who is not so good, and learn from each of them. Think about a change or move if you feel



Pictured: Dr Chris Green, Chair of UKCPA

you are getting stale or frustrated. Grab experience when the opportunity arises - you can learn a lot about a job and yourself if you stretch yourself. Finally, enjoy yourself and don't rush too quickly through your career. My favourite quote is from Ghandi and goes something like, "Teaching gives you knowledge, experience gives you wisdom". Ambition is fine, but you have to deliver in your role, whatever it may be. Some people think it's great to be a chief pharmacist as early as possible but it's a tough job and you could be in it a long, long time!

People probably don't know that I'm in a céilidh band called "Love thy caber" (not my choice!) and play bass guitar. I've also been in a rock'n'roll band and a Jazz band.

"The UKCPA promotes expert practice in medicines management for the benefit of patients, the public and members by establishing standards, workforce development and advancing innovation in all health care settings.

The UKCPA encourages Excellence, Leadership and Partnership"

Editorial

Welcome to the 2010 Summer edition of *In Practice*. As part of my role as General Secretary I will now be editing our valued newsletter, although still under the expert guidance of Duncan McRobbie as Editor-in-Chief. You may notice some minor changes in this quarter's edition which I hope you view as improvements. There will be a more dramatic makeover in the next edition so keep an eye out. Please let me know what you think about the changes - good and bad! - email me at general.secretary@ukcpa.com.

Editing *In Practice* is one of a number of tasks I am now undertaking as General Secretary of UKCPA. Find out a little more about this new role on Page 3.

Of course, the big news is that UKCPA has a new Chair as of May 15th 2010. Dr Chris Green took over from Helena Hodges at the UKCPA/GHP conference in Leeds. He

is Director of Pharmacy and Medicines Management at the Countess of Chester Hospitals NHS Foundation Trust, has been a member of UKCPA for 17 years and an active member of the General Committee for 10 years. We warmly welcome him as Chair of the Association. Page 1 features an interview with Chris, including his views of the profession and what he hopes to achieve whilst Chair of UKCPA.

Whilst on the subject of the May joint conference, we report news from the keynote speakers including Duncan Rudkin, Chief Executive and Registrar Designate of the General Pharmaceutical Council, and representatives from the RPSGB (from page 4).

Dr Sarah Carter
General Secretary, UKCPA

Pharmacy can't afford to rest on its laurels with new Government

"Andrew Lansley's new NHS agenda contains interesting challenges for both community and hospital pharmacy", says David Taylor, Professor of Pharmaceutical and Public Health Policy at the School of Pharmacy University of London.

Professor Taylor believes that these challenges will relate to saving money and adding to health improvement in the years of limited or no funding growth ahead. In the contexts of commissioning, public health and primary care delivery many people will welcome the renewed focus on a patient and primary care led NHS.

However, he warns that "with PCTs being pulled back to a public health focused role and GP commissioning groups leading change pharmacy will need to build strong relationships and present its economic case well."

Announcements

Gill Hawksworth, fellow and former president of the Royal Pharmaceutical Society and Chair of the UKCPA Community Pharmacy group, has been awarded the Society's Charter gold medal for 2010. She says, "I am both honoured and privileged to receive this award. My contribution to the profession has been inspired by the many outstanding pharmacists I have met through the unique UKCPA network." We congratulate Gill on her outstanding achievement.

Mark Tomlin has been designated a Fellow of the Royal Pharmaceutical Society for his outstanding work in the practice of pharmacy. Mark is a Consultant Pharmacist in Critical Care at Southampton General Hospital and a key member of the UKCPA Critical Care group. Many congratulations Mark.



Tribute to John Hall

It was with great sadness that I heard of the untimely death of John Hall on March 20th. John was a long time member of UKCPA and together with his business partner Noel Dixon, developed impressively innovative services from their pharmacies in the North East of England. Not only did their patients benefit from the clinics they ran, at a time when most of community pharmacy was busy dispensing prescriptions, but UKCPA members also benefitted from listening to John and Noel extolling just what could and should be done. Between them they ran workshops, freely giving of their expertise and enthusiasm, and delivered with a unique blend of humour and intelligence. Community pharmacists owe a debt of gratitude to John's drive and determination to implement clinical services. The pharmacy profession is a poorer place with his passing.

Linda Stephens

General Secretary tasked with new plans for UKCPA

Dr Sarah Carter tells us about her role and her ideas for UKCPA

What does your role involve?

The role of General Secretary is tasked with overseeing and directing member service development and building on the continued success of UKCPA to deliver world-class education and training, and member services and support, under the direction of the General Committee and Business Management Group. My job will be to direct the marketing and communications strategies, implement policy and ensure good governance practice, and oversee the enhancement and development of opportunities for new member services.

What experience do you bring to UKCPA?

I have worked in the field of pharmacy and pharmaceutical public health for almost a decade and my professional background is in health psychology and research. I have worked closely with the Competency Development and Evaluation Group (CoDEG) and have directed several pharmaceutical public health and professional development projects. I understand pharmacy while hopefully bringing in fresh ideas and a multidisciplinary approach to the UKCPA team.

What do you hope to achieve in the next year?

A lot, I hope!

I plan to identify and develop new and innovative services for UKCPA

members, particularly based around new technology. I will also assist UKCPA in implementing its new governance structures which will mean that members can see exactly what the association is focusing on and how it has demonstrated its achievements.

More conferencing, short courses and education services are on the horizon, as well as improved IT services and enhanced communications, such as a better functioning website, which will greatly benefit existing UKCPA members and increase the membership overall. I will also assist UKCPA in making UKCPA services relevant to other pharmacy interest groups, and groups who are currently underrepresented by UKCPA such as practitioners working in the community and within industry, and students and pre-registration practitioners.

What new projects are on the horizon for UKCPA?

Collaborative projects with other organisations such as the new Professional Body which will benefit UKCPA members and the profession as a whole. Using the strengths of multiple groups by working in partnership will be a key approach for UKCPA in the future.

UKCPA is also involved in a number of new IT-driven projects, such as a wiki-based knowledge and expertise sharing platform called Pharmapedia. Some members will have seen

Pharmapedia in action at the May conference and it will prove to be a huge resource for practitioners. I am also working with CoDEG who are developing an online professional development tool, based on the Advanced and Consultant Level Framework.

Changes that you will see shortly include a new look website and a makeover for *In Practice*. We are also implementing a professional profile system so that UKCPA members can search for other members who share their professional interests, or find someone with expertise outside their practice area.

Anything else you want to tell UKCPA members?

UKCPA already has an outstanding reputation for leadership, partnership and innovation and yet has the potential to progress even further. Now is an excellent opportunity to embrace the growth of UKCPA and I am delighted to be involved.



Bayer HealthCare
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A corporate partner of the UKCPA

Keynote presentations from the 6th UKCPA/GHP Conference

The 6th UKCPA/GHP joint conference held in Leeds in May this year attracted speakers and delegates from all over the UK. Keynote presentations included the future of the GPhC and the new Professional Body, and the vision for professional development for practitioners.

View of Professional Leadership – gaining a UK perspective

Representatives from the RPSGB (Paul Gimson, Wales; Howard Duff, England; Lyndon Braddick, Scotland; and Mark Neale, Northern Ireland) gave an update on the progress of the new Professional Body in their respective home countries. These included being involved in issues such as decriminalisation, talking with political parties, engaging with the public and working with the media to promote the profession.

When asked how they would engage with UKCPA they emphasised the importance of working together, and not doing things to or for the profession.

“UKCPA may be a model of what the RPS wants to do in the future” said Lyndon Braddick.

Pharmacy education

Education was the focus of the day with representatives from England, Northern Ireland and Scotland reporting on current situations and developments in their home countries.

Rob Darracott, Chief Executive of the Company Chemists’ Association and Board member of Medical Education England reported on the plans of the Modernising Pharmacy Careers Programme in England. They have already identified the strengths and weaknesses of current education and pre-registration training and found that they “could do better”. The main

area for improvement is the integration of theory and practice. The current structure of a 4-year MPharm plus 1-year pre-registration year, he said, perpetuates two identities for students: academic and professional. Current assessment systems also divert students’ attention away from practice. They propose exposure to practice early in the academic career and a close collaboration between Higher Education Institutions (HEIs) and practice, with a possible solution being the integration of the pre-registration year into a 5-year MPharm and concurrent graduation and registration in Year 5.

Susan Sanders, Director of London Pharmacy Education and Training, emphasised the benefits of collaborations between HEIs, and between HEIs and the NHS, to ensure a consistent approach to post-registration professional development. She particularly noted the work of the Joint Programmes Board as an excellent example of HEIs and the NHS working together to provide training for practitioners which meets the modern requirements of the NHS.

She also highlighted other opportunities for collaboration with organisations such as UKCPA and the Guild of Healthcare Pharmacists.

Colin Adair, Director of NICPLD reported on post-registration education delivery in Northern Ireland. A vocational training programme for early years practitioners requires completion of a

portfolio of evidence based on the GLF cluster structure and practice-based assessments such as OCSEs. They also provide a Masters degree in Advanced Pharmacy Practice, and other non-clinical Advanced Diplomas in, for example, Management or Procurement, based on the ACLF. Northern Ireland has not yet appointed Consultant pharmacists but they are in talks with the Department of Health. These posts would also use the ACLF as a tool for evaluating candidates.

Bill Scott, the Chief Pharmaceutical Officer in Scotland, highlighted the need for Scotland to radically review its hospital pharmacy career structure. He reported on a hospital pharmacy vocational training programme for Band 6 practitioners, which implements learning into practice, but doesn’t currently provide an award, such as a Diploma, and has no recognised career ladder. Similarly, community practitioners in Scotland have no career structure to follow. As with Northern Ireland, Scotland has yet to appoint any Consultant pharmacists.



From left: Duncan Rudkin, Colin Adair, Rob Darracott, Susan Sanders.

“Regulation does not exist primarily to benefit the professional but to protect the public”, claimed Duncan Rudkin, Chief Executive and Registrar Designate of the General Pharmaceutical Council

In his keynote presentation titled “Update on the progress of the GPhC—what are the benefits for the practitioner?”, Mr Rudkin went on to suggest that while the purpose of regulation was to sustain and improve patient care, the effect of regulation should be of benefit to practitioners. This may be through ensuring the public status of the practitioner and cohesion of the profession, ensuring improvement of standards, and facilitating career development via the regulation of CPD.

Mr Rudkin stressed that in order to gain public credibility, modern regulators need to be independent of professional pressure. In order to achieve this, the make up of the regulator must

at least have parity of lay members with professionals. Significantly, a statutory regulator also needs to be independent from governmental control.

All health care regulation is about describing the threshold below which practice would be unacceptable. Mr Rudkin believed that if this was the sole purpose of regulation, this would be an uninspiring role. He believed that there was an opportunity to support the “pull” from the leaders in the profession with a “push” from the regulator. Collaborative working relationships are therefore essential between the professional leadership groups and the GPhC.

In response to a question from the floor, Mr Rudkin recognised that there was an increase of complexity in the area of regulation because of the interrelationship between the legal statutes - particularly the Medicines Act - and the role of the regulator.

The GPhC has not yet announced a start date as changes to the rules requires ministerial approval which in turn requires parliamentary time. Mr Rudkin was keen to ensure that the professional voice is heard and directed participants to the GPhC website www.pharmacyregulation.org.

John Quinn, Director of Pharmacy at Buckinghamshire Hospitals NHS Trust highlights the need for consistency in postgraduate pharmacy programmes across the UK

In his keynote presentation, John Quinn described his research into this area which uncovered a huge variation in number of teaching hours, duration and clinical content of postgraduate education provision for practitioners. He acknowledged that the variation was probably due to differences in the needs and available expertise across different regions, but nonetheless such variation was “not acceptable”, he said. “Consistency is required for employers, the taxpayer and for patients”.

He noted the work of the Joint Programmes Board where HEIs and the NHS work together to provide a consistent post-registration Diploma programme. “The widespread use of CoDEG’s professional development frameworks - the GLF and the ACLF - across the UK and internationally are

also examples of unification”, he said.

His work with the Specialist Curriculum Group, which consists of representatives from most national specialist groups, both clinical and non-clinical and from primary and secondary care, develops a consistent approach for defining core knowledge and advanced general practice.



Pictured: John Quinn

RPSGB plans for educational standards and revalidation

Conference delegates were informed of plans from the RPSGB for educational standards and revalidation by Damian Day, Head of Education and Quality Assurance at the Society.

He reported that new standards have been drawn up and will be ready for consultation in October this year. He called for involvement and feedback via seminars and online mechanisms that will be in place during the consultation.

It is envisaged that the standards will be implemented in October 2011.

Revalidation will come into effect in 2013 or shortly after, following a consultation period and pilot studies. Practitioners will be revalidated against ‘core’ standards such as a code of ethics and professional conduct, and job-related standards based on a scope of their practice which they will have provided for the purpose.

Pharmacists on charge!

Chief Pharmacist, Consultant Pharmacist and Responsible Pharmacist accused of corporate manslaughter and medical negligence are interrogated in this year's Court Case



Back row: Mark Tomlin ('Consultant Pharmacist'); Graeme Richardson ('Responsible Pharmacist'); Richard Cattell ('Chief Pharmacist'). Front row: Allan Karr; ('Prosecutor'); Tony West, Phil Howard, David Miller ('Defence Lawyers').

The ever-popular Court Case was one of the highlights of this year's joint conference in May. The case involved the hypothetical death of a young mother through the use of an unlicensed Polish medicine. The Court ruled that the Chief Pharmacist was guilty of corporate manslaughter and was sentenced by 'Judge' Cathy Mooney to 20 years in jail. The Consultant Pharmacist was found guilty of gross medical negligence and the Responsible Pharmacist was found not guilty. All those on trial were examined on their failure to follow policies and procedures.

Conference award winners

The Pfizer Patient Safety Award 2010 was presented to Fiona McFarlane and King Sun Leong from the Wirral University Teaching Hospital NHS Foundation Trust for their work



Pictured: Fiona McFarlane being presented with her award by Pfizer's Howard Tebby

on the development and evaluation of a standardised glucose potassium insulin prescription chart to minimise prescribing errors.

The TEVA Leadership Award 2010 was given to Helen Williams, Consultant Pharmacist for Cardiovascular disease at Southwark Health & Social Care and South London Cardiac and Stroke Networks for her work on cardiovascular prescribing across a managed clinical network.

The UKCPA/GHP 2010 Best Poster prize went to Pritesh Bodalia for his poster on 'Comparative

efficacy and tolerability of antiepileptic drugs for refractory epilepsy'. His meta-analysis and presentation of his doctoral research impressed the judges unanimously.



Pictured:

Pritesh Bodalia being presented with his award by Dr Sarah Carter of UKCPA

Care of the Elderly Group news

Committee News

There have been a number of recent changes in our committee. We would firstly like to say a big thank you to Caroline for all her hard work over the seven years that she has been on the committee and we wish her well for the future. We welcome the following new members to our committee:

- Balwinder Bolla, Lincoln County Hospital
- Sarah Crotty, Interface Pharmacist, Bucks PCT
- Lorraine Lanchbury, Royal Cornwall Hospital
- Rhona Petrie, Southern General Hospital

Did you see ...?

A recent study by Lang et al in the journal *Age and Ageing* which aimed to determine the prevalence of and risk factors for inappropriate prescribing and prescribing omissions in elderly patients with mental co-morbidities. 150 consecutive inpatients with mental co-morbidities hospitalised in Switzerland for acute medical illness (mean age 80 +/- 9 years; 70% women) were considered for the study. Inappropriate prescribing and prescribing omissions were prospectively identified according to STOPP/START criteria at hospital admission.

The results showed that more than 95% of patients were taking one or more medicines (median = 7) which amounted to 1137 prescriptions. The prevalence of inappropriate prescribing was 77% and for prescribing omissions it was 65%. The most frequently encountered inappropriate prescribing was drugs adversely affecting falling (25%) and antiplatelet therapy without atherosclerosis (14%). The most common prescribing omission related to antidepressants with moderate/severe depression (20%) and calcium-vitamin D supplementation (18%).

Independent predictors for **inappropriate prescribing** were:

- increased number of concomitant drugs (odds ratio (OR) 1.54; 95% CI, 1.13–1.89)
- being cognitively impaired (OR 1.83; 95% CI, 1.55–2.24)
- a fall within the preceding 3 months (OR 2.03; 95% CI, 1.52–2.61)
- hospitalised in the preceding year (OR 1.09; 95% CI, 1.02–1.23).

- Living in an institutional setting (OR 1.45; 95% CI, 1.27–1.74)

Independent predictors for **prescribing omissions** were:

- psychiatric disorder (OR 1.64; 95% CI, 1.42–2.01)
- increased level of co-morbidities (OR 1.79; 95% CI, 1.48–1.99)
- living in an institutional setting (OR 1.67; 95% CI, 1.32–1.91).

PO Lang, Y Hasso, M Drame, et al. Potentially inappropriate prescribing including under-use amongst older patients with cognitive or psychiatric co-morbidities. *Age and Ageing*, May 2010;39(3):373-381.

Recommendations from the Report for the Minister of State for Care Services – the use of antipsychotic medication for people with dementia

1. PCT Medical Directors must put in place a system for good practice around antipsychotics in dementia - reducing the use of antipsychotic drugs for people with dementia and assuring good practice when they are needed
2. Tsar to report audit figures every six months to government
3. National audit - on the use of antipsychotic medication in dementia
4. PCT's must set goals for reduction in antipsychotics
5. Research- to assess the clinical and cost effectiveness of non-pharmacological therapies
6. Training of healthcare professionals and care staff – through the development of a skills curriculum
7. Mental health service extension for care homes – provision of in-reach services that support primary care in its work in care homes
8. Inspections by CQC
9. Train and support carers – through the Improving Access to Psychological Therapies programme
10. Discussion of care for patients in their own homes between GP & mental health experts.

Care Home Use of Medicines Study (CHUMS)

The study, funded by the Department of Health, investigated the prevalence, consequences, causes and solutions to

medication errors in nursing and residential care homes. The study included 256 patients in 55 homes.

Patients were on a mean of 7.2 medicines each and 69.5% of patients had at least one error. The prevalence of errors was: prescribing 8.3%, monitoring 14.7%, dispensing 9.8% and administration 8.4%. In terms of patients receiving errors: 39.1% received a prescribing error, 18.4% (of those who needed it) a monitoring error, 36.7% a dispensing error and 22.3% an administration error.

These results were attributable to many possible causes including lack of knowledge of the patient when prescribing, prescribing without computerised notes or prescribing software, ineffective communication between primary and secondary care, the use of monitored dosage systems, poor ordering of medicines, inadequately trained staff, badly-designed medicine trolleys and too many distractions whilst administering medicines.

Whilst the results of this study show that there is an urgent need for pharmacists to reduce their dispensing errors, there is also a huge opportunity for pharmacists to become more actively involved in providing training and support for both prescribers and care home staff. The report outlines some of the ways in which pharmacists can get more involved :

www.haps.bham.ac.uk/publichealth/prsrp/documents/PS025_CHUMS_-_Final_Report_with_appendices.pdf

Handbook for Specialist and Advanced Practice

We have had many requests already from the membership but just another reminder that the Care of the Elderly Group has, in liaison with the London Older People Pharmacist Network, produced a handbook which outlines the knowledge and experience required for pharmacists working within older people services both at foundation and excellence level. The content and format of this document has now been endorsed by the British Geriatric Society's Education and Training Committee. Copies of this handbook can be obtained from Derek at Derek.Taylor@lhch.nhs.uk

Derek Taylor

Chair, Care of the Elderly Group

Community Group news

Gill Hawksworth, Chair of the UKCPA Community Pharmacy Group, reports on research opportunities through Local Practice Forums

The UKCPA stand created a lot of interest amongst community pharmacists attending a recent West Yorkshire Local Practice Forum (LPF) showcase of best practice. Another important development on the day was the mix of community and hospital pharmacists present, which created an opportunity to engage many pharmacists in the LPF who had not previously been involved through a LPF Research stand.

Volunteers were requested to submit their names to the research group which resulted in the recruitment of 20 pharmacists into the network locally. Of the 20 volunteers who indicated their preferred way to be involved in research five chose to be research champions, three offered premises, eight chose to be discussion forum/network members, five would provide material for databases. Four did

not specify a preference. In addition, five academic pharmacists indicated that they were already actively involved in research.

There is now coverage of the whole LPF area and different organisations are represented including the LPC, multiples, hospitals and PCTs which will enable a strategy or agenda for pharmacy practice research to be developed in the future. Meetings are planned to look at skills and agenda setting in order to take this forward by the LPF research group. The objectives of this group, led by Jon Silcock, are:

- To build a network of “research ready” community pharmacies in the LPF area and encourage participation in high quality research
- To have “research champions” in all the local trusts, organisations and companies;

who should understand funding streams and regulatory issues

- To make links between research active pharmacists and people who want to conduct research projects
- To promote pharmacy research to other healthcare professionals and within local clinical networks
- To establish a database of local pharmacy research activity

This excellent work done so far is valuable to enable ongoing development of the national work of LPFs and the creation in the future of local science and research forums.

Gill Hawksworth, Chair of the UKCPA Community Group, is helping to plan a future ‘Vision’ event later in the year in London to discuss a national science and research network for pharmacy.

Critical Care Group news

Ruth Forrest at Western Infirmary in Glasgow reports on the development of a simple tool to improve communication in an ICU, and the rest of the Critical Care Group news.

Improvement in Medicines Reconciliation in an Intensive Care Unit

A previous study within an intensive care unit (ICU) demonstrated that medicines reconciliation on admission was poor and that changes to therapy as well as deliberate omissions made by clinical staff were not adequately communicated to the next team taking over the care of the patient.¹ Within

the Medicines management work-stream of the Scottish Patient Safety Programme² one of the drivers states that policies need to be developed to ensure that when a patient is transferred out of any ICU or high dependency unit that medicines which are no longer appropriate for the next setting are discontinued. A system to improve both medicines reconciliation on ad-

mission and the reasons for changes to medication during the patient’s stay was developed in the intensive care unit at the Western Infirmary.

Using the methodology of the Scottish Patient Safety Programme a medicines reconciliation form was designed which included details of the admission medication, source of this information, details of other drug use (e.g. over the

counter, herbal, homeopathic or illicit) as well as allergies and previous adverse drug reactions. A further section detailed the medications commenced within ICU, whether this should be continued, stopped or reviewed and any further comments. This also included details of all antimicrobial therapy which the patient had received during their stay in ICU. Standard ICU therapy not to be continued in the ward setting was not included. The form was designed so that any member of the multidisciplinary team could start, complete and update and it was not seen solely as the responsibility of the clinical pharmacist. This allows medical staff to complete drug histories and plans when the clinical pharmacist is absent, often at weekends.

Examples of information which might be communicated included: plans for a reducing dose of methadone for patient who had been on long term opiates, a patient who was not prescribed enoxaparin as they had been admitted with a high INR, plans for increasing dose of ramipril, information on therapeutic drug levels of phenytoin and plans for treatment of patients with heparin induced thrombo-cytopaenia.

The reconciliation form was implemented and incorporated into the discharge process in January 2009. On discharge from ICU pharmacy and medical staff from the

ward receiving the forms for the first 25 patients were contacted to ascertain their opinions on the form and the information contained within them using a structured questionnaire. The results from this were positive with all respondents saying the information was helpful. Twenty one (84%) respondents were impressed with the clear information given about current drug therapy and the reasons for discontinuation of medicines on admission. Four (16%) respondents were impressed with the information and found it helpful but suggested some amendments to the form. One comment was that the form was sometimes difficult to find within the medical record and in response to this the forms were printed on coloured paper to make them more visible. The communication of clear plans for continuing drug therapy was welcomed.

Although a paper based system at present this documentation will be incorporated into our electronic patient record within the next few months. It has been implemented at other ICU's within Glasgow with plans for further expansion to all other units within NHS Greater Glasgow and Clyde.

This demonstrates that a simple but effective tool can improve patient safety by improving communication regarding drug therapy.

1. Campbell,AJ, Bloomfield, R and Noble, DW, An observational study of changes to long-

term medication after admission to an intensive care unit. *Anaesthesia*, 2006, **61**,1087-1092

2. www.patientsafetyalliance.scot.nhs.uk

If you would like more information, or would like to discuss this further please contact Ruth Forrest: at ruth.forrest@ggc.scot.nhs.uk or call 0141 211 2000 Page 4656.

Critical Care Group Advanced Practitioner Meeting

When: 24th September 2010

Where: Kingsway Hall Hotel,
London

Fees: Members £120
Non Members £185

Further details on this event
will be circulated via the
Critical Care message board
on the UKCPA website in due
course.

Educational Events

Once again the very successful beginners Study Day was held on 27th February and evaluation was very positive. The committee are discussing how to improve this day and are looking at ways in which we could use technology to deliver some of the sessions. The Advanced Practitioners Study Day programme has been finalised and will be held in London on 24th September. Further details are available from the UKCPA office.

Election to Council of Scottish Intensive Care Society

Congratulations to Alan Timmins, principal pharmacist from Dunfermline, who was elected to the council of the Scottish Intensive Care Society as associate member representative in January.

Visit by President of the SCCM

Judi Jacobi is the President of the Society of Critical Care Medicine in the United States. The SCCM is a multiprofessional organisation representing the Critical Care workforce in the US and worldwide. Judi is also a pharmacist and is the first non medical president. One of her aims for her presidential year is to meet as many pharmacists as possible. Judi spent two days in London in June visiting ICU at UCLH and GSTT.

An informal meeting was held to give Judi a chance to meet pharmacists working within critical care and a more formal presentation in the evening where Judi spoke about Critical Care Pharmacy in the US and credentialing.

Emergency Care Group news

The engagement exercise to discuss proposals to introduce prescribing responsibilities for paramedics closed on 11 June 2010. The issues raised are applicable to all practitioners prescribing in emergency and urgent care and should be of interest to all pharmacists who may be called upon to dispense prescriptions from these practitioners.

The proposed extension of the paramedic role aims to empower “advanced paramedics” who have usually undertaken additional training for example as Emergency Care Practitioners (ECPs). ECPs usually work independently and treat patients in their homes as well as working in Minor Injuries Units and Walk-in centres.

The engagement document identified the key risks of extending prescribing to paramedics as:

- the risk to patient safety of inappropriate prescribing of medicines; and
- the risk to patient safety of failure to share information e.g. if the patient’s GP was not made aware of a prescription being given to a patient.

The UKCPA Emergency Care Group took the view that the delivery of prescribing services should be determined by patients and the local NHS, and should support the completion of episodes of care, and that commissioners should specify a service requirement rather than how it is delivered. In placing the emphasis on the need for organisations to determine how they deliver safe and effective care, and to take responsibility for that delivery, our views differed from the principles outlined above.

In terms of eligibility and training the document proposes that paramedics would be expected to:

- intervene pharmacologically where necessary to complete and resolve a

The principles underlying prescribing responsibilities were identified as follows:

- That patient safety is paramount. Prescribing responsibilities should only be extended when this will deliver safer and more convenient care for patients
- That prescribers should only prescribe and practice within the limits of their clinical competence
- That such prescribing must be underpinned by robust clinical governance
- That independent prescribers must take full clinical and professional responsibility for their decisions and be able to recognise when they need to ask for support in relation to a patient’s care
- That commissioning of prescribing services should be determined by the needs of patients and the local NHS
- That training should be defined locally, within a nationally agreed outline curriculum for prescribing training
- That dispensing pharmacists and those charged with prescription reimbursement need to be able to easily identify those who are entitled to prescribe, and any constraints within which the individual can prescribe.

consultation; and

- be able to recognise the risks of polypharmacy.

Discussions with educators suggested that this training was beyond the scope of some current non-medical prescribing courses and we proposed that for such practitioners additional underpinning knowledge must be provided to meet this requirement.

The engagement proposed several options to deliver safe paramedic prescribing and asked which option would be most likely to add the most value to patient care and to balance this with the risks. The Group took the view that prescribing for any

condition (rather than a set of defined conditions) would be most appropriate in the Emergency Care environment. This would enable practitioners to make decisions at the time of presentation and for practice to develop within organisational frameworks. We could not agree on whether prescribing from a specified formulary or from a full formulary (within competence) was most appropriate. The former minimises risk by ensuring competence with a narrow range of medicines, whilst the latter overcomes the challenges presented by new developments.

The Group proposed that a limited formulary listing medicines by name is restrictive and might impair the quality of patient care as patients would not benefit from practice or technological developments. Formulary amendment never appears to maintain pace with practice. If this option is selected then the list should be broadened to include therapeutic classes rather than individual preparations.

Paramedics working in emergency and urgent care need to be able to prescribe controlled drugs (for pain management and seizures, for example) and we accepted the principle of the current limited list and indications for Nurse Independent Prescribing, but suggested this would need to be amended to meet the needs of paramedics.

Overall we believed that paramedic prescribing has the potential to improve patient access to good quality emergency care. We emphasised the need for these services to be flexible to meet local patient needs. To achieve this, organisations must have robust and transparent governance arrangements. The issues discussed in the engagement are equally applicable to all practitioners providing emergency care in the community and in the hospital environment.

Gastroenterology & Hepatology Group news

Journal Review

The investigational hepatitis C virus (HCV) protease inhibitor telaprevir combined with pegylated interferon and ribavirin significantly improved sustained response rates compared to standard therapy in genotype 1 chronic hepatitis C patients who did not achieve a cure with prior interferon-based treatment, according to findings from the PROVE 3 study reported in the *New England Journal of Medicine*.

Approximately half of people with hard-to-treat HCV genotype 1 do not achieve sustained virological response (SVR), or undetectable HCV viral load 6 months after completion of treatment, using a standard-of-care regimen of pegylated interferon alfa plus ribavirin for 48 weeks. However failure with this regimen leaves few options. Telaprevir a protease inhibitor is one of several investigational agents that specifically target HCV with the goal of improving the chance of SVR.

This trial examined its efficacy in adult patients with HCV infection who had not responded to or relapsed standard therapy. Patients were randomised to one of four regimes with the primary outcome being sustained virologic response (undetectable HCV RNA levels 24 weeks after the last dose of study drug).

The finding from this study are promising and indicate that treatment with pegylated interferon alfa and ribavirin and telaprevir is more effective than treatment with pegylated interferon alfa and ribavirin alone. The significant higher SVR rates observed in this study with the telaprevir based regimes represents an important step forward and provided an insight into the potential future use of telaprevir based regimens in the treatment of patients who have failed to respond to currently approved therapies.

NEWS:

New NICE Guidance on Infliximab and adalimumab published 19th May 2010 <http://guidance.nice.org.uk/TA187/Guidance/pdf/English>

Updated CD guidelines 2010:

The second European evidence-based consensus on the diagnosis and management of Crohn's disease.

Reference:

JG McHutchison, MP Manns, AJ Muir et al. Telaprevir for Previously Treated Chronic HCV Infection. *New England Journal of Medicine* 362(14): 1292-1303. April 8, 2010.

Joyeta Das

Joyeta.Das@imperial.nhs.uk

Hepatitis C in the Community

The 19th May 2010 saw the 3rd World Hepatitis Day take place. The campaign this year aims to focus on the public health challenge of the chronic disease with the thought 'Am I number 12?' This expresses the figure that 1 in 12 of the world population has chronic HBV or HCV infection and that the infection is often undiagnosed and could be any one of us.

The Department of Health have recently awarded a grant to the Hepatitis C Trust to enable the Trust to help set up testing for HBV and HCV in local pharmacies. This follows on from a successful pilot study conducted last year.

Pilot Study Findings: 19 community pharmacies conducted a total of 234 dried blood spot tests over a three month period. The results identified 35 people to be positive for HCV and 4 people to be positive for HBV. Intravenous Drug Use was identified as a risk factor in 31 people who tested positive for HCV and in two people who tested positive for HBV. Essentially one in every six people tested was positive for HBV or HCV. From an anonymous questionnaire completed by 19 service users, all stated that pharmacy testing was convenient and they would recommend it to friends who might be at risk. 18 out of the 19 users stated that they preferred being tested at a pharmacy rather than at a GP surgery.

How to Get Involved: The Hepatitis C Trust is running free training sessions for pharmacists from July to November 2010. They can provide all the materials necessary to run the service to any pharmacy or PCT that wishes to become involved. Payment for the tests will need to be arranged with the PCT, as will any payment for the pharmacist themselves.

Jackie Swabe

Jacqueline.Swabe@suht.swest.nhs.uk

Sonic study: Infliximab, Azathioprine, or Combination Therapy for Crohn's Disease

Aim: Patients with moderate-to-severe Crohn's disease who were treated with infliximab plus azathioprine or infliximab monotherapy were more likely to have a corticosteroid-free clinical remission than those receiving azathioprine monotherapy.

Endpoints: Corticosteroid-free clinical remission at week 26; the rates of corticosteroid-free clinical remission at other time points were secondary efficacy end points. Additional secondary efficacy end points included the proportion of patients with mucosal healing at week 26 among those who had ulcerations at baseline, the rate of any remission, response-70, response-100, the IBDQ score

Result: N=318 completed trial. At week 26, a total of 96 of the 169 patients (56.8%) receiving combination therapy, 75 of the 169 patients (44.4%) receiving infliximab, and 51 of the 170 patients (30.0%) receiving azathioprine were in corticosteroid-free clinical remission (P = 0.006 for the comparison of infliximab vs. azathioprine, P<0.001 for the comparison of combination therapy vs. azathioprine, and P = 0.02 for the comparison of combination therapy vs. infliximab).

Safety: Comparable for all groups, 1 pt on combination developed TB, 1 pt on azathioprine died of sepsis post colectomy and 2 pt in azathioprine group developed colonic cancer.

Discussion: Combination therapy was most effective however the increased risks of rare but serious toxic effects associated with combination therapy must also be considered.

It is possible that there may be greater efficacy with concomitant immunomodulators in naive patients but not in those who have already failed these drugs. Available data also suggest an increased risk of hepatosplenic T-cell lymphoma when azathioprine is administered in combination with infliximab therapy. Long term effects need to be investigated.

Reference:

N Engl J Med 2010;362:1383-95 <http://content.nejm.org/cgi/reprint/362/15/1383.pdf>

HAT Group news & Cardiology Group news

The Cardiac and HAT committees ran a joint work session on oral anticoagulants at the May conference: here they report their news together.

May joint conference update:

The May UKCPA/GHP Symposia provided an opportunity for the HAT & Cardiac committee to build on their project plans (as well as socialise a little!).

HAT are currently building research plans, a continuing professional development module and planning a HTML email pilot on behalf of UKCPA endeavouring to improve communication with HAT members. We hope to launch this within the next month, so keep an eye out.

The Cardiac group are proud to launch the long awaited new antiplatelet medicine card (see below). This card replaces the previous 'Plavix Card' and following feedback from UKCPA members and users, there have been many slight changes; the wordings been simplified, there is a section for the person completing the card to fill their name in (for clinical governance); additional antithrombotics section and adequate space to write the drug. The cards can be obtained from the UKCPA office.

Bayer Haemostasis, Anticoagulation & Thrombosis Award

The HAT committee were delighted to launch their new award at the Symposia. The award is £1500 and allows the winner to attend the November conference and present their work as a poster. The closing date for this award is 1st September. Full details at www.ukcpa.org.uk

was a focus of many sessions at the conference. It is clear that pharmacy is under huge pressure to re-model services to support the delivery of the £20 billion NHS efficiency savings required from April 2011 (possibly set to rise under the new coalition). With this in mind VTE management was discussed in several forums. It is clear that as part of the multidisciplinary team we need to support the VTE agenda and to facilitate (directly or indirectly) the achievement of the 90% standard for VTE risk assessment, by Quarter 4. We have a pivotal role in ensuring that appropriate prescribing follows risk assessment. Pharmacists are clearly very much involved nationally, supporting this work. This was demonstrated by the number of posters presented on this topic, assessing prescribing practice and compliance with national guidance. Hospitals are responding in different ways: Lewisham Hospital NHS Trust has developed PGDs to facilitate prescribing of Low Molecular Weight Heparins whilst St Bartholomew's Hospital (London) have extended the pharmacists role to conduct VTE risk assessment.

Anticoagulants/Antiplatelets: Choices, Choices, Choices – How do you decide?

The May conference saw a joint session presented by members of the HAT & Cardiac Groups. The session was a lively discussion and debate

around the management of a patient with acute coronary syndrome and when we should use clopidogrel, Prasugrel or ticagrelor. The latter is not yet available but when it is, it highlights the opportunities and the integral role pharmacists could have around the appropriate choice of antiplatelet therapy, balancing the delicate risk of bleeding with an improvement on outcomes. There was also some discussion around the choice of anticoagulant and the timely publication of the recent NICE ACS guidelines (no conflicts of interest there then!). It did highlight that expert opinions in relation to international guidance are not yet agreed on the place of various anticoagulants in therapy, yet we're expected to decide on a day to day basis. This is only likely to be further complicated with new antiplatelets and oral anticoagulants currently being studied for the management of ACS.

This led us onto our next topic for discussion - the future management of atrial fibrillation. Is there a role for the newer oral anticoagulants in place of warfarin? What are the considerations for the smooth introduction, or will the price simply prevent their introduction? NICE is currently reviewing one such agent to publish a recommendation to coincide with a license approval.

Interesting times ahead.



Photo: HAT and Cardiology Group members enjoying the social aspects of the May joint conference

4. Taking antiplatelet medicines may not be advisable before you have an operation (including dental surgery). Please check with your doctor.

Antiplatelet medicines are a vital part of your treatment and important surgery may have to be delayed.

2. You will usually be advised to continue taking aspirin after you have finished your course of antiplatelet medicine.

Please carry this card with you at all times, including when travelling abroad, and show it to any doctor, nurse, dentist or pharmacist.

Always carry this card with you

It has not yet been approved by the Medicines Commission. It is not for sale in the UK. It is for use in the UK only. It is not for sale in the UK. It is for use in the UK only.

ANTIPLATELET medicine card

Name: **Luigi Boccherini**

Hosp no: **WHT 19276**

NHS no: **LS2 560**

Consultant: **Mr Centurion**

Hospital: **BLT**

Tel no: **020 7377 7000**

You have been prescribed an additional antiplatelet medicine to help prevent your blood clotting too easily, especially following placement of a stent.

The medicine is usually taken in combination with Ticagrelor daily.

You have been prescribed:

Drug: **Clopidogrel**

Dose: **75mg**

Frequency: **daily**

Start date: **29/02/10**

Planned duration: **12 months**

Reason for starting antiplatelet medicine (this may not be necessary):

• ACS (MI) or STEMI (heart attack)

• Stent (catheter) or bare metal (wire)

• Other

Other antiplatelets at discharge:

Card completed by your name and designation: **Sofonia Madrid RGN**

It is important to read the following:

- Do not stop taking your antiplatelet medicines without first talking to your doctor.
- If you experience any of the following side effects speak to a doctor immediately:
 - Bleed in your urine or black (tarry) stools.
 - Any other prolonged/unexplained bleeding.
 - Allergy.
- Please check with your doctor or pharmacist if you start taking or are prescribed any additional medication including over the counter medicines.

QIPP In Quids Out!

This may be a flippant title but certainly Quality, Innovation, Performance and Prevention (QIPP)

Medicines Safety & Quality

Group news

The Medicines Safety & Quality Group and the Gastroenterology & Hepatology Group report on the need to view NPSA alerts as an opportunity to review procedures to assure patient safety.

A recent NPSA alert on reducing the risk of harm from oral bowel cleansing solutions prompted pharmacists to review their procedures on how solutions were being administered and what information was given to patients.

The consensus guidelines are a useful reference to help introduce processes methodically, for example, checking renal function and documenting that the clinician has done so. It is also important to think about the whole patient journey. For example, is the out-patient clinician checking contraindications or is it being sent in the post? One Trust discovered that they were sending Picolax, a white powder, in the post during the Anthrax scare, which in hindsight perhaps wasn't a good idea.

Patient counselling should also be considered: are they being advised to stay home from work when

taking a bowel cleansing preparation, and to take the preparation on the day of their procedure?

By chance Rachel Leff, Principal Pharmacist at North Middlesex University NHS Trust, found herself on a blog for patients who were about to go for a colonoscopy. She found that these patients are extremely concerned about their procedure. She realised that it is imperative to check where these preparations are being used in order to minimise failures and prevent some patients having to repeat the process a second or even a third time.

Rachel looked at failure rates and found that the Endoscopy unit was not compliant with the standards set out by the Joint Advisory Group on GI Endoscopy. By reviewing the bowel preparations they managed to significantly decrease their failure rates. Furthermore, they

designed a combined checklist and prescription to be used when the clinician assesses the patient. When all the contraindications have been excluded, it is passed onto the relevant health care professional who counsels the patient and gives out the pre-pack and leaflets which explain the procedure.

Rachel has also been involved in training and providing support for radiographers so that they can identify any problems related to the procedure.

Rachel views a NPSA alert like an onion: you peel away one layer and you start to cry and there always seems to be another layer, but you will eventually get to the core!

If you would like to obtain the proforma/checklist/prescription, an updated version will be available on the UKCPA message boards.

Moving house?

Changing employer?

Please remember to update your contact details with the UKCPA office. Please notify us by letter, or by emailing:
membership.services@ukcpa.com

Neurosciences Group news

Do you have an interest in the management of patients with epilepsy? Would you like to provide better pharmaceutical care to your patients on anti-epileptic therapies?

The UKCPA Neurosciences group is organising its first workshop at this autumn's Residential Symposium titled 'Epilepsy in Focus'. The aim is to provide a crash course in epilepsy that will be useful to all clinical pharmacists, whether they encounter patients with the condition daily or occasionally.

Learning outcomes will cover:-

- Types and causes of epilepsy
- Management options and latest guidelines
- Factors affecting choice of anti-epileptics for specific groups and the role of TDM
- The role of the pharmacist in managing patients with epilepsy

In addition, the Neurosciences group is organising a fringe meeting to discuss potential risks and benefits of the forthcoming new therapies available for the management of multiple sclerosis.

David Kearney
University Hospitals of Leicester

Hitting the headlines:

3,4-diaminopyridine licensed for Lambert-Eaton Myasthenic Syndrome

Lambert-Eaton Myasthenic Syndrome (LEMS) is a rare autoimmune disorder characterised by slowly progressive muscle weakness which usually improves on exertion. Respiratory muscles are usually unaffected, except in severe cases. Most commonly, the proximal limbs are affected and patients struggle to lift the arms or walk with a 'waddle'. Most patients will complain of a dry mouth, and perhaps a metallic taste, and many will have a further sign of autonomic dysfunction such as male impotence, or postural hypotension. Unlike in myasthenia gravis (MG), where antibodies target acetylcholine receptors on the neuromuscular endplate, auto antibodies in LEMS target the release of acetylcholine.

The exacerbation of weakness can be elicited by some inconspicuous medicines. Gentamicin, 4-fluoroquinolones, magnesium, beta-

blockers, quinine-like anti-arrhythmics and anti-malarials, calcium-channel blockers, and iodine-containing contrast agents are just some. The diagnosis of LEMS is not unusual following surgery where a prolonged recovery from neuromuscular paralysis is noted.

The incidence of LEMS is rare – about 1 in 100,000 which in the EU equals about 4,000 people in total. LEMS has therefore obtained orphan designation in 2002 as the incidence is below the threshold set by EMEA which stands at 50 in 100,000.

In about 60 percent of cases, LEMS is associated with *small-cell lung cancer* (and more rarely with other types of cancer), which might be diagnosed at the same time as LEMS or years later. Manifestations of LEMS usually precede the diagnosis of cancer.

The link between cancer cells and LEMS is thought to relate to surface antigens on cancer cells which are structurally similar to voltage-gated calcium channels (VGCC), and trigger the formation of antibodies against VGCC. These antibodies cross-link the VGCC causing them to cluster and decrease in number.

Treatment options involve reducing the number of antibodies (intravenous immunoglobulin, plasmapheresis, immunosuppression), increasing the amount of acetylcholine received post-synaptically (by the use of muscle cholinesterase-inhibitors like pyridostigmine), and increasing the amount of acetylcholine released (aminopyridines – 3,4-DAP). Treating underlying cancers where found can improve symptoms and can produce remission. First line immunosuppression usually involves prednisolone and azathioprine. Cyclosporin or mycophenolate mofetil have been suggested as second-line agents. Guanidine has also been touted as a potential treatment during waking hours only, and acts by increasing acetylcholine release (5-10mg/kg/day).

Since December 2009, Biomarín has obtained marketing authorisation for amifampridine (Firdapse®) as an orphan drug. Amifampridine is the accepted marketing name for the chemical 3,4-diaminopyridine.

The drug is available as scored 10 mg tablets allowing titration up to a maximum recommended dose of 60 mg per day (split in three to four daily

doses). The optimum dose may change with the course of the disease. Specialists suggest titrating the dose down by 5mg increments at 2-week intervals until the lowest effective dose can be determined, at least at 12 monthly intervals. Contraindications – amongst others - include epilepsy, uncontrolled asthma, and use of drugs with narrow therapeutic window. For more information refer to the summary of product characteristics.

The development of orphan drugs is not cheap. Treatment cost for a patient on maximum recommended dose is approximately £40k pa. This is a significant increase compared to the current unlicensed product which costs approximately £1k pa.

We are looking forward to hearing from colleagues about their views and experiences especially from centres who may see disproportionately more of these patients as well as colleagues who get patients referred already on the drug. Please join in the discussion!

Annett Blochberger
St. George's Healthcare NHS Trust

David de Monteverde-Robb
Cambridge University Hospitals NHS Trust

Out and About:

Report from the 1st International Dystonia Conference in Hannover

From 6th May to 8th May 2010, professionals - mainly neurologists, pharmacologists, neurophysiologists and researchers – descended on Hannover (Germany) to attend the 1st International Conference on Dystonia. It turned out to be busy days for all attendants as the program was packed with presentations and podium discussions on different aspects of dystonia – from surgery to pharmacological treatment, history, treatment of task related cramps, deep brain stimulation (DBS) and much more. A visit to Marienburg castle where the attendants were treated to the local and seasonal speciality (white asparagus) should also not be forgotten.

During the conference, I heard the following question fairly often: What does a pharmacist get out of a conference like this? So, what did I get out of it?

[Continued on Page 16]

Pain Management Group news

The Pain management group provide an overview of the pharmacological management of neuropathic pain in adults.

Neuropathic pain (NeP) results from damage to, or dysfunction of, the body's normal pain signalling systems and can be resistant to treatment with simple analgesics. As a result, antidepressants and anti-epileptics are the mainstay of therapy.

Conditions where NeP is prominent include post-herpetic neuralgia (PHN), painful diabetic neuropathy (PDN) and trigeminal neuralgia (TN). It is typically characterised by descriptors such as burning, stabbing, shooting or like an 'electric shock', and may be accompanied by tingling or 'pins and needles'. Further information is available at: www.neuropathicpainnetwork.org/english/NeP/index.asp

In certain clinical situations, 'mixed' pain types exist such as chronic low back pain, where sciatic pain provides a neuropathic component. Any musculoskeletal pain may respond well to simple analgesics.

Pharmacological Management

The guideline development group, or GDG, decided at the scoping stage to treat NeP as a 'blanket condition', unless the evidence-base suggested that this was inappropriate. Unusually, no new economic modelling was undertaken for this guideline because there was a relevant health technology assessment in development to which the GDG had been given access. The HTA is not yet available but we understand that it will be shortly (see www.hta.ac.uk/1527).

NICE separate out painful diabetic neuropathy and recommend that all other types of NeP are treated in the same way. Their specific recommendations are discussed below, but importantly, they suggest considering the side effect profile, patient factors and contraindications of the individual agents, and also state:

"Continue existing treatments for people whose neuropathic pain is

already effectively managed."

In PDN, duloxetine is recommended as initial therapy (or amitriptyline, where duloxetine is contraindicated). For those initially treated with duloxetine, switch to amitriptyline or pregabalin (or combine with pregabalin). If amitriptyline was initially used, switching to or combining with pregabalin is advised. On a practical level, the decision as to whether switching or combining is appropriate will be highly dependent on the efficacy of initial therapy (i.e. ineffective therapies should be stopped). If a therapy is effective but poorly tolerated, reducing the dose and combining with another therapy may be an option. Early and regular clinical review is advocated and NICE suggest that the dose may be weaned down gradually where sustained improvement is seen.

In neuropathic pain (other than PDN), a choice between amitriptyline and pregabalin is advocated, with the other drug replacing or being combined with the first in cases where the desired result is achieved (see guidance above). Alternative tricyclics (e.g. nortriptyline) may be useful if amitriptyline is effective but poorly tolerated. Be aware that anticholinergic side effects can occur, even at low doses, and slow titration may be important. I would suggest counselling that if a dose is increased and side effects occur, it is worth reverting to the previous dose for around a week and before trying to increase the dose again. If analgesia is seen at the lowest dose, stay on that dose.

It is important to note that amitriptyline is not licensed for the management of NeP, and informed consent should be obtained and documented. Those prescribed the drug should be informed that the patient information leaflet does not mention pain relief but focuses on depression.

If these drug therapies are ineffective, the person should be referred to a

specialist pain service. In severe cases, referral may be indicated earlier. At this point, NICE advocate considering using oral tramadol, or topical lidocaine for localised pain in those unable to take medication orally.

Doses for all of the drugs are included within the guidance although it is noteworthy that gabapentinoids (gabapentin and pregabalin) may be started more cautiously in pain clinics than the BNF specifies. Often gabapentin is started at a dose of 300mg BD for a week or even more cautiously, and pregabalin can be started at doses as low as 25mg BD. One reason for this is that the range of effective therapies for these conditions is limited, and if the patient loses faith with a medicine due to intolerance, this can be devastating as this potentially could have been the only effective agent.

Note that all doses of pregabalin cost the same amount so TDS dosing costs more but would not be expected to improve efficacy or reduce adverse effects.

Controversies

The biggest issue for primary care and commissioners is likely to be the recommendation to use pregabalin rather than gabapentin. Commissioners do not necessarily have to follow NICE clinical guidelines to the word but would have to provide justification where they do not. If a PCT does decide to do things differently, patients may then ask why they haven't been treated in accordance with NICE and this could be potentially difficult.

This decision alone has the potential to have massive financial implications but NICE have made a decision that this is the most cost-effective approach. The reason for this is that the cost-effectiveness modelling also includes non-drug costs and the utilisation of resources in this type of patient is large (e.g. clinic consultations and hospital stays). *[Continued on Page 16]*

Pain Management Group News continued...

As a result, only a small (and clinically insignificant) benefit may be needed to demonstrate cost-effectiveness. Incidentally, the model was rerun with the cost of gabapentin as zero, and pregabalin was still found to be the most cost-effective.

Many pain specialists have expressed surprise regarding the endorsement of duloxetine. This may be related to the management of this condition primarily outside pain clinics. However, perhaps it is not entirely shocking that a drug marketed for diabetic neuropathy is more evidence-based than the unlicensed tricyclic antidepressants (e.g. amitriptyline).

Insufficient evidence exists to allow

support of combination therapy based on the evidence alone, but the experts on the GDG felt that inclusion of this guidance was clinically appropriate.

The HTA only assessed evidence relating to PHN and PDN, primarily because these are seen as good clinical models of neuropathic pain and most neuropathic pain trials recruit patients with these conditions. However, NICE extrapolates to other types of neuropathic pain. Is this appropriate? In my opinion, yes. I would have liked NICE to have gone a step further and not singled out diabetic neuropathy. We have had guidance for non-specific neuropathic pain which has been helpful locally for a number of years, and are in the process of updating this

in accordance with the recommendations of NICE.

Interestingly, further research is requested regarding the question of whether carbamazepine should be used for trigeminal neuralgia. Weak evidence supporting use of this drug is available but is generally quite old (often dating back to the 1960s) and centres around one highly positive trial. However, there are a number of problems associated with studying this condition, low prevalence perhaps being the most important. Probably because of the disabling nature of this condition and years of clinical experience with the drug, carbamazepine is still often the initial treatment of choice.

Neurosciences Group News continued...

First and foremost – I was trying to obtain an objective view on the scope of pharmacological treatment of dystonia with botulinum toxin to inform myself about the current state of scientific knowledge and to network with other members of the multidisciplinary team.

Botulinum toxin is derived from *Clostridium botulinum*. Out of 7 different toxins (A-G) only A and B have a pharmacological role to play. Botulinum toxin A is manufactured as Botox® (Allergan), Dysport® (Ipsen), and Xeomin® (Merz), whereas Botulinum toxin B is available as Neurobloc® (Eisai).

Are commercial products interchangeable?

There is much debate about the comparability of the different botulinum toxin brands. Due to different assays (LD₅₀) in the manufacturing process it is difficult to compare the various brands. Botox® and Dysport® have both been formulated with complexing proteins, whereas the fairly new Xeomin® has been formulated without them. Results from a study undertaken by Frevert established that the amount of neurotoxin is lowest in Xeomin® whereas the

amount of protein is markedly higher in the other 2 formulations. The commercial products therefore have a different specific biological activity (determined by the amount of toxin) and are not interchangeable on a unit-to-unit basis.

What is the role of complexing proteins?

Complexing proteins are there to protect the toxin from a hostile environment (such as gastric acid). There is compelling evidence that the complexing proteins dissociate rapidly after injection, releasing the free neurotoxin to exert pharmacological action. This questions the claim for product-specific differences in terms of diffusion.

The determining factors for diffusion may therefore be the concentration of the toxin (not the size of the complex), the degree of dilution, and last but not least the individual skills of the injector. A high concentration of toxin leads to local saturation of toxin acceptors as diffusion takes place. This would permit unbound toxin to freely diffuse from the initial site until all molecules are bound.

Neutralising antibodies

Many discussions circled around the incidence and mechanism of resistance. It is emerging that the incidence of resistance is less of a problem than previously thought. Neutralising antibodies are targeted towards botulinum toxin. It was postulated that the complexing proteins in Botox® and Dysport® may act as catalysts for antibody production. However, other speakers suggested that the fact that the complexing proteins dissociate within minutes from the toxin, raised the question whether Xeomin® has the same potential for immunogenicity as the other brands. The jury is still out and there seems to be a great degree of uncertainty of the true incidence of resistance. Patients resistant to botulinum toxin A are unresponsive to treatment with all brands, however there is evidence (from case reports) that antibody titres may decline over the years.

Annett Blochberger
St. George's Healthcare NHS Trust

Research Group news

Nuttan Tanna reports on the success of the UKCPA R&D and NIHR CLAHRC joint fringe meeting held at the joint UKCPA / GHP conference in Leeds in May

The aims of the meeting were twofold, reports Nuttan Tanna, UKCPA GC member & Fellow of NIHR CLAHRC NWL. UKCPA wished to:

- support the raising of awareness of CLAHRC (Collaboration and Leadership for Applied Health Research and Care), a five year NIHR -funded program that aims to accelerate integration of valuable research findings within routine NHS clinical practice to improve patient care; and
- invite discussion to understand how pharmacist practitioners members may wish to engage.

There are nine CLAHRC organisations across the UK, and each has developed priorities in line with local needs. Jackie Valentine is the programmes lead for acute care for CLAHRC NW London sector. After providing information of work in place at the national level and locally across NW London, discussion took place to highlight the improvement methodology techniques used and the support that was available from CLAHRC. Currently, there are six Clinical Pharmacists across six sites leading on CLARHC Round 1, Round 1 Roll out or Round 2 projects. All further 26 projects teams to date have dedicated pharmacy involvement in learning and applying these techniques.

Project teams working in collaboration invariably use 'Plan - Do - Study - Act' (PDSA) cycles. This allows small incremental changes to be made which engender buy-in and acceptance of change for a

common goal: delivery of improved patient care. This includes a specially designed real time web-based reporting tool for project teams to document their PDSA cycles, comments and sustainability scoring against criteria used to assess project progress. CLAHRC NWL sector run quarterly collaborative learning and development (CLD) events to build capability and capacity of team members in leadership research and improvement methodology. These events also serve as a platform for networking, sharing ideas, and presentation of project findings.

Delegates then worked on a process mapping activity which is a key improvement methodology technique and the first crucial step in any improvement project. The activity is designed to demonstrate what is actually happening on the shop floor as far as systems and processes are concerned. Are we actually doing what the current policy says? If not, where are the gaps, barriers or facilitators and how can we improve as multidisciplinary team members influencing that process or system for patient benefit? The attendees devised a practical process map, considering one of two themes; either getting up from bed to getting into work or buying groceries for a dinner party. (However, the group looking at buying groceries decided it was much more interesting to focus on a theme around buying a dress for the UKCPA conference dinner!) There were plenty of ideas for improvement on getting to work,

more to do with planning the night before and a big 'gender' difference between mapping a male versus female shopping experience. For improvement in time management, the decision was to send a male to do the shopping!

Nuttan talked about the CLAHRC fellowship program, with nine fellowships being awarded for 2010-2011 and the second call due to come out in September 2011. This was another way in which CLAHRC NWL aimed to meet its vision of increasing R&D skills, resources and capacity across the NHS.

For further information please visit your local CLAHRC website and make contact with designated leads. Whatever the level of expertise, if you are interested in R&D, improvement methodology and working to enhance NHS patient care then CLAHRC may be a way forward. Many pharmacists asked about funding support. CLAHRC NWL have funded projects to the tune of £100,000 with matched funding from the employing organisations in Rounds 1 and 2. Calls for funding proposals are being invited for Round 3 projects, with registration of interest by 31st July 2010. If invited to submit a full proposal, CLAHRC will provide support to write a robust project proposal that should be submitted by end September 2011. See www.clahrc-northwest.london.nihr.ac.uk for more details.

Respiratory Group news

Department of Health Consultation on a Strategy for Services for Chronic Obstructive Pulmonary Disease (COPD) in England has been launched

The Department of Health has published the final consultation document on services for COPD and asthma in England. The document can be found on the Department of Health website (www.dh.gov.uk). It is estimated that over 3 million people in England live with this condition - less than a million of which have actually been diagnosed. The harsh reality is that one person dies in England and Wales from COPD every 20 minutes. COPD is also the second most common cause of emergency admission to hospital and the fifth largest cause of readmission to hospital. The national strategy will aim to tackle the growing problem of COPD with better co-ordinated and integrated services, changing our approach to prevention, diagnosis and treatment.

The UKCPA Respiratory group welcomes the publication of the draft strategy. The committee will be submitting a response to this consultation and is keen to hear your views in order to develop a submission which represents the views and perspectives of pharmacists.

Legal Issues Concerning Pulmonary Function Tests

Pulmonary Function Tests (PFTs) allow a useful means for both diagnosing different respiratory conditions as well as determining the severity of the disease. Certain tests measure current lung function, whilst others measure the response of airways to drugs such as bronchodilators, oxygen or even to drugs designed to cause bronchoconstriction.

These PFTs (such as reversibility testing to bronchodilators, airway hyperresponsiveness testing, oxygen assessments and nebuliser assessments) are often performed by nurses, physiotherapists or respiratory physiologists. This essential service has been provided in many UK hospitals for many years, although in many centres these tests have been performed on receipt of only a request card asking for the test to be performed.

This raises certain clinical governance concerns, because some of these tests require the administration of prescription only medicines (e.g. oxygen, salbutamol,

mannitol, histamine), which historically have frequently not been prescribed to authorise their administration. The difficulty in this scenario lies in the fact that patients often undergo these tests as outpatients, where a doctor is not present to prescribe the drugs required, and that request cards are not prescriptions.

Many hospitals have recognised this as a problem and some centres have produced patient group directions (PGDs) to provide specific written instructions for the administration of named medicines in identified clinical situations. This solution works well for the administration of drugs as part of PFTs, since the healthcare professionals concerned will be familiar with the drug and test, and overcomes the problem of a lack of prescription. However PGDs can only be used by registered healthcare professionals such as nurses, physiotherapists and pharmacists. In many UK centres, PFTs are performed by respiratory physiologists, who are currently unregistered practitioners and so legally cannot administer drugs using a PGD.

In Leeds, the majority of our PFTs are performed by respiratory physiologists and so a PGD could not be used to authorise the administration of drugs as part of any tests. Consequently we have recently redesigned our Pulmonary Function Tests request card in order to incorporate a prescription and administration record for the medicines that are given as part of any test that is requested.

The doctor is required to sign the request card to authorise each test required. In addition, if the test requested requires the administration of medicines, the doctor is also required to sign the pre-printed prescription request on the reverse side of the request card. This prescription then allows the respiratory physiologists to sign the administration section of the prescription. After completion of the test(s), the request card is attached to the final Pulmonary Function Test Report, and filed in the patient's medical records to provide permanent documentation of who performed each test and which drugs were administered.

A third solution endorsed by some centres has been to refuse to perform certain PFTs without the provision of a prescription. This works well if the requesting doctor knows this policy, but could result in delays in the test being performed if no prescription is provided.

Useful tips on selecting the right inhaler device

Little advice is provided regarding the selection of an appropriate inhaler device. If drug delivery is inefficient, or if the patient struggles to learn or remember how to use the device, the effectiveness of therapy will be reduced.

Several factors need to be considered when choosing an inhaler device:

- Patient's age – most children under the age of five cannot generate sufficient suction to use dry-powder inhalers, while some elderly patients cannot use metered-dose inhalers due to a lack of co-ordination or dexterity
- Patient's preference – ideally, patients should try a range of devices before choosing the one with which they are most comfortable
- Physical or cognitive impairment – a patient with arthritic hands might not have sufficient dexterity to, for example, depress the canister on a metered-dose inhaler
- Availability – no medicines are available in all inhalation devices
- Local formularies – might show preference for one device over another (eg, because of cost).

Ideally, inhalers should only be prescribed after a patient has received training in the use of the device and has, subsequently, demonstrated satisfactory inhaler technique. Poor drug delivery can decrease disease control and increase unnecessary inhaler use. This has financial implications in terms of the cost of extra medicines used, and might result in additional GP visits or hospital admissions. Any time spent educating patients on the use of their inhalers could, potentially, reduce these costs.

Surgery & Theatres Group news

Debra Morris, Chair of the Surgery & Theatres Group, reports on the forthcoming Study Day, their work on the ACLF to recognise advanced practitioners, and asks for experiences of using the CQUINS risk assessment for VTE.

Share your experiences of CQUINS risk assessment for VTE

As you are no doubt all aware, the new NICE guidelines for VTE prophylaxis have been available for a few months now. It has been acknowledged by the DoH that pharmacy can have great contributions in implementing guidelines and focusing on patient safety aspects.

The Expert Working Group 2007 report estimated a possible 25,000 preventable deaths per year in the NHS as well as other morbidities associated with the complications of VTE. Measures have since been made to address such issues. As well as the new NICE guidance, which now combines all of the speciality areas, there has been the introduction of CQUINS. This requires that a risk assessment for VTE be carried out on all patients admitted to hospital. Subsequent payments to each Trust will be based on compliance rates of completion of the documentation and that the appropriate therapy is given.

Pharmacy plays a vital role in ensuring local guidelines are in place and adhered to, and in conducting audits in order to fulfil the required target set by CQUINS.

It would be interesting to hear, via the UKCPA mail base, how

different Trusts are tackling this huge project. So please, share your comments, particularly if something has been successful or if there are certain obstacles you have faced. This would be a good way to communicate your experiences as others may be able to offer advice or benefit from your practice.

Surgery & Theatres Group Study Day

This is a good opportunity to remind everyone of the up and coming study day which is soon to be advertised. It will be a joint session with the pain group looking at behind the scenes in theatres. So, if this is an area you are interested in, or like myself, unfamiliar with and scared to venture into then this will be an ideal way to recap and improve your knowledge.

The study day is planned for September and will be looking at medication used during surgical procedures with a large emphasis on pain management during this time and in recovery.

If this is something that you feel will be beneficial either from a job point of view or just for personal development then look out for the adverts and book yourself onto the day.

Surgical pharmacists using ACLF to recognise advanced and consultant level practice

Over the past few months members of the Surgery and Theatres group have been working on the Advanced Consultancy Level Framework for surgical pharmacists in order that consultant pharmacists can be recognised within this field.

The document looks at the core clinical knowledge required for practice in surgical care and what is required to obtain advanced level status. This has been drafted by Shola Ajiboda, Suparna Bali (STPG committee) and Caroline Broadbent in the hope of bringing surgical pharmacy in line with other leading specialities such as critical care.

As well as clinical knowledge, there are other areas which a pharmacist has to demonstrate competence in to achieve advanced or mastery level. These include, leadership, management, building working relationships and training and development. This is a work in progress, with the end result being to produce consultant pharmacists within the specialised field of surgery.

If anyone would like to contribute to the document or would like to know more please contact myself or Suparna via UKCPA (contact details on website).

Thank you!

UKCPA takes this opportunity to thank all corporate members and sponsors for their support.

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Consultation responses

UKCPA has responded to the following consultations in recent weeks:

- NICE bacterial meningitis and meningococcal septicaemia in children clinical guideline pre-publication check
- NICE COPD clinical guideline pre-publication check
- NICE Venous thromboembolic diseases draft scope
- MHRA consultation on request to reclassify Ibuleve Speed Relief Max Strength Gel 10% w/w from P to GSL (ref ARM 68)
- MHRA (Ref MLX 367) proposal to amend the prescription only medicine (human use) order 1997
- GPhC Standards consultation
- NICE draft scope the Type 2 diabetes Public Health Intervention: preventing the progression from pre-diabetes to type 2 diabetes among high risk groups
- MHRA (Ref MLX 364) consultation on the regulation of nicotine containing products
- NICE Motor neurone disease: non-invasive ventilation guideline pre-publication check
- British Thoracic Society Guidelines for advanced diagnostic and therapeutic flexible bronchoscopy in adults
- National Clinical Guidelines Centre for Acute and Chronic Conditions and the Guideline Development Group for Delirium: pre-publication check.

The deadline for contributions to the next issue is 31st August 2010.

Letters, editorials and short papers welcome.

Email the Editor-in-Chief at: admin@ukcpa.com

What do you think of the changes to this issue of *In Practice*?

Please let me know. Email your thoughts and comments - good and bad! - to:
general.secretary@ukcpa.com

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