



Royal
Pharmaceutical
Society
of Great Britain



*National Treatment Agency
for Substance Misuse*



Best practice guidance for commissioners and providers of pharmaceutical services for drug users

Service specification (Tier 2 or 3)



February 2006

Reader information

Document purpose:	To provide commissioners and providers of pharmaceutical services for drug users with information and advice in order to inform commissioning and ensure best practice.
Title:	Best practice guidance for commissioners and providers of pharmaceutical services for drug users.
Lead author:	Marion Walker, pharmacist, NTA Clinical Team
Publication date:	February 2006
Target audience:	Commissioners of drug treatment services and pharmaceutical enhanced services in England. Providers of pharmaceutical services to drug users in primary and secondary care.
Circulation list:	Managers and commissioners of treatment services Co-ordinators and chairs of local partnerships (e.g. drug action teams and crime and disorder reduction partnerships). Service user and carer groups. Commissioners of pharmaceutical enhanced services local pharmaceutical committees. Regional government department leads on drugs. Central government department leads on drugs.
Description:	Detailed sample service specifications for commissioning pharmaceutical services. Includes pharmacy needle exchange and dispensing, supervised administration (consumption of prescribed medicines) and pharmaceutical shared care for drug users. Includes information and advice to help commissioners and providers ensure pharmaceutical services follow best practice. Clarifies current and future roles for pharmacists in the provision of services to substance users. Explains the new pharmacy contract and how community pharmacists are paid.
Action required:	Providers and commissioners to work together to ensure appropriate capacity and quality of pharmaceutical services are available to meet projected demand. Commissioners and providers to maximise the potential for extended roles of pharmacists and pharmacy technicians in both primary and secondary care.
Timing:	Ongoing
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Gateway/ROCR approval:	The NTA is a self-regulating agency in relation to Department of Health Gateway

Foreword

Every year, pharmacists provide more than 14 million face-to-face contacts with drug users. They play an important role in their treatment and care, including dispensing drugs as part of supervised consumption arrangements and offering needle exchange services.

However, as highlighted by the Audit Commission's report *Changing habits*, "...research has shown that many [pharmacists] are an underused point of contact for the drug misusing population and would benefit from a closer relationship with prescribing services and improved training."

Following the memorandum of understanding between the National Treatment Agency for Substance Misuse (NTA) and the Royal Pharmaceutical Society of Great Britain (RPSGB), this document was developed with the aim of providing guidance for commissioning of pharmaceutical services for drug users.

The introduction of the new pharmacy contract, as well as new approaches to prescribing and supplying medication, requires close co-operation between professionals, particularly doctors, drugs workers and pharmacists, and a need to develop positive partnerships with service users. Supplementary prescribing is a prime example of how flexible approaches to the delivery of care and new professional roles can contribute to providing quality services to drug users. Plans are in place for enhanced roles for pharmacists working in substance misuse, as pharmacists with a special interest and consultant pharmacists. Advanced training programmes for pharmacists and pharmacy technicians through; for example, the Centre for Pharmacy Postgraduate Education and the Royal College of General Practitioners, are ensuring we have a well-trained pharmacy workforce. The valuable role of pharmacists and technicians working in secondary care services and specialist substance misuse teams should also not be forgotten.

It is early days for many of these new developments and the introduction of new ways of working presents many challenges. This briefing offers best practice guidance for commissioners and providers on the development of service specifications for pharmacists providing services to drug users, and helps providers, service users and commissioners to consider the benefits available and plan to make any developments safe and sustainable.



Paul Hayes
Chief executive, National Treatment Agency

Purpose of the guidance

This briefing offers best practice guidance for commissioners and providers on the development of service specifications for pharmacists providing services to drug users. It is subdivided into the following sections:

1. **Executive summary** – this provides a brief summary of each of the sub-sections in the main part of the document and provides a rapid overview of the service specification.
2. **Detailed sample service specifications** – pharmaceutical services to drug users.

Each section is subdivided, where relevant, into:

- Pharmacy-based needle exchange and harm reduction
 - Dispensing and supervised consumption of substitute medications by pharmacists involved in shared care
3. Clarifying current and future roles for pharmacists in the provision of services to substance users. This section briefly describes additional services that pharmacists and their staff can, and do, provide for drug (and alcohol) users
 4. Sample schedules.

Appendix 1: How community pharmacies are paid

Appendix 2: Understanding the new pharmacy contract

Appendix 3: NHS community pharmacy contractual framework enhanced service – needle and syringe exchange

Appendix 4: NHS community pharmacy contractual framework enhanced service – supervised administration (consumption of prescribed medicines)

Appendix 5: NHS community pharmacy contractual framework enhanced service – supplementary prescribing by pharmacists

Appendix 6: Abbreviations used in this document.

Drug and alcohol misuse

The primary focus of *Models of care: Update 2005* (NTA, 2005), and the service specifications described here, is adult drug misuse treatment including harm reduction initiatives. This guidance concentrates on the provision of:

- clean injecting equipment and advice on safer injecting as part of a needle and syringe exchange programme
- dispensing, supervised consumption of oral prescribed drugs such as methadone and buprenorphine and shared care services to drug users.

However, it is important for commissioners to recognise the wide range of services available from pharmacists and community pharmacies and the applicability of these service specifications to alcohol treatment services. Section 3 of this guidance looks at the differing roles and services that pharmacists can and do provide to drug (and alcohol) users.

The Royal Pharmaceutical Society of Great Britain

The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional and regulatory body for pharmacists in England, Scotland and Wales. It also regulates pharmacy technicians on a voluntary basis, which is expected to become statutory under anticipated legislation. The primary objectives of the society are to lead, regulate, develop and represent the profession of pharmacy.

Key responsibilities of pharmacists

The RPSGB specifies a code of ethics and standards, to which all pharmacists (and pharmacy technicians) must comply. In addition, the society publishes practice guidance, which includes guidance for pharmacists on needle and syringe exchange schemes and instalment dispensing services to drug users. More recently, the RPSGB has published the *Clinical governance framework for pharmacist prescribers and organisations commissioning or participating in pharmacist prescribing (GB wide)*. From 1 January 2005, there is a professional requirement for all pharmacists to put in place and operate written standard operating procedures within individual pharmacies to cover the dispensing process. Quite simply, a standard operating procedure specifies in writing what should be done, when, where and by whom. In addition, the new NHS community pharmacy contract requires pharmacies to have standard operating procedures in place for locally commissioned enhanced services, including needle exchange and supervised consumption of prescribed medication.

The National Treatment Agency

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harm caused by drug misuse to individuals' well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000 – 300,000 problematic drug misusers in England who require treatment.

The NTA is responsible for meeting the Department of Health's (DH) targets to:

- double the number of people in effective, well-managed treatment between 1998 and 2008
- increase the percentage of those successfully completing or appropriately continuing treatment year on year.

The Pharmaceutical Services Negotiating Committee

The Pharmaceutical Services Negotiating Committee (PSNC) is recognised by the Secretary of State for Health as representative of community pharmacy (in England and Wales) on NHS matters. Much of the PSNC's work involves discussion and negotiation with the Department of Health.

The Pharmacy Misuse Advisory Group

The Pharmacy Misuse Advisory Group (PharMAG) enables pharmacists with a professional interest in substance misuse to share their expertise and aims to raise the profile of pharmacists working in the field of substance misuse, both within the profession and at national and international level. PharMAG aims to encourage high-quality pharmaceutical care in this field, acting as a source of information and responds to national and local policy issues.

Membership of PharMAG is open to all pharmacists and other professionals with an interest in optimising the pharmaceutical care of drug misusers. Current membership includes pharmacists from community, hospital, primary care, industry, prison service and academic branches of the profession. The group publishes a quarterly magazine, *PharMAGazine*, sent to all members. Further information and membership application forms can be obtained from the chairman, Kay Roberts by email kay@mymbrob.freereserve.co.uk or by phone 0141 337 6799.

This document is based on policy for England but the principles are applicable to other UK countries.

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1 Executive summary

1.1 Definition of the service

There are a wide range of pharmaceutical services which many pharmacists can and do provide. Commissioners should work with pharmacists in the community, hospitals, local pharmaceutical committees (LPCs), primary care trusts (PCTs) and primary care organisations (PCOs), to ensure there is widespread provision of a broad range of pharmaceutical services available for drug users. Section 3 of this guidance describes the different roles and responsibilities of pharmacists working in the various sections of the NHS, as well as detailing the differing levels of expertise attained by pharmacists.

This guidance concentrates mainly on provision of needle exchange and supervised consumption of prescribed medicines. These form part of the enhanced services tier of the new community pharmacy contract. (Appendix 3 and Appendix 4 detail the NHS enhanced service specifications for these services – published September 2005). These enhanced services are locally commissioned by PCTs and PCOs. *Appendix 1: How community pharmacies are paid* and *Appendix 2 Understanding the new pharmacy contract*, provide more information and NTA guidance on local enhanced and national enhanced services.

Where pharmacists have undertaken specific training and attained the required level of expertise and competence, they may be able to offer additional enhanced services to clients such as supplementary prescribing (Appendix 5 – published September 2005) that further support the NTA's treatment effectiveness strategy, to promote progression through the treatment system for all individuals. At the time of writing, the law has only recently been changed to allow supplementary prescribers to prescribe controlled drugs. As a result, it has not been possible to include detailed guidance for commissioners or providers on supplementary prescribing by pharmacists. However, commissioners and providers should refer to the RPSGB publication *Clinical governance framework for pharmacist prescribers and organisations commissioning or participating in pharmacist prescribing (GB-wide)* (RPSGB, 2005).

A number of pharmacists who have completed the Part 2 Royal College of General Practitioners (RCGP) certificate in the management of drug misuse have now also completed supplementary prescribing training. Commissioners are advised to contact local pharmacists who have completed these courses with a view to investigating the potential for commissioning pharmacists as supplementary prescribers.

1.2 Aims and objectives of the services

The overall aims of pharmacy services to drug users are to assist the service user to remain healthy, reduce drug-related harm, provide service users with regular contact with a healthcare professional and help them access further advice or assistance.

Pharmacy needle exchanges aim to reduce the rate of sharing and other high-risk injecting behaviours by providing sterile injecting equipment and other support, as well as ensuring the safe disposal of used injecting equipment.

Pharmacies providing dispensing services aim to ensure compliance with the agreed treatment plan, improve retention in drug treatment by providing instalment dispensing and ensuring each supervised dose is correctly administered to the patient for whom it was intended. They contribute to the shared care of the patient by liaising with the prescriber or named keyworker directly involved in the care of the patient. They reduce the risk to local communities of diversion of prescribed medicines onto the illicit drugs market.

1.3 Service user group served

Pharmacy needle exchange facilities are available to all adult injectors who are using drugs illicitly. Where possible, needle exchange and harm reduction facilities should also provide interventions relevant to non-injectors.

Community-based dispensing, supervised consumption and shared care are available to all individuals, in receipt of an NHS prescription, who have drug-related problems, including dependent opioid users as well as those who present with additional polydrug use or concurrent use of benzodiazepines, psychostimulants and alcohol.

1.4 Contraindications and exclusions

Models of care: Update 2005 (NTA, 2005) focuses on the commissioning of services for adults (those aged 18 years or over). A person aged 17 years or under will normally access a young person's service. It is likely that the young person will remain with the same pharmacy or pharmacist after transferring to the adult service.

The pharmacist will not dispense a controlled drug prescription if it does not fully comply with legal requirements. Dispensing and supply can be refused, in certain circumstances as defined by the new pharmacy contract.

1.5 Referral pathways

Access to pharmacy needle exchange facilities and harm reduction initiatives is voluntary and open. Referrals are accepted from a wide variety of sources, with self referral being the most usual route of access. Whenever possible and where appropriate, pharmacy service providers should facilitate onward referral to specialist drug treatment services.

Access to treatment in a pharmacy is voluntary. Patients have the right to choose which pharmacy they take their prescription to be dispensed.

Commissioners and providers must work together to ensure the overall capacity of the local dispensing system is sufficient to meet the combined demand from all the various prescribing services.

1.6 Basic assessment and ongoing harm reduction advice and support

Pharmacists or other appropriately trained pharmacy staff should provide direct input wherever possible to promote harm reduction. Interventions should include a clear health promotion element.

1.7 Care planning

A care plan for clients of pharmacy needle exchange facilities is not required. Pharmacy staff should reinforce the harm minimisation message and encourage hepatitis B immunisation and course completion.

All patients who are prescribed treatment should have written and structured care plans resulting from assessment, prior to prescribing. Providers should work with prescribers, keyworkers and care co-ordinators to ensure the name of the patient's chosen pharmacy is included in the prescriber's care plan and the pharmacist should liaise with the multidisciplinary team on a regular basis.

Commissioners should ensure shared care arrangements continue to include the pharmacist as the patient moves between different prescribing services.

1.8 Co-ordination of care

Pharmacists will support the keyworker responsible for co-ordinating the patient's care by monitoring continuity of care and contributing to the aim of maximising retention of patients in the treatment system.

1.9 Description of services, care and interventions provided

Pharmacists should be involved in strategic and operational planning of services to drug (and alcohol) users, through the inclusion of specialist pharmacy representation on drug (and alcohol) action teams and shared care monitoring groups.

Pharmacy needle exchanges provide (but are not limited to) screening, risk assessment, referral, advice and appropriate needle exchange equipment.

In addition to supervised consumption and shared care, pharmacy dispensing services provide (but are not limited to) screening, risk assessment, referral, advice, and compliance with legal and professional responsibilities.

1.10 Competencies and training

Health and safety training must be provided to staff, including training on the handling of injecting equipment.

Pharmacists are encouraged to complete the two open learning modules, *Substance misuse and opiate treatment: supporting pharmacists for improved patient care*, provided by the Centre for Pharmacy Postgraduate Education (CPPE) in England, or the equivalent Scottish, Welsh, or Northern Ireland packs. Pharmacists who have completed the Part 2 Royal College of General Practitioners Certificate (RCGP) in the Management of Drug Misuse in Primary Care may be eligible, in future, to apply for posts as pharmacists with special interest (PhwSI) in drug misuse.

In addition, the National Pharmacy Association (NPA) provides its members with a resource manual on operating a pharmacy needle exchange, as do some multiple pharmacy chains.

1.11 Service principles

Pharmacy needle exchange facilities and harm reduction initiatives provide an easy, low-threshold, open access and user-friendly service.

The pharmacist ensures that supervised consumption takes place in a private or quiet area of the pharmacy.

Participating pharmacists have effective links with prescribing services (including GPs) and provide advice and shared care where required. Pharmacists liaise with services (including GPs) about specific patients and prescribing regimens. The pharmacist shares relevant information with all professionals involved in the treatment, within the bounds of pharmacists' professional confidentiality guidelines.

Pharmacists are provided with support (for example, from a dedicated scheme co-ordinator) to operate needle exchange, shared care and supervised consumption schemes and there is pharmaceutical representation on the local shared care monitoring group.

1.12 Policies, protocols and written strategies

All pharmacists will have standard operating procedures (SOPs) in place specific to their individual premises.

Pharmacy service providers will ensure information is available enabling locum pharmacists to continue to provide the commissioned services.

1.13 Monitoring and review

The manner in which monitoring and review are undertaken may vary from area to area. In some areas, the local PCT, PCO or DAT may develop and agree milestones and targets, whereas in others these may be agreed by the local pharmaceutical committee on behalf of all the pharmacy contractors in the area.

1.14 Data collection and claims for payment

Data collection should be standardised to ensure uniformity across the schemes. *The task force to review services for drug misusers*, (Department of Health, 1996) recommended a number of key performance indicators for pharmacies, and (pharmacy) needle and syringe exchange schemes.

Robust payment arrangements for participating pharmacies must be agreed locally. (See also Appendix 1: How community pharmacies are paid, section 4.6.)

There must also be clear information on how to contact scheme co-ordinators and what support and resources the pharmacy can expect from scheme co-ordinators.

1.14.1 Payments to community pharmacies

Under the new pharmacy contract (see Appendix 2), the enhanced services are locally commissioned by PCTs and PCOs in response to local health needs. Services can be based on nationally produced service specifications or locally designed and negotiated with local pharmaceutical committees (LPCs) at a local level.

Work has been ongoing to seek to agree benchmark prices, but after meetings between the PSNC, NHS Confederation and Department of Health, it appears that a better approach is the publication of a pricing toolkit. At the time of writing, the PSNC is developing a jointly agreed toolkit for pricing, which will identify the elements to be considered in pricing the service at a local level. It is envisaged these toolkits will be available on the PSNC website at www.psn.org.uk.

2 Detailed sample service specifications – pharmaceutical services to drug users

- This sample service specification is evidence-based and reflects *Models of care for treatment of adult drug misusers update* (NTA 2005) and the *Drug Misuse and Dependence: Guidelines for Clinical management* (Departments of Health 1999) as well as the legal and ethical frameworks under which pharmacists are required to practise
- This sample service specification is intended to provide general guidance, and should not to be used as a fixed and prescriptive template. The sample should be adapted at local level, tailored to the particular type of providers (pharmacists and pharmacies) and the interventions purchased, and should not hamper the development of innovative work
- It is good practice for commissioners to develop specifications in partnership with service providers, including prescribers, pharmacists, community pharmacies and local pharmaceutical committees (LPCs), in consultation with service users and carers
- This sample service specification should be read in conjunction with section 3.1 of the NTA commissioning drug treatment systems – resource pack for commissioners (introduction, contracts, service agreements and specifications)
- See also the NTA briefings *Needle exchange and harm reduction* (NTA, 2003) and *Community prescribing* (NTA, 2003).

2.1 Definition of the services

The following service specifications are intended for the purchase of pharmaceutical services for adult drug users (those aged 18 years and over). These specifications form the basis for providing pharmaceutical services to drug users within the community in which they reside or work.

Models of care: Update 2005 (NTA 2005) places a greater focus on the need to improve the effectiveness of drug treatment systems by:

- improving interventions to reduce the risk of blood-borne virus (BBV) infection and risk of overdose
- improving retention in drug treatment
- improving drug treatment delivery, completion and reintegration into communities.

Pharmaceutical services to drug users may involve both community and hospital pharmacists,

In addition, PCT and PCO pharmacists will be involved in their organisations' commissioning of enhanced pharmaceutical services, such as pharmacy needle exchange and supervised consumption of prescribed oral drugs. The development of enhanced services should be informed or directed by the pharmaceutical needs assessment (PNA) that PCTs and PCOs are advised to undertake. PCTs, PCOs and DATs need to work together to ensure pharmacy service provision matches local need for drug and alcohol services.

All DATs, PCTs and PCOs are expected to ensure there is widespread provision of:

- pharmacy needle exchange services
- dispensing, supervised consumption and shared care services for drug users involving pharmacists.

It is considered good practice that there is a named person who is responsible for co-ordinating pharmacy needle exchange schemes, supervised consumption and shared care schemes (although it need not necessarily be the same person). Co-ordinators can be employed by the provider organisation, PCT, PCO, DAT, or another organisation such as the hospital trust pharmacy department.

In addition, there are a wide range of pharmaceutical services which many pharmacists can and do provide. Commissioners should work with pharmacists in the community, hospitals, PCTs and PCOs to ensure that a broad range of pharmaceutical services are available for drug users. (See Section 3: Clarifying current and future roles for pharmacists in the provision of services to substance users.)

An individual pharmacy may be limited in the range of services that it can provide. However, commissioners should ensure that a full range of interventions can be provided within local systems. The eventual aim should be for the majority (over 75 per cent) of community pharmacies to provide dispensing, supervised consumption and shared care, so that individual patients have maximum choice on where to have their prescription dispensed. In addition, the aim should be that a significant proportion (over 25 per cent) provide needle exchange, distributed appropriately across the DAT, PCT and PCO localities.

Needle exchange and supervised consumption form part of the enhanced services tier of the new community pharmacy contract. Appendices 3 and 4 detail the enhanced service specifications for pharmacy needle and syringe exchange, and supervised consumption of

prescribed oral medicines. These enhanced services are locally commissioned by PCTs and PCOs. (See Appendix 2 for more information.)

In addition to services provided by community pharmacists, pharmacists may be employed as part of specialist community-based prescribing services that deal exclusively with people with drug (and alcohol) misuse problems. Such services are usually staffed by a multidisciplinary team of people with specialist knowledge in the field and led by an addiction specialist. Pharmacists may be either directly employed in such services to provide a wide range of pharmaceutical services for drug (and alcohol) users, which may include needle exchange and supervised consumption. Alternatively, pharmaceutical advice and services may be provided by the hospital pharmacy department of the specialist service NHS trust.

Pharmacies where the pharmacist has undertaken specific training and attained the required level of expertise and competence may be able to offer additional services to clients, which further support the NTA's treatment effectiveness strategy to promote progression through the treatment system for all individuals.

2.1.1 Pharmacy needle exchange – definition of service

Models of care: Update 2005 (NTA 2005) classifies pharmacy needle exchange as a Tier 2 intervention. Pharmacy-based needle exchanges are an important, easily accessible public health intervention. Pharmacy needle exchange and harm reduction initiatives are developed as part of the overall wider approach to prevent the spread of blood-borne diseases (most particularly HIV and hepatitis) and other drug-related harm, including drug-related death. They often have contact with drug users who are not in touch with other specialist treatment services. They have a health remit as well as a social welfare role within the wider community.

The local pharmacy needle exchange provision:

- must ensure the service is integrated and co-ordinated with the overall local needle exchange and harm reduction facilities
- should, as part of the overall needle exchange service, meet the demands of the local population, for example, in terms of geographical spread across the locality, opening times and accessibility
- should include the distribution and collection of sterile injecting equipment and associated materials and their safe disposal. They should promote safe injecting practices, to reduce transmission of infections by drug users
- should provide the necessary level of privacy to clients,¹ for example the availability of a private area or consulting room.² Particular consideration should be given to the safety of pharmacy staff using completely closed consultation rooms (advice on this is available from the NHS Security Management Service)
- should ensure the ongoing provision of a range of other harm reduction support and advice for the users of the service, including referral to primary care and specialist drug and alcohol services where appropriate
- must have agreement by providers and commissioners on whether or not the provision of services to steroid users is within the remit of the scheme.

DATs or commissioning partnerships should not depend solely on community pharmacies for harm reduction and needle exchange services, although these provide a particularly important service. Pharmacy needle exchanges should be seen as complementary to specialist services rather than alternative settings. A range of models of reaching and engaging with those at risk of drug-related harm should be commissioned, including intensive harm reduction work with those most at risk.

¹The term 'client' is used in this paper when referring to pharmacy needle exchange service users.

²The new community pharmacy contract requires pharmacies that opt to provide the advanced tier of services to have private consultation facilities in place. These consultation areas or rooms must allow the patient and pharmacist to sit down together and talk, without being overheard by other people in the pharmacy. The area must be clearly designated as being for private consultations. As this national requirement will increasingly be met by community pharmacies, commissioners may wish to set local criteria with these requirements in mind.

Commissioners and providers may agree to the separate commissioning of the different elements which may additionally be needed to complement the pharmaceutical needle exchange service, for example:

- Co-ordination of the scheme including co-ordination with other harm minimisation services
- Supply of equipment (needles, syringes, sharps bins and associated paraphernalia) for the scheme
- Packing and delivery of equipment
- Collection of clinical waste, i.e. sharps bins and used equipment
- Sourcing and distribution of leaflets, information, printing and stationery
- Training of pharmacy staff
- Payment systems (see Appendix 1, section 5.4)
- Support for pharmacists and staff
- Hepatitis B vaccination for staff and clients.

Commissioners should investigate the potential for co-funding with other organisations and funding streams – for example DAT and pooled treatment budgets, social services, drug intervention programmes (DIPs), probation, local authorities and HIV funds.

2.1.2 Dispensing, supervised consumption and shared care – definition of service

Models of care: Update 2005 (NTA, 2005) recognises that community-based drug treatment can provide a range of interventions spanning across both Tier 2 and Tier 3. However, it also acknowledges that all substitute prescribing interventions should be redefined as Tier 3. This is because they require comprehensive assessment, should be care planned and carry a high duty of care for the clinician prescribing (and the pharmacist dispensing) controlled drugs.

Shared care is defined as: “the joint participation of specialists and GPs (and other agencies as appropriate) in the planned delivery of care for patients with a drug misuse problem, informed by an enhanced information exchange and beyond routine discharge and referral letters. It may involve the day-to-day management by the GP of the patient’s medical needs in relation to their drug misuse. Such arrangements should make explicit which clinician is responsible for different aspects of the patient’s treatment and care. These may include prescribing

substitute drugs in appropriate circumstances (Drug misuse and dependence: Guidelines on clinical management, Departments of Health, 1999).” Pharmacists providing shared care will share relevant information with other healthcare professionals and agencies, in line with locally determined confidentiality arrangements.

Pharmacy dispensing, supervised consumption and shared care services for drug (and alcohol) dependent adults are therefore Tier 3 and include those patients³ prescribed:

- for opioid dependence (titration, detoxification and reduction) and maintenance regimens (such as methadone or buprenorphine⁴)
- for withdrawal from opioids with non-opioid medications (e.g. lofexidine)
- for stabilisation and withdrawal from sedatives, where appropriate (such as benzodiazepines and alcohol)
- for relapse prevention where appropriate (e.g. naltrexone, disulfiram)
- for dependent stimulant use, including symptomatic treatment medications (although some substitute prescribing for amphetamines does occur there is still no national consensus on its appropriateness and the evidence base remains limited).

Pharmacists will continue to provide shared care for patients whether or not doses are prescribed to be administered under the supervision of the pharmacist.

Pharmaceutical services to drug users must:

- be integrated and co-ordinated with the local prescribing services and treatment systems
- meet the demand of the local population and prescribing services
- provide the necessary level of privacy to clients, for example the availability of a private area or consulting room.² Particular consideration should be given to the safety of pharmacy staff using completely closed consultation rooms (advice on this is available from the NHS Security Management Service).

³ The term ‘patient’ is used in this paper when referring to service users who have been prescribed medication for their substance misuse.

⁴ Buprenorphine refers to buprenorphine products licensed for the treatment of drug misuse, for example Subutex®

In addition:

- Arrangements must be in place to cover situations where patients choose to use a pharmacy outside the DAT, PCT or PCO area. (See Appendix 1: section 4.6 for further guidance. In general, pharmacies will be paid for contracted services by their PCTS and PCOS, irrespective of where the prescription originates, but some commissioners will restrict the provision of services to people resident in their area.)
- The provision of this service includes ensuring patients have:
 - access to a daily dispensing service (excluding Sundays and bank holidays)
 - access to a daily supervised consumption service for prescribed oral medicines (excluding Sundays and bank holidays), which ensures the prescribed dose has been administered to the patient.

And that:

- Relevant information can be shared between the healthcare professionals about the drug user without compromising the individual's rights (for all patients prescribed for according to the specification)
- the ongoing provision of a range of other harm reduction support and advice for the users of the service, including referral to primary care and specialist drug and alcohol services, is available where appropriate.

Commissioners may commission the different elements which may additionally be needed to complement the pharmacy dispensing, supervised consumption and shared care services, for example:

- leaflets, information, printing and stationery
- training of pharmacy staff
- co-ordination of the scheme including with various prescribing services, e.g. secondary care, primary care and the Drugs Intervention Programme (DIP)
- support for pharmacists and staff
- hepatitis B vaccination for staff and patients.

2.2 Aims and objectives of the services

The overall aims of pharmacy services to drug users are:

- to offer user-friendly, non-judgmental, confidential and user-centred services
- to liaise with healthcare professionals and others involved in the care of the patient having due regard for the patient's confidentiality

- to help the service user to remain healthy and reduce drug related harm
- to reduce health problems related to drug misuse
- to reduce the dangers associated with drug misuse, including the risks of HIV, hepatitis B and C, other blood-borne infections and the risks of drug-related death
- to provide and reinforce focused harm reduction advice and initiatives, including advice on overdose
- to facilitate access to primary care where relevant
- to provide service users with regular contact with a healthcare professional and to help them access further advice or assistance. The service user will be referred to specialist treatment centres or other health and social professionals where appropriate.

2.2.1 Pharmacy needle exchange – aims and objectives

- To reduce the rate of sharing and other high-risk injecting behaviours by providing sterile injecting equipment and other support
- To promote safer injecting practices, to reduce the risk of blood borne virus (BBV) infection and risk of overdose
- To help service users access other health and social care and to act as a gateway to other services (e.g. key working, prescribing, hepatitis B immunisation, hepatitis and HIV screening, primary care services etc)
- To ensure the safe disposal of used injecting equipment
- To maximise the access and retention of all injectors, especially the highly socially excluded, through the low-threshold nature of service delivery and interventions provided
- To prevent initiation into injecting and to encourage alternatives to injecting.

2.2.2 Dispensing, supervised consumption and shared care – aims and objectives

- To ensure compliance with the agreed treatment plan by:
 - dispensing prescribed medication in specified instalments
 - ensuring each supervised dose is correctly administered to the patient for whom it was intended (doses may be dispensed for the patient to take away to cover days when the pharmacy is closed)
 - liaising with the prescriber, named keyworker and others directly involved in the care of the patient (where the patient has given their written permission)
 - monitoring the patient’s response to prescribed treatment; for example, if there are signs of overdose, especially at times when doses are changed, during titration of doses, if the patient appear intoxicated or when the patient has missed doses, and, if necessary, withholding treatment if this is in the interest of patient safety, liaising with the prescriber or named keyworker as appropriate
 - improving retention in drug treatment
 - improving drug treatment delivery and completion.
- To reduce the risk to local communities of:
 - overuse or underuse of medicines
 - diversion of prescribed medicines onto the illicit drugs market
 - accidental exposure to the dispensed medicines.

2.3 Service user group served

2.3.1 Pharmacy needle exchange – client group served

Pharmacy needle exchange facilities are available to all adult injectors who are using drugs illicitly, but special attention should be given to clients who are not in touch with drug and alcohol misuse treatment services.

Where possible, needle exchange and harm reduction facilities should also provide interventions relevant to non-injectors. These include, but are not limited to:

- interventions to prevent transition into injecting
- interventions aimed at reducing the harm of smoking crack cocaine (see NTA’s service specifications and guidance on working with crack users)
- interventions aimed at reducing harm of other drugs (e.g. cannabis and ecstasy).

These interventions should be adequately resourced.

2.3.2 Dispensing, supervised consumption and shared care – patient group served

The target group for community-based dispensing and shared care is individuals, in receipt of an NHS prescription, who have drug-related problems, including dependent opioid users as well as those who present with additional polydrug use or concurrent use of benzodiazepines, psychostimulants and alcohol.

Pharmacists are required to dispense NHS prescriptions with reasonable promptness and provide, when requested (for example by the prescriber), supervised consumption of certain specified medicines (most commonly methadone oral mixture 1mg in 1ml and sublingual buprenorphine tablets).

Supervised consumption is not part of the dispensing process and will not be provided by the pharmacist, except as part of an agreed scheme.

2.4 Contraindications and exclusions

Models of care: Update 2005 (NTA 2005) focuses on the commissioning of services for adults (those aged 18 years or over).

A person aged 17 years or under who requires treatment will normally access a young person’s service. Commissioners of both adult and children’s services need to have plans in place to ensure a smooth referral and transition between their services. It is possible that the young person will remain with the same pharmacy after transferring to the adult service. Service users should only be excluded for behaviour that has breached accepted rules and standards at the discretion of the pharmacist but within a structure of users’ rights and responsibilities. Service users may be excluded as a result of a professional risk assessment and if they pose a serious risk to staff, other service users and members of the public. Where appropriate, work is carried out to re-engage drug users in this or other more appropriate services and referral to more appropriate services is made where possible.

2.4.1 Pharmacy needle exchange – contraindications and exclusions

For guidance on work with young people refer to *Making harm reduction work. Needle exchange for young people under 18 years old* (Drugscope and Department of Health, 2001). Commissioners and providers must agree arrangements for young people who request needle exchange from a participating pharmacy.

2.4.2 Dispensing, supervised consumption and shared care of substitute medication – contraindications and exclusions

For guidance on dispensing, supervised consumption and shared care refer to *Drug misuse and dependence – guidelines on clinical management* (Departments of Health, 1999).

2.4.2.1 Dispensing

The pharmacist cannot dispense the prescription if it does not fully comply with legal requirements.

Dispensing and supply can be refused in certain circumstances, as defined by the new pharmacy contract:

- If the pharmacist believes the prescription is not genuine or for the person named on the prescription form
- If the pharmacist believes the prescriber has made a clinical error or that the prescription is clinically inappropriate
- If the patient or anyone with them behaves or threatens to behave violently, or commits or threatens to commit any criminal offence (in the pharmacy).

Patients may be excluded as a result of a professional risk assessment – this can include patients who have, for example:

- missed collecting their prescribed medicine for a specified number of instalments and their tolerance to the drug may have reduced
- those who appear intoxicated. Patients must be informed prior to initiation of treatment what types of behaviour may result in exclusion.

2.4.2.2 Supervised consumption of substitute medication (including shared care)

Commissioners must clearly identify and agree with providers which patients are included or excluded – in particular, whether shared care will be expected to continue whether the patient is supervised or not. This will depend upon what service is required from the community pharmacies and, where appropriate, specialist team pharmacists, for example, does the service commissioned include or exclude:

- patients prescribed using FP10MDA (or the equivalents from Wales, Scotland and Northern Ireland), i.e. instalment prescriptions?
- patients prescribed methadone mixture 1mg in 1ml or buprenorphine sub-lingual tablets?
- patients prescribed injectable opioid substitute treatment (diamorphine, methadone)?

- patients prescribed within the local 'shared care model'?
- patients in 'shared care' but no longer required to be supervised?
- patients who have been started in shared care but are now on a maintenance prescription from a GP and are no longer considered necessary to be part of the local shared care model?
- patients prescribed for by the local specialist substance misuse services?
- patients prescribed for by named GPs?
- patients prescribed for by any GPs in the local DATs, PCTs and PCOs?
- patients prescribed for by a supplementary prescriber?
- patients prescribed for by GPs and specialist services outside the DAT or commissioned area?
- patients prescribed for by UK prescribers outside England?
- patients whose treatment has been initiated by the specialist services?
- patients prescribed other drugs, for example, benzodiazepines, naltrexone, or disulfiram?
- patients prescribed for by the Drugs Intervention Programme (DIP)?
- patients released from prison?
- patients prescribed for by another treatment service not commissioned by this DAT or PCT?

2.5 Referral pathways

2.5.1 Access and referral

Provider opening times should be clearly displayed and service users must be given clear information when there is any variation, if the service is not available during these times. Providers and commissioners should ensure that service users have access to services at as wide a range of times as possible. Commissioners should work with providers to ensure a service is available over as many days and for as many hours a day as possible.

Providers must ensure service user confidentiality is maintained to avoid service users being prevented from accessing services, as a result of concerns that they will be recognised or identified as a drug user.

Whenever possible and where appropriate, pharmacy service providers should facilitate onward referral to specialist drug treatment services, GPs, other healthcare professionals in primary care, accident and emergency departments or minor injuries units.

2.5.1.1 Pharmacy needle exchange

Access to pharmacy needle exchange facilities and harm reduction initiatives is voluntary and open. Referrals are accepted from a wide variety of sources, with self-referral being the most usual route of access, and do not require contact with other drug misuse treatment and care agencies.

Patients who are receiving prescribed medication (for example opioid substitution treatment) will not be refused access to clean injecting equipment and needle exchange, and this service will be provided confidentially by the pharmacist. In such circumstances, the pharmacist will generally, where appropriate, encourage the client to discuss this with their doctor or keyworker.

Whenever possible and where appropriate, pharmacy service providers should facilitate onward referral to specialist drug treatment services, GPs, other healthcare professionals in primary care, accident and emergency departments or minor injuries units.

Pharmacy service providers will encourage clients to register with a GP.

2.5.1.2 Dispensing, supervised consumption and shared care – access and referral

Access to treatment in a pharmacy is voluntary. Patients have the right to choose which pharmacy they have their prescription dispensed at. It is inappropriate for prescribers to direct patients to individual, named pharmacies.

Commissioners and providers must work together to ensure the overall capacity of the local dispensing system is sufficient

to meet the combined demand from all the various prescribing services. It is good practice for prescribers to contact the patient's chosen pharmacy prior to initiating prescribing, as some pharmacies may not have the capacity to take on new patients. Capacity may be increased, for example, by:

- improving consultation areas
- providing larger controlled drugs cabinets
- improving security
- reducing dispensing time by the use of automatic "bottle-top" dispensers and the use of electronic systems for controlled drug record keeping.

Providers must work with prescribers to find ways of minimising delays for patients accessing pharmaceutical services, for example by:

- improving systems to verify that the prescriber and the patient are genuine, before dispensing a prescription
- ensuring prescriptions comply with all current legislation prior to dispensing
- arranging for prescriptions to be sent direct to the pharmacy in advance of the patient, where appropriate
- facilitating pharmacies dispensing the prescribed medicine for the first time (i.e. where the pharmacy may not have the item in stock).

Access to a supervised consumption service will only be provided where there is an agreed funded service.

2.5.2 Basic assessment and ongoing harm reduction advice and support

Pharmacists or other appropriately trained pharmacy staff should provide direct input wherever possible to promote harm reduction including:

- recognising people with physical health problems or severe mental health problems and referring them to appropriate services
- carrying out risk assessments and identification of immediate risks (e.g. injection site injuries, harm to others, and physical and mental health emergencies) and providing advice, treatment and referral as appropriate
- actively encouraging service users to access hepatitis B immunisation and to complete the course
- emphasising the risks of overdose, strategies to reduce those risks and to respond to overdose (including polydrug use and alcohol misuse)
- advising on safer sex, sexual health, HBV immunisation and HBV, HCV and HIV testing.

Harm reduction work should be provided in a form that is appropriate to the needs and desires of the service user. Interventions should include a clear health promotion element.

2.5.2.1 Pharmacy needle exchange – ongoing support and advice

A comprehensive assessment of needle exchange clients is not required, especially if it constitutes a barrier to service utilisation.

Commissioners and providers should agree the level of harm reduction advice and support to be provided.

Messages have to be periodically reinforced.

- As a minimum, all clients must be:
 - informed of drug (and alcohol) treatment services in their locality, with clear information on referral and eligibility criteria
 - encouraged to register with a GP
 - provided with details of other pharmacy and non-pharmacy needle exchange services in the locality
 - provided with information about harm reduction and harm reduction services (e.g. advice, information and details of support agencies)
 - provided with information on overdose risks
 - informed about the reasons for providing injecting equipment and the risks of sharing injecting equipment, unsafe injecting and sexual practices
 - informed about the risks of unsafe disposal of injecting equipment
 - informed of alternative sites for safe disposal of used injecting equipment
 - the importance of always returning used equipment for safe disposal.
- Additional services, offered by some pharmacy needle exchange providers to ensure that harm reduction is ongoing, include but are not limited to:
 - risks of unsafe injecting practices (local and systemic infections, including HIV, HBV and HCV, venous and arterial thrombosis, avoiding site infections, abscesses, damaged blood vessels, TB and endocarditis)
 - safer injecting practices, including hygiene advice, vein care and information on related equipment and paraphernalia
 - alternatives to injecting
 - information about the range of services provided by needle exchange schemes, other drug treatment services and other health and social care services

- harm reduction information specific to the drug injected (e.g. information is given to amphetamine and other stimulant users about the increased levels of paranoia, hallucinations and violent behaviour resulting from injecting).
- Access to on-site services such as blood-borne virus (BBV) testing, hepatitis immunisation, tetanus booster vaccination, checking of injection sites, wound care, health checks and diagnostic checks (which could be provided by the pharmacist or provided by a nurse on site).

2.6 Care planning

2.6.1 Pharmacy needle exchange

A care plan for clients of pharmacy needle exchange facilities is not required. It is good practice for needle exchanges to work to engage clients in the development of a brief and basic plan that identifies goals and milestones for changes in risk behaviours and harm reduction. However, this should not be a prerequisite for accessing clean injecting equipment. It should not constitute a barrier to service utilisation, in particular when the client first accesses the pharmacy.

Pharmacy staff should reinforce the harm minimisation message and encourage hepatitis B immunisation and course completion.

Reviews of the needs of clients should be possible.

2.6.2 Dispensing, supervised consumption and shared care – care plans

All patients should have a written and structured care plan resulting from assessment, prior to prescribing. Care plans are developed with the active participation of patients and take into account their wishes and needs. Care plans are tailored to patients' needs and circumstances and respond flexibly to the patients' problems.

Providers should work with prescribers, keyworkers and care co-ordinators to ensure the name of the patient's chosen pharmacy is included in the prescriber's care plan. The Department of Health's *Drug misuse and dependence – guidelines on clinical management* recommends the inclusion of the pharmacist in shared care as a model of good practice and the pharmacist should liaise with the multidisciplinary team on a regular basis.

- A care plan review does not necessarily require a case conference of all providers involved in the care of individuals. For example, prescribers (e.g. GPs or specialists) can undertake the review during an ordinary appointment and decisions are discussed with other

professionals and fed into the joint care planning process. Pharmacists will be expected to contribute to this process, for example, by providing regular verbal and written reports on issues that may be of concern, or may help demonstrate the improvement in the patient's health. However, commissioners need to recognise that where pharmacists are required to attend team meetings, they will require payment of locum and possibly other expenses.

Pharmacists will be able:

- to work with the different prescribing services as patients move through treatment. Patients will be encouraged to remain with the same pharmacy, providing a valuable, constant, and regular link with the same healthcare professional
- to refer patients experiencing difficulties back to the prescriber or keyworker for reassessment
- to withhold treatment if this is in the interest of patient safety; for example, during titration of doses, if the patient has missed doses or is intoxicated and to liaise and agree with the prescriber or keyworker the appropriate ongoing treatment with future doses
- to provide a routine assessment of stabilised patients, for example for side effects, concordance issues, symptoms of withdrawal, intoxication, and childcare issues.

Commissioners should ensure shared care arrangements continue to include the pharmacist as the patient moves between different prescribing services.

2.7 Co-ordination of care

2.7.1 Dispensing, supervised consumption and shared care

Pharmacists will support the keyworker responsible for co-ordinating the patient's care by monitoring continuity of care and contributing to the aim of maximising retention of patients in the treatment system:

- by reporting when patients drop out of treatment (e.g. when doses are not collected)
- by reporting any relevant concerns about the patient
- by providing relevant information when requested by care co-ordinators and keyworkers.

Pharmacists will share relevant information with other health professionals (including keyworkers) and agencies, in line with locally determined confidentiality arrangements.

2.8 Description of services, care and interventions provided

The following section describes the services, care and interventions that most participating pharmacists and pharmacies are expected to provide when offering needle exchange and dispensing, supervised consumption and shared care services.

However, commissioners, DATs, PCTs and PCOs should take advantage of the opportunities to engage pharmacists more fully in the planning, provision, delivery and extension of services for substance users. Pharmacists and their staff make a considerable contribution to the prevention of substance misuse and the care and treatment of drug and alcohol users, but there are significant opportunities to improve and develop these services. In some cases, this can be managed as part of the essential and enhanced services of the pharmacy contract. (See Appendix 2). Pharmacists can be involved in strategic and operational planning, with implementation supported by pharmacists with specialist knowledge of substance misuse and its treatment. This can be achieved through the inclusion of specialist pharmacy representation on:

- drug (and alcohol) action teams
- share care monitoring groups
- multidisciplinary teams.

This will ensure access to specialist pharmacist advice on all areas of substance misuse.

- Pharmacy service providers enhance engagement in treatment and motivation for change by paying special attention to (in respect of substance misusers):
 - Good pharmacist and staff interpersonal skills
 - Good pharmacist and staff-service user relations (including feeling that they are listened to, concerns are understood, helpful responses are provided, pharmacist-staff empathy is shown and there is a good rapport with drug users)
 - Working to enhance patients' perceptions of the helpfulness of a service
 - Working to improve patients' confidence in pharmaceutical care.

Pharmacists will liaise, within the bounds of their professional code of ethics and the RPSGB Medicines, Ethics and Practice confidentiality guidelines, with:

- the local scheme co-ordinator
- the local commissioning authority
- drug addiction clinics and drug teams
- the police, to collaborate on general issues.

Pharmacists will ensure there is appropriate professional indemnity and insurance for staff and premises providing commissioned services.

Scheme co-ordinators will ensure they are in regular contact with participating pharmacies. They will ensure pharmacists and staff are supported in their role and will further encourage new pharmacies to join schemes.

Tasks of the role of co-ordinator include but are not limited to:

- Liaison between primary care and specialist drug and needle exchange services
- Ensuring lines of communication are open and effective
- Provision of clear protocols
- Delineating clear roles and responsibilities of all parties involved in needle exchange and shared care to ensure services are harmonised
- Ensuring robust clinical governance pathways
- Ensuring an appropriate audit of clinical activity and performance management.

2.8.1 Pharmacy needle exchange – description

Providers and commissioners should agree funding.

The services, care and interventions offered by a pharmacy needle exchange will depend on the level of competence and training achieved by the individual pharmacists and staff at each pharmacy.

Services, care and interventions offered can include, but are not limited to:

- Screening, risk assessment and referral:
 - referral to appropriate services to access psychosocial interventions or advice on health, social and legal problems
 - referral to other treatment services and assessment where appropriate
 - basic health examinations, including checks on injection sites, first aid, dealing with minor infections (including, where possible, using patient group directions to supply prescription-only medicines and dressings), provision of medicines through a local minor ailment scheme, health checks and diagnostic tests, or referral to appropriate services
 - referral to immunisation services and, where possible, on-site immunisation (e.g. pharmacy needle exchanges where pharmacist, using a patient group direction, has received training and has necessary level of private area on site)
 - brief interventions for alcohol misuse.

- Advice – including handing out written information and verbal information:
 - pharmacy needle exchange providers should encourage and support motivation for change and treatment readiness where relevant
 - provide advice on safer injecting practices (risks of sharing, lending and borrowing injecting equipment, filters, spoons and water), including avoiding injection site infections
 - risk reduction advice and health promotion. This includes advice on a range of issues including the prevention of drug related death, preventing blood-borne infections, contraception and safer sex, alcohol misuse, nutrition, dental health, care of minor infections
 - advice on legally available paraphernalia including whether and where this can be accessed by clients if not available via the pharmacy needle exchange scheme
 - periodic development of a range of harm reduction and health promotion campaigns
 - advice on prevention of HIV, hepatitis and other drug-related problems
 - advice and information on HIV and hepatitis B and C testing, or referral to testing
 - encouragement to complete vaccination courses
 - overdose prevention and response advice and information
 - advice specific to the drug injected (including stimulants and steroids)
 - advice on the safe storage and handling of injecting equipment
 - advice on safer sex and sexual health
 - advice and interventions that prevent or curtail transition into injecting. These interventions should be targeted at current injectors and smokers of substances that can be injected
 - advice and interventions on drug-related harm that does not involve injecting (e.g. harm related to smoking crack).
- Handing out equipment:
 - distribution of a range of free sterile needles and syringes⁵
 - safe disposal of injecting equipment, including supply of personal sharps bins
 - distribution of other appropriate harm minimisation injecting paraphernalia. Changes in Section 9A of the 1971 Misuse of Drugs Act now allow the lawful supply

of certain articles of drug paraphernalia to drug users for harm minimisation purposes, specifically swabs, spoons, bowls, filters, citric acid, ascorbic acid and water for injections (containing not more than 2ml of sterile water)

- consistent effort to maximise return of used injecting equipment. A failure to return used equipment should not automatically result in a denial of further supply.

2.8.2 Dispensing, supervised consumption and shared care – description

Providers and commissioners should agree funding.

The services, care and interventions offered will depend on the level of competence and training achieved by the individual pharmacists and staff at each pharmacy.

Services, care and interventions offered can include, but are not limited to:

- Dispensing
 - For titration of treatment
 - For reduction and detoxification regimens
 - For long-term dispensing for harm minimisation (e.g. methadone or buprenorphine maintenance treatment).
- Supervised consumption
 - Which ensures the dose of a drug prescribed has been administered to the patient at the point of dispensing.
 - In the case of methadone, this will include specific measures to ensure the dose has been swallowed; for example, the patient should be offered a drink of water and asked to speak after consuming the dose, to demonstrate the dose has been swallowed.
 - In the case of buprenorphine, providers and commissioners will need to agree what is the maximum amount of time that the pharmacist should spend in supervising consumption of each dose, as dissolution of the sublingual tablets may take several minutes. If a local decision is made for tablets to be crushed prior to supervising consumption, then this must be supported by the shared care monitoring group and the chief pharmacist of the PCT, PCO or local NHS trust, to ensure strict clinical governance processes are in place as this is an unlicensed use of the medicine. Pharmacists should ensure that their indemnity insurance covers such activity. Pharmacists should not crush buprenorphine tablets prior to administration, without the permission of the prescriber

and the patient (*Society guidance for buprenorphine tablets*, RPSGB, March 2005).

- Shared care
 - Such that there is sharing of relevant information with other healthcare professionals and agencies, in line with locally determined confidentiality agreements
 - Continued dispensing, (and supervised consumption if requested) and shared care arrangements, for patients who move from one prescriber to another, as patients often remain with the same pharmacy. Pharmacists will provide a valuable link between different prescribing agencies.
- Screening, risk assessment and referral
 - Pharmacists feed back appropriate information to keyworkers and prescribers with the agreement of the patient, in accordance with their professional code of practice and the local shared care arrangements
 - Pharmacy service providers make a clinical judgement as to when it may be appropriate to withhold a dose, e.g. during dose titration, if the patient is intoxicated with drugs or alcohol, if there are signs of overdose, if the patient has missed three days' prescribed treatment (or the assigned number of days as defined in any local agreement), or if the pharmacist has cause for concern about the patient's safety
 - Referral to appropriate HIV and hepatitis testing services and encouragement to complete vaccination courses
 - Advice or referral to appropriate services on relapse prevention as a component of the treatment programme
 - Referral for assessment for access to appropriate treatment services (e.g. the local community drug service)
 - Referral to practical social support (e.g. housing, welfare benefits and legal advice)
 - Referral to appropriate counselling services.
- Advice, including handing out written information and verbal information
 - Patients are prepared for the provision of substitute medications from a pharmacy. This includes advice and written information about methadone, buprenorphine or other pharmacotherapy, alcohol use, risks of overdose, loss of tolerance following missed or uncollected doses, drug interactions, an explanation of supervised consumption and where and how this will occur, and opening and closing times.

⁵ The Pharmaceutical Services Negotiating Committee (PSNC) recommends community pharmacies only issue needle exchange equipment in packs. The PSNC do not recommend community pharmacies use a "pick and mix" distribution system.

- Advice on a range of issues including the prevention of drug-related death, overdose prevention, blood-borne infections, oral health, sexual health, contraception and safer sex, nutrition, minor infections, wound dressings, dental health and nicotine replacement therapy.
- Legal and professional responsibilities
 - Ensuring the legality of the prescription and correctness of detail
 - Registering the patient onto the Patient Medication Record
 - Dispensing the medicine in accordance with the prescription system
 - Explaining that missed doses cannot be collected the next day
 - Following local agreed arrangements (via the shared care monitoring group) allowing the dispensing and supervised consumption of doses not collected on specified days – in accordance with Home Office guidance on instalment prescribing (Reference Pharmaceutical Journal Volume 274, number 7347, 30th April 2005 page 531)
 - Pharmacy service providers co-operate with the chemist inspecting officer and the RPSGB inspector, as required by the professional code of practice (and future inspection bodies introduced following the Shipman Inquiry)
 - Compliance with current legislation, including the Medicines Act 1968, Misuse of Drugs Act 1971, Misuse of Drugs Regulations 2001 as amended, Misuse of Drugs (Safe Custody) Regulations 1973, National Health Services (Pharmaceutical Services) Regulations 2005.

2.9 Competencies and training

All pharmacists must have an appropriate level of competency to undertake these services – this will be determined by the requirements of the enhanced services within the new pharmacy contract and local agreements prior to commissioning of the service.

The training of pharmacists and their staff should be determined by competency analysis based on the Drug and Alcohol National Occupational Standards (DANOS). The RPSGB has a range of policies covering minimum training and competence requirements for pharmacy support staff, including pharmacy technicians, medicines counter assistants, and dispensing and pharmacy assistants.

Providers must ensure staff are trained to provide the

appropriate level of service. Pharmacists and their staff will adhere to the standards and practice guidance set by the RPSGB for the provision of services to drug misusers and needle exchange services in community pharmacies. These standards are detailed in *Medicines, ethics and practice: a guide for pharmacists* (RPSGB, latest edition).

Health and safety training is provided to staff, including training on the handling of injecting equipment.

Pharmacists are encouraged to complete the two open learning modules, *Substance misuse and opiate treatment: Supporting pharmacists for improved patient care*, provided by the Centre for Pharmacy Postgraduate Education (CPPE) in England, or the equivalent distance learning packs available from the Scotland, Wales and Northern Ireland Centres for Pharmacy Postgraduate Education. An open learning module on substance misuse should be available from CPPE for pharmacy technicians in summer 2006.

In addition, the National Pharmacy Association (NPA) provides its members with a resource manual on operating a pharmacy needle exchange, as do some multiple pharmacy chains.

Training must be updated regularly in response to changes in drug use, risk behaviours, BBVs, harm minimisation, local and national policies and legislation. This may be through formal training events, newsletters, information packs, telephone support and regular visits by the co-ordinator. Pharmacy service providers are encouraged to regularly refer to the substance misuse management in general practice website (www.smmgp.org.uk) and join the UK psychiatric pharmacists *substance misuse* e-mail group (www.ukppg.org.uk).

Pharmacists who have completed the CPPE open learning module *Substance misuse* and intend to provide additional or enhanced services to drug users may wish to complete Part 2 of the Royal College of General Practitioners Certificate in the Management of Drug Misuse in Primary Care. Such pharmacists may then also provide support and advice to other pharmacists. Pharmacists who have completed and passed the Part 2 RCGP certificate may, in future, become pharmacists with a special interest (PhwSI) in drug misuse. (The PhwSI framework is being developed alongside the implementation of the new community pharmacy contract.)

DATs, PCTs and PCOs should ensure commissioning of services with both levels of competencies to ensure there is a professional support structure for pharmacists providing services to drug users to avoid the risk of community pharmacists becoming isolated. Individual pharmacies and pharmacists should be supported to ensure that they are able to provide a service that conforms to the service

specification. Involving all pharmacy staff as well as service users (or ex-service users) in pharmacy training should be considered.

Barriers to recruitment of pharmacists and staff who provide services for drug users can include pharmacist perception of the client group, for example, the stigma attached to the clientele, or the pharmacist does not want to appear to be condoning illegal drug use. In addition, pharmacists may stop providing services as a result of adverse incidents, for example, clients shoplifting, increased crime rates and aggressive client behaviour. Commissioners and providers should work together to ensure training and support mechanisms cover effective ways to reduce and manage such incidents.

Funding should be available for identified training needs.

2.10 Service principles

2.10.1 Pharmacy needle exchange

- Pharmacy needle exchange facilities and harm reduction initiatives provide an easy, low-threshold, open access and user-friendly service
- Pharmacists and their staff operating needle exchange have standard operating procedures in place for their individual premises
- Staff operating pharmacy needle exchanges should be competent to provide information on the range of drugs injected, including heroin, cocaine, crack cocaine, amphetamines and steroids
- Advice and information is provided which is appropriate and relevant to the needs of diverse populations and literacy levels – available in a number of languages and suitable for the visually impaired, where relevant
- Pharmacy needle exchange and harm reduction interventions should work with the full range of tiers, to integrate harm reduction initiatives into practice
- Pharmacy needle exchanges actively encourage returns of used injecting equipment, but this should not be a condition for accessing sterile injecting equipment
- Injecting equipment and safe disposal of equipment must meet UK standards
- Pharmacists and pharmacies participating in a needle exchange scheme must comply with the guidelines laid down by the RPSGB, e.g. participating pharmacists and their staff should be offered hepatitis B immunisation
- Pharmacists are provided with support (such as from a dedicated scheme co-ordinator) to operate the needle exchange scheme

- Scheme co-ordinators ensure quality through appropriate clinical governance arrangements
- Local communities are proactively consulted on discarded used injecting equipment
- Pharmacies receive prompt payment for services provided
- Pharmacies are provided with regular supplies of required equipment at levels required to meet clients' needs
- The pharmacy needle exchange service is integrated and co-ordinated with other needle exchange and harm minimisation provision in the locality.

2.10.2 Dispensing, supervised consumption and shared care – service principles

- There is a multidisciplinary approach to prescribing (including GP prescribing) which is carried out in line with the recommendations of *Drug misuse and dependence – guidelines on clinical management* (DH,1999) and other central guidance, and includes the patient's pharmacist
- Pharmacists providing shared care, dispensing and supervised consumption services provide a user-friendly service
- Pharmacists and their staff providing dispensing, supervised consumption and shared care for drug users have standard operating procedures in place for their individual premises
- Pharmacists provide the service user with information about their medicines
- Shared care, dispensing and supervised consumption services are based on clearly defined protocols providing both detoxification (reduction) and maintenance regimens
- The pharmacist ensures that supervised consumption takes place in a private or quiet area of the pharmacy
- The pharmacist, as part of the multidisciplinary team, has measures in place to limit the leakage of prescribed drugs to illicit markets (e.g. supervised consumption) and to prevent drug-related deaths. Pharmacists are aware of exceptions when supervised consumption is not considered necessary or appropriate
- Pharmacists (or suitably trained, qualified or competent members of staff) are required to supervise (when prescribed or required) the consumption of the prescribed oral medicine (e.g. methadone, buprenorphine) at the point of dispensing, ensuring that the dose has been administered to the patient. In certain circumstances, pharmacists may initiate supervised consumption (e.g. where the prescriber has omitted to include the direction to supervise on the prescription or where the

patient requests supervised consumption), but this should be with the agreement of other members of the shared care team

- Patients are provided with support and advice, including referral to primary care or specialist centres where appropriate
- Pharmacies participating in shared care, dispensing and supervised consumption services comply with the guidelines laid out by the RPSGB
- Pharmacists will only dispense prescriptions which comply with current legislation (e.g. Misuse of Drugs Act 1971, Misuse of Drugs Regulations 2001)
- Participating pharmacists have effective links with prescribing services (including GPs) and provide advice and shared care where required. Pharmacists liaise with services (including GPs) about specific patients and prescribing regimens. The pharmacist shares relevant information with all professionals involved in the treatment, within the bounds of pharmacists' professional confidentiality guidelines
- Pharmacists abide by local arrangements for clinical governance (e.g. PCT, PCO or provider trust arrangements).
- Pharmacists are provided with support (for example, from a dedicated scheme co-ordinator) to operate shared care and supervised consumption schemes
- Pharmacies receive prompt payment for services provided
- There is pharmaceutical representation on the local shared care monitoring group. Decisions are to be agreed at local levels, but should comply with central guidance.

2.11 Policies, protocols and written strategies

Pharmacy services commissioned should have all the written policies and protocols identified in this briefing and in briefing 3.1 of the NTA commissioning drug treatment systems – resource pack for commissioners (introduction, contracts, service agreements and specifications).

All policies should have a named person (e.g. the scheme co-ordinator) with responsibility for implementation and monitoring and dates for review.

Commissioners should work with service providers to identify:

- gaps and priorities in service provision
- clear objectives and measurable targets
- timescales
- funding and other resources available

- monitoring requirements
- agreed channels of communication with local pharmaceutical committees (LPCs), PCTs, PCOs and trusts.

Pharmacy service providers will adopt the DAT, PCT or PCO strategy on:

- the reduction of drug-related deaths (blood-borne infections and overdose prevention)
- hepatitis B immunisation, which aims to maximise the number of clients immunised and the number of completed courses of immunisation
- improving treatment access, appropriateness and effectiveness of treatment to women, people with learning or physical disabilities, young people, minority ethnic drug users, women, stimulant users and other groups who may not be fully utilising the services.

All pharmacists will have standard operating procedures (SOPs) in place specific to their individual premises.

All pharmacy services to drug users will have systems in place to assess client satisfaction with the service.

Pharmacy service providers will ensure information is available enabling locum pharmacists to continue to provide the commissioned services.

2.11.1 Pharmacy needle exchange – policies and protocols

The standard operating procedures for pharmacy needle exchange must detail requirements around the following issues:

- Security of staff, stock and premises
- Minimising risk to staff and members of the public
- Dealing with unacceptable behaviour and guidance on:
 - what constitutes unacceptable behaviour
 - ways of minimising unacceptable behaviour.
- Seeking to prevent needle stick injuries
- Client confidentiality, including what to do when a patient requests needle exchange who is also being prescribed substitute medication
- Dealing with needle stick injuries based on up-to-date information
- Dealing with spillage or contamination by potentially infected blood or body fluids, or spillages of sharps
- Dealing with requests for needle exchange where the pharmacist identifies an increased risk to an individual

for example, a client who is at risk of overdose, e.g. recently released from prison, intoxicated and receiving prescribed medication

- Ensuring all staff who may be involved in the service are instructed on procedures to be followed in order to minimise risk
- How clients and members of the public can comment on the service, including making complaints
- What to do when a client under 18 requests needle exchange. (Written policies and procedures as agreed with the local area child protection committees, DATs and PCTs and PCOs.)
- Distribution of clean injecting equipment, personal sharps containers, citric acid, ascorbic acid, water for injection (ampoules of not more than 2ml volume) and other (legally allowed) paraphernalia etc., including guidance on:
 - whether there is a maximum number of syringes which can be issued
 - whether this is linked to the number of returns received
 - local policies concerning secondary distribution of equipment (i.e. clients collecting for other injectors)
 - where injecting paraphernalia can be accessed by clients if the whole range is not available from the pharmacy scheme.
- Safe storage, disposal and destruction of used equipment and clinical waste (in line with Environment Agency requirements – note these are currently (Autumn 2005) being reviewed).
 - The disposal of sharps is not included in the funding from PCTs for the disposal of unwanted medicines
 - The Environment Agency will prosecute if it considers the pharmacy causes pollution or harm to health when storing or disposing of sharps.
- Advice and health promotion materials relating to harm reduction
- Information on other local harm reduction, needle exchange and treatment facilities, including service user groups
- Advice on access to vaccination against hepatitis A and B, relevant to both staff and clients
- Information, including contact details, on which organisations at a local level are responsible for collecting drug litter

- How to contact the scheme co-ordinator and what support and resources the pharmacy can expect from the scheme co-ordinator.

Pharmacy needle exchanges should have a written policy on how to maximise the return of used equipment. This will be decided at local level and could include actions such as a target return rate agreed with the scheme co-ordinator and a requirement for users to return equipment and periodic awareness raising campaigns. This strategy should be in line with *Medicines, ethics and practice: a guide for pharmacists* (RPSGB, latest edition).

Scheme co-ordinators will engage local communities and respond to their concerns in a proactive way – particularly in response to discarded used injecting equipment.

2.11.2 Dispensing, supervised consumption and shared care – policies and protocols

The NTA (2005) requires prescription services and community pharmacies to have agreed systems and procedures to provide appropriate dispensing and supervision of consumption of controlled drugs. Pharmacists can only provide supervised consumption and shared care where there are clear channels of communication with keyworkers and prescribers, and the pharmacist is included as part of the shared care arrangements.

The standard operating procedure for the provision of dispensing, shared care and supervised consumption services for substitute medication should include:

- ensuring security of staff, stock and premises
- minimising risk to staff and members of the public
- storage and dispensing of medications in accordance with current legislation e.g. the Misuse of Drugs Regulations 2001 and the Medicines Act 1968
- the provision of supervised self-administration procedures that are discreet and efficient, to ensure the dignity of the client
- strategies and procedures for ensuring the dose has been fully consumed; for example,
 - in the case of methadone oral mixture, patients should be offered a drink of water and should speak after swallowing their dose;
 - in the case of buprenorphine a longer time will be needed to allow dissolution of the tablets. Patients should be offered a drink of water before taking their dose. If local policies support pharmacists crushing buprenorphine tablets (an unlicensed use of the medicine) then the local policy and lines of accountability should be clearly indicated in the

policy/protocol. Pharmacists may need to take out additional insurance to cover this procedure. (The NPA will indemnify members provided they comply with the NPA model protocol.) Procedures describing the crushing of doses must be evidence based, fully supported by the local shared care monitoring group, the prescriber, clinical governance leads and informed patient consent must be obtained. A risk assessment must be made to minimise/ remove any risks to the operator or patient as a result of crushing. (examples of potential risks include danger from inhaling the powder, danger from crushing the tablets too finely can create a sludge that sticks to the buccal mucosa)

- what the pharmacist should do if s/he suspects the patient is avoiding supervised consumption; for example, by palming buprenorphine tablets, by holding methadone mixture in the mouth and not swallowing.
- safe storage, disposal and destruction of clinical waste (in line with Environment Agency requirements), for example the containers used for administering supervised doses
- safe storage, disposal and destruction of items which may identify patients, for example, labelled containers which are discarded after supervised consumption
- dealing with unacceptable behaviour and guidance on:
 - what constitutes unacceptable behaviour
 - ways of minimising unacceptable behaviour.
- the provision of locally developed and agreed guidance, which includes information on other relevant services and contact points, including service user groups
- the development of agreements on how and when any relevant information will be shared between prescribers, keyworkers, social workers and pharmacists
- guidance on what to do if a patient is intoxicated, is showing signs of overdose or misses collecting doses
- guidance on what to do if the patient requests that their prescribed medicine be collected by another person
- service user confidentiality, including what to do when a patient requests needle exchange and is also being prescribed substitute medication
- the provision of guidance to patients, of those services the pharmacy is legally able to provide, what restrictions apply and why there are limitations
- advice and health promotion materials relating to harm reduction
- advice and access to vaccination against hepatitis A and B

- how patients and members of the public can comment on the service, including bringing complaints
- specifying which service users the standard operating procedure includes and excludes. This will depend on what pharmaceutical service is commissioned. For examples, see section 2.4.2.2
- guidance on what the pharmacist should do when a prescription or patient does not meet the agreed inclusion criteria – for example, the pharmacist has not been contacted by the prescriber or keyworker, or a shared care agreement has not been provided, or a patient's prescription is from “out of area”
- guidance on what the pharmacist should do when an expected patient does not appear at the pharmacy
- how to contact the shared care or scheme co-ordinator and what support and resources the pharmacist can expect from the scheme co-ordinator.

2.12 Monitoring and review

Monitoring is an integral part of the contract or service agreement and continuation or termination of the contract.

Information agreed between the commissioner and the provider will be supplied to shared care and scheme co-ordinators, in accordance with the requirement stated in the service specification. Information may also be required on issues not specified in this service specification, including issues based on principles and arrangements of clinical governance.

Where local milestones and targets are set to aid contract monitoring, these are developed and agreed with pharmacy service providers.

Service reviews are undertaken where and when required, including those investigating client satisfaction of services.

The manner in which monitoring and review are undertaken may vary from area to area. In some areas, the local PCT, PCO or DAT may develop and agree milestones and targets, whereas in others these may be agreed by the local pharmaceutical committee (LPC) on behalf of all the pharmacy contractors in the area.

Commissioners must ensure there is an up-to-date and comprehensive list of pharmacy needle exchange outlets and pharmacies providing dispensing, supervised consumption and shared care, to avoid payment continuing after pharmacies have closed down, moved premises or withdrawn from the scheme. This is also important for strategic planning for the service.

2.13 Data collection and claims for payment

Data is collected in order to monitor the uptake of the service, calculate key performance indicators and calculate payments to the participating community pharmacies.

Information agreed between the commissioner and providers will be supplied to the authorised officer in accordance with the requirements stated in the service specification. This should include:

- a minimum data set which must be collected (see below)
- how data should be collected, e.g. the forms to be used
- data confidentiality issues approved by Caldicott Guardian of the PCT, PCO or NHS trust
- where data should be sent for processing
- when data should be submitted for processing.

Data collection should be standardised to ensure uniformity across the scheme. *The task force to review services for drug misusers* (Department of Health, 1996) recommends the following key performance indicators for pharmacies and pharmacy needle and syringe exchange schemes:

- Percentage of pharmacies participating in:
 - needle exchange
 - supervised consumption
 - providing advice
- Numbers of exchange packs given out per month
- Numbers of needles and syringes sold to drug misusers per month
- Numbers of individuals using the service (by gender)
- Numbers of pharmacies prepared to provide facilities for return of used equipment
- Return rates of used equipment
- Costs per pack distributed.

Data collection may also include the number of client contacts (i.e. visits) and the number of contacts per client per year/per month.

The Department of Health and NTA are planning to issue national guidance on the minimum data set to be collected following the national needle exchange audit carried out in 2005.

Robust payment arrangements for participating pharmacies must be agreed locally. (Also see Appendix 1: How community pharmacies are paid, section 4.6). These include:

- what documentation will be used for informing pharmacies how their payments are made (e.g. via the Prescription Pricing Authority, cheque, BACS or local

PCT and PCO arrangements) and how they can be individually identified (for example, not merged with other enhanced service payments)

- how payments are calculated
- the frequency of payments (e.g. monthly, quarterly)
- who to contact concerning any payment queries
- specific arrangements for multiple pharmacy groups (e.g. individual branch payments may need to be sent to a central head office and clearly identify branch number and the service being paid for)
- arrangements for auditing payments (including reference numbers for payment tracking)
- arrangements to identify and prevent fraudulent claims.

There must also be clear information on how to contact the scheme co-ordinator and what support and resources the pharmacy can expect from the scheme co-ordinator.

3 Clarifying current and future roles for pharmacists in the provision of services to substance users

Pharmacists, as part of a team of healthcare professionals, have a key role to play in providing services to substance users.

This section seeks to clarify the different levels of expertise required in each area and the different roles played by pharmacists in the different branches of the profession. Although there are similarities to the medical practitioner structure of generalist, specialised generalist, GP with special interest and specialist, there are fundamental differences. In particular, hospital pharmacists and PCT and PCO pharmacists will often have quite different – and specific – roles and responsibilities.

To become a pharmacist, a Masters degree in pharmacy, approved by the Royal Pharmaceutical Society of Great Britain (RPSGB), is needed. After the four-year pharmacy degree, graduates must spend a year in practical training in community, hospital or industry and pass a pre-registration exam before they can become registered with the RPSGB and are allowed to work as a pharmacist. Often pharmacists will study further to achieve a postgraduate qualification, such as a clinical diploma.

3.1 The generalist: Level 1

Generalist⁶ pharmacists may be involved in the treatment of drug misuse although this is not their main area of work. Appendix 2: Understanding the new pharmacy contract explains mechanisms and ways in which commissioners and DATs can help pharmacists, to ensure their core, essential and advanced service provision includes substance misusers.

A large number of pharmacists have already completed substance misuse training through the Centre for Pharmacy Postgraduate Education (CPPE) in England or the equivalent training provided through the Scotland, Wales and Northern Ireland centres. Pharmacists who have completed the CPPE *Substance misuse* distance learning pack are eligible to claim exemption from the Part 1 training of the Royal College of General Practitioner's (RCGP) certificate in the management of drug misuse in primary care. These pharmacists would be considered to be the pharmaceutical equivalent of the generalist medical practitioner.

Some PCT and PCO pharmacists and some hospital pharmacists will have also completed the CPPE distance learning pack *Opiate treatment: supporting pharmacists for improved patient care*.

3.2 The specialised generalist or PhwSI in drug misuse: Level 2

A significant number of pharmacists who have obtained exemption from the Part 1 RCGP certificate have gone on to complete the Part 2 certificate and these are sometimes referred to as pharmacists with a special interest (PhwSI) in drug misuse. However, the roles and responsibilities of pharmacists with special interests are still (December 2005) being defined. Some pharmacists who have completed the Part 2 certificate are developing their roles further, for example, by becoming supplementary prescribers. In addition, co-ordinators of pharmacy needle exchange schemes and shared care schemes are often pharmacists who have completed Part 2.

Pharmacists who have completed Part 2 are an untapped resource with whom commissioners and DATs are encouraged to make contact. Such pharmacists are well suited for inclusion on shared care monitoring groups and strategic discussions with PCTs, PCOs and local pharmaceutical committees (LPCs), as often these groups may not have any specific specialist knowledge of the substance misuse field.

Specifically, such pharmacists can also help persuade other pharmacists to become involved in the work of needle exchange and supervised consumption, as often the preventing factor is isolation and a lack of professional support.

Specialist generalist pharmacists can work in a number of different settings for example, in community pharmacies, hospital pharmacies, PCTs and PCOs, specialist drug services and community drug teams.

⁶ Note: "generalist pharmacist" is not a term commonly used by the pharmaceutical profession.

3.3 The consultant pharmacist: Level 3

In April 2005, the Department of Health produced guidance for the development of consultant pharmacist posts. Posts are defined and developed based on local need and structured around four main functions:

- expert practice
- research evaluation and service development
- education mentoring and overview of practice
- professional leadership

Specific strategic health authority panels approve such posts, in the same way that consultant nurses or consultant allied health professionals are approved and appointed.

3.4 Pharmacists as supplementary or independent prescribers

Legislation relating to pharmacist prescribing is complex, particularly in the field of substance misuse. Supplementary prescribing, where a doctor (e.g. a psychiatrist or GPwSI) undertakes an initial client assessment and then agrees a clinical management plan with the supplementary prescriber, is particularly appropriate for the management of long-term conditions. One of its major benefits is providing the opportunity for pharmacists (and nurses) to jointly manage the prescribing responsibilities for patients on long-term maintenance or detoxification programmes, which is underpinned by robust local policies and procedures. In practice, this should lead to better quality prescribing and, as a result, improved treatment effectiveness. (See *Nurse prescribing in substance misuse NTA* May 2005 (further updates will include information on pharmacist prescribing) for more information about supplementary and independent prescribing.) In November 2005, the Department of Health announced an extension to the prescribing powers of pharmacists and nurses, allowing them to become independent prescribers. This extension does not include the prescribing of controlled drugs, but will allow appropriately trained nurses and pharmacists to prescribe for other conditions.

Pharmacists (and nurses) will be able to undertake these roles once they have successfully completed the relevant training courses accredited by their respective regulatory bodies and had these qualifications noted on the professional register. Once trained, they will be required to keep their skills up to date. Employers will allow nurses and pharmacists to prescribe once they are satisfied that they have appropriate registration and have all the skills and competencies relevant to the clinical area where they will be prescribing.

Pharmacist and nurse prescribers will have to work within their employers' clinical governance frameworks and they will be accountable to both their employers and their regulatory bodies for their actions. The RPSGB has published a *Clinical governance framework for pharmacist prescribers and organisations commissioning or participating in pharmacist prescribing (GB wide)*.

It is important that pharmacist (and nurse) prescribing initiatives are developed within a clear strategic managerial framework, which identifies the organisational and support mechanisms necessary for implementation and a clear vision of how pharmacist prescribing will contribute to improved service delivery and patient care. Commissioners will need specialist pharmaceutical advice from hospital pharmacists or primary care trust pharmacists concerning, for example, ordering of prescription forms needed for use by supplementary and independent prescribers, obtaining prescription data analyses and producing prescribing formularies.

3.5 Pharmacists and patient group directions

Patient group directions (PGDs) are written instructions for the supply and consumption of medicines to groups of patients who may not be individually identified before presentation for treatment. It is not a form of prescribing and there is no specific training that health professionals (e.g. pharmacists, nurses, occupational therapists) must undertake before supplying medicines under a PGD, although local training is usually given for specific PGDs.

Examples where PGDs can be used by pharmacists (and nurses) to administer medicines, which would normally require a prescription, are hepatitis A and B vaccination, antibiotics, medicated dressings and one-off symptomatic relief of opioid withdrawal. However, controlled drugs such as methadone and buprenorphine cannot be administered under a PGD.

A pharmacist must be included as part of the multidisciplinary group producing any PGD, which must then be ratified by the NHS trust, PCT or PCO.

For more information, refer to the RPSGB *Fitness to Practice and Legal Affairs Directorate Patient Group Directions. A Resource Pack for Pharmacists* (January 2004, www.rpsgb.org.uk)

3.6 Pharmacist roles in substance misuse

Generally, community pharmacists with an interest in drug misuse, will usually provide needle and syringe exchange services and dispensing services for drug users. They would also provide treatment in the context of a shared care scheme and provide supervised consumption. Pharmacists are encouraged by the RPSGB to provide such services only as part of a locally agreed scheme to ensure consistent standards and integrated care. Where schemes are not co-ordinated and managed in a way that adequately supports the individual community pharmacist, pharmacists may be reluctant to get involved. Pharmacists may be willing to provide a service, but only if there is adequate recompense for the time involved. (See *Appendix 1: How community pharmacists are paid*).

However, there are many more areas where pharmacists can, and do, contribute to the wider field of substance misuse work in prevention, harm minimisation and treatment as well as helping retain people in treatment. These may not necessarily be in the community pharmacy setting and include:⁷

- provision of smoking cessation services
- signposting to other services
- health promotion and health education
- advice and treatment for self-limiting conditions
- prescription monitoring
- care management
- drug testing
- treatment of overdose
- detection and management of solvent misuse
- over-the-counter medicines
- brief alcohol interventions
- emergency hormonal contraception
- advice about and testing for sexually transmitted infections (e.g. chlamydia)
- providing hepatitis A and B immunisation under, for example, a patient group direction
- wound care
- checking injection sites.

Some of these areas of development have been made possible as a result of changes in legislation and the changing context in which healthcare is being delivered to the population, including:

- the extension of prescribing rights and supplementary prescribing by pharmacists – which includes (from April 2005) controlled drugs
- the new community pharmacy contract
- the use of information technology to enhance service provision
- UK-wide developments, such as the recommendations flowing from the Shipman Inquiry.

Commissioners and DATs are encouraged to liaise with community pharmacists, either through the local pharmaceutical committee (LPC) or PCT and PCO pharmaceutical advisers, so that drug users in the community can access and gain maximum benefit from services, which are available from the community pharmacist which they are entitled to receive.

3.7 PCT and PCO pharmacists

PCT and PCO pharmacists, such as pharmaceutical advisers or chief pharmacists for these organisations, are key people for commissioners to liaise with, as generally they will be directly involved in commissioning other services from pharmacists and will have established links with the LPC, community pharmacists and hospital pharmacists. In addition, they will also be involved in activities such as writing patient group directions, procedures and protocols, contracts, and analysing prescription data.

3.8 Hospital pharmacy services

It is important for commissioners to understand that hospital pharmacists have no managerial responsibility for community pharmacists. However, they will regularly liaise with PCT and PCO pharmaceutical advisers and will often provide advice and information to community pharmacists.

Not all hospitals will have pharmacists with a special interest in substance misuse. Commissioners and DATs should work with NHS trusts to ensure that pharmaceutical care of drug users is maintained when patients are under the care of the secondary care team, for example when drug users are admitted into hospital via A&E or for planned procedures.

⁷ See “Scottish Executive Health Department. National pharmaceutical Forum / Scottish Medical and Scientific Advisory Committee. Delivering the Right Medicine: A Strategy for pharmaceutical Care in Scotland. The Prevention and Treatment of Substance Misuse. Edinburgh: Astron 2005.”

3.8.1 Specialist mental health pharmacists

Hospital pharmacists working in mental health trusts may work with the specialist substance misuse teams. It is important for commissioners to ensure that pharmaceutical services are included either as direct costs or as on-costs for specialist services.

Pharmacists' responsibilities include but are not limited to:

- contributing to risk reduction by supporting safe medication practice
- participating in multidisciplinary patient reviews
- providing prescribing and pharmaceutical advice and medicines information
- medicines management training for medical, nursing and other staff
- drug interactions with methadone, buprenorphine and other medications
- running titration clinics
- developing clinical audits to qualitatively monitor and review drug use across the service, to reduce prescribing risks
- public health and health promotion
- ensuring medicines are used safely
- advising on safe and secure storage of controlled drugs, including working with local police and nursing staff concerning procedures for dealing with illicit substances brought in by patients and visitors
- providing clinical pharmacy services to inpatients undergoing substance misuse treatment
- developing and writing treatment guidelines, procedures and protocols
- developing and writing patient group directions
- writing and providing patient information leaflets
- working with service users, looking at their medicines and managing medication
- contributing to the clinical governance agenda
- monitoring prescribing and prescriptions, including adverse drug reactions and avoiding drug interactions
- ensuring staff comply with legal and professional requirements
- analysing prescribing data, e.g. from the Prescription Pricing Authority
- providing medicines information and advice to clinicians and other staff for example, use of drugs in pregnancy, drug interactions

- working with the substance misuse services:
 - dispensing and providing supervised consumption of prescribed medicines
 - providing needle exchange services
 - advising on prescription storage, handling, writing and automatic prescription writing software systems.

In addition, their specialist psychiatric pharmacy knowledge ideally places them to run specialist groups for, for example, patients treated for mental health problems that may use illicit drugs, for example bipolar patients who use cannabis.

Pharmacists working with a specialist community drugs team will often be employed as part of the hospital pharmacy service to ensure clinical governance, CPD and professional support is provided.

For outpatient populations, the hospital pharmacist has a role in communicating and liaising with hospital, community and primary care professionals.

3.8.2 Acute hospital pharmacists

Hospital pharmacists in acute trusts have specific roles and responsibilities:

- Ensuring pharmaceutical care of patients on substitute prescribing programmes continues on admission to hospital, for example, ensuring treatment is not curtailed due to a lack of understanding and acceptance of the substitute prescribing programme by hospital-based staff
- Ensuring that patients admitted into hospital do not have inappropriate discontinuation or disruption of substitute medication which can result in early discharge from secondary care and a return to the use of street drugs
- Ensuring adequate pain relief
- Providing advice on the practicalities of issuing instructions to nursing staff when controlled drugs are being prescribed
- Hospital-based medicines information pharmacists may also play an important role in advising both community and secondary care colleagues on treatment regimens, providing written information and literature research, as well as assisting in the identification of tablets following accidental poisoning.

3.9 Pharmacy technicians

Pharmacy technicians work in both community and hospital pharmacies and work under the supervision of qualified pharmacists. Senior technicians train and supervise junior staff.

To qualify as a pharmacy technician requires an NVQ Level 3 in pharmacy services. The training involves both practical experience and study at a college or by open learning and takes about two years to complete.

Pharmacy technicians working under the supervision of the pharmacist will:

- manage all aspects of supply and dispensing of medicines
- support management of the dispensary
- provide final accuracy checking of prescriptions
- provide supervision of pharmacy assistants
- provide client advice and education for compliance with medication
- store medicines properly and securely
- participate and assist in clinical audit
- assist with modernisation of pharmacy computer systems including automation and prescribing software programmes
- keep records, order stock and check expiry dates of drugs.

As the clinical role of the pharmacist expands, pharmacy technicians are becoming more involved in substance misuse work, for example, assisting the pharmacist with providing supervised consumption and needle exchange.

The Centre for Pharmacy Postgraduate Education (CPPE) is currently producing an open learning training pack specifically aimed at pharmacy technicians working in the field of substance misuse.

4 Sample schedules

All contract and service level agreements must include a series of schedules. The schedules may vary according to local contracting arrangements and should be developed at local levels with (where relevant) the primary care organisation (PCO), NHS trust, local pharmaceutical committee (LPC), and relevant departments of commissioning organisations.

The manner in which decisions regarding local negotiations are made at present may vary from area to area. In some areas, the local pharmaceutical committee will negotiate with the PCT, PCO or DAT on behalf of all the pharmacy contractors in an area, in others the local PCT, PCO or DAT will negotiate with individual pharmacies.

However, it is recommended that the information outlined below be identified prominently in the contract or service level agreement.

4.1 Schedule 1: The care service

The care services are the provision of pharmaceutical services for drug users aged 18 years and over, who access the services of the provider. The care services are to be delivered in accordance with the standards detailed in the service specification.

The anticipated capacity level of the care service should be included in the schedule.

4.2 Schedule 2: The providers and project locations

(For services commissioned from a community pharmacy.)
The providers will be individual community pharmacies, e.g. Any Pharmacy Ltd whose registered address is at:

Somewhere pharmacy, Any Road, Any Town XX1 2YY

Arrangements will need to be in place for pharmacies outside the drug action team or primary care organisation area. Patients may choose to have their prescription dispensed elsewhere – a pharmacy will not provide a supervised consumption service unless the service has been commissioned.

For services commissioned from a secondary care trust:
The provider organisation's legal title, registered office or place of business, and the address of the project should be included here.

4.3 Schedule 3: Contract period and payment procedures

The contract period will be determined locally by negotiation between, for example, the local pharmaceutical committee (LPC) and the primary care organisation, subject to the terms of the contract and the monitoring requirements stated in the service specification.

The manner in which the contracted fees are paid will be determined locally, for example, by negotiation with the local pharmaceutical committee or the primary care organisation, subject, where appropriate, to the submission of activity data on the agreed proforma.

4.4 Schedule 4: Monitoring requirements

Monitoring requirements based on the service specifications and any other locally determined requirements may be included.

4.5 Schedule 5: Responsible officers

This section should include details of the authorised officer from the commissioning body (i.e. primary care trusts and primary care organisation) and the contract manager from the service provider.

The authorised officer for [Any PCT or PCO] under the contract is:

Name: John Anybody
Designation: Commissioning director, primary care director, chief pharmacist or prescribing advisor
Location: Any PCT/PCO / Address of PCT/PCO
Telephone no:

The contract manager for [Any Pharmacy] is:

Name:
Designation: In some cases this may be a national, regional or area manager (e.g. in the case of multiple pharmacies)
Location: Address of pharmacy
Telephone no:

Reference – PSNC guide on SLAs –
www.psn.org.uk/resources/publications

5 Appendix 1: How community pharmacies are paid

5.1 NHS community pharmacy contract

Community pharmacies are independent contractors, who offer NHS services, in a similar way to GPs, dentists and optometrists. They hold a "contract"⁸ with the local primary care trust or organisation (PCT or PCO).

The current (from April 2005) national contractual framework requires pharmacies to dispense NHS prescriptions and operate a repeat dispensing service. It also requires them to provide self-care advice and support to people with self-limiting conditions such as coughs, colds and minor skin complaints. Pharmacists and their staff will also refer people to other sources of help within the local health and social care community, including to the voluntary sector.

Community pharmacies offer healthy lifestyle advice to certain defined groups of patients, including those who smoke, and they are also expected to take part in up to six PCT or PCO-organised health promotion campaigns each year. The contract also requires them to collect unwanted medicines from the public, for safe disposal (but not sharps and clinical waste) and to operate within a clinical governance framework. Pharmacists must also operate within the requirements of the Medicines Act and the Misuse of Drugs Act and its regulations. These services are all part of the essential tier of the contract that all pharmacy contractors must provide (see Appendix 2 for more details about the new pharmacy contract).

5.2 Payments to community pharmacies

Pharmacy contractors are not paid a salary by the PCTs, PCOs or the NHS. However, in return for providing NHS services, community pharmacy contractors are paid a number of nationally agreed fees and allowances. These fund the costs of provision of NHS community pharmacy services and provide a fair return for the contractor. Details of the national fees and allowances are contained in the current edition of the Drug Tariff (see www.ppa.nhs.uk). In the case of FP10MDA (instalment prescriptions), each prescription requires multiple dispensing (commonly 12 for a 14-day prescription). For each prescription, the pharmacist must dispense the item 12 times into 12 containers, resulting in 12 dispensing fees, 12 practice payments and 12 container allowances. In addition, controlled drugs such as methadone or buprenorphine

require special storage and recording, resulting in 12 controlled drug (CD) fees. (NB: the CD fee for methadone is higher than for buprenorphine.) There is also reimbursement for the cost of the drug supplied.

These nationally agreed payments are determined by taking into account the cost of the pharmacist's time and also all the costs incurred in running the business (for example, heating, lighting, business rates, salaries and employing staff, telephone, fax and computer costs).

Any extra work, which a community pharmacy undertakes over and above the core requirements of the contract, incurs additional costs. For example, shared care requires more time per patient and may involve extra telephone calls and a greater level of record keeping. Similarly, needle exchange and supervised consumption require additional time, additional storage space for equipment and additional training time for all staff members. Any costs for special fixtures such as CCTV, private areas or extra controlled drug cabinets are additional costs that have to be resourced. It is therefore vital that commissioners clarify what additional services are being commissioned, together with the inclusion and exclusion criteria and ensure these criteria are clearly communicated to other service providers who expect to work with community pharmacies.

At the end of each month, pharmacies send all NHS prescriptions dispensed to the Prescription Pricing Authority (PPA). The PPA prices the prescriptions by calculating the costs of the medicines and appliances dispensed. Pharmacies are then paid these costs together with the national fees and allowances, less any NHS prescription charges collected by the pharmacy from patients. The costs of some of these fees and allowances are charged back to PCTs and PCOs and in some circumstances to secondary care trusts. This is dependent on whether the prescription is generated in primary or secondary care. Commissioners and secondary care specialist service budget holders are encouraged to discuss the difference in fee structure with hospital and PCT and PCO chief pharmacists, especially if new prescribing services are being planned.

The community pharmacy receives the same nationally agreed NHS payments irrespective of where the prescription originates.

⁸Strictly speaking, there is no contract in the normal legal sense of the word. Community pharmacies actually work within a national contractual framework laid out in secondary legislation (Regulations and Secretary of State Directions).

These payments do not include payment for supervised consumption or shared care.

A number of secondary care substance misuse services have worked to reduce costs by arranging in-house dispensing or setting up an outpatient-style supervised consumption arrangement. It is important when calculating secondary care in-house dispensing costs that costs such as staff time, equipment, heating lighting, enhanced security, insurance and VAT are all included to ensure the true cost of the service is established.

5.3 VAT

Some locally commissioned services, such as needle and syringe exchange services, can sometimes be subject to VAT. Historically, there has been some degree of variation across the country in the way HM Revenue & Customs have treated similar schemes – sometimes they were VAT exempt and sometimes VAT had to be paid by the commissioner. Attempts are ongoing to obtain clarity on this issue at a national level – however commissioners should be aware of the potential that VAT may have to be paid when needle exchange services are commissioned. In some cases it may be possible to reclaim some of the VAT paid, for example, VAT charged on pack preparation. VAT should not be seen as a barrier to commissioning.

Community pharmacies are able to reclaim VAT paid on medicines they supply on prescriptions from doctors or dentists. However, hospital pharmacies are unable to reclaim VAT on the medicines they purchase and dispense.

5.4 Payment issues

A single DAT or commissioner may be dealing with many pharmacies across a locality. It will be necessary to have payment arrangements in place that are simple to administer and provide a regular reporting mechanism for individual pharmacies to check how payments have been calculated.

Where payments are made locally, as with enhanced services, a community pharmacy will generally be paid irrespective of where the prescription originates. This should be confirmed locally with the pharmacy contractors, local pharmaceutical committee (LPC), PCTs and PCOs, so that pharmacies will be assured of payment (and ensure pharmacies are not paid twice). For example, if they are commissioned to provide supervised consumption for patients, this should include those patients whose prescription has been written by a prescriber outside the DAT, PCT or PCO area. Commissioners should bear in mind the following:

- The Prescription Pricing Authority can process payment for some services on behalf of commissioning agencies
- Some NHS areas have shared contractor management agencies that manage local relationships with primary care contractors and process local payments for these contractors. These agencies may be able to offer this service to DAT commissioners
- Payments will normally need to be made to the individual pharmacy contractor. In the case of multiple pharmacy groups, payments may be made to individual pharmacies by arrangement if their branches normally operate as individual business units
- Multiple pharmacy groups may require payment details to be available to their head offices and regional managers, in order to check payments have been made
- Remittance advice notes accompanying payments need to clearly explain what the payment is for and specify individual branch numbers in the case of multiple pharmacy groups
- Pharmacy contractors need to understand how payments have been calculated and know in advance what payment to expect
- Pharmacies and commissioners need to clarify in advance (for example through service level agreements which are reflected in the standard operating procedures) what services the pharmacist is expected to provide and for which service users, namely inclusion and exclusion criteria
- Pharmacies should be provided with a single point of contact who can deal with all payment queries
- Any payment claim system must also have a system for validation of the claim to prevent fraud (advice can be obtained from local NHS counter fraud professionals)
- A system needs to be in place for notification of changes of ownership of pharmacies
- BACS payments are preferred by many pharmacies (where PPA payment systems cannot be used), but again systems need to be in place to ensure changes in ownership and bank accounts are communicated
- Payment claims and receipts must be available for audit by both commissioners and community pharmacy contractors.
- See section 6.4: Enhanced services for an explanation of how payment fees will be calculated.

6 Appendix 2: Understanding the new pharmacy contract

6.1 Contracted services available from community pharmacies

The new contract aims to provide clear minimum standards for pharmacies, reward high-quality services and make better use of the skills of pharmacists and pharmacy staff. The new NHS community pharmacy contract is made up of three levels:

- essential services
- advanced services
- enhanced services.

Implementation of the new contract is being phased over time. Essential services will be provided from 1 April 2005, but pharmacy contractors do not have to comply with all the requirements until October 2005. Advanced services are being introduced during 2005/06 and the first enhanced services will probably be commissioned from April 2006 – however pre-existing locally commissioned services are likely to continue during 2005/06. Some primary care organisations (PCTs and PCOs) are already commissioning local enhanced services.

Pharmacy contractors are paid according to the services they provide. Essential services are mandatory, however advanced services and locally commissioned enhanced services are two optional tiers of service provision. Pharmacists who have completed certain training and work in pharmacies that have particular facilities are able to provide advanced services.

The enhanced services are locally commissioned by PCTs and PCOs in response to local health priorities. The local PCT and PCO decides which of the enhanced services are required in a particular area and can appoint one or more pharmacies to provide them. To allow equal opportunity for all community pharmacies to take part, the service must be offered to all pharmacies in the specified locality – commissioners, PCTs and PCOs must not select them. The services may be based upon nationally produced service specifications, or designed and negotiated with local pharmaceutical committees (LPCs), PCTs and PCOs at a local level. The nationally agreed enhanced services list includes specifications for a needle and syringe exchange scheme (Appendix 3) and a supervised consumption scheme (Appendix 4).

6.2 Essential services offered by all pharmacy contractors

There are seven essential services, which all pharmacies will be paid for providing. These are:

- dispensing, including support for people with disabilities
- repeat dispensing
- disposal of unwanted medicines
- promotion of healthy lifestyles (public health)
- signposting
- support for self care
- clinical governance.

DATs are encouraged to work with PCTs and PCOs to maximise the opportunities of those essential services which could benefit substance misusers. For instance:

- **Promotion of healthy lifestyles** requires pharmacists to provide brief (one to two minutes), opportunistic one-to-one advice on healthy lifestyle topics such as smoking cessation to certain patient groups that present prescriptions for dispensing. In addition, pharmacists are required to be involved in six local campaigns annually, organised by PCTs and PCOs. For example, DATs may be able to initiate a local campaign on hepatitis B vaccination, nutrition and prevention of blood-borne viruses, by working with PCTs and PCOs to disseminate information via community pharmacies.
- **Signposting patients to other healthcare providers.** Pharmacists and staff refer patients to other care providers when appropriate. For example, DATs may work with PCTs and PCOs to provide literature to community pharmacies on local substance misuse services.
- **Support for self-care.** The provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families. The service will initially focus on self-limiting illnesses, but support for people with long-term conditions is also a feature of the service. For example, DATs may work with PCTs and PCOs to work with pharmacists to enable patients on substitute prescriptions to access advice and treatment for self-limiting conditions and minor ailments.

6.3 Advanced services requiring accreditation of the pharmacist and pharmacy

Pharmacists must pass a competency assessment before they can provide advanced services.

Currently, there is only one advanced service available – the medicines use review and prescription intervention service – although more will evolve over time.

- The medicines use review involves the pharmacist reviewing the patient's medication, identifying any problems and then feeding back to the prescriber. The patient also receives a copy of the review report. This is usually conducted on a regular (e.g. annual) basis. These must only be provided for patients who have been using the pharmacy for the dispensing of their prescriptions for the previous three months
- The prescription intervention service is similar to a medicines use review, except that it is triggered by a significant problem with a patient's prescription, which would be over and above the basic interventions, relating to safety, which a pharmacist would make as part of the essential level dispensing service. Again, suggestions are fed back to the GP.

It is up to the pharmacist to decide which patients receive this service. However, PCTs and PCOs are able to recommend that pharmacists concentrate on specific groups of patients. DATs are encouraged to work with PCTs and PCOs to ensure this service is available to patients on methadone and buprenorphine together with other medications, such as anti-retrovirals, anti-tuberculosis drugs, ritonavir and psychotropics.

Reviews must be conducted in a consultation area, which ensures patient confidentiality. Such an area would also be suitable for providing needle exchange and supervised consumption of medicines.

Once accredited, pharmacists will be able to provide medicines use reviews or prescription intervention service for up to 200 patients in the first year.

6.4 Enhanced services

Each PCT and PCO may commission individual pharmacies to provide particular enhanced services, depending on the specific needs in each local area. These services may include the following:

- minor ailments management
- stop smoking services
- needle exchange schemes
- supervised consumption of prescribed medicines
- supplementary prescribing.

See Appendix 3 for the service specification for needle exchange, Appendix 4 for the service specification for supervised consumption of prescribed medicines and Appendix 5 for the service specification for supplementary prescribing by pharmacists.

The enhanced services are locally commissioned by PCT and PCOs in response to local health priorities. As with the nGMS contract, these services are not mandatory. Services can be based on:

- nationally produced service specifications. Work has been ongoing to seek to agree benchmark prices but after meetings between the PSNC, NHS Confederation and Department of Health, it appears that a better approach is the publication of a pricing toolkit. The PSNC are currently (December 2005) developing a jointly agreed toolkit for pricing, which will identify the elements to be considered in pricing the service at a local level.
- locally designed and negotiated with local pharmaceutical committees (LPCs) at a local level. These are similar to local enhanced services.

Local contractual arrangements offer more flexibility in the models of provision and financial payment. These may be useful for maintaining the status quo in areas where local arrangements are working.

The local shared care monitoring groups (SCMGs) have responsibility for the monitoring of local shared care arrangements, including supervised consumption of substitute medication. This should continue.

Local joint commissioning groups, PCTs and PCOs interested in the prevalence of blood-borne viruses should contact the Health Protection Agency, which monitors their incidence and prevalence in the UK.

6.5 NTA recommendations

The NTA recommendations on *Drug treatment and the new GMS contract (2003)* are equally applicable to the new pharmacy contract:

- Joint commissioners, on behalf of local drug action teams (DATs), should undertake brief reviews of local arrangements for shared care and commission or recommission pharmacy shared care schemes, using a mixture of nationally enhanced service and locally enhanced service contracts according to local needs.
- Future commissioning of primary care services should aim to increase the quantity and quality of primary care provision. Such increases should not lead to a destabilising of current local drug treatment provision, either through disinvestment in primary or secondary care services.
- Where shared care monitoring groups (SCMGs) exist and are working effectively, they should continue to have responsibility for monitoring local shared care arrangements and advise joint commissioning groups on the most appropriate contractual arrangements.
- In areas that do not have effective SCMGs, they should be developed and include the appropriate membership as outlined in Department of Health guidelines. (i.e. including pharmacists and LPC representation).
- Local areas, via their SCMGs and joint commissioners, should continue to ensure that pharmacists and pharmacies involved in shared care schemes are increased and maintained at a level appropriate for local need and this proportion is made explicit for planning purposes. In many areas, the Department of Health target to have 30 per cent of GPs involved in shared care has been built into local delivery plans. Although no target has been set for pharmacy involvement, there needs to be sufficient to support this proportion of GPs as well as others, for example specialist prescribers and DIP prescribers. This document recommends that the eventual aim should be for the majority (over 75 per cent) of community pharmacies to provide dispensing, supervised consumption and shared care, so that individual patients have maximum choice on where to have their prescription dispensed. In addition, the aim should be that a significant proportion (over 25 per cent) provide needle exchange, distributed appropriately across the DAT, PCT and PCO localities.
- Where pharmacy services are negotiated locally, payments should be the same within that DAT area for comparable services and should not vary between primary care trusts (PCTs and PCOs). Differential payments could lead to a postcode lottery of primary care service within the DAT area, where differing PCTs and PCOs adopt different pay structures for pharmacists.
- Primary and secondary care should work together in collaborative partnerships within integrated care pathways to best meet the needs of drug users. The pharmacy contract implementation should complement rather than disrupt Models of care implementation.
- Shared care should be supported by a mixture of mainstream health money (via PCTs and PCOs) and drug treatment pooled treatment budget with payment linked to the level and quality of treatment activity.
- Drug treatment services in primary care should be underpinned by robust service level agreements with the primary care trusts, which have responsibility for service provision.
- Whatever local arrangements are agreed, decision making should go through the normal joint commissioning group and be agreed with NTA regional teams in the context of the drug treatment planning process.

More details on the contract can be obtained from www.psn.org.uk/contract.

7 References

Departments of Health, The Scottish office Departments of Health, Welsh Office, Department of Health and Social services Northern Ireland (1999) – Drug Misuse and Dependence – Guidelines on clinical management

The Royal Pharmaceutical Society of Great Britain, Clinical governance framework for pharmacist prescribers and organisations commissioning or participating in pharmacist prescribing (GB wide). (October 2005).

Centre for Pharmacy Postgraduate Education (CPPE) (England) – open learning packs (available free of charge to all registered pharmacists)

- *Substance misuse* (formerly called Drug use and Misuse) 2005
- *Opiate treatment: supporting pharmacists for improved patient care.* 2002

The Scottish, Welsh and Northern Ireland centres for pharmacy post-graduate education provide similar support for their pharmacists.

Department of Health (1997) *Purchasing effective treatment and care of drug misusers: guidance for health authorities and social services departments*, p16, London: Department of Health.

National Treatment Agency for Substance Misuse (2002) *Models of care for treatment of adult drug misusers*, London: NTA.

National Treatment Agency for Substance Misuse (2005) *Models of care for treatment of adult drug misusers Update*, London: NTA.

National Treatment Agency for Substance Misuse (2002) Commissioning drug treatment systems. Resource pack for commissioners

National Treatment Agency for Substance Misuse (2003) 3.3 *Service specification tier 2: Needle exchange and harm reduction*, London: NTA.

National Treatment Agency for Substance Misuse (2003) 3.6 *Service specification tier 3: Community prescribing*, London: NTA.

Royal College of General Practitioners (2004) RCGP *National Drug Misuse Training Programme*, London: RCGP.

Royal Pharmaceutical Society of Great Britain (latest edition) *Medicines ethics and practice: a guide for pharmacists*.

Skills for Health (2002) *Drugs and alcohol national occupational standards (DANOS)*, London: Skills for Health.

Drugscope and Department of Health's (2001) *Making harm reduction work. Needle exchange for young people under 18 years old*, London.

8 Appendix 3: NHS community pharmacy contractual framework enhanced service – needle and syringe exchange

1 Service description

- 1.1 Pharmacies will provide access to sterile needles and syringes, and sharps containers for return of used equipment. Where agreed locally, associated materials, for example condoms, citric acid and swabs, to promote safe injecting practice and reduce transmission of infections by substance misusers will be provided.
- 1.2 Pharmacies will offer a user-friendly, non-judgmental, client-centred and confidential service.
- 1.3 Used equipment is normally returned by the service user for safe disposal.
- 1.4 The service user will be provided with appropriate health promotion materials.
- 1.5 The pharmacy will provide support and advice to the user, including referral to other health and social care professionals and specialist drug and alcohol treatment services where appropriate.
- 1.6 The pharmacy will promote safe practice to the user, including advice on sexual health and STIs, HIV and hepatitis C transmission and hepatitis B immunisation.

2 Aims and intended service outcomes

- 2.1 To assist the service users to remain healthy until they are ready and willing to cease injecting and ultimately achieve a drug-free life with appropriate support
- 2.2 To protect health and reduce the rate of blood-borne infections and drug related deaths among service users:
 - by reducing the rate of sharing and other high risk injecting behaviours
 - by providing sterile injecting equipment and other support
 - by promoting safer injecting practices
 - by providing and reinforcing harm reduction messages including safe sex advice and advice on overdose prevention (e.g. risks of poly-drug use and alcohol use).

- 2.3 To improve the health of local communities by preventing the spread of blood-borne infections by ensuring the safe disposal of used injecting equipment.
- 2.4 To help service users access treatment by offering referral to specialist drug and alcohol treatment centres and health and social care professionals where appropriate.
- 2.5 To aim to maximise the access and retention of all injectors, especially the highly socially excluded.
- 2.6 To help service users access other health and social care and to act as a gateway to other services (e.g. key working, prescribing, hepatitis B immunisation, hepatitis and HIV screening, primary care services etc).

3 Service outline

- 3.1 The part of the pharmacy used for provision of the service provides a sufficient level of privacy and safety and meets other locally agreed criteria.
- 3.2 The pharmacy contractor has a duty to ensure that pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in the operation of the service.
- 3.3 The pharmacy contractor has a duty to ensure that pharmacists and staff involved in the provision of the service are aware of and operate within local protocols.
- 3.4 The pharmacy will allocate a safe place to store equipment and returns for safe onward disposal. The storage containers provided by the PCO commissioned clinical waste disposal service will be used to store returned used equipment.
- 3.5 The pharmacy contractor should ensure that their staff are made aware of the risk associated with the handling of returned used equipment and the correct procedures used to minimise those risks. A needle stick injury procedure should be in place.
- 3.6 The pharmacy should maintain appropriate records to ensure effective ongoing service delivery and audit.
- 3.7 Appropriate protective equipment, including gloves, overalls and materials to deal with spillages, should be readily available close to the storage site.
- 3.8 The pharmacy should clearly display the national scheme logo or a local logo indicating participation in the service.
- 3.9 Staff involved in the delivery of this service should be offered immunisation for Hepatitis B.

- 3.10 Pharmacists will share relevant information with other healthcare professionals and agencies, in line with locally determined confidentiality arrangements.
- 3.11 The PCO should arrange at least one contractor meeting per year to promote service development and update the knowledge of pharmacy staff.
- 3.12 The PCO will provide the exchange packs and associated materials and will commission a clinical waste disposal service for each participating pharmacy. The frequency of waste collection should be agreed to ensure there is not an unacceptable build up of clinical waste on the pharmacy premises.
- 3.13 The PCO will need to provide a framework for the recording of relevant service information for the purposes of audit and the claiming of payment.
- 3.14 The PCO will need to provide details of relevant referral points which pharmacy staff can use to signpost service users who require further assistance.
- 3.15 The PCO should consider obtaining or producing health promotion material relevant to the service users and making this available to pharmacies.

4 Suggested quality indicators

- 4.1 The pharmacy has appropriate PCO provided health promotion material available for the user group and promotes its uptake.
- 4.2 The pharmacy reviews its standard operating procedures and the referral pathways for the service on an annual basis.
- 4.3 The pharmacy can demonstrate that pharmacists and staff involved in the provision of the service have undertaken CPD relevant to this service.
- 4.4 The pharmacy can demonstrate that the rate of return of used equipment meets locally agreed targets.
- 4.5 The pharmacy participates in an annual PCO organised audit of service provision.
- 4.6 The pharmacy co-operates with any locally agreed PCO-led assessment of service user experience.
- To offer user-friendly, non-judgmental, client-centred and confidential services
 - To assist the service users to remain healthy until they are ready and willing to cease injecting and ultimately achieve a drug-free life with appropriate support
 - To reduce the rate of sharing and other high risk injecting behaviours by providing sterile injecting equipment and other support
 - To reduce the rate of blood-borne infections among drug users
 - To reduce drug-related deaths (immediate death through overdose and long-term such as blood borne infections)
 - To promote safer injecting practices
 - To provide focused harm reduction advice and initiatives, including advice on overdose prevention (e.g. risks of poly-drug use and alcohol use)
 - To provide and reinforce harm reduction messages
 - To help service users access drug treatment to refer to other specialist drug (and alcohol) treatment services
 - To help service users access other health and social care and to act as a gateway to other services (e.g. key working, prescribing, hepatitis B immunisation, hepatitis and HIV screening, primary care services etc)
 - To facilitate access to primary care where relevant
 - To ensure the safe disposal of used injecting equipment
 - To prevent initiation into injecting and to encourage alternatives to injecting
 - To aim to maximise the access and retention of all injectors, especially the highly socially excluded, through the low-threshold nature of service delivery and interventions provided
 - To improve the health of local communities by preventing the spread of blood-borne viruses and by reducing the rate of discarded used injecting equipment.

There is good evidence that community pharmacy based needle exchange services can complement and support other needle exchange and harm minimisation initiatives commissioned by drug treatment agencies.

Background information – not part of the service specification

The National Treatment Agency for Substance Misuse service specification for Needle Exchange and Harm Reduction sets out a series of objectives for needle exchange services generally, these apply to services commissioned from community pharmacy and are reflected within the service specification:

Background information for drug action team commissioners:

Service Specification Tier (2 or 3), Pharmaceutical Services for Drug Users,

National Treatment Agency for Substance Misuse, 2005,
www.nta.nhs.uk

CPPE training which may support this service:

Opiate treatment: Supporting pharmacists for improved patient care open learning Public Health – drug users, harm reduction workshop

9 Appendix 4: NHS community pharmacy contractual framework enhanced service – supervised administration (consumption of prescribed medicines)

1 Service description

- 1.1 This service will require the pharmacist to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient
- 1.2 Pharmacies will offer a user-friendly, non-judgmental, client-centred and confidential service
- 1.3 The pharmacy will provide support and advice to the patient, including referral to primary care or specialist centres where appropriate
- 1.4 Examples of medicines which may have consumption supervised include methadone and other medicines used for the management of opiate dependence, and medicines used for the management of mental health conditions or tuberculosis.

2 Aims and intended service outcomes

- 2.1 To ensure compliance with the agreed treatment plan by:
 - dispensing in specified instalments¹ (doses may be dispensed for the patient to take away to cover days when the pharmacy is closed)
 - ensuring each supervised dose is correctly consumed by the patient for whom it was intended.
- 2.2 To reduce the risk to local communities of:
 - overuse or underuse of medicines
 - diversion of prescribed medicines onto the illicit drugs market
 - accidental exposure to the supervised medicines.
- 2.3 To provide service users with regular contact with healthcare professionals and to help them access further advice or assistance. The service user will be referred to specialist treatment centres or other health and social care professionals where appropriate.

3 Service outline

- 3.1 The part of the pharmacy used for provision of the

service provides a sufficient level of privacy and safety and meets other locally agreed criteria.

- 3.2 The pharmacy will present the medicine to the service user in a suitable receptacle and will provide the service user with water to facilitate administration and/or reduce the risk of doses being held in the mouth.
- 3.3 Terms of agreement are set up between the prescriber, pharmacist and patient (a three-way agreement) to agree how the service will operate, what constitutes acceptable behaviour by the client, and what action will be taken by the GP and pharmacist if the user does not comply with the agreement. A “four-way” agreement could also be developed which would include the specialist centre.
- 3.4 The pharmacy contractor has a duty to ensure that pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in the operation of the service.
- 3.5 The pharmacy contractor has a duty to ensure that pharmacists and staff involved in the provision of the service are aware of and operate within local protocols.
- 3.6 The pharmacy should maintain appropriate records to ensure effective ongoing service delivery and audit.
- 3.7 Pharmacists will share relevant information with other healthcare professionals and agencies, in line with locally determined confidentiality arrangements.

In this service specification it is assumed that instalment dispensing is provided for by the provisions of the dispensing or repeat dispensing essential services. If this is not the case for a particular medicine which may be included in the service, local arrangements will need to be developed.

- 3.8 The PCO should arrange at least one contractor meeting per year to promote service development and update the knowledge of pharmacy staff
- 3.9 The PCO will need to provide a framework for the recording of relevant service information for the purposes of audit and the claiming of payment
- 3.10 The PCO will need to provide details of relevant referral points which pharmacy staff can use to signpost service users who require further assistance
- 3.11 The PCO should consider obtaining or producing health promotion material relevant to the service users and making this available to pharmacies

4 Suggested quality indicators

- 4.1 The pharmacy has appropriate PCO provided health promotion material available for the user group and promotes its uptake
- 4.2 The pharmacy reviews its standard operating procedures and the referral pathways for the service on an annual basis
- 4.3 The pharmacy can demonstrate that pharmacists and staff involved in the provision of the service have undertaken CPD relevant to this service
- 4.4 The pharmacy participates in an annual PCO organised audit of service provision
- 4.5 The pharmacy co-operates with any locally agreed PCO-led assessment of service user experience

Background information

(not part of the service specification)

Current guidelines² recommend all new treatment of opiate dependence be subject to supervised consumption for the first three months or a period considered appropriate by the prescriber. The rationale for this recommendation is to provide routine and structure for the client, helping to promote a move away from chaotic and risky behaviour.

Supervision of the consumption of medicines used in the treatment of people with mental illness can in a similar way help to reduce chaotic and risky behaviour. Regular contact with the pharmacist and pharmacy staff can help to reduce the social isolation felt by many people with mental illness. Pharmacists and their staff are well placed to spot the deterioration of a person's mental state and alert other members of the healthcare team to the person's need for further support if appropriate.

Tuberculosis is becoming an increasing problem in many parts of the country, especially among socially disadvantaged groups such as the homeless. The effective treatment of tuberculosis and the prevention of acquired drug resistance relies on full compliance with medication treatment regimens. Directly observed therapy schemes (DOTS) have been used in many countries to improve compliance. A comparison of self treatment versus various forms of DOT has shown that completion of treatment is

significantly higher when the treatment is supervised.³

An example claim/audit form and "three-way" agreement form are provided with this service specification, which could be adopted locally by PCOs.

Background information for Drug Action Team (DAT) commissioners:
Service Specification Tier (2 or 3), Pharmaceutical Services for Drug Users,
National Treatment Agency for Substance Misuse, 2005,
www.nta.nhs.uk

CPPE training which may support this service:

Opiate treatment: Supporting pharmacists for improved patient care open learning

Public health – drug users, harm reduction workshop

Mental health workshop series

¹ In this service specification it is assumed that instalment dispensing is provided for by the provisions of the dispensing or repeat dispensing essential services. If this is not the case for a particular medicine which may be included in the service, local arrangements will need to be developed.

10 Appendix 5: NHS community pharmacy contractual framework enhanced service – supplementary prescribing by pharmacists

1 Service description

- 1.1 The service is based on a voluntary partnership between an independent prescriber (doctor or dentist) and a supplementary prescriber, to implement an agreed patient specific clinical management plan (CMP) with the patient's agreement. The supplementary prescriber will need to be able to access patients' medical records.
- 1.2 The supplementary prescriber will support the patient in managing their condition, including ordering of diagnostic tests, monitoring test results and response to treatment and adjusting treatment accordingly. The supplementary prescriber will also refer to other primary care professionals where appropriate.

2 Aims and intended service outcomes

- 3.1 Maximising patient and NHS benefit in relation to quicker and more efficient access to medicines.
- Improving choice, convenience and access to treatment.
 - Improve quality of service to patients without compromising patient safety.
 - Make better use of the skills of pharmacists.
 - Contribute to the introduction of more flexible team working across the NHS.
 - Provide support and advice, including referral to the GP and other healthcare professionals when appropriate.
 - Increase the involvement of the patient in treatment decisions.
 - Improve primary care capacity by reducing medical practice workload.

3 Service outline

- 3.1 Prior to commissioning this service the following issues must be considered:
- patient safety
 - how to maximise patient and NHS benefits

- local NHS need
 - ability of the supplementary prescriber to prescribe in their post immediately following training
 - access to a budget and prescription pads
 - access to patient records
 - access to a designated medical practitioner during training, recognised by the commissioning organisation as (i) having the experience in the relevant field of practice, (ii) training and experience in supervision, support and assessment of trainees, and (iii) who has agreed to provide the student with opportunities to develop competencies in prescribing, and to supervise, support and assess the student during their clinical placement
 - access to CPD opportunities and ideally a mentor (not necessarily the independent prescriber)
- 3.2 The pharmacist has at least two years post-registration experience and has successfully completed an accredited supplementary prescribing training course and is registered with the RPSGB as a supplementary prescriber.
- 3.3 A doctor/dentist has been identified and agreed to take on the role of independent prescriber.
- 3.4 Eligibility criteria and referral protocols are agreed locally with the PCO and doctor and should be in line with DH guidance (supplementary prescribing by nurses, pharmacists, chiropodists/podiatrists, physiotherapists and radiographers within the NHS in England, A guide for implementation).
- 3.5 The location used for the provision of the service provides privacy and safety and appropriate facilities for examination of patients, for example hand washing facilities. The facilities should comply with good infection control practice.
- 3.6 Protocols and audit for quality assurance of any equipment used are in place.
- 3.7 For each new patient identified for the service an individual clinical management plan is agreed between the independent prescriber, supplementary prescriber and patient. The CMP should include:
- the name of the patient
 - the illness or conditions which may be treated by the supplementary prescriber

² Drug misuse and dependence: guidelines on clinical management. Department of Health (1999)

³ Chaulk CP, Kazandjian VA. Directly observed therapy for treatment completion of pulmonary tuberculosis: consensus statement of the Public Health Tuberculosis Guidelines Panel. JAMA 1998; 279: 943-948

- the date on which the plan takes effect and when it is to be reviewed by the independent prescriber
 - a reference to the class or description of medicines or types of appliances which may be prescribed or administered, following any local formularies which are in place
 - any restrictions or limitations on the strength or doses of medicines
 - length of treatment if applicable
 - relevant warning about the patients sensitivities to medicines
 - arrangements for notification of important adverse drug reactions; and
 - the circumstances in which the supplementary prescriber should refer to or seek the advice of the independent prescriber.
- 3.8 The CMP should be kept as simple as possible and where national guidelines already exist (e.g. BTS Guidelines for Asthma) these could be referred to within the CMP.
- 3.9 Supplementary prescribers should have the ability to request a range of tests from the local pathology laboratory, as described in the CMP.
- 3.10 Pharmacist supplementary prescribers should make contemporaneous records of all their interventions in the common patient record. If however this is not possible a separate record should be made which should be transferred to the common patient record as soon as possible. Only in exceptional circumstances, (e.g. a weekend or public holiday), should this period exceed 48 hours from the writing of the prescription.
- 3.11 For each patient the pharmacist should where appropriate:
- carry out a medication review
 - perform or request any testing that may be required
 - monitor the patient for response to treatment
 - assess the results of any testing carried out
 - adjust medicines dosages accordingly (within CMP),
 - discuss the treatment options with the patient
 - prescribe,
 - update the patient record, and
 - communicate with the independent prescriber appropriately.

- 3.12 Patients would normally be seen within the community pharmacy or GP surgery; however domiciliary visits may be appropriate in some circumstances.
- 3.13 The PCO will need to provide a framework for the recording of relevant service information for the purposes of audit and the claiming of payment.
- 3.14 The PCO will need to provide details of relevant referral points which pharmacy staff can use to signpost service users who require further assistance.

4 Suggested quality indicators

- 4.1 The pharmacy reviews its standard operating procedures and the referral pathways for the service on an annual basis.
- 4.2 The pharmacy can demonstrate that pharmacist supplementary prescribers involved in the provision of the service have undertaken CPD relevant to this service.
- 4.3 The pharmacy can show that prescribing by the supplementary prescriber is in accordance with CMPs.
- 4.4 The pharmacy can demonstrate robust quality assurance for any processes or equipment used.
- 4.5 The pharmacy participates in an annual PCO organised audit of service provision.
- 4.6 The pharmacy co-operates with any locally agreed PCO-led assessment of service user experience.

Background information – not part of the service specification

Supplementary prescribing by nurses, pharmacists, chiropodists/podiatrists, physiotherapists and radiographers within the NHS in England, A guide for implementation, DH May 2005

(http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4110032&chk=c4V6nR)

Amended POM order – SI 2003 No. 699 The NHS (Amendments relating to prescribing by nurses and pharmacists etc.) (England) Regulations 2003
(<http://www.opsi.gov.uk/si/si2003/20030699.htm>)

CPPE training which may support this service:

Medicines management workshop series
Prescribing support open learning series

11 Appendix 6: Abbreviations

BBV	Blood-borne virus
CPPE	Centre for Pharmacy Postgraduate Education (University of Manchester)
DAT	Drug action team
DIP	Drugs Intervention Programme
GPwSI	General practitioner with special interest
HBV	Hepatitis B virus
LPC	Local pharmaceutical committee
MoC	<i>Models of care 2002 and Models of care: Update 2005</i> – produced by the National Treatment Agency for Substance Misuse
NHS	National Health Service
NPA	National Pharmacy Association
NTA	National Treatment Agency for Substance Misuse www.nta.nhs.uk (England only)
PSNC	Pharmaceutical Services Negotiating Committee www.psnc.org.uk (England and Wales)
PCO	Primary care organisation
PCT	Primary care trust
PhwSI	Pharmacist with special interest
RCGP	Royal College of General Practitioners
RPSGB	Royal Pharmaceutical Society of Great Britain
SOP	Standard operating procedure

12 Further information

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Our thanks go to the Royal Pharmaceutical Society's substance misuse group, chaired by Sue Kilby, for their help in compiling this document and in particular to:

Kay Roberts FRPharmS ,
Sadia Khan MRPharmS, RPSGB
Alastair Buxton MRPharmS and Barbara Parsons
MRPharmS, PSNC.

In addition our thanks go to:

Paul Brookes, Annette Dale-Perera and Emily Finch,
National Treatment Agency, for their help in producing
this document

We are grateful for the additional comment and advice
provided by Colin Bradbury, Jonathon Buisson,
Julie Daneshyar, Barry Eveleigh, Mark Galloway,
Mark Harris, Vanessa Hayward, Gillian Hawksworth,
Duncan Jenkins, Hugo Luck, Andrea Nunney,
Graham Parsons, Lisa Stanway, David Skidmore,
Vanessa Taylor and Debbie Woolley.

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