P&MM
Prescribing and Medicines Management

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Pharmacists in St Helens take on new services in advance of contract deal

Pilot projects in St Helens Primary Care Trust anticipate the new pharmacy contract. **Debbie Andalo** investigates

Community pharmacists in the North West are already putting the new contract to the test, despite the delays in the Government's, the NHS and the profession's negotiations in reaching a national agreement. Services which will be given enhanced status under the new contract, such as minor ailments management and providing emergency hormonal contraception, are being offered by pharmacists in St Helens Primary Care Trust in a series of pilot projects which will be rolled out across the district in the next 18 months.

The PCT has invested nearly £200,000 in the initiative — to cover the cost of pharmacy time and increased drugs costs — with 22 of the district's 38 pharmacies taking part. Senior primary care pharmacist and community pharmacy lead pharmacist Davina Halsall said: "This is all about increasing our capacity to achieve our targets in order for the people of St Helens to get the best out of their medicines — the pharmacists have the skills to help us increase our capacity."

The PCT has deliberately developed the role of the community pharmacist as part of its overall strategy. Historically the responsibilities of the profession have been allowed to develop in an ad hoc way, Mrs Halsall admitted. She said: "Before now there wasn't any thought about how it all fitted into the bigger, wider picture. But now, for example, pharmacists offering the emergency hormonal contraception service fits in with our priority to reduce teenage pregnancies, while the support they offer to asthma inhaler users came about because locally we have high levels of chronic obstructive pulmonary disease and respiratory disease."

Other services that some pharmacists are taking on for the first time are a needle exchange scheme and supervision of methadone consumption for drug misusers, a minor ailments service and smoking cessation counselling. All services have been given enhanced service status under the new contract. Seven of the pharmacies are also involved in a national pilot — one of only three in the country — to offer direct support to patients with Parkinson's disease.

Pharmacists rely on an agreed pro forma to keep GPs informed about their patients and a team of primary care support pharmacists are on hand to offer any extra advice or help to the pharmacists who have taken on these new responsibilities.

The new roles for pharmacy reflect the PCT's strategies for medicines management and community pharmacy — the priority was not the new contract, Mrs Halsall said. But she added: "All these services which we have thought for pharmacy do fit into the framework of the new contract — if it ever gets approved and funded."

The PCT acknowledged right from the start that if pharmacists were to offer these extra services it would cost them time. Mrs Halsall explained: "If you consider that pharmacists can get £1 for dispensing — without talking to a patient — and they can dispense one item a minute, then I think if you expect them to have a five-minute consultation with the patient you have to reimburse them."

Phil O'Neil is one of the community pharmacists who, since last year, has taken on a range of additional services. He admitted that the extra money they generate is noticeable. Giving minor ailments advice, he estimates, has brought in on average an additional £600 a month while offering smoking cessation counselling has boosted income by around £3,000 a month of which 25 per cent, he believes, is probably profit. He said: "This is money which wasn't there before. It's noticeable. There is also the added benefit that by offering these services it is bringing people into the pharmacy who weren't coming in before. We are getting more and more prescriptions — patients are seeing the services which we provide and feel that we are offering a really professional service so they decide to bring their prescriptions to us as well."

Mr O'Neil has been offering patients and customers minor ailments advice by working to an agreed formulary of over-the-counter medicines and to a list of conditions agreed with the PCT. The conditions include hay fever, constipation, head lice, headaches and temperatures. He explained: "If, however, somebody comes in with a minor ailment which we cannot support and we feel they need to see a doctor there is the ability for us to fast track the patient to the practice for a GP appointment."

The pharmacist who manages Knights Pharmacy is also involved in offering patients smoking cessation counselling. Patients can either be referred to him by the GP for a session which takes place in the pharmacy's consulting room, or patients can self-refer. The initial consultation takes half an hour but with two pharmacists working in the pharmacy he has the flexibility he needs to offer the service. He said: "Sometimes if a patient just comes in off the street and wants advice about smoking cessation I can see them straight away. If not I can arrange a consultation for them at a later date."

Working to patient group directions the pharmacist also offers female patients trimethoprim for uncomplicated urinary tract infection and he can also give chloramphenicol for conjunctivitis. The pharmacy also supervises methadone consumption for 12 patients.

Expanding pharmacy services in the community has been popular with patients and brings professional satisfaction. Mr O'Neil's advice to other pharmacists who may be reluctant to adopt these new professional roles was simple. He said: "I think people have to be positive and look at these new services not as new work, but as another income stream and a way to improve patient care. Anybody interested in doing what we are doing should go and speak to their PCT. Fourteen years ago when I qualified I don't think I ever thought that this was the future for pharmacy but over the past couple of years I have begun to believe that this is the direction in which the profession should be going."

How supplementary prescribing is working for pharmacists in practice

At the start of this week, 97 pharmacists had registered with the Royal Pharmaceutical Society as supplementary prescribers and the number is rising all the time. **Clare Bellingham** finds out how the early starters are getting on

Supplementary prescribing by pharmacists started at the end of March when Neil Frankland, lead pharmacist for surgery at North Tyneside General Hospital, North Shields, wrote his first prescription (*PJ*, 27 March, p369). A month later, Fiona Reid became the first pharmacist to prescribe in primary care at Newbyres Medical Group surgery in Gorebridge, Midlothian (*PJ*, 1 May, p533). This was quickly followed by the first community pharmacist prescriber, Campbell Shimmins of Woodside Pharmacy, Doune, Perthshire (*PJ*, 8 May, p559).

A number of pharmacists have started prescribing since. So how are they getting on? Those working in primary care are surging ahead: supplementary prescribing is being used to add value to pharmacist-run clinics, many of which were already set up in GP surgeries. In hospitals too, pharmacists have started to use supplementary prescribing successfully in both clinics and on wards.

The pharmacists facing the most difficulties are those in the community. Although some community pharmacists are choosing to use their qualification to undertake sessional work in GP surgeries, it is proving difficult for them to prescribe in their own premises.

It has been said many times before, but the lack of access to patients' medical records at community pharmacies is a barrier to prescribing. It can be overcome (as two pharmacists have proven, see later) but it is certainly an important issue. Another difficulty for community pharmacists is funding. In order to leave the shop floor so they can have a consultation with a patient, a second pharmacist is needed. And this costs money. Pharmacists also need to have access to a prescribing budget, something that is much easier to address when a clinic is run in a GP surgery or a hospital.

Asked how these barriers would be overcome, a Department of Health spokeswoman said: "One of the fundamental principles of supplementary prescribing is that the supplementary prescriber should have access to the common patient record. We recognise that in the first instance, there may be some problems for community pharmacists wanting to prescribe from their own pharmacies." In terms of the funding issue, she commented: "The DoH allocates funding to strategic health authority workforce directorates to implement supplementary prescribing who determine how funds are used. Access to a prescribing budget is also a pre-requisite for pharmacists prescribing in the community or in primary care. Funding issues should be settled, prior to candidates undertaking prescribing training courses."

Health is a devolved issue, so how supplementary prescribing is implemented in Scotland will differ. For a start, there is more of a focus on getting community pharmacists trained as prescribers than in England.

Frank Owens, chairman of the Scottish Pharmaceutical General Council, says: "So far 160 pharmacists, over 100 of whom are community pharmacists, have either completed or are completing the training programmes." He comments: "This will provide a very solid foundation for the clinical and patient care components of the new community pharmacy contract in Scotland. The SPGC and the Scottish Executive are continuing to work together to ensure further initiatives with community pharmacists will be forthcoming, utilising the skills of these prescribers as we move towards the implementation of the new contract."

Guidance for supplementary prescribing pharmacy practitioners is expected to be published by the Scottish Executive next week.

Hospital pharmacy

Hospital pharmacists have started to use supplementary prescribing in two situations: on wards and in out-patient clinics.

Emma Graham-Clarke has been prescribing since the middle of April. She is a locum consultant pharmacist within the division of anaesthesia and critical care at City Hospital, Birmingham. "I can prescribe anything and everything on the critical care ward," she explains. "Most commonly I am prescribing longer-term drugs used in intensive care, such as for treating infections, hypoglycaemic control, prevention of stress ulcers and DVT, and for bowel motility." However, her prescribing is not limited to these areas: "I include anything that might require a dose change when the independent prescribers are not around."

Miss Graham-Clarke uses a generic clinical management plan (CMP) which is then customised for each patient, and prescribes according to the hospital formulary and guidelines stated on the CMP. She says that the CMP can be restrictive: "We always forget to put something on it that I want to prescribe." The other problems she has faced have been over the current restrictions on supplementary prescribing: neither Controlled Drugs or unlicensed medicines can be prescribed. "We use a lot of Controlled Drugs in intensive care and not being able to prescribe them is a problem." Overall, Miss Graham-Clarke says that supplementary prescribing has helped to take her role forwards. "It has made me more involved in the ward team, given me confidence within the unit and improved my working relationships."

Neil Frankland wrote his first prescription for an elderly patient with constipation and is still prescribing in the same area. He has not yet been able to extend his role further. "We are in the process of getting other pharmacists through the prescribing course. Until we reach a critical mass of pharmacist prescribers we cannot do a lot more because of ensuring continuity of care," he explains. "We are also addressing issues such as the CMPs and patient consent. Using a paper-driven system is too cumbersome."

A hospital pharmacist who plans to start prescribing at an out-patient pain clinic next week is Mark Thomas, lead clinical pharmacist for ward services at the Queen Elizabeth Hospital in Gateshead. "Patients will be seen by a consultant and then referred to me for prescribing pain relief. This will include prescribing for chronic back and joint pain, and neuropathic pain," he explains. "I will also see patients who are having pharmacy-related problems, such as compliance difficulties, or side effects with rheumatoid arthritis drugs."

Primary care

Of all the situations in which pharmacists can now prescribe, clinics in GP surgeries is by far the most common.

Amanda Evans, lead pharmacist for supplementary prescribing at Burntwood, Lichfield and Tamworth PCT, has just been awarded a research grant by the research charity The Health Foundation to look at the implementation of supplementary prescribing in primary care. "I will be comparing implementation in two PCTs and will be able to track problems as they happen. I will also be interviewing people to see how their opinions of supplementary prescribing change over time," she explains.

Mrs Evans is one of five pharmacists in the PCT who have completed the supplementary prescribing course. All are already running clinics at GP surgeries and will prescribe within these. "In future, pharmacists will find it easier to start prescribing because we are putting the infrastructure in place now, such as ensuring we have covered clinical governance, and working out funding." Funding has come from a number of sources: the new GP contract, the

personal medical services contract and prescribing monies. Mrs Evans will start prescribing next week for patients with dyspepsia. "I hope to branch out into other areas of chronic disease management, concentrating on targets in the new GP contract. This is the way the surgery will be able to fund me." She adds: "Having a CMP means that patients are partners in deciding what treatment they will have. This buy-in is important in terms of concordance."

Marian Bradley is practice pharmacist at Northgate Practice in Walsall in the West Midlands where she runs warfarin clinics. "I have been seeing these patients and monitoring their warfarin for nine years. Getting the CMPs written is the rate-limiting step because I want to have patient-specific CMPs," she explains. Many patients see Mrs Bradley for all their medicines, not just warfarin, so a CMP to cover all their medicines has to be drawn up. "It is wonderful not to have to leave the patient, go up the corridor and wait outside the doctor's door to get a prescription signed," she comments. "Even though the prescriptions are not computer-generated yet so I have to write each one out by hand, it is still quicker than standing outside the doctor's door."

Fiona Reid has been prescribing for several months now and is positive about her experience: "Patients and the GPs have been very supportive. No patient has refused to be managed with supplementary prescribing," she comments. "The biggest issue is not having computer-generated prescriptions. At the moment, we have been told that because of the small number of prescribers it is not cost-effective to produce computer-generated prescriptions." What this means is that pharmacist prescribers have to put the data into the computer so the patients' record is updated, print out a prescription that they cannot sign and then write out the items again on a handwritten prescription pad. The other difficulty that Mrs Reid has faced is that she had hoped to extend the clinics by employing a community pharmacist to run the existing clinics so she can set up new ones. "The problem is that I have not been able to get funding to do this," she says.

Doncaster West PCT employs Mohammad Ahmed, a primary care pharmacist, to run hypertension clinics at Conisbrough Health Centre and Petersgate Medical Centre, both in Doncaster. He has been prescribing for five weeks. New patients identified with hypertension are referred to him. "Once I have agreed the CMP with the patient, I send an electronic message to the GP," he explains. "All our CMPs are on the computer, we don't have any paper forms." The GP then adds a code to the patient's CMP to confirm agreement and sends a message to Mr Ahmed with any comments needed.

Mr Ahmed says that agreeing CMPs with the GP is the biggest hindrance to supplementary prescribing. Both he and the GPs run clinics in the afternoons between 2pm and 4pm and this makes it difficult to gain their agreement to CMPs during these hours. An advance agreement for the majority of patients was the solution the practice came up with. He can use supplementary prescribing for any patient who can be treated according to the Doncaster West PCT hypertension guidelines. "I only have to wait for GP approval if I want to prescribe outside the Doncaster West guidelines," he explains.

Garry Barrett is a community pharmacist who undertakes sessional work at Winshill Health Centre in Burton-on-Trent where he prescribes for patients with diabetes, hypertension and chronic obstructive pulmonary disease. Patients are referred to clinics run by him and a nurse prescriber by the GPs at the practice. "The GPs are trying to focus on the acute side and leave chronic disease management to us," he explains.

New pharmacist prescribers at Burntwood, Lichfield and Tamworth PCT (left to right): Mohammed Ibrahim, Thao Lam, Helen Bates, Amanda Evans and Stephen Bullock

Community pharmacy

Campbell Shimmins was the first pharmacist to write a prescription in a community pharmacy in the UK. He is prescribing in the cardiovascular area, mostly beta-blockers, ACE-inhibitors and nitrates, at a rate of about two or three prescriptions a week. "One advantage is that patients have access to me without having to wait for an appointment. Because the number of patients I am prescribing for is still fairly low at the moment, I am seeing them without an appointment. This is one of our main strengths and I don't want to undermine it," he comments. "Becoming a prescriber has certainly increased my professional standing."

Mr Shimmins has financed the service through money he was already receiving as part of the pharmaceutical care model schemes that operate in Scotland. Through the model scheme, he has been going to the surgery to review patients' notes for some time. This allows him to identify patients with drug-related problems who need monitoring. "These are patients on five, six or seven drugs. Any blood tests needed are carried out and then I monitor them closely for the next few months, prescribing for them according to the CMP. Once they have stabilised I refer them back to the surgery to be managed through the usual repeat prescription service," he explains.

Mr Shimmins has regular meetings with the GP to agree and update CMPs. Overall, he says that he has not encountered any barriers to introducing supplementary prescribing, although comments that communication could be better. One particular problem is finding out patients' blood test results for which he has to telephone the surgery. "An electronic system would obviously be best. And this would be improved further if I could take the blood samples here and if I could have access to the blood testing laboratory system rather than having to go to the surgery for results," he comments.

George Romanes, who runs a community pharmacy in Duns, Berwickshire, is about to start prescribing. He has negotiated funding to allow him to run asthma and hypertension clinics at his pharmacy and is currently writing CMPs in preparation for the first clinic. "Initially I am targeting patients with asthma who have high 'do not attend' rates at the surgery or who have poor control. We are hoping that they will respond better to the open-access situation that I can offer at the pharmacy," he explains. Similar patients with hypertension are also being selected. Mr Romanes highlights the fact that some patients do not visit surgeries because they are not in town centres and because of a wait for appointments: easier access is one of community pharmacy's strengths.

At the moment, Mr Romanes has to go to the local surgery to access patients' medical notes and he writes the CMPs there. "I have just been connected to the NHSnet so this makes communication with the surgery much easier," he explains. Using the NHSnet connection, he will feed back information such as changes to patients' medicines to the practice manager who has agreed to update the notes.

Mr Romanes has managed to overcome many of the barriers facing other community pharmacists in putting supplementary prescribing into practice. He will be paid £36 an hour to the run the clinics by NHS Borders. And one of the technicians working for him is currently training to become a checking technician so this will allow him to leave the shop floor for consultations. In addition, he comments: "One of the reasons asthma and hypertension have been picked is because I don't need to carry out invasive testing in the pharmacy." Although he would be happy to take blood samples, using non-invasive tests initially helps to give people confidence about his new role.

These pharmacists are proving that supplementary prescribing works. It will be easier for future pharmacists to follow in their footsteps, but community pharmacists, in particular, face real issues that need to be addressed or their prescribing training will be wasted.

Faculty goes from strength to strength

Annie Coppel, chairman of the faculty of prescribing and medicines management, College of Pharmacy Practice, describes the faculty's work

The faculty of prescribing and medicines management was the first faculty set up under the College of Pharmacy Practice, recognising the need to support the development of specialist areas of pharmacy practice. Created in 2001, it provides a strong and influential professional support body for UK pharmacists working, or with an interest, in prescribing and medicines management.

Three years on it has proved itself to be a dynamic and evolving specialist interest group of about 540 pharmacists, from all areas of professional practice in the UK, who are committed to high standards of practice. This article looks at what the faculty has achieved to date, and what it offers to those who join.

High standards

The faculty is managed by an elected and working board of six members, with provision to co-opt up to a further three members with expertise to lead on specific projects, or to represent member interests in one of the home countries. The board works to a formal constitution, and within an agreed corporate governance framework, with membership fees and sponsorship enabling the development and delivery of faculty activities.

The main aim of the faculty is to encourage and support the professional and personal development of its members to help them become recognised specialist practitioners. The faculty has an agreed framework of competencies, which in generic terms define the skills, knowledge and expertise around prescribing and medicines management that pharmacists must demonstrate before they can become accredited as full practitioner members. Accreditation is a rigorous, peer review process that involves preparing a reflective practice continuing professional development portfolio and making a submission of competency for assessment, followed by an interview. To date seven associates have achieved practitioner member status, with four of those simultaneously achieving the advanced award of the college.

Both the faculty competencies and the approach to reflective practice tie in with the plan and record approach of the Royal Pharmaceutical Society, and discussions are ongoing to try to ensure that the respective portfolios can be shared and used for a variety of purposes.

Professional development

To help the membership carry out their day job effectively and competently, and to progress towards accreditation, the faculty runs an extensive education and skills development programme. Designed specifically to link with the faculty competency framework, workshops and conferences deliver skills training on topics identified by the membership that they need to develop or build on. The highly successful "Develop yourself" series of one-day workshops covered leadership, team working and communication, developing personal responsibility, standards, outcomes and innovation, strategic thinking, and influencing. Two series of these have already been delivered around the UK, and a further series is planned for Autumn 2004 that will include two new modules (performance and project management) and a reflective practice learning set. A separate series of workshops provided training on facilitation skills, and recent conferences have covered risk and change management set in the context of NHS policy. Feedback from delegates has been positive and the building of local networks has been an additional benefit.

Personal support

From this summer, an initial network of 12 trained mentors will be available to provide support to associates seeking accreditation, and to others who want career or personal development guidance. All the mentors have attended a two-day mentoring master class, have the necessary skills and are volunteering their support within the limits of their own competency and capacity. This network will grow as new practitioner members are invited to attend training and to provide peer support to others.

Networking

Networking is an obvious but welcome side effect of the annual conference and workshop series that run during the year, allowing members to build supportive and professional friendships with each other. Obtaining responsive peer support from like-minded pharmacists is the major benefit of faculty Smartgroups, the members' electronic e-mail group, which is in constant use as people seek answers to questions and issues, and share ideas with each other to prevent duplication. *Faculty Focus*, the quarterly membership newsletter, carries news pieces and information on faculty activities, and articles to help learning and to share best practice

Support for important developments

Pharmacist prescribing is an important and evolving professional development that has implications for practising members. The faculty has already produced several tools and resources on supplementary prescribing to help members to engage primary care trusts on this agenda and to help them develop this professional role. In the near future, further support will be offered to newly qualified prescribing pharmacists for CPD against recognised prescribing competencies and through the building of peer networks. With independent prescribing around the corner, the faculty will also look to provide appropriate support to those members taking on these extra professional responsibilities.

The NHS environment is rapidly changing and with it comes a myriad of opportunities in terms of role expansion and skills development, eg, pharmacists with a special interest and consultant pharmacists. The faculty keeps a watching brief on emerging policy initiatives and formally responds to those most pertinent to the personal and professional development of its membership.

Practice research

Reviewing current, and investigating new, practice is an important component of personal and professional development that informs patient care. The faculty has developed a practice research strategy through an expert working group, and will help increase members' knowledge and engagement in the first instance by providing support through educational materials and events.

It is also hoped to offer a travel bursary, through a competitive process, that will enable a member to travel abroad to study prescribing and medicines management in different health care systems. Successful candidates will be expected to share their learning formally with the rest of the membership.

From strength to strength

The faculty has proven to be a specialist interest group really worth joining. It provides a comprehensive programme of personal and professional support to its growing and active membership, based on identified needs. It supports and contributes to prescribing and medicines management policies, and promotes learning and the sharing of good practice. Many associates are working towards becoming accredited practitioner members, which as a result will affirm the faculty as a body of recognised expertise.

All pharmacists welcome

If you are interested in joining, details are available on the faculty's website www.collpharm.org/PMM.htm, or directly from the college. Entry-level membership is as an associate (AFPMM, CPP) with full member status (MFPMM, CPP) being conferred through the accreditation process when knowledge, skills and experience are demonstrated against the competency framework.