

What is needed to take pharmacist prescribing into the mainstream

It is more than two years since the first pharmacist started prescribing, in March 2004. **Clare Bellingham** reports on progress in Scotland

Pharmacist prescribing is pushing forward. With 7 per cent of practising pharmacists in Scotland registered as supplementary prescribers, and a pharmacist prescribing in 5 per cent of community pharmacies, the agenda now is about how to make prescribing a mainstream activity.

This is exactly what was discussed at a national pharmacy conference, held in Stirling on 26 November. "The conference aimed to share best practice, develop support networks and spread change," explains Annamarie McGregor, pharmacist prescribing co-ordinator at NHS National Services Scotland.

Although being a pharmacist prescriber is becoming less unusual, it is still hard work and every pharmacist at the conference had to overcome barriers before starting to prescribe. But Ms McGregor believes pharmacy in Scotland has reached a tipping point. "With any new service, once more than 2.5 per cent of people are offering it, you are getting beyond the threshold where the new practice is restricted to the innovators," she explains. Pharmacist prescribing, it seems, is starting to become mainstream.

Bill Scott, chief pharmaceutical officer, Scottish Executive, wants to see all pharmacists who directly provide patient care become prescribers. "Prescribing is one of the tools that pharmacists will have to enable and improve the pharmaceutical care of patients," he told *The Journal*. But he says mass pharmacist prescribing is largely dependent on prescribing being part of the undergraduate pharmacy degree.

Drawing on experience

Central to prescribing taking off was the Scottish Executive's decision to make national funding available for community pharmacists to run prescribing clinics. "One of the successes of this funding was its lack of restrictions. It allowed pharmacists to develop their own clinic, rather than specifying the way in which the money should be spent," explains Ms McGregor. "We now have many examples of how prescribing can be used and, because they have been developed by the pharmacists who use them, we know these models work in practice."

Now Ms McGregor is drawing on these examples to create a best practice guide. The guide will not be restricted to supplementary prescribing. It will help inform the development of independent prescribing services too. The guide will provide examples of service protocols and clinical management plans, and case studies of what individual pharmacists



Pharmacist prescribers are becoming less unusual

are doing. Some of the featured pharmacists have told *The Journal* about their work (see Panels).

If prescribing is to become mainstream, what needs to happen? First, pharmacists have to work out how prescribing fits into their everyday job. As pharmacists develop different roles and areas of expertise, the profession needs to debate how pharmacists will work together to provide an optimal pharmacy service.

Many examples exist of community pharmacists who have set up prescribing clinics, most frequently in hypertension and asthma. It is a fantastic start, demonstrating that pharmacist prescribing works. But now pharmacy has to decide how to make best use of prescribing: is it beneficial for patients to go to one pharmacy for a hypertension clinic then another for diabetes? Or should community pharmacists be thinking about using prescribing within a more generalist role, such as making dose adjustments across a range of therapeutic areas as part of medication review? This would not prevent them having a specialist clinical area, but perhaps this needs to form a secondary prescribing service to deal with complex cases. Such a service could be offered jointly with hospital and primary care pharmacists, with pharmacists in one locality teaming up to ensure all clinical areas are covered.

In Glasgow, the case of Alia Gilani (see Panel 2, p692) demonstrates how the skills of a prescribing pharmacist can complement those of a community pharmacist. Without the community pharmacist's ability to identify patients — which comes from establishing relationships with regular patients — the prescribing pharmacist's role would be less effective at targeting patients with the greatest need.

Panel 1: Hospital prescribing in acute situations

How supplementary prescribing can fit into acute situations is demonstrated by Pamela Mills, principal pharmacist in redesign, NHS Ayrshire and Arran. She uses supplementary prescribing in a clinical decisions unit at Crosshouse Hospital in Kilmarnock. This means she prescribes in acute, unscheduled care.

The unit aims to make a rapid diagnosis to shorten the length of a patient's hospital stay. "The initial problem was how to adapt the supplementary prescribing model into this acute situation," says Ms Mills. The solution was the production of six clinical pathways, each with standard clinical management plans (CMPs) which are pre-signed by the clinical director.

The clinical pathways are for non-traumatic chest pain, suspected pulmonary thromboembolism, deep vein thrombosis, cellulitis, hypoglycaemia and minor gastrointestinal bleed. Once a diagnosis has been made, Ms Mills takes over. She follows a standard CMP to start new medicines, to adjust doses of these medicines according to laboratory results and to issue discharge medicines. She can also prescribe any of the patient's existing medicines.

"Take the chest pain pathway for example. If the patient has an exercise tolerance test which is positive for an angina diagnosis, I would then start appropriate medicines — aspirin, statin, glyceryl trinitrate spray and beta-blockers unless contraindicated. I would also look at replacing existing medicines that are now contraindicated, such as non-steroidal anti-inflammatory drugs," Ms Mills explains.

Ms Mills is currently the only prescribing pharmacist on the unit but the pathways are followed by non-pharmacist prescribers when she is away. This ensures standardisation of care. She advises pharmacists who are thinking about introducing supplementary prescribing to produce similar pathways. "They are useful in making clear exactly what is going to happen," she says.

"As more and more pharmacists are becoming prescribers, it enables us to support each other," she says. This concept has clearly worked in Ayrshire where 13 pharmacists in secondary care have registered as supplementary prescribers and 11 more are in training.

"All pharmacists need to work out how our different roles will fit together and how we support each other, including how we work with our own team," says Ms McGregor. This underlines another consider-

Panel 2: Three case studies from community pharmacy and primary care in Scotland

Overcoming GP barriers in community pharmacy

Many GPs are supportive of supplementary prescribing. But what happens when one GP in a practice is not keen and holds others back from developing supplementary prescribing? This was the problem faced by David Raeburn, community pharmacist at The Spa Pharmacy, Strathpeffer. How did he overcome the barriers? "I did something for the surgery," he explains. "They had been asked to review their elderly patients on NSAIDs to ensure they were all receiving a proton pump inhibitor. I offered to do the reviews," he explains. His input was valued and gave Mr Raeburn the opportunity to demonstrate his competence. "I was then able to move on to setting up the pain clinics," he says.

Mr Raeburn is currently focusing on migraine. The surgery invites patients receiving migraine treatment to attend a review clinic run by Mr Raeburn. "In the first appointment, I take a clinical history and carry out a medication review. I then give the patients a pain diary. The second appointment is about determining if the patient is receiving the right treatment," he explains.

Mr Raeburn has opted to run the clinics in the surgery. He believes having his presence there is of value to remind the GPs of his role, and to reinforce to patients the working partnership between the GP and the pharmacist.

Joint approach to run community pharmacy clinics

If a pharmacist does not want to be a prescriber, or has not yet undertaken the prescribing training, it should not restrict their patients' access to a pharmacist prescriber.

Alia Gilani, pharmacy and prescribing support pharmacist at NHS Greater Glasgow, has been running prescribing clinics for some time, focusing on the needs of the South Asian community. A recent development was setting up prescribing clinics in a community pharmacy where the pharmacist is not a prescriber. "We were keen to take the clinics to where people are, so we found a pharmacy in the centre of the community in Pollokshields," she explains.

The community pharmacist identifies patients with diabetes or coronary heart disease, gets patient consent forms signed and then hands them over to Ms Gilani. She sees the patient at a clinic in the pharmacy where she conducts a full

medication review, issues prescriptions, carries out investigations and may refer the patient to another service.

"I have reviewed 81 patients so far and have about 20 on the waiting list. On average, I see patients for three to nine months," Ms Gilani explains. "One of the differences between patients identified at the pharmacy and those at the surgery is the pharmacy patients tend to be younger. They want to change their lifestyle to tackle health issues."

Practice and community pharmacists team effort

In Dundee, a practice pharmacist and community pharmacist have teamed up to offer supplementary prescribing clinics. Both can prescribe and they have contributed different skills to a successful joint approach.

Jackie Duncan, practice pharmacist at Hawhill Medical Centre and Ryehill Medical Centre in Dundee, explains that the starting point was building relationships with GPs. "I had been working with the practices for seven years when I started prescribing so had built up a relationship," she says. This made it easier for community pharmacist Helen Christie of Alliance Pharmacy to start running hypertension clinics.

"It made sense to start clinics at the surgery so Helen could develop a relationship with the doctors. If she had started in the pharmacy then this would not have happened," Ms Duncan explains. After a while, they targeted certain patients, including the "do not attend" group. "This is when we moved some of the clinics out into the pharmacy because it is positioned near to a university so catches students who do not attend the surgery. Another use of pharmacy clinics is on Saturday mornings," she adds.

What Ms Duncan would like to do next is develop a CMP that covers all surgeries within the local Community Health Partnership. Dundee has over 20 medical practices, and a supplementary prescriber currently needs a standard CMP and prescription pad for each surgery. "We are now looking at the possibility of getting a CMP that would be signed by the lead clinical at the CHP. There is a precedent for this as heart failure nurses in Tayside have a CHP-wide agreement," she explains.

ation: how pharmacy staff fit into prescribing services. Their role as checking technicians — a way to separate prescribing and dispensing — is frequently mentioned. But how about more clinical roles, like measuring blood pressure or taking blood samples? This could help pharmacists to provide a holistic service.

Importantly, pharmacists need to prove that prescribing is a service that works. David Raeburn, a prescribing pharmacist in Strathpeffer, says audit is essential. "We need to evaluate what we have achieved and how patients have benefited. The only way to convince people of our worth as prescribers is to provide documented evidence," he explains. He suggests a national agreement on what to audit is needed — then all prescribers can produce evidence on the same defined outcomes.

Support needed

One of pharmacists' key demands is a network for prescribers to swap ideas and practice. Exactly how such a network would be structured is open for debate: should it be for pharmacist prescribers only or for all prescribers? Should it be divided into clinical areas? And who should run it?

Mr Scott thinks this is the sort of role that should fall to the Royal Pharmaceutical Society. He would like to see cross-professional standards for prescribing, and is calling on the Society to develop them. "I would like the Society to raise its game and become the

body in Britain that is coordinating prescribers," he says. "The Society should see itself as the body with most interest in medicines and a central focus for all prescribers. If it will not do this then someone else will. It is not about creating a set of rules but about developing standards of good practice, and allowing prescribers to exchange views and support each other."

Then there is IT. Pharmacists still have to handwrite prescriptions, which is time consuming and means that prescriptions are not automatically added to the patient's medical record. The other IT issue is the lack of access to patient's medical records in community pharmacy: this, more than any other issue, is preventing prescribing clinics being shifted from a GP practice into the community pharmacy.

But there are examples of pharmacists who have found a way around the problem. Martin Jackson, a community pharmacist and prescriber at Aberdour Pharmacy in Aberdour, Fife, has access to medical records at his pharmacy. "Initially, I had access via a laptop. The doctors had a system for out-of-hours access and we tapped into that," he explains.

The GP practice with which Mr Jackson works is based elsewhere but uses premises in Aberdour to run a village surgery. "When these premises became unsuitable, the practice started to use the large consultation room

in the pharmacy to offer twice weekly surgeries," says Mr Jackson. For this to work, the GP computer system had to be available in the pharmacy. Mr Jackson now makes the most of this access to run supplementary prescribing clinics for patients with a variety of long-term conditions including pain, respiratory disease and cardiovascular disease.

Mr Jackson finds it difficult to understand why pharmacy-access to notes is so unusual. "The technology is available now to allow pharmacies to dial into surgeries to access notes, or access could be via laptops or palm-tops. There are practical difficulties for pharmacies that deal with many surgeries but a large number of pharmacies only deal with one or two surgeries," he says.

When access to notes is discussed, it is easy to blame the lack of IT. But the underlying problem is much wider. Doctors are happy for pharmacists to access records when it is within the walls of the medical practice, but they are nervous about taking the records out of the practice and into a pharmacy. Mr Scott admits it is a political minefield. "If pharmacists, GPs and patients can come up with local agreements like this then it will demonstrate to politicians that the fears they have might not be realised," he says.

Prescribing is certainly on the way to becoming mainstream in Scotland, but there are still a number of issues that need ironing out and lessons to be learnt across Britain.