

# Pharmacist prescribers: is finding a mentor a barrier to accreditation?

With more pharmacists taking up prescribing, there have been murmurs about a potential shortage of GP mentors. Clare Bellingham investigates

In order to enrol on a supplementary prescribing course, pharmacists need two things: a medical supervisor and a specified service for which prescribing will be required. Many pharmacists have successfully found a mentor and qualified as prescribers but for others finding a supervisor has proved harder than they imagined. What it seems to come down to is location and the sector in which the pharmacist works.

Amanda Evans, deputy head of medicines management at Burntwood, Lichfield and Tamworth Primary Care Trust, is the PCT's lead for non-medical prescribing. All requests for prescribing training are made to her. "None of the pharmacists who have applied so far has had a problem finding a mentor but, having said that, all are practice pharmacists who are already working closely with GPs. We have not had any applications yet from community pharmacists," she said.

A similar picture has emerged in London. Anne Lovejoy, pharmacy practice lecturer at King's College, told *The Journal*: "I do not have any evidence, but the impression I get from talking to pharmacists enrolling on the course is that community pharmacists find the process harder than hospital pharmacists. Hospitals seem to be set up for training so pharmacists just slot into an existing system. Similarly, practice pharmacists and prescribing advisers find the process relatively easy because already they have the support of the PCT."

Other universities paint a slightly different picture. At Keele University, Pat Black, director of postgraduate studies, commented: "Our experience has been positive and we have not come across any particular issues. Yes, there has been the odd student who has changed supervisor but that is usually for logistical reasons within a GP practice. I would say that there may be individual cases of pharmacists having difficulties with supervising doctors but it is not a general pattern."



Brian Addison, pharmacy practice lecturer, Robert Gordon University, Aberdeen, also believes most pharmacists can find a mentor. "We have heard of certain locations where local politics seem to create problems but it is certainly not widespread," he said. However, he noted the following caution: "Having a medical supervisor is a requirement of the

course, so we would not necessarily know the whole degree of the problem because we only see those pharmacists who make it onto the course."

Perhaps this is demonstrated by the experience of one pharmacist, who asked not to be named. She explained: "It is difficult to find a GP mentor. They want something in return for helping you and they are still uncertain about the pharmacist's role in prescribing. I have had to persuade my mentor that I can be of benefit to him by seeing the patients the practice is struggling to see. This ticks boxes in the GP contract but what I would really like is someone who is interested in training me to work effectively in their team, rather than feeling I have to prove myself first."

An issue mentioned by a number of pharmacists is money. Some doctors think they should be paid to be a mentor, particularly if the pharmacist works in a different location to them. Ms Evans pointed out that nurses in primary care have had fewer problems than pharmacists finding doctors to supervise their training because they are direct employees of GP practices.

Sharon Maxted, medication review pharmacist, Rugby PCT, reports mixed experiences. "My GP approached me about supplementary prescribing so that I could make better use of my time supporting him with clinics. He could see the potential benefits and was not concerned that he would not be paid for the supervision time," she said. "But when another surgery, which was considering supporting a medication review pharmacist through the course, found out that there was no payment, it backtracked. This was despite the fact that we are a 'free' resource paid for by the PCT and that the course itself would be funded through the local workforce development confederation," she added.

Something that must be recognised is that supplementary prescribing is still in its infancy. As Bob Saunders, prescribing adviser,

### Characteristics of a mentor

Detailed information is available in the National Prescribing Centre's guide to training non-medical prescribers (see [www.npc.co.uk](http://www.npc.co.uk)). But pharmacists say they need a mentor who:

- Has time — a considerable amount of time is needed to learn skills, and to discuss competencies and clinical issues
- Understands the training needs specific to pharmacists, for example, obtaining hands-on skills
- Provides opportunities to learn in consultations
- Gives honest feedback
- Offers support during training and after qualification

Wolverhampton City PCT, commented: "In the early days of the first cohort, it was difficult because there was no real understanding of what was required of medical supervisors in terms of both support and workload."

Perhaps many of these problems will be solved as more and more pharmacists undertake the training. Encouragingly, pharmacists are helping their colleagues. Amy Chan, a locum community pharmacist in Glasgow, said: "I had help from an established pharmacist supplementary prescriber to find a GP mentor. As a locum moving from place to place, it is difficult to build rapport with any one GP practice. If I had to approach a random GP it would not have been an easy task to persuade them to mentor me."

### Art of persuasion

How should a pharmacist persuade a doctor to supervise his or her prescribing training?

"Demonstrating a clinical need for the service is key. It is much easier to persuade a doctor to become a supervisor if they can see the potential outcome of the time invested in training," explained Mr Addison. In today's target-driven world, ensuring a pharmacist-run service will meet a target is bound to be a winner. For example, setting up a clinic in a community pharmacy can reach patients who do not attend GP practices.

"Initially we approached innovative GPs with significant training experience and a role in the PCT, for example, prescribing leads," said Mr Saunders. "They were predisposed to try something new and possibly challenging. They were used to training health professionals and they understood the future need for more prescribers."

One of the biggest concerns for potential medical supervisors is finding the time to support a trainee. Mr Addison com-

mented: "GPs ask how they can spare 12 days for the training. But it is not a requirement for the GP to support each of the 12 days on a one-to-one basis. Some can be delegated, perhaps to a nurse or an existing supplementary prescriber." But he added that at the end of the training it is the GP's responsibility to ensure that the pharmacist is competent.

Another suggestion is to split the training into small chunks so it seems more manageable, for example, two days learning specific skills then two days observing consultations and so on. Presenting the training to a GP in this way makes it appear less daunting.

Maybe the most important thing is to keep trying: the practice mentioned earlier which pulled out of training a pharmacist was, eventually, convinced of the idea. The trouble with all new ways of working is that they rarely come easily.

## Funding and lack of access to records could slow progress of independent pharmacist prescribing

Concerns that a lack of funding could hinder the progress of independent prescribing were raised at a meeting in London last week, organised by the Social Market Foundation. Continuing professional development for pharmacist and nurse prescribers is one of the first things being pushed to one side as primary care trusts struggle to balance their books, said David Green, specialist pharmacist at Essex Rivers Healthcare NHS Trust. PCTs are still putting people through supplementary prescribing courses but if qualified prescribers want to refresh and improve their knowledge through further training they are finding it difficult to obtain funding and time for study, he explained.

David Pruce, director of practice and quality improvement at the Royal Pharmaceutical Society, added that he has concerns over whether the NHS's financial problems would affect PCTs' ability to commission enhanced services. "Prescribing is a tool and clinical services need to be developed alongside it. A critical factor is whether PCTs will have enough money to commission enhanced services where it would be useful to have pharmacists prescribing," he said.

Lack of access to patients' medical notes was also raised as a possible stumbling block. "This is a big debate, a lot of which is driven by patient confidentiality," said Mr Green. "We have to keep pushing for electronic access to records, and equality of access to records for all prescribers," he said.

Potential conflict between community pharmacists' commercial interests and the interests of their patients was also raised. Mr



**David Green: nurse and pharmacist prescribers should have access to the full patient record**

Pruce explained that supplementary prescribing courses for pharmacists and nurses include a section about external influences on prescribing. The Society is still in discussions with the Department of Health about courses for independent prescribers but Mr Pruce suspects that they will be similar to those for supplementary prescribers. The course also deals with the influence of pharmaceutical industry representatives. Mr Green said that he believes pharmacists are more aware of the need for critical appraisal of marketing material from the pharmaceutical industry than those working in other sectors.

Teamwork will be essential if independent prescribing by pharmacists and nurses is

to be a success. "The word 'independent' conjures up people working in isolation — that would be a disaster. We must work as part of a team so that everyone is aware of what each other is doing," said Mr Pruce. He predicted that the first independent pharmacist prescribers are not likely to qualify before the end of the year.

### Awards for prescribing and medicines management

Servier Laboratories has launched the Servier Prescribing and Medicines Management Awards. The awards support the implementation of educational and clinical initiatives and fund project development in the areas of osteoporosis, coronary heart disease and diabetes.

The College of Pharmacy Practice is administering the awards on behalf of a number of pharmacy and nursing organisations, including the Association for Nurse Prescribers, the Faculty of Prescribing and Medicines Management, the Guild of Healthcare Pharmacists, the National Pharmacy Association, the Royal Pharmaceutical Society of Great Britain, the UK Clinical Pharmacy Association and UK Medicines Information.

The awards include five best practice awards of £1,500 and a practice research award of £10,000. In addition, two awards of £250 will be given for the best poster and best oral presentation at the UK Medicines Information Conference (Chester, 14–16 September).

Further information can be obtained from the College of Pharmacy Practice (tel 024 76221359) or visiting [www.collpharm.org.uk](http://www.collpharm.org.uk)

# How to make MUR accreditation easy

Pharmacists who want to offer medicines use reviews need to get accredited. Chris Rose, communications lead for Essex Local Pharmaceutical Committee, describes a mass accreditation organised by his LPC



Essex Local Pharmaceutical Committee has a robust mechanism for communicating with contractors. It was this feedback that identified the need to assist pharmacists across Essex who wanted to conduct medication use reviews but were not yet accredited and to improve the practice of those who were already accredited. The LPC discussed the ways in which this need could be met and one committee member was given the task of organising an MUR accreditation event. Clare Mackie, head of the Medway School of Pharmacy, was invited to present a workshop at Hylands House in Chelmsford.

The LPC worked hard to invite all the contractors in Essex using fax-back invitations, electronic invitations and postal returns. The event was announced in LPC newsletters and brought to the attention of contractors and pharmacists at local meetings. As a result, over 90 pharmacists turned up on a freezing January evening. A few pharmacists were already MUR-accredited but most were not. The event was funded with joint sponsorship by Abbot Laboratories and Merck & Co.

Professor Mackie explained that MURs are intended to strengthen existing relationships with regular patients and to ensure that they get maximum benefit from their medicines. The workshop was in two parts. The first part explored using patient medication records to identify patients who might benefit from an MUR and included advice on managing significant drug interactions and adverse drug reactions. To prepare and conduct the MUR interview, three factors need to be applied to each medicine:

- Appropriateness (ie, indication, no unnecessary therapy)

- Safety (ie, side effects, drug interactions and contraindications)
- Effectiveness (ie, of choice, dose, formulation, and non-compliance and monitoring)

In the second part of the workshop participants reviewed three case studies and their corresponding PMRs to identify drug therapy problems. As each case study was looked at, participants were encouraged to complete an action plan for each patient because these had to be submitted for accreditation.

Once a patient has been identified as a candidate for an MUR, ideally about 10 minutes should be spent on preparing for the interview and checking the PMR and 10 minutes should be spent on the interview itself. A further 10 minutes is needed to complete the paperwork at the end, which includes an audit log and the copy of the action plan to send to the GP.

## Other issues

One question raised during the workshop related to the time needed to do all the paperwork and to conduct MURs in a busy pharmacy. The answer is to involve and empower the pharmacy support team. For example, filling in the form with patient details could be delegated to a dispensing technician. Arranging planned MURs (see Panel) means that the service can be provided when the maximum number of support staff are available or during quiet periods. Intervention MURs can be fitted in in the same way pharmacists discuss patients' medication queries during the working day. The paperwork can be completed later.

At the end of the workshop, 42 pharmacists submitted action plans to Professor

## What is an MUR?

An MUR:

- Identifies whether or not patients understand how their medicines should be used and whether or not they use their medicines as prescribed
- Identifies how patients should correctly use their medicines and any issues affecting correct use (eg, timing)
- Identifies if patients know why they have to use their medicines and explains the condition for which each medicine is prescribed
- Identifies side effects
- Identifies medicines no longer used

An MUR is not:

- A discussion about changes to drug treatment
- A discussion about a medical condition beyond its drug treatment
- A discussion on the effectiveness of treatment based on test results

There are two types of MUR:

**Planned MURs** A planned MUR is when the patient is invited for an interview. It can be conducted for patients on multiple medicines and those with long-term conditions.

**Intervention MURs** An intervention MUR (also called a prescription intervention) is one conducted around dispensing. It is carried out in response to a significant problem with a patient's medicine (eg, the need for patients to develop their understanding of their medicines in order to improve use is highlighted). The pharmacist will need to make a decision as to whether or not the intervention is clinically significant and requires more than brief advice. Dose optimisation and synchronisation alone do not warrant an intervention MUR.

For both types of MUR the patient must have used the pharmacy for dispensing their prescription for at least the previous three months.

Mackie for marking. Others were given the option of posting their plans at a later date. Over 70 per cent of attendees were "very satisfied" with the event and comments included "brilliant" and "this made accreditation so much easier".

The workshop will be reviewed at an LPC meeting in April with a view to repeating the exercise in the autumn.

# FPMM aligns with national agendas

Bruce Warner and Ros Grant, board members of the Faculty of Prescribing and Medicines Management, describe changes to faculty requirements

The Faculty of Prescribing and Medicines Management (FPMM) was set up as a semi-autonomous professional body within the College of Pharmacy Practice (CPP) in March 2001, to support pharmacists in any health care sector who have a specific interest in this area of practice. Since the faculty's inception, associates have steadily progressed to full membership through demonstration of both CPP and FPMM competencies.

The Department of Health has adopted a series of competency frameworks developed by the Competency Development and Evaluation Group (CoDEG). As a result, demonstration of competencies is likely to become a prerequisite to career advancement as employers and employees get to grips with progression via the NHS knowledge and skills framework, and certificated achievement of defined competency levels. In the community sector, for example, the new contract requires accreditation through the demonstration of competencies before the pharmacist can exploit fully the opportunities afforded by advanced and enhanced services.

In light of these developments the faculty has decided to adopt these frameworks, in place of its own framework published in September 2002, and to use them as the basis for membership of both the FPMM and the CPP. Competency assessment helps to develop FPMM members. It fits with professional accreditation and the anticipated re-accreditation and validation to continue to practise. Competency assessment assists in identifying any gaps in a member's capabilities and in recognising training needs. For employers, competency assessment can also confirm the suitability of an individual for a specific post.

## Levels of membership

In a bold move to make faculty membership more relevant and more applicable, three membership levels have now been established, based on the general and advanced or consultant level frameworks.

**General level** Prescribing and medicines management was originally considered by the faculty to be a specialty that required advanced practice, particularly in primary care. However, the new community pharmacy contractual framework will increase the number of pharmacists providing medicines management services to GP practices. Furthermore, as hospital pharmacists' roles move away from medicines supply they are becoming increasingly involved with prescribing and medicines management services.

The faculty recognises that these changes require a review of the place of faculty membership for pharmacists practising in general roles, such as community pharmacy, rather than exclusively in specialist roles within the NHS or private sector.

In recognition of the introduction of the new contractual framework, and the generalist professional roles undertaken in secondary care by many pharmacists, the FPMM now promotes general membership of the faculty and college. Roles for which this level of membership may be most appropriate include: community pharmacists, hospital pharmacists not working solely in a single clinical specialty and pharmacists with less than three years' experience in practice.

Pharmacists who wish to apply for general level membership will be delivering general services, although will be encouraged to move towards advanced membership if they take on specialist roles. This level of membership is achieved by working through the general level competency framework.

**Advanced level** Advanced level membership is achieved by working through the advanced or consultant level competency framework. It is likely to be the most appropriate level of membership for:

- Pharmacists working as specialists in the prescribing and medicines management arena of primary care or at the interface with secondary care
- Professionals and managers supporting pharmacists (eg, area managers, professional development managers, pharmaceutical advisers)
- Local professional group and network members

**Fellowship level** Fellowship level is also achieved by working through the advanced or consultant level competency framework and again is aimed at pharmacists working in specialist roles under advanced level. However, competence must be demonstrated, and evidence provided, at a considerably higher level than for advanced membership.

## How to become a faculty member

Pharmacists seek FPMM membership to be formally recognised as a specialist practitioner in the field of prescribing and medicines management. Membership confirms that a pharmacist:

- Has proven high standards of practice (ie, he or she has demonstrated that the com-

petencies agreed, set and required by the faculty have been met)

- Has had his or her skills, knowledge and expertise reviewed by a peer group (pharmacists working in the same specialist area of practice)
- Is committed to continuing professional development and maintaining high standards of practice

For faculty membership, associates will now be asked to present a self-assessment version of the appropriate CoDEG framework, with a portfolio of evidence. Membership will be approved either at general, advanced or fellowship level, depending on the candidate's experience and level of working. Attaining faculty membership in this way will be an excellent method of demonstrating competence to employers.

The application is processed by two faculty assessors. After discussing the submission, the assessors will invite the candidate to interview or ask for more evidence. Alternatively, candidates may be told that some areas of competency need further attention and may be invited to re-apply for membership at any time.

To help associates move towards full membership, the faculty operates a mentoring system. This involves a faculty member being available to offer advice and support to associates in preparing their submission for membership. The mentor will listen, encourage, challenge and question in such a way as to empower associates to achieve their goal. Mentors can give advice and feedback on:

- How to structure the portfolio
- The scope of the portfolio
- Pieces of evidence
- The application
- The level of membership to apply for

In addition, associates are encouraged to contact each other to provide mutual support.

In summary, the FPMM is moving in a proactive way to deliver a support mechanism for pharmacists to achieve career aims in a structured way that is in line with national agendas and likely local requirements. Gaining full faculty membership can go a long way towards demonstrating the competencies required in a pharmacy world, changing at an unremitting pace. The challenge is whether just the committed few or the mass of the pharmacy profession will grasp this strategy in assessing competencies and take advantage of all opportunities.