NHS Executive

Headquarters

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To: Regional Directors
Regional Pharmaceutical Officers
District Chief Executives
District Pharmaceutical Officers

Copy: FHSA Chief Executives
NHS Trust Chief Executives
Directors of Social Services - for information

EL(95)22
23 February 1995

Dear Colleague,

Specialist palliative care services including the Drugs for Hospices scheme

1. This letter gives guidance on contracting for specialist palliative care services from 1995/96, and on the scheme for the supply of drugs to voluntary hospices.

2. You will now have received your financial allocations for 1995/96. As notified in EL(94)14, funding for specialist palliative care services (including hospices), which was separately identified in 1994/95, has now been incorporated into baselines.

3. Still separately identified within Initial Cash Limits is funding for the supply of drugs for voluntary hospices, which for 1995/96 is:

   £6,854,000 (Distributional adjustment to general allocation - see **Annex B** for Regional allocations).

4. Regions are asked to:

   - ensure that purchasing authorities have agreed service contracts for specialist palliative care to meet the needs of their resident populations for the new financial year no later than **1 April 1995**;

   - publish within 3 months of the date of this letter a summary of these contracts, and notify the Department of Health (NHS Executive HQ) at the address given in paragraph 5 of this letter (below);

   - ensure that purchasing authorities are acting in accordance with previous guidance in EL(94)14 and the additional guidance given in **Annex A** to this letter, with regard to contracting for specialist palliative care services;

- follow the guidance in **Annex B** to this letter on the drugs for hospices scheme;

- provide the return on the drugs for hospices scheme at **Annex C** to the Department of Health by **31 May 1995** (District level information is needed by this date to meet the 1996/97 main allocation timetable. If this date is difficult to meet, please contact Sandra Novit at the address below);

- promulgate the attached professional guidance on the drugs for hospices scheme to all interested parties (**Annex D**);

- ensure that those purchasing authorities collaborating with "total fundholding" pilot schemes make this guidance available to the appropriate GP fundholders and project managers.

5. Enquiries about the content of this letter should be addressed to:

(general enquiries)
Miss Sue Row, Room 528, Eileen House, 80-94 Newington Causeway, London SE1 6EF (Tel: 0171 972 2816)

or,

(drugs for hospices)
Miss Sandra Novit, Room 504, Eileen House, 80-94 Newington Causeway, London SE1 6EF (Tel: 0171 972 2751).

The completed returns should be sent to Mrs Lisa Westall, Room 515, at the same address.

Yours sincerely,

Graham Winyard

DR GRAHAM WINYARD
Medical Director
NHS Executive

This letter will be cancelled on 1 April 1997

Purchasing specialist palliative care services

Contracts for specialist palliative care services

1. Health authorities have a duty to ensure that the identified health needs of their resident populations are met. This includes the needs of terminally ill people who require specialist palliative care. As notified in EL(94)14, funding for hospices/specialist palliative care has been built into recurrent baselines and ceases to be separately identified from 1995/96.

2. The removal of separate identification from funding for specialist palliative care should not be seen in any way as representing a reduction in priority for this area. Ministers and the NHS Executive consider the provision of high quality specialist care to terminally ill people of great importance and are committed to the continued provision of these services. Regions will wish to ensure that an appropriate level of palliative care services for terminally ill people, based on local needs assessment, is purchased through service contracts. Further guidance on Epidemiologically - Based Needs Assessment for Palliative Care and Terminal Care by Dr Irene Higginson will be published by the NHS Executive later this year.

3. **EL(94)14 (Annex A)** gave guidance on contracting for specialist palliative care services. **This guidance remains extant.** In particular, every effort should be made to ensure that contracts are agreed **by the beginning of the financial year** and that, wherever possible, these should be **three-year rolling contracts** to ensure stability of service provision. It is unacceptable for contracts still not to be agreed half way into the financial year.

4. ***Specialist palliative care*** for terminally ill people is defined by the National Association of Health Authorities and Trusts as :

> "active total care when disease is not responsive to curative treatment.Palliative care neither hastens nor postpones death; provides relief from pain and other distressing symptoms; integrates the psychological and spiritual aspects of care; offers a support system to help the family cope during the patient's illness and in bereavement."

It may be provided in an in-patient unit, or in a day care or home setting, and should be available without regard to the individual's diagnosis.

5. ***Terminally ill people*** are those with:

> "active and progressive disease for which curative treatment is not possible or not appropriate and from which death can reasonably be expected within 12 months".

Monitoring

6. Regions should monitor health authorities' performance in this area, paying particular attention to the timely agreement and term of contracts. Although formal monitoring returns to the Department of Health are no longer required (except for the drugs for hospices scheme), Regions should publish locally to providers and other interested parties a summary of agreed contracts *within three months* of the date of this letter, and notify the Department of Health (NHS Executive HQ).

Guidance

7. A Working Party convened by the National Council for Hospice and Specialist Palliative Care Services is producing a series of guidelines concerning specialist palliative care. The first of these ***"The Management of Cancer Pain in Adults"*** was commended to the NHS in EL(94)74 ("Improving the effectiveness of the NHS") in September 1994. Copies can be obtained from the National Council at 59 Bryanston Street, London W1A 2AZ (price £1). Further guidelines are planned; NHS Executive officials are closely involved in this work.

8. The National Council has recently (October 1994) updated its guidance on "Contracting with the National Health Service: Revised Guidelines for Voluntary Hospices" - Occasional Paper 6 (Price £3), which can be obtained from the National Council at the address above. The National Council is also working with professionals in the field to develop more detailed definitions for palliative care, as well as information for purchasers on the Background to Available Specialist Palliative Care Services and Guidance on Outcome Measures for palliative care. Once available, these will be circulated to the NHS and/or to voluntary sector providers, as appropriate.

GP Fundholding

9. Specialist palliative care (including specialist nursing care) is not included in the List of Goods and Services for either "standard" or (from April 1996) "community" fundholding. The 53 pilot schemes announced by the Minister for Health on 16 February, as taking part in the national evaluation programme for "total purchasing" whereby GP fundholders purchase all hospital and community health care on behalf of their patients, will be able to purchase palliative care. Health authorities collaborating with total purchasing pilot projects should ensure that this guidance is available to the appropriate GP fundholders and fund managers.

10. In addition, pilot schemes will be established in 1995/96 to consider the appropriateness of extending the "standard" fundholding scheme to include the purchase of specialist palliative care services. Decisions will not be taken until these pilots, and the total fundholding pilots, have been carefully evaluated.

Health authorities' responsibilities for purchasing palliative care services other than in hospices

11. EL(93)14 and EL(94)14 set out how the NHS's responsibilities for securing palliative care would be affected by the introduction of the new arrangements for community care from April 1993. This guidance still applies. Authorities should address the requirements of HSG(95)8 on **"NHS responsibilities for continuing health care needs"**. It requires all health authorities, in consultation with local authorities and GPs, to develop local policies and eligibility criteria for the range of continuing health care services they will arrange and fund. Annex A of that guidance sets out the key national conditions which must be included in local policies. In this context, authorities should note, in particular:

- **Section D** on responsibilities for funding and arranging palliative health care;

- **Section E** on responsibilities for people who after acute care or specialist palliative in-patient care in a hospital or hospice are likely to die in the near future and where discharge from NHS care would be inappropriate;

and,

- **Section I** on arrangements for specialist transport, including transport to and from a hospice.

Income Support Transfer

12. EL(94)14 gave guidance on the allocation of £5.72 million transferred from the Department of Social Security in consequence of the implementation of the NHS and Community Care Act which removed eligibility for higher rate Income Support from people resident in hospices. This funding, as for the funding for specialist palliative care services, has now been incorporated into health authorities' baselines.

The supply of drugs to hospices

Introduction

1. This scheme which has been in operation since April 1991, was reviewed in 1993. Ministers accepted the Review's recommendation that the supply of drugs and items listed in Part IX of the Drug Tariff to voluntary hospices free of charge through health authority contractual arrangements with community and hospital pharmacists should continue after 31 March 1994.

2. This Annex gives general guidance on arrangements for this scheme in 1995/96. Good practice professional guidance for pharmacists working with voluntary hospices in the scheme is at **Annex D**.

Allocations

3. The funds for each Region for 1995/96 are based on the national average cost per bed and distributed to Regions pro-rata to the forecast number of voluntary hospice beds except for the specialist AIDS hospices in North and South Thames. Funds for the specialist AIDS hospices have been allocated in line with expected expenditure.

Region	Amount (£000)
Northern and Yorkshire	1,006
Trent	273
Anglia and Oxford	542
North Thames	1,186
South Thames	1,157
South and West	911
West Midlands	542
North West	1,237
Total	6,854

Use of funds

4. The funds identified above should be used to contribute to:

- costs incurred by HAs in arranging for drugs to be supplied free of charge to hospices for their use in treating patients for whom the hospices have clinical responsibility;

- costs of supplying dressings, appliances and chemical reagents listed in Part IX of the Drug Tariff to those hospices who would otherwise be obliged to purchase them because the FP10 route is not open to them; and

- associated professional costs.

5. These funds are **not** intended to be used to contribute to:

- costs incurred by HAs in pursuance of statutory obligations; or
- the reimbursement of direct expenditure by hospices.

6. Under this scheme:

- a **hospice** is a registered nursing home, managed by a voluntary organisation, which provides specialist palliative in-patient care for terminally ill people.

Contractual arrangements

7. HAs will continue to be responsible for securing contracts between eligible hospices and suppliers (hospital or community pharmacies) situated in their districts for the supply of drugs and, where relevant, items listed in Part IX of the Drug Tariff. The contractual arrangements should enable hospices to obtain stock drugs and professional advice on the use of medicines. Subject to agreement on the items and services to be supplied, and the application of appropriate cost and quality controls, the HA should arrange for designated suppliers to make these supplies without charge to the hospice.

8. Hospices participating in this scheme will be expected to co-operate in providing such information as HAs may reasonably require to monitor the scheme's operation.

VAT

9. Paragraph 9 of Annex B to EL(94)14 informed health authorities that the supply of medicinal products to a hospice may be zero-rated, provided the hospice is a registered charity and it issues a certificate of zero-rating. EL(94)14 also stated that the paperwork required will depend on the structure of the contractual arrangements. Since EL(94)14 was issued HM Customs and Excise have requested the NHS Executive to expand its guidance on VAT, to reflect the full conditions for VAT relief.

10. Zero rating is for:-

i. "The supply to a charity, providing care or medical or surgical treatment for human beings or animals, or engaging in medical or veterinary research, of a medicinal product where the supply is solely for use by the charity in such care, treatment or research".

ii. "The supply of any relevant goods .... to an eligible body which is a charitable institution providing care or medical or surgical treatment for handicapped persons".

Relevant goods includes medical equipment which includes bandages and dressings etc. 'Handicapped' means chronically sick or disabled. A voluntary hospice registered as a charity qualifies as a charitable institution caring for handicapped persons. There is therefore a wide measure of relief available for supplies to voluntary hospices.

11. HM Customs and Excise have asked pharmacists, through the Hospice Pharmacists Association, to review by 1 April 1995 any contracts or informal arrangement they have for the supply of drugs to voluntary hospices. They have been asked, if they wish to zero-rate or continue zero-rating to ensure that the paperwork makes it clear that they are making *the supply* for VAT purposes (and not merely delivery), to the voluntary hospice and not to the health authority. Although the health authority is paying for the goods the paperwork should make it clear that the ownership of the goods passes to the voluntary hospice and not to the health authority.

12. Community pharmacists' enquiries about VAT should be made to their local VAT office. NHS enquiries should be addressed to the following office which has responsibility for all NHS matters.

Geoff Graham
HM Customs and Excise
Dorset House
Stamford Street
London SE1 9PY

Telephone 071 202 4008
Fax 071 928 3061

Use of FP10s

13. It should not normally be necessary for a GP to prescribe drugs on form FP10 for a patient who has been admitted to a hospice unless, exceptionally, the item required is not in stock and cannot otherwise be supplied without unacceptable delay. GPs may continue to prescribe Drug Tariff items other than drugs on Forms FP10 for patients on their lists.

Statutory requirements

14. This scheme does not affect in any way the obligations of hospices, pharmacists or health authorities in relation to the Registered Homes Act 1984 and the Misuse of Drugs Act 1971 and to Regulations made under these Acts.

Arrangements for 1996-97

15. Allocations for 1996-97, subject to legislation, will be made direct to DHAs. From April 1996 it is intended that DHAs will be responsible for securing or continuing contractual arrangements under the scheme for eligible hospices situated in their districts.

Information for 1996-97 allocations

16. Allocations for 1996/97 will need to be based on District level information. Regions are, therefore, requested to complete and return the proforma at **Annex C** *by 31 May 1995* to meet the 1996/97 main allocation timetable. If you have any difficulty in returning the proforma by this date, please contact Sandra Novit (tel: 0171 972 2751).

The supply of Drugs to Hospices: return for

..... **Region**

District	1995/96 Allocation to support the scheme	Voluntary managed hospice in-patient unit		
		Name	No of beds included in the scheme	
			1995/96	1996/97 forecast
Total for all districts				

Please send returns by **31 May 1995** to Mrs Lisa Westall, Room 515, Eileen House, Newington Causeway, London SE1 6EF

GOOD PRACTICE GUIDANCE FOR PHARMACISTS WORKING WITH VOLUNTARY HOSPICES

Background

1. The scheme for supplying drugs free of charge to voluntary hospices was introduced following problems experienced by hospices in obtaining medicines, especially controlled drugs. Because many hospice directors do not hold a GP qualification, they are not permitted to prescribe medicines using FP10 forms. Consequently, hospices had to buy their drugs or rely on the good will of local GPs to treat hospice patients.

2. In 1991-1992, a sum of money was transferred from the family health services drugs bill and allocated to the 14 regional health authorities (RHAs) in England for the supply of drugs to hospices at no cost to the voluntary hospice movement. This money was provided initially for a two year trial period. The original transfer was supplemented from top-sliced funds.

Hospices

3. For the purposes of the Department of Health scheme to provide medicines free of charge to hospices, a **hospice** is a nursing home registered under Part 2 of the Registered Homes Act 1984, which is managed by a voluntary organisation, and which provides specialist palliative in-patient care for terminally ill people. The term "terminally ill" is not a term that appears in or is defined by this Act. The scheme for supplying drugs to hospices does not affect hospices' obligations under the Registered Homes Act 1984, the Misuse of Drugs Act 1971 nor the regulations made under those Acts.

The Scheme

4. The scheme provided RHAs with a separately identified allocation to meet the costs to health authorities of supplying, free of charge, drugs and items listed in Part IX of the Drug Tariff, and associated services to voluntary hospices. The medicines could be supplied by a hospital or a community (retail) pharmacy. RHAs, for the most part, devolved the money to district health authorities who were responsible for securing contracts between eligible hospices and community or hospital pharmacies. The scope of the contracts, and the range of payment mechanisms, varied considerably. Guidance to purchasing authorities was given in a series of NHS Executive Letters.

5. Following the two year trial, it was decided that the scheme should be continued for one further year, during which a review of the scheme should take place. Following the review in 1993, Ministers decided that the scheme should continue and good practice guidance be produced for pharmacists working with these hospices.

Working Group

6. A working group was set up to consider the role of pharmacists within hospices and to produce professional guidance for pharmacists working with hospices to promote good practice and improve patient care. This working group included representatives from hospital and community pharmacies, purchasing authorities and hospices. A list of the members of the working group is at **Appendix I.**

Contracting

7. Pharmacists wishing to supply medicines to hospices under this scheme do so through contracts arranged by the purchasing authority covering the area in which the hospice is situated. Service specifications should be discussed between the purchasing authority (with pharmaceutical advice), pharmacist and the hospice medical director. **The service that is finally agreed upon should be mutually acceptable to all three parties.** A Checklist of what should generally be included in a contract is at **Appendix II.**

Split Provider Arrangements

8. These are complex arrangements whereby the service to a hospice is split between a hospital and a community pharmacy provider. These arrangements can work only if careful attention is paid to the contracting process so that both parties receive a fair rate of remuneration for the service they provide. Where these arrangements exist, communication between the pharmacists is vital if the hospice and the patients are to receive a good and consistent quality of pharmaceutical care.

VAT

9. Schedule 5 Group 16 (Charities) item 9 and item 5 allows the supply of medicinal products and dressings to registered charities to be zero-rated. This applies to hospices which are registered charities and which issue a certificate of zero-rating. The paperwork required will depend on the structure of the contractual arrangements (see **Annex B** for details).

Dressings and Appliances

10. The money allocated includes funds to provide dressings, appliances and reagents listed in Part IX of the Drug Tariff. Purchasers have the flexibility, where funds permit, to allow for the provision of other dressings that may be beneficial for the care of hospice patients. An agreed list of dressings should be drawn up in consultation with the hospice, purchaser and pharmacist provider and included in the service contract. Items such as sterile goods may be funded by resources other than the money allocated for medicines. These may be included in the contract between the purchaser and the pharmacist provider and invoiced separately.

Out of Hours Services

11. Arrangements should be made locally for the provision of emergency pharmaceutical services to hospices at night, and during weekends and public holidays. This will depend upon the availability and co-operation of the contracted pharmacist. It is good practice for pharmacists who work with hospices to inform their local pharmaceutical committee and the police so that in emergencies local

pharmacists and police officers know which pharmacists in an area are most likely to have supplies of the required medicines.

Oxygen Services

12. The funds allocated for the supply of drugs to hospices are not intended to cover items in Part X of the Drug Tariff. An oxygen service does not, therefore, have to form part of the service contract and may continue to be provided by the FP10 route.

Medicines To Take Home

13. It is good practice for patients to receive both their inpatient and take home medicines from the same pharmacy. This permits changes to medication to be confirmed and reduces the possibility of transcription errors being overlooked. It should also allow patients to ask questions about their discharge medicines from the pharmacist who is familiar with their ongoing treatment and any changes that have been made whilst the patient was in the hospice. It is therefore desirable, if funds are available, for hospice patients to be given a small supply of medicines on discharge to allow time for communication between the hospice and their patients' GPs.

Discharge Planning

14. Patients' homes may be many miles from the hospice and the pharmacist who is familiar with their pharmaceutical care needs. It is good practice for hospice pharmacists to communicate information about a patient's medicines to a pharmacist of the patient's choosing. Information forms for the transfer of information about patients and their medicines between pharmacists are available from the National Pharmaceutical Association and the Royal Pharmaceutical Society of Great Britain. If discharge plans are not formalised or the patient cannot identify a regular pharmacist, patients should be given a name and contact number of the pharmacist who provides the service to the hospice.

Day Care

15. Visits to a hospice day care centre should not normally include routine prescribing of medicines. In exceptional circumstances, arrangements should be in place to ensure that patients obtain the medicines they require without unnecessary delay. If, during a day care visit, the hospice doctor decides that a change of medication is required, arrangements should be in place for the hospice doctor to facilitate this and to communicate the change to the patient's GP. Where funds are available, the supply of medicines to day care centres at hospices, which provide these services in addition to in-patient care, may be included in the contract between the pharmacist and the purchasing authority.

Controlled Drugs

16. Hospices, as nursing homes, must fulfil the requirements of the Misuse of Drugs Act 1971, and subsequent regulations, with regard to the ordering, storage and use and destruction of controlled drugs. Controlled drugs must be stored securely in a controlled drug cabinet and their receipt, supply and removal for destruction must be recorded in a controlled drug register by the person responsible for supply of medicines at the hospice. This will usually be the person in charge of the hospice.

17. The person responsible for the supply of drugs at the hospice may obtain a supply of controlled drugs from a hospital or community pharmacy. However, requisitions made by the person in charge of the hospice must be countersigned by a doctor or dentist employed in the hospice.

18. Where a patient is prescribed controlled drugs to take home, full patient details are required as for any other prescription. Pharmacists may find it helpful to refer to the NPA Information leaflet on Nursing Homes.

19. Where a patient in a hospice is supplied with controlled drugs in accordance with the directions of a doctor, legally, the drugs may be used subsequently for another patient **only** in the following circumstances:-

(i) the first patient obtained them from hospice stock and consciously returned them to the doctor, pharmacist, or the person in charge of the hospice (but not a sister or acting sister in charge of a ward) from whom he obtained them.

(ii) the first patient left his prescribed drugs (whether supplied to him by the hospice or otherwise) in the hospice and subsequently died, without having supplied them to anyone. A doctor, pharmacist or the person in charge of the hospice (but not a sister or acting sister in charge of a ward) may then take vacant possession of them.

Where a patient brings controlled drugs into a hospice (whether previously supplied by the hospice as take home medicines or by another party), these controlled drugs may not be taken into the hospice's stock and used for other patients unless the conditions in paragraph (ii) above apply.

20. Controlled drugs obtained from a patient and returned to hospice stock in either of the ways described in (i) or (ii) above must be recorded as a supply received. In the case of Schedule 2 drugs, the record must be made in the hospice's controlled drugs register. Whilst this advice is legally correct pharmacists should **heed their professional obligations** with regard to re-use of medicines. Pharmacists should take account of the medicine expiry date, satisfy themselves that medicines have been stored at the appropriate temperature, and that systems are in place to provide the appropriate safeguards. Particular attention should be given to the guidance in the RPSGB publication "Medicines, Ethics and Practice: A guide for Pharmacists", Paragraph 5.7(b) "Standards for Dispensing Procedure".

21. Where a hospice patient dies at home, a relative or friend who wishes to return the deceased's drugs may only supply them to a doctor or pharmacist for the purposes of destruction. The drugs must NOT be re-used.

22. For good practice, stock balances should be regularly reconciled with the controlled drugs register at intervals agreed by the medical/nursing director and local health authority inspection teams.

23. Controlled drugs stock which is no longer required within a hospice, for example, out-of-date stock, should:-

(i) either be destroyed by the person in charge of the hospice in the presence of a person who is authorised under the Misuse of Drugs Regulations to witness the destruction;

(ii) or be returned by the person in charge of the hospice to a doctor or pharmacist for destruction.

A record must be made of all Schedule 2,3 and 4 controlled drugs destroyed in the hospice and of all controlled drugs returned to a doctor or pharmacist for destruction. It is good practice for this to be witnessed by another member of staff. In the case of (i) above, the record must be countersigned by the person authorised to witness the destruction. For Schedule 2 drugs, the record of medicines destroyed or returned to a pharmacy for destruction must be made in the hospice's controlled drugs register.

Management of Stock Medicines

24. A list of medicines kept as stock by the hospice should be drawn up in consultation with the provider pharmacist, hospice medical director and senior nursing staff. This should take account of the variety and quantity of medicines that will be required by the hospice. Stock should be rotated to reduce waste. Stock lists of medicines and the quantities stored in the hospice should be regularly reviewed. Provision may be made for separate storage of medicines no longer required in the hospice.
Under the Nursing Homes Regulations (SI 1984 No. 1578), the "registered person" is required to "make arrangements for the recording, safe keeping, handling and disposal of drugs no longer wanted within the home".

Ordering and Paperwork

25. A system should be set up to record:
- orders for stock medicines
- orders for other medicines
- medicines to take home
- date supply made to the hospice
- medicines ordered but not yet supplied
- record of medicines destroyed
- prepared invoices sent to hospice/health authority
- date payments received by provider pharmacist

Legal requirements for recording, and retaining invoices for Controlled Drugs apply in addition to the above.

Patient self-administration of medicines

26. Where patients administer or are assisted to administer their own medicines, an assessment procedure for this needs to be agreed by health care professionals and arrangements discussed with the patients or their carers. Patients who administer their own medicines should be provided with a lockable cabinet or drawer to enable them to store them securely out of the reach of other patients or visitors to the hospice. Such medicines should be labelled for individual use.

Patients' own medicines

27. Local agreements need to be reached about the use of patients' own medicines during in-patient treatment at a hospice. A written protocol should be agreed between medical nursing and pharmaceutical staff involved with care in the hospice. Use of patients' own medicines can overcome difficulties where there would otherwise be an unnecessary delay in obtaining the item(s). The hospice medical director or pharmacist should satisfy himself that the patients' own medicines can be clearly identified and are in a suitable condition for use. Such medicines may also be used on discharge from the hospice if appropriate for the patient's needs. Patients' own medicines may only be destroyed with their permission.

*** Patients' own medicines should not be taken into stock and used for other patients.**

Elements of good pharmacy service to hospices

28. A good hospice pharmacy service would include the following:-

* Advice on the legal requirements for medicines use (Misuse of Drugs Act 1971, Medicines Act 1968 and the Registered Homes Act 1984)
* A prescription monitoring service - checking doses and instructions, looking for contraindications and adverse drug reactions and answering drug information queries
* Specialist advice on the use of dressings, syringe drivers, infusion pumps and intravenous additives
* Education of staff and patients about correct methods of administering medicines
* Information for patients and carers about medicines - doses, instructions for use and possible adverse effects
* Training for hospice staff on stock control, use of medicines and legal requirements
* Participation in multidisciplinary meetings about patients' treatment with a view to better symptom control
* Communication between pharmacists and other healthcare professionals.

Training

29. Pharmacists who contract to provide services to hospices may wish to undertake additional specialist training to help them develop the service they provide. In some districts, pharmacists who wish to contract to provide a service to hospices may be required to receive training as part of their contract.

There are a number of national courses available which may be of interest to pharmacists:

Community Pharmacists:

* The Home Away from Home - Centre for Pharmacy Postgraduate Education (CPPE) - gives information about the principles of drug management within homes, and good background for any pharmacist undertaking to provide services to any residential or nursing home.
* Terminal Care in the Community - CPPE- distance learning course and workshops available.

All Pharmacists:

* Macmillan Palliation in Advanced Cancer (MCPAC) - a computer and distance learning pack, funded by Cancer Relief Macmillan Fund, aimed at GPs, based on case histories.
* Multidisciplinary courses - a list of courses is compiled by the Hospice Information Service, St Christopher's Hospice, 51-59 Lawrie Park Road, Sydenham, London SE26 6DZ.

Networking

30. Pharmacists who contract to provide hospice services may wish to form links with other hospice pharmacists to facilitate information exchange and promulgate good practice. The Hospice Pharmacists Association (HPA) produces a newsletter and holds regular meetings for pharmacists with an interest in the care of terminally ill people. The HPA is administered by the National Pharmaceutical Association. For further information contact Mary Allen HPA, c/o NPA, Mallinson House, 38-42 St. Peters Street, St Albans Herts, AL1 3NP.

APPENDIX I

MEMBERS OF THE WORKING GROUP

Mary Allen	-	National Pharmaceutical Association
Carol Blackshaw	-	University of Keele
Mike Chapman	-	Chairman, Hospice Pharmacists Association
Catherine Dewsbury	-	Pharmaceutical Officer, Department of Health
Dr Philip Jones	-	National Council for Hospice and Specialist Palliative Care Services
Ann Lewis	-	President (formerly, Vice President), Royal Pharmaceutical Society of Great Britain
John Stapleton	-	Newcastle Royal Infirmary
Mary Tompkins	-	North Thames Regional Health Authority (formerly, North East Thames RHA)

CHECKLIST FOR CONTRACTS

APPENDIX II

A service contract would generally include the following provisions:

* ***Parties to the contract***

(a) the name and address of the purchasing authority;
(b) the name and address of the pharmacy contracting to provide the service;
(c) the name and address of the hospice to which the service is provided.

* ***Purpose of the contract***

What the contract is for - ie. the provision of a pharmaceutical service to a named hospice and subject to the terms of the agreed service specification.

* ***Contract period***

Period of time the contract covers, including start date. Date of termination of the contract, and the agreed notice required by both parties should they wish to terminate the agreement at an earlier stage.

* ***Contractors' obligations***

This relates to the service specifications eg.,

- What will be provided by whom and when
- Professional services and the amount of time the pharmacists spends at the hospice
- Provision of non-stock items
- Advice to patients, carers and hospice staff on use of medicines
- Information to patients and carers on discharge medicines.

Specifications may either be set out in the body of the contract or in an annex.

* ***Charitable status of the hospice***

Reference should be made to the charitable status of the hospice. Contractors will need to have proof of this status for the purposes of zero-rating for VAT.

* ***Terms and fees***

Payment terms for drugs, dressings, appliances and professional services.

* ***Standards***

As required by the Misuse of Drugs Act 1971, the Registered Homes Act 1984 and subsequent regulations, and in accordance with local inspection unit policies, NAHAT guidance and the Royal Pharmaceutical Society of Great Britain standards for good practice.

* ***Data protection***

Pharmacists' responsibilities in relation to records of patients' treatment by the hospice.

* ***Signatures and dates***

Contracts are only valid if signed and dated by all the parties.