SPECIAL VALUE

Primary Care Today and the Association of Pharmaceutical Specials Manufacturers brings together members from general practice, pharmacists, CCGs and the Specials industry to debate whether Specials are value for money

The APSM

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The Association of Pharmaceutical Specials Manufacturers (APSM) represents licensed commercial manufacturers of Specials in the UK and member companies produce a significant proportion of the Specials supplied to primary care.

The APSM's key interest is in maintaining a viable and high quality supply of Specials that meets the clinical needs of patients and satisfies the ethical and regulatory standards and expectations of the MHRA and the wider community of healthcare professionals. We achieve this by working closely with pharmacists, clinicians, regulators and other government and professional bodies and patient groups to provide technical support about appropriate manufacture and sourcing of Specials as well as guidance about quality and safety. We are delighted to support this Specials Round Table and see it as an important step in facilitating greater understanding and more effective communication between our industry and those involved in the Specials decision-making process.

More information and a list of members is available from www.apsm-uk.com

SETTING THE SCENE

LN: A warm welcome to this roundtable event titled Specials: If, What, How, Who Makes the Decision hosted by Primary Cars Today. I'd like to start by expressing my thanks to the Association of Pharmaceutical Specials Manufacturers for supporting the event and making the discussion possible. The Drug Tariff provides this definition of a Special: "Specials are a licensed medicinal product manufactured in the UK for human use that have been specially prepared to meet a prescription ordered for individual patients without the need for the manufacturer to hold a marketing authorisation for the medicinal product concerned." According to the APSM's white paper on the cost effective nature of Specials, £99.7 million was the total spend on Specials in 2013; 1.06 per cent of the spend of all drugs in England and Wales that year and a mere fraction of the £115.4 billion NHS budget set for 2015/16. This may seem surprising considering the column inches Specials medicines receive when it comes to cost. That being said, too many conversations on Specials centre around cost rather than their clinical need. Patients that are prescribed Specials have complex medical needs and without Specials may suffer complications or adverse reactions to medicines. We need to put the clinical need for, and use of, Specials back in the driving seat of discussions around the drugs.

An APSM survey among GPs found 54 per cent said they had been asked to reduce the prescribing of Specials by their CCG. Forty-five per cent said they were happy to prescribe a licensed medicine with instructions to the patient to split or crush capsules or tablets compared with just 29 per cent in 2012. Such pressures exerted by commissioners could be leading these GPs to offer crushing instructions – the risks of which are well documented. Where is the prescriber and patient voice when it comes to Specials? Is it too CCG sided? Can I ask Sharon to kick things off by setting the scenes of the Specials industry amid funding pressures and increasing patient demand?

SG: Post the Drug Tariff we did see a decline in prescriptions, however, they've been steadily going back up and have almost plateaued so that's a positive. The Tariff was designed to add value for money and to put a mechanism in place to control the cost of Specials. Cost is an inevitable part of Specials, but we're seeing that people now have the confidence to prescribe more. I'm here on behalf of the APSM membership and I can't discuss individual prices around members, however, we're all in support of the Drug Tariff; we always have been and we continue to be.

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Key outcomes

1. There is a legacy and the Specials industry needs to do more to be transparent and ethical to facilitate better understanding of why Specials are recommended.
2. Communication needs to improve across the board: between pharmacists and GPs, primary and secondary care, and with patients.
3. Standardising communication and processes between primary and secondary care is essential to increasing understanding of why Specials are recommended.
4. Pharmacists must play a bigger, more consultative role in the provision of Specials

WHO'S WHO?

David Evans (DE)
superintendent pharmacist at the Manor Pharmacy Group in the Midlands

Dr Anil Shah (AS)
local GP and clinical lead, Newham CCG

Sharon Griffiths (SG)
chairman of the APSM and managing director of the Specials Laboratory

Lynsey Niblett (LNT)
senior quality manager at BCM Specials

Mark Robinson (MR)
pharmacy lead at the NHS Alliance

Nanette Kerr (NK)
chief executive of the Company Chemists' Association

Tim Root (TR)
specialist pharmacist, clinical governance and technical services, East and South East England Specialist Pharmacy Service

Carla Jones
CEO, Allergy UK

Louise Naughton (LN)
Managing editor at *The Pharmacist*

Key outcome one: Value for money

While the Drug Tariff has provided some confidence and reassurance around Specials cost, the role of prescribing advisors within CCGs has reportedly become more managerial and strategy based, reflecting the grip commissioners want to keep on Specials spending. The need to keep control of costs is rooted in history, and the need to prove each Special offers value for money is increasing. Participants shied away from advocating a 'blanket' rule approach to costs and felt protective over the prescriber's autonomy in assessing clinical need.

MR: There's quite a history that I can't forget within Specials that needs an element of explanation. At one point medicines managers in PCTs felt that the cost of Specials were out of control. That's why CCGs are still monitoring the use and cost of Specials: Many have a performance metric linking the prescribing of Specials to the number of patients in a practice. We started to review things like simvastatin suspension that was being used in 80-year-old people in nursing homes that we were spending £300 a bottle on. So you actually have to consider this special clinical need to make sure it's properly identified and properly documented; recognising that with the way licensing of medicines is going it becomes unviable now for pharma companies to go through a licensing process. It costs companies many millions of pounds to license a new form so there'll be more and more gaps coming in that licensed medicine list. There will be the same pressure about how you provide an appropriate medicine under a Special, which has both the quality and the value.

AS: It depends on the patient though because that 80-year-old patient may be fit and well and actually have another 20 years of good life.

SG: Do you think because of that history people would be inclined not to prescribe a Special? Although very separate, the clinical need and the cost, do they get merged together?

AS: So it's about looking at the clinical need for that specific patient; not putting in blanket rules. I think it's really important that we do remember that, it is the prescriber's decision and the prescribing advisors and the CCGs that come in that are there to offer advice and support.

SG: So when would it be the patient's decision?

AS: The patient is always involved throughout the whole of the process. It's the job of the GP and the secondary care doctor to explain to patients what the medication is, what it's used for, what the alternatives are and what the side effects are. Ultimately, in today's world it's a very much patient-centred approach: the patient decides whether they take the medication and whether they're complaint or not. The doctor is merely there to facilitate that decision making process.

SG: Post the Drug Tariff do you feel more confident with the mechanisms that are in place, or are there still questions about added value?

MR: The tariff has been brought in to control the reimbursement of the most frequently prescribed Specials so that's fine – at least we've got some lid on the price that can be charged and that's quite a reasonable thing to have in place. But, for me, there's still this question about the Special clinical need that's driving the use of a Special: whether you're talking about a very accepted medicine that needs to be provided in a different form or whether you're talking about a virtually untried or untested product. So you try and think when you're talking to a GP about trying to give that some sort of explanation about where it fits, the level of knowns and unknowns and therefore the level of risk that a GP might be facing in this. You try to desperately translate that to a patient.

AS: All that within the 10-minute consultation where you have to explain the medical condition as well as the drugs too. I think it makes it really difficult.

TR: In some ways we're trying to simplify something that is inherently complicated and it should be. The clue's in the name: Specials are all about meeting an individual patient's special clinical needs so at the end of the day within a set of principles and guidelines, the only thing you can do is look at the patient at the time, at the condition and make a decision about that patient, on that day for that drug.

SG: I agree. Some Specials are made once and never again.

LN: Anil how does your CCG look at the Specials spend in your area?

AS: The CCG's role predominantly tends to be more finance-based, i.e. going and looking or reviewing the Specials on a four month basis.

The prescribing advisor's role has changed significantly and so in some ways the community pharmacists or hospital pharmacists are better placed, potentially, to give that support and advice on the clinical need for Specials and the value add.

LN: In what way has it changed?

AS: It's more managerial; it's more strategy based. It's more around how do we look at the budgets overall rather than the individual case and patient so it's grouped together as a CCG as the total Specials costs. In some ways there's a real push to push your patients off Specials simply to reduce cost and in some cases using different medication, which is potentially just or as efficacious but not as much you'd like it to be simply due to cost.

TR: I think a lot of the cost issue is generated by multi-party supply chains when products are changing hands two, three, four, five times between manufacturer and patient. I do think we should be talking about value for money rather than cost.

MR: From a payer point of view I just want to know I get value and to know that I'm not being ripped off. If Specials manufacturers can facilitate that conversation, can help community pharmacists understand what's reputable, what's not, what's good value, what's not and do some liaison work with the clinicians around where special clinical needs really fit then that will be a good way forward. →

"It is clear there are many patients out there with complex medical needs that require the use of Specials drugs. As a CCG, we have to ensure we have the correct systems in place to make sure we are getting the best value for care, considering all of our patients. This often means we have to seek novel solutions to patient care scenarios. Specials availability is one of these situations where we know that there are other ways to secure medications for these patients. Obviously we need to take in to consideration the guidance from our pharmacy colleagues though, in making sure what we are doing is safe."

Dr Hasan Chowhan, clinical director, North East Essex CCG

"Being transparent and ethical across the industry is vital to securing the confidence of patients, prescribers, commissioners and regulators. There is no doubt that Specials medicines have a key part to play in the lives of people who need special treatment. It is by improving the quality of care to these individuals that we will improve outcomes. It is equally imperative that health systems do make use of these medicines appropriately. These arguments sit within the context of all the challenges facing the NHS."

Dr Minesh Patel, chair, Horsham and Mid-Sussex CCG

"As a GP, clinical director in vascular and GP member of NICE's Quality Standard Advisory Committee with my old hat of clinical director in medicine optimisation, I strongly feel that we must prescribe cost-effective, evidenced-based medication making sure of patient's safety at all times. Specials are defined as a medicine made to satisfy an individual patient need. The Medicine Act allows the prescriber to prescribe without a licence providing the prescriber takes full liability for the prescription. The medical defence will not protect the GP if a patient came to any harm, a major factor as to why GPs are reluctant to prescribe Specials. If a prescriber wishes to prescribe a Special they must give a patient an information leaflet explaining what is different about the medication, why do they need one, how do they know that it is safe and how to obtain future supply. If a carer is involved, they should be given an information sheet on the Special product emphasising that they get the supply from the same pharmacist who will make sure that the same manufacturer is used."

Dr Anita Sharma, clinical director – vascular, Oldham CCG

Key outcome two: Communication

Communication across primary and secondary care and with patients on the subject of Specials was found to be lacking, and was a consistent theme throughout the discussion. The fractured environment that exists within primary care and blocked access to a common shared record were cited as barriers to taking a more integrated approach to Specials. More worryingly, Nanette Kerr, chief executive of The Company Chemists' Association, said pharmacists were simply not prepared for discussions on Specials with patients, with this contributing to a 'ping-pong' scenario for patients, whereby primary care practitioners believe others are responsible for, or have the answers to, questions around Specials. Carla Jones, chief executive of Allergy UK, called for standardised guidance that all stakeholders could refer to.

Between primary care professionals...

LN: Tim, you mentioned a tripartite decision making model involving the patient, prescriber and pharmacist. Are those conversations happening in primary care?

TR: They're certainly happening in secondary care but they need to start happening more in primary care. Of course the environment in which we all work is very different in primary and secondary care and it's much easier for the pharmacist, prescriber and patient to get together in secondary care than for all three to have a coherent discussion in primary care. The other issue for community pharmacists is that the contract doesn't incentivise them to spend lots of time discussing the formulation of a potential Special in detail with a prescriber or patient.

Between GPs and pharmacists...

AS: The communication needs to be better between GPs and pharmacists and we need to have that discussion. Maybe asking pharmacists to come into GP practices and potentially work a bit closer. We have prescribing advisors within each of the CCGs who are paid pharmacists to help support us and yet we still have the issue. So it begs to differ what actually is their role as prescribing advisors in CCGs working contractually with GPs?

NK: Wouldn't the problems be resolved if we had an electronic mechanism for getting information back to the GP? Because if you have only a paper mechanism or you have to give something to the patient for them to take back to the GP then that's not efficient is it? We have had a little step forward now we've got access to the summary care record but we've only got read access at the moment. So if there was a mechanism to write something on that which could be fed in to that system then we'd be in a much better position.

AS: Definitely.

Between pharmacists and patients...

NK: At the moment I don't think community pharmacists are particularly well prepared for the discussion about Specials medicines with patients. I don't think they're prepared for the fact that the person in front of them may not have any relevant information about their choice in the matter, the fact that it might take longer to come through, the fact that they've got to be more careful about it, that it doesn't necessarily last for the rest of their life and that they may have it for a specific period of time. None of that, from what I hear from my colleagues, is happening consistently in community pharmacy and that is a big problem.

LN: What are the conversations that prescribers should be having with patients to make sure they know exactly why they're being prescribed this medicine and how to take it?

AS: Having a discussion around the method of absorption, having a discussion about the quantity and the actual form of the medication with the patient is all important. Most of the cases it tends to be the liquid preparations that we use for Specials. They're unlicensed so ideally the GP should be having that discussion with patients at the point of prescribing and explaining to them the reason of the choice. But also, at the same time, offering, ideally, the opportunity to use a licensed product in a different form if that's available. So it's only on the rare occasion that we'd really use Specials if there was, for instance, a swallowing difficulty or if it was a PEG feed that they need to put the medication through it.

LN: Dr Minesh Patel, chair of the Horsham and Mid Sussex CCG, said he is amazed by the amount of people that come into surgeries in his area and almost demand Specials saying they are entitled to the drugs, leading to unnecessary Specials being prescribed. Carla, do you think patients are informed? Do they know what they're entitled to and are they part of that decision making process?

CJ: I would say there are a lot of people in the UK who don't realise they have an allergy and there is a growing number who think they have

allergy and have never been tested. There's a huge need for guidance and information for patients as well as us as a patient organisation.

LN: Who would you look to to provide that guidance and support in terms of helping patients understand Specials and educate them a lot more?

CJ: I think it's a variety of stakeholders, it's the pharmas, Specials as an industry, the pharmacists and the GPs. We need to look at how we can collate something can be used as guidance across those groups.

MR: I'm sure patients would love to know the evidence base of the Special medicine that is being prepared for them. They appreciate they've got a clinical condition, that it's a bit unusual or it's a bit difficult, a bit tricky and that adds up to a special clinical need that cannot be fulfilled by existing licensed medicines.

CJ: Some people may have a fatal reaction to a component in a medicine and that's why you have to have Special medicines for them. It's incredibly important.

AS: It's interesting but I think you should remember that, also, not every single thing that we use and prescribe has got an evidence base to it. They may feel better with it and it's working for them, and it's going to prevent them going into hospital and give them a better quality of life. We use medications like this all the time and we forget. We use placebo medication indirectly throughout all our clinical practice. That's really important to bear that in mind so I think about Specials and actually unlicensed medications. Most of the medications that we use as GPs for young children are all unlicensed, paracetamol, Ibuprofen haven't really been tested in babies or in two or three yet we use them on a regular basis.

CJ: We have a lot of patients that contact us about Specials who are caught in these debates and they can't get what they need at all because the pharmacist they're going to is saying "it's not my responsibility; it's the GP's" and the GPs are saying "no it's not my responsibility, it's the pharmacist's responsibility". Then they're calling us and we're saying we can't advise you because we legally can't tell you what medication you can take or not take. So these poor families are stuck between a triangle and us.

MR: In all my time working within CCGs it is actually my job to get medicines that patients need to them. The issue there is the word need as opposed to want or fancy.

TR: So if there's been discussion between patient and GP, ideally with the pharmacist's involvement, and they are satisfied that this is the treatment that meets a documented special clinical need, then that is the end of the conversation. It's down to the community pharmacist, hospital pharmacist or whoever to then source that product in the most reasonable, sensible way they can and it should be possible to achieve a timely supply to the patient. If there's questions about the special clinical need then there's a risk of you getting into a ping-pong discussion, and therefore delay.

AS: We still have postcode prescribing and still have postcode medications available in some CCGs and some not. I'm all for patient choice but there also has to be an element of clinical decision making without the patient having the final say. Because we have an ultimate NHS budget and if we can treat 100 patients with a slightly substandard drug, we have to look at how far the funds will go.

SG: Some of our members have had patients saying they can't get access to a Special and are asking them directly what they can do? So there is a real need that sometimes isn't being met.

Between primary care and secondary care...

LN: What communication do you get from secondary care when they recommend a Special be prescribed?

AS: Essentially we just get a one-page letter with the name of the condition and the medication to prescribe. The clinical letter sometimes comes weeks or even months afterwards because we're that behind in the NHS in terms of IT and technology. If we got the IT sorted out within the organisations and we worked as one big NHS rather than separate institutions, separate little clinics all over we would have a lot more patient success.

TR: A lot of what you're asking for is actually happening in hospital →

"I appreciate that the issue at hand is communication. Too often we enter debates about the passing on of prescribing for both licensed and unlicensed medications. I don't think it is particularly helpful in this context to try and separate these. When a medication is advised for a patient the initiating clinician should make that informed decision backed by sound clinical evidence. One of the key roles a pharmacist can play within the CCG is in supporting or challenging that rationale."

Dr Hasan Chowhan, clinical director, North East Essex CCG

pharmacy, probably much more so in areas like paediatrics than dermatology. The means of communicating what has been agreed in an easy, effective and timely manner to primary care is not there at present and we need to address that.

LN: How can we address that?

NK: Some of it is starting to happen thanks to the roll out of the summary care record to community pharmacists. A problem is that the money that's available for that is tiny to help them to set up the system so that we can actually get access. And that's only to read it. We're fighting for write access so that we can document any interventions that we make when we do have someone in front of us.

"Inherent in the drive for high quality and cost effective care, and in an environment where we need to reduce harm to patients, is clear, reasoned and timely communication between professionals and with our patients. There should be an expectation that patients make an informed decision about their treatments in the context of what the NHS can offer."
Dr Minesh Patel, chair, Horsham and Mid-Sussex CCG

"It is always a prescriber's responsibility to decide whether the patient has special clinical needs in which a licensed product can not meet, and should only be used where there is no suitable licensed alternative for example a soluble tablet instead of a liquid medicine. In my area, I am fortunate that I have GMMMG. This is the coordinating group for decision making around medicines and, in particular, high cost medicines for Greater Manchester. The group has a membership of GPs, secondary care, pharmacists and other key healthcare professionals. Their aim is to identify and champion the appropriate use of medicines across Greater Manchester taking into account patient safety. The group is formally accountable to the GM collaboration of CCGs and their work is facilitated and supported by the Regional Drug and Therapeutic Centre in Newcastle and the GM CSU. If I am not sure about any medication, I ring one of the members and get an answer. There has to be a discussion between primary and secondary care to determine the need and whose responsibility is it to review the patient. The request to prescribe specials by secondary care does not diminish the responsibility of the prescriber."
Dr Anita Sharma, clinical director – vascular, Oldham CCG

Key outcome three: Integration with secondary care

With around 80 per cent of Specials prescriptions or recommendations happening in secondary care, the importance of good communication and integrated structures between clinicians working in hospital and primary care is essential. Unfortunately, participants described a decidedly disjointed reality, with very little information flowing between the two.

SG: So would you say that a lot of the time Specials prescriptions come from secondary care?

AS: In my experience, 70 to 80 per cent of all recommendations for Specials medicines come from the hospital. These are specialist case conditions, mainly neurology departments and dermatology departments. As GPs we don't have the expertise, to make that swap so we tend to use the consultant guidance. However, the consultant, unfortunately, doesn't accept the responsibility as a prescriber of that medication so we in general practice accept it on the backing that a consultant has verified it, checked it through on their knowledge skill base. Then we ask and rely on the pharmacist to provide us with the safe preparation. It really does lie with the pharmacist and their ethical governance to make sure they choose a reputable company and have those assurances in place and to use potentially big companies, which have hopefully got the backing and the support and the guidance out there. I don't think it's the GP's job to explain the storage of how it's kept, how frequently it needs to be replaced, replenished or the expiry date because we wouldn't have that information, but the discussion of what medication it is needs to happen by the prescriber itself.

LN: Dr Minesh Patel, chair of the Horsham and Mid Sussex CCG, absolutely concurs what you're saying. He says that a lot of time Specialists in secondary care tell patients: "you need

this Special drug, go to general practice and they'll prescribe it for you".

AS: If we're getting 80 per cent of prescriptions coming from secondary care we have clinical pharmacists who work on the wards with these consultants who are supposed to be working side by side; having joint clinics. Therefore what is the role of the pharmacist in the hospital?

MR: I also spent some time working in hospitals. All of those Specials that were prescribed on the wards – in particular the newborns – they were all done with clinical pharmacist input. Many outpatient services do not supply routine medicines so a clinician might recommend a Special to a GP without clinical pharmacy input. A lot of them prescriptions happen in outpatients and outpatients are not necessarily sited within the main hospital; they have no pharmacist attached. People don't want to dispense medicines in hospital anymore so they go out on a letter to GPs without any clinical pharmacy input.

AS: It is worrying though because we do have clinical pharmacy specialists in pretty much each of the divisions of the medicine, i.e. you've got a clinical dermatology pharmacist, you've got a clinical gastro-pharmacist. These are all attached to a hospital, all attached to a clinical team, all attached to clinical wards and attached to the outpatients so therefore it begs to what is their role if they're not doing medicines, medication reviews or even working alongside their consultant colleagues to work on a mini formulary. Or is it the consultant's job, potentially, to ask that clinical pharmacist before prescribing medication before it goes out in the community where we know all the issues exist at the moment?

NK: Well we haven't got a hospital pharmacist representative around the table so it's difficult for us to comment on that I would have thought.

DE: Yeah, I think it probably is beholden on the consultant to ask the pharmacist. Again we're back to pharmaceutical care in its purist. I want to prescribe this for this patient, please go away and sort it out. →

"This is a continuation of the theme of communication. Most, if not all, of Special medications are prescribed on the recommendation of specialist teams. The question is not about taking responsibility, but in ensuring the clinical evidence base for that prescribing is sound. If there were national guidance on such formulations then this would address this issue and put to rest the continual debates about taking responsibility for prescribing."

Dr Hasan Chowhan, clinical director, North East Essex CCG

"Special medicines are often used where a licence for the particular application may not exist and usually under specialist supervision. Often there are local guidelines on who should prescribe and supervise treatment. It is vital then that standard information needs to support safe prescribing and monitoring of treatments as well as any necessary actions required that conform to both national and local guidelines. No professional should have to be compromised in the care they provide by a lack of good information and agreements on accountabilities."

Dr Minesh Patel, chair, Horsham and Mid-Sussex CCG

"I fully agree with Dr Anil Shah that most prescriptions come from secondary care. The patient is asked to see their GP for the prescription. If as a GP you refuse to prescribe, it damages your relationship with the patient. Patients don't know what Specials are and how they differ from other drugs. They think it is the cost issue why you won't issue the prescription. Dealing with an 'angry' patient is an uncomfortable situation for any clinician. When it comes to Specials, we must work together: All Together Now: 3 P's: Prescriber (Primary/Secondary care), Pharmacist and Patient."

Dr Anita Sharma, clinical director – vascular, Oldham CCG

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Key outcome four: The pharmacist's role

There is more of a need for pharmacists to play a more active role in Specials prescriptions than ever before – far from being passive dispensers, they must be involved in the patient's Specials journey and play a crucial clinical, consultative role.

LN: What support do pharmacists need to help them get more involved in the Specials discussion?

DE: Possibly, I think there are two issues that have driven it here. There was the peppermint water issue many years ago, which actually made the liability for Specials difficult – it drove an external Special supply. Then there was the constant refusal of the Department of Health to increase extemporaneous dispensing for years so you'd end up doing quite complex pharmaceutical preparations for three quid. You think well, what's the point? You could probably make more money on actually buying through a third party wholesale than you could actually make it yourself. So there was absolutely no incentive.

TR: There are still too many community pharmacists who believe that by outsourcing the preparation of Specials they outsource accountability. They do not. They are every bit as liable for the quality of the medicine they dispense now; whether they buy a Special made by somebody else or whether they make it themselves. The accountability and the liability do not change.

NK: So we have a situation where we've deskilled the profession in making their own products. So they buy in from suppliers. They're not necessarily looking for the right documentation. They don't necessarily always know what the right documentation is to look for. The work we've done on Specials guidance is to try and help pharmacists prepare themselves in a better way so that their confidence is in a good place to discuss Specials.

AS: In an ideal world it would very nice to work a bit more closely with pharmacists. Because I hear pharmacists have a good skill base and they're knowledgeable on medicines, the production of medicines and where to source them. However, with multiple pharmacies around the corner and patients having complete choice of where they go, the relationships that we used to have before with our local pharmacists don't exist.

DE: The community pharmacist intervention input is missing. If a GP or doctor has someone presenting to them with complex pharmaceutical needs and needs novel dose forms, there should be a mechanism to pay the community pharmacist for their time with something like a medication use review.

NK: One of the things we talked about at the Specials group was the possibility of doing a new medicine service if it was allowed for people coming out of secondary care with a prescription for a Special product. So the service is already there and there's a payment mechanism

already there for it. But Specials don't fit in that package so it seems a real shame not to make use of that service opportunity for this particular situation, which would help.

AS: You say it doesn't fit in there but from a clinical point of a view, as a GP, the medication use review is in place. So when the community pharmacist does see that patient they should be doing that automatically.

NK: Yeah but there are restrictions.

TR: There is a whole lot more involved in the decision about choosing a Special now than there was 20 or so years ago. Medicines are more complex and more potent, with potentially more toxic entities presented in more complex formulations. Doctors aren't trained in pharmaceutics and can't possibly be expected to keep up with the pharmaceutics of modern medicines. Many pharmacists struggle to do it but when it comes to prescribing Specials, pharmaceutics has now become far more important at the point of prescribing than it was then. That's why, now, I think pharmacists have to play a more active part than ever before.

NK: Thanks to joint liability, if pharmacists believe that there is a product that is as close to a Special as possible in a licensed format that is what they have to dispense. So then they are advised to go back to the GP and say, do you know this licensed product is available? Our ethical code says that that's what we should be dispensing. Some advice around that is mostly definitely needed.

LNT: I think we're (Specials manufactuerers) much more aware of the risks than the community pharmacies that are supplying them. Part of our role is educating them on the risks they're taking, which is why we take it so seriously. If there is anything we think would serve as an alternative we will supply them that information – it is not something legally that we have to do but ethically most of my staff are pharmacists and we take that seriously. It is about making sure that the patient gets a safe and efficacious medicine.

NK: The big challenge is confidence. The confidence to go back to the prescriber and challenge and discuss a Special. You need a different level of confidence to do that than you do in the general scheme of what else you do in your pharmacy. That's where the challenge comes to get the right result for your patient. ■

"Within the healthcare sector we are seeing the roles of clinicians blurring and overlapping. Pharmacists have an important role to play in the future of the NHS, and as seen by recent developments their role is evolving, but we must not blur the margins so much that we lose expert opinion."

Dr Hasan Chowhan, clinical director, North East Essex CCG

"With more than 400 million health-related visits to pharmacies every year, pharmacists play a vital role in effective use of medicines. Some people have more complex needs than others and all those involved need to contribute their skills in this area of prescribing, especially our pharmacist colleagues."

Dr Minesh Patel, chair, Horsham and Mid-Sussex CCG

"It is a pharmacist's professional duty to assist prescribers, whether it is primary care or secondary care to ensure that a Special is only used where there is no possible licensed alternative. I will go and add that it is the professional responsibility of the pharmacist to ensure that the most cost effective medicines are used. Both prescribers and pharmacists need to ensure the safety of all patients. We work together when it comes to prescribing controlled drugs, we work together when it comes to prescribing cost effective alternatives, why do we not work together when it comes to Specials?"

Dr Anita Sharma, clinical director – vascular, Oldham CCG