

How community pharmacists support disease management in Scotland

Supplementary prescribing in Scotland got a kick-start recently when funding for community pharmacy clinics was announced. **Clare Bellingham** reports on how pharmacists are using the money and asks chief pharmacist Bill Scott about his long-term views on supplementary prescribing

When new money to enable community pharmacists to set up supplementary prescribing clinics was announced in Scotland a few weeks ago (*PJ*, 16 July, p73), it marked a turning point. Those community pharmacists who had so far struggled to use their supplementary prescribing qualification jumped into action. Some have already managed to get clinics up and running and other clinics will start in the coming weeks.

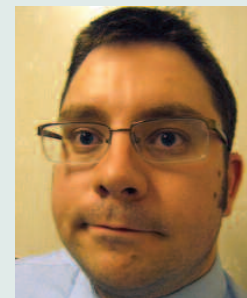
Chief Pharmaceutical Officer in Scotland, Bill Scott, explains: "We were very aware that after pharmacists had qualified as supplementary prescribers, unless they were using those skills, they would probably lose them. So I was keen to put the message out that we wanted to encourage pharmacists to use those skills." But why the funding for community pharmacy? "If you look at the pharmacy workforce in Scotland, 90 per cent works in community pharmacy. For most of the people living in Scotland, their experience of pharmacy is with a community pharmacist."

The funding does more than allow community pharmacists to set up clinics: it also aims to find the best way to use supplementary prescribing. "There is an element of allowing pharmacists to have a blank sheet of paper," Mr Scott comments. "It is early days for these new powers and it will take some

Running asthma clinics at Stirling University campus

At Campus Pharmacy at Stirling University, Jonathan Burton (pictured) is setting up a supplementary prescribing clinic for asthma patients. He will launch the service at the start of the new term in mid-September.

Patient sign-up will be done by local GPs. The GPs will offer the service during patients' appointments and they will have pre-prepared clinical management plans on hand. Mr Burton's CMPs will include steps 1 to 3 of the British Thoracic Society guidelines. "I discussed with the surgery where the gaps in the system are, and it is not with patients in steps 4 or 5 of the BTS guidelines — they are well monitored. The gaps are with those patients in step 1 or bordering on step 2, patients who are often not good at attending clinics at the surgery but who come to the pharmacy regularly for their inhalers," he comments. "I will start with a reasonably small number of patients — say half a dozen — for the first couple of months. We will then expand once we have checked to see that it works," he explains. "Having the clinic based at the pharmacy is more sustainable than holding it at the GP practice. It also means I can provide a service on an ad-hoc basis rather than having defined clinics at the surgery. There will always be patients who cannot make appointment times so I will provide the service whenever I am on duty."



time to work out how to use them in the optimal way."

Although there are similarities between the clinics that have been set up so far, there are also some differences. One major difference is the type of patients that are being targeted: some pharmacists are opting for long-term monitoring of stable patients while others are intensively managing patients with complex needs. Mr Scott says there is room for both models.

Jonathan Burton is targeting patients with asthma for his supplementary prescribing clinics at Campus Pharmacy at Stirling University. "Asthma and depression are the only two chronic diseases we see a lot of within our young population," he explains. "Although I am concentrating on asthma, I have added allergic rhinitis and smoking cessation to my areas of competence for supplementary prescribing."

And there are examples of pharmacists prescribing in other areas. At Fisher Pharmacy in Dunfermline, Anne Eadie and Shona Tarvit started running a

clinic for stroke patients last week. Through the clinic, they will manage patients who currently have uncontrolled hypertension. "The focus is to monitor blood pressure closely," explains Mrs Eadie.

In Coatbridge, Lanarkshire, Marie Therese Rogers is working in the same clinical area but will use supplementary prescribing for patients with stable hypertension. She will monitor their blood pressure every three months in clinics to be held at McNulty Pharmacy. "Three-monthly blood pressure checks is more often than the GP offers and the pharmacy is more accessible in terms of its location for most patients," she explains.

Similarly, in Doune, Perthshire, Campbell Shimmins will be prescribing for patients with coronary heart disease, including patients on complex regimens involving 10 or more medicines.

A striking similarity in three of the examples mentioned is that all the pharmacists are prescribing for cardiovascular disease. Mr Scott is not surprised by this, since cardiovascular disease is a priority for the Scottish Executive. But he adds that there is a need to extend the range of areas in which supplementary prescribers are interested. "We have to work with colleagues in general practice and share out the work. For example, it might be beneficial for pharmacists to look at patients who are non-attenders at clinics in general practice but who go to the pharmacy to collect their medicines," he comments.

Since the funding was announced, supplementary prescribing in community pharmacy

Setting up a stroke clinic in Dunfermline

At Fisher Pharmacy in Dunfermline, Anne Eadie (pictured) and Shona Tarvit started providing a new supplementary prescribing stroke clinic last week. Clinics for initial appointments will be held every other week. "We are aiming to see the first 60 patients by the end of September. Once we have done the initial reviews the follow-up appointments will only be for 10 minutes each so we can be more flexible about fitting them in on other days," explains Mrs Eadie. Preparation for the clinic began last month. The surgery wrote to every patient on its list who had had a stroke or transient ischaemic attack — a total of 120 patients — to explain the supplementary prescribing service. Initial consultations take about half an hour and involve a discussion of the patient's condition, any tests needed and preparation of a clinical management plan. A standard CMP for hypertension is used with adjustments made where appropriate, eg, for diabetes or reduced renal function. The patient will be seen at the clinic at intervals determined by the CMP. "From a patient's point of view, these clinics mean better access and closer monitoring. The ultimate aim is preventing strokes," says Mrs Eadie.



Prescribing for patients with cardiovascular diseases in Doune

From next month, Campbell Shimmins will be running supplementary prescribing clinics for patients with coronary heart diseases on complex medication regimens.

The surgery will refer patients to Mr Shimmins (pictured) and, to begin with, he plans to see four or five patients per half-day session. Referral will be on the basis of a particular care issue so the clinical management plan will depend largely on this. "I have a number of template CMPs for specific conditions and drugs. The CMP will specify how often I see a patient. For example, if a drug is being added or adjusted, a patient might need to be seen weekly or fortnightly," he explains. He will measure blood pressure, recommend any blood tests needed and adjust medicines as appropriate. "Once the initial patients reach their therapeutic goals, I will sign them off and take on new patients," he says. Initially Mr Shimmins will run the clinics from the local surgery. "The pharmacy is too small to have a sit-down consultation room so I will be using a portable cabin at the surgery which has been installed to allow the practice nurse, me and other professionals, such as a visiting chiropodist, to have a consultation room," he says. But in the longer term, he plans to extend his pharmacy into part of the shop next door in order to have the consultation room there. "That way I will be able to use it on Saturdays so I can see people who work during the week, and it will fill the gap created by a lack of prescriptions on Saturdays when the GP surgeries are closed."



seems to have a new impetus. Although a prior lack of funding was not the sole reason that community pharmacists struggled to use supplementary prescribing, it was certainly a significant factor.

Mrs Eadie explains: "Shona and I qualified as supplementary prescribers last November. We knew before we started the course that we would use it to run a stroke clinic but we have been waiting for funding."

Although Mr Shimmins managed to start prescribing a year and a half ago, it did not last. He explains: "After an initial flurry of activity for six months when I optimised medicines for a batch of patients, I stopped prescribing. Although I have continued to monitor and review these patients, I no longer prescribe for them and I have not taken on any new patients." He says that the lack of funding was challenging: "Having to make supplementary prescribing work within existing model schemes money was difficult."

Perhaps Mr Burton sums it up when he says: "Recognition is the main thing. The funding shows that the Scottish Executive is willing to facilitate new ways of working and it means I can move forward without making a loss."

However, there is one issue that is still causing some difficulties and that is access to patients' medical records. Mr Scott says access must be agreed at a local level, rather than a broad statement being made at an Executive level. And this is why a number of different approaches are being taken.

Mrs Rogers plans to borrow patients' notes from the surgery on the morning of the clinic and, after seeing the patient and annotating the record, return the notes to the surgery in the evening. At Fisher Pharmacy, the pharmacists visit the surgery to prepare a summary of the patient's medical record, which is then used at the clinic. It includes the patient's current medication, co-morbidities, drug allergies, previous antihypertensive treatment, blood test results and risk factors. In addition, the patient's notes are flagged at

the surgery so if any subsequent entries are made, the pharmacists will be alerted. After each clinic, the pharmacist will go to the surgery to update the patients' notes.

Mr Burton will be using his own notes system, too — one which mirrors a system used by asthma nurses so that the notes are in a format that the doctors are used to seeing. He plans to visit the surgery before each clinic to check the patients' medical record for any recent additions.

Future developments

Exactly how supplementary prescribing will be used is still being determined. Community pharmacists in Scotland are waiting for the detailed negotiations on their new contract to be completed, and perhaps the outcomes of these negotiations will partially answer the question. It is expected that supplementary prescribing will form part of the chronic medication service, one of the four core services in the new contract. However, it will be through the experience of the pharmacists running the supplementary prescribing clinics that the real answers will come: what works, what does not and where real patient benefit is gained.

Mr Scott's long-term view is one of expansion beyond prescribing for a single disease area. "It is early days but clearly pharmacists have to deal with all medicines in the British National Formulary. So the strength of pharmacists is that they can look at a patient's medicines in total rather than focus on one

disease area. Patients rarely present with just one disease," he explains. He hopes pharmacists will use supplementary prescribing in polypharmacy clinics.

Does Mr Scott see supplementary prescribing as a stepping stone to independent prescribing? "Some pharmacists will never move from that stepping stone but others will see independent prescribing as the end goal. So, yes, if those powers are conferred on pharmacists, then I would like to see them using it. But independent prescribing is about teamwork, not detachment."

He explains that the model of independent prescribing he would like to see is one in which, following diagnosis, a patient's care is handed over to a pharmacist who then tailors a medicines regimen to the individual patient. "If anything, this would involve closer working, since the GP and pharmacist would have to have complete confidence in each other."

The Scottish Executive's support for supplementary prescribing continues this autumn when it funds another 180 places for pharmacists to train as supplementary prescribers. But, in the long term, Mr Scott wants to see supplementary prescribing become part of the undergraduate curriculum and he wants all community pharmacists to be supplementary prescribers. "So the contract will then have to reflect these skills," he says. What about those pharmacists who do not want to be prescribers? "Clearly there will be a transitional phase but, if prescribing is in the undergraduate course, then it will become as acceptable as dispensing." And he is not thinking about a long timescale: just 10 to 15 years "depending on how pharmacists react to these opportunities". He concludes: "It is early days. We have got to explore supplementary prescribing and unleash its potential. Hopefully this is what we are doing with the new funding for supplementary prescribing clinics."

Addressing hypertension in Coatbridge

At her pharmacy in Coatbridge, Marie Therese Rogers (pictured) will be prescribing for patients with stable hypertension by the end of the month. "Nurses and primary care pharmacists already offer supplementary prescribing in GP practices. We need to offer something else to be of benefit and that's why I want to hold the clinics in the pharmacy," she explains.

Since refitting her pharmacy to provide consultation space four months ago, Mrs Rogers has started running a blood pressure monitoring service. This has helped her to increase her confidence before she starts prescribing: like most community pharmacists she is used to talking to patients every day, but in the shop not in a consultation room. In the supplementary prescribing clinic, she will monitor patients' blood pressure every three months. Patients are currently being identified from their repeat medication slips. Mrs Rogers will draw up clinical management plans and agree them with the GP in advance of the clinics. "I aim to prescribe for a couple of hundred patients. Initially I will run a half-day clinic each week and then go to a full day as the patient numbers increase," she explains.

