By ensuring that chronic conditions are diagnosed and managed appropriately pharmacists can play a major part in improving patients’ health. But first they need to demonstrate their value to local GPs.

How independent prescribing can be nurtured in primary care

By Helen Williams, PGDip (Cardiol), MRPharmS

Pharmacists in primary care have struggled to develop prescribing roles since the introduction of supplementary and, latterly, independent prescribing. The reasons are multifactorial, but key barriers include a lack of infrastructure (IT systems, access to patient records, joint working with local GPs), time, failure to identify a budget for independent prescribers and, possibly, a lack of vision and drive from both community pharmacists and primary care trusts to “make it happen” (see Box 1, p265).

As an experienced prescriber in my previous role as a specialist cardiac pharmacist in a tertiary cardiac centre, I am keen to boost and support the development of other pharmacist prescribers in primary care.

I tested the water, in terms of working in primary care, by accepting a secondment to Lambeth PCT and Southwark PCT to work as part of a hypertension “hit team” in 2006. Although case management was part of the original plan, the secondment was only intended to be for nine months. With this in mind, it seemed more appropriate to work with and mentor other prescribers to build a sustainable system, rather than simply run my own clinics for the duration of the secondment.

Now, five years later, I spend most of my time working in primary care and the development of prescribing roles for pharmacists remains an important goal (see Box 2, p266).

Why hypertension?

Hypertension is a major cause of mortality and morbidity in the UK. Locally we have a low detected prevalence of this disease, compared with the expected prevalence based on our local population demographics; we believe we have only diagnosed around half of our hypertensive population, for example.

There is a wide variation between local GP surgeries in how well hypertensive patients are treated to achieve the blood pressure (BP) audit standard of ≤150/90mmHg. This ranges from 50% of patients achieving this target in the worst performing practice to over 80% in the best performing practice.

Stroke and kidney disease are also high priorities for each PCT, and hypertension is a key modifiable risk factor for both of these. There is robust evidence that controlling BP can reduce the incidence of stroke, myocardial infarction and the development of renal impairment.

Successful hypertension management depends on good patient education, rational prescribing of antihypertensive medicines and sufficient follow-up to assess efficacy of the chosen regimen and address patient adherence issues. As such, this is an ideal opportunity for input from a pharmacist independent prescriber.

First healthy heart clinic

Pharmacist prescribing — supplementary and independent — remains a relatively new concept in
primary care. GPs are more familiar with the role of nurse prescribers. The first hurdle was therefore to persuade practices that the pharmacist had something to offer, with the onus on my colleagues and I to demonstrate our value in a hypertension clinic.

To maximise the value of pharmacist input, it was agreed that:

- We would work with practices failing to achieve quality and outcomes framework (QOF) targets for hypertension
- Only patients with uncontrolled BP would be invited to the clinic
- Clinic administration would be provided by the practice

As well as looking at BP, the pharmacist would address global cardiovascular risk through formal risk assessment and appropriate intervention — a concept which is now built into the QOF for newly diagnosed hypertensive patients.

The first clinic was established in 2007, in a practice where only 56% of patients were achieving the QOF BP target of ≤150/90mmHg; more than 200 patients on the practice register had uncontrolled hypertension.

The clinic ran once a week for a single clinical session for six months, listing 122 patients, with a "do not attend" rate of 21%. Accordingly, I was able to review 96 patients in a total of 139 clinic appointments.

Most patients were seen only once or twice, with eight patients requiring three visits and four patients attending for four visits in the six-month period. At the end of that period, 57% of this difficult-to-manage group were controlled to the QOF target of BP ≤150/90mmHg.

The overall practice QOF achievement for BP control to ≤150/90mmHg increased from 56% to 68% (target is 70%) over the six months, increasing to 76% at the end of the first year.

Full cardiovascular risk assessment was carried out for all patients and 39 of the 96 patients (42%) were newly identified as at high risk of developing cardiovascular disease (≥20% risk over the next 10 years), indicating statins should be started.

**Box 1: Challenges facing pharmacist prescribers**

- Infrastructure: Lack of infrastructure, particularly IT connectivity and access to the patient record, limits the sites at which clinics can be offered to GP surgeries, polyclinics or PCT health centres. This disadvantages community pharmacists who are seeking to extend their role since, despite the availability of consulting rooms on site, they cannot readily access patients or their medical records. Pharmacists wanting to take on prescribing roles should approach GP surgeries initially to forge partnerships, with a view to offering services from their own premises in future when trust has been built.

- Time: Setting up new services takes time to engage the relevant parties, develop systems and protocols, undertake audits and ensure appropriate governance arrangements are in place. Individual pharmacists often struggle to find the time for such service development alongside their other commitments and, as a result, progress is thwarted.

- Funding: Prescribing budgets are allocated to GPs based on their registered patient populations. Identifying budgets for non-medical prescribers who do not sit within traditional settings in primary care is difficult and, to date, most pharmacists rely on accessing the GP prescribing budgets — again emphasising the importance of partnership working. Funding issues go beyond accessing a prescribing budget, because pharmacists need to secure payment for the services they are to deliver. Pharmacists need to be empowered to develop business cases for submission, for example, to practice-based commissioning groups or individual practices to secure such funding to allow these services to become embedded in primary care.

- Vision: Many pharmacists have been funded through the prescribing courses only to find a lack of vision and drive to make use of their skills. As a result their skills start to atrophy and enthusiasm wanes. After investing in them and to ensure equity, PCTs should be supporting prescribing pharmacists to develop in the same way that GPs are currently supported in service development.
during the first six months, with 35 patients (33%) newly identified as being at high risk of cardiovascular events. Over six months the practice QOF for BP control improved from 56% to 77%.

Clinics 4 and 5 are ongoing, led by local prescribing advisers, and we expect a combined patient database of over 500 patients in the coming months.

My role in these clinics has been to train and support the pharmacist prescribers, help with difficult clinical issues, audit their service and support them in demonstrating their effectiveness to those who will ultimately commission the service.

I hope that these pharmacist prescribers will be commissioned directly by the GP practices once our project monies run out. This has already happened for the third clinic we established, which is now funded by the GP practice in which it is based.

My primary role as a consultant pharmacist for cardiovascular disease is to promote the best possible care for cardiac patients, particularly with regard to medicines management. However, I cannot personally deliver this to the whole population of south London and, therefore, developing, supporting and mentoring others — be they pharmacists, nurses or doctors — to enhance their roles and improve their clinical skills is the most efficient and effective way to achieve this goal.

Supporting non-medical prescribers is just one aspect of how I can have an impact; other elements of my work include:

- Development and implementation of sector-wide prescribing guidance for cardiovascular disease through the local cardiac and stroke network
- Running a network of cardiac pharmacy leads in all primary and secondary care organisations in south London
- Delivering education and training across all disciplines, informing the commissioning process for new services (such as pharmacy-based NHS health checks)
- Working at a national level with organisations such as the National Institute for Health and Clinical Excellence

Box 2: My role

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Reflections of an independent prescriber

We should not be afraid to discuss death

By Paul Forsyth, MRPharmS

Prognosis and death are topics that pharmacists historically have not had to broach with patients. Does becoming a prescriber change this?

After a first acute hospital admission for heart failure, for example, a patient has a worse prognosis than for most common types of cancer. Pharmacist prescribers are likely to become involved in the care of these patients during an acute hospital admission or at a chronic management clinic. During an initial admission patients in heart failure will be prescribed many medicines — taken to reduce mortality as well as to prevent hospital readmission and relieve symptoms. Therefore, if pharmacists are going to be involved in prescribing and up-titrating these medicines then it only seems fair that these pharmacists should be available to discuss with the patients the reasons why.

Patients should be monitored regularly for worsening of symptoms. Different medicines are indicated for heart failure as the patient progresses through his or her illness. Spironolactone is a good example of this, since it is typically considered when a person becomes either breathless upon very light “less than normal” activity or potentially breathless even when at rest.

It stands to reason that if a pharmacist becomes involved in a heart failure clinic and chooses to prescribe drugs like spironolactone then he or she must be prepared to explain this decision to the patient — and discuss the long-term pros and cons of the therapy. This, by its very nature, involves the topics of prognosis and death. When I first qualified as a prescriber I was uncertain how to broach these with patients. In some ways I was scared about how the person might react. I certainly felt that the course hadn’t prepared me for this. But I also felt that my patients had a right to be given all the information they needed about their condition. National guidelines, healthcare standards and patient groups now all recommend as much.

Talking about long-term prognosis and death isn’t a skill that can be learnt and perfected overnight. All patients react differently to the subject and some patients don’t want to discuss it at all. Since qualifying as a prescriber in 2007 I have developed more confidence through shadowing colleagues and hearing how they managed the issue. This also meant simply talking to patients and seeing what they knew about their heart failure and, most importantly, what they wanted to know.

Premature death is an inevitable end to many patient journeys. If, as pharmacists, we want to get involved in prescribing for chronic conditions, we shouldn’t be afraid of this and, using respect, tact and compassion, should be happy to discuss it.

Paul Forsyth is a heart failure pharmacist working in primary care for NHS Greater Glasgow and Clyde