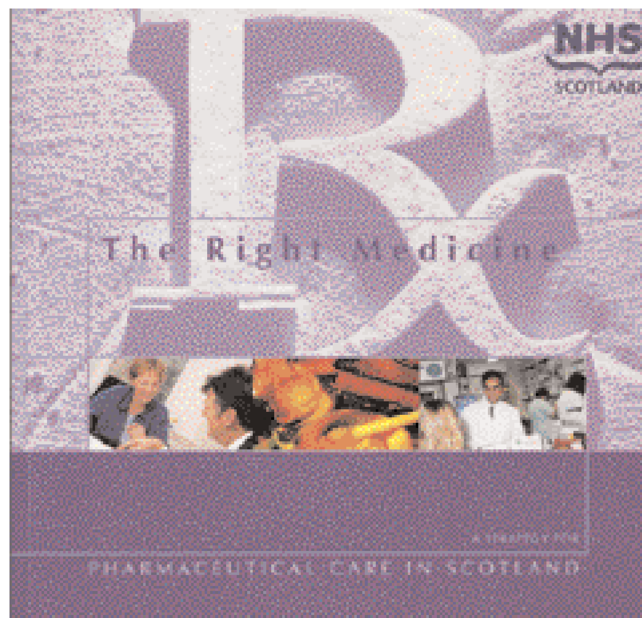
ONE YEAR ON: HAS IT BEEN THE RIGHT MEDICINE FOR SCOTLAND?

By Jonathan Buisson

"The right medicine: a strategy for pharmaceutical care in Scotland" was published a year ago. This feature looks at how it is being implemented and what progress still needs to be made.* The Journal *visited Tayside and Fife to see two of its key pilot schemes, direct supply and repeat dispensing, in action. Other articles describe how they are moving towards regional and then national roll-out



STRATEGY MAKES STEADY PROGRESS

Individual parts of the strategy are progressing well. The challenge will be to make these into a greater whole

In its introduction, the Scottish pharmaceutical care strategy — "The right medicine" — says that it sets out an achievable vision for modernising pharmacy services. This phrase appears to sum up the strategy's key strengths to date: the projects undertaken have been modest but achievable and contribute towards the larger vision of a modern pharmacy service. The biggest challenges will come as the strategy nears its completion date of 2005 and the individual parts have to be melded into the whole of a new contract for community pharmacy in Scotland.

Bill Scott, chief pharmaceutical officer at the Scottish Executive Health Department (SEHD), says that seven of the key action points identified in the strategy for delivery in the first year have been achieved and the remainder are near to achievement.

"'The right medicine' has 60 action points in total," says Mr Scott. "These are all interrelated to deliver three key objectives for pharmacy in Scotland, which are health improvement, the treatment of minor illnesses within the NHS and contributing to chronic disease management."

Among the action points completed so far are trials of electronic transmission of prescriptions (including the connection of community pharmacies to the NHSnet), which are under way in Ayrshire and Arran, and starting pharmacist prescribing, which is being extended across Tayside in the form of the direct supply of non-prescription medicines to patients exempt from prescription charges (see p198). In addition, repeat dispensing is rolling out in north-east Fife (see p200). All of these appear to be, individually, successful so far. The SEHD has also supported some "quick win" schemes, such as encouraging community pharmacies to display the NHS Scotland logo (*PJ*, 11 January, p40).

A programme for modernising some community pharmacy premises, supported by over £500,000 of funding, has also been implemented (see Panel, p198).

David Thomson, chairman of the Scottish Executiveof the Royal Pharmaceutical Society, says that a one-year report card for the Scottish pharmaceutical care strategy should read "Good work in progress — more to follow".

"It hardly seems 12 months since the launch of 'The right medicine'," says Mr Thomson. "This reflects the pace of activity that has been evident in this time. Clearly the promise that the strategy would herald a period of unprecedented change for pharmacy in Scotland has been extremely accurate. This pace will continue to gather momentum as the support networks become established."

Frank Owens, chairman of the Scottish Pharmaceutical General Council, is also pleased with the progress being achieved to date with the strategy.

"The strategy may well be bold and ambitious, but we need to be aware that it is only one part of a much bigger and bolder plan for the modernisation of the entire Scottish primary care service."

He adds that the modernisation process offers opportunities for pharmacy that it declines at its peril.

"Of course, delivering the vision will necessarily require considerable resource. Realising that resource will be the responsibility of the SPGC in negotiating a new pharmacy contract."

Discussions have already begun on the principles of this contract. The pharmaceutical care strategy covers the period until 2005 and the new contract may well take effect from then. The key principles identified mirror those in the strategy, namely health improvement, access to pharmacy

Jonathan Buisson is news editor of The Pharmaceutical Journal

services and chronic disease management. Access will cover areas such as direct supply, repeat dispensing and out-of-hours services.

In terms of chronic disease management, Mr Owens says that while good progress has been made to date through some of the pharmaceutical care model schemes, there is still a long way to go in developing the necessary infrastructure, changing practice and applying suitable support and finances. "That said, I firmly believe that the effort involved, monumental as it may be, will be well rewarded, securing a viable future for the next generation of pharmacists."

COMPLIANCE NEEDS

One sign of this future role can be seen in the compliance needs assessment initiative launched within the past three months. Under this initiative, vulnerable patients living at home who are experiencing difficulties managing their medicines can be referred by a range of health and social care professionals. Pharmacists then carry out assessments either in a pharmacy or at the patient's own home. If appropriate, monitored dosage systems can be supplied.

"In essence, there are two aspects to this scheme," Mr Owens says. "There is the mechanical filling of the boxes, but of far more importance is the fact that it provides pharmacists with an opportunity to develop consultation skills for when medication review becomes part of normal practice."

The pharmaceutical care strategy has been supported by a review of pharmaceutical public health carried out by the Public Health Institute of Scotland (*PJ*, 18 January, p70). "Pharmacy for health" makes 23 recommendations in four key areas of health improvement, support networks, skills development and evidence-based practice. Among its suggestions are the use of "spotter pharmacies" to monitor public health and disease spread through patterns in the sales of non-prescription medicines and consultations with pharmacists. The report has been sent to pharmacists and senior public health figures in Scotland.

Viewed from afar, it is clear that good progress is being made in several separate areas of the pharmaceutical care strategy. This progress will be given a hard test this year as pilots are extended to larger areas. After that comes the hardest part of all — making a coherent and sustainable future role out of the individual successes.

Community pharmacy premises upgrades

The Scottish Executive Health Department set aside around £400,000 for a series of projects to upgrade some community pharmacies when the Scottish pharmaceutical care scheme was launched. *The Journal* found that in the main these projects are progressing well with several completed last year and dates set for work on others early this year. Some of the projects include:

- ***Duns*** George Romanes of Duns Pharmacy received funding for a new consultation area, patient information displays and computer networking
- ***Dundee*** Moss Pharmacy has established a health promotion centre at its Albert Street, Dundee, branch (*PJ*, 24 August 2002, p240)
- ***Dornoch*** Mitchells Pharmacy will start work this month on a refurbishment which will include lowering the shop floor to improve disabled access and the installation of two patient counselling and services rooms
- ***East Kilbride*** Munro Pharmacy installed "drive through" facilities

TAYSIDE DIRECT SUPPLY PROJECT MOVES TOWARDS FULL REGIONAL ROLL-OUT

An increasing number of pharmacists in Tayside are now prescribing under the "DirectCare at the Chemist" scheme. In Arbroath and Montrose, the scheme is already well established. More urban areas will adopt the scheme this year

Tayside's "DirectCare at the Chemist scheme is doing more than just allowing community pharmacists to write prescriptions, it is establishing a new model of how pharmaceutical services can be provided and remunerated, John Hamley, chief pharmacist at Tayside Primary Care Trust, believes.

Under the scheme, patients who are exempt from paying prescription charges can register with a community pharmacy and be prescribed non-prescription medicines by pharmacists on the National Health Service. Pharmacies are paid a capitation fee and are reimbursed by the Prescription Pricing Division in the normal way for the medicines supplied. Thus, Mr Hamley and his colleagues point out, it has established the principles of patient registration, capitation fees and pharmacist prescribing. Information technology links and the use of a single common patient identifier are also important parts of the scheme.

Ken Penman, project co-ordinator for the scheme, explains that the scheme started in November 2000 with baseline data on general practitioner consultations and prescribing being gathered. In April 2001, the first pilot phase of the scheme started in the Arbroath area, involving five GP practices and six pharmacies (both independents and multiples).

Ken Penman: patients and pharmacists are happy with the direct supply scheme

Mr Penman explains that the aim of the scheme is to avoid patients who are exempt from paying prescription charges making appointments with their GP just to get a prescription so that they can get an over-the-counter medicine without having to pay for it themselves.

"The scheme improves access to health care for patients, GPs make more use of their skills because they see a more appropriate range of patients, community pharmacists make more use of their skills, and it encourages joint working between pharmacists and GPs," he says.

Registered patients can receive a range of non-prescription medicines used to treat common minor ailments (see Panel, p199). In addition, patient group directions are used to allow some medicines, particularly those for hay fever, to be supplied in quantities larger than the pharmacy medicine pack sizes. Patients can also be given appropriate advice (with or without a medicine) or referred to their GP. CP1 prescription forms are used to record the medicines supplied, allowing reimbursement, and each consultation is noted in the pharmacy patient medication record (PMR) system with the pharmacist as the prescriber.

Mr Penman says that since the start of the scheme in Arbroath, over 2,000 patients

have been registered. Of these, around half have consulted a pharmacist with 92 per cent subsequently receiving a medicine, 3 per cent being given advice only, 2 per cent making an over-the-counter purchase and 3 per cent being referred to their GP for a routine appointment. Only a few consultations have required an urgent appointment with a GP.

The most common complaints treated have been head lice infestation, pain in children, coughs, indigestion, nasal congestion and hay fever. Both patients and pharmacists have been happy with the scheme and are keen to see it continue.

ROLL OUT THE BARREL

Where the DirectCare scheme differs from other similar and successful pilots in England is that it is progressively being extended across the whole of Tayside. In November 2002, it was extended to Angus Local Health Care Co-operative, a rural area of 110,000 people with five population centres and a further 16 community pharmacies. By April it will cover Perth and Kinross LHCC and 133,000 people in an area which is largely rural but also includes the city of Perth. If this is successful then it will be rolled out to Dundee, the main urban area in Tayside, it is hoped by the end of the year. The rest of Scotland would then be covered, region by region, next year.

Mr Hamley explains that one reason why Tayside was selected as one of the direct supply pilot sites (the other is at Patna, Ayrshire, see *PJ*, 4 January, p26) is the widespread use of the community health index (CHI) number. This is a unique patient identity number, encoding the patient's date of birth and sex, which is now used on all patient records in both primary and secondary care in Tayside. Using the CHI number on the pharmacist prescriptions allows them to be linked to all the other health records, and for the appropriate GP budgets to be cross-charged. The CHI number will also become important when the scheme is extended to Dundee and there is a greater use of IT.

One of the reasons why the direct supply scheme is now forging ahead is the appointment of Mr Penman as its project manager. Jean Wallace, now one of Tayside's 35 practice pharmacists, was involved with the first phase of the pilot as manager of the Lloydspharmacy branch in Arbroath. "Before Ken arrived, we were going nowhere," she says. "There was lots of heated discussions but no agreement. Ken brought the GPs and pharmacists together and took away our fears."

One of Mr Penman's tasks has been to visit all the GP practices and pharmacies ahead of the scheme's roll-out in Angus. Each pharmacy was allowed to choose its own start date. Local publicity for DirectCare starts this month. The procedure for enrolling patients has also been simplified, with the main difficulty being obtaining patients' CHI numbers. Mr Penman ran well-attended training evenings for pharmacy staff.

As the roll-out goes regional, and then national, a number of corporate governance issues need to be addressed, Mr Hamley says. These cover fraud prevention, ongoing funding and payments, data protection and confidentiality and the possible need for a separate pharmacy prescribing budget. "It is these corporate issues we need to address if we are not to be in big trouble later," he says. The Association of Scottish Trust Chief Pharmacists is trying to draw up a template for these issues.

PRESCRIBING IN ACTION

In Arbroath and Montrose, pharmacists and their green CP1 prescription forms have become part of the health care scene. At Boots The Chemists in Arbroath, pharmacists Angus McNicoll and Margaret Hagan say that direct supply has been well received by customers. Apart from some initial confusion between pharmacist prescribing and repeat dispensing, patients have found the scheme useful. One common scenario is where a mother is told about a head lice problem when collecting her children from school. With the DirectCare scheme she can come straight to the pharmacy and receive the necessary treatments without needing either a doctor's appointment or any money.

Diane Manzi: I hope the formulary can be expanded

At Steeple Pharmacy, Montrose, pharmacist owner Diane Manzi says that supplying non-prescription medicines is something pharmacists have always done. "Now, with DirectCare, we can supply those exempt patients who would previously have had to wait two or three days to get a prescription." At Steeple Pharmacy, a recently installed consultation area, part-funded by Tayside NHS Board, allows the pharmacist to access the PMR system while counselling patients. Consultations before a direct supply are made here.

Mrs Manzi says that the formulary against which pharmacists can prescribe is limited at present. She hopes it will be extended when it is reviewed later this year. "For example, I could see patients wanting nicotine replacement therapy coming in every couple of weeks. Using our Smokalyzer [carbon monoxide breath analyser] we could demonstrate to them the benefits of giving up smoking while prescribing the next instalment."

So far, the DirectCare pharmacist prescribing scheme is proving a success. Extending it to cover Dundee will be challenging, because a more mobile population is likely to use more than one pharmacy at different times, but if the scheme can be made to work there then there should be less difficulty in extending it to the rest of Scotland. There will then be the opportunity to widen the range of conditions treated and the variety of medicines which can be prescribed, perhaps with prescription only medicines being included.

DirectSupply at the Chemist formulary

The pharmacist formulary for the DirectSupply at the Chemist scheme covers a range of common minor ailments, such as indigestion, hay fever, pain, athlete's foot, cold sores, eczema and head lice infestation. Each of the six sections in the formulary contains the products and pack sizes that can be prescribed, listed in British National Formulary order, together with any specific advice to be given to patients. There is also guidance on when patients should be referred to a general practitioner or where self-care is encouraged. An example from the formulary is given below.

PAEDIATRIC ALLERGY

Chlorpheniramine syrup 2mg/5ml 150ml

Refer to GP *Wheezing or shortness of breath; tightness of chest; persisting painful ear or sinuses; purulent conjunctivitis; failed medication (no improvement in symptoms after 10 days)*

REPEAT DISPENSING WILL MERGE WITH ETP AND MEDICINES MANAGEMENT

Master and slave prescriptions await dispensing at Elie Pharmacy, Fife. To extend the scheme nationally, paper prescriptions will need to be replaced by electronic ones and dispensing integrated with medicines management

The master prescription is accompanied by up to five slaves plus compliance and diagnosis sheets

If repeat dispensing is to become an established service it will need to be integrated with medicines management, supplementary prescribing and electronic prescriptions as part of a new philosophy of care, Alison Strath believes.

As well as piloting repeat dispensing at the pharmacy in the coastal village of Elie in Fife, which she owns with her husband, Ms Strath is also principal pharmaceutical officer at the Scottish Executive Health Department (SEHD) charged with overseeing implementation of the Scottish pharmaceutical care strategy.

For the Elie pilot, software at the local medical practice has been amended to issue batches of up to six "master and slave" prescriptions for patients taking part (56-day prescriptions can also be issued). The master prescription contains the complete quantity for the six-month period and instructions for dispensing in instalments. The master prescription is signed by the prescriber and is pre-endorsed with the final quantity to be supplied. It is the last of the six to be dispensed. The other five numbered forms are preprinted with the quantity and instructions for each instalment but are not signed. The forms each contain a maximum of two items (rather than the normal three) and a barcode of the type being used in the Scottish electronic transfer of prescriptions (ETP) pilot. In addition, patients are given a compliance form which they use to indicate which items they want to collect on each occasion and a diagnosis form which they can hand to the pharmacist if they wish.

Ms Strath says the compliance forms are a helpful reminder to the pharmacist of which patients are in the scheme. They can also be used to measure trends in medicine use. An example of this is the frequency of requests for asthma inhalers, which may not always need replacing monthly.

"Patients give consent to join the scheme and for agreed diagnosis data to be shared. The diagnosis forms allow this sharing and also promotes the idea that the patient record belongs to the patient. To date, no patient has refused to allow sharing," she says.

Two modifications have been made to help the scheme run smoothly. First, the repeats work on six-month horizons. So if a patient has a new medication added, the system calculates the quantity needed to reach the end of the current block (rather than just adding six-months worth). As a result, the instalments do not get out of sync. Second, the prescriber can put items, such as inhalers, that might not be required each time, on a separate prescription form. "The one problem we have not cracked yet is what happens when a patient has a medicine stopped or discontinued. You get some feedback from the fact that it is not being ordered on the compliance form, but we want to use the NHSnet so that a message is sent to the pharmacy when this happens," Ms Strath says.

PATIENTS APPRECIATE THE SERVICE

"Repeat dispensing takes away patients' worries about running out of medicines," Ms Strath says, adding that patients are pleased to see their GP and pharmacist working together. A further 12 GP practices and 16 pharmacies, including multiples, in north east Fife will join the scheme in April.

Paper prescriptions have helped make the repeat dispensing pilot work, but it is easy to see how they could quickly overwhelm busy pharmacies if the scheme was to become commonplace. "Prescriptions are an anomaly for the way pharmacists will work in the future," Ms Strath says. "We need to look at prescribing events, not just prescriptions."

The aim is to bring together supplementary prescribing for chronic conditions with repeat dispensing and ETP, or e-pharmacy. In this way, pharmacists will generate the necessary prescriptions as the patients need them.

"We are looking at this as part of a programme of activity and we are discussing with the Scottish Pharmaceutical General Council how it might be funded. There will still be a need to remunerate pharmacists for the medicines supplied."

Ms Strath adds that it is intended that both community and hospital pharmacists will be part of the first training programme for supplementary prescribing in Scotland later this year. "We want to get repeat dispensing ready for them so that they have the tools needed for managing chronic conditions." It is hoped that the next release of the GPASS software, which is used in 85 per cent of GP surgeries in Scotland, will be "repeat dispensing ready". Talks are also taking place with pharmacy software suppliers and the Scottish ETP project team.

A CRITICAL STAGE

"Repeat dispensing is a critical stage. If we can get this underpinned by ETP it will make the biggest difference to pharmacists, GPs and the Prescription Pricing Division. It shifts a large amount of work from GPs to pharmacists while helping pharmacists plan their workload and stock control. We need to make sure we get the practice right and then design the IT around that," she says.

Discussions have begun on a new contract for community pharmacists in Scotland with the aim of it being implemented in 2005. It is likely to focus much more on services rather than volume of dispensing. The challenge will be to define a new chronic medicines management service taking in the work started in Elie.