

Pharmacists and GPs work together to support benzodiazepine withdrawal

Many patients want to stop taking benzodiazepines. **Debbie Andalo** finds out how they can be helped

Many programmes have been developed to help patients stop taking benzodiazepines and, in one of the latest, a practice pharmacist and a GP have successfully been working together.

In a pilot — which is due to be extended across a primary care trust area — around 50 per cent of those patients who had been on the drugs long-term, and wanted to stop taking them, have done so. GPs at the practice in Cleveland have in the past offered benzodiazepines on a 14-day acute prescription but they were keen to reach those patients who had been on repeat prescriptions for a long time. Since the pilot was launched two years ago, six of the 16 practices in Langbaugh Primary Care Trust have also developed a partnership with their support pharmacist to tackle benzodiazepine use.

Now the PCT is planning to employ a specialist mental health nurse to work across all practices to give extra support to the pharmacists and GPs to tackle the problem of those patients who have been on benzodiazepines long term.

The initiative coincides with plans by chief medical officer in England Sir Liam Donaldson to introduce “installment dispensing” for benzodiazepines where pharmacists, relying on a GP’s single prescription, can dispense the drug daily in an attempt to reduce patient access and control GP prescribing to ensure they reflect national prescribing guidelines (*PJ*, 28 February, p238).

The prescribing project in Cleveland began after GPs at the Woodside Surgery wanted their pharmacist, Elizabeth Walker, to help them address the number of patients who had been taking diazepam, nitrazepam and temazepam for a long time. Mrs Walker carried out an audit of patient records and sifted out those patients who were on long-term use, in some cases up to 20 years, who had no record of intervention with psychiatric services.

She said: “These were just ordinary people, with no mental health issues who were on these drugs.”

The patients were then written to and invited to attend a practice clinic where they would be supported in being weaned off the drugs in a structured way. They were also sent a “sleep hygiene” leaflet, which spelt out simple advice for having a good night’s sleep. Patients were reminded to relax towards the end of the evening and not to drink coffee late at night.

Perhaps surprisingly the pack was the only catalyst which some patients needed to wean themselves off the drugs. Mrs Walker said: “Some of the patients would come in and say to me ‘I have gone down from two to one and a half tablets’. At the clinic we would spend time talking to them but it was the patient who made the final decision. The significance, I think, was that we were supporting those patients who were interested in being helped.

“The practice was also supportive because it was something which the GPs wanted me to look at.”

Behavioural therapy training

She suggested that other pharmacists who are keen to introduce a similar scheme might consider having some cognitive behavioural therapy training.

“I hope that I am able to empathise with people but I think some formal cognitive behavioural therapy would be useful. I probably could have benefited from some specialist training beforehand.”

Stephen Childs, the PCT’s director of primary and community services, said local GPs were committed to reducing benzodiazepine prescribing and meeting government guidelines but were pressed for time.

He admitted: “GPs don’t always feel they have got the time they need to devote to these patients — the time that is needed to

counsel them off the drugs and what we want to do is bring in dedicated support.

“I think we may end up with a combination of support provided by the practice pharmacists — who work a maximum two sessions a week in a practice — and the specialist nurse.”

He said the pharmacists are good at supporting patients who are being weaned off benzodiazepines but lack the specialist knowledge that a mental health nurse would have in managing the cause of the original problem which led to the drugs being prescribed.

Mr Childs said the benzodiazepines initiative has worked well because of the improved inter-professional relationship between GPs and pharmacists in the past two years. “Before we used to have to push the pharmacists on practices, but now the GPs can’t get enough of their support — it’s a complete turn around. I think another benefit from this is that it opens up the door for a lot more work between GPs and community pharmacists who are increasingly working with practices. I think our pharmacist team has opened up GPs’ minds about what they can offer.”

GP Carolyn Rigby, whose Woodside Surgery was involved in the original project, said the practice did not have a particularly high prescribing rate for benzodiazepines. She explained that the GPs had traditionally offered benzodiazepines on 14-day prescription but some patients who had been using the long term received their drugs on repeat prescription.

She said: “GPs are busy and we don’t always have the time to do the things as perfectly as we would like to and to have somebody like a pharmacist come in to do this work for us is extremely useful.”

She said the practice was now trying to persuade all its patients who have been on long-term benzodiazepines to have only a two-week prescription.

Minor ailments scheme now involves over a third of Sheffield's pharmacists

A community pharmacy minor ailments scheme in Sheffield is widening as increasing numbers of GPs opt in to the project and patients attest to its value. **Naomi Kempner** reports

With schemes that enable pharmacists to treat a wide range of minor ailments now firmly on the health agenda, one of the more established schemes in England has been running for over two years. The Sheffield scheme started in February 2002, with community pharmacists being able to prescribe for a range of self-limiting minor conditions under the NHS. Patients exempt from charges no longer need a GP's appointment for a prescription, allowing GPs more time to deal with more serious consultations.

To the end of January 2004 a total of 7,782 patients had been seen under the scheme and just under 10,000 items had been prescribed by participating pharmacists. Headlice is the most common condition treated, comprising a third of all consultations, followed by headache, earache and fever and then cough (see Table).

The project lead, community pharmacy facilitator Peter Magirr, says: "We anticipated that treating headlice would figure prominently because we had reviewed GP prescribing for the condition from e-PACT data. The management of this condition in the community pharmacy setting is entirely appropriate and the volumes indicate just how much GPs' time can be freed with such a service."

He explains that the scheme initially involved 13 practices and 29 community pharmacies. "This has now increased to 29 practices — around a third of the city's total — and 44 pharmacies (out of a total of 106), with numbers continuing to rise."

Dr Magirr was pleased with the view of the Commission for Health Improvement, which described the scheme as "a cost-effective and popular development" in its recent clinical governance review. He also believes that the scheme has helped all four of the city's primary care trusts to reach their GP access targets.

"The situation is continually evolving," he says. "The scheme has been shown [to be] effective and all of Sheffield's PCTs have be-

come convinced of its value and are allowing more surgeries to join. What's more, the practices see a real advantage in being able to offer this service to their patients.

"It is up to the practices to sign up to the scheme. The service is for their patients. Pharmacies serving that practice are then asked if they want to participate. Patients don't have to register with pharmacies but the pharmacists must be satisfied that the patient is registered with a participating surgery. This is usually straightforward. Patients are informed of the service when they contact their GP practice for an appointment. They can also self-refer."

In a telephone survey of patients who had used the scheme, 98 per cent said they wanted it to continue. Over 90 per cent found the service user-friendly, and 82 per cent would have had to see the GP instead had the scheme not existed.

GP practices and pharmacies were also positive, with extensive support for the scheme to be continued and enlarged. Several GPs commented on the change occurring with the mix of consultations that had emerged, noticing an impact from the project.

No extra training was needed for pharmacists. But in the scheme they work to a "fairly robust" protocol treating specified conditions. They prescribe from a formulary aligned with the existing Sheffield formulary. If a patient seeks advice on a condition not in the protocol, or if the patient presents for a third time with the same ailment, they are referred back to their GP. Treatment for children is included within the scheme, with a number of medicines for common childhood ailments included within the formulary.

Dr Magirr says that the protocol and formulary remain under constant review. "Feedback from all involved allows us to improve the service. For example, the treatment of mouth ulcers has recently been added to

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Table: Conditions treated in Sheffield minor ailments scheme (n=7,782)

Minor ailments treated	Percentage of total
Head lice	34.4
Headache/earache/fever	28.8
Cough	11.6
Thrush	8.1
Hay fever	5.9
Nasal congestion	4.8
Diarrhoea	2.8
Indigestion	1.9
Constipation	1.7

the protocol with appropriate preparations included in the formulary."

"We are still learning as we go along," Dr Magirr continues. "We are working on communication and training issues, particularly with GP practice staff. It is often the receptionist who will be informing patients about the scheme and who will be selling the idea. They often know the patients well but need to be comfortable with the idea themselves."

"We have also improved surgery posters and leaflets explaining the scheme. But, at the end of the day, it is up to the patient to use the service. They are not obliged to go to the pharmacy and can still see the GP if they want. It is about patient education too, about what constitutes a minor ailment or a more serious condition and where is the appropriate place to seek treatment"

Dr Magirr says that the programme offers good value for money for the NHS. Pharmacists receive a fee of £2.50 per consultation, £20 per month for reaching a threshold number of patients and reclaim their prescribing costs. "This is less than half the cost of a GP consultation."

It is important to note, however, that GPs still report seeing as many patients as before. This is because patient demand continues to fill their appointment slots. However access to the GP is improved by managing minor ailments in the pharmacy and the total number of patients treated overall is, of course, greater than before.

Another benefit of the scheme, according to Dr Magirr, is the strengthening of links between GPs and pharmacists, who, after all, are now sharing patients, seen "in the most appropriate setting for their condition".

What should pharmacists expect to be paid for medicines management?

The new general medical services contract could mean community pharmacists become more involved in medicines management work. But what remuneration should they receive? Dawn Connelly finds out

The new general medical services contract, which comes into effect in April, may open the door for community pharmacists to become more involved in carrying out medicines management work, for example, medication reviews, at GP practices.

The question many community pharmacists will want answered is, what can they be expected to be paid for this sort of work? Pharmacists can negotiate payment either directly with GP practices or with the relevant primary care organisation. There are several factors to take into account when negotiating rates of pay. What standard of review is the pharmacist offering to undertake? How much will the GP be paid to provide a medication review service under the new general medical services contract? It is also worth considering how "Agenda for change" might affect rates of pay for community pharmacists offering to carry out these services?

Sue Carter, head of prescribing and pharmacy at Adur, Arun and Worthing Primary Care Trust, said that it depends on what is regarded as a medication review. "When I have talked to GPs in our area in preparation for the medication review aspects of the new GMS contract, their understanding of what constitutes a medication review is different to the standards and complexity of review often expected by pharmacists."

What pharmacists can earn

A quick flick through the recruitment section of *The Pharmaceutical Journal* over the past few months reveals that the pharmacist who secures a position as director of prescribing and medicines management at a PCT in south-east London can expect to receive an annual salary of around £60,000 to £65,000. This is clearly a senior position.

In the same issue, a practice-based pharmacist post at a PCT in the West Midlands is advertised at £25 per hour.

PM&M also learnt that another PCT in the West Midlands offers pharmacists who undertake a variety of practice-based activities £22 per hour for sessional work. In north-east London the negotiated rate is higher, at £150 per session, with each session lasting three to four hours, and in the south of England, medication review work is paid at a rate of £30 per hour, with some pharmacists charging up to £40 per hour.

She explained that, to begin with, if community pharmacists are trying to be commissioned by GPs to carry out medication reviews then they should carefully look at the level of review required. "Many GPs will expect quick and easy reviews, for example, at the level of the questions asked in 'Ask about medicines week'," she said. However, a lot of primary care trusts are separately funding pharmacists to carry out medication reviews at a higher level, as per the guidance in "Room for review".

"The quick and easy reviews could act as a signpost and filter for the more in depth reviews that pharmacists can offer," added Mrs Carter.

She also pointed out that if GPs are approached directly, rather than pharmacists negotiating with PCOs, then the payment negotiated would have to be within the bounds of what the GP is going to be remunerated for providing the service under the new GMS contract.

Mrs Carter believes that "Agenda for change", the new pay system for NHS staff which is intended to harmonise conditions of service and ensure that staff receive equal pay for work of equal value, could have a major impact in primary care, a sector that has traditionally had a varied approach to setting rates of pay. Community pharmacists may currently offer services at private sector commercial rates.

Once "Agenda for change" is implemented, she predicts that it may not be feasible for PCOs to pay community pharmacists significantly more than permanent employees would be paid to do the same job. Under "Agenda for change", the skills and person specification needed for medication reviews will fall into a particular band of payment, and this band may also apply to community pharmacists, she said. "Pharmacists need to continue to show that they represent a cost-effective way of providing these services."

Maria Smith has been working as an independent pharmacy consultant in primary care

for the past three years. She works on a sessional basis across three trusts in the Buckinghamshire and Berkshire areas. As well as carrying out project work, conducting warfarin clinics and being involved with patient group directions, she also does medication reviews.

She says that the best method of payment for medication review work is to charge per hour, rather than per patient. "It is difficult to charge per patient because there are lots of variables to consider, for example, is the review taking place in the surgery or is it a home visit? What is the nature of the review? Is it a full brown bag review or is the pharmacist going through a patient's notes and picking up problems that will later be reviewed by the GP?"

Ms Smith alluded to the fact that many GPs have no experience of clinical pharmacists. "Although the culture is changing there are still many aspects to overcome — we have got a lot of mileage to prove our worth," she said.

She says that there are opportunities for pharmacists in the new GMS contract, but only if GPs are willing to pay for them. "They see nurses as a cheaper source of providing the same thing," she said.

"However, pharmacists shouldn't be compared with nurses; they should be compared with doctors." It is not until GPs work with good pharmacists that they see what additional value they are getting, she added. She believes that pharmacists should be charging at least £25 to £30 per hour for medication review work.

Ms Smith says that another problem is that many community pharmacists have little hands-on experience of clinical pharmacy, and therefore lack the confidence to carry out medicines management work.

With only two weeks to go until the new GMS contract comes into effect, it is worth thinking about the opportunities that it will create for pharmacists — and brushing up on your negotiation skills.

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New avenues for technicians to explore

Opportunities for pharmacy technicians in primary care have increased in recent years, **Debbie Andalo** reports

Pharmacy technician Sandra Wild has never looked back since leaving hospital pharmacy for primary care nearly five years ago. "I would never go back to hospital. The role I have now is just so different and is a completely new way of life — the challenges are a lot different and I feel I have more autonomy," she admitted. Sandra was one of the first technicians to be employed by a primary care trust (PCT) but today there are estimated to be around 160 of them working in PCTs with their own support group, Prescribing Advice and Support Technicians Association (PASTA). Their roles and responsibilities vary according to the confidence of the PCT in developing the post and its ability to recognise the value of their skills. Some PCTs use technicians to carry out audit — scanning patient records to ensure their medication is up to date — while others have given their technicians greater responsibility including becoming medicines management collaborative facilitators or developing an action plan for medicines management in the prison service.

This new career path for pharmacy technicians reflects the Government's and the pharmacy profession's commitment to improve skill mix in pharmacy. It is also a development which is essential if the profession is to meet the demands of "Pharmacy in the future".

"I think the technicians we have in the PCT are invaluable. They can fulfill many of the roles that pharmacists do, in fact they can work in primary care in exactly the same way as they do in the hospital," said pharmacist Vivienne Ben-David, head of medicines management at Rochdale PCT in Lancashire, and Heywood and Middleton PCT in Greater Manchester. She added: "They offer good support to both patients and pharmacists and, where they are more senior, they can lead in a particular project." This can include medicines review where their recommendations have to be signed off by the pharmacist. But they also have a more subtle role to play in medicines management. She said: "They can be the face of medicines management in the practice — influencing prescribing by having a relationship with the practice." GPs who have been working with the technicians do not see them as a threat, she said. "They are just seen as part of the pharmacy team. I think GPs, like any other health professional, realise their own limits and appreciate having people helping them."

Mrs Wild, who is employed by Rochdale PCT, said she was not in the practice to perform a prescribing policing role although she admitted that at first some GPs were suspicious: "Practices were a bit wary at first. They thought we were there to check up on them. It took a while to get them on our side. We are there to

bring help to the practice — to achieve cost effectiveness and get the best out of prescribing."

It is this target which can bring the greatest job satisfaction and reflects the biggest difference when compared to working in a hospital pharmacy. Mrs Wild who is chairwoman of PASTA and one of its founder members added: "It can be a satisfying job in primary care because we are there to save money in one area and move it to another."

Mrs Wild is answerable to the pharmacist in charge of medicines management but her views are taken on board if she can suggest improvements. She said: "I think because my pharmacist works part-time my role is probably greater than technicians in other PCTs." Her responsibilities also include liaising with community pharmacists. She said: "We try and get community pharmacy involved whenever we can. We send them our newsletters and if there is anything that we are doing in the practices which will affect their stock we go and meet them. We try and fit any changes in around them and the length of time it will take them to get rid of their existing stock." She also consults the community pharmacists when carrying out medicine reviews of patients in nursing homes. She added: "I do not think they feel we are treading on their toes — we get calls from them asking us for our advice."

In Rochdale the responsibilities of the primary care technicians are well developed because it was one of the first to use them in this new way. Mrs Ben-David said: "Bury and Rochdale Health Authority, as it was then, had the foresight to employ technicians from the outset when primary care groups were established, but over the years more are taking technicians on board. You can get more pharmacy technicians to the pound than you can pharmacists."

Project facilitator

Hartlepool in Cleveland is another of the growing number of PCTs which has the vision to see the potential of primary care technicians. For the last year Jayne Parkinson has worked as facilitator for its medicines management collaborative project which has a broad remit to optimise prescribing across the PCT and improve the prescribing experience and outcomes for each patient. She took on the new role after spending three years as a primary care technician in another PCT giving prescribing support to GP practices. That PCT had also drawn up a proposal for a medicines management collaborative and, although the bid was unsuccessful, it made Ms Parkinson realise she had the skills and the knowledge to become a project facilitator and she began applying when the posts became available. She said: "I think that some technicians would be intimidated at the

thought of taking on this kind of role. I think as a technician working in practices or hospital it's quite regimented and you are very much part of a team. In this job as a facilitator I have a blank page — I have targets to deliver but it is up to me how I achieve that and manage my own time. My knowledge as a technician is valuable because I understand about patient compliance and the importance of dosage labels informing patients about how often and how many tablets have to be taken. Having some knowledge about national clinical guidelines has also been an advantage." Her previous experience working in hospital pharmacy and starting off in retail pharmacy has also given her a breadth of knowledge. She said: "A major aim of the project is to look at medicines management from different environments, and to use community pharmacy skills. Because I come from a pharmacy background in retail and hospital I understand what the limits and the boundaries are in those sectors."

Ms Parkinson's decision to become a project facilitator is not unique, according to Richard Seal director of the national medicines management collaborative at the National Prescribing Centre.

He said: "We do have some project facilitators who have a pharmacy technician background but I am also aware of pharmacy technicians working directly with PCTs or GP practices outside of the medicines management programme and, where they are working, they are doing a good job." Technicians are involved in checking patient computer records to make sure they are up to date and reflect the medicines that the patient is currently taking. They are also involved in searching for types of drugs or groups of patients as part of practice or PCT general medicines management, he said. Others are carrying out the preparatory work for medicines review on behalf of nurses or doctors.

The development of pharmacy technicians in primary care is vital if pharmacists and technicians want to increase their own professional roles and responsibilities which have been outlined in "Pharmacy in the Future" and more recently "A Vision for Pharmacy in the New NHS". Although not all technicians have the ambition to develop this new career path it is clear that those who are marching with their feet are making it a success. They are determined to show what can be achieved if you have the courage to take on new challenges and the support and vision of others within the pharmacy team. Jayne Parkinson had this advice: "There may be some technicians who don't think they are capable of doing what I and others have done. But they can — it's all about having the courage to do something new and the faith in their own skills."