



Pharmacist Prescribing in London: what have we learned so far?

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with thanks to Jane Nicholls and the London Pharmacist Prescribing Support project



Pharmacist prescribing in London: what have we learned so far?

- What's been achieved so far in London?
- What have we learned?
- What are the critical success factors for pharmacist prescribers?
- What are the implications for implementation of pharmacist independent prescribing?

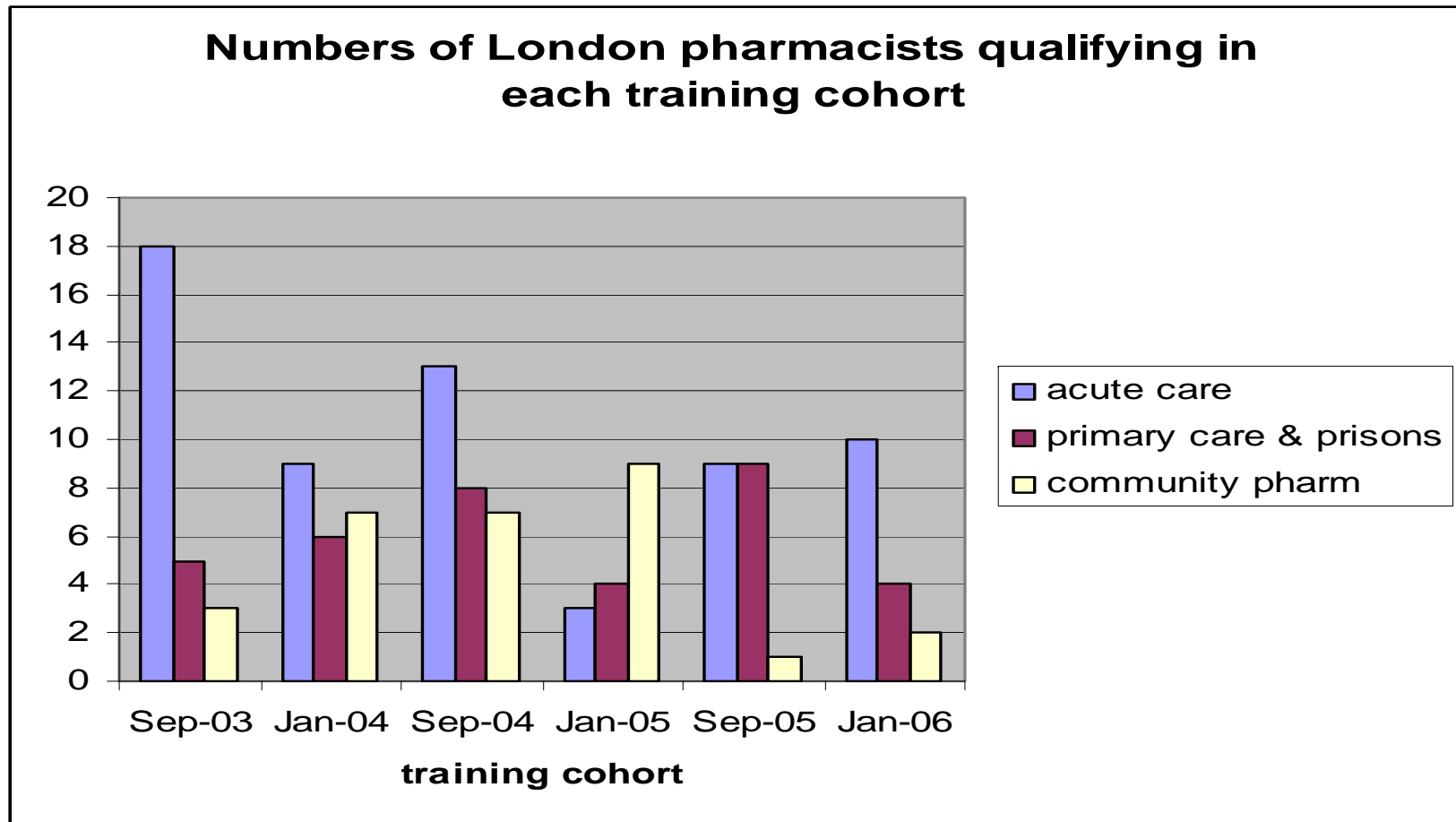


Learning and data sources for this presentation

- Data collated by London pharmacist supplementary prescribing support project during 2003-7
- Data from Lambeth PCT audit
- Outcomes from two workshops for senior managers



The facts and figures for London



Plus Sept 06: 21 Jan 07: 28 May 07: 25



The current context for new prescribers

- Wider context for developments in prescribing – patient group directions, medicines management
- Political context – access to medicines, developing the workforce, care closer to home
- Rapid pace of change in the NHS – especially for PCTs and community health services
- The challenge: a great time to redesign services, but funding is extremely difficult



Examples where pharmacist prescribing is already successful

Cancer chemotherapy for patients in hospital and at home	Palliative care
Services for patients with aids-related disease	Parenteral nutrition
Antimicrobial chemotherapy for hospital inpatients	Managing cardiac failure
Monitoring and prescribing of drugs with high risk of toxicity	Managing clozapine therapy
Pain control in post operative acute care	Older people in long-stay facilities
Substance misuse – prescribing methadone, supervised consumption, needle exchange	Rheumatology outpatients
Surgical pre-admission clinics	COPD in a community pharmacy setting
Anticoagulation in hospital and community settings	Diabetic patients in GP practice setting
Smoking cessation in community pharmacy settings and in prison settings	Renal transplant patients
Hypertension management in GP practices	Critical Care
Heart and lung transplant	Cardiac rehabilitation
Specialist liver disease unit	



Clinical management plan templates made available at www.nelm.nhs.uk by individual authors working in secondary care

Heart Failure	Template for minor ailments
Older people in long term care	Template for management of falls
IBD Patients	Generic template for discharge planning
Plan for diabetes type 2	Use of methadone in opiate dependence
Haemato-oncology	Use of buprenorphine in opiate dependence
HIV patients	Hypertension
Ischaemic heart disease	Liver transplant
Diabetes	Chronic renal failure
Surgery pre-admission	Inflammatory bowel disease
Parenteral nutrition	



Key success factors for individual prescribers

- **A good relationship between the supplementary prescriber and independent prescriber prior to setting up the service, and a long standing existing relationship of trust between professionals in the multidisciplinary team**
- **Adding supplementary prescribing into an established pharmacist-led service. e.g. total parenteral nutrition (adults and children), medication review, practice-based pharmacists, pharmacist-led specialist clinics**
- The support of the local employing organisation.
- Finding a designated medical practitioner (DMP) but in London very few applicants have not gone forward for training for lack of this support
- Enthusiasm and perseverance of the 'early adopters'
- Employing organisations which had selection criteria and an application process agreed in advance of any candidates attending courses.



More key success factors

- Easy availability of local and respected university course
- Establishment of and adherence to Non Medical Prescribing policies and processes within the organisation
- Tackling the practical implications of setting up a prescribing service. Including:
 - finding clinic space and time
 - administrative assistance (time and personnel)
 - ensuring the support of all relevant personnel for the development
 - establishing IT infrastructure
 - establishing the capability of the IT system to support pharmacist prescribing
 - ordering prescription pads (if relevant)
 - policy changes if needed
 - ensuring individual's prescribing role is recorded for the purposes of vicarious liability
 - deciding what professional indemnity is required



Outcomes from November 2006 workshop - training and development

There was no criticism of the prescribing courses and it seemed that participants considered it produced prescribers who were fit for purpose

Pharmacists should be exposed to prescribing pharmacists as good role models in the foundation years between registering as a pharmacist and becoming eligible to prescribe

The HEIs need to link up with providers as well as commissioners to ensure the quality and outcomes that are required

The practice element of the HEI training requires strengthening and supporting

Organisations should develop guidance for the selection of designated medical practitioners (DMPs).

Thought needs to be given to sustainability of medical practitioners providing the DMP role

Local 'scope of practice' agreements may help ensure that individuals are working within a scope that is receiving corporate support

More thought needs to be given as to how to recognise therapeutic competence

Clinical supervision should be developed and linked to CPD

A prescribers' 'dating agency' needs to be established which would link prescribers for peer support with those providing similar services (e.g. for a clinical specialty)

Prescribing needs to be incorporated into service provision and issues of succession planning must be addressed. Are pharmacists best suited to the prescribing role or to the role of training and developing other prescribers?



Service redesign – a key driver

- Independent prescribing is primarily about new roles, fulfilling patient need, shifting care to the community, decreasing unscheduled episodes of care
- Fit to national and local priorities
- Identify gaps
- Do not get hung up on the need to 'diagnose'. Pharmacists can take over the monitoring and continuation of medicines started by doctors. e.g. anticoagulants, gentamicin
- Be patient – timing may not be right
- Redesign other work to release pharmacists' time for prescribing e.g. remote supervision, skill mix, robots, accredited checking technicians
- Pick up on implications of care closer to home
- Reduction in junior doctor's hours



Examples where pharmacist prescribing may be helpful (opportunities and gaps)

Specific:

- Optimizing medicines use in long term conditions
- Gentamicin, vancomycin optimisation in hospital inpatients
- Improving the quality of prescribing and reducing risk e.g. issue of junior doctor turnover
- Prescribing in clinical trials – the ‘evidence free zone’
- Minor ailments
- GOUT re GP quality targets
- Weight management
- Take referrals from hospital to and from community pharmacist to maintain /monitor therapy

General:

- Admission and discharge in acute care
- Care pathways
- Concordance
- Self medication use
- Public health
- Minor ailments
- Formulation issues
- Prevent double referrals



Pharmacists' strengths

- Guideline production – consistency across all prescribers in all sectors
- Attention to detail
- Evaluating evidence and putting it into practice
- Providing up to date information
- Controlling and monitoring prescribing (formulary and guidelines)
- Health promotion
- A source of medicines information and interpretation

- ● ● | Examples of the issues that arose during the implementation of pharmacist prescribing in secondary care

- I am the only pharmacist who monitors these prescriptions for safety. Now that I am also prescribing, how do I ensure that my prescriptions are screened by another pharmacist so that the same level of safety for the patient is assured?
- I am registered as a new prescriber with the professional body and have agreed with the clinical team to prescribe for a cohort of outpatients alongside the medical team. However there is no 'free' space for me to see patients and the organization seems unwilling to help me to resolve this.



More examples of the issues that arose during the implementation of pharmacist prescribing in secondary care

- The medical records department will not pull notes for me. They say they must receive extra payment for this.
- In order to have my practice covered by vicarious liability, there must be a record of my change in role and the Trust will not facilitate this.
- My Trust has a policy that states that all my outline CMPs must be reviewed by the non-medical prescribing committee before I can practice as a prescriber. This process is taking many weeks.



What happens after they qualify?

- Average delay between qualification and active prescribing was initially a year, but this reduced to six months over time
- A significant minority have never prescribed, or have started and stopped
- Key factors:
 - establishing long term funding for a new service
 - confidence
 - practicalities (pads, ordering tests, changing JDs etc)
 - awaiting Trust infrastructure



Prescribing rates amongst qualified nurse prescribers vary... but what about pharmacists?

Extended Formulary Practice Nurse Prescribing across Lambeth PCT - 2004 to 2005			
Prescriber Name	BNF Name	Total NPEF Nurse Items	Total NPEF Cost
Practice nurse/nurse practitioner 1	BNF	777	£5,816.78
Practice nurse/nurse practitioner 2	BNF	301	£1,226.67
Practice nurse/nurse practitioner 3	BNF	67	£168.20
Practice nurse/nurse practitioner 4	BNF	48	£158.98
Practice nurse/nurse practitioner 5	BNF	38	£205.54
Practice nurse/nurse practitioner 6	BNF	19	£126.46
Practice nurse/nurse practitioner 7	BNF	8	£3.03
Practice nurse/nurse practitioner 8	BNF	7	£34.92
Practice nurse/nurse practitioner 9	BNF	1	£0.65
		1,266	£7,741.23

Reported barriers for nurse and pharmacist prescribers	Proposed solution (From Lambeth PCT strategy)
IT - generating scripts via GP systems, incorporating clinical management plans into GP systems	Targeted IT support and shared solutions Commission IT workshops for new prescribers and practice staff
Awareness and understanding within practices of NMP models	Accessible and clear information pack for practices, including standard presentation Use LMC, and protected learning time Increase awareness of scope of nurse practitioner role Use DMPs to champion new prescribing
Workload pressures	Substantial time saved if IT upgrades used successfully Ensure adequate time for prescribing role factored into service redesign work
Lack of confidence amongst new prescribers	Introduce and support buddying system for all sectors Follow up low prescribing activity Introduce primary/secondary care links and support
Practical frustrations	Check and maintain BNF distribution systems Inform community pharmacists re what can be prescribed by nurses, and follow up dispensing refusals Support systems for easy access to prescription pads via PPA and Astron
Need for 'headroom' and funding for service redesign work, especially in community pharmacy	Build in development of prescribing roles into PCT-led service redesign work (access, long term conditions, first contact care, self care) including in community pharmacy

- ● ● | What are the implications for independent pharmacist prescribing?

- Reflect on SP story and build on success, learn from what has not gone so well
- Enthusiasm alone is not enough - sustainability is an issue
- What are the 'niche' independent prescribing opportunities?
- New challenges for IP – private sector, clinical governance, working within competence and scope of practice



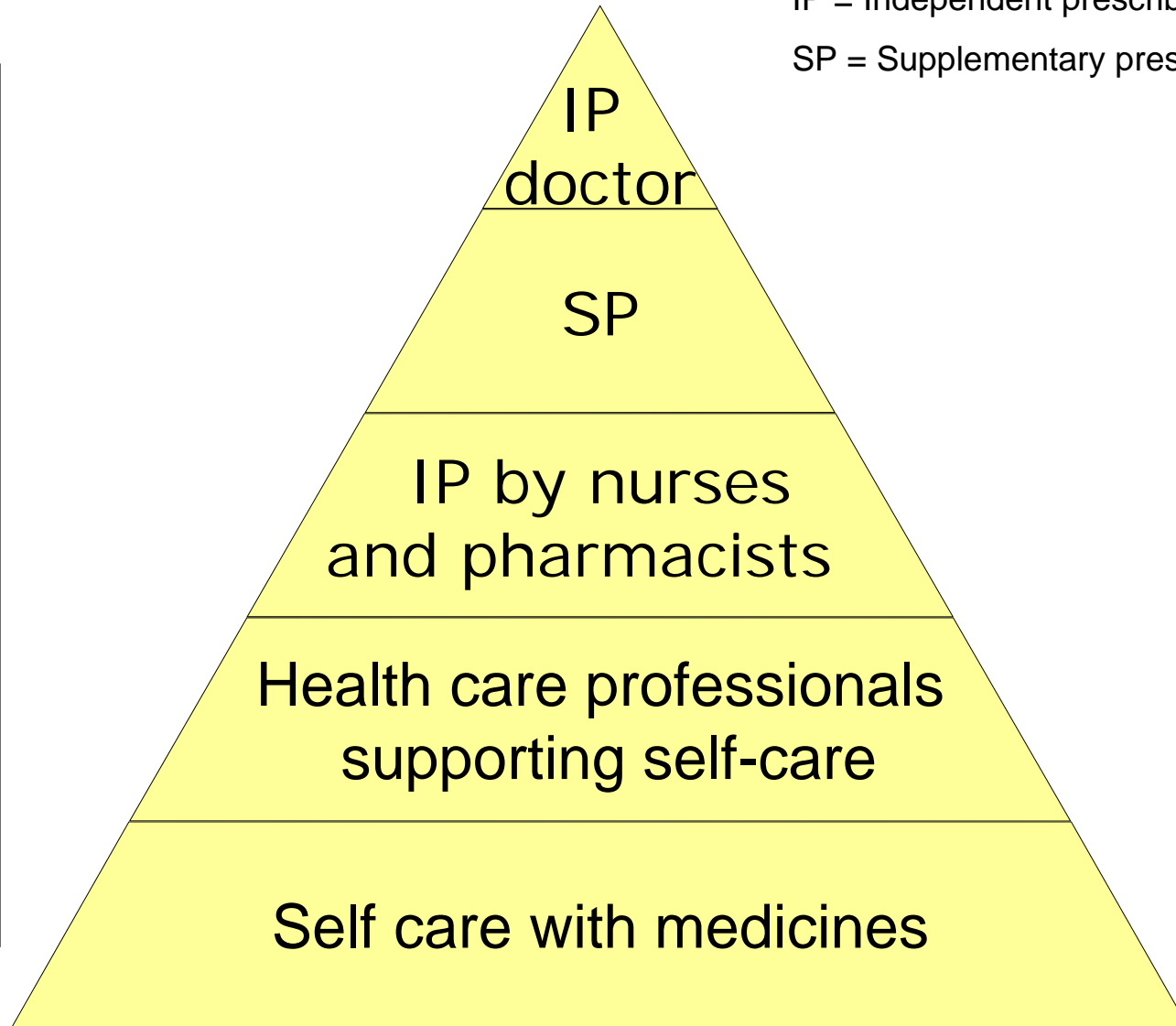
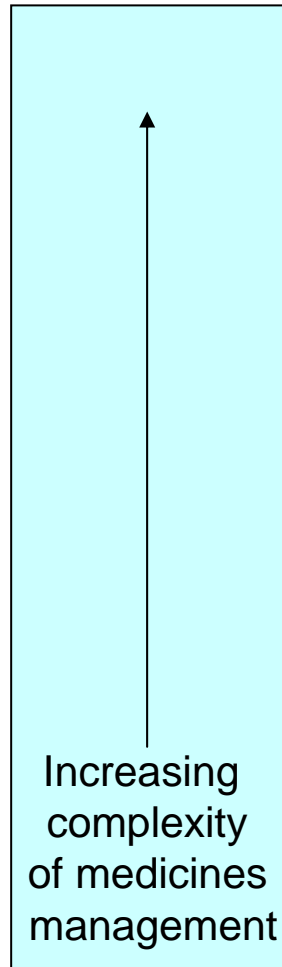
What will we need to have in place to support new independent prescribers?

- Updated governance frameworks in line with national guidance at national and local levels, in all organisations (NHS/private sector)
- Resources – support from PCTs and Trusts to make sure new prescribers are supported through courses *and implementation*
- IT solutions
- Access to patient records

A proposed hierarchy of prescribers?

IP = Independent prescribing

SP = Supplementary prescribing





Resources from London pharmacist prescribing project

- www.druginfozone.nhs.uk/search/product.aspx?id=71 or see non-medical prescribing/support materials
- Project report 2003-6
- Workshop summary
- Implementation tools

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