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Introduction

There is a window of opportunity for community pharmacists in delivering diabetes services. The medical profession cannot deliver what it is being asked to deliver for at least six and possibly 10 years. GPs are retiring at an earlier age, and nurses are also having a manpower shortage. The Diabetes NSF and the GMS contract are likely to put doctors under even more pressure resulting in the opportunity for pharmacists to take some of the burden of care. A new pharmacy contract is expected, where community pharmacists will be paid more for extra services and less for dispensing. The time is ripe to start considering new services and planning.

The Impact of Diabetes Mellitus

Diabetes mellitus is a common metabolic disorder, characterised by chronic hyperglycaemia with disturbances of carbohydrate, fat and protein metabolism. It can have serious complications.

Type 1 diabetes (formerly IDDM, or insulin dependent) results from destruction of the insulin producing beta cells. It accounts for about 20% of diagnosed diabetes (about 25 patients per average pharmacy contract), and generally affects younger non-obese people.

Type 2 diabetes (formerly NIDDM, or non insulin dependent) is caused by a combination of resistance to insulin action and an inadequately compensated insulin secretory response.

Table 1

<table>
<thead>
<tr>
<th>Impact of diabetes on a person</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>reduced &gt; 20 yrs in Type 1 ≤ 10 yrs in Type 2</td>
</tr>
<tr>
<td>CHD (mortality)</td>
<td>increased x 5</td>
</tr>
<tr>
<td>Risk of stroke</td>
<td>increased x 3</td>
</tr>
<tr>
<td>Renal failure</td>
<td>increased (leading cause)</td>
</tr>
<tr>
<td>Lower limb amputation</td>
<td>2nd commonest complication</td>
</tr>
<tr>
<td>Blindness</td>
<td>leading cause (in people of working age)</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>increased risk to baby</td>
</tr>
</tbody>
</table>

Prevalence

Diabetes affects 1 child in every 400 by the age of 16 and adults of all ages, but becomes more common in advancing years - reaching a peak in people between 65 and 74. It is significantly more common in non-Caucasian ethnic communities - up to five times more common in people of Asian descent and up to four times more common in people of African and African Caribbean descent. Around 1.4 million people in the UK (about 114 per average pharmacy contract) have diagnosed diabetes. At least a million (80 per average pharmacy contract) more are undiagnosed.

Effect of Poor Management

Poorly managed, diabetes reduces life expectancy by between 10 and 20 years, particularly by raising the risk of CHD and stroke. It is the leading cause of non-traumatic amputation, the leading cause of end state renal failure and the leading cause of blindness in people of working age. It can adversely affect the successful outcome of pregnancy for both mother and child.
The Costs of Diabetes

Estimates of the precise cost of diabetes vary. However, according to one study, diabetes accounts for some 9% of the annual NHS budget\(^6\). This represents a total of approximately £5.2 billion a year. The presence of complications increases the costs to social services four fold. Pharmacist consultations provided to people with Type 2 diabetes can decrease total health care costs by 20%\(^7\).

Table 2

<table>
<thead>
<tr>
<th>Impact of diabetes on health and social services</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS resources</td>
</tr>
<tr>
<td>Hospital inpatient costs</td>
</tr>
<tr>
<td>Hospital admission</td>
</tr>
<tr>
<td>Stay in hospital</td>
</tr>
<tr>
<td>Diabetic complications – NHS costs</td>
</tr>
<tr>
<td>Social service costs</td>
</tr>
<tr>
<td>Diabetic complications – social service costs</td>
</tr>
</tbody>
</table>

Deprivation and social inequality

The least affluent 20% of the population are at 50% greater risk (worse blood pressure and blood glucose control) than the top 20% (most affluent)

People in the lower socio-economic classes are disadvantaged by having a higher incidence of obesity, smoking more and have lower physical activity rates.

Improving Outcomes

A significant proportion of Type 2 diabetes can be prevented or delayed by a healthy lifestyle. Early detection, monitoring and appropriate management can reduce the risk and progression of the complications.

Market research data indicates that over the last 5 years remarkable increases in the use of antidiabetic medication, particularly metformin and the sulphonylureas, have occurred. This reflects the impact of the United Kingdom Prospective Diabetes Study (UKPDS)\(^8\), the largest study conducted on people with Type 2 diabetes. The study recommended that metformin is used as a first line treatment in the obese with Type 2 diabetes\(^9\).

There are a number of policy documents that are particularly relevant to this resource pack:

- the National Service Framework (NSF) for Diabetes
- the new General Medical Services (GMS) contract
- A Vision for Pharmacy in the new NHS (‘Vision’)
- ‘Tackling Health Inequalities: a programme for action’
- the White Paper ‘Building on the best: choice, responsiveness and equity in the NHS’
- the proposed framework for the new pharmaceutical services (PhS) contract
- NHS Priorities and Planning framework for PCTs

and website references for all of these documents can be found under ‘Useful websites’
Relevant Policy Documents

The National Service Framework (NSF)

NSFs set national standards and define service models for a specific service or care group, put in place programmes to support implementation and establish performance measures against which progress within an agreed timescale will be measured. NSFs apply to England only and diabetes is the fourth NSF following those of CHD, Mental Health and Older People.

NSF Goals
The goals of the NSF are to:

- Decrease the incidence of Type 2 diabetes
- Improve health outcomes of people with diabetes
- Reduce unacceptable variations in the quality of services for people with diabetes

To achieve these goals the scope of the NSF will encompasses:

- The prevention of diabetes, focusing in particular on the prevention of Type 2 diabetes
- The identification and management of diabetes in people of all ages
- The surveillance for and management of the complications of diabetes, including the rehabilitation and continuing care of those suffering the long term sequelae of diabetes, such as amputation, blindness and renal failure
- The effective management of diabetes in pregnancy

Standards for Diabetes Services (launched December 2001)
National Standards to improve the care for people with diabetes across the country are now available on http://www.publications.doh.gov.uk/nsf/diabetes/index.htm

These standards formed the first part of the Diabetes NSF and outlined a new care blueprint for people with diabetes. The Diabetes NSF contains twelve standards in the following nine areas:

- Prevention of Type 2 diabetes
- Identification of people with diabetes
- Empowering children, young people and adults with diabetes
- Clinical care of adults with diabetes
- Clinical care of children and young people with diabetes, including the transition from specialist paediatric diabetes services to specialist adult diabetes services
- Management of diabetes emergencies
- Care of people with diabetes during admission to hospital
- Diabetes and pregnancy
- Detection and management of long-term complications of diabetes and the provision of integrated health and social care

Delivery Strategy (launched January 2002)
The initial emphasis of the Diabetes NSF for the first few years was to put the building blocks in place that would allow the Strategy to be delivered e.g. setting up diabetes networks.

A National Clinical Director for Diabetes (Diabetes Tsar), Dr Sue Roberts has been appointed.
Early milestones
There are only 2 national diabetes milestones to be achieved before 2006, to:
• Provide digital retinopathy screening to 80% of people with diabetes,
• Update primary care diabetes registers in general practice, and to systematically review care
data and patient notes

All other diabetes specific milestones to be achieved between 2006 and 2013
Primary Care Trusts (PCTs) should be looking at all the standards, and working towards achieving
them by 2013. They have been tasked with reducing health inequalities and improving access to
services.

The NSF Delivery Strategy recommends targeting those with the highest risk of complications and
getting good control early. It suggests PCTs could phase the introduction of systematic treatment
regimens by focusing initially on people diagnosed with diabetes after April 2003 (along with those
with poor diabetes control).

At present community pharmacists are not generally recognised as being part of local diabetes
networks.

The Department of Health’s long-term conditions care group workforce team is looking at how the
roles of all health care professionals, including community pharmacists, might be enhanced to
provide better support for people with diabetes.

The Delivery Strategy mentions new roles: ‘Diabetes services are well positioned to take advantage
of the extension of prescribing to nurses, pharmacists and allied health professionals. Pharmacists
are a regular point of contact for people with diabetes and can play a central role in improved
medicines management.’

Whether PCTs will involve pharmacists in any new service will be up for local discussion, and the
new pharmaceutical services (PhS) contract.

Traditionally, the main involvement of many community pharmacists in the diabetes network
would be to liaise with a variety of people e.g. GP practice clerks, diabetes specialist nurses, to
ensure the patient gets the right medication/ appliance e.g. the right tablet/insulin, pen/cartridge,
needles, and lancets.

The new General Medical Services (GMS) contract
- the implications for community pharmacy

The two NSF ‘early milestones’ are not directly related to pharmacy services. However, the new
GMS contract for GPs (full implementation by April 2004), could offer options for pharmacy. GP
practices will have the opportunity to receive additional funding by reaching certain quality targets.
GPs working under a PMS contract will have to decide whether they would be better off under the
new GMS contract, or not.

Much of what is listed in the new GMS contract is already a high priority on a PCT’s agenda in
meeting the NSF targets.
How points are earned
Of the 550 points awarded to GPs under the new contract for achieving clinical quality indicators, 99 points are for diabetes (18%) and Table 3 lists the top 5 clinical indicators for diabetes, making up over half the total points awarded for diabetes. An average 3 partner practice of list size 5,500 could earn £75 per point in 2004/5; £120 per point in year 2005/6.

Quality indicators not listed in Table 3, are for recording, in the last 15 months, the smoking status of the person with diabetes, their BMI, HbA1c, BP, total cholesterol, retinal screening, neuropathy testing, peripheral pulses, microalbuminuria, serum creatinine. [It is interesting to note that the quality indicators, at this point in time, are only for recording and not improving.]

Finally there are indicators for offering smoking cessation advice/ referral, treating patients with proteinuria or microalbuminuria with ACEIs (or A2R blockers) and giving people with diabetes an annual flu jab.

Table 3
The top 5 clinical indicators for diabetes in the new GMS contract for GPs

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Points for achieving targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice producing register of people with diabetes</td>
<td>6</td>
</tr>
<tr>
<td>55% with last BP of ≤ 145/85 mmHg</td>
<td>17</td>
</tr>
<tr>
<td>In last 15 months:</td>
<td></td>
</tr>
<tr>
<td>50% with last HbA1c of ≤ 7.4%</td>
<td>16</td>
</tr>
<tr>
<td>85% with last HbA1c of ≤ 10%</td>
<td>11</td>
</tr>
<tr>
<td>60% with last total cholesterol of ≤ 5mmol/L</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total points for achieving these targets in these 5 indicators</strong></td>
<td><strong>56</strong></td>
</tr>
</tbody>
</table>

Table 3 refers to people with diagnosed diabetes. GP practices are aware that proactive screening for diabetes, could significantly increase the workload of GPs and nurses in trying to achieve the quality targets indicated.

Pharmacists could state their case in terms of helping with smoking cessation, and medication reviews to tackle concordance and reduction of waste. In the future, supplementary prescribing pharmacists may well be able to carry out chronic disease management reviews, even if initially they only monitor hypertension.

The new GMS contract under ‘medication review’ rewards reviewing:
- ‘80% of patients on 4 or more medicines in the last 15 months – excluding OTC and topical medication’ [7 points], and
- ‘80% of patients on repeat medication in last 15 months excluding OTC and topical medication [8 points]
A Vision for Pharmacy in the New NHS (‘Vision’)

This document describes the progress made so far against the targets set in Pharmacy in the Future and states that community pharmacy should:

• Be – and be seen to be – an integral part of the NHS family providing primary care and community services
• Support patients who wish to care for themselves
• Respond to the diverse needs of patients and communities
• Be a source of innovation in the delivery of services
• Help deliver the aspirations within NSFs
• Help tackle health inequalities

The ‘Vision’ particularly emphasises the following roles for community pharmacists:

• Supplementary and independent prescribing
  • Diagnostics and monitoring
  • Medicines management within the NSFs

• Public health – tackling smoking cessation, obesity and minimizing health inequalities.

The ‘Vision’ states say that PCT pharmaceutical advisers and pharmacist members of PCT professional executive committees (PEC) have a key role in taking this work forward.

Tackling Health Inequalities: A Programme for Action

This document highlights the importance of community pharmacists in addressing health inequalities and reinforces public health messages with key interventions which include:

• Reducing smoking in manual social groups
• Preventing and managing other risks for CHD (and cancer) such as poor diet and obesity, physical inactivity and hypertension through effective primary care and public health interventions – especially targeting the over-50s
• Reducing smoking in pregnancy

The Programme states that there should be improved access to primary care services in currently under-used areas, e.g. by making greater use of community settings and services, including community pharmacy.

Building on the best: choice, responsiveness and equity in the NHS

This outlines plans to increase access in primary care, including developing a range of primary care providers, as an alternative to appointments with GPs. Chronic disease management will happen in pharmacies rather than GP practices.

The NHS Priorities and Planning Framework for PCTs

The three year planning cycle initiated in 2003 has relevance to diabetes planning and priority specifically in relation to CHD and Older People.
The new Pharmaceutical Services (nPhS) contract (proposed).

Services relevant to diabetes and CHD (these two conditions are so interlinked that it makes sense to consider them together), are mentioned under:

• **Essential services**
  
  Offered by all contractors and include:
  
  • Dispensing
  • Repeat dispensing
  • Signposting patients to other health care providers
  • Public health – healthy lifestyle promotion
    – opportunistic one-to-one counselling on smoking cessation
    – opportunistic one to one counselling of CHD patients on CHD risk factors
    – promotion of flu vaccination in at-risk groups (e.g. diabetes, CHD, Older People)
  • Medication waste disposal
  • Clinical governance requirements e.g.
    – patient questionnaires
    – intervention monitoring

• **Advanced Services**
  
  • Accreditation requirements – training & facilities
  • Gradual transition to providing the service giving time to implement changes
  • All contractors should eventually provide these services as part of the gradual contract development

The services currently proposed are:

• Medicines use review
  
  – the pharmacist undertakes medicines use review face to face with the patient
  – a concordance centred review, which assesses patients’ problems with current medication and its administration
  – a patient’s knowledge of medication regimen is assessed and developed
  – report fed back to the patient’s GP

• Prescription Intervention Service
  
  – initiated by a significant issue with the patient’s prescription
  – intervention made
  – feedback to prescriber

• **Enhanced services**
  
  • Specification and value agreed nationally
  • Commissioned locally by PCTs
  • The essential and enhanced contracts may include provision of a number of these services, in agreement with the local PCT
  • LPS will continue to be an option available to PCTs for delivery of local services
Some enhanced services may become essential or advanced services and include:

- Healthy living
- Diabetes screening
- CHD screening
- Concordance services
- Full clinical medication review
- Disease specific medicines management services
- Care homes and intermediate services
- Domiciliary assessment
- Prescriber support services (GP practice based)

**How does it all fit together?**

Government documents like the ‘Vision’; ‘Building on the Best’; ‘Tackling Health Inequalities’; NHS Priorities and Planning Framework; the NSF for Diabetes (medicines management); and the new GMS contract show the opportunities for community pharmacists in extending their role. The challenge will be using these opportunities within the new PhS contract, to start and sustain fairly funded new services.

**Practical Guidance**

The following section gives information which provides community pharmacists with discussion points, ideas, examples of services and relevant paperwork for use in discussion with PCTs about pharmaceutical services for people with Diabetes in the future and in the setting up and running of these services. The services have been designed to target the main priorities of primary prevention, management of diabetes and reducing complications of the disease and can be mixed and matched to tailor to local needs.
Prevention Of Type 2 Diabetes -
Raising Public Awareness

Aim: To reduce the number of people who develop Type 2 diabetes

Standard 1: The NHS will develop, implement and monitor strategies to reduce the risk of developing Type 2 diabetes in the population as a whole and to reduce the inequalities in the risk of developing Type 2 diabetes.

Obesity and inactively can increase insulin resistance, speed up the onset of Type 2 diabetes, in the genetically predisposed. A healthy diet and increased physical activity can delay this onset.The prevention of obesity in children and young adults is also important. Type 2 diabetes (originally named ‘mature onset’) has started to appear in obese young people, with an increased risk of their developing complications of diabetes earlier in life.

This service involves:

Increasing the general public’s awareness of:
- The signs and symptoms of diabetes
- The serious nature of diabetes and its risk factors
- The action to take
- An involvement in primary prevention;
  - healthy diet
  - increased physical activity
  - alcohol advice
  - smoking cessation (see Service 13)

Resources:
- Posters, leaflets (see Appendix 1)
- Local health promotion unit, pharmaceutical companies, Diabetes UK
- Videos, books, touchscreen systems [details at Diabetes UK]
- National campaigns - using material offered
- Local support programmes and initiatives
- Questionnaire devised to detect a need for knowledge and whether a person is at risk. (see Appendix 2 and the RPSGB guidelines).
- Window displays - e.g. during national ‘Diabetes Week or for a month at different times in the year. Research shows that people take notice of health messages in pharmacy windows.
- Dedicated display areas (one or two bays) - for leaflets, blood glucose meters, insulin travel wallet e.g. Frio (to keep insulin cool whilst travelling), blood pressure monitors, magazines
- Ethnic issues - local translators

Training/Accreditation:
CPPE distance learning
- ‘Improving the public’s health through Health Promotion’
- ‘Nutrition’ (second edition)
Evaluation:

- Advice is given in the RPSGB guidelines\textsuperscript{11,13}

Examples of campaigns/services

<table>
<thead>
<tr>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthy Eating and Increased Activity ‘Born to be Fat’ Campaign\textsuperscript{14}</strong></td>
</tr>
<tr>
<td>- ‘Eating more healthily and becoming more active’</td>
</tr>
<tr>
<td>- Registering clients</td>
</tr>
<tr>
<td>- Support material</td>
</tr>
<tr>
<td>- Weekly/biweekly weigh-in</td>
</tr>
<tr>
<td>- Group meeting</td>
</tr>
<tr>
<td>- Facilitated cooking and ‘activity’ classes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Barnet High Street Health Scheme\textsuperscript{15}</strong></td>
</tr>
<tr>
<td>- Promoting health - advice/information</td>
</tr>
<tr>
<td>- Communication skills</td>
</tr>
<tr>
<td>- Stickers on window to identify the pharmacy as participating in the scheme</td>
</tr>
<tr>
<td>- Steering group with representatives from the Health Authority and Local Pharmaceutical Committee (LPC), constantly monitoring the scheme and developing new initiatives</td>
</tr>
<tr>
<td>- Training</td>
</tr>
<tr>
<td>- Screening services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Green Light Pharmacy, Euston, London</strong></td>
</tr>
<tr>
<td>- Health Promotion</td>
</tr>
<tr>
<td>- Using trained ethnic speaking volunteers to interpret</td>
</tr>
<tr>
<td>- Weekly/biweekly weigh-in</td>
</tr>
<tr>
<td>- Group meeting</td>
</tr>
<tr>
<td>- Facilitated cooking and ‘activity’ classes</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Pharmacy, Tamworth</strong></td>
</tr>
<tr>
<td>- A client-operated touch screen facility for risk assessment, with the opportunity to discuss the assessment with the pharmacist</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Dorset LPC</strong></td>
</tr>
<tr>
<td>- Clients lifestyle risk assessed on a touchscreen programme</td>
</tr>
<tr>
<td>- Further tests e.g. BP, lipid profile – for those at high risk</td>
</tr>
<tr>
<td>- Counselling and advice offered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A Hertfordshire community pharmacist suggests</strong></td>
</tr>
<tr>
<td>4 levels of service which pharmacists could provide, to tackle obesity:</td>
</tr>
<tr>
<td><strong>Basic level:</strong> provision of advice and health education</td>
</tr>
<tr>
<td><strong>2nd level:</strong> Calculate BMI, and refer at-risk clients to their GP</td>
</tr>
<tr>
<td><strong>3rd level:</strong> A full weight management service with weekly consultations</td>
</tr>
<tr>
<td><strong>4th level:</strong> Supply of anti-obesity drugs on a Patient Group Direction (PGD)</td>
</tr>
</tbody>
</table>
Early Identification of Diabetes

Aim: To ensure that people with diabetes are identified as early as possible

Standard 2: The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes.

The onset of Type 2 diabetes occurs on average between 9 and 12 years before people are diagnosed, by which time up to 50% have signs of complications, and in no respect can it be termed a ‘mild’ form of the condition. The sooner a person knows they have diabetes, gets professional advice and acts on it, the more chance they have of delaying the progression of long term complications.

If Type 1 diabetes is suspected (losing weight etc), the person should be urgently referred to their GP.

Pharmacists should be aware that some diabetes professionals feel so overstretched at present that they maybe resistant to pharmacists identifying potential new cases. The NSF states that ‘further research is required to inform the advice on targeted screening for diabetes that the NSC (National Screening Committee) will provide in 2005’.

Community pharmacists now see the ‘apparently well’ and are therefore well placed to help identify people who have a predisposition to diabetes.

Pharmacist doing medication reviews on the general population, should keep the following target groups in mind for screening:

- People with signs and symptoms of diabetes
- Those who have previously been found to have impaired glucose regulation
- Women with a history of gestational diabetes
- People with multiple risk factors for diabetes e.g. age, ethnicity, obesity, family history
- People with heart disease or stroke

Resources:

- The RPSGB screening guidelines
- National campaigns - use material offered
- Local support programmes and initiatives
- Local translators
- Private consultation area
- Risk assessment questionnaire
- Pilot schemes – discuss initial plans and final results with LPC/PCT
- Advertise the service (posters, leaflets in the pharmacy and local practices; local newspaper)
Training:
- Multidisciplinary (ideally)
- Consistency of advice with local professionals
- Liaise with local diabetes specialists nurses, practice nurses
- Organise a training evening
- CPPE Diabetes Distance learning pack
- Accreditation [plus a sticker on the window to advertise this]

Equipment and Evaluation:
- Advice is given in the RPSGB guidelines\textsuperscript{11,13}.

Examples of services

<table>
<thead>
<tr>
<th>An example of a service piloted in one pharmacy chain</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Involves an initial questionnaire to assess risk</td>
</tr>
<tr>
<td>- Asked to return to pharmacy for a fasting blood glucose test</td>
</tr>
<tr>
<td>- Referral to GP, if above a certain level</td>
</tr>
<tr>
<td>- People are also referred to the service by GPs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Superdrug Stores plc</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Commercially available diabetes awareness packs were used</td>
</tr>
<tr>
<td>- Diabetes nurse educators visited the pharmacies and provided further information</td>
</tr>
<tr>
<td>- Screening sessions ran in the evening up to 9 p.m. – allowing extended public access</td>
</tr>
<tr>
<td>- Nurses offered blood glucose testing and counselling on results</td>
</tr>
<tr>
<td>- Nurse educators provided staff training when they visited, so that they could continue to provide the screening service.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RNIB Initiative (Bedfordshire LPC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Pharmacists and staff attended a training evening to identify patients at risk of diabetes</td>
</tr>
<tr>
<td>- Clients at risk were referred to optometrists to check for retinopathy</td>
</tr>
</tbody>
</table>
Cardiac Risk Assessment Programme

People with diabetes often also have Coronary Heart Disease (CHD) risk factors and it may be opportune to assess this at the same time as identifying potential cases of Type 2 diabetes.

This service involves:
- Blood pressure monitoring
- Cholesterol measurement, both TC and TC: LDL ratio
- Questionnaire assessment and referral
- British Heart Foundation
- British Hypertension Society

Resources:
- Private consultation area
- Information leaflets about CHD and the service
- British Heart Foundation
- British Hypertension Society
- National Service Framework for Coronary Heart Disease
- Liaison with local GPs on referral readings, referral notes etc

Training:
- CPPE distance learning
- Equipment training
- Liaison with local practice

Equipment:
- British Hypertension Society 'Approved' equipment to be used (see website)
- Near patient testing - lipids
  Supplier: Anglo European Marketing, Unit 10, Brenton Business Complex, Bond Street, Bury, Lancashire. BL9 7BE Tel: 0161 724 1983
- Quality control
- Touchscreen assessment
  Supplier: Hadley Healthcare, 96 Worcester Road, Malvern, Worcestershire WR14 1NY Tel: 01684 578678

Evaluation:
- Record of the number of clients referred to the GP practice
- Feedback from the doctors, nurses and clients
  – constructive criticisms, appropriate referrals?
Examples of services

Green Light Pharmacy, Euston, London
- Giving a leaflet about the service, including explaining the concepts of diabetes, CHD, cholesterol and healthy lifestyle, and their relevance to a client’s health
- High-risk clients identified and contacted for a follow up visit, at a pharmacy or GP practice
- Tests carried out - total cholesterol, BP, blood glucose, Body Mass Index (BMI)
- Lifestyle advice given - diet, increased physical activity, not smoking etc.
- Target groups: at risk over 30’s never having been screened for BP, cholesterol or diabetes; poorly controlled CHD and people with diabetes; ethnic minorities
- Initial targets - to screen at least 100 ‘at risk’ undiagnosed clients and refer/monitor/advise 200 previously diagnosed subjects
- Leverage for funding: use of resources and facilities at various sites (e.g. pharmacies, GP practice, community centers, churches, pubs, cafes), leaflets provided by Health Promotion Department, use of doctors and practice nurse at the Medical Centre, use of trained volunteer translators.

Primary Care Pharmacy, Tamworth
- People with symptoms of, or concerns about diabetes are booked an appointment
- Blood glucose, cholesterol and blood pressure are tested at the initial consultation
- The whole process takes less than 15 minutes
- Clients are asked to fast for 12 hours before the test for glucose (can drink water)
- Once diagnosed (at the GP Practice), clients then register for the diabetes monitoring programme (see Service 6)

The Healthy Heart (Dorset LPC)
- Touchscreen system incorporates the ‘Heartscore’ coronary risk programme
- Provides initial lifestyle risk analysis, with printout
- Blood glucose and cholesterol testing
- Alterable lifestyle risk factors and action plans to improve the health of the individual are given, including Exercise prescriptions
- Those at significant risk referred to their GP, using a referral protocol

Heart Disease Screening Programme (Harrow, London)
- Use the Coronary Heart Disease NSF
- Pharmacy liaison group involved Health Authority, PCO prescribing advisors and LPC members
- Training evening
- Target people coming into pharmacies to buy low dose aspirin, have a prescription dispensed for low dose aspirin, or response to window posters
- Short interview
- Results faxed to Webstar Health, a pharmacy Internet consultancy, for analysis
- Details are then passed to PCO advisers to be followed up with the patient’s GP Practice
Empowering people with diabetes

Aim: To ensure that people with diabetes are empowered to enhance their personal control over day-to-day management of their diabetes in a way that enables them to experience the best quality of life

Standard 3: All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process.

Provision of Education on Self Monitoring of Glycaemia (Diabetes Service 4a)

The NSF Delivery Strategy also states:

• People who take a greater responsibility for the management of their diabetes have been shown to maintain reduced blood glucose levels, with no increase in severe hypoglycaemic attacks, a marked improvement in quality of life and a significant increase in satisfaction with treatment.

The monitoring of glycaemic control is a patient-centred tool in the day-to-day management of diabetes. Tight glycaemic control improves long term outcomes. Pharmacists have shown that there is an additional need for motivating patients to test at recommended frequencies and action their results, and that they are well placed to do so.

People with Type 1 diabetes are given instruction on blood glucose meter use by their nurse or doctor. The situation is more variable with Type 2. Patients or their carers often purchase the meters, but may not receive instruction on best use or advice on undertaking quality control procedures.

It would be useful (and good PR) for pharmacists to discuss self testing with the local GP practice to ensure that patients are not given conflicting messages e.g. how often to test a person with Type 2 who is well controlled.

The NSF recommends that 'A personal diabetes record card that contains the clinical record of treatment and management (including test results) and is held by the person with diabetes and used by them and the diabetes team'. This could be a useful educational tool for the pharmacist, if accessed.

The service involves:

Helping patients with blood glucose monitoring:

• Through point-of-dispensing input to review quantities requested and used on NHS prescription
• Advice on the purchase/use and quality control of testing equipment

Purchase/use of testing equipment:

• Explaining the use of urine testing equipment
• Helping the client choose blood glucose meters, taking account of dexterity, visual disability, sample size needed and ease of use. A chart on different meters is available from Diabetes UK.
• Demonstrating blood glucose meter use, explaining the results, and helping the patient take control of their condition
• Giving advice on frequency of testing, timing in relation to food, recording results, storage of strips etc.
• Offering a facility to download blood glucose meter results to a computer program for analysis, to be used as part of a monitoring service [see Services 5, 6, 7]
• If appropriate, stocking a locally agreed range of monitoring equipment, but allowing for patient choice
• Giving advice/interpretation of results (especially important when client is ill)
• Explaining the difference between whole blood results and ‘plasma-equivalent’ ones. [The meter information booklet should clearly state which result is being displayed. If a meter converts the whole blood sample into a plasma-equivalent result – the latter shows a 12% higher reading on the display. This could cause concern if a client’s old meter displayed a ‘whole blood’ reading (i.e. 12% lower)]

Calibration and quality control of blood glucose meters:
• Supplying and explaining the use of manufacturer’s quality control solutions for blood meters
• Providing a blood glucose meter ‘MOT’ check facility.
  – Contacting the meter company helplines (see Appendix 1), and arranging for a representative to call and maybe sponsor an occasional meter testing day.
  – PCT funding
• Using a trained assistant, pre-registration trainee or the pharmacist to provide a standard calibration service
• Liaising with the local Pathology Department, if appropriate

Training/Accreditation:
• CPPE Diabetes distance learning pack
• Local training arranged by the Health Authority, PCT or LPC
• Training using meter company representatives (see Appendix 1)

Evaluation:
• Number of clients helped
• Feedback on the usefulness/problems with each monitor type
• Record of information given
• Evaluation questionnaire for feedback of the service from client

Examples of services

Dixon and Hall¹⁹
Multiple pharmacies e.g. Moss Pharmacy Ltd, Superdrug plc
Provision of Education on Diabetes Care and Medication (Diabetes Service 4b)

The NSF Delivery Strategy states that: ‘The provision of information, education and psychological support that facilitates self-management is a cornerstone of diabetes care’.

This service involves ensuring:

People newly diagnosed with diabetes
• Know how to test their urine/blood
• Know about support groups, locally and nationally
• Realize the importance of keeping their diabetes-care appointments

People on new medication
• Understand the dosage regime, and formulation recognition (e.g. insulin)
• Understand why this has been prescribed
• Understand the benefits of adherence to treatment
• Have any concerns about taking the treatment, addressed
• Know how to minimize possible side effects e.g. taking metformin after a meal
• Know to report any side effects, in case a change of treatment is needed

The need for appropriate and consistent education is strongly emphasized in the NSF. This could form part of the ‘medicines use review’ proposed in the PhS contract. It is important to identify any patient’s gaps in knowledge about their medication and also useful to reinforce:
• A healthy lifestyle (healthy eating, increased physical activity, moderation in alcohol consumption, not smoking)
• Appropriate footcare routine
• Keeping regular healthy-check appointments
• ‘Sick day’ rules (see Appendix 7)
• Recognition of hypoglycaemia & hyperglycaemia
  – how to prevent
  – how to deal with each

The use of questionnaires could identify knowledge gaps and save pharmacist time

Training/Accreditation
• CPPE Diabetes distance learning pack
• RPSGB Guidance

Evaluation:
• Number of clients helped
• Nature of the intervention
• Evaluation questionnaire for feedback on the service from client

Example of service:

Green Light Pharmacy, Euston, London
Diabetes Service [5]
Management of Type 2 Diabetes

Clinical care of adults with diabetes

**Aim:** To maximize the quality of life of all people with diabetes and to reduce the risk of developing the long-term complications of diabetes

**Standard 4:** All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimize the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.

### Medicines Management

A person with diabetes, generally needs increasing amounts of medication (for glycaemia, hypertension, neuropathy etc) with time. Undertaking medication review by pharmacists has been shown to improve the quality of prescribing, improve the patient outcomes and avoid inappropriate or unnecessary drug expenditure. It involves provision of information to the patient, appropriate referral to the GP or nurse and progress monitoring.

An in-depth review of patients’ medication can be carried out either within the GP practice, with access to the medical notes, or from the pharmacy - working solely from repeat prescriptions and Patient Medication Records (PMR). PMR only help to identify half of all medication problems. Talking to the patient identifies a further 30% and having medical records identifies the remainder. Access to medical records is therefore an important consideration when community pharmacists undertake a full medicines management service and viewing the medical notes prior to pharmacy appointments should be considered.

A number of research projects, including some funded by the Department of Health, have looked at both formats. These studies showed that where the pharmacist worked actively with the practice, recommendations were implemented in between 50% and 75% of cases. However, where feedback to the practice was of a passive written nature the implementation rate was much lower - at about 20%. The studies showed that medication review services were generally well received by both patients and the GPs and that a number of models can be successful.

Conducting pharmacy based medication reviews as an ‘enhanced PhS’ service will help contribute to the GMS quality framework standards on medication review (Nos 5 and 9)

The NSF recommends that ‘A personal diabetes record card that contains the clinical record of treatment and management (including test results) and is held by the person with diabetes and used by them and the diabetes team’. This could also prove to be a useful tool for the pharmacist.

To reduce health inequalities, PCTs need to focus on those with the poorest management of their diabetes and on populations at the greatest risk of developing the condition (see Services 1 & 2). Poor management could be due to problems with:

- Inadequate monitoring by professionals
- Monitoring but not changing treatment, when indicated
- Inadequate advice/education given
Or, lack of concordance could be due to:
• Inappropriate beliefs by patient
• Too complex a medication regimen
• Problems in access to medicines e.g. house bound or blister packs
• Depression
• Deliberate non-adherence to advice and treatment

Whether a service is designed to tackle just people with diabetes; those with diabetes and CHD; or all over 75 on 4 or more medications etc (joining up recommendations from the different NSFs, NHS Planning and Priorities framework, the NICE and the SIGN guidelines) is a matter to be determined locally.

The NSF Delivery document on the subject of pharmacists says ‘pharmacists are a regular point of contact for people with diabetes and can play a central role in improved medicines management’. This creates an opportunity for pharmacists to establish themselves within the diabetes care team.

Community pharmacists are the most easily accessible health care professionals. As part of the new PhS contract, PCTs could consider using them to provide information, education and psychological support, as part of the multidisciplinary team:
• Advanced services - medication use review
• Enhanced services - disease specific medicines management services
  - domiciliary assessments
  - full clinical medication review
  - diabetes screening

How to go about it:
The ‘Model Service’ (see Appendix 3)^28 gives practical ideas for the setting up of a service. It proposes a way for a pharmacist to work with doctors and nurses, ensuring that medication is used in the best way, focusing on realistic outcomes. Being comprehensive, it allows pharmacists to tailor it to their own requirements. GPs should be given a preview of these ‘tailored’ service proposals. A meeting should be arranged with relevant staff from the practice to agree a protocol for the medication review process. This will need to include the following aspects:
• How patients are selected for review
  – by the practice manager from the surgery computer system?
  – by the pharmacist from the PMR?
  – by the district nurse, GP or Diabetes Clinic as having problems with their medications?
• The mechanism of review
  – interview with patients in the surgery or pharmacy etc.?
  – access to medical records?
• Having a named person at the surgery to amend the patient’s notes, after GP agreement
• The process for implementing agreed changes
• Agreement for further meetings with practice staff for review of service

Once the protocol is agreed, it is a matter of identifying patients suitable for review. If the agreed protocols specify the number of patients to be reviewed and more are identified than can be accommodated, prioritisation may be needed.
A patient profile should be prepared from the computer records and/or case notes to include relevant medical history, allergies, current and previous drug therapy, recent investigations and monitoring by the practice and secondary care as available. Further guidance is given in Appendix 3 (E1).

Pharmacists recommending medication change/ addition/ removal to doctors, should be aware of local and National Institute for Clinical Excellence (NICE) guidelines (e.g. various ones for Type 2 Diabetes, also thiazolidinediones, insulin glargine and Type 1 diabetes)

The long term complications and costs of diabetes can be decreased, if early management is improved16, 17.

Resources:

Pharmacist cover:
- Locum/part-time staff to free up time when necessary

Training/Accreditation:
- Locally arranged training, workshop-style training
- Relevant CPPE distance learning is necessary before the workshops e.g. diabetes; medicines management; adverse drug reactions; angina, myocardial infarction and heart failure; hypertension and hyperlipidaemia
- ‘Room for Review’ guide to medication review

Other considerations:
- Private consultation area
- Access to medical records
- Appropriate computer systems
- Accessible literature
- Legislative issues

Evaluation:
The Summary of Care issues Appendix 3 (B3) serves well as an evaluation tool. Reasons for not attaining objectives and patients’/GPs’ opinions of the service should be noted.

Examples of Services:

‘Pharmaceutical Care using a systematic approach’23
This study showed that all the patients had medication problems that needed addressing, and the number of problems correlated to the number of chronic diseases. Implementation of pharmaceutical care plans by pharmacists resulted in 79% of the problems being resolved, particularly those relating to monitoring, dose discrepancies, repeat prescriptions not required, potential Adverse Drug Reactions and the need for education. 12.9% of the study had Type 2 diabetes.”
Diabetes Service [6]
Management of Diabetes

Disease Management Services

Aim: To maximize the quality of life of all people with diabetes and to reduce the risk of developing the long-term complications of diabetes

Standard 4: All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimize the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.

In recent years pharmacists have been involved in running disease management clinics e.g. hypertension, anticoagulation. These divert workload away from the GP, and patients benefit from longer consultations than are often possible during a busy GP surgery. There are few examples of diabetes clinics run by pharmacists, but those thinking about getting involved would need to discuss the way forward with local diabetes professionals. The new White Paper, ‘Building on the best: choice, responsiveness and equity in the NHS’, speaks of chronic disease management occurring in pharmacies - but there are barriers to overcome:

- To become a supplementary prescriber, a community pharmacist will need a local GP for mentorship, and for the PCT agree to fund training.
- To carry out a disease management clinic away from the GP practice in a community pharmacy will require the availability of a suitably equipped private consultation area.

Resources:

Training/Accreditation:
- Relevant CPPE distance learning
- Supplementary prescribing course
- Drug company sponsored training
- Training/working with diabetes professionals
- Diabetes Diploma
- A check list for the review discussion (Diabetes UK website)

Further information is available under Useful Websites - Training

Protocols need to incorporate the following:
- Aims and objectives of the clinic
- How, why and when patients should be referred to the clinic
- The format of the clinic
  - who will interview the patients?
  - how will dosages of drugs be changed?
  - what should patient counselling cover?
- How often will patients be reviewed?
- What happens if a patient fails to attend?
- When should patients be referred for medical/nursing/dietetic/podiatric advice?
- What documentation is completed, by whom?
• Quality assurance of any testing or diagnostic equipment used
• Legislative issues

This service is rare at present, but those that can see the vision of a pharmacist working with a nurse and GP running a diabetes clinic, can draw from the following examples.

**Examples of Services**

**Diabetes Management Services [Primary Care Pharmacy, Tamworth]**
- Involves screening for hyperglycaemia, hypertension and cholesterol
- Referral to GP practice for diagnosis, if appropriate
- After diagnosis at the GP practice, the first appointment at the pharmacy includes the use of blood glucose meter and testing HbA1c, microalbuminuria, ketones; membership of Diabetes UK

Thereafter the pharmacist is involved in:
- Referral, adherence issues, recommending dosage adjustments, advice on use of insulin (checking technique), quality assurance of blood glucose meter every 6 months, quarterly HbA1c, quarterly BP, quarterly random blood glucose, annual microalbuminuria, annual foot check (podiatrist), medication review every 6 months, questionnaire for understanding of condition/treatment, management of optical assessment

**Dependent Prescriber managed Type 2 diabetes clinics [Labib Tadros, Darlington Memorial Hospital]**
Even though this is a service by a pharmacist in secondary care, it has served as a model for PCTs to learn from and adapt for primary care. The pharmacist initiates medication and adjusts dosages, liaising with a diabetes physician.

**Harrogate and Durham** hospitals have examples of pharmacist-led clinics for people with diabetes and hypertension

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**Diabetes Service [7]**

**Management of Diabetes**

**Repeat Prescribing/Pharmacist Intervention Schemes**

**Aim:** To maximize the quality of life of all people with diabetes and to reduce the risk of developing the long-term complications of diabetes

**Standard 4:** All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimize the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.

Up to 75% of prescriptions issued by GPs are repeat prescriptions where the patient does not actually see the doctor and account for an estimated 81% of prescribing costs in general practice. A review of repeat prescriptions and the controls in place for their issue can identify many opportunities for reducing costs.

In many practices a review of repeat prescription requests will reveal that a large number of patients consistently reorder all items on their repeat request form, despite not needing all their medication. This can particularly arise where the repeat prescription includes a mixture of items prescribed for varying duration, ‘prn’ items, and products prescribed by pack size e.g. injections, lancets, creams, cottonwool.
Prescribing support to practices can take two forms in relation to repeat prescribing - advice on safe and appropriate repeat prescribing system, or a brief review of some (e.g. diabetes and CHD) or all repeat prescriptions by a pharmacist.

Core services proposed as part of the new PhS contract will actually ensure GP practices meet some of the GMS goals e.g. repeat dispensing as an essential PhS service will ensure that standards related to the request for repeat prescriptions (numbered Med 4 and Med 8 in the new GMS framework) are much easier to achieve.

The NHS Repeat Dispensing Pathfinder Trials funded by the Department of Health will also serve to inform the new PhS contract.

**Looking at the current system:**
A pharmacist should examine the current procedure for repeat prescribing within the practice, making sure that the views and experience of all the practice staff who are involved in the process are collected. It may also be helpful to follow the process through for a number of repeat prescriptions that are being prepared, looking at the separate steps involved e.g. verification of the request by practice staff, monitoring and review of medication, authorisation of the prescription by the GP.

**Within the pharmacy:**
Community pharmacists are in an ideal position to identify potentially inappropriate repeat prescribing from their Patient Medication Records - particularly situations where patients seem to be presenting prescriptions far more frequently than is expected. Such cases can be brought to the prescriber’s attention, through formal or informal contact with the practice.

Repeat prescriptions can also be involved in a narrower form of medicines management, targeting people with diabetes for a short review of medication by appointment. Points to arrange include:

- Agreed referral mechanisms
- Access to medication records
- Education and motivation of patient, negotiating adherence targets to improve outcomes

**GP Practice:**
A pharmacist who is working with a practice for one or more sessions per week and spends regular time within a practice may be able to become more actively involved in the repeat prescribing process. This could involve:

- Reviewing all repeat prescriptions for diabetes and cardiovascular disease
- Dealing with ad hoc queries that have arisen from repeat prescriptions

Repeat prescribing is a way for community pharmacists to control and monitor repeat prescriptions. It may be a vehicle for providing pharmaceutical care as well as having the capacity to reduce medicine overuse. It has been found that the more technical and complicated a prescription item is e.g. new dressings, insulin, needles, syringes, tablets, the greater the chance of error and waste.

This service would save on the GP’s budget, since according to RPSGB standards, pharmacists must not take back into stock dispensed items that have left the pharmacy (e.g. when patients have mistakenly ordered them).

Community pharmacist input at point-of-dispensing has been shown to improve blood glucose levels and increase patient adherence to diabetes medication to 90%, and has been demonstrated to have positive effects on blood pressure control in patients with hypertension.
Resources:
• The PCT pharmaceutical adviser or your LPC secretary will have access to ‘Intervention Schemes’ that have already been developed.
• Examples of good practice are available on the PSNC’s database of community pharmacy services at www.psnc.org.uk/database.
• A short review form can be useful (see Appendix 4).

Evaluation:
• Log the number of interventions recommended and actioned.
• Record reasons for not attaining objectives.
• Note patients’/GPs’ opinions of the service.

Examples of Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit of pharmacist intervention in the dispensing process [Morecambe Bay LPC]</td>
<td>Each FP10 prescription was checked against the Patient Medication Record held. Items which appear to be repeated unnecessarily e.g. duplicated items or discontinued items were checked by the pharmacist with the GP practice and patient to verify that this was intended. Evaluation showed that even within a limited scheme, considerable net savings to the NHS were made.</td>
</tr>
<tr>
<td>Community Pharmacy intervention scheme [Sheffield LPC]</td>
<td>Approved interventions were identified by the community pharmacist and actioned by the GP practice. Results showed financial savings for the PCO, improved communication between pharmacy and GP practice, involvement of community pharmacy in helping GPs achieve their incentive scheme targets and the PCO to achieve its objectives.</td>
</tr>
<tr>
<td>Community Pharmacy Prescription Intervention Scheme [South Cheshire LPC]</td>
<td>Accredited pharmacists made opportunistic changes to patients’ medication at the point of dispensing.</td>
</tr>
<tr>
<td>Community Pharmacy Intervention Scheme [Rotherham PCT]</td>
<td>Following pilots that produced significant savings, a scheme was set up for community pharmacists to identify changes to the patient’s prescription which would result in clinical benefit for the patient and/or cost savings to the PCT. The scheme also provided a formal notification process between GP and community pharmacist and is a further example of the beneficial collaborations established in Rotherham.</td>
</tr>
<tr>
<td>Prescribing Efficiency Scheme [Cotswold PCT]</td>
<td>Assessment and review of prescribed medication, at the point of dispensing, for interventions which would result in a financial (GP practice) and clinical (patient) benefit.</td>
</tr>
<tr>
<td>Community Pharmacist Intervention Scheme [South Hams &amp; West Devon PCT]</td>
<td>Quality, cost – effective interventions were made at the point of dispensing repeat prescriptions by community pharmacists.</td>
</tr>
<tr>
<td>Repeat Prescribing Study [Merton, Sutton and Wandsworth Health Authority]</td>
<td>Involved a questionnaire gauging patient satisfaction with repeat prescription services.</td>
</tr>
</tbody>
</table>
Diabetes mellitus is one of the most chronic diseases of the elderly. Approximately 20% of the population are over the age of 65 years and the prevalence of diabetes is under-recorded and growing. It has been suggested that people with diabetes in care homes are a forgotten population. Studies assessing diabetes within residential homes have calculated an incidence around 20%, with only half of these diagnosed. Although it appears that diabetes control is generally monitored, few results are acted upon and protocols, when they do exist, tend to be ambiguous and non-specific. This figure is projected to double in the next 10 years. Medicine management services have to be in place nation-wide by 2004, for older people.

Evidence:
Previous studies on medicines management in residential homes involving pharmacists, have improved the pharmaceutical care of patients and produced a reduction in prescribing costs. Older people with diabetes in care homes are in great need of such care.

Resources:
• Guidelines from Diabetes UK show what sort of general care a resident should have, but do not mention pharmacist involvement
• Liaison with PCTs, LPCs, Residential/Nursing Home Inspectorate, Clinical Governance leads, pharmaceutical advisor, training personnel

Evaluation:
• Interventions
  – number proposed and number implemented
  – interventions not acted upon and reasons
  – documented outcomes
  – potential cost implication, if appropriate
• Quality of prescribing before and after the intervention
• Medication usage before and after intervention
• Cost of provision
• Time implications
• Hospital admissions
• Qualitative feedback from prescribers, persons in charge of homes, and participating pharmacists

(Also see Appendix 3, 4 and 5)
Domiciliary Pharmaceutical Services

Aim: To maximize the quality of life of all people with diabetes and to reduce the risk of developing the long-term complications of diabetes

Standard 4: All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimize the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.

Often the patients who would most benefit from a review of their medication are those who are unable to visit the GP practice or pharmacy in person. Medication review can be undertaken in the patient’s home\textsuperscript{42}, although this is obviously more time consuming than GP practice or pharmacy based services. This is a particularly useful service for chronic conditions like diabetes and cardiovascular disease. Care of older people has been highlighted with a National Service Framework\textsuperscript{38}.

This service includes:

- A referral from social services, local GP practice
- Using the ‘tailored’ medication management model (see Appendix 3)
- Addressing any problems encountered e.g. tops, compliance aids
- Referral to the GP practice, if appropriate
- Ensuring the necessary monitoring is carried out at recommended levels: eyes, feet, blood glucose etc. - liaising with the GP practice
- With permission, checking for hoarding of medicines and destroying out of date ones

Resources:

- Liaison with PCTs, LPCs, social services, Clinical Governance leads, pharmaceutical advisor, training personnel

Evaluation:

- Interventions
  - interventions not acted upon and reasons
  - documented outcomes
  - cost savings, if appropriate
- Quality of prescribing before and after the intervention
- Medication usage before and after intervention
- Cost of provision
- Time implications
- Hospital admissions
- Qualitative feedback from prescribers, and participating pharmacists

Training/Accreditation:

- CPPE distance learning - Care for the Elderly, Diabetes, Adverse Drug Reactions, Visiting Patients at Home
Diabetes Services [10]

Management of Diabetes

Pregnancy

Aim: To achieve a good outcome and experience of pregnancy and childbirth for women with pre-existing diabetes and for those who develop diabetes in pregnancy.

Standard 9: The NHS will develop, implement and monitor policies that seek to empower and support women with pre-existing diabetes and those who develop diabetes during pregnancy to optimize the outcomes of their pregnancy.

Pre-conceptual advice should be given at the diabetes clinic. The management of the diabetes should normally be under specialist secondary care.

This supplementary service includes:

- Having dialogue with women of child bearing age, on medication which is contraindicated in pregnancy e.g. ACEI, glibenclamide, that when they are planning to have a child, to see their doctor for a medication review
- If planning a pregnancy, being advised on folic acid supplement, and stopping smoking and the benefits of tight blood glucose control before and during pregnancy. (These help reduce the risk of congenital malformation rates and perinatal mortality).
- Supporting and advising the patient through her pregnancy, checking if she is having any problems with her glucose control etc.
- Referring her to the appropriate clinic for a sooner appointment if necessary
- Ensuring the patient has ketone testing strips
- If running a glucose screening service, recalling women who have had gestational diabetes at regular intervals (agreed locally) after the birth

Evaluation:

- Interventions
- The follow up
- Referrals
- Feedback from professionals involved
Diabetes Service [11]
Management of Diabetes

Sick Day Rules

People with diabetes sometimes do not know how to manage their condition if they are ill. In these situations where they may think it is not serious enough to contact the doctor, or if they cannot get an appointment, a pharmacist is well placed to advise.

This service includes:
- A short questionnaire handed out with the prescription to establish their knowledge of ‘Sick Day Rules’
- An offer to discuss this with the pharmacist at the next visit
- A pharmacist going through a leaflet on Sick Day Rules with the patient (see Appendix 7)
- A pharmacist referring a person to the GP, practice nurse or diabetes specialist nurse with the appropriate degree of urgency, if necessary

Evaluation:
- Results from the questionnaires
- Uptake of leaflets
- Referrals to the GP
- Feedback from professionals involved

Diabetes Services [12]

Ethnic Issues

There are many pharmacies in high ethnic areas. Pharmacists having access to trained local translators (including Medicine Counter Assistants) can involve them in many of the services discussed in this PSNC resource pack.

Example of service:

Green Light Pharmacy, Euston, London has involved trained translators in the administration of questionnaires as part of funded education, screening and monitoring services.
Reducing the Complications of Diabetes

**Aim:** To minimize the impact of the long-term complications of diabetes by early detection and effective treatment and by maximizing the quality of life of those who develop long-term complications.

**Standard 10.** All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.

**Standard 11.** The NHS will develop, implement and monitor agreed patient protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death.

**Standard 12.** All people with diabetes requiring multiagency support will receive integrated health and social care.

**Smoking Cessation**

- Smoking cessation is relevant to:
  - Primary Prevention (NSF Standard 1)
  - Clinical Care (NSF Standard 4)
  - Management of long-term complications (NSF Standards 10,11 and 12)
  - GMS contract, PhS contract, ‘Vision’, ‘Priorities & Planning’

A smoker with diabetes (compared to a non-smoker), has:

- Twice the risk of dying with Coronary Vascular Disease
- 8 times the risk of dying, if hypertension and high cholesterol levels are present
- Double the chance of neuropathy (foot problems, impotence)
- Double the chance of microalbuminuria (a marker for renal failure)

Stopping smoking is one of the most important acts of self-care that a person with diabetes can do.

**Smoking Cessation Service already in place:**

Trained and accredited pharmacists and medicine counter assistants already providing a funded service, can proactively target people with diabetes and Coronary Heart Disease risk factors.

**Proposed New Smoking Cessation Service:**

Pharmacists not providing a smoking cessation service, but wishing to start as part of a ‘diabetes care’ package can:

- Contact their LPC for local initiatives to joint. If none available then;
- Ask the LPC or Pharmacy Development Group to investigate the potential for a funded smoking cessation service locally
- Contact the local PCT or local GP practice, and offer a smoking cessation service as part of a package

**Resources:**

- NHS Smoking helpline on Tel: 0800 169 0 169 - is useful for patients and professionals. Contact them for:
  - Posters, leaflets, stickers, ‘credit’ card
  - Asian Quitline numbers
- Contact your local LPC, Health Authority or PCT for a local smoking cessation contact
Training/Accreditation:
For pharmacists and MCAs, organised by:
• Health authorities, PCTs
• CPPE, NPA - distance learning packs

Training to include:
• Behavioural Change Models
• Assessment of Readiness to Quit
• Update on NRT
• Update on Zyban (if appropriate)
• Mechanics of the Service

Equipment:
Details from PCTs, local ‘Tobacco control coordinator’ if available
• Leaflets
• Posters
• Carbon monoxide monitors
• Smokers Self Help Packs
• National campaign materials around ‘No Smoking Day’

Specialist Support (if available)
Referral to a specialist for clients requiring intensive support

Caution:
Smoking increases insulin resistance and also may affect the absorption of insulin after subcutaneous injection. When reducing or stopping smoking, it is advisable for people on antidiabetic medication (injection or oral) to monitor their glucose levels more frequently. Some will have been advised how to adjust their insulin, but others can be advised by a pharmacist or referred as appropriate.

Evaluation:
National Guidelines identify the need to strictly quantify the success of programmes. Data to be collected includes:
• How many smokers have been supported by the programme
• Profile of smokers, gender, age, postcode, ethnic group, pregnant, entitled to free prescriptions
• How many have successfully completed a course of treatment
• Initially one month quit rates and subsequently 12 month quit rates
• The number of staff employed through the service
• The overall cost of the programme
• Users impressions of the quality of the programme
Negotiation of funding could cover:

- Recruitment and/or referral from other health care professionals
- Initial interview, assessment of ‘readiness to quit’
- Quit date setting, carbon monoxide test, supply of NRT, advice
- Setting the time interval for the next interview, which would include a carbon monoxide test
- Carbon monoxide tests could be carried out every 2 to 4 weeks - up to 12 weeks
- Motivational telephone calls could be arranged in between visits to the pharmacy.
- The cost of NRT and Zyban, if through a Patient Group Direction or voucher service
- Documentation and submission for payment (agreement on frequency)
- Evaluation - agreement on outcomes assessment e.g. still stopped at 4 weeks, 12 weeks, 1 year

Examples of services:

- Wirral LPC and Wirral HA, North Staffordshire LPC, Doncaster and more

Patient Group Direction (PGD):
Pharmacists can legally supply NRT without a prescription, but they may wish to use it in an unlicensed way or to provide it as part of an agreed NHS service with prescription exemptions/charges applied.

A PGD could be developed for this and an example of a PGD for NRT can be found on the NHS Website, www.groupprotocols.org.uk and is entitled ‘Nicotine: Sample PGD for supplying NRT on the NHS.’

Examples of services:

- East Riding and Hull have a PGD for NRT and Zyban
- East London have a PGD for NRT
Diabetes Service [14]
Reducing the Complications of Diabetes

Diabetic Retinopathy

<table>
<thead>
<tr>
<th>Aim: To minimize the impact of the long-term complications of diabetes by early detection and effective treatment and by maximizing the quality of life of those who develop long-term complications</th>
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<tr>
<td><strong>Standard 12.</strong> All people with diabetes requiring multiagency support will receive integrated health and social care.</td>
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</table>

**NSF early milestone** to be achieved before 2006 to:

Provide digital retinopathy screening to 80% of people with diabetes,

A patient or their carer see a community pharmacist more than any other health care professional, and there are may opportunities for a pharmacist to assess if there is a need for intervention.

A pharmacist can help a person to delay the progression of retinopathy by:

- Early screening for diabetes and referring to the GP practice for diagnosis
- Helping the patient to manage their condition well, with education, advice and monitoring

**This service offers:**

- Active encouragement/reminding of a person to visit an optician or ophthalmologist at least annually
- Support with large labels etc. if needed

**Evaluation:**

- Number of referrals to the GP practice - because a problem has been detected e.g. patient having eye symptoms
- Number of referrals because eyes have not been examined for more than a year
Diabetes Service [15]
Reducing the Complications of Diabetes

Lower Limb Complications

Early detection and good diabetes control is the best way to help prevent/delay lower limb complications. Stopping smoking is very important. Diabetic neuropathy affecting the feet can lead to pain, ulcers and gangrene of toes, feet or legs of people with diabetes. Evidence of neuropathy may be found in up to 50% of patients with Type 2 diabetes, causing problems for about one-third of them. Lower limb and foot problems caused by peripheral neuropathy and ischaemia are common, causing prolonged hospital admission and amputation, and therefore costs. Although patients recognize the severity of their condition, they do not always accept their own vulnerability to foot ulcers. Many neuropathic foot ulcers are preventable, and a community pharmacist regularly asking patients at risk about their feet could potentially help to prevent foot ulceration, hospital admissions and even amputations.

The average hospital stay to treat severe foot ulceration is 27 days and 50% of all amputations are for people with diabetes.

This service includes:

• Proactive education/reminding of a good foot care routine by a pharmacist or trained Medicines Counter Assistant going through a foot care leaflet with a patient/carer (see Appendix 6)
• Proactive education/reminding of a patient (or their carer) to inspect their feet every day and report any changes e.g. colour, athlete’s foot, a sore etc.
• Proactive encouragement/reminding of a person to have their feet inspected by a professional (preferably a registered podiatrist) at least annually.
• Ensuring the patient is on the most appropriate medication e.g. care with a beta-blocker if the circulation is poor, most effective analgesia (considering tricyclics, capsaicin etc.)
• Educating the Medicines Counter Assistant to always check for diabetes when selling corn/athletes foot etc. remedies
• Early referral to the GP practice/podiatrist if foot problems are suspected
• A questionnaire could be devised to help detect early problems, and regularly put into the dispensing bags

Training/Accreditation:

• CPPE foot care distance learning

Aim: To minimize the impact of the long-term complications of diabetes by early detection and effective treatment and by maximizing the quality of life of those who develop long-term complications

Standard 10. All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.

Standard 11. The NHS will develop, implement and monitor agreed patient protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death.

Standard 12. All people with diabetes requiring multiagency support will receive integrated health and social care.
Evaluation:
• Number of referrals to the GP practice or podiatrist - because a problem has been detected
• Number of referrals because feet have not been examined by a professional, for more than a year
• Feed back about the service from the patients and professionals

Diabetes Service [16]
Reducing the Complications of Diabetes

Renal Complications

<table>
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Up to 40% of people with Type 2 diabetes have some degree of renal disease. Delaying the progression of diabetic nephropathy involves tight control of blood pressure and glycaemia.

This service involves:
• Checking with the GP practice for people with diabetes, with poor renal clearance
• Reviewing current medication and all new medication for renal clearance
• Checking whether a person newly started on for example an ACEI, is having their renal function monitored appropriately
• Appropriate intervention

Evaluation:
• Feed back about the service from the GPs
**Diabetes Service [17]**

**Management of the Complications of Diabetes**

**Impotence**

Up to 30% of men with diabetes suffer from erectile dysfunction. It can cause embarrassment asking for help, and few men attending diabetes clinics seek help.

**This service provides:**

- Leaflets to men with diabetes

The most sensitive way is to offer a set of leaflets e.g. on diet, increased physical activity, foot care, sick day rules and impotence, and to have a covering note saying the patient can discuss any of these matters with the doctor, nurse or pharmacist.

The value of this service is to give the patient the confidence to go to their doctor, armed with the knowledge of treatments available.

**Resources:**

- Leaflets on male impotence
- Impotence Association/ Helpline
  [PO Box 10296, London SW17 9WH; Tel: 08707743571]
- NHS Direct on www.nhsdirect.nhs.uk
- Local impotence clinics
- Knowledge about current treatments - counselling (from clinic), vacuum devices, self-injection medication, oral medication, penile implants
- Private consulting area

**Evaluation:**

- Compare the number of scripts per month for impotence products dispensed before the service starts with those after a suitable interval (e.g. six months to allow the service to become established).
- Record any feedback from patients or professionals
Integration into the Diabetes Team

More diabetes care is being devolved to primary care. PCTs may encourage local GPs to become generalists specialising in different disease states. Such GPs can be the lead in diabetes, working with a diabetes nurse, dietitian, podiatrist and a pharmacist who would be a resource on medication matters for the others in the team, e.g. the more judicial use of medication. In this way, the community pharmacists would support the GP Practice and become integrated into the local Diabetes Team.

**Resources:**
- Access to leaflets etc. using the same sources as the other professionals
- Access to medical records
- Access to the same local guidelines
- Protected time e.g. half a day a week locum cover to see patients with problems e.g. adherence, use of meter, explaining the results

**Training:**
- CPPE distance learning
- Multidisciplinary learning organised by the PCO
- Drug company sponsored
- Diploma (therapeutics, diabetes)

**Evaluation:**
- Number/type of queries asked by the other professionals
- Interventions
- Outcomes - successful or not
- Number referred
- Feedback from the other professionals
Example of service:

**Community Pharmacist involvement in Primary Care of Type 2 diabetes [Eastern Hull PCT]**

Working with Primary Care Trust diabetes clinic professionals, GPs and practice nurses and providing a community based expert resource for patients. The target group are those with Type 2 diabetes who do not visit the GPs, overweight, often male, smokers, high cholesterol, high BP. The pharmacist is developing a specialist/generalist role in the community.

**Training:**
- Local sponsored course
- Visiting the pharmacist led diabetes clinic at Darlington Hospital
- PCT sponsored training
- Diabetes UK Conference

Community pharmacy based service advising people with diabetes on aspects of medication, diet and foot care based on current guidelines. To reinforce information given by primary care diabetes clinics. Advertised to GPs and via surgeries and primary care clinics. Pharmacy holds information on diabetic/podiatric/dietetic/general health and pharmacist is available to reinforce, encourage and educate people with diabetes on the best method of health care and managing their condition. This includes the provision of relevant patient literature.

A pharmacist initially targets newly diagnosed patients, and later goes on to the more established. (Appendix 8)

**The Future:**
Developing a community pharmacy ‘clinic’ on a regular weekly basis (e.g. Saturday afternoon, when the pharmacy is closed) using an appointment system. Attending ‘case conferences’ at the clinic on one day a week. The funding for locum cover will come from the Primary Care Trust.

---

**Getting Involved**

Having decided you would like to become involved in providing diabetes services, actually doing so needs some planning.

It is important to influence the right people and promote a service that is seen as being needed locally. PCTs are more likely to take a bid developed by the LPC or Pharmacy Development Group (if established) that all local contractors have the opportunity to participate in, more seriously than an individual case. The proposed new PhS contract will help focus the discussions.

Whichever you go ahead with, discuss the service with local professionals.

1. **Who to Contact**
   - Local practice - GPs, nurses
   - Diabetes centre – physician, specialist nurse
   - LPC secretary, other local pharmacists
   - PCT Pharmaceutical adviser(s)
   - PCT executive committee pharmacist
   - Local diabetes co-ordinator
   - Local Implementation Team (names may vary). Check there is a pharmacist on the group, if not consider whether you would wish to join, and ask the LPC to nominate you, if you do

2. **Find out what the local PCT priorities are**
   - Does your area have a high ethnic minority population e.g. South Asian? There could be a need for diabetes/CHD screening
   - Has your PCT a large overspend on medication? Target the elderly on 4 or more medications (NSF for Older People target) – initially those with diabetes and/or CHD
3. Gather local evidence of need
Gather evidence of need for your service, by surveying ‘targeted’ (the cohort that would potentially need the service or their carers) patients/ customers with a questionnaire. The design of the questionnaire would naturally depend on the service under consideration. Test out your questionnaire with other professionals and some patients, and adjust as necessary.

Doing a small pilot to test the potential service out, would take you through the logistics of the new service, and point to any adjustments that may be needed e.g. use of pro-forma. Measure and document the outcomes and it could serve as evidence of need when a bid is put to the PCT.

4. Diabetes Register
All areas should be working on a diabetes register (early NSF milestone). Many areas are inputting into a diabetes register. If the results are available, find out (from e.g. specialist nurse, the local diabetes co-ordinator) some local details, for example:

- What percentage of patients diagnosed with diabetes have an HbA1c over 7, 8, 9, 10 etc.?
- Has there been a local diabetes and/or CHD screening programme? (important in areas with high ethnic minorities).

5. Presenting Your Business Case
Be ready to make formal or informal presentations. Try to make any presentation as professional as possible. Make use of presentational or word processing software, such as PowerPoint or Word if you can access it. Prepare a summary of points that you are going to discuss, to leave with the PCTO to consider.

Primary Care Trusts will be held accountable for the quality and performance of diabetes services. Find out what their ‘key issues’ are, and sell the ‘solutions’. So instead of talking to a PCT about providing a domiciliary medication review service for vulnerable people with diabetes, talk to them about how you can help them achieve their waiting lists by reducing the number of avoidable admissions. Have a positive meeting, with good will, approachability and a vision as to the difference a pharmacist can make.

The PSNC diabetes services in this resource pack have all been designed to fit in with many local needs and to complement their services. Pick and choose whichever parts you need to tailor your proposal.

Diabetes may not be a local priority, but PCTs still may be interested if they see your proposed services in Diabetes as targeting Government set national priorities such as coronary heart disease, medicines management or the elderly.

6. Costing out services
A comprehensive, well thought out proposal developed in conjunction with the PCT and that targets PCT priorities must be accurately costed before funding applications are made.

Steps to consider include:

- Agree standards with the purchaser e.g. seeing patients in the pharmacy is less expensive than seeing them at home. Some of the services listed in this resource pack can be done in between dispensing, but others may need locum cover.
- Break down the service into the individual components, basically ‘manpower element’ and ‘other resources’
A. Manpower Element
Pharmacist/assistant/technician time (including time for documentation)

Training
To determine the cost per day:
1. Take the annual salary
2. Add national insurance at the relevant rate
3. Add any additional company benefits
4. Divide by 46 to give weekly cost
5. Divide by 5 to give daily rate

Now you must identify all the tasks that need to be completed to perform each aspect of the service, and calculate how many hours and therefore what percentage of a day, you would need to complete that task

B. Other Resources
• Cost of equipment (non-disposable)
• Cost of disposable equipment e.g. lancets, tissues, disposable gloves, sharps bin
• Private space
• Furnishing
• Stationary
• Quality Control
• Advertising
• Telephone calls
• Petrol
• Monitored Dosage Devices

Add up all the individual human resource components to give a total figure in terms of days needed to provide the service. Likewise, you categorise your fixed and variable costs and calculate a total cost for each of these items.

This should be presented as a cost breakdown, as an appendix to your proposal.

When you submit your costing, you should be able to discuss them in detail and be confident that you can back up your assumptions with sound arguments.

7. Having Obtained the Funding
• Set up and manage the service
• Secure long-term commitment (consider at the start!)
8. Advertising of services
For those services that it is appropriate to advertise, you can use:

- Prescription bag inserts - leaflets, questionnaires
- Posters (in the pharmacy, GP practice, library, working men's club, ethnic community centres in the appropriate dialect etc.)
- Window displays
- Local media
- A leaflet drop (through letterboxes)

Let other professionals promote your service, by delivering what you have promised.

Standards
Pharmacists providing some of these extended services must make sure that they are adequately covered by indemnity insurance. Existing insurance arrangements, particularly for locums, may only cover the ‘traditional’ professional activities, and the insurance of the practice that you may be working with, doing some of the Diabetes Services in this resource pack, will not include liability for the actions of an independent professional working on the self-employed basis. Also make sure you are familiar with the relevant Code of Ethics requirements, and any additional guidance issued by the RPSGB that is relevant to the service you are providing.

Competencies
You need to tailor your training to the Services that you will provide, and there is advice throughout this resource pack to direct you.

Multidisciplinary working
Integrated care plans have been identified as the way forward in the management of patients with chronic diseases. Diabetes UK have defined integrated care for diabetes as involving the working together of all people involved in diabetes care, regardless of their role, in a partnership where each person is fully aware of the roles and responsibilities of the other people involved. A functional team is characterized by regular communication among its members and the pursuit of common and agreed goals.

Multidisciplinary working in diabetes has been highlighted by the Government. The (then) Health Minister, Jacqui Smith commented at the launch of the NSF Standards that partnerships between patients with diabetes and health professionals in primary care and specialist services must be at the centre of modern diabetes services. These partnerships are the key to delivering the NSF and improvement in patient care.

Resources
Sources of funding:

- Local Pharmaceutical Services
- Personal Medical Services
- General Medical Services
- Pharmaceutical companies
- Research and development grants e.g. Diabetes UK
- PCTs

Pharmacists will eventually have a new contract, which will ‘shift (pharmacists) away from being paid mainly for dispensing of individual prescriptions towards rewarding overall service’.
**Clinical Governance**

It is essential to regularly review any service provided to patients. Clinical governance is about improving outcomes. It focuses on high quality services for patients and accountability of those professionals providing them. In relation to a service for people with diabetes, clinical governance embraces setting and maintaining standards, monitoring and audit, continuing professional development, evidence based practice and risk management.

**Relevant courses**

These are listed in this guide under Useful websites - training and also in the RPSGB Diabetes Guidelines.

**Useful websites**

**Government Plans**

www.pharmacyinthefuture.org.uk
- Putting government policy into practice - specifically ‘Pharmacy in the Future’ and the ‘NHS Plan’

The NSF for Diabetes – also contains links to supplementary information, health inequalities, interventions details, draft service models, and qualitative work with patients.

http://www.dh.gov.uk/assetRoot/04/07/92/84/04079284.pdf
The NSF for Diabetes – One year on

http://www.dh.gov.uk/assetRoot/04/01/91/20/04019120.pdf
The NSF for Coronary Heart Disease

http://www.dh.gov.uk/assetRoot/04/07/00/99/04070099.pdf
A vision for pharmacy in the new NHS

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/fs/en
Tackling Health Inequalities: A Programme for Action

http://www.dh.gov.uk/assetRoot/04/06/83/57/04068357.pdf
Framework for the new pharmacy contract
Additional information: www.psnc.org.uk/contract - PSNC website, contract page

http://www.nhs.uk/nationalplan/
The NHS Plan

http://www.dh.gov.uk/assetRoot/04/05/89/62/04058962.pdf
The NHS Plan – Technical Supplement - target setting for health improvement

http://www.dh.gov.uk/assetRoot/04/07/65/22/04076522.pdf
Shifting the Balance of Power (guidance on commissioning of local services)

http://www.dh.gov.uk/ assetRoot/04/07/02/02/04070202.pdf
Improvement, Expansion & Reform: The Next 3 Years (Priorities & Planning Framework 2003-2006). This Framework applies the political objectives at a more local level. Local PCT Public Health Departments can be asked for the latest Public health report.

http://www.dh.gov.uk/assetRoot/04/06/84/31/04068431.pdf
Supplementary Prescribing guide

http://www.dh.gov.uk/assetRoot/04/06/69/43/04066943.pdf
The study, which was commissioned by the Department of Health, seeks to provide an account of service users’ and carers’ views of NHS diabetes services
Screening

http://www.nelh.nhs.uk/screening/diabetesproject/home.htm
Diabetes, Heart Disease and Stroke prevention project

Guidelines when writing protocols

http://www.dh.gov.uk/assetRoot/04/05/08/64/04050864.pdf - the introduction
http://www.dh.gov.uk/assetRoot/04/05/08/68/04050868.pdf - screening
http://www.dh.gov.uk/assetRoot/04/05/08/66/04050866.pdf - partnership working
http://www.dh.gov.uk/assetRoot/04/05/08/60/04050860.pdf - funding streams
http://www.dh.gov.uk/assetRoot/04/06/37/04060637.pdf - chronic disease management and self care

Guidance and Guidelines on diabetes

http://www.dh.gov.uk/assetRoot/04/06/74/11/04067411.pdf
Workforce matters – a guide to role redesign in diabetes care

http://www.nursesnetwork.co.uk/medicine/generalmed/04_05_03diabs.shtml
Recognising diabetes and guidance on standards

www.nice.org.uk
To access NICE guidelines

www.sign.ac.uk/guidelines
See reports 4 (vision); 9 (pregnancy); 10 (children/ young people); 11 (renal disease); 12 (foot diseases; 19 (CVD); 25 (Minimum data set); 55( management of Diabetes)

www.rpsgb.org.uk/pdfs/diabguid2.pdf
Guidance for community pharmacists on the care of people with diabetes

www.rpsgb.org.uk/pdfs/diabidentguid.pdf
Guidance on the early identification of diabetes by community pharmacists

www.psnc.org.uk/database
PSNC community pharmacy services database for information on local diabetes services

Changing Practice

The aetiology and pathology of Type 2 diabetes

Treatment of Type 2 diabetes

What pharmacists can do for diabetes

www.pharmj.com/pdf/pcp/200103/pcp_200103_article2.pdf
Monitoring and screening for diabetes

www.update-software.com/abstracts/ab001481.htm
Interventions to improve management of diabetes mellitus in primary care, outpatient and community settings (Cochrane Review)
www.managingmedicines.com
Medicines management and pharmaceutical care

**Leaflets**

Diabetes UK  www.diabetes.org.uk/home.htm
Asian Quitline  www.asianquitline.org
Has a leaflet on NRT and Zyban. Available in Bengali, Urdu, Hindi, Gujarati and Punjabi.

Living with Diabetes  www.dh.gov.uk/assetRoot/04/07/92/84/04079284.pdf
This booklet explains how the NHS aims to improve standards of care for people with diabetes, through a National Service Framework. Available in English, Urdu, Punjabi, Chinese, Gujarati and Bengali

**Diabetes Patient & Professionals Interest Groups**

Diabetes UK  www.diabetes.co.uk
Information for patients & professionals

Diabetes insight  www.diabetes-insight.info/
Information/support for patients

Diabetes monitor  www.diabetesmonitor.com

Diabetes one stop. com  www.diabetesonestop.com
Information for patients & professionals

**Training**

Training should be appropriate to the service offered. A population approach requires a basic or low-level training whereas the specific approach would require a higher level of training

Diabetes UK  www.diabetes.co.uk
but courses are mostly for nurses

Primary care Pharmacists Association (PCPA)
www.pcpa.org.uk

CPPE  www.cppe.man.ac.uk
basic knowledge

Warwick University  www.diabetescare.warwick.ac.uk
diabetes diploma

[Some drug companies sponsor professionals to do a Warwick University accredited course e.g. GlaxoSmithKline, Novo Nordisk]

National Electronic Library (NeLH)
www.nelh.nhs.uk

**National Organisations**

Diabetes UK (formerly the British Diabetic Association) is the national organisation for people with diabetes. It is a very useful first point of contact for all sorts of information (e.g. leaflets, videos) and advice.

www.diabetes.co.uk  (0845 120 2960)
British Hypertension Society was founded in 1981 to provide a forum to bring together research workers in the United Kingdom and the Republic of Ireland. They provide a comprehensive information service and are a useful contact for a variety of educational material (e.g. Leaflets, videos).

www.bhsoc.org (020 8725 3412)

The British Heart Foundation are involved in educating the public and health professionals about heart disease, its prevention and treatment.

www.bhf.org.uk (020 7935 0185)

The Pharmaceutical Services Negotiating Committee (PSNC) maintains the Community Pharmacy Services Database (www.psnc.org.uk/database) and is able to provide advice on the development and provision of services. Contact: Barbara Parsons, Head of Pharmacy Practice, PSNC, 59 Buckingham Street, Aylesbury, Buckinghamshire, HP20 2PJ.
E-mail: barbara.parsons@psnc.org.uk (01296 438404)

Medicines Management Project

Based exclusively in the community pharmacy setting, the project is to design a comprehensive medicines management service delivered by community pharmacists, which will be evaluated by academic researchers. The outcome will be a rigorously tested service which will provide much needed evidence for further development.

Contact: Helen Rhodes, Project Manager, Marine Avenue Surgery, 47a Marine Avenue, Whitley Bay, NE26 1LZ.
E-mail: Helen.rhodes@psnc.org.uk (0191 251 6064)
Website: www.medicinesmanagement.org.uk

The National Prescribing Centre produces a variety of publications, including MeReC, available for pharmacists providing prescribing support. Copies of the GP Prescribing Support Document, Competency Framework and other documents can be downloaded from their website. NPC also maintains a database of prescribing advisers.

Contact: The Infirmary, 70 Pembroke Place, Liverpool, L69 3GF. (0151 794 8134)

Collaborative National Medicines Management Services Programme
Contact: Richard Seal, Medicines Management Project Team Leader National Prescribing Centre, 70 Pembroke Place, Liverpool, L69 3GF.
E-mail: npc-mms@liverpool-ha.nhs.uk (0151 794 8137)

The National Pharmaceutical Association (NPA) is able to provide advice on the provision of services and have developed resource packs relating to a number of service developments.

Contact: Professional Development Team, National Pharmaceutical Association, Mallinson House, 38-42 St Peter’s Street, St Albans, Hertfordshire. AL1 3NP
E-mail: prof.dev@npa.co.uk (01727 832161)

The Royal Pharmaceutical Society of Great Britain (RPSGB) are able to provide advice on the provision of services and have developed a number of resource documents relating to diabetes including, ‘Practice Guidance on the Early Identification of Diabetes by Community Pharmacists.’

Contact: Liz Griffiths, Royal Pharmaceutical Society of Great Britain, 1 Lambeth High Street. London. SE1 7JN
Email: lgriffiths@rpsgb.org.uk (020 7735 9141)
**Glossary**

<table>
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<td>Angiotensin Converting Enzyme (ACE) Inhibitor</td>
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<tr>
<td>BMI</td>
<td>Body Mass Index - a measurement of height and weight</td>
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<tr>
<td>CPPE</td>
<td>Centre for Pharmacy Postgraduate Education</td>
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<tr>
<td>HAZ</td>
<td>Health Action Zone</td>
</tr>
<tr>
<td>HbA_{1c}</td>
<td>A measure of glycaemic control over the last 8 - 12 weeks</td>
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<tr>
<td>LPC</td>
<td>Local Pharmaceutical Committee</td>
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<tr>
<td>LPS</td>
<td>Local Pharmaceutical Services</td>
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<tr>
<td>MCA</td>
<td>Medicines Counter Assistants (assistants working in pharmacies trained to sell and advise on OTC medicines)</td>
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<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
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<td>NSF</td>
<td>National Service Framework</td>
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<td>National Pharmaceutical Association</td>
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<tr>
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<tr>
<td>OTC</td>
<td>Over the Counter medicines</td>
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<td>Primary Care Organisation</td>
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<td>Patient Group Direction</td>
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<td>TC</td>
<td>Total Cholesterol</td>
</tr>
<tr>
<td>TC:LDL</td>
<td>Total Cholesterol: Low Density Lipoprotein ratio</td>
</tr>
</tbody>
</table>
Appendices

Appendix 1

Sources of Diabetes Related Health Promotion Material

The following provide drugs, equipment, booklets, leaflets, posters, videos, identification cards, monitoring diaries, GP information, clinic packs etc. (local representatives will have specific details of what is available)

Diabetes UK
For various leaflets, videos
www.diabetes.co.uk - to download a limited number of leaflets
Tel 020 7424 1000  Fax: 020 74241001

Bayer plc
Tel: 01635 566331

Golden Key Company (SOS/Talisman)
Identity bracelets etc.
Tel: 01797 663403

Medic-Alert Foundation
Tel: 020 7833 3034  Fax: 020 7713 5653
Appendix 2

Coronary Heart Disease Risk Assessment Questionnaire

Should You be Helping Your Heart?

To find out whether you need to speak to your doctor or nurse about keeping your heart healthy, simple fill in this questionnaire and hand it in at the pharmacy. Please ask if you find anything confusing.

About your lifestyle
1. How old are you?
2. Has the doctor or nurse ever told you that you have - diabetes?
   - high cholesterol?
   - high blood pressure?
   - a heart problem?
3. Would you say you are overweight?
4. How often do you exercise?
5. How many cigarettes do you smoke?
6. How many times a week do you eat fried or fatty food?
   (e.g. sausages, pies, cheese, bacon, cake)
7. What is your ethnic origin?
   e.g. white, Asian, black, oriental
8. Please comment about your health or any condition you may have
9. Do you have a lot of stress in your life?
10. How many alcoholic drinks do you have in a week (singles or pints)?
11. How many portions of fruit and vegetables do you have in a day (normal helpings)?

About your family
12. Have any of your grandparents, parents, brothers or sisters had diabetes, heart attacks, strokes or heart problems?
   If yes, what happened

About check-ups
13. When did you last have these taken: - your blood pressure?
    - your cholesterol?
12. When was your diabetes last checked at the clinic/surgery?

Thank you for completing this questionnaire. Depending on your answers we might contact you for a chat. If you consent to this please leave your contact details below.

Name: ____________________________ Pharmacist: ____________________________ GP: ____________________________

Address: ____________________________ E-mail: ____________________________
Appendix 3

Medicines Management Model Service

Flowchart for Pharmacists

Patient Recruitment
1. Identification by pharmacist, or through referral from GP (A1) or others
2. Notification to patients through an insert in dispensed medicines (A2)
3. Verbal expression of interest by patient
4. Completion of consent form (A3 - two copies) if patient agrees to continue
5. Appointment made to attend pharmacy for review (A4)
6. Notification to GP (A5), enclosing copy of consent form (A3) if appropriate, plus Service Information Leaflet (A6) if GP is not likely to be aware of the service.

Pre-visit preparation
Medication regimen entered on Table 2 of form (B2), from Pharmacy PMR and/ or case notes. Metabolic control factors entered on Table 3 from the case notes by pharmacists having a greater involvement in advising on medication adjustment.

First Medication Review
1. Completion of patient’s Personal Data Sheet (B1) for record folder
2. Completion of Pharmaceutical Assessment Questionnaire (B2)
3. Completion of Summary of Pharmaceutical Care Issues (B3)
4. Completion of Current Medication List (C3)

No Problems Identified
1. Patient given general advice and reassurance
2. Post-visit letter (C2) sent to GP, along with copy of Current Medication List (C3) and Summary of Care Issues sheet (B3) marked ‘NONE’
3. Follow-up phone call to patient, later
4. Monthly claim form sent to commissioning body (e.g. PCO)

Minor or Major Problems Identified
1. Details of each Pharmaceutical Care Issue entered on Care Action Plan sheet (C1)
2. Patient given advice and follow-up action identified
3. Post visit letter (C2) sent to GP, along with Summary of Care Issues sheet (B3 - green copy), Current Medication List (C3), and any Care Action Plan Sheets (C1) requiring GP co-operation (pink and blue copies)
4. Blue copies completed and returned to GP

Second Medication Review (within 3 months)
1. Care Action Plan sheets (C1) updated
2. Summary of Care Issues sheets (B3 - white and yellow copies) updated
3. Amended Medication List completed (D2)
4. Final letter (D1) sent to GP, with Medication List (D2) and completed yellow copy of B3
5. Follow up phone call to patient
6. Monthly claim form sent to commissioning body
Appendix 3

Medication Management in Diabetes

Dear (Pharmacist)

I would be grateful if you would arrange to see this patient and assess how well his/her medicines are being managed.

Name:  
Address:  

Male/Female:  
Date of Birth:  
Tel. No.  

This patient has diabetes (on diet alone, or diet/medication) and appears to fulfill the inclusion criteria for Medicine Management in Diabetes services, i.e. at least one criterion from each Box:

[Tick where appropriate]

Box 1

Having problems with their medication or poor control?

Box 2

On antihypertensives, lipid lowering agents, nitrates, digoxin, warfarin, GTN?

Taking 4 or more medications?
Living alone/poor home support?
Poor medication compliance evident from practice records or other information?
Recent hospital discharge where medication has been changed?

I have included overleaf, further information, which may be useful in carrying out this review. The patient has been told that you will be contacting him/her. I look forward to receiving a copy of your report and recommendations.

Yours sincerely,

Dr:  
Practice:  
Contact Number:

A1 Referral letter from GP
Appendix 3

Current Medication

(Attach a printout from the computer records if more convenient)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Directions</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

Current Medication Problems

Further Comments
Appendix 3

Managing Your Medicines

Patient Leaflet

A new service is now available from this pharmacy to help you in managing your medicines.

This service is being offered to people with diabetes who might need a little extra help with their medicines. The aim is to help you understand more about your medicines (what they are for and how to take them) and to assist with any problems or queries which you may have.

It will involve a consultation with you in a quiet area of the pharmacy at a time that suits you. You will bring your current medicines and I will ask you some questions about them. Any matters discussed will of course be strictly confidential.

To get further details, please talk to me in the pharmacy or telephone the number below:

<table>
<thead>
<tr>
<th>Pharmacist Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone number:</td>
</tr>
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</table>

Pharmacy stamp
Appendix 3

Managing Your Medicines

Patient Consent Form

<table>
<thead>
<tr>
<th>Patient’s Reference No:</th>
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<tbody>
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<td>(contractor no/2 digits)</td>
<td></td>
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<tr>
<td>Name:</td>
<td></td>
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<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Male/Female</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Tel. No:</td>
<td>Doctor:</td>
</tr>
</tbody>
</table>

CONFIDENTIAL PATIENT RECORD

I wish to take part in the ‘Managing Your Medicines Service’
Yes/No

I give my pharmacist (_____________________________) permission to access my medical notes
I understand that any information given to my pharmacist will be held as confidential records
Yes/No

I do not wish my pharmacist (_____________________________) to access my medical records
Yes/No

Patient’s signature:

Pharmacist’s signature:

Print name in block capitals:

The patient should be asked to sign two copies of this form, one for the pharmacy and one for the GP.

Pharmacy Stamp:
Appendix 3

Managing Your Medicines

Appointment Card

<table>
<thead>
<tr>
<th>Patient’s Reference No:</th>
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<tbody>
<tr>
<td>(contractor no./2 digits)</td>
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<tr>
<td>Name:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>Male/Female</td>
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<tr>
<td>Tel. No:</td>
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</table>

Your Next Appointment is:

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Time</th>
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It is important that you bring all your medication that you have in your home to your first appointment. This includes anything that your Doctor has prescribed for you as well as any medication that you may have bought from your pharmacy or shop (for example tablets, injections, blood meters, inhalers or other devices)

It is important that you arrive at the pharmacy at the appointed time. If you need to change or cancel your appointments please contact the pharmacy as soon as possible.

Pharmacist’s name:
Tel. No:
Pharmacy Stamp
Appendix 3

Medicines Management in Diabetes

Dear Dr [Date]

I am writing to inform you that I have arranged an appointment for the patient named below as I feel he/she would benefit from this service.

This patient fulfils the inclusion criteria as indicated below. At least one from each Box: [Tick as appropriate]

Box 1

Having problems with their medication/ poor control?

Box 2

On antihypertensives, lipid lowering agents, nitrates, digoxin, warfarin, GTN?

Taking 4 or more medications?
Living alone/ poor home support?
Poor medication compliance evident from practice records or other information?
Recent hospital discharge where medication has been changed?

Overleaf, I have included this patient’s medication details from my records and I would be grateful if you would confirm these together with any further points (see the attached Table) which may be of benefit in this medication review. I have enclosed the patient’s written consent form, which includes a statement that they do/do not give permission for me to access their medication notes.

Thank you for your support

Pharmacist’s Name/Address

Contact Number

---

A5 - Appointment arranged (Pharmacist - attach Table 3 if appropriate)
Appendix 3

Current Medication from Pharmacy PMRs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Directions</th>
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</tbody>
</table>

Current Medical Problems/Diseases being treated

1.
2.
3.
4.
5.
6.
7.
8.

Further Comments
Appendix 3

Medicine Management in Diabetes

This is a new initiative which has been implemented by ............................................................ (PCO, LPC etc.). It is a pharmacy based medication review service, provided from designated pharmacies for people with diabetes who are vulnerable or at risk. This includes people who are:

Having problems with their medication/poor control and who are on/have:

- Antihypertensives, lipid lowering agents, nitrates, digoxin, warfarin, GTN
- Taking 4 or more medications (systemic, not prn)
- Poor home support/ living alone, or
- Poor medication compliance (evident from pharmacy or GP patient records), or
- Been recently discharged from hospital

Patients meeting these criteria will be identified by the pharmacist (or referred by other professionals). Following patient agreement and notification to their GP, the pharmacist will review the patient’s management of his/ her medication, identifying any problems and appropriate remedial action. A report will be forwarded to the GP, specifying action points including those requiring GP co-operation. A follow-up interview will be carried out in most cases to assess outcomes.

The aim of this new service is to:

- Ensure that both OTC and prescription medicines are used appropriately
- Educate the patient in order to improve the patient’s knowledge and understanding of medication usage
- Liaise with other members of the primary healthcare team in order to agree and implement measures to overcome any problems the patient might be experiencing
- Liaise with the GP concerning outcomes and medication changes

This should assist in achieving safe and cost-effective use of medication, improve compliance and ensure that all measures are implemented to achieve the best possible quality of life for the individual patient.

If you require further information about this initiative contact ............................................................ on .............................................................
**Appendix 3**

**Medicines Management in Diabetes**

**Confidential Patient Records**

**Patient Record Folder**

<table>
<thead>
<tr>
<th>PATIENT</th>
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<tbody>
<tr>
<td>Ref. No</td>
<td><em>(Contractor no./two digits)</em></td>
</tr>
<tr>
<td>Name: Mr/Mrs/Miss/Ms</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Tel No</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Male/Female</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>TELEPHONE No</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
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<tr>
<td>NEXT OF KIN</td>
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<tr>
<td>CARER</td>
<td></td>
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<tr>
<td>SOCIAL WORKER</td>
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<td></td>
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<tr>
<td>OTHER</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT CONTACT</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview One:</td>
<td>Interview Two:</td>
<td>Other Contacts</td>
</tr>
<tr>
<td>Date:</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Time:</td>
<td>Time:</td>
<td></td>
</tr>
<tr>
<td>Location:</td>
<td>Location:</td>
<td></td>
</tr>
<tr>
<td>Name of Pharmacist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Any Other Person Present</td>
<td></td>
<td></td>
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<tr>
<td>State Relationship to Patient</td>
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</table>

**B1 - Personal Data Sheet for Record Folder**
Appendix 3

Medicines Management in Diabetes

Pharmaceutical Assessment Questionnaire
(First Medication Review)

<table>
<thead>
<tr>
<th>Patient’s Reference No:</th>
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<td>(contractor no./2 digits)</td>
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<tr>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
</tbody>
</table>
| Male/Female                       | Date of Birth:  
| Tel. No:                          | Doctor:  

Please ensure that the medication column of Table 2 (page 5) is completed prior to
interview, and Table 3 (page 6) (if appropriate)

Please note that when completing this questionnaire all pharmaceutical care points should be
appropriately circled
A  NO Problems
B  YES - Minor Problem
C  YES - Significant/ Major Problem

The purpose of the interview should be explained to the patient before beginning.
Appendix 3

Supply of Prescriptions and Medicines

Problem Identified

Q1 Do you ever have any difficulty in ordering or collecting your prescriptions from the doctor? If YES, please give details:

Q2 Do you ever have any difficulty collecting your medicines from the pharmacy? If YES, please give details:

Q3 Do you ever run out of any of your medicines? If YES, please complete Table 1 stating:
   • Name of medication
   • How often does this happen
   • Why does it happen?

TABLE 1: Medicine Supply

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Frequency</th>
<th>Reason</th>
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</table>

Q4 Do you normally have more than two month's supply of your current medicines at home? If YES, why?
Appendix 3

Medication Regimen and Patient Knowledge

TABLE 2: Medication Regimen, Patient Knowledge, Medication management problems

<table>
<thead>
<tr>
<th>Medicine Name and Directions*</th>
<th>NP**</th>
<th>Knowledge gaps Identified</th>
<th>Medication Management problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason for taking:</td>
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<tr>
<td>Dosage/Frequency:</td>
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<tr>
<td>Special Instructions</td>
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<td>Name:</td>
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<td>Reason for taking:</td>
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<td>Dosage/Frequency:</td>
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<td>Reason for taking:</td>
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<td>Reason for taking:</td>
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<td>Dosage/Frequency:</td>
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<td>Special Instructions</td>
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<td>Reason for taking:</td>
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<td>Dosage/Frequency:</td>
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<tr>
<td>Special Instructions</td>
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</tbody>
</table>

* To be completed prior to interview
** NP - No Problem
More than one sheet may be required
See E1 for more guidance

Problem Identified

Would you let me see ALL of the medication that you have brought with you today?
Does anyone help you take your medicines?
If YES, give details (e.g. from relative, neighbour, home help, nurse)

I would like to check with you which medicines and devices you currently use (e.g. tablets, liquids, injections, blood meters, inhalers, creams,)

Pharmacist has previously completed the first column of Table 2 with names and directions of medicines from PMRs. Please use the other columns in Table 2 to record any problems with knowledge/understanding of the following:

Would you tell me this:

Q5 Names of the medicines you use
Q6 Why you take your medication?
Q7 How often you take your medicines and how much? (how often do you test blood/urine?)
Q8 Are there any specific instructions when taking or using the medicines?
Appendix 3

Medication Regimen

This section to be complete after the interview based on the patient’s previous responses and the PMRs. Details should be recorded in Table 2.

Problem Identified

Q9  Does any medication dispensed not correspond to medication currently used? If YES, please give details:

Q10 Have the outcomes been reached (Tables 2,3)? Are there any symptoms of inadequate control? Did the patient mention any conditions, which appear to be untreated? If YES, please give details:

Q11 Were there any discrepancies in the record of products/ strengths being used (between GP/Pharmacy/ Patient/ Hospital)? If YES, give details

Q12 Were there any discrepancies in the directions recorded or given (between GP/Pharmacy/patient/ Hospital)? If YES, give details

Q13 Did any of the directions appear to be inappropriate for the product or patient? If YES, give details:

Q14 Were there inadequate directions on the labels? Yes/No

Q15 Were any of the product formulations inappropriate for this patient? (e.g. swallowing problems). If YES, give details:

Q16 Were there any inappropriate product combinations (e.g. duplicate or opposing pharmacological effects)? If YES, give details:
Appendix 3

Long term monitoring service

TABLE 3: Targets for metabolic and risk factor control

Realistic targets should be discussed with the GPs at the start of the service, and tailored to the individual

<table>
<thead>
<tr>
<th></th>
<th>Last</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plasma glucose</td>
<td></td>
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<tr>
<td>Fasting</td>
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<td></td>
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<tr>
<td>Postprandial</td>
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<tr>
<td>HbA1c</td>
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<tr>
<td>Urine Glucose</td>
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<td></td>
<td></td>
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<tr>
<td>Total cholesterol</td>
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<td>HDL - cholesterol</td>
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<td>LDL - cholesterol</td>
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<tr>
<td>Fasting triglycerides</td>
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<td>Renal Function</td>
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<td>Hepatic function</td>
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<tr>
<td>Microalbuminuria</td>
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Appendix 3

Storage of Medicines

Problem Identified

The medication brought in by the patient is discussed

Does the patient have difficulty with storage of medication?

For each medicine (including separate supplies of the same item), the pharmacist will record in Table 4 any of the following storage problems; based on inspection of the products and discussion with the patient.

Q17 Different drugs stored in the same container? (> 1 drug in container)

Q18 Incorrect storage (temperature, location, out of reach of children (If appropriate).
   [Insulin in use, should be stored at room temperature]

Q19 Illegible labels, storage containers damaged?

Q20 Out of date drugs? If YES, seek patient’s written consent for disposal

TABLE 4: Medication Storage Problems

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Description of Storage Problems</th>
<th>Action Necessary (e.g. extra labels, new containers)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Appendix 3

Adverse Drug Reactions

Problem Identified

Q21. Is the Patient suffering from any adverse effects?

You may prompt the patient by naming/ indicating each medication currently prescribed. You may also use the following list of possible unpleasant effects to aid the patient:

a) nausea
b) heartburn
c) vomiting
d) stomach pains
e) diarrhoea
f) constipation
g) flatulence
h) dizziness
i) falls
j) drowsiness
l) light head when you get out of bed/chair
m) frequently going to toilet
n) shaking/sweating
o) dry mouth/thirst
p) visual disturbances
q) swollen ankles
r) rash
s) breathlessness
t) dry cough
u) sore mouth
v) itching

Q22. Is the patient pregnant/breast feeding? If YES to any, please complete Table 5

Pharmacist should consider:

- Which medication or combination responsible?
- Frequency of occurrence of side effects (rarely, sometimes, or with every dose)
- The nature of the effect mild, uncomfortable, or severe
- Any action taken to alleviate the unpleasant effect

TABLE 5: Adverse Drug Reactions (ADR)

<table>
<thead>
<tr>
<th>Unpleasant effect</th>
<th>Medicine(s)</th>
<th>Frequency</th>
<th>Severity</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

B2
Appendix 3

Over-the-Counter (OTC) Medicines

Problem Identified

Q23 In the past 6 months have you taken any other medicines apart from the ones you get from your doctor? If patient is unsure prompt if necessary:
   a) indigestion remedies
   b) cough remedies
   c) cold remedies
   d) pain relief remedies
   e) vitamins
   f) laxatives
   g) anti-diarrheals
   h) herbal remedies
   i) homeopathic remedies
   j) rubs or creams
   k) foot care remedies
   l) any other (please specify)

If YES to any of the above the pharmacist should consider the following issues:
   • Range of medicines taken and the reasons
   • Compliance with directions?
   • How often does patient take medication?
   • Who recommended the medicine?
   • Is GP aware of patient taking OTCs?
   • Evidence of effectiveness/ benefit
   • Any unpleasant effects experienced with OTC product?

Q24 Is OTC medicine use inappropriate? If YES please complete Table 6

Table 6: Inappropriate use of OTC Medicines

<table>
<thead>
<tr>
<th>Name of OTC medicine</th>
<th>Description of Inappropriate Use of Medicines</th>
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<tbody>
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</table>

B2
Appendix 3

Concordance/Compliance

Problem Identified

Q25  Do you feel you need more help at home with managing your medicines?
     If YES, give details

Q26  Some people do not take their medication in exactly the way that their doctor has ordered. For example, they may skip some doses from time to time, or they may simply forget to take their medicine. They may even occasionally take more than the prescribed doses of their medicine if for example they are feeling ill. **Do you ever deliberately skip any doses of your medicines?** because you have forgotten? because you are unhappy taking them?

Q27  Do you ever take more than then the prescribed amounts of your medicines?
     If YES, to either please complete Table 7 below, stating:
     • Name of medicine
     • The frequency of non compliance (rarely, sometimes, frequently)
     • Any particular reason for non-compliance

**TABLE 7: Compliance**

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Compliance</th>
<th>How often?</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*Over</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>*Under</td>
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<td></td>
<td>*Over</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Under</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If appropriate,

Q28  **I see you have:**
     syringes, blood meters, inhalers, spacers, peak flow meters
     Would you show me how you use it/them?
     Patient needs counselling on correct technique for using **Yes/No**
     Please counsel the patient on the correct technique, if necessary or if appropriate refer patient to a diabetes nurse e.g. if having problems with injection technique, rotation of sites etc.
Appendix 3

Q29  How do you remember to take your medicines? If patient has problems record YES and note how patient tries to remember, (clock/ meals, special systems, someone reminds me/lays them out). Give details:

Q30  Do you have problems with the packaging or containers in which the medicines prescribed for you are dispensed. (ask patient to open containers that are prescribed) If YES, please describe:

Q31  Would you please read the small print on your medication container? If patient has problems record YES and please state if the patient:

- Normally wears glasses
- Has an annual eye test, (please state benefits of regular eye examination in diabetes)
- Has poor reading skills
- Has difficulty understanding the instructions
- Does not speak good English/has language difficulties

Disease Management

Problem Identified

I would like to ask you some questions about your health
Pharmacist should now ask the patient about their main medical conditions, symptoms experienced and efficacy of medication. Care should be taken to avoid alarming patients or providing them with unnecessary information.

Q32  Does patient need/ require further background information regarding their medical condition? If YES, give details

Q33  Does patient need/ require further information regarding the use of their medicines? If YES, give details

Q34  Does patient have realistic expectations about benefits and the limitations of their medication? If YES, give details

Q35  Does patient know how to monitor the control of their condition? If YES, give details

- Discussion of testing equipment and problems encountered.
- Ensure know how record and action results
- Consider quality control issues
Appendix 3

Health Promotion

Problem Identified

Q36 Are you able to take any form of increased physical activity? If NO, please give advice appropriate to patient’s physical condition or is referral for professional advice necessary? If YES, please note suitability of this activity

Q37 Do you, or have you ever smoked (e.g. cigarettes, cigars or a pipe)? If current smoker, consider smoking cessation service

Q38 Do you drink alcohol? If YES, How much alcohol would you drink in a week (state beer, wine etc.)?
   • Pharmacist should subsequently convert into units per week: (     ) and assess against recommended intake.
   • Do units consumed exceed advice on reducing alcohol intake? If YES, please give advice on reducing alcohol intake
   • Give advice on suitability of drinks e.g. avoid sweet drinks like sherry

Q39 From your observations during the interview do you consider the patient:
   • Has mobility difficulties
   • Has hearing difficulties
   • Was confused
   • Was depressed/lonely/socially isolated
   • Has other problems (please specify)
   • If any of these problems were observed please refer to GP for further investigation

Further Comments:
## Appendix 3

### Summary Of Pharmaceutical Care Issues Identified

**Reviews:**

<table>
<thead>
<tr>
<th>Patient’s Name/Address:</th>
<th>Ref. No:</th>
<th>Date:</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Doctor:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Male/Female</th>
<th>Tel. No:</th>
<th>D.O.B.:</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

A star should be crossed if a care issue (minor or major) has been identified. It should also be circled if GP action is required.

### Supply of Prescription Medicines

<table>
<thead>
<tr>
<th>Minor</th>
<th>Major</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Problems obtaining prescriptions (assistance required with ordering/ collection)</td>
<td></td>
</tr>
<tr>
<td>2. Problems obtaining medicines (assistance required with collection)</td>
<td></td>
</tr>
<tr>
<td>3. Running out of medicines (investigation of possible reasons/ actions)</td>
<td></td>
</tr>
<tr>
<td>4. Excess stock of current medicines (investigation of possible reasons/ actions)</td>
<td></td>
</tr>
</tbody>
</table>

### Patient Knowledge of Medication (counseling required)

<table>
<thead>
<tr>
<th>Minor</th>
<th>Major</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Poor knowledge of product name</td>
<td></td>
</tr>
<tr>
<td>6. Poor knowledge of medication purpose</td>
<td></td>
</tr>
<tr>
<td>7. Poor knowledge of dosage/frequency</td>
<td></td>
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<tr>
<td>8. Poor knowledge of other special instructions</td>
<td></td>
</tr>
</tbody>
</table>

### Medication Regimen (review/ action required)

<table>
<thead>
<tr>
<th>Minor</th>
<th>Major</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Query - some prescribed items not needed</td>
<td></td>
</tr>
<tr>
<td>10. Query - Outcomes not met /untreated conditions</td>
<td></td>
</tr>
<tr>
<td>11. Product Discrepancy - GP/ Pharmacy/Patient/ Hospital</td>
<td></td>
</tr>
<tr>
<td>13. Query - inappropriate directions on label</td>
<td></td>
</tr>
<tr>
<td>14. Query - inadequate directions</td>
<td></td>
</tr>
<tr>
<td>15. Query - inappropriate product formulation</td>
<td></td>
</tr>
<tr>
<td>16. Query - inappropriate product combination</td>
<td></td>
</tr>
</tbody>
</table>

### Storage and Disposal

<table>
<thead>
<tr>
<th>Minor</th>
<th>Major</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Inappropriate storage containers (replacement/ counseling required)</td>
<td></td>
</tr>
<tr>
<td>18. Inappropriate location - temperature/ security (counseling required)</td>
<td></td>
</tr>
<tr>
<td>19. Damaged containers/ labels (replacement/ counseling required)</td>
<td></td>
</tr>
<tr>
<td>20. Obsolete products (removal following consent)</td>
<td></td>
</tr>
</tbody>
</table>

### Adverse Drug Reactions (Review/action required)

<table>
<thead>
<tr>
<th>Minor</th>
<th>Major</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. Possible ADR from a single product (Yellow Card?)</td>
<td></td>
</tr>
<tr>
<td>22. Possible ADR from an interaction</td>
<td></td>
</tr>
</tbody>
</table>

### Over-the-counter Medicines (review/ counseling required)

<table>
<thead>
<tr>
<th>Minor</th>
<th>Major</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Apparent overuse of OTCs</td>
<td></td>
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<tr>
<td>24. Inappropriate use of OTCs</td>
<td></td>
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</tbody>
</table>
Appendix 3

Medicines Concordance/Compliance

25. Patient feels more help is needed with medicines (assessment/action) * *
26. Doses intentionally omitted (discussion/counseling/review required) * *
27. Extra/higher doses being taken (discussion/counseling/review required) * *
28. Poor technique (e.g. inhaler, injection) (instruction/referral) * *
29. Problems remembering dosing times (advice/compliance aids required) * *
30. Problems opening containers (advice/assistance/different packs required) * *
31. Problems reading/ understanding labels (advice/special labels required) * *

Disease Management (information required)

32. Poor understanding of condition * *
33. Poor understanding of medication effects * *
34. Unrealistic expectation of medication benefits/ limitations * *
35. Poor understanding of how to monitor disease state/ control * *

Health Promotion

36. Unable/not motivated to exercise adequately (advice/ referral required) * *
37. Smoker (assess cessation service where appropriate) * *
38. Inappropriate alcohol intake (advice/ referral required where appropriate) * *
39. Other health limitation/ problems (advice required where appropriate) * *

Progress on reaching targets (if involved in monitoring)

<table>
<thead>
<tr>
<th></th>
<th>Last</th>
<th>Current</th>
<th>Target</th>
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</thead>
<tbody>
<tr>
<td>40. Plasma glucose</td>
<td></td>
<td></td>
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<tr>
<td>41. Fasting</td>
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<td></td>
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<tr>
<td>42. Postprandial</td>
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<tr>
<td>43. HbA1c</td>
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<tr>
<td>44. Urine Glucose</td>
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<tr>
<td>45. Total cholesterol</td>
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<tr>
<td>46. HDL - cholesterol</td>
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<td>47. LDL - cholesterol</td>
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<tr>
<td>48. Fasting triglycerides</td>
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<td>49. Body Mass Index</td>
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<td>50. Blood Pressure</td>
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<tr>
<td>51. Smoking Status</td>
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<tr>
<td>52. Renal Clearance</td>
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<td></td>
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<tr>
<td>53. Hepatic function</td>
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<td></td>
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<tr>
<td>54. Microalbuminuria</td>
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</table>

Pharmacist - discuss whether the targets need changing, with prescriber. Also record: S - significant change; N/S - not significant or no change
### Appendix 3

### Medicines Management in Diabetes

#### Care Issues – Action Sheet

**Patients Name/Address**

<table>
<thead>
<tr>
<th>Reference No:</th>
<th>Doctor:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>PCI*</th>
<th>1st Appointment: Details of action recommended</th>
<th>Pharmaceutical Response</th>
<th>GP Response</th>
<th>Follow-up Date 2nd Appt: Date of Phone Call:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat.No. &amp; desn **</td>
<td>Problems identified <em>Minor</em> <em>Major</em></td>
<td><em>Tick if action by Pharmacist needed Action Taken:</em></td>
<td><em>Tick if action by GPs recommended</em></td>
<td>Comment on Outcome Problems remaining <em>None</em> <em>Minor</em> <em>Major</em></td>
</tr>
</tbody>
</table>

* PCI - Pharmaceutical Care Issue

** Enter Category Number and Description

---

C1 Ref.: Pharm Care Issues - Three Copies (White, Blue, Pink)
Appendix 3

Medicines Management in Diabetes

Dear Dr [Name]  

I carried out a medication review with the above patient on [Date].

I have highlighted on the attached summary report any pharmaceutical care issues associated with this patient's medication management. I have also included my understanding of the medicines this patient is currently taking/using together with corresponding dosage and directions. The review indicated that this patient has:

NO medication/disease* management problems
You may wish to retain the summary report (B3) and the medication list (C3) for your records

Medication/disease* management problems requiring pharmacy action only
You may wish to retain the summary report (B3) and the medication list (C3) for your records

Medication/disease* management problems for which your co-operation would be greatly appreciated

The problems requiring your attention are circled on the summary sheet (B3) and further details of the issues are given in the blue and pink sheets (C1). I would be grateful if you would consider the suggestions and indicate any action taken, if appropriate, in the GP Response column on the (C1) sheets. Please return the blue copy to me as soon as possible. The pink copy and other documents may be retained for your records. Thank you for your assistance. I have arranged to review this patient in the next 3 months. If you wish I would be happy to discuss any of these matters before the follow-up visit.

Yours sincerely,

[Pharmacist’s Name/Address]

Contact Number

*delete if not appropriate

---

C2 - Letter to GP after first assessment
Appendix 3

Medicine Management in Diabetes

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSAGE</th>
<th>DIRECTIONS</th>
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</thead>
<tbody>
<tr>
<td>Prescribed</td>
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<tr>
<td>Other</td>
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</table>

Pharmacist signature

Pharmacy Stamp

Date
Appendix 3

Managing your Medicines

Patient Consent Form – Removal of Medicines

Medicines removed:

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>REASON</th>
<th>APPROX. QUANTITY</th>
<th>DATE OF SUPPLY</th>
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<tbody>
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</table>

The pharmacist has explained to me that some of my medicines are out of date or are no longer needed by me.

I allow him/her to remove these medicines and I understand that he/she will dispose of them on my behalf.

SIGNED: DATE

SIGNATURE OF CARER (if applicable):

SIGNATURE OF PHARMACIST:
Appendix 3

Medicines Management in Diabetes

Dear Doctor,

Thank you for returning the Pharmaceutical Care Action Sheet(s) relating to this patient. I have now carried out a second review with this patient and reassessed how his/her medicines are being managed. The changes are summarized on the attached yellow sheet (B3) which you may retain for your records.

Your co-operation in this patient care initiative is greatly appreciated. I would be happy to discuss any aspect further with you.

Yours sincerely,

Pharmacist Signature Date

Pharmacist’s Name/Address/

Contact Number (Capitals)

Other Enclosures:
Updated Medication List D2 (if applicable) YES/NO

D1 - Letter to GP after second assessment
Appendix 3

Medicine Management in Diabetes

### AMENDED MEDICATION REGIMEN

**SECOND REVIEW**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Directions</th>
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<tbody>
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<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Pharmacist signature  
Pharmacy Stamp

Date  
(PMR updated on same date)
## Appendix 3

### Medicines Management in Diabetes

#### Claim Form

**MONTH**

**YEAR**

<table>
<thead>
<tr>
<th>FOR OFFICE USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start-up fee (payable when first assessments completed)</strong></td>
</tr>
<tr>
<td>£ per pharmacy</td>
</tr>
<tr>
<td><strong>Start-up Fee</strong></td>
</tr>
<tr>
<td><strong>Reviews completed this month:</strong></td>
</tr>
<tr>
<td>Number of patients:</td>
</tr>
<tr>
<td><strong>First Assessment</strong></td>
</tr>
<tr>
<td>First assessments @ £ per patient: £</td>
</tr>
<tr>
<td><strong>Final Assessment</strong></td>
</tr>
<tr>
<td>Final assessments @£ per patient £</td>
</tr>
<tr>
<td><strong>Total to be paid £</strong></td>
</tr>
</tbody>
</table>

**For Office Use only**

**Signature for authorisation of payment**

To: (Address of the Commissioning Body e.g. PCO)

I claim payment for the above patients and certify I have carried out the assessments as documented. The records are retained in the pharmacy for inspection.

**Contractor Name/Address**

__________________________

**Pharmacist Signature**

__________________________

**Please Print Name.**

__________________________

**Date**

__________________________

D3 - Claim Form
## Appendix 3

Contractor's Name/Address

### DETAILS OF PATIENT ASSESSMENTS COMPLETED DURING

(MONTH) (YEAR)

*TICK ONLY ONE BOX PER PATIENT*

<table>
<thead>
<tr>
<th>PATIENT Ref.: (Contractor No.)</th>
<th>PATIENT DETAILS</th>
<th>FIRST ASSESSMENT Specify date/time of Interview and name of Pharmacist who assessed</th>
<th>FINAL ASSESSMENT Specify date/time of Interview and name of Pharmacist who assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name Address Tel</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Name Address Tel</td>
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<tr>
<td>Name Address Tel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name Address Tel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name Address Tel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name Address Tel</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Details of Patient Assessment Completed - attach to claim form
Appendix 3

Guidance

Problem identification

The aim is to solve or avoid and medication-related problems that interfere with the desired patient outcome. Some problems may require further investigation.

- Are there any untreated indications? e.g. aspirin
- Is this the most appropriate drug for the indication(s)?
- Is the drug effective and is the treatment goal being achieved?
- Have there been changes in evidence/best practice since it was first prescribed?
- Have appropriate non-drug measures been instituted?
- Is there an ongoing need for this drug? Have any drugs been initiated to treat adverse drug effects?
- Are the dose, frequency and formulation appropriate?
- Has the dose been individualized for the patient? Consider weight, age, renal function, etc…
- Is there duplication? Drugs in same therapeutic class, generic-brand duplication?
- Does the patient have contraindications e.g. heart failure, to any medications?
- Consider disease states, pregnancy, renal function, liver function, drug allergies etc. and consider therapeutic alternatives
- Could the regimen be simplified, reducing polypharmacy?
- Is the regimen cost-effective for the patient and taxpayer? e.g. replace brands with generics, consider NICE guidelines
- Is there a facility to download glucose results onto a computer, get a printout and give advice in between clinic appointments?
- Checking general feelings of well being

Action plan

- Dose/frequency changes e.g. doses are sub-therapeutic or medication is taken improperly
- Discontinuation of medication e.g. an inappropriate drug is being used
- Adding an alternative or a new medication or instituting non-drug therapy e.g. drugs used are ineffective or therapeutic outcome has not been achieved
- Ensure carers have appropriate advice and information
- Liaise with the diabetes clinic - ask to have a system where the patient is given a duplicate letter with their new treatment to take to their community pharmacist
- Counselling/instructions for patient/carer
Appendix 4

Repeat Prescribing - Medication Review

<table>
<thead>
<tr>
<th>Significant medication</th>
<th>Compliance</th>
<th>Problems</th>
<th>DRUG No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>A Side effect/Adverse Reaction</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>B Contraindication</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>C Drug interaction</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>D Sub-optimal dose</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>E Unpalatable dose form</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td>F Drug/disease incompatibility</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>G Medication synchronized</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>H Potential generic substitution</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>J Cost effective treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>K No indication for medication any more</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>L Indication but no medication provided</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>M Therapeutic duplication of drugs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N Other (specify)</td>
</tr>
</tbody>
</table>
Dear Doctor

The current review of this patient’s medication prompts the following observations:

Dear Nurse

The patient has also mentioned the following symptoms, which you may wish to follow up:

• Lethargic
• Thirsty
• High glucose readings
• Foot problem
• Blurred vision
• Cannot remember when eyes last tested
• Problems with injection sites

I consent to the information and advice contained on this form being made available to other members of the healthcare team:

signature of patient (or carer) date

pharmacist’s signature date

Evaluation

Patient Benefit:

Cost implications:

Next Review:
Appendix 5A

Medicines Management in Care Homes

The Models in Appendices 3 and 4 could be adapted to this service.

In addition:
- Recommendations also discussed with home manager
- Liaison with the practice/district nurse about tests being done at recommended times e.g. BP, blood glucose, HbA1c etc.
- Actioning of test results - liaison with GP and nurses
- A diabetes screening service in the home, using local GP approved referral levels
- Recording room number, allergies, special requirements
- If cost savings need to be documented, then a column for monthly cost of each medication could be added

Timings per home

<table>
<thead>
<tr>
<th>Each Home</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial discussion with surgery</td>
<td>1 hour</td>
</tr>
<tr>
<td>Initial discussion with home</td>
<td>1 hour</td>
</tr>
<tr>
<td>Setting up files etc..</td>
<td>1 hour</td>
</tr>
<tr>
<td>Preparation of final report</td>
<td>3 hours</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6 hours</strong></td>
</tr>
</tbody>
</table>

Appendix 5B

Timings per patient

<table>
<thead>
<tr>
<th>Each Patient</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtaining results</td>
<td>10 min</td>
</tr>
<tr>
<td>Review of medication</td>
<td>40 min</td>
</tr>
<tr>
<td>Preparation of reports</td>
<td>30 min</td>
</tr>
<tr>
<td>Liaison with nurse</td>
<td>10 min</td>
</tr>
<tr>
<td>Discussion with GP</td>
<td>10 min</td>
</tr>
<tr>
<td>Discussion with Home</td>
<td>10 min</td>
</tr>
<tr>
<td>Implementation of changes</td>
<td>15 min</td>
</tr>
<tr>
<td>Administration</td>
<td>5 min</td>
</tr>
<tr>
<td>Follow up</td>
<td>10 min</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>140 min</strong></td>
</tr>
</tbody>
</table>
Appendix 5C

**Intervention Form** [Summary for each Home]

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Frequency</th>
<th>Reason (see codes below)</th>
<th>GP agrees YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic substitution</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose modification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formulation change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab. test request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse monitoring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Codes [for Reasons]**
A. Side effect/Adverse Reaction  
B. Contraindication           
C. Drug interaction           
D. Sub-optimal dose           
E. Unpalatable dose            
F. Drug/disease incompatibility  
G. Medication asynchronisation 
H. Potential generic substitution  
I. Economy of treatment    
J. No indication for medication any more  
K. Indication but no medication prescribed  
L. Therapeutic duplication  
M. Other (specify)            

Appendix 5D

**Clinical/Biochemical Readings**

<table>
<thead>
<tr>
<th></th>
<th>BP</th>
<th>HbA1c</th>
<th>RBG</th>
<th>Renal Function</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Service for more than one Home**

<table>
<thead>
<tr>
<th>Name of Home</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of residents selected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timings per home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions per yr</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6

Patient and carer information:
Looking after your feet

• Keep your feet clean: wash and dry gently between toes
• Moisturise your feet with hand cream, olive oil, E45 cream, but not between your toes
• Do not dig down the sides of your toenails
• Cut your nails (softer after washing) according to the shape of your toes. If you cannot cut your own, request a visit to a state-registered chiropodist (podiatrist)
• Check your feet and shoes daily - using a mirror if necessary. You may not be aware of injury
• If possible involve a third party, such as your partner
• Do not ignore even the slightest injury to your feet
• Report any sores, swelling, cracks, corns, skin damage or change of colour immediately to your doctor
• Avoid walking barefoot you should wear shoes or slippers all the time
• Choose shoes that provide good support: broad, long and deep
• Check that you can wriggle your toes inside your shoes.
• As a general rule trainers are a good choice
• Try to buy shoes where you can have them fitted by a trained person
• Wear new shoes for short periods of time to start with
• Check your shoes regularly for ridges, sharp points or nails; tip them upside down before putting on
• Wear the correct shoes for the job and the health of your feet
• Do not wear tight-fitting socks; choose ones with no ridges but if they have then wear socks inside out; change daily
• Avoid extremes of temperature, very hot baths, sitting close to fires and radiators, and hot water bottles
• Do not treat corns yourself; visit a state-registered chiropodist
• Never use a surgical blade, corn-paring knife or corn remedies on your feet
• Treat your feet with respect
Appendix 7

Patient and Carer information:
‘Sick Day Rules’ (what to do when you’re ill)

- A minor illness, such as a cold, may cause your blood sugar (glucose) levels to rise
- Keep taking your tablets even if not eating; if vomiting prevents you keeping your tablets down - consult your doctor
- Never stop your insulin, even if you feel really ill
- Blood glucose levels will return to normal once the infection is over
- Consult your doctor if the illness persists, if you have symptoms of high glucose levels or if you have high test results
- Headaches and sore throats can be safely treated with paracetamol or aspirin
- Sugar-free remedies are available - ask at the pharmacy
- Vomiting and diarrhoea may cause serious loss of fluid - consult your doctor
- You may need this fluid replaced by means of a drip
- You may need insulin for a short time

Important Rules

- Continue with your diabetes treatment (diet and tablets or insulin)
- Ensure that you drink plenty of liquid (water, tea etc.)
- Test urine or blood every day to check how you are doing
- If you are not hungry, substitute meals with a liquid or light diet (soup, ice cream, glucose drinks, milk)
- Consult your doctor in good time

Appendix 8

Integrated Pharmacist/PCT clinic

Data Collection

Log each consultation
- Time taken
- Nature of query
- Outcome
- Origin of referral

Other possibilities
- Age
- Gender
- Number of GP visits per year
- Smoker
- Length of diagnosis
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