

Sample Service Specifications

SSS 1: Care of people with diabetes as part of essential services

Service Description

Certain aspects of diabetes care fall within the 'essential services' element of the community pharmacy contractual framework and must be provided by all community pharmacies. Specific elements could be tailored to provide support to patients with diabetes as part of a local diabetes management plan. These services are already an integral part of the national contractual framework and could be a useful starting point when looking at how pharmacists can engage in the care of people with diabetes.

Essential Services within the Community Pharmacy Contractual Framework:-

The following services comprise the 'essential' element of the pharmacy contractual framework:

1. Dispensing of medicines
2. Repeat dispensing
3. Health promotion and healthy lifestyle advice
4. Signposting to other services
5. Support for self-care
6. Disposal of medicines
7. Clinical governance

Specific aspects that are of particular relevance in helping people with diabetes to manage their condition are highlighted below:

- The provision of opportunistic healthy lifestyle advice, for example about weight management, stopping smoking, alcohol etc, to patients receiving prescriptions who appear to have diabetes and those 'at-risk' of diabetes. Resources available at www.pharmacymeetspublichealth.org can be of assistance.
- Pro-active participation in national and local public health campaigns promoting messages relevant to diabetes to general pharmacy visitors and provision of relevant leaflets. PCTs could identify diabetes as one of their six public health campaigns targeted each year.

- Support for self-care in diabetes; providing advice to people with minor ailments and long-term common conditions to support appropriate use of non-prescription medicines, especially advice on non-prescription medicines which are not suitable for use by people with diabetes.
- Signposting people with diabetes to other health and social care providers, and relevant patient support organisations e.g. Diabetes UK.
- The supply of medicines and appliances for diabetes prescribed on NHS prescriptions, together with information and advice, to enable safe and effective use by patients and carers, and maintenance of appropriate records. This includes recording medicines dispensed and key advice provided, and assessing and providing compliance aids for those patients who fall within the provisions of the Disability Discrimination Act 1995 and need assistance with medicine-taking.
- The management and dispensing of repeatable NHS prescriptions for medicines and appliances, in partnership with the patient and the prescriber. This includes ascertaining the patient's need for the repeat of a particular medicine, checking for changes to the medicines regimen, educating patients to reduce hoarding and waste, and communicating any clinically significant issues to the prescriber.
- Supporting people with diabetes in the disposal of waste medicines, especially the safe disposal of sharps.
- Ensuring pharmacy staff are appropriately trained and participate in continuing professional development relevant to the delivery of services to people with diabetes.



SSS 2: Medicines Use Review Plus (MUR+)

In addition to the standard Medicines Use Review (MUR) service defined as an ‘advanced’ service within the community pharmacy contractual framework, some PCTs are developing a locally commissioned ‘MUR Plus’ Service.

In general, such services are made up of two components:

- a. The standard MUR service
- b. A locally commissioned MUR+ ‘bolt-on’ (enhanced service) which provides scope for additional clinical support e.g. specific aspects aimed at improving clinical management of a condition such as monitoring blood pressure and tailoring advice on medicines usage accordingly.

A. Standard MUR Service

Service Description

Each PCT must make arrangements for the provision of medicines use review and prescription intervention services (“MUR services”). The requirements on PCTs with regards to MUR services are defined in:

- The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2005
- The Pharmaceutical Services (Advanced and Enhanced Services) (England) Amendment Directions 2006 (two sets of Directions, from March and September 2006)
- The Pharmaceutical Services (Advanced and Enhanced Services) (England) Amendment Directions 2007

MUR services include medicines use reviews undertaken periodically, as well as those arising in response to the need to make a significant prescription intervention during the dispensing process. The underlying purpose of MUR services is, with the patient’s agreement, to improve his knowledge and use of medicines.

Aims of Service

To improve patient knowledge and use of medicines by:

- Establishing the patient’s actual use, understanding and experience of taking their medicines (all medicines not just diabetes);
- Identifying, discussing and resolving poor or ineffective use of their medicines;
- Identifying side effects and drug interactions that may affect patient compliance with instructions given to him by a health professional for the taking of medicines;
- Improving the clinical and cost-effectiveness of prescribed medicines and reducing medicine wastage.

Service Specification

The full requirements for MUR services are set out in the Directions listed above. Key summary points defining the services include:

1. MUR services generally will be carried out face-to-face with the patient, usually in the community pharmacy. If a pharmacist wants to provide MUR services in another location, e.g. patients' homes or day care centres, or by telephone, they must seek the prior approval of the PCT.
2. For face-to-face consultations, the premises used for provision of MUR services must meet certain requirements (as defined in Directions).
3. An MUR can be conducted with patients on multiple medicines and those with long-term conditions, every 12 months. These regular MURs, initiated by the pharmacist, must only be provided for patients who have been using the pharmacy for the dispensing of prescriptions for at least the previous three months. The next regular MUR can be conducted 12 months after the last MUR, unless in the reasonable opinion of the registered pharmacist the patient's circumstances have changed sufficiently to justify one or more further consultations during this period.
4. PCTs, working with their community pharmacists, may identify specific patient groups who would be appropriate for targeting, based on the needs of the local health economy. Pharmacists may accept referrals for a MUR from other health care professionals and pharmacists can accept requests from patients for a MUR to be conducted as long as the requirements are met.
5. Pharmacists providing the service will have passed an assessment based on nationally agreed competencies. Pharmacists must supply their PCT with a copy of their MUR certificate.
6. A written record of each MUR service consultation is made by the pharmacist on a nationally approved form. This form, or part of it, or a notification that the patient has received MUR services, will be sent to the patient's GP
7. A copy of the MUR record is given to the patient.

Interventions that may be made as part of a MUR service include:

- Advice on medicines usage (prescribed and OTC), aiming to develop compliance and adherence;
- Effective and appropriate use of 'when required' medicines;
- Ensuring appropriate use of different medicine dosage forms [e.g. inhaler type, soluble tablets];
- Advice on tolerability and side effects;
- Dealing with practical problems in ordering, obtaining, taking and using medicines;

- Identification of items without adequate dosage instructions;
- Identification of unwanted medicines (patient is no longer taking the medicines);
- Identification of the need for a change of dosage form to facilitate effective usage;
- Proposals on changing branded medicines to generics (exclusions will apply)
- Proposals on changing generic to branded where appropriate to ensure consistent supply or when clinically appropriate;
- Proposals for dose optimisation (higher strength substitution where multiple doses of lower strength products are prescribed, provided it does not interfere with the patient's clinical management).

The RPSGB have developed an audit tool for the evaluation of MURs and would recommend that PCTs use this as their multidisciplinary audit. More details can be found at the [Quality Improvement for Pharmacy website](#).

B. MUR 'Plus' Elements

The 'bolt-on' elements of MUR+ will be locally determined, driven and commissioned and may include suggestions to improve clinical effectiveness. These interventions could be agreed at a local level between the PCT, pharmacist and prescribers.

Examples could include:

1. Highlighting patients who are using glucose testing strips outside agreed local diabetes guidelines;
2. Identifying and making recommendations to achieve tighter control of modifiable risk factors such as blood pressure and cholesterol.
3. Additional advice and appropriateness of medicines and advice to GP / nurse on adjustments.
4. Recording of activity for the whole MUR+ process on the PCT's standardised data collection system. The data should be evaluated to gauge the success of the project. Both quantitative and qualitative data should be gathered e.g. control of risk factors, patients understanding about their medicines and service satisfaction amongst patients and healthcare professionals. The data collection, provision of advice on prioritisation, and assessment of clinical appropriateness of therapy, are considered to be additional to the requirements of the standard MUR.

Evaluation Criteria

- Number of MUR+ interventions
- Category of interventions
 - Understanding of diabetes
 - Understanding of medicines
 - Poor compliance
 - Advice on diet and lifestyle
 - Advice relating to 'Diabetes Hand' (treatment priorities)
 - Overuse of glucose testing strips
 - Underuse of glucose testing strips
 - Number referred to Stop Smoking services
 - Number referred to weight management services
 - Number of referrals to GPs
 - Reason for referral
- Poor control of risk factors
- Poor compliance
- Recommended change in therapy
- Other

SSS 3: Helping people with diabetes to manage their medicines more effectively

Service Description

The pharmacist will provide a medicines management service to improve the safe and effective use of medicines and risk factor monitoring for patients with type 1 and type 2 diabetes delivered via the local commissioning process and in agreement with local GPs.

The service could include:

- A medicines management service for patients with diabetes to improve adherence with medicines by addressing patient understanding and concerns about medicines (and diabetes in general if necessary). This will be in the form of a face-to-face Level 3 medication review³⁷, covering clinical aspects of treatment.
- The service may be provided within the pharmacy, GP practice, domiciliary setting or other location (agreed by local commissioners), but may need access to the patient's medical notes (in order to maximise impact) and approval of the patient's GP.
- Support for people who may be experiencing problems with taking their medicines, particularly those with complex regimens.
- Monitoring modifiable risk factors – blood pressure, blood glucose and HbA_{1c} within the pharmacy to aid decision making and to guide the advice given by the pharmacist.

Aims and Intended Service Outcomes

- To ensure patients are on optimum therapy by reviewing and making recommendations to optimise therapy to the prescriber:
 - treatment optimisation to maximise control of modifiable risk factors;
 - appropriateness of treatment based on latest evidence / local guidelines;
 - identifying adverse drug effects;
 - interpreting and acting on test results as required;
 - assessing whether the recommendations of previous reviews have been acted upon;
 - recommending new treatments, e.g. aspirin or statins;
 - if the pharmacist is a prescriber, making changes to the patient's treatment as agreed with the doctor.
- To improve patient adherence with therapy by:
 - providing an opportunity for the patient to discuss concerns and ask questions about their medicines;
 - improving the patient's understanding of their medicines and their medical condition generally;
 - simplifying the medicines regimen and prescription ordering process where appropriate;

- identifying practical problems in medicine taking and referring the patient for assessment of support required if necessary;
- providing advice and support to the patient and carer, including referral to specialist centres or other health and social care professionals where appropriate; ensuring that there is active participation of the patient, i.e. shared decision making and agreement about any changes.

SSS 4: Weight management

Service Description and outline

The potential service description may encompass:

- A screening and weight management support service for people with diabetes, or at risk of diabetes, and who are overweight or obese.
- Pharmacists will monitor weight, blood pressure and height.
- Patients with a BMI above levels agreed within local guidelines will be invited to take part in the weight management programme. This will be either on a one-to-one basis or in group sessions.

Examples of pharmacy-based weight management services are included below:

The Management of Obesity with associated risk factors service for Coventry Teaching PCT.

Aim

To provide a 12 month weight management service for obese patients over 18 years of age with at least ONE diagnosed or established risk factor.

Risk factors include:

- Hypertension
- Type-II Diabetes
- Hyperlipidaemia
- Increased Waist Circumference

Objectives

- To facilitate a 5% weight loss in patients recruited onto the programme
- To identify obese patients “at-risk” of developing long-term conditions
- To educate patients in healthy living
- To explore the role of community pharmacists in the primary health care team and the extension of that role into the provision of clinical pharmacy services
- To explore the potential to extend the role of community pharmacists in weight management

Outcome measures:

- Number of patients achieving a weight loss of $\geq 5\%$, since enrolment onto the programme
- Nature and number of pharmacist interventions
- Number of people identified “at-risk” of developing a long-term condition
- Number and nature of referrals to GPs
- Number of people with poorly controlled Type-II diabetes
- Assess GP and pharmacist satisfaction with the scheme

Nottingham City PCT, Community Pharmacy Weight Management Service**Aim**

To provide a weight management service for overweight and obese patients:

- Defined as having a BMI $\geq 30\text{kg/m}^2$

and/or

- Increased Waist Circumference – Male 102cm (40ins) & Female 88cm (35ins)

NB: The waist circumference for Asian men should be below 90cm (36 inches) & Asian women should be below 80cm (32 inches)

Objectives

- To facilitate a weight loss of at least 5% in obese patients
- To identify obese patients “at-risk” of developing long-term conditions
- To educate patients in healthy living
- To explore the role of community pharmacists and their support staff in the primary health care team and the extension of that role into the provision of clinical pharmacy services
- To explore the potential to extend the role of community pharmacists and their support staff in weight management

Outcome measures

- Number of recruited patients achieving a weight loss of $\geq 5\%$ of recruitment weight
- Nature and number of pharmacist / support staff interventions
- Number of people identified “at-risk” of developing a long-term condition
- Number and nature of referrals to GPs
- Nature and number of patients referred to community pharmacies by GP practices
- Assess patient and pharmacist team satisfaction with the scheme.

SSS 5: Foot care

Service Description

This service includes preventive health education, risk factor monitoring, and signposting and rapid referral mechanisms for patients with type 1 and type 2 diabetes. Foot care should be considered an important part of self-care for people with diabetes in the same way that monitoring blood glucose or controlling diet is part of the self-care routine.

Pharmacists have a key role to play in providing information and identifying early signs of damage or disease. Within their community health team, pharmacists are also well placed to refer people with diabetes who develop, or who are at risk of developing, foot problems to the relevant healthcare professional.

Service outline

The Level 1 service includes:

- The main role for pharmacists will be early signposting to the appropriate healthcare professional.
- Raising awareness of regular and effective foot care as part of every patient's management of their diabetes in line with local guidance.
- Providing information and support to patients, which allows them to be active participants in their care and to take part in the decision making process. Rapid referral to appropriate local services for any patient with diabetes who presents with a new ulcer or wound, swelling or discolouration of the feet.
- Identifying practical problems in self-care and barriers to effective foot care with rapid referrals to other agencies and health professional as appropriate.

Level 2 services

- Pharmacists may complete additional training to become part of their local foot protection team and undertake 3-6 monthly reviews for people with diabetes who are assessed to be at risk of ulceration.

SSS 6: Pre-conception and pregnancy in diabetes

Background

Approximately 650,000 women give birth in England and Wales each year, and two to five per cent of pregnancies occur to women with diabetes. Diabetes in pregnancy is associated with risks to the woman and to the developing foetus. Pregnancy outcomes for women with diabetes and their babies are worse compared with those for women who do not have diabetes.

Miscarriage, pre-eclampsia and preterm labour are more common in women with pre-existing diabetes, and diabetic retinopathy can worsen rapidly during pregnancy. Stillbirth, congenital malformations, birth injury, perinatal mortality and other postnatal problems are more common in babies born to women with pre-existing diabetes.

Pharmacy's role in pre-conception and pregnancy in diabetes

The various elements of the levels of service in diabetes in pre-conception and pregnancy can be incorporated into other Pharmacy Diabetes Service Specifications, rather than considered as a stand-alone service. Opportunities for pharmacy are as follows:-

Pharmacy provision of advice, information and support on the following:

Pre-Conception

- All women with diabetes should be signposted to receive advice from their GP or relevant healthcare professionals (in line with local signposting contacts) to help them understand their individual contraceptive and pre-pregnancy needs:
 - to assess suitability for pregnancy
 - to optimise glucose control in very early pregnancy
 - to give information about pregnancy and general measures to improve outcome.
- Lifestyle interventions: diet, body weight and exercise during pre and post-natal care
- Taking folic acid supplements (5 mg/day) from pre-conception until 12 weeks of gestation
- Weight management for women with a body mass index (BMI) over 27 kg/m² (before conception) as part of the women's care pathway and in line with local guidelines.
- Advice, support and referral to the GP (if changes to medicines are necessary) with regards to medicines use before conception e.g. advice on the risks of taking ACE inhibitors and statins at conception

Pregnancy

- Reducing risks of diabetes complications in pregnancy with good glycaemic control and self-care
- Awareness of risks of hypoglycaemia in pregnancy, particularly in the first trimester with insulin-treated diabetes
- Taking folic acid supplements (5 mg/day) from pre-conception until 12 weeks of gestation
- Review of, and possible changes to medicines, glycaemic targets and self-monitoring routine
- Signposting where required to other healthcare professionals and local support, including provision of emergency telephone numbers for local out of hours and diabetes helplines to the individual
- Signposting potential gestational diabetes individuals. Risk factors are:-
 - BMI above 30 kg/m².
 - Previous macrosomic baby weighing 4.5 kg or above.
 - Previous gestational diabetes.
 - First-degree relative with diabetes.
 - Family origin with a high prevalence of diabetes (South Asian, Black Caribbean and Middle Eastern).
- The safety of medicines for diabetes during pregnancy and breastfeeding.

SSS 7: Insulin Initiation / Titration

Service Description

- To provide a pharmacist-led insulin initiation service for people with type 2 diabetes and poorly controlled HbA_{1c} requiring insulin. Sessions may be conducted on an individual or group basis.
- To provide a pharmacist-led insulin-dose titration for patients diagnosed with type 2 diabetes and currently on insulin.
- The pharmacist will work under a clinical management plan / local prescribing guidelines agreed by the PCT or local diabetes network.
- Once targets are achieved, patients will be referred back to their GP.
- A fast track referral system will be in place for patients who need a referral to a community dietician and for those who required a referral to secondary care.

Inclusion Criteria (type 2 diabetes)

- All previous attempts to achieve desired target have failed i.e. lifestyle measures, maximum oral therapy
- Persistent failure to achieve desired HbA_{1c} (targets defined in local / national guidelines)
- Patient symptomatic, e.g. unintended weight loss, lethargy
- Intolerance to oral agents
- More suitable to patient's lifestyle

Service outline

- Clinical sessions for people with uncontrolled type 2 diabetes provided within GP practices / community pharmacies for patients referred into the pharmacy service
- Insulin initiation or titration to be carried out in line with locally agreed protocols.
- Patient's current HbA_{1c} value recorded, and a target HbA_{1c}/BG value set for that individual.
- Patient's blood glucose values / HbA_{1c} levels are monitored and recorded.
- This procedure is then repeated at set-intervals, until optimum blood glucose levels are reached.
- Patient HbA_{1c} values are noted at 3-6 month intervals (GP-led or pharmacist-led).
- Pharmacists will need to be trained and accredited to provide this service.

Competencies

- Pharmacists providing this service will be required to meet the same competencies that are needed by other health care professionals e.g. practice nurses and GPs initiating insulin.
- Pharmacists will be required to meet the criteria laid out in the framework document for 'Practitioners with a special interest in diabetes'
- They will also be required to have completed or be undertaking an independent prescribing qualification (if they will be prescribing).

SSS 8: Pharmacist Prescribing

Service Description

- Clinical sessions for people with uncontrolled type 2 diabetes provided within GP practices / community pharmacies.
- Pharmacists will provide a core medication review and prescribing service to patients with a view to treating patients with appropriate medicines to achieve HbA_{1c}, lipid profile and blood pressure targets.
- The pharmacist will work under a clinical management plan (if supplementary prescribers) / local prescribing guidelines agreed by the PCT or local diabetes network.
- Once targets are achieved, patients will be referred back to their GP.
- A fast track referral system will be in place for patients who need a referral to a community dietician and for those who require a referral to another healthcare professional.

Service Outline

- The pharmacist has at least two years post-registration experience and has successfully completed an accredited prescribing training course and is registered with the RPSGB as a prescriber.
- The location used for the provision of the service provides privacy and safety and appropriate facilities for examination of patients, for example hand washing facilities and infection control measures. The facilities should comply with good infection control practice.
- The clinical management plan / prescribing guidelines should be kept as simple as possible
- Pharmacist prescribers should have the ability to request a range of tests from the local pathology laboratory, as described in the clinical management plan
- Pharmacist prescribers should make contemporaneous records of all their interventions in the common patient record. If, however, this is not possible a separate record should be made which should be transferred to the common patient record as soon as possible. Only in exceptional circumstances, (e.g. a weekend or public holiday), should this period exceed 48 hours from the writing of the prescription.

- For each patient the pharmacist should, where appropriate:
 - carry out a medication review;
 - perform or request any testing that may be required;
 - monitor the patient for response to treatment;
 - assess the results of any testing carried out;
 - adjust medicines dosages accordingly (within clinical management plan / local guidelines),
 - discuss the treatment options with the patient;
 - prescribe,
 - update the patient record, and
 - communicate with the independent prescriber appropriately.
- Patients would normally be seen within the community pharmacy or GP practice; however domiciliary visits may be appropriate in some circumstances.
- The PCT will need to provide details of relevant referral points to which pharmacy staff can signpost service users who require further assistance.