

THE PHARMACIST
ROUND TABLE

A PRESCRIPTION FOR PROGRESS?

HOW INDEPENDENT PRESCRIBING IS CHANGING PHARMACY

As the first cohort of newly trained independent prescribers enters the workforce, what impact is this having on the pharmacy profession? Independent prescribing is seen as a way to maximise pharmacists' skills, ease pressure on general practice and improve NHS capacity.

In this roundtable, four pharmacists join editor Victoria Vaughan to discuss the opportunities and challenges of independent prescribing and its possible impact on the workforce

THE PANEL

Nigel Dugmore
Co-owner of a pharmacy and nearing completion of independent prescriber training, Telford

David Evans
Independent prescriber who runs 12 pharmacies employing 15 IPs in Nottingham and Derby

Garry Myers
Independent prescriber, partner in a medical practice and pharmacy contractor running two community pharmacies, Sheffield.

Babatunde Sokoya
Independent prescriber and NHS Prescribing Pharmacist Pathfinder Programme participant, Essex

BENEFITS

Victoria: The first question is whether you see the move to independent prescribing in Pharmacy First as a good thing and, if so, what are the main benefits?

Babatunde: Yes, it's a big yes. I've been waiting for this for the last 10 years so you can probably understand my enthusiasm about this. I've been an independent prescriber for the last 10 years. I've been part of the independent prescribing pathfinder programme and I'm currently training two prescribers.

I've seen the number of antibiotic prescriptions reduce and that's something that's been echoed across the country when we look at antibiotic prescribing compared to previous years when we didn't have Pharmacy First.

One of the key things, which is the unique selling point of community pharmacy, is the accessibility.

The feedback we're getting from patients is that this is a wonderful service.

Garry: One of the things about prescribing is it dovetails with the act of supply. We prescribe and amend prescriptions as we need to if there's a supply shortage problem. The main thing, though, is that patients get a one-stop-approach to pharmaceutical care.

We know about the medicines they need, we know when there's something that's not available, and we also know what it costs. So, bringing prescribing into that environment is a no-brainer, quite honestly. It will save the NHS billions, and it could also save NHS patients a lot of time instead of going backwards and forwards between GP and pharmacy.

I've been working in general practice and community pharmacy and we've been operating an integrated model now for about the last 15 years. We have access to GP clinical software systems in our pharmacy consultation rooms and we've been able to write prescriptions for patients on the practice list for some time. All the patients we see think it's wonderful because we don't have to ping pong them around.

The relatively self-limiting conditions currently included in the Pharmacy First pathways are the thin end of a wedge. If it's the beginning of a radical change and a move towards chronic disease management, then it makes a lot of sense. That's where it will actually start to pay real dividends.

At the moment, we're scratching the surface

because acute need is fine and it obviously needs to be treated and it gives patients better access. But if we're really going to make a difference and support the shift of care into the community, we need to start picking up some of the chronic disease work around some of the commonest conditions that GPs wrestle with, like hypertension, diabetes, cardiovascular disease – all the real killers that we could actually treat more effectively in community pharmacy, save lives and increase capacity across wider primary care.

> Obviously, a lot of pharmacists are still not IPs. My question is why not? – Babatunde Sokoya

David: We have to start somewhere and I think we have to start with on-the-day illness. It's all right aspiring to do long-term condition management, but without access to all the things that go with long-term condition management – like blood tests and requests for this, that and the other – that's going to be difficult to achieve.

Nigel: We do need to be a bit careful that we don't overcommit because there's cost implications of trying to provide these services. There needs to be a little bit more flexibility because it's very constrained and I would much prefer a formulary or something similar that we could pick out of for those who are not an independent prescriber.

Because there are quite a significant number of pharmacists with significant experience, who won't be IPs, and therefore it will be very much dependent upon who's on duty or who's there when the patient actually goes in.

Victoria: The conditions covered are being decided at the moment with bacterial and allergic conjunctivitis, oral thrush, skin infections and respiratory tract infections being mentioned. What would you like to see in there?

Babatunde: The big one for me would have to be respiratory – you know, the chesty coughs and things like that. UTIs obviously, but if you're an IP, you can go outside the PGD anyway.

Garry: As far as I'm concerned, the additional IP-only pathways need to be dramatically expanded.

Dermatology is another big area which I think is wasting GP time. When I was doing my mentoring, there was somebody walking through the door with something that could easily have been treated or didn't need treatment at all in terms of dermatology at basically every single session. It's a huge area.

Nigel: We were in a ridiculous situation when Pharmacy First came out because we had a local PGD for eye infections from one month to five, and we also had the UTI PGD that went up to the age of 75. And then Pharmacy First comes in and the PGDs have gone. People were coming in to find that last week they could have got the antibiotic eye ointment or drops, and this week, no, you can't, and we were having to refer people back to the GP or to out-of-hours or to A & E. Absolutely ridiculous.

Victoria: And does that impact your relationship with customers and your GP practice who're wondering why they're suddenly getting all these referrals that they didn't get before?

Nigel: Yeah, it does. It doesn't serve anybody at all. The customers are absolutely fuming. This is when you start getting personal abuse because you're having to refuse people.

So, I would have the age group for the UTI extended because they cut out the exact cohort that we're trying to save from going into hospital. We definitely need the children's eye infections, and a lot of minor skin infections should be included in it.

With IPs in the pharmacies, it won't be an issue. However, there are so many pharmacists who are who are not IPs and therefore we're still in the same situation.



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> You need to look at the funding in the round
> – David Evans

FUNDING

Victoria: Let's move on to funding. As I understand it, it's £17 per delivered consultation. Is it enough? And how does that compare with the funding during the pathfinder programme?

Babatunde: The money is not anywhere near what we should be getting for what we're providing. I'm probably going to be paid less than half of what I was getting during the pathfinder to do this.

We've left it up to Community Pharmacy England to negotiate the contract. Unfortunately, they've not come back with what we would like.

Nigel: Yeah, it's wholly inadequate. It doesn't cover the actual cost of delivering the service.

The other thing is that we're a 100-hour pharmacy. And although we have the opportunity to reduce our hours, we're still a 100-hour pharmacy. I took the view that everybody else had changed their opening hours and therefore nobody was covering the traditional out-of-hours. In fact, we're the only pharmacy in the entire county that's open on a Sunday teatime and evening, and so we get a lot of referrals for prescriptions from the hospital and we see people who are travelling 40-50 miles.

The way that the funding works is that we exceed our allocated or paid consultations probably in about the second week of the month. So, what the hell are we supposed to do then? If I've got a parent with a child who comes in on a Sunday afternoon, I know I'm not going to get paid for it but I can't turn them away so I've got to do it at a loss.

Why isn't there a recognition for pharmacies that do out-of-hours so that there isn't a cap on the number of consultations that you're paid for?

David: I'm going to take a slightly different view regarding the funding in that you need to look at it all in the round.

If you do 100 Pharmacy First clinical pathway consultations, and you do 20 or 30 of the normal pharmacy first referrals where they're urgent supplies, you get £1,000 every month.

You also get £525 per month for IT, and because Cleo only costs £210- £215 per month, you've £300 sloshing around. If you run those together, you're getting between £27 and £30 per consultation.

Garry: PGDs are basically a cost-saving exercise to prevent too much money flowing into community pharmacy. In this particular scenario, if you're already trained as an independent prescriber, it's an absolute gift. Certainly, it is for me.

It depends on whether or not we're having to spend extra money on the IT system. I've already got an IT system so for us, it's worth even more. I worked out the cost per consultation was something like £64 per consultation.

That said, I would agree that there should be more funding for upfront costs. There should be more funding for training and for personal development.

I was at a conference recently that brought GPs and pharmacists together and I criticised the guy that came along from NHS England. I asked the question: When independent prescribing was a manifesto commitment, why did you put £200 million into margin instead of reducing the amount that went into margin and putting

more of it into this service?

The amount of money being allocated overall was about £11 million or £ 12 million, or whatever it is being allocated to it, and £200 million into margin. They should have put more into this than they are doing.

But the answer is, 'Well, we're only expecting 12% of community pharmacies to deliver the service anyway'. So they had obviously anticipated that the money would actually be distributed amongst a lot fewer pharmacists.

Babatunde: I think it was Community Pharmacy England that took a decision to put that money into the margin rather than into services because they reckoned only 20% of pharmacies would be in a position to provide this service. I'm obviously not in agreement with that; I would have preferred it in the services.
But I think what David said makes a lot of sense with costing because there's other bits around the headline figure of £17. Obviously, we can use technology and AI now, so you could potentially get three or four people in that one hour. And a lot of us are going down the automation route – you know, using a robot to do the dispensing – which again frees up time for other members of the team to get involved in doing some of the early bits of the consultation.

WORKFORCE

Victoria: Some interesting figures are being talked about – that only 12% or 20% of pharmacies are in a position to be able to do IP. What does that mean for the workforce and the profession?

Nigel: What about the 80% – or 88% – that aren't going to do it? Where does that leave them?

And the other thing is, with the increase in IPs, then obviously those [funding] figures are ridiculous, aren't they?

Babatunde: But the IPs that are qualifying – the majority of ones I've spoken to – don't intend to start prescribing because of their lack of experience.

So, you're going to see a lot of community pharmacies and GP practices putting special measures in place because, obviously, it's all right saying, 'I'm a prescriber', but that lack of experience might play a part in when they actually start prescribing.

Garry: Fundamentally, there is a problem with the current contract model.

One of my criticisms of Community Pharmacy England is that there's a lack of practising prescribers on the committee. When the British Medical Association's (BMA) general practice committee sits down with the Government, it's chock-full of people who are regularly patient-facing clinicians.

If you're talking about barriers, integration and contractual alignment is basically the barrier, really. A lot of GPs, and if I'm honest, senior managers see us as outside the NHS because "all we do is basically blow the NHS drug budget", right? I've heard this said by people



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> The community pharmacy contract is inappropriate as a backdrop to independent prescribing – Garry Myers

inside general practice that "we can't be trusted" etc etc. You get all this nonsense and myth.

Babatunde: Yeah, I just want to go back to what Nigel was saying about the lack of IPs. Obviously, a lot of pharmacists are still not IPs. My question is 'why not?'.

I paid £4,000 to do my IP 10 years ago and since then there's been massive opportunities every single year. We're now being given funding for technicians, and it's so obvious to me that technicians are going to be running the dispensary. So why aren't our colleagues taking this opportunity to become IPs?

Because you know, next year, when they start rolling out services for IPs, it'll be like, 'There's not enough money in dispensing'. It's so obvious from my perspective. I think the government has recognised that pharmacy can play a major role in taking more from the GPs and hoping the GPs take more from hospital.

Garry: I'm not being ageist, but you can imagine that's a difficult ask for some pharmacists who have been

operating for 20-30 years.

I did the IP training course five or six years ago now, and there wasn't anybody else in the room who was older than my daughter. That's not easy. It wasn't easy for me, even with my general practice background, to actually step up to the plate.

I'm acutely aware that a lot of my colleagues are worried about being left behind. One guy put it that he's feeling like a dinosaur. I have a lot of sympathy for my colleagues who've been around a long time. They've been trained in the way that I was trained initially. They've been trained to run a dispensing operation.

The difference in my career pathway is that I did my training as a practice pharmacist and I've always been interested in working both in community and general practice, which is why I ended up being a practice pharmacist and then practice partner where we operated a model to bring pharmacy and general practice together under one roof.

I'm hypercritical of all the national bodies with regard to a lot of legacy pharmacists who, through no fault of their own, are being left behind. I feel as though there's an awful lot more to be done.

FUTURE

Victoria: What are your thoughts on the future of independent prescribing? And what stands in the way of it?

Garry: Basically, the community pharmacy contract, which is nearly all dispensing volume and margin-driven, is completely inappropriate as a backdrop to independent prescribing.

When you look at the data, all the evidence shows that dispensing practices prescribe more than non-dispensing practices. This is well known by medicines optimisation teams up and down the land.

It's one of the reasons that we've never been seen as part of the NHS family – because we look commercial. We grow our business by growing our dispensing volume and our margin at the expense of a local budget holder. We have got to tackle that problem if we want to be perceived differently by the wider NHS.

Now, that puts us in a difficult position because some of our corporate colleagues would rather not prescribe and keep the existing contract model. I think that's extremely dangerous for our long-term future as a profession.

Nigel: If the NHS is committed to making community pharmacy an integral part of the NHS, then we have to get over the barriers because we're not going to have all the IPs, and we need to be focusing on what we can do now to make things better and to give better patient service.

We need a broader number of conditions that we can treat with Pharmacy First, and of course the importance of that will diminish with the increase in the number of IPs.

> We need to be careful that we don't overcommit
> – Nigel Dugmore

Garry: We've got a lot of scope to expand all this and, as far as I'm concerned, the sky's the limit.

I can't emphasise enough the importance of an IT system that allows us full read-write access to the entire clinical history of any patient that we see.

If you're operating an integrated system, I'm sitting in the community pharmacy and I can see SystmOne. So, all the questions that you might want to ask from the point of history taking are already answered, and you can just deal with what's in front of you and make decisions around that. It makes life so much easier and collapses the time taken to actually see and treat an individual patient.

I can book an appointment with the practice phlebotomist because I want to do the urea and electrolytes. The patient gets the appointment, they come back to see me again when I've got the results and I can see it on the clinical system.

This is not rocket science. It's not clinically hard. We just need the IT system to give us that interface.

And the government is moving in that direction because they've taken exclusivity from GPs in that we're going to get a shared patient record that we'll all be able to have access to.

David: I quite agree, but it's much easier in an integrated setting like Gary's got. I'd like to see how that would work in a traditional community pharmacy setting on the high street.

Out of my four IP pathfinder sites, I have two that were really very well integrated – not co-located, but very well integrated in relationships with GPs.

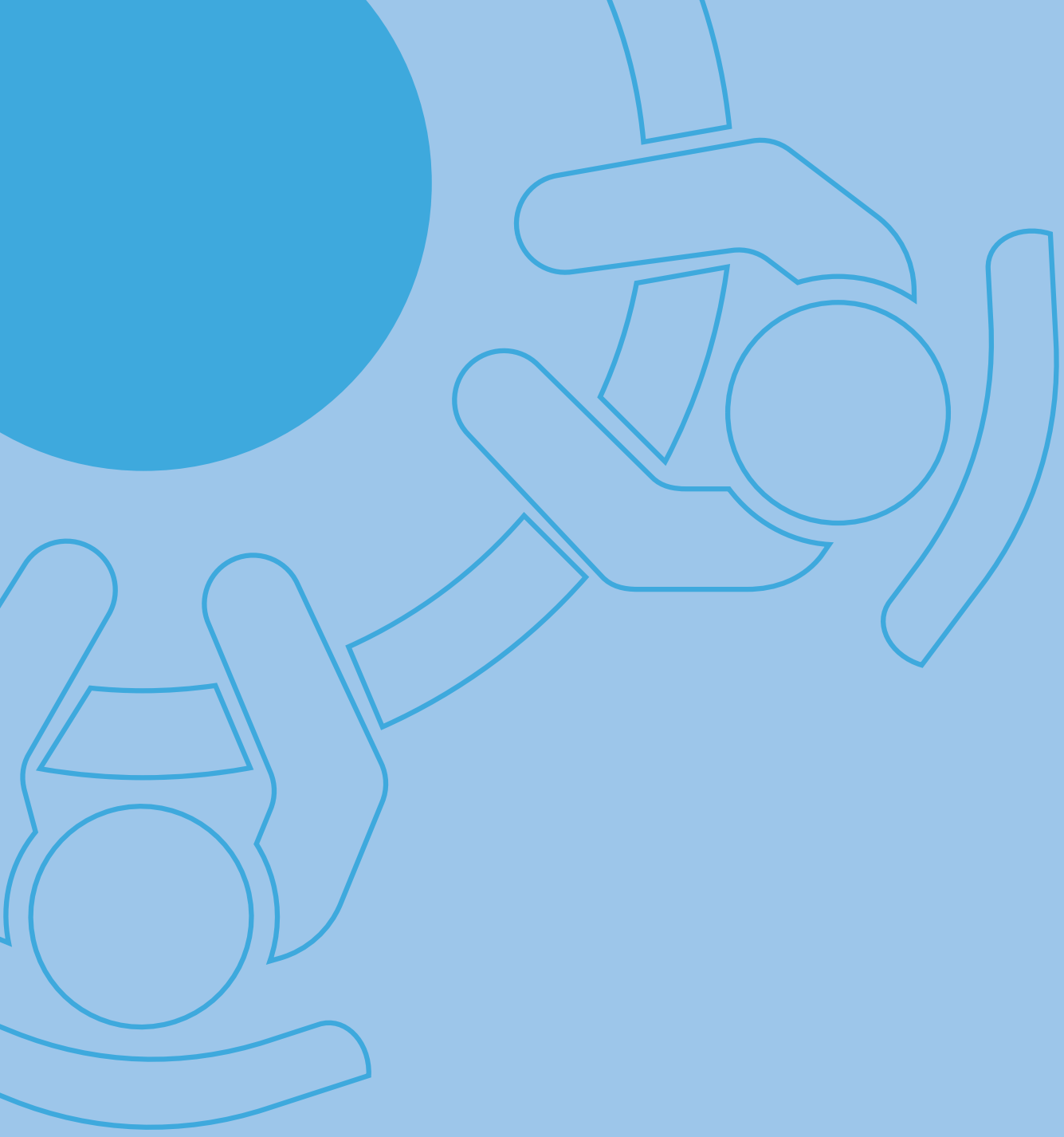
Babatunde: I was very fortunate. I had a fantastic relationship with my local practice. Without them, I wouldn't have been able to do the pathfinder. They actually put me on their calendar and gave me a laptop so I can see what appointments they've booked for me.

If we can just get GPs and pharmacists working together. One of the things in the new contract is around the four hours that we can close for and Essex LPC decided to try and do meetings where you get the GPs and pharmacists together because once you can get that relationship right, honestly, for me, that is going to be the solution to primary care.

We, as part of the pathfinder, did have full access. Before my consultations take place, we've got consent to access that record and, as you rightly said, it made such a difference.

So, you know, someone comes in and they've had an antibiotic two weeks ago – they might not mention it, but you know that because there's access to the record.

Now, everybody that works in my pharmacy – because there's two of us IPs and the two trainees – will always access that record before we do the consultation.



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