



**Royal
Pharmaceutical
Society**
of Great Britain

SUPPLEMENTARY PRESCRIBING ONE YEAR ON

This report was prepared on behalf of the Practice and Quality Improvement Directorate of the Royal Pharmaceutical Society of Great Britain.

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SUPPLEMENTARY PRESCRIBING: ONE YEAR ON

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EXECUTIVE SUMMARY

In April 2005 – a year after the first pharmacist wrote a supplementary prescription – the Royal Pharmaceutical Society of Great Britain (RPSGB) held a one-day conference to assess how supplementary prescribing is working in practice and how to move the supplementary prescribing agenda forward.

This report describes the outcomes of the conference. It reflects the voices of the supplementary prescribers themselves: it covers their successes, their concerns and finds out what they think are the solutions for the future.

The **key issues** identified by supplementary prescribers as needing action are (in order of priority):

- The lack of a competency assessment both before and after qualification as a supplementary prescriber
- Limitations of supplementary prescribing when trying to incorporate it into existing practice
- The lack of a support network to provide updates relating to supplementary prescribing
- The lack of IT support from GP computer software systems for supplementary prescribing
- A number of issues relating to funding, from remuneration of the role itself, to training, access to prescribing budgets and indemnity insurance
- Difficulties with clinical management plans (CMPs), particularly for patients with co-morbidities
- Poor understanding of the supplementary prescribing role among other health professionals and the public, in part caused by the complexity of non-medical prescribing models
- Problems arising from the lack of access to patient records in both primary and secondary care but particularly in community pharmacy

Among the recommendations made by the group, two themes came through again and again. They are a need to *increase awareness of supplementary prescribing among the public and health professions*, and the fact that *supplementary prescribers want more support*. The key recommendations are:

- Bring supplementary prescribing materials together into one resource pack
- Promote the role of supplementary prescribers among other professions and the public
- Define exactly where pharmacists add value as supplementary prescribers
- Simplify the supplementary prescribing model
- Encourage multidisciplinary work between national professional bodies, and between pharmacists and nurses at a local level
- Set up a good practice database
- Establish a system that allows new supplementary prescribers to be mentored by existing supplementary prescribers
- Improve communication between the RPSGB and supplementary prescribers
- Provide more support and regular updates to supplementary prescribers

INTRODUCTION

It is a year since the first pharmacist wrote a supplementary prescription in March 2004. To mark this event, the RPSGB held a one-day conference on 11 April 2005 which aimed to:

- Identify the challenges faced by early supplementary prescribers
- Identify how those prescribers have overcome these barriers
- Work out how to move the supplementary prescribing agenda forwards

Conference participants were largely registered supplementary prescribers: 45 out of a total of 54 participants fell into this category. Of the 45, 29 were currently working as supplementary prescribers in the following areas of practice (more than one field applied to some):

- Community 3
- Hospital 19
- Primary care 14
- Prison 1

Many of the conference participants were also involved in other aspects of supplementary prescribing, including training, management and policy development.

The Conference

Introducing the day, chairman Clive Jackson, chief executive of the National Prescribing Centre, said that pharmacy is currently coming into a golden age. "Prescribing developments are the key that we have," he explained. "But pharmacy is not developing prescribing responsibilities in a vacuum; other professions are doing it in parallel." He pointed out that nurses are ahead of pharmacists in developing prescribing and that prescribing rights are now being extended to a range of allied health professionals. "By the end of the decade, there will be more non-medical prescribers than medical prescribers. It is an absolute revolution," he commented.

In terms of the developing prescribing agenda, Mr Jackson said that the important points for the pharmacy profession to consider are:

- Determine how to deliver prescribing for the maximum benefit of patients and the public
- Identify pharmacy's unique selling point (among the other prescribing professions)
- Consider how pharmacy can tell if it is delivering prescribing well

The profession has to think about this in terms of three audiences:

- Patients and the public (Is it known what the public thinks about pharmacists taking on prescribing roles?)
- The NHS and wider health care organisations (Persuading them that pharmacists can increase patient care and offer value for money.)
- The profession itself (The whole profession needs to move forwards together in order to avoid creating a two or three-tier profession.)

Much of the conference was taken up by workshops in order to maximise participants' opportunity to put their views forward. In addition, a Department of Health perspective on supplementary prescribing was given by Gul Root, principal pharmaceutical officer at the Department, and three pharmacists (one from each sector of the profession) described their experiences of supplementary prescribing.

This report is divided into two sections. The first section describes the background to the supplementary prescribing agenda, and covers the experiences of the three pharmacists and the Department of Health perspective. The second section reports the findings of the workshops.

SECTION ONE

Background

Supplementary prescribing has its roots in the 1999 Crown review into the prescribing, supply and administration of medicines. The report suggested that a new form of prescribing should be introduced, a type of prescribing that took place after a diagnosis had been made and which could be carried out by non-medical health professionals. A public consultation followed and, in late 2002, the Government announced its plans to introduce supplementary prescribing.

The first pharmacists completed the supplementary prescribing training in early 2004. On 18 March that year, Neil Frankland, lead pharmacist for surgery at North Tyneside General Hospital, became the first pharmacist to write a supplementary prescription. In May, Fiona Reid, primary care pharmacist for cardiovascular disease at Newbyres Medical Group practice in Gorebridge, Midlothian, wrote the first pharmacist supplementary prescription in primary care. This was quickly followed by Campbell Shimmins of Woodside Pharmacy, Doune, Perthshire, who was the first pharmacist to write a supplementary prescription in community pharmacy.

Definition

Supplementary prescribing is based on a voluntary partnership between an independent prescriber (a doctor or a dentist) and a supplementary prescriber, and it must have the consent of the patient. Supplementary prescribing should be in accordance with a patient-specific clinical management plan that lists exactly which conditions can be treated. The other requirement is that both the independent and the supplementary prescriber must share access to the same patient medical record.

Nurses and pharmacists were the first health professionals to become supplementary prescribers; supplementary prescribing is now being extended to physiotherapists, radiographers, podiatrists/chiropractors and optometrists.

Initial restrictions on which medicines could be prescribed by supplementary prescribers have recently been lifted and prescription of any medicine, including Controlled Drugs and unlicensed medicines, is permitted.

By April 2005, over 500 pharmacists had become supplementary prescribers, with the number increasing every week.

Supplementary prescribing in hospital

At the conference, Helen Williams described how supplementary prescribing is being used within a heart failure service at King's College Hospital in London. Ms Williams is the pharmacy team leader for cardiac services.

She explains that the traditional approach to managing heart failure involved patients being seen at intervals by the cardiology team, a number of professionals carrying out interim management (such as dose titration) and a lack of structured support for patients. Altogether, this resulted in patients failing to achieve therapeutic targets, recurrent readmissions, poor symptom control, high mortality rates and poor compliance.

In order to address these problems, King's set up a new *multidisciplinary heart failure service* which is being run by a nurse consultant and a specialist pharmacist (Ms Williams). Both are supplementary prescribers.

On the patient's first visit to the clinic, his or her diagnosis is confirmed by the consultant cardiologist (the independent prescriber) and thereafter the patient is managed by the nurse and pharmacist team. Responsibility for all follow-up care is delegated to the supplementary prescribers. This includes on-going assessment and examinations, further investigations, changes to drug therapy, psychosocial adjustment and liaison with primary care practitioners. Any changes in diagnosis or complications are referred back to the independent prescriber.

Initially patients are seen weekly and then monthly until symptoms are controlled and drug therapy has been optimised. Patients are then reviewed every three or six months. Patients are also referred back to the independent prescriber for an annual review.

The work balance between the pharmacist and nurse works well. "Instead of competing for roles, we have carved them up between us," explains Ms Williams. "We have different skills to offer. The nurse knows more about heart failure but I can give the broad drug knowledge." Not surprisingly, the pharmacist's roles are more medicines-related.

The role of the pharmacist:

- Taking drug histories
- Undertaking medication reviews
- Optimising dosing
- Tailoring drug therapy
- Monitoring response to drug therapy
- Dealing with adverse events
- Providing patient information and GP letters

The role of the nurse:

- Initial assessment
- Carrying out tests, investigations and physical examinations
- Educating patient on heart failure pathology
- Giving lifestyle advice
- Addressing social issues/psychology
- Dealing with carers
- Co-ordinating clinic visits
- Providing tele-clinics

Ms Williams points out that the division of roles is not always as strict as this appears, since both are trained to provide the complete service so that they can cover for each other during annual leave or other absences. "One area in particular that pharmacists need training on is putting their hands on the patient: feeling their ankles, listening to their lungs and so on," she comments.

The clinic has now set up clinical management plans (CMPs) for 150 patients. Ms Williams stresses that the important point is to ensure that the CMPs are broad enough to allow efficient practice. "It is not just about dose titration of ACE inhibitors and beta-blockers," she says. Other issues might also have to be addressed, such as gout. This year, the clinic provided flu vaccines. And sometimes patients arrive at the clinic having run out of all their medicines, not just those for heart failure, so these too have to be prescribed. In these instances, an independent prescriber has to confirm diagnoses to allow supplementary prescribing to go ahead.

In order to address the difficulties with CMPs, the clinic produced a two-page CMP from which the parts that are not relevant to a particular patient are removed. This has significantly reduced the time it takes to initiate a CMP.

The CMP includes the following:

- Heart failure symptom control
- Optimising outcomes in heart failure
- Hypertension management
- Secondary prevention of ischaemic heart disease
- Anti-anginal therapy
- Atrial fibrillation management
- Management of other conditions such as obesity and sexual dysfunction

An audit of prescribing from November to March shows that the nurse, who works at the clinic for five days a week, prescribed 116 items. Ms Williams, who works at the clinic for one afternoon a week, has prescribed 79 items. Of the total 195 items, 180 were cardiac drugs.

Problems

The problems Ms Williams has identified with supplementary prescribing are:

- Addressing how supplementary prescribing and the management of co-morbidities fit together, eg, the fact that NSAIDs used for rheumatoid arthritis can effect the management of heart failure so should pain control be in the CMP?
- The restrictions of working within a CMP, eg, if a patient develops gout should this be considered as a new diagnosis or as an adverse effect?
- Difficulties with pharmacists ordering diagnostic/monitoring tests because pharmacists are not authorised to order some of these tests
- Pharmacists need to learn about non-pharmacological aspects of the disease

Benefits

In terms of the benefits of supplementary prescribing, Ms Williams lists:

- Better use of skill mix in the clinic team
- Holistic approach to care
- Continuity of care
- Tailored dosing regimens
- Achieving drug dose targets more quickly
- Patient satisfaction increased

Challenges

The challenges with supplementary prescribing she outlines are:

- Developing CMPs
- Consultation skills for pharmacists, including undertaking physical examinations, dealing with sensitive issues such as explaining the prognosis and being able to see the bigger picture (beyond medicines)
- The prescribing process for nurses
- Getting support within trusts
- Resources, in particular for indemnity insurance. Ms Williams points out: “My indemnity premium has doubled despite the fact that I am not getting paid any more for doing the prescribing work.”

Supplementary prescribing in primary care

Karen Acott is a pharmacist and partner at Wallingbrook Health Centre in Chumleigh, Devon. She described how she is using supplementary prescribing within the GP practice.

Ms Acott became a partner at the practice a year ago. “The key task for me was to ensure a sound foundation to develop the role of the pharmacist within the practice,” she explains. This meant developing new relationships with the team, gaining their trust and the trust of patients, and developing her own confidence. She then had to define her role as a supplementary prescriber.

“The practice nurse has been key to the successes of the GP practice for some time. I had to identify the values that I could bring to augment what was being done already,” Ms Acott says. For example, there would have been no point in saying she would set up a clinic in one therapeutic area when the nurse had already done so. Other challenges she faced included dealing with the “*proxy prescribing*” when a nurse writes a prescription for the doctor to sign, improving the quality of all prescribing and improving concordance.

Pharmacy’s selling point is as a “*pivot for medicines use*”, Ms Acott says. “Giving advice on medicines remains the most important aspect of the pharmacist’s knowledge and a skill which is important as a supplementary prescriber.” She says that the unique selling point of pharmacy is that pharmacists are more sensitive towards the use of medicines. Pharmacists address prescribing with more sensitivity, take a more targeted approach and do not “use a hammer to crack a nut”, she explains.

Focusing on the fact that pharmacists are the experts in medicines has led Ms Acott to set up medicines review clinics in which she prescribes for all patients, rather than specifically targeting individual therapeutic areas. “I have a number of generic CMPs for bite-sized conditions that can be added to patients’ notes,” she comments.

Ms Acott says that there are lots of “hooks” onto which supplementary prescribing can be added, for example, opportunities within the new pharmacy and new GP contract, the long-term conditions agenda and within intermediate care. “Come up with the ideas, don’t wait for them to come to you. Primary care trusts (PCTs) are so busy at the moment, they will jump at anyone who comes to them with ideas,” she suggests.

Asked about *succession planning*, Ms Acott explained that because her care is planned, she can put appointments off for up to a week if she is absent (eg, for holidays). If her absence is longer than a week, then the doctors will step in and run her clinics.

Top tips

Ms Acott's 10 tips for success as a supplementary prescriber are:

1. Remember that patient safety is paramount. It is important to record all your thought processes in the patients' notes, eg, any doubts or questions
2. Communicate, communicate, communicate. All doubts and questions must be communicated with the independent prescribers. Ms Acott has a "worry list" of patients she has particular concerns about which can be regularly checked with the independent prescribers
3. Work with clinicians and patients. Find out what the patients want and meet their expectations: if they would rather see the doctor that is fine
4. Start small. One of the difficulties Ms Acott faced was finding therapeutic areas in which to prescribe. So she started by looking at the quality and outcomes framework and picked out "unsexy" conditions that no-one else was addressing: these were hypothyroidism and epilepsy
5. Repackage the care to maximise your input. Patients see the nurse for diagnosis and tests, and see Ms Acott for medicines advice and medicines review (since pharmacists are the experts in medicines)
6. Participate in the practice team and learn from other members of the team. "Be visible," she stresses
7. Ask others for advice. This is a particular problem for community pharmacists who have tended to work in isolation. However, she says that it is important to ask when you are unsure. "It is not a sign of weakness to discuss something, few clinicians have developed their practice in isolation," she comments
8. Know when to refer on, there is no point in delaying referrals
9. Be accessible. Ms Acott is in the practice every day and patients can telephone her directly
10. Be confident. "As pharmacists, we always underestimate ourselves. We know a heck of a lot and should be proud of that and sell it," she says.

Supplementary prescribing in community pharmacy

Mahesh Sodha is a community pharmacist in Chelmsford. He works as a supplementary prescriber with a local GP practice, running clinics mainly at the practice but also at his pharmacy.

An electronic link between Mr Sodha's pharmacy and the surgery has enabled him to access patients' medical records at the pharmacy. The link was funded by the local PCT and, in turn, Mr Sodha paid for a consultation area to be installed in the pharmacy. Despite this capability to run clinics at his pharmacy, he says that at the moment his comfort zone is in the GP practice so he tends to run more clinics there. "I prefer to be in the practice because the staff arrange the appointments for me, plus having the other clinicians and resources such as blood test forms there is better," he explains.

Mr Sodha currently manages between 50 and 60 patients using one generic CMP that was agreed by all five GPs at the practice. "Few GPs want to be involved in writing each CMP so my generic plan states that I can treat three conditions and can prescribe any drugs for these according to the BNF," he explains. "I practise within my competencies so there are some drugs within the appropriate chapters of the BNF that I would not prescribe."

Case Study 1

Mr Sodha's first patient was a 53 year old man with type II diabetes. His glycated haemoglobin (HbA_{1c}) was 8.7 per cent (previously 11.3 per cent), blood pressure 146/86 mmHg and cholesterol 4.32 mmol/L. The patient was receiving 80mg gliclazide (recently increased from 40mg) and had never been treated for hypertension. Mr Sodha took the following action:

- Initiated metformin 500mg once daily, increasing to twice daily
- Initiated ramipril at 1.25mg daily and titrated upwards
- Attempted to increase the metformin to three times a day but the patient could not tolerate it, so kept the dose at twice a day

The patient outcomes were: blood pressure reduced to 132/84 mmHg and HbA_{1c} reduced to 6.3 per cent. Mr Sodha has since increased the ramipril dose again to 5mg daily in an attempt to further reduce the blood pressure. He points out that some people have questioned whether this is supplementary prescribing, since he made the diagnosis of hypertension. "Perhaps, but it is within the CMP," he says.

Case Study 2

Mr Sodha provided a second case study: a 56 year-old man with type II diabetes. His HbA_{1c} was 8.9 per cent and cholesterol 5.5mmol/L. He was receiving metformin 500mg twice a day. Mr Sodha took the following action:

- Increased metformin to three times a day
- Initiated simvastatin 20mg once a day

Despite the fact that the patient appeared to be well-motivated to manage his diabetes, he had not been back for his blood tests and was well over-due for his follow-up appointment. Mr Sodha comments that these are the same challenges that other health professionals face in following up patients.

Problems

Mr Sodha lists the following hurdles to supplementary prescribing:

- Selling the idea of supplementary prescribing to PCTs; some PCTs and pharmaceutical advisers are not interested in pharmacists becoming prescribers
- Obtaining funding for training and to cover locum costs while training. However, Mr Sodha comments that the training is about pharmacists' own development and questions: "If you are not prepared to invest in this, who will?"
- Difficulty of the training course. He says that the training course is not the scientific, analytical type that pharmacists are used to and that this made it difficult
- Funding of clinics. Describing this as the biggest challenge, Mr Sodha says: "GPs don't want the money for enhanced services under the GMS contract to go to pharmacists." So the challenge is: "Who pays?"
- Having to write out prescriptions by hand and then add them onto the electronic record afterwards. "If I print a repeat prescription, I cannot sign it even if it was me that initiated the drug in the first place," he comments
- Deciding how to deal with additional conditions that are not listed on the CMP, particularly minor ailments

"Despite these hurdles, I think supplementary prescribing is working," Mr Sodha says.

Benefits

Mr Sodha gives the following benefits of supplementary prescribing:

- Patients get longer appointments with Mr Sodha than with a GP
- Longer appointments mean more thorough counselling, eg, for public health advice
- Longer appointments also mean more extensive monitoring
- Enables GPs to concentrate on the needs of more complex patients
- Promotes good use of skill mix

Mr Sodha reports that a patient survey has just been completed and is currently being analysed by the PCT. The headline results show that of 29 surveys, 27 rated the consultation with Mr Sodha as “very good” or “excellent”.

Finally, Mr Sodha gave a list of criteria needed by a successful prescriber:

- **A clear focus on exactly how, why and where you want to prescribe**
- **Good clinical practice skills, for example he studied for a certificate in diabetes in parallel with the supplementary prescribing course**
- **The support of the PCT**
- **A good relationship with an independent prescriber**
- **Enthusiasm and motivation to pursue an ambition of managing patients in clinical practice**
- **Excellent consultation skills which focus on psychosocial aspects of disease management as well as good therapeutic skills**

He concludes: “It is not rocket science; all pharmacists can do this.”

Department of Health perspective on supplementary prescribing

Just over 500 pharmacists are now registered as supplementary prescribers, but Gul Root, principal pharmaceutical officer at the Department of Health, says that she still wants to see more. “While it is great that we have lots of hospital and primary care pharmacists registered, Ministers are very keen to see community pharmacists become supplementary prescribers too,” she explains. “We also need to think about how to get different kinds of pharmacists working in different therapeutic areas to become supplementary prescribers.”

Turning first to training, Ms Root highlights two areas that need to be strengthened. First, it needs to be clear to pharmacists *how to become a supplementary prescriber* and how to *use prescribing once qualified* (eg, one-third of those qualified supplementary prescribers present at the conference were not prescribing). And second, robust process are needed for entry onto a supplementary prescribing course but these should not be so bureaucratic that they prevent access. Pharmacists should not be going on the supplementary prescribing course because they want to improve their curriculum vitae. “We want them to start prescribing immediately. They must be able to use prescribing within their current post,” she comments. A considerable amount of the course is self-directed learning: both the pharmacist and the organisation he or she works for need to be aware of this.

“It is really important that the skills of the pharmacist who want to become supplementary prescribers are appropriate,” says Ms Root. She would like pharmacists in all areas of the profession to become prescribers but she also points out that, within each field of pharmacy, there have been some discrepancies in terms of the pharmacists who have become supplementary prescribers so far. For example, few hospital paediatric pharmacists have undertaken the training. In addition, pharmacists need to decide early on the therapeutic area in which they will prescribe. “I have heard of pharmacists going on the training course who don't know which area they want to prescribe in,” comments Ms Root. The curriculum does not provide training in therapeutic areas: it is up to the pharmacist to be an expert in an area and then the PCT or NHS trust need to find a way to assess this expertise.

Funding issues should be thought through before a pharmacist goes on the prescribing course. “We have heard examples over and over again of community pharmacists qualifying as prescribers and then not being able to do anything for six months,” she says. “I hope that with supplementary prescribing becoming a locally commissioned enhanced service under the new pharmacy contract [in England and Wales] that – once a national template has been developed – these problems will be solved.” She also comments that money is given to Strategic Health Authorities to spend on non-medical prescribing, and that the decisions about how to use that money are made at the SHA level. Of course there are expectations around the number of pharmacists and nurses expected to qualify but, if the SHA thinks it would be useful to have a supplementary prescriber in a certain location and a mentor cannot be found there, then it might be appropriate to pay someone to become a mentor. Similarly an SHA could choose to make a contribution towards backfill using this funding.

Discussing *clinical management plans*, Ms Root says: “We don't want CMPs to be so bureaucratic that they stop independent prescribers from wanting to use them.” In particular, she clarifies that stating that prescribing should be according to national or local guidelines is sufficient. “There is also a view that patients' formal written consent is needed but this is not true,” she explains. It is acceptable for the pharmacist to record in the patients' notes that verbal consent was agreed following a discussion of what supplementary prescribing involves: a signature is not required.

Questions from Conference participants

A paediatric pharmacist present at the conference pointed out that one of the problems she faces is that off-licence and unlicensed products are commonly used in paediatrics. Ms Root said that supplementary prescribers could prescribe off-label providing they are willing to accept the responsibility of doing this and that there is a body of evidence to support off-label use. Since the conference took place, a change to the regulations has allowed supplementary prescribers to prescribe unlicensed medicines.

A conference participant asked Ms Root why the Department of Health has not produced a leaflet for patients and the public about supplementary prescribing. Ms Root replied that the reason is that supplementary prescribing is based on a one-to-one decision so it is important for it to be discussed with individual patients. However, she added that there is nothing to stop PCTs or NHS trusts producing their own leaflets.

Another participant raised a concern over applicants for the supplementary prescribing course who are self-funded: they are not subject to the same scrutiny as those who apply via the local Workforce Development Directorate. Ms Root said this would be resolved once supplementary prescribing becomes an enhanced service since PCTs will want to be involved in decisions over training regardless of whether or not a pharmacist is self-funded.

A hospital pharmacist said that she is frustrated that she cannot write a prescription in hospital for some medicines that a community pharmacist can counter-prescribe. Ms Root replied that a supplementary prescriber can prescribe all over-the-counter medicines so long as they are included in the clinical management plan.

Mr Jackson pointed out that a major policy area currently taking off is that of long-term conditions. Roles exist in this area for supplementary prescribing. Ms Root agreed. She said the Department of Health is aware of what pharmacists can do in terms of long-term conditions but that there is a need to increase awareness of pharmacists' prescribing role in this area.

SECTION TWO: THE WORKSHOPS

Conference participants were divided into six groups to look at the following topics:

1. **Challenges of setting up a new or re-modelled service**
2. **Challenges associated with fitting the supplementary prescribing model to practice**
3. **Challenges associated with the clinical management plan**
4. **Issues relating to working with doctors, nurses and patients with regards to supplementary prescribing models**
5. **Challenges with technology**
6. **Training and support for supplementary prescribing**

Initially, conference participants brainstormed all the topics, writing down problems they had encountered on post-it notes and sticking these on boards (one for each of the six topics). Next, each group took a topic and summarised the issues raised on the post-it notes. These were written onto a large sheet of paper and presented to all the participants. In order to identify the most important issues, each participant was given five red dot stickers and was asked to place them against the issues about which they were most concerned.

The groups then discussed the solutions that they had used to overcome the identified problems. They also came up with things they would like to be done in the future to help solve any remaining problems.

The next section of this report takes each topic in turn and examines the issues identified and the solutions proposed. The number of red dots – indicating the level of importance participants placed on a particular problem – is given in brackets after each issue. A list of all the comments made on the post-it notes is given in appendix one and some quotes from conference participants are included in boxes throughout this section.

Group one: Challenges of setting up a new or re-modelled service

The main issue identified by this group was *funding supplementary prescribing*. The following **challenges** were identified:

- Funding: insurance, backfill (both for training time and for when prescribing), mentors, clinics (service delivery), prescribing budgets (either top-slicing the overall prescribing budget or access individual GPs' budgets) and remuneration (14)
- Planning and structure: writing a business case (for PCTs), fitting supplementary prescribing into existing duties, infrastructure of communication and documentation, driving supplementary prescribing, and the “chicken and egg” scenario (what should be done first – develop the service or undertake the training?) (6)
- Time: to run clinics, to participate in continuing professional development and to attend additional meetings, such as at GP practices (5)
- Recognition: perceptions, selling roles, a clear vision of the benefits of supplementary prescribing needed at PCT level, lack of support from PCTs (3)
- Prescribing across the interface (2)
- Legal aspects: no case law to work from (1)
- Service delivery: probity, conflict of interest, self-dispensing, process for risk management (1)
- Lack of a defined career structure for pharmacists (1)

“How do we engage with PCT pharmacy leads who do not think supplementary prescribing will work for pharmacists generally?”

“Supplementary prescribing is well received by patients once they understand what it means”

The **solutions** the group suggested for these problems are:

- Keep the relationship between the supplementary and independent prescribers on a clinical basis and find someone else to negotiate remuneration separately
- Hope that using the enhanced services in the new pharmacy contract will help to solve some of the remuneration difficulties faced by community pharmacists
- Change perceptions of some people at PCT level
- Demonstrate delivery of the service first and ask for money afterwards
- Identify an issue facing the PCT and then offer a supplementary prescribing service as a solution to that particular need
- Define a need for a service using the quality and outcomes framework or surveys
- Build relationships with doctors to take advantage of practice-based commissioning
- Share practice, such as building up a database of good practice and business case templates, plus a discussion forum
- Obtain more information about how supplementary prescribing fits into clinical governance frameworks (both the PCT and RPSGB clinical governance frameworks)
- Recommend that a “starter pack” is drawn up for supplementary prescribing explaining how to get started and details of where to get further information
- Audit services, evaluate and revalidate them

Group two: Challenges associated with fitting the supplementary prescribing model to practice

The issues relating to *fitting supplementary prescribing to practice* identified by the group were:

- Limitations of supplementary prescribing (20)
- Marketing of supplementary prescribing: raising awareness of the role, particularly among doctors, nurses and patients (6)
- Funding and resources, particularly of indemnity insurance (5)
- Succession planning, training and protected time (4)
- Service development: blurring of boundaries and fitting supplementary prescribing into the health service (4)
- Governance arrangements: insufficient funding for this (1)
- Time, particularly time to discuss issues with the independent prescriber (0)
- Education and information to stakeholders: both health professionals and PCTs (0)

“You need to be proactive in getting clinics organised and acquiring a patient list”

“Many nurses are already working in a 'supplementary prescribing' model. It is sometimes difficult for pharmacists to find a niche”

“I am concerned about being dumped with repeat prescribing”

The **solutions** the group suggested for these problems are:

- Address the inequality regarding what extended nurse prescribers are able to do compared with pharmacists
- Share innovative practice so that those who find the supplementary prescribing model limiting are able to see different approaches
- Develop a resource pack for doctors, nurses and patients to promote supplementary prescribing. The pack should be endorsed by both the RPSGB and British Medical Association
- Ring-fence money
- Identify the unique selling point of pharmacy
- Provide central guidance on how to deliver a supplementary prescribing service
- Include succession planning in the business plan. Include resources for training time and locum costs
- Introduce clinical supervision
- Address the lack of time by planning for this in advance (include in the business plan)
- Remember the impact of devolution on supplementary prescribing. For example, there is a much greater focus on setting up systems to allow community pharmacists to become supplementary prescribers in Scotland compared with England and Wales and this has resulted in many more community pharmacists in Scotland undertaking the training

Group three: Challenges associated with the clinical management plan

The group stated that one post-it note summarised feelings towards *clinical management plans (CMPs)*. It stated: **“huge anxiety”**. The identified issues are:

- Difficulties in using CMPs for patients with co-morbidities, and particularly the use of multiple CMPs (14)
- CMPs are cumbersome and time-consuming to use and set up (4)
- Difficulties in ensuring the CMP is appropriate to the local setting/client group, which might be different from what is appropriate at another location (3)
- Clarity of content (2)
- Lack of organisational support (1)
- Clarity of process (0)
- Clarity of legality (0)

“How many CMPs are needed for a medication review? CMPs need to be kept concise but potentially have to cover many chronic diseases”

“CMPs are time consuming. I sometimes prefer to carry on the old practice of transcribing and writing on drug charts and getting doctors to sign them”

The **solutions** the group suggested for these problems are:

- Keep CMPs as simple as possible
- Ensure that supplementary prescribing is the best solution for each situation; it is not the “be all and end all”. For example, Addenbrookes hospital in Cambridge has accepted that drug charts are not technically prescriptions so the trust has changed its policy so that pharmacists can change or write drug charts without having to be a supplementary prescriber
- Spend time initially thinking about the CMP and area of practice: do the legwork at the beginning
- Define the patient group to which the CMP applies and select patients carefully
- Curb enthusiasm and start small, get a small service working efficiently and then expand
- Ensure that the content of a CMP comes down to what the supplementary prescriber and independent prescriber think is the supplementary prescriber's level of competence

Group four: Issues relating to working with doctors, nurses and patients with regards to supplementary prescribing models

The most important issues identified by the group looking at working with other people were: first that non-medical prescribing models are seen as too complicated by other health professionals and second, problems relating to mentors. The **challenges** they identified were:

- Non-medical prescribing models are too complex and confusing so there is a lack of understanding of the new roles (12)
- Difficulties in getting mentors and post-qualification support (9)
- Threats to other prescribers: turf protection and the “we only stick on labels” attitude (2)
- Patient perceptions of the pharmacist's role, including national patient organisations' perceptions (2)
- Issues relating to secondary care: spread too thinly, communication issues since the independent prescriber is the consultant but junior doctors are often involved too, budget allocations for consultants (2)
- Issues relating to community pharmacy: separating prescribing and dispensing, and pharmacists refusing to dispense supplementary prescriptions (1)
- Convincing PCTs and health care professionals of the benefits of supplementary prescribing (1)
- Clarifying roles within the team (1)
- If pharmacists' time is spread too widely, they don't have enough time to develop relationships and trust with prescribers (0)

“Clinicians do not understand the supplementary prescribing process nor its benefits. It takes a long time to change perceptions and establish the role”

The **solutions** the group suggested for these problems are:

- Simplify models of non-medical prescribing. A model is needed for which the background does not have to be explained before prescribing can go ahead: it should allow prescribing to start on qualification. In addition, it takes a long time to increase awareness of new roles so a simpler model would help this
- Encourage health professionals to learn together through providing protected time
- Gain the support of mentors by developing a greater understanding of what the mentor role involves
- Decide whether or not mentors should be paid: some think it is inappropriate but others think it is necessary
- Define a clearer strategy setting out how supplementary prescribing will benefit services in secondary care
- Develop better communication in large clinical teams in hospitals, perhaps making use of trust intranet systems
- Find out if national patient organisations are supporting supplementary prescribing
- Clarify roles in prescribing teams so everyone knows what is expected of them
- Ensure that all pharmacists are aware of supplementary prescribing so that the problem seen with pharmacists refusing to dispense supplementary prescriptions is overcome
- Encourage joint working between professional bodies since many of the issues facing pharmacists are the same as those facing nurses
- Learn from each other: sometimes nurses take different approaches to pharmacists in addressing challenges that supplementary prescribing presents, so learning from each other should be encouraged. New prescribers should contact other supplementary prescribers at a local level to develop this. The National Prescribing Centre (NPC) is looking at ways of bringing supplementary prescribers from all professions together over the next 12 months
- Find out whether a national pharmacy body could undertake a campaign about supplementary prescribing along the lines of the “ask your pharmacist” campaign
- Encourage supplementary prescribers to tell the RPSGB, the Department of Health and the NPC about the roles they have developed so that the word can be spread at a national level

Group five: Challenges with technology

A lack of IT support from GP computer systems was a particular challenge identified by the group discussing technology. It listed the following problems:

- Lack of IT support from GP computer systems for prescriptions (15)
- Lack of access to patient records in both primary and secondary care but particularly in community pharmacy (11)
- Lack of IT support from GP computer systems for CMPs (5)
- Repeat prescribing not being integrated (2)
- Lack of hardware, eg, computers, printers, laptops (0)
- Few hospitals have computerised prescriptions and some GP practices don't use their computer systems (0)

“Access to patient records is the 'holy grail’”

“The lack of computerised prescription forms for supplementary prescribing is an issue. We need to get away from hand writing prescriptions: copying from computer records is a risk”

The **solutions** the group suggested for these problems are:

- Share creative solutions to overcome IT difficulties
- Lobby those who produce GP software systems to support CMPs and computer-generated prescriptions for supplementary prescribing
- Encourage community pharmacists to use a paper-based system for prescribing initially and log the information onto patients' records later. It is hoped that this will be a short-term solution until the National Programme for IT solves the problem with community pharmacists not having access to patient records
- Identify where funding for hardware will come from

One conference participant commented that her PCT had approached all the computer software suppliers to provide a training day for supplementary prescribers on how to use the GP software. The PCT had to pay in the region of £100 per person for this training.

Group six: Training and support for supplementary prescribing

The majority of participants' comments were around *competency and assessment*, the group examining training issues concluded. They identified the following challenges:

- Competency assessment needed pre- and post-qualification (23)
- Support network for updates and changes relating to supplementary prescribing required (15)
- Funding for training for the independent and supplementary prescriber (10)
- Mentorship from other pharmacists and from GPs (2)

“Pharmacists have no networks for mentorship and ongoing support”

“There is a need for national guidance on acceptable methods for demonstrating competence”

The **solutions** the group suggested for these problems are:

- Develop formal continuing professional development (CPD) for supplementary prescribing
- Consider the possibility of an interview process before starting supplementary prescribing
- Ensure supplementary prescribing training is not more difficult for pharmacists compared with other health professions but, at the same time, ensure appropriate standards are maintained
- Ensure individual prescribers keep a reflective diary and maintain their CPD
- Ensure appropriate training is undertaken if prescribers change the therapeutic area in which they prescribe
- Improve public and professional awareness of non-medical prescribing

- Provide ongoing support and accreditation after a prescriber has qualified. Unclear who this responsibility should fall to – the RPSGB, local PCTs/hospital trusts, and the Faculty of Prescribing and Medicines Management were all mentioned as organisation that could play roles. In addition, contact Workforce Development Directorates about funding to set up support networks
- Write to chief executives of NHS organisations, particularly Workforce Development Directorates, to increase their awareness of supplementary prescribing
- Encourage NHS organisations to fund the role of non-medical prescribing lead so that the agenda is taken forward; in some trusts the role is treated as an add-on to someone's existing roles

KEY RECOMMENDATIONS

At the end of the conference, the participants came up with a list of key recommendations to help take supplementary prescribing forward. The recommendations apply to a number of different people and organisations, including pharmacists, national pharmacy bodies (particularly the RPSGB), the Department of Health and NHS bodies.

The key recommendations are:

- **Bring supplementary prescribing materials together into one resource pack. It should include details of available support and training, template CMPs, patient information, information for other professions and any other available resources. The pack should be endorsed by national organisations and the Department of Health**
- **Promote the role of supplementary prescribers among other health professions and the public. One idea is a themed issue of the *BMJ*. Another is to find champions among supplementary prescribers to promote their role**
- **Define exactly where pharmacists add value as supplementary prescribers**
- **Simplify the supplementary prescribing model needs**
- **Encourage multidisciplinary work between national professional bodies and between pharmacists and nurses at a local level**
- **Set up a good practice database**
- **Establish a system that allows new supplementary prescribers to be mentored by existing supplementary prescribers**
- **Improve communication between the RPSGB and supplementary prescribers, eg, the RPSGB should tell pharmacists the key messages in any lobbying it undertakes so that pharmacists can use the same messages for lobbying at a local level**
- **Provide more support and regular updates to supplementary prescribers, perhaps by setting up support networks or by providing regular updates to prescribers, eg, through a quarterly article in *The Pharmaceutical Journal*.**

An early result

The head of practice at the RPSGB, told the conference that the Society has set up a discussion forum for supplementary prescribers. Supplementary prescribers wishing to join should e-mail supplementary.prescribing@rpsgb.org. The head of practice explained that the forum is only for supplementary prescribers and it is up to them to decide which topics to discuss. The only people at the RPSGB who have access to the forum are the practice directorate. One of the documents currently available via the discussion forum is an updated clinical governance framework. The RPSGB would like comments on this draft to be submitted by 11 May 2005.

Appendix one

Full details of conference participants comments

The conference workshops began with participants writing down the problems they had encountered with supplementary prescribing on post-it notes. This appendix lists the content of every post-it note (as written, not edited). It is divided into six topics:

1. Challenges of setting up a new or re-modelled service
2. Challenges associated with fitting the supplementary prescribing model to practice
3. Challenges associated with the clinical management plan
4. Issues relating to working with doctors, nurses and patients with regards to supplementary prescribing models
5. Challenges with technology
6. Training and support for supplementary prescribing

1. Challenges of setting up a new or re-modelled service

Funding issues

- The F word FUNDING community pharmacy services
- Funding (mentors): insurance, clinics, backfill, rates, individual/drug, selling role, recognition/perception, support, structure – planning – business: time (CPD)
- ?Indemnity still in consultation
- Funding!
- Funding for supplementary prescribing in primary care – should it be from drug budget or individual GMS budget?
- Funding – pharmacists not employed by practices. Many practice pharmacists paid by topslice of prescribing budget
- GPs reluctant to pay for (ie, individually) pharmacists' time
- Funding community pharmacists
- No extra money to back-fill pharmacists' other roles as new roles, eg, supplementary prescribing develops
- Increase in indemnity insurance – no remuneration
- No suitable indemnity for hospital prescribers. Personal?
- Securing funding for supplementary prescribing clinics
- Getting professional indemnity for supplementary prescribing work
- How do we overcome the problem of no money available for funding mentors?
- Funding community pharmacists
- Supplementary prescribers may expect increase remuneration which is not likely to be available
- Funding and rates of pay

Planning and structure

- We need current models written up as examples of how it could happen
- Training and support; IT; multidisciplinary issues; CMP challenges; fitting supplementary prescribing to practice
- Should you set up a new service model before undergoing training as supplementary prescribing (difficult) or after which may lead to long delay before prescribing?
- Workforce developments but service slow to evolve
- No strategy in place
- No PCT infrastructure at all – lead nurse left trust and we had to start again

- Setting up paperwork and documentation
- Space – another person requiring a consulting room
- Writing a business case for new service and support
- Manpower; supplementary prescribing has raised expectations of pharmacists which must be met to allow for recruitment and retention
- Support structures
- How does it fit in with hospital practice?
- Concern that it is just accumulated into post without resourcing and without being able to drop other defined tasks, ie, increasing tasks and responsibilities resource

Time issues

- Additional clinical commitments – with medical team's expectations of me attending additional meetings, eg, audits and MOT meeting, and time commitments and pulling away out of pharmacy department, ie, resources
- Getting sufficient time allocated to achieve potential of role
- Time – consultant (supplementary prescribing) prescriber's time to set up and review, appraise and reflect supplementary prescribing services within speciality
- Finding clinic time; teaching others what supplementary prescribing is; talking to patients; receptionists need to understand supplementary prescribing role; getting backing by the trust

Recognition of the role

- Getting supplementary prescribing role into my job description
- Lack of support
- Persuading chief pharmacists and trust managers to provide money for pharmacist supplementary prescriber – which may save money from other budgets (but not pharmacy)
- Clinicians do not understand supplementary prescribing process nor its benefits – takes a long time to change perceptions and establish role
- Lack of recognition of increased responsibility in terms of grading/ increase in indemnity and fees when supplementary prescribing would only be used within my organisation – too specialist to transfer to other trusts
- PCT hierarchy not supportive of pharmacists (commissioning!)
- PCTs do not have a clear vision of/for pharmacist prescribers
- Psychosocial skills of challenging perceived wisdom. Are we King Canute?
- Selling it to independent prescribers (and others)
- How do we engage the PCT pharmacy leads who do not think supplementary prescribing will work for pharmacists generally?
- Pharmacist not considered at organisational level by planners of service development

Miscellaneous

- Prescribing across primary/secondary care interface
- No case law for supplementary prescribing
- Service delivery – space – additional meetings; legal – case law; dispensing and prescribing; career structure
- Community pharmacist supplementary prescribing (probity?) What measures are needed?
- No career structure in primary care for pharmacist? advanced pharmacist practitioners

2. Challenges associated with fitting the supplementary prescribing model to practice

Limitations of supplementary prescribing

- Problems of being able to “counter prescribe” but not write a prescription for it, ie, would like to be able to use the nurse extended prescribing list
- Developing a paediatric service for supplementary prescribing – awaiting legislation change for unlicensed medicines
- Difficult to implement in inpatient setting – who is independent prescriber, patient on many drugs, only see patient briefly then discharged, CMPs may not be efficient use of time
- p.s. not if you are holistic
- Not giving impression of fitting round pegs in square holes

Marketing of supplementary prescribing

- Clarity of role within department often lacking – seen as a repeat prescriber, doctor! etc
- Ensuring all GPs, practice staff understand where supplementary prescribing fits in
- Managers want us to use supplementary prescribing on an acute hospital admissions unit. How???
- Keeping the clinicians' expectations within the bounds of supplementary prescribing
- Making the supplementary prescribing model fit into the acute hospital setting, ie, patients with acute conditions rather than chronic
- Meaning of supplementary prescribing not clear to other professions
- Lack of information to patients
- Lack of understanding by others

Funding and resources

- How to go about getting trust approval for supplementary prescribing
- Funded by PCT therefore tend to have to fit its agenda

Service development

- Need to be very proactive in getting clinics organised and acquiring a “patient list”
- Some good models already in place – eg, pharmacist-led warfarin clinics – why change a good system?
- Need to resolve issue of patients seeing so many specialists
- Supplementary prescribing process doesn't always fit with service or resources but would benefit patient, increased problem with introduction of allied health professional prescribing
- To address whether existing practices work well. Why they should change/ whether it is worth changing
- Difficult to work with, ie, blurred boundaries, proxy prescribing
- Do I need to have a service model?

Miscellaneous

- Getting time to discuss issues with the independent prescriber – he is always so busy
- Changing roles and starting out a new practice
- Acceptance and compilation of the CMP
- Lack of flexibility in department/system to allow/fund others time to train, to cover or time for availability to do clinics. Often successful work to challenge perceptions and establish roles where a safe and effective service provided is appreciated, patient care is lost in an instant
- Prescribing for conditions outside CMP? How much can supplementary prescribers take on, eg, minor ailments/other conditions under prescriber by another speciality

3. Challenges associated with the clinical management plan

Using clinical management plans

- Using CMPs for a total medication review
- How many CMPs for a medication review? – keep concise and simple but to cover potentially many chronic diseases
- Can patients have more than one CMP? As suggested by Karen who spoke of generic bite-sized CMPs
- Support for nurse prescribers in developing CMP is one of my roles – highlighted training issues for nursing staff regards to drug therapy and use. Some inappropriate decisions made and feeding this back professionally
- Real risk of CMPs being so generic as to be “independent prescribing” by proxy
- To paraphrase “It’s the CMP stupid!”
- Coping with continuing therapy for conditions not covered by the CMP
- Generic CMPs for nutrition
- With CMP not being able to deal with co-morbidities. My consultants would like me to be able to deal with those to add real value to the team

Setting up clinical management plans

- Needing CMP signed by independent prescriber before issuing
- CMPs – GPs find frustrating, especially as they have already agreed for us to work for them and yet have to have all these forms! (for every patient)
- Initial designated medical practitioners and independent prescribers are mostly innovators and do not appreciate signing/approving every CMP
- In acute sector struggling follow-up of patients to close the contract with patient. At present I ring patients (this is for pain relief post operation) as the workload increases it’ll be too difficult to phone patients
- For inpatient setting – admissions, discharge prescribing – more time consuming to write CMP and get agreed than just status quo – getting doctor to countersign prescription
- Time consuming with manual CMPs
- Cumbersome; time consuming; what it doesn’t include
- Keeping things simple; working at keeping it paperless
- Time consuming and additional paperwork with CMP prefer sometimes to carry on previous style of practice transcribing and writing on drug charts as per protocols and getting doctors to sign
- Its implementation causes huge anxiety
- Validation; clinical governance; responsibility

Appropriate use of clinical management plans

- Difficult to put a CMP to some clinical situations, eg, admission/discharge prescribing
- In admissions setting difficult to establish the independent prescriber
- Seem to be different ideas on how specific CMPs need to be. Some examiners expect drug names others accept drugs within guidelines

- Using supplementary prescribing for medication reviews. Only practical if the CMP is very broad/non-specific and if this is the case what is the point? Independent prescribing better
- Clinical management plans in my experience do not provide any interest for the independent prescribers in general practice. If they trust you to run a service, then they must trust you to prescribe safely

Clarity of content and process

- What to include in the CMP? – do I restrict it or broaden it?
- Must be simple/easy to use/easy to understand by all in team
- Unclear guidance

Organisational support

- Designing trust form and getting it accepted; electronic CMPs required
- Non medical prescribing committees who may not have enough experience of clinic roles and supplementary prescribing can make process bureaucratic and the implementation a nightmare!

Legal issues

- What qualifies legal as agreement of the independent prescriber? Is a signature needed or can it be electronic?
- Testing in court of law

4. Issues relating to working with doctors, nurses and patients with regards to supplementary prescribing models

Complexities of the non-medical prescribing models

- Practice understanding of role
- Defining clearly roles of each – GP, nurse, pharmacist. Who is the best person patient should see?
- Educating and informing “staff” – colleagues from other disciplines with regards to exactly what supplementary prescribing means and law if works. Misconceptions – common
- Most GPs still not convinced of benefits
- Lack of understanding by other health care workers as to what supplementary prescribing actually entails
- Lack of understanding by clinicians of concept of supplementary prescribing – but blind support anyway because of previous working relationship
- Major problems with doctors understanding supplementary prescribing model – needs national link as local is too time consuming
- Not repeating work already been done
- Understanding of role by other professionals

Mentors and post-qualification support

- Problems in getting mentors who understand what's involved during and after course – primary care

Threats to other prescribers

- Medics seeing it as a way to shift prescribing to another member of the team. One cannot replace multiple prescribers within a clinical team
- Doctors and nurses – decreasing knowledge and “turf protection”
- We are a threat to other prescribers
- Not stepping on “each other's toes”
- Getting past misconceptions: after all we only put labels on bottles don't we?
- Interdisciplinary issues around status and responsibilities associated with supplementary prescribing – non prescribing practitioners however colleagues may feel threatened
- Nurses are cheaper to employ (?Agenda for Change)
- Ensure GPs/ nurses are not threatened
- Doctors perceive pharmacist supplementary prescriber same as nurse, but more expensive
- Managing relationship with other healthcare professionals within team, ie, competitive nurse
- Some GPs feel they have nothing left to do
- Are we a threat to other professions?
- Doctors feel threatened when they “relinquish” prescribing
- Many nurses already working in a “supplementary prescribing” model – sometimes difficult for pharmacists to find a niche

Patient perceptions of the pharmacist's role

- Too many clinicians for patient – need careful planning
- Well received by patients once they understand what it means – limitations, ie, can prescribe for principal diagnosis but can't deal with their bad back while you're at it

Issues relating to secondary care

- Essential to get doctors “on board” before starting course
- Independent prescribers time to plan, re-evaluate and appraise the supplementary prescribing system set up
- Doctors too busy with GMS contract to take on supplementary prescribing
- Clear communication pathways
- Clear roles and communication pathways
- Inpatient setting – independent prescriber may be consultant but discussion may be with junior doctors/registrars
- Duplication between disciplines
- Focus on pharmacy specific areas for supplementary prescribing and work with and not against other supplementary prescribers

Issues relating to community pharmacy

- What models work particularly well for supplementary prescribing in community pharmacy setting?
- Separation of prescribing and dispensing by community pharmacist supplementary prescriber
- Challenging existing working practices to incorporate supplementary prescribing
- Difficult to have a team approach if working as a community pharmacist

Convincing people of the benefits of supplementary prescribing

- Implementing supplementary prescribing – getting everyone on board, ie, pharmacy colleagues, consultants, trust management
- Real bonus to have good relationship with independent prescriber and other respected prescribers in trust/directorate/PCT as already have confidence in one's prescribing competence

Clarifying roles within the team

- Concern about being “dumped” with repeat prescribing
- Defining roles, establishing trust

Time issues

- PCT sharing pharmacist time between all practices. Not enough time allowed at any practice to build up necessary rapport and confidence

5. Challenges with technology

GP computer systems and prescriptions

- Electronic prescribing, electronic CMP
- National Programme for IT – should we upgrade our prescribing system now or wait for NPfIT?
- Electronic prescriptions; computer generated prescriptions
- Remote access to own laptop for trust IT systems would be helpful
- IT (GP) – not set up for non medical prescribers
- Electronic prescriptions/repeat prescribing issues

Access to patient records

- Access to medical notes where there is no electronic roles and prescribing
- Access to patient records is the “holy grail”
- Getting access to records
- IT. Patient safety is paramount therefore IT access (remote if necessary) should be available as soon as possible to supplementary prescribers in the community

GP computer systems and CMPs

- Recording consultations away from surgery
- Either use of systems or lack of!
- Lack of electronic CMP facility on GP systems (only EMIS have facility at present)
- Development of eCMPs
- CMPs cannot always be merged and stored on GP computer systems
- Prescription forms – getting away from hand writing prescriptions. Risk issue – copying from computer record
- Management of CMP – electronic versions not possible on all GP systems
- Practices not understanding or wanting paper CMP but not having CMP template (electronic)
- No computer template for CMPs
- CMP – electronic practice notes – some GPs in the practice don't use them – patchy work system in one practice

Integration with repeat prescribing

- Repeat prescribing of supplementary prescribers' prescriptions

Hardware issues

- Lack of facility to print lilac prescriptions from GP systems
- Prescriptions need to be compatible with all printers
- Lack of printable prescriptions for supplementary prescribers
- Not enough computers
- Computer printed prescriptions – lack of
- NB – for printing the prescription does not need to be lilac – but green
- Lack of computer generated prescriptions
- Lack of printer compatible prescriptions

Computerised prescriptions

- Getting CMP onto electronic prescribing system in hospitals
- Most prescriptions in hospitals very little computerisation

6. Training and support for supplementary prescribing

Competency assessment pre- and post-qualification

- Need entry criteria for course to show competence in chosen area of prescribing
- Support for ensuring pharmacist competent and remains competent in therapeutic area of prescribing
- Prescribing in a different therapeutic area to the one you trained in
- Competencies for supplementary prescribing – these should be available as options on RPSGB “plan and record” website
- Confidence of other health care professionals and of ourselves in supplementary prescribing ability
- Who in PCT assesses competency for supplementary prescribing?
- Need for national guidance on acceptable methods for demonstrating competency, eg, audit, assessments
- If the Department of Health is keen for pharmacists to prescribe where is the accreditation framework to assess competency, and where is the funding to allow this in a structured national way?
- Ongoing CPD and competency assessment. How do I/others know I'm competent?

Support network

- Academics' understanding of the challenges in practice and being flexible when problems are encountered
- Recording CPD to demonstrate competency – fitting in with national CPD requirements
- A need for structural support as demonstrated in the medical profession
- Lack of clarity as to mechanisms of ongoing assessment/support locally in trust
- Need local support or specialist networks for CPD
- Lack of organisational support post qualification
- Not a lot available once qualified
- Time is needed to made available for supplementary prescribers to prescribe
- Alerting current supplementary prescribers to changes
- Regular (eg, annual) updates on supplementary prescribing issues from RPSGB needed – legal, ethical developments in prescribing
- Little post qualification support. No audit programme
- There is still lack of support once qualified

Funding issues

- Jerry Maguire – “show me the money!”
- No funding for further training once qualified as supplementary prescribers
- Recruitment of mentors is limited due to lack of funding
- No cover available for pharmacists attending courses
- Funding of GP mentors
- Funding!
- Funding not available to support pharmacist training
- Self funded community pharmacist not being supported adequately by PCT
- Designated medical practitioners not paid for their time
- More consultation skills please
- No structured CPD
- Lack of ongoing mentorship and CPD for qualified prescribers – where does this responsibility lie – is it just on the pharmacist themselves!! And it is not funded!
- Ongoing training/mentoring once qualified
- Structured CPD
- Not in place
- CPD – appropriate course to develop clinical consultation skills further
- No formal CPD criteria: How am I doing? On ongoing basis
- CPD in my specialist area – lack of time to further update knowledge
- No structured CPD at all for pharmacists in trust – only for GP and nurses

Mentorship

- Mentorship within pharmacy rather than reliant on GPs
- Pharmacists have no networks that are funded for mentorship and ongoing support, compared to nurse prescribers – why is this?

Miscellaneous

- Networks within workplace between nurses/pharmacists need to be improved
- Promotion of information about supplementary prescribing in “big journals” and newspapers helpful as still find many healthcare professionals know nothing about it