Evaluation of the first pharmacist non medical prescriber in addiction treatment in Somerset: Report for Somerset DAAT

Lead Researcher & Report Production:

Jenny Scott PhD MRPharmS(IP)
Senior Lecturer in Pharmacy Practice

Research Officer:

Hannah Dawson MSc (Psych)

Dept Pharmacy & Pharmcology
University of Bath
BA2 7AY

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GLOSSARY:

CMP	Clinical Management Plan
DAAT	Drug & Alcohol Action Team
GPwSI	General Practitioner with a Special Interest (in this case substance misuse)
IP	Independent prescriber / independent prescribing
NMP	Non medical prescriber / Non medical prescribing
OST	Opiate Substitution Therapy (e.g. methadone, buprenorphine)
OTC	Over the counter (e.g. medicines that can be sold by a pharmacist without a prescription)
PGD	Patient Group Directive
PwSI	Pharmacist with a Special Interest (in this case substance misuse)
SP	Supplementary prescriber/ supplementary prescribing

SUMMARY:

In 2008 Somerset DAAT commissioned a 2 year pilot project to introduce pharmacist non medical prescribing (NMP) into the specialist drug treatment service provided by Turning Point. This pilot included the training and development of the appointed post holder in the first year and the provision of services as a qualified prescriber in the second year. This pilot had a set of core purposes and key performance indicators which the University of Bath were commissioned to evaluate during the first six months of the post holder being qualified.

Key performance indicators:

- Numbers of clients seen

One hundred and sixty six appointments were booked with 88 different clients. The average number of appointments booked per day was eight. One hundred and four (63%) appointments were attended, 55 (33%) were not attended with no notification (DNA). In five cases (3%) the client cancelled. Of the attended appointments, 82 (79%) were with male clients and 22 (21%) with female (2 were not recorded). The mean age of clients who attended was 32, with a range of 19 to 60 years.

One hundred and eight prescriptions were issued in 97% (n=101) of attended appointments, all for items indicated in the management of addiction. The pharmacist also gave advice on minor ailments and over the counter treatments and support on managing drug interactions.

The pharmacist documented contact with community pharmacists with respect to 34 attended appointments (34%). The pharmacist sought advice from a doctor in 38% of attended appointments, with a tendency for this to reduce as time progressed.

- Client Feedback

Client feedback was given via a questionnaire on their experience of being seen by a pharmacist NMP (n=29). The level of care received was rated as ‘average’ by two people (7%), ‘good’ by 11 (38%) and ‘excellent’ by 16 (55%). No one rated the level of care as ‘poor’ or ‘below average’. Information received was rated as ‘average’ by three people

(10%), 'good' by 10 (35%) and 'excellent' by 16 (55%). No one rated information received as 'poor' or 'below average'. When asked to rate the level of knowledge the pharmacist prescriber has about addiction treatment, two (7%) considered this to be 'average', eight (28%) considered it to be 'good' and 17 (59%) said 'excellent'. In terms of involvement that the client felt they had in their care, one person (3%) felt 'involved a little bit'. Six (21%) felt 'quite involved' and 22 (76%) felt 'very much involved'. When asked if they would accept the option of seeing a pharmacist prescriber in the future one person (3%) said 'No' and the remaining 28 (97%) said 'Yes'.

Client interviews (n=6) explored views on pharmacist prescribing in more depth. Interviewees recognised that pharmacist NMPs could reduce waiting lists and improve access to treatment. Clients had no concerns about seeing a pharmacist or nurse NMP, describing trust in Turning Point to put appropriately trained and competent people into such posts. Some cited examples of healthcare issues where they would rather see a GP than a NMP but all were happy with their addiction treatment to come via NMPs. Some described the benefit of a pharmacist as understanding other medication that they may be taking and managing interactions. In terms of their own experience with the pharmacist NMP, they talked extensively of their positive therapeutic relationship. This included personal qualities of the pharmacist NMP that were liked, feeling that their opinion was valued and feeling involved in their treatment decisions.

- Key worker feedback

The key workers all talked positively of the pharmacist and identified personal qualities that had enabled effective team working and relationships. In terms of their opinion of pharmacist NMPs they identified a clear benefit to the team of having pharmacological expertise on which they could draw. This was cited by workers from both healthcare and non healthcare backgrounds.

- Lead and deputy lead clinician feedback

The lead and deputy lead clinicians were positive about the pharmacist NMP post, although they made less distinction between nurse and pharmacist NMPs than the staff team. They however also identified the ability of the pharmacist to advise on drug interactions and safe use of medicines as a unique strength. They recognised that pharmacists are less 'hands on' in terms of clinical examination skills and therefore this has to be developed in pharmacist NMPs when training. This was felt to be a negative aspect compared to nurse NMPs who are trained in examination skills prior to training to become NMPs. Another issue was around the investment of Turning Point time and money in training NMPs. As nurses are permanent members of staff it was felt that investment is more likely to be made in their training as NMPs. There was some feeling that pharmacist and nurse NMPs should not prescribe for alcohol patients as this client group require medical assessment. However, there was some suggestion that these assessment skills could be learned, but opinion tended towards this remaining a medical function.

- Cost effectiveness

The cost effectiveness of the pharmacist NMP is better compared to a doctor but may be less cost effective than a nurse NMP. This is because typically NHS nurse prescribers appear to be on at least *'Agenda for Change'* band 6 (£25,472 - £34,189) but more commonly band 7 (£30,460 - £40,157). NHS Pharmacist NMPs tend to be on band 7 or 8a

(£38,851 - £46,621) or above, depending on their other management and clinical responsibilities.

However calculation of cost effectiveness would be an over simplification: The clients identified that DNA rates may be influenced by interpersonal relationships with the prescriber, which cannot be readily measured and appear to be independent of professional status. The data also suggests that making direct comparisons of costs of the different post holders is inaccurate because a nurse NMP, pharmacist NMP and doctor cannot be directly compared. This evaluation has identified that the skills and contribution to the team from each post is different. It is therefore an over simplification to say all prescribers do the same thing. They may ultimately achieve the same outcome of safe and effective prescribing but the route to doing so may depend on the complexity of the case to begin with, their unique professional contribution e.g. preventing drug interactions and the extent to which they utilise each other and other members of the multidisciplinary team to achieve the outcome.

- Future costs

Future costs of the post would depend on how the post was configured. Employment on a sessional basis to provide clinics is likely to be the cheapest but not necessarily provide the greatest return in terms of additional work that could be done to improve cost efficiency of community pharmacy and GP substance misuse services. Suggested future roles are outlined in section 6.0.

Core purpose of the post

- *To improve patient care without compromising their safety*

The pharmacist NMP post facilitated quicker throughput in the specialist service by reducing waiting times through the provision of the Limbo clinic. This may be defined as an improvement in patient care. There was no evidence to suggest that patient care was lacking in any way prior to the introduction of the pharmacist NMP, but there was sufficient evidence from several sources to suggest that the pharmacist's contribution of knowledge on pharmacology, drug interactions and over the counter medications has benefited both the team and clients. There were no safety incidents raised by the clinical lead or pharmacist NMP and nothing identified to suggest that the pharmacist NMP post compromised safety in any way.

- *To improve patient access to the medications they need*

The reduced waiting list and the ability of the pharmacist to respond to prescription issues in the absence of a doctor improved patient access to the medication they need.

- *To increase patients choice in accessing medications*

All clients were happy to be seen by a pharmacist NMP and 97% said they would wish to see a pharmacist NMP again. In theory this provides patients with a greater choice of who prescribes for them. However, in practice it was felt that availability of the prescribers and the needs of the service often dictated who sees which client and therefore more could be done to improve client choice. It is an ethical requirement that patients can request to see a medical prescriber instead of an NMP. The client interviews however suggested that

clients were happy with the system in place and as long as they received their appropriate care they had no particular wish to be seen by a medical prescriber as opposed to a non medical prescriber.

- *To better utilise health professional skills*

The pharmacist post holder felt his skills were being utilised well within the post. He described it as challenging and a learning curve. Whether his skills are being better used than they would be in community pharmacy environment is difficult to compare, as the skill set for prescribing does vary to some extent. In particular the consultation skills need to be deeper and more extensive. The pharmacist NMP post allows doctors time to see more complex cases, something that was recognised by several sources including clients, doctors and the team. Hence it may be argued that the post allows better utilisation of doctor's skills by reserving their clinic time for new and more complex cases.

- *To contribute to the introduction of more flexible team working across the NHS*

Turning Point already had nurse NMP posts in place before the pharmacist NMP post was introduced. Flexible working appeared from the staff team data, nurse NMP data and clinician input to already be part of the fabric of the service. The pharmacist NMP post has added to flexible working in that it has broadened the NMP contribution to Turning Point services. However, because the post did not move out of the specialist service there is no opportunity to consider flexible working across the NHS.

- *Cost efficiency*

Cost efficiency is defined as the cost of a service divided by the number of recipients. This does not consider outcomes. If the service is taken to be delivery of a service based on the model of the Limbo clinic then nurse NMPs could be more cost efficient than pharmacist NMPs who in turn are more cost efficient than doctors. A network of Limbo clinics could in theory be overseen by one doctor and provided by a team of nurse NMPs or nurse and pharmacist NMPs at greater cost efficiency than a doctor prescribing service. However, the evaluation shows that to consider cost efficiency in isolation is misguided. The 'added value' to the team of the pharmacist NMP post was specialist pharmacological input, advice on preventing drug interactions and over the counter medicines. Each of these may avoid costs to the NHS e.g. cost of managing a drug interaction or cost to primary care of treating a self limiting illness that can be treated OTC. This raises the difficult to measure issue of how much this contribution is worth, which would require a more extensive health economic study.

When considering the cost difference between nurse NMPs and pharmacist NMPs the configuration of the posts also needs to be considered. If the 'cost of a service' is taken to be 'cost of providing a prescribing clinic' then as said the pharmacist NMP is more cost efficient than a doctor and the nurse NMP can be more cost efficient than the pharmacist at face value. However if the 'cost of a service' is taken to be the cost efficiency of drug treatment in Somerset then there are wider issues for future consideration:

Nurse NMPs within Turning Point appear to have three roles – key worker, NMP and manager. The pharmacist NMP post was based on a locum model with the provision of sessional prescribing work. The difference in cost therefore has to be reconciled with the difference in contribution to patient care and other aspects of service delivery that the pharmacist could make if the post were full time equivalent. The pharmacist NMP can take referrals from both nurse NMPs and doctors. The contribution of the pharmacist to

managing poly-pharmacy cases and drug interactions, both within the specialist service and for shared care GPs, has to be considered in terms of improved clinical outcome and client safety. Also, the potential for the pharmacist to contribute to liaison with community pharmacists, review the appropriateness of supervised consumption and audit community pharmacy to improve overall cost efficiency of drug treatment in Somerset (discussed in section 6) has to be considered.

In conclusion, this evaluation found the pharmacist NMP post to be safe, acceptable to patients and acceptable to clinicians and key workers. This echoes the findings of research studies cited by the National Prescribing Centre in their guide to NMP for commissioners (reference 3 listed in section 8.0, p41). When considering costs it has to be remembered that investment costs in training have already been made and that cost efficiency could potentially be widened across drug treatment in Somerset, depending how the post was configured.

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1.0 Overview

Somerset Drug & Alcohol Team DAAT (a Partnership between NHS Somerset, Somerset County Council, Avon & Somerset Constabulary and the Probation Service) commission specialist services for people with problems of drug dependency. Commissioning includes the provision of specialist prescribing services (Turning Point), shared care between GPs and community pharmacists and pharmacy based needle exchange. Somerset PCT is responsible for addressing the health needs of people who live in the county of Somerset and part of the NHS partnership, through GP and community pharmacy contracted medical and pharmaceutical services.

An innovative approach has begun in Somerset to utilise the new opportunities that non medical prescribing brings to drug treatment. Nurse prescribing is already established within Turning Point. A pilot project funded by the DAAT used a pharmacist non medical prescriber to contribute to the provision of drug treatment. This first pharmacist NMP began training in 2008 and qualified as a prescriber in 2009. Since November 2009 the pharmacist NMP has been working within Turning Point.

Somerset DAAT commissioned the University of Bath to evaluate this first pharmacist NMP post during, this was done by collecting data during the first six months post qualification (mid November 2009 to mid May 2010). This report presents the findings.

2.0 Background to non medical prescribing

Since the publication of the Review of Prescribing, Supply and Administration of Medicines Final Report in March 1999[1], known as the 'Crown Review' report, non medical prescribing has developed. Non medical prescribing refers to prescribing that is undertaken by health professionals who are not doctors. First supplementary prescribing was established, followed by independent prescribing. Nurses, pharmacists and optometrists can undertake qualifications to allow them to become independent prescribers. Independent prescribers can act in a supplementary prescriber capacity where required to do so. Nurses can also train to become community practitioner nurse prescribers. Chiropodists/podiatrists, physiotherapists and radiographers can train to become supplementary prescribers.

2.1 Supplementary prescribing (SP)

Supplementary prescribing is described as *'a partnership between a medical practitioner (independent prescriber) who establishes the diagnosis and initiates treatment, a pharmacist* [or other qualified healthcare professional] *(supplementary prescriber) who monitors the patient and prescribes further supplies of medication and the patient who agrees to the supplementary prescribing arrangement*'[2].

A framework for supplementary prescribing, in the form of a clinical management plan (CMP), is required for each individual patient. The CMP is a legal document which contains details of the patient, their condition, the detail of the medicines that can be prescribed and detail of when the patient should be referred back to the doctor. Patients

should be seen by the doctor initially, because of the requirement for the doctor to establish the diagnosis and thereafter patients should be reviewed yearly by the doctor. Unlike independent prescribing, a supplementary prescriber can only prescribe within the limits of the CMP and cannot prescribe for conditions not included in the CMP.

2.2 Independent prescribing (IP)

A pharmacist independent prescriber is able to prescribe any medicine for any condition, with the exception of controlled drugs, although this is expected to change (see 2.2.1). Nurse independent prescribers can prescribe some controlled drugs in limited circumstances e.g. diamorphine for myocardial infarction, but they cannot prescribe controlled drugs for addiction. Independent prescribers work as autonomous practitioners making prescribing decisions based on their diagnosis, assessment of the patient's condition and their judgement of the most appropriate medication regime[2]. There is no legal requirement for a CMP. The independent prescriber should be working to a treatment plan, however this does not legally need to be written down. Good practice would suggest that the treatment plan should be linked with the overall care plan for the patient. Shared access to medical records is advocated.

Both pharmacist and nurse independent prescribers must practice within their competency and this acts as a limit on the extent of the medicines that any individual person is likely to prescribe. The generic nature of the training enables practitioners from a range of clinical areas to undertake the same course and to move across therapeutic areas (if their competency allows). Pharmacist and nurse non medical prescribing courses however are distinct and the two professions train separately.

Those who trained as supplementary prescribers prior to the introduction of independent prescribing can undertake a conversion course to upgrade to IP status.

2.2.1 Independent prescribing of controlled drugs

At present a non medical independent prescriber working within addictions needs to act as a supplementary prescriber in order to prescribe opiate substitution therapy (OST) such as methadone and buprenorphine. This is because these are controlled drugs. This means a CMP needs to be in place for the NMP to prescribe OST and a doctor needs to make the initial diagnosis of addiction. However the same NMP can act as an independent prescriber when responding to, for example, side effects of methadone such as constipation, prescribing non-controlled drugs, such as laxatives, without the CMP detailing the treatment of constipation.

The law on independent prescribing of controlled drugs is expected to change around winter 2010. Following a consultation conducted in 2007, the Home Office's Misuse of Drugs regulations relating to non-medical prescribing of controlled drugs are to alter. This will allow pharmacist independent prescribers to prescribe, within their competence, schedule 2, 3, 4 and 5 controlled drugs and remove the existing limitations on the prescription and administration of controlled drugs by nurse independent prescribers. An amendment to the Prescription Only Medicines (Human Use) Order 1997 has been made, which came into force on 1 April 2008. This went part way to achieving these changes, but a change to the Misuse of Drugs Regulations 2001 is also necessary and awaited. This will mean non-medical prescribers within addictions can act as independent prescribers and CMPs will no longer be needed.

2.3 Scope of non medical prescribing

The aim of NMP is to improve patient access to medication whilst using the skills of non medical health professionals fully. NMP is seen as a cost effective way to deliver appropriate prescribing services, allowing the time and expertise of doctors to be used more efficiently. Nursing is a far larger profession than pharmacy in the UK. Not surprisingly therefore the extent of NMP by nurses far exceeds NMP by pharmacists. The National Prescribing Centre suggests there are approximately 14,000 independent nurse prescribers in England and 1,700 pharmacist IP and SPs[3]. Baqir et al quote there to be pharmacists prescribing in 107 out of the 152 PCTs in England[4].

Caution is needed in assuming that nurse and pharmacist NMPs are interchangeable. Nurses and pharmacists have different basic skill sets and different areas of expertise. Nurses are well experienced in 'hands on' clinical skills for example taking blood, giving vaccinations, blood pressure monitoring and wound management. They also have a history of training and working in multidisciplinary teams. Pharmacists have less 'hands on' clinical skills training but more extensive training in clinical pharmacology and therapeutics. Those who work in community practice are experienced in 'counter prescribing', that is differentiating minor ailments from major diseases and making appropriate over-the-counter recommendations. Those who work in hospital and PCTs are used to advising on prescribing. This means that when qualified as NMPs, nurses and pharmacists should not be seen as interchangeable. Instead their different areas of expertise can be built upon to contribute in different ways to patient care.

3.0 Scope of this evaluation

3.1 Core purpose

When Somerset DAAT established the first pharmacist NMP post in addictions in their locality, it was agreed that the core purpose of the post was:

1. To improve patient care without compromising their safety
2. To improve patient access to the medications they need
3. To increase patients choice in accessing medications
4. To better utilise health professional skills
5. To contribute to the introduction of more flexible team working across the NHS
6. Cost efficiency
7. *Emergency back-up*

Regarding the last core purpose of emergency back up: It was originally envisaged that the pharmacist NMP could provide some out of hours support to community pharmacists e.g. dealing with wrongly written prescriptions when Turning Point offices and GP surgeries are closed. However this was probably a premature goal as the pharmacist NMP post remained within the core Turning Point team for the duration of the evaluation and therefore this part of the post did not evolve. Hence it is not assessed.

3.2 Key performance indicators

The key performance indicators stated in the DAAT bid for funding for this first post were as follows:

- Numbers of clients seen
- *Treatment outcomes (e.g. TOP's quarterly)*
- Client Feedback
- Key worker feedback
- Lead prescriber feedback
- *GP Feedback*
- *Out of hours contact*
- Cost effectiveness
- Future costs

The performance indicators in italics were not measured in this evaluation for the following reasons: As the pharmacist NMP post remained within Turning Point core team, GP feedback was not sought as the post holder's contact with GPs was limited to GPs receiving copies of the pharmacist NMP clinic notes. For the reasons stated above 'Out of hours contact' did not happen and therefore was not measured. TOPs quarterly statistics were not gathered for two reasons. Firstly, the clients had to remain anonymous to the evaluation team. This was a condition of Turning Point governance approval for the evaluation. Therefore to gather and anonymise data from clients seen by the pharmacist NMP, nurse NMPs and doctors for comparison, would have required a significant administrative input from Turning Point staff, which could not be funded. Secondly, the pharmacist NMP was working in a multidisciplinary team, receiving input when needed from doctors and key workers into his treatment decisions. Therefore, it is unlikely that anything meaningful could be established from TOPs scores as any differences could not be attributed to the pharmacist NMP alone.

3.3 Aim and objectives

The **aim of this evaluation** is to establish the contribution that the first pharmacist non medical prescriber post in addiction treatment makes to patient care in Somerset in order to inform commissioning of Adult Treatment services on the role out of the scheme in the future.

Objectives:

(1) To establish whether the core purposes that underpin this scheme have been met.

(2) To evaluate the key performance indicators stated above.

3.4 Approach and presentation of findings

A mixed methods approach was used to investigate the first pharmacist NMP role. This report will outline these methods in the next section. It will then present the relevant findings that relate to each method use and reflect on whether the core purposes and key performance indicators have been met.

It will then go on to consider the future of the pharmacist NMP post, by considering the findings from the evaluation and the priorities of commissioners, concluding with some suggestions for key stakeholders to consider.

4.0 Evaluation methods

4.1 Research governance

NHS research ethics approval for this evaluation was not required as this work was deemed a service evaluation (*personal communication J Scott and National Research Ethics Service Queries Line via email 29.10.09*). Ethical approval was granted via the University of Bath internal review system. Honorary contracts were granted by Somerset PCT (November 2009) and approval for the work obtained from the Turning Point Quality, Risk & Assurance Team (*personal communication J Scott and J. Carman via email 18.03.10).*

4.2 Setting

The Pharmacist NMP was based within Turning Point, specialist provider of drug and alcohol treatment services in Somerset, in the newly established 'Limbo' clinic. This is a low threshold clinic which aims to reduce waiting times by getting clients into treatment and stabilised on a prescription while they await allocation of a key worker. The first few weeks post qualification the pharmacist undertook 90 day reviews of clients in a different Turning Point office, prior to the Limbo clinic being established.

4.3 Data collection and analysis

Contact with other pharmacist prescribers within addictions known to the author found no previous evaluation of such a post. Consequently the methods used were derived specifically for this work by J Scott.

The face-to-face data collection was undertaken by Hannah Dawson, Research Officer, Dept Pharmacy & Pharmacology. Miss Dawson is a psychology graduate. This was considered important to promote honesty and encourage open discussion in interviews as data collection by a pharmacist may have led to bias in the data provided.

All data analysis and interpretation was undertaken by J Scott, who is a pharmacist. Therefore consideration had to constantly be given as to whether bias could creep into the design, analysis or interpretation stage. This was managed by seeking external advice from non pharmacists and in a reflexive way. The research design and final report was peer reviewed by the external scrutiny panel (4.4). The design also received internal peer review of the ethical implications (4.1). Quantitative analysis was descriptive in nature and qualitative analysis specifically bore a heightened awareness of identifying negative aspects. Grouping themes were reviewed several times to ensure they used unbiased terms. Regarding reflexivity, the lead researcher was conscious of trying to provide factual information at all times and in writing this report has tried to constantly reflect on whether the findings and suggestions for the future apply equally to nurses and pharmacists or whether there are factual reasons why they apply only to pharmacists.

4.3.1 Pharmacist activity data

The pharmacist NMP post holder was asked to collect real time data on the activities undertaken in the post during the first six months (appendix 1). This was to enable a description of the post to be given and activity to be analysed. Data was coded and entered into Statistical Package for the Social Sciences (SPSS v14), which then allowed quantitative analysis to be generated.

4.3.2 Client opinion on their experience of the pharmacist led clinic

All clients were invited to complete an evaluation form after their first appointment with the pharmacist prescriber (appendix 2). This was used to gather quantitative data on the client experience. Again data was coded and entered into SPSS v14 for quantitative analysis of their views.

Additionally, more in depth understanding of the client experience was sought via semi structured interview. The research officer visited the Turning Point office on two occasions to interview willing participants after they had had an appointment with the pharmacist prescriber. These participants were reimbursed their travel costs and provided with a £10 High Street Shopping Voucher to recompense them for their time. With permission of the participant, the interview was tape recorded. Data was then transcribed and subject to thematic analysis using the qualitative software management tool NVivo v8. Analysis was undertaken at three levels. Initial coding to identify salient points, axial coding to condense the first level data and then grouping to further refine the key themes, which are reported here.

4.3.3. Key stakeholder opinion on pharmacist prescribing and the pharmacist NMP post at Turning Point.

The views and opinions of key stakeholders were sought using qualitative interviews and a focus group. Again, with permission of the participants, the interview/focus group was tape recorded. Data was again transcribed. Interviews were grouped under the headings given below and these units subject to thematic analysis, at three levels, as above, using NVivo v8.

The commissioning view
Interviews with two commissioners, one from the PCT and one from the DAAT, and the shared care co-ordinator were undertaken to gain a greater understanding of what they expected of the post and the direction that they envisaged that the post might take. Their expertise with regard to the wider commissioning and treatment provision agenda was expected to give the research team greater insight into the potential scope for development of the pharmacist NMP post.

The medical view
Interviews with the clinical lead and deputy clinical lead at Turning Point were undertaken in order to gain insight into their experiences of working with the pharmacist NMP post holder. The aim was also to explore their views on the future of such a post within the organisation. The clinical lead was interviewed twice, once at the start of the post and again as the first six months was ending to identify any changes of opinion over time. The

deputy clinical lead also has a strategic role within the development of shared care and therefore this expertise was also drawn upon.

The staff team view
A focus group was conducted with eight members of the Turning Point key workers team, who had experience of working within the environment where the pharmacist NMP post was in place. This was done in order to gain insight into their opinion of adding a different healthcare professional into the staff team who can also undertake a prescribing role.

Additionally a one to one interview was undertaken with an experienced nurse NMP within the team who had worked alongside the pharmacist NMP post holder.

The NMP post holder view
Two interviews were conducted with the pharmacist NMP post holder, once shortly after qualification and one close to the end of the six month evaluation period. The purpose was to gain further insight into the activities of the post, identify any challenges, explore the post development through the eyes of the post holder and their thoughts on the future role.

The external expert
One interview was conducted with an experienced pharmacist with a special interest (in addictions) (PwSI) outside of Somerset. This pharmacist had a similar background to the Somerset post holder but had been qualified for longer and therefore had greater experience of providing such a role. This person also held a post within their PCT therefore had insight into potential strategic development of such a post at their local level, which was considered useful to inform this evaluation. They had been involved in recruitment of the Somerset post holder.

The interview/focus group topic guides broadly focused on two areas –general opinion on pharmacist prescribing within the addictions field and specific opinion on the pilot Pharmacist NMP post. They also explored issues specific to the role and expertise of the participant(s).

4.4 External scrutiny

An independent project scrutiny panel was convened. This comprised an academic from the University of Bath, Department of Psychology and an experienced research manager based in a neighbouring PCT. Their remit was to review the conduct of the evaluation and to ensure the impartiality of the interpretation of the findings. They commented on the protocol and the final report to ensure bias was controlled. They did not have access to any person identifiable data such as names or transcripts. Copies of their feedback can be made available.

5.0 Findings

5.1 Description of the post

As outlined in 4.2, the post was based within a Turning Point office. The Pharmacist NMP provided prescribing services within the Limbo clinic for most of the pilot. During each session a nurse prescriber and independent prescriber (doctor) were also working on the

premises. Clients are initially seen by the independent prescriber then seen by an NMP. This arrangement alternates for each appointment. Clients are seen fortnightly or more frequently if the prescriber considers it necessary.

5.1.1 Pharmacist activity data

Clients were assigned a code by the pharmacist, which related to the first date they were seen and their appointment number on that day. This kept their identity from the research team but allowed individuals to be tracked. Data was collected on 166 client appointments scheduled with the pharmacist prescriber between 06 November 2009 and 20 May 2010, over 20 'all day' clinic sessions. These 166 appointments were booked with 88 different clients. The average number of appointments booked per day was eight, although this ranged from two to 13. The mean age of clients who attended was 32, with a range of 19 to 60 years.

5.1.1.1 Attendance

One hundred and four (63%) appointments were attended, 55 (33%) were DNA, which means the client did not attend and gave no notification. In five cases (3%) the client cancelled and data was missing for two appointments. Clients who attend the Limbo clinic are issued with their prescriptions during the clinic. This therefore acts as an incentive to attend. It is therefore inappropriate to compare this attendance rate with attendance rates in other aspects of the service such as 90 day prescribing reviews. For clients attending the latter their prescriptions will most usually be sent directly to the pharmacy instead of being collected in clinic.

Of the attended appointments, 82 (79%) were with male clients and 22 (21%) with female. The DNA rate was comparatively higher in females (27% n=15) than males (70% n =39) but not with any statistical significance.

5.1.2.1 Clinic activity

The pharmacist briefly summarised the key issue(s) from the appointment, which were subject to thematic analysis, from which five major categories emerged. The majority of activity fell into the first two categories:

- **Prescribing of medication for addiction:**
  This includes induction, titration, detoxification and changes to supervised consumption and pick up arrangements,

- **Safety of medication issues:**
  These include assessment for drug interactions, responding to side effects, advice on driving/DVLA notification and referral for ECG due to methadone dose >100mg.

- **Minor ailment advice:**
  This refers to giving advice on minor ailments, in the same way as a community pharmacist would. It includes suggesting over-the-counter medication to purchase.

- **Medication review**

This refers to the review of prescribed medication received from the GP for appropriateness and safety with respect to addiction treatment.

- **Harm reduction advice**

For example advice given on anabolic steroid use.

5.1.2.2 Prescribing

One hundred and eight prescriptions were issued in 97% (n=101) of attended appointments, as shown in table 1:

Medication	Number of prescriptions issued	Percentage of total number of prescriptions issued
methadone	73	68%
buprenorphine	26	24%
diazepam	7	6%
vitamins inc. thiamine	1	1%
disulfiram	1	1%

Table 1: Medication prescribed by the pharmacist

The medications prescribed are all indicated in the management of addiction in the British National Formulary edition 60 (Sept 2010). In all cases where diazepam was prescribed it was an adjunct medication to others e.g. with buprenorphine.

In the case of 22 prescriptions, the pharmacist initiated a new medication, most commonly buprenorphine (n=10), followed by methadone (n=7), diazepam (n=4) and disulfiram (n=1). The rest were continuation prescriptions. The pharmacist altered doses (either increase or decrease) in the case of 32 (41%) of continuation prescriptions.

Eighty three (83%) of clients were on supervised consumption. In four appointments the pharmacist made changes to supervision arrangements; in two cases supervision was restarted and in two cases it was removed. This high percentage of supervision is appropriate for an early treatment clinic and in line with the current recommendations of NICE[5] and the UK Clinical Guidelines[6]. The pharmacist changed one person to less frequent collection intervals and three people to more frequent collection intervals in response to concerns about compliance.

5.1.2.3 Pharmacy liaison

The pharmacist documented contact with community pharmacists with respect to 34 appointments (34%). The reasons for this were:

- To check if the pharmacy was willing to take on a new client
- To notify the pharmacist of a dose increase
- To notify the pharmacist of a change in pick up arrangements
- To arrange transfer to another pharmacy
- To check up on client attendance at the pharmacy

5.1.2.4 Referral to the clinical lead (IP)

The pharmacist referred to the clinical lead with respect to 38 appointments (38%). Reasons for this included verification of prescribing decisions, legal issues (e.g. to have a CMP signed), child protection concerns, medical problems identified (e.g. leg ulcer) and clients with needs outside of the CMP e.g. methadone dose >90mg. In the case of verification of prescribing decisions, a review of these by the researcher suggests that these appear to be sensibly cautious actions for a newly qualified prescriber. Figure 1 illustrates the general trend of reduction in referral to the doctor over time, suggesting increased confidence in prescribing decisions made by the pharmacist NMP. This was also recognised by the clinical lead. However, it would not be expected or desirable that referrals would stop altogether. The framework for non medical prescribing advocates team work and for many issues, such as child protection concerns and legal matters, ongoing referral is entirely appropriate.

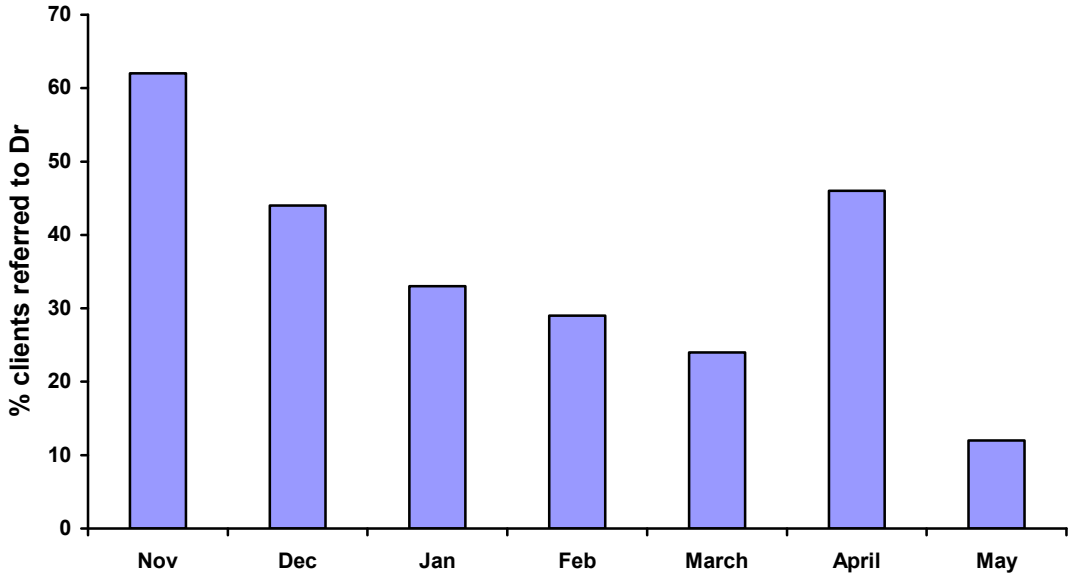

Figure 1: Percentage of clients seen per month for whom the doctor was consulted.

5.2 Client opinion on their experience of the pharmacist NMP clinic

5.2.1 The feedback questionnaire

Twenty nine clients completed the feedback questionnaire (appendix 2) after their first appointment with the pharmacist; it is unknown how many overall were invited to do so. As this form was designed to be quick and easy to fill in, with a size limit of one side of A4, no demographic data was collected on respondents. Opinion expressed is limited to that held immediately after consultation.

- When asked to rate their consultation with the pharmacist prescriber 22 (76%) said it was *'better than I expected'* and 7 (24%) said it was *'about what I expected'*. No one chose 'worse than I expected'.

- The level of care received from the pharmacist prescriber was rated as 'average' by two people (7%), 'good' by 11 (38%) and 'excellent' by the majority, 16 (55%). No one rated the level of care as 'poor' or 'below average'.

- The information received from the pharmacist prescriber was rated as 'average' by three people (10%), 'good' by 10 (35%) and 'excellent' by 16 (55%). No one rated the information received as 'poor' or 'below average'

- When asked to rate the level of knowledge the pharmacist prescriber has about addiction treatment, two (7%) considered this to be 'average', eight (28%) considered it to be 'good' and 17 (59%) said 'excellent'. Two people omitted this question. The reason for this is unclear. Since all other questions were answered and the questions were clearly listed, it may perhaps be because the clients felt uncertain of their response. *'Don't Know'* was not a given option.

- In terms of involvement that the client felt they had in their care, one person (3%) felt 'involved a little bit'. Six (21%) felt 'quite involved' and 22 (76%) felt 'very much involved'.

- When asked if they would accept the option of seeing a pharmacist prescriber in the future one person (3%) said 'No' and the remaining 28 (97%) said 'Yes'.

Clients were invited to add comments at the end of the questionnaire; eight chose to do so. These comments suggest clients felt listened to, treated with respect and that they had received personal attention. They also recognised and valued being given information:

- *"I have been a user of very uncommon drug* [drug name stated] *and had many problems with previous care as no knowledge was or is know of this drug. So am very aware of the inconvenience this can cause, but* [names pharmacist] *has done very well by me by being understanding and taking the time to look into this drug for my benefit and the benefit of others"*

- *"I believe his knowledge is excellent and I look forward to future meetings with him. I think he has the right motivation"*

- *"Excellent, opened my eyes a lot and helped me out a lot thanx and keep up the good work"*

- "*I was not expecting the level of involvement from the pharmacist that I received and so I was impressed with the service that was given. Thank you."*

- *"He was a very well mannered man and made me feel at ease"*

- *"Unknown side effect urinary retention on buprenorphine. This was noted by pharmacist"*

- *'The doctor I saw today was very helpful and listened to what it was I thought I needed before telling me what he thought'*

- *"He was very up on self-helping myself! I'm having trouble sleeping I asked about some help and he gave me a list of books to read? Probably to bore me to sleep!"*

The use of the word 'doctor' suggests this person may have not been fully aware, despite the briefing given by the pharmacist, that he is not a medical doctor.

The last comment suggests this person was looking for pharmacological therapy to assist with sleep and felt disgruntled that this was not provided. This however may have been in

his best interests and in line with national and Turning Point guidance on use of benzodiazepines.

5.2.2 The in depth interview with clients

Six in depth interviews were conducted with clients to explore their opinions on the pharmacist prescriber and receiving their care from a pharmacist as opposed to a doctor. Five major themes emerged, as shown in figure 2:

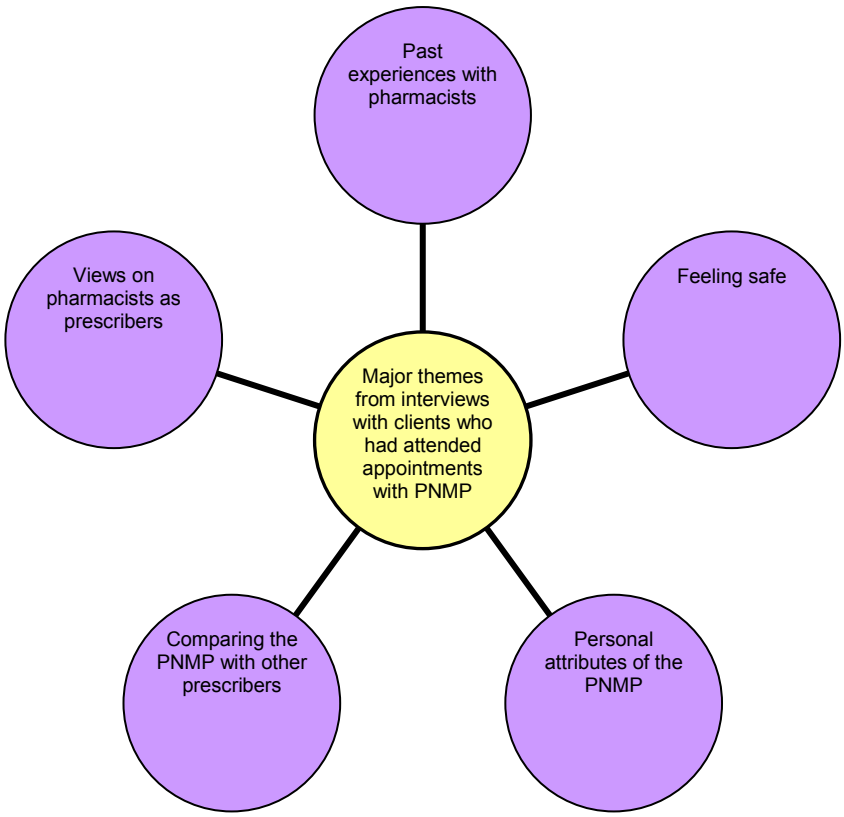

Figure 2: The five major themes that emerged from client interviews

5.2.2.1 Past experiences with pharmacists

All had past experience of attending drug treatment, where they had been seen by doctors and key workers. No one had received care from a pharmacist prescriber prior to their experience at Turning Point. All had had extensive contact with community pharmacists for dispensing and in some cases supervised consumption. One person had a family member who was a pharmacist.

It was mentioned on several occasions that pharmacist's attitudes towards drug users had improved in recent years. In general interviewees held a positive view of how they were currently treated by community pharmacists.

5.2.2.2 Views on pharmacists as prescribers:

Views were given on pharmacist prescribing in general and on the perceived benefit of having a pharmacist NMP at Turning Point

All interviewees thought pharmacist prescribing was a good thing mainly because it reduced waiting lists. P2 reflects on past experience:

'I think it's good [having a pharmacist NMP]*…..if there was other places like this that don't have people like him I think they should get people like him. It's so much better than it used to be, I had to wait back in 2005, last time I came. I had to wait about a month to be seen to be able to get a prescription, so I had to continue using heroin until I was seen. The fact that my GP wouldn't write a prescription, all the red tape and everything in Turning Point*[1] *it took months to get assessed and…probably two months before I actually got a prescription'.*

Interviewees talked about freeing up doctors time so they could see new or complicated patients. This was described both within Turning Point and in general practice, where interviewees felt community pharmacists could take over some prescribing. When asked about limits and safety, interviewees felt that as long as pharmacists could refer to doctors for advice when necessary there was adequate safety. The qualification requirements on pharmacists to prescribe had already been explained at the start of the interview.

Some identified that motivation can change while on a drugs service waiting list, so being seen promptly was key, as illustrated by P2:

'I think it is a really good idea cause the doctors can see newer patients…cause the older patients who are stable can be seen by the pharmacist which frees up the doctor to see newer patients who are wanting to….you know, cause if you go on a waiting list by the time you see the doctor you are so fed up of waiting that you just don't go…you know. I have been there…a few times, where in the end I have just not turned up or I have had to support my habit somehow so I have ended up being arrested and not been able to go….' P2

Some mentioned cost savings as a benefit. Participant 007[2] discussed this, although these relate to the format of the Limbo clinic as opposed to the use of pharmacist NMPs:

I think since X has been here they have got a lot more people through on their scripts a lot quicker, quite a few people I have spoke to say how handy it is to come in and see X and get a prescription and not have to have counselling, because if you are not at a point that you want counselling then it is just a waste of time, it's a waste of resources, it a waste of money' P007

Interviewees considered that the same benefits were possible from nurse prescribing; mentioning nurse key workers within the service who they knew could prescribe. No one specifically identified at this point the addition of pharmaceutical knowledge to the multidisciplinary team as a benefit, or distinguished between nurse and pharmacist prescribers, but those who had received specific pharmaceutical advice from the pharmacist NMP discussed later how this was a benefit from their appointment:

[1] In 2005 the service was provide by a different provider, Somerset Drugs Service.
[2] Participant 007 requested this code be used for him as he is a Bond fan, there were only six interviewees.

'Just the little minor things that you get, like I said the rash I had, and little things like that….[the pharmacist NMP] *can say you can buy it* [over the counter cream] *on the shelf sort of thing….that will help, so you don't see a doctor'.* P1

'I was getting really bad migraines…and he went all through my medications and he was getting stuff up on the computer and he was really going into depth and getting really interested in what was going on with me and really he didn't have to because you know the migraine wasn't his problem' P007

This theme also contained two related sub themes which will be discussed together:

(i) What is important to interviewees in a consultation?
(ii) Interviewees views on their experience with the pharmacist NMP.

Being included in decision making and having some control over dose changes was important to all the interviewees. They all felt the pharmacist NMP had done this in their consultation.

'Well yeah I found it quite surprising that he included me and asked me what I thought….a lot of places I have been to….drug agencies…they just tell you what you are getting……I found it really helpful that he included me in my treatment'. P3

This also linked with good communication, which was identified as important. P1 illustrates this:

[Pharmacist NMP] *puts it in a way that a normal person can understand where with a doctor he might baffle on a bit and then you wouldn't understand what he was saying, you just go along with it 'cause you need your script'.*

Feeling valued by the prescriber was also identified as important. Some interviewees mentioned this was specifically felt from their pharmacist NMP consultation, as P007 illustrates:

'It made me feel good actually that someone has actually gone to the effort of stepping over the mark a bit to you know, because they could see I was making an effort and that means a lot. …it goes a long way. I thought I have to fulfil my end of the bargain now' [said in relation to being given a requested appointment time by the pharmacist NMP in order to avoid other drug users on the premises].

Continuity was also identified as important. This refers to seeing the same prescriber each time. Some clients had past experience of seeing several prescribers at Turning Point but now felt the Limbo clinic offered them the chance to develop a rapport.

'You see a different doctor every time, I would rather see the same doctor every time so you get to know them and that….find them easier to talk to. If you see a different doctor every time, it is quite difficult because you have to go through the same things every time and explain to them you know?...cause they don't know you very well….would be a lot easier if it was just the same one every time….[when asked about the experience of seeing a pharmacist NMP].. *I would rather see the same person every time…'* P3

On a related point, the **relationship with the prescriber** was considered important**.** It is well established in the academic literature that positive therapeutic relationships benefit the drug treatment process. This was echoed by the interviewees and is well illustrated by P3, when asked what he thought was the most important part of a consultation:

'Being involved in your treatment I suppose…ask me what I am thinking, make me feeling comfortable….. I have seen other doctors before and I have felt uncomfortable talking to them. I haven't got across what is wrong with me properly and I come out of there thinking [blows through teeth]*…do you know what I mean?....because I haven't got my point across. I haven't felt comfortable talking to them'.*

Learning consultation skills forms a significant part of the Independent Prescribing course that the pharmacist undertook. The Calgary-Cambridge consultation model[3] is taught during this course and the evidence from the interviewees suggests that the pharmacist NMP was utilising this effectively.

None of the interviewees said they knew they were going to see a pharmacist instead of a doctor prior to their appointment. In all cases they said the pharmacist had introduced himself. This suggests that clients were not given the prior opportunity to decline to see a pharmacist prescriber, which is suggested as good practice. This was also identified as an issue for improvement by the nurse NMP when interviewed. However, interviewees recalled little concern over this, which may be because of the implicit trust in Turning Point that was identified (see below):

I did think 'Oh what's going on here?' but you know nothing major went through my mind….' P007.

5.2.2.3 Comparing the pharmacist prescriber with other prescribers:

Comparison with doctors

Comparisons were mostly made on a personal basis rather than contrasting professional roles, until this was specifically asked for. Most interviewees said they did not think that their pharmacist appointment was any different from that with a doctor at Turning Point.

There were mixed views when interviewees were asked to consider if there are any circumstances when they would rather see a doctor than a pharmacist or nurse prescriber. P6 identified competence as the key rather than professional status:

'It doesn't bother me at all in the slightest if it is a doctor or a pharmacist who is prescribing as long as they know what they are doing…. whoever it is has, has been chosen to do it so are obviously capable…' P6

P6 and other interviewees talked about how they felt certain that Turning Point would not have NMPs if they were not capable, demonstrating implicit trust in the service.

[3] For more information on the Calgary-Cambridge consultation model see: http://www.gp-training.net/training/communication_skills/calgary/guide.htm

In contrast to P6, P007, although happy to see the pharmacist at Turning Point, suggested there are some personal issues that he would rather see his GP about, because he felt his GP knew him better, although competence was also part of this:

'Yeah it would probably be a close network thing because I know the doctor [GP] *and I know I can talk to him. I think quite a lot of people would be the same and you don't want to discuss everything with the pharmacist until you get to know this person and realise that they are just as qualified and just as good as the doctor anyway….but you know virtually everything I go and see the* [community] *pharmacist about, but there are certain things I wouldn't'.* P007

However, when asked to consider NMPs in primary care, again most interviewees said they would be happy to see an NMP for their general health needs. Some did suggest that they would rather see a GP for what they termed 'serious or chronic' illnesses. This lack of concern about NMPs was in some ways surprising. Other studies have found patients to place more limits on what they would and would not see an NMP for. The above may be a reflection on the relatively young and healthy nature of the client group or a lack of experience of seeing doctors for anything other than drug problems. It may also reflect the greater contact with pharmacists experienced, because of daily supervised consumption, when compared to the general population.

Reflecting on their experience at Turning Point, it was also suggested that the pharmacist had more time to get more involved in their treatment compared to doctors, who were felt to be very busy. This was valued by interviewees, who felt they had had more in depth discussions and effective communications with the pharmacist NMP.

'He went into a bit more detail with everything. Whereas the doctor will, you know, ask you certain things and obviously they are busy people so they are a bit more preoccupied or whatever, so they will write your prescription out and that…..' P4

'Well it's better than the actual doctor so I thought, it's better -bit more communication with them [pharmacist NMP]*'.* P1

Another reason why interviewees were happy to see NMPs was the speed with which they had found prescription changes could be made. This was again valued and helps explain the satisfaction with non-medical prescribing.

'But when he explained what he is doing I thought it is a win-win situation to be honest. I know that it used to be only doctors that can prescribe but recently …I have forgotten her name now…but my key worker used to be the same sort of thing as [pharmacist NMP]*. I came in once to get my prescription and instead of waiting to see a doctor which could have been a week for an appointment, she could do it on the spot and she put my methadone up because she knew me a lot better, she was my key worker, so she knew me and my problems and how I was living and everything else…so she knew what…that it needed to go up…so she done it on the spot…..and that saved me from going from here and using for the next week while I am waiting to see a doctor.* P4

Comparison with nurse NMPs

Some interviewees had previously seen a nurse NMP within Turning Point or at another drugs service. When asked to compare nurses with pharmacists as NMPs, all interviewees did this on a personal basis, describing personal qualities that they had connected with. When probed to consider professional differences, the interviewees largely did not see

there to be any. One person mentioned if the person was on other medicines then the pharmacist may have more insight into the safety issues.

5.2.2.4 Feeling safe

Interviewees identified that it was important to them that they 'felt safe' when being prescribed for and that their treatment was delivered in a planned and careful way. There were no concerns about safety of pharmacist prescribers expressed. This was probed for extensively. There was an implicit trust in Turning Point, as said, and it was suggested that they would not use a pharmacist NMP if this was not 'safe'.

'Obviously they [NMPs] *are trusted by doctors* [at Turning Point]*…and stuff like that…and a nurse, you would go to see a nurse in a hospital… or if you were ill and you could not get an appointment* [with GP] *you could go and see a pharmacist to get advice'* P6

Interviewer: So would trust Turning Point that they [NMPs] could do it?

'Yeah Turning Point have been brilliant with me, absolutely fantastic, so yeah I would' P6

Some felt the Limbo clinic was limited because they did not have access to a key worker, so some described lack of key worker counselling as a limit when seeing the pharmacist NMP, but it was recognised that this is the 'system' and was not regarded as a limit to pharmacist prescribing.

5.2.2.5 Personal attributes of the pharmacist prescriber

All interviewees talked highly of the personal attributes of the pharmacist NMP post holder and how this had enabled them to 'connect' with him. There was a general liking for him on a personal level. Interviewees felt they had been given time, been listened to and been treated with polite respect. They welcomed his 'firm but fair' approach. These attributes were recognised as important in encouraging clients to return for further appointments. It was suggested that the pharmacist had 'gone out of his way' for some, examples included finding out information for follow up appointments. This made these clients feel valued and taken seriously and was highly appreciated. This highlights the importance of considering personal qualities in the recruitment of pharmacist NMPs as well as competence and professional background.

'He just seemed to understand where I was coming from and not to judge me at all and he was just a really, really nice bloke' P007

5.3 Key stakeholder opinion on pharmacist prescribing and the pharmacist NMP post at Turning Point.

5.3.1 The commissioning view

The information from commissioners largely informs this evaluation in two ways. Firstly it gave the research team insight into the background to this post and the rationale for this pilot. Secondly, it gave insight into the commissioning agenda and factors that need to be considered when making suggestions for the future. Hence, the data from commissioners is presented and used in the next section.

5.3.2 The medical view

The lead clinician was interviewed at the start and end of the evaluation period. The deputy lead clinician was interviewed once. To provide some anonymity, their data has been analysed together, quotes limited and not assigned codes.

5.3.2.1 Views on non medical prescribing

The clinicians talked positively of non medical prescribing. NMPs within Turning Point were seen as an important way to deliver cost effective services across the county, especially in rural areas. It was also recognised as important in preventing waiting lists and being able to action prescription changes quickly.

The 'hub and spoke' model in use was considered essential. That is where initial assessment and intermittent reviews are done by a doctor and referral can be made to a doctor by the NMP when needed. The role of doctors in assessing health, making complex case decisions and providing clinical leadership was considered key in providing comprehensive care. If addiction prescribing was only provided by NMPs there would be a reliance on the client's GP to provide all medical input, which may be adequate for most cases but could be problematic for others, particularly for alcohol clients and clients with co-morbidities. The planned independent prescriber status for NMPs regarding controlled drugs was seen as useful in an operational sense. For example lack of CMP currently prevents any NMP activity. However a change to IP status for controlled drug prescribing was not seen as bringing a change to the need for the 'hub and spoke' model. It was felt that clinicians need to assess clients initially.

'When it comes to assessing people's health that is actually what we [doctors] *do and even if we had…IP status for nurses and pharmacists now, I would still want a doctor to be seeing people at the front of their treatment whether that has to be the first appointment or whether that can be seen within a couple of weeks or so doesn't really matter, but they need to be seen at the front end because they need to have their general health assessed- that's what we do'*

The clinicians had seen the progression of nurse prescribing from the early days and had extensive experience of working with nurses. They appeared comfortable with their understanding of the role of nurses and in some ways compared pharmacists against this when considering their strengths and limits. Pharmacist prescribers were new to them. They identified the key strength that the pharmacist brought to the team as advice on the

identification and management of drug interactions. It was suggested that such advice could be extended to support GPs working within shared care. The clinicians were clearly more familiar with the skills of nurses. A perceived limit to pharmacist's skills, which was perceived less of a limit to nurse NMPs, was the lack of 'hands on' clinical examination skills. The pharmacist NMP course contains basic clinical examination skills (e.g. cranial nerve examination, blood pressure monitoring, pulse taking, chest sounds and abdominal examination). However these will be new skills to the majority of pharmacists as they have only recently been introduced to undergraduate curriculum. In addition, the opportunity to utilise these skills once learned could be minimal and therefore they may easily be lost, especially by pharmacists working in community pharmacy. Interestingly the pharmacist NMP identified the learning of these skills as one of the most important parts of his training, which he had utilised in practice since qualification.

It was felt by the clinicians that pharmacist NMPs were not appropriate to work with alcohol patients, where some 'hands on' clinical assessment and examination by a doctor is needed. This was perceived as applying to some extent to nurse NMPs, although their clinical examination skills were recognised.

'Umm the only limitation is they don't do alcohol work and clearly you know they aren't replacing doctors and I need to keep reminding everybody that they are not this sort of cut-down cheap doctor but that does mean that they don't do alcohol work'

When this was discussed with the external expert it was felt that this could be overcome through training and experience to fit with the 'hub and spoke' model (e.g. not to replace doctor involvement but to compliment it). Certainly there are examples in other clinical areas of pharmacist NMPs developing and using 'hands on' clinical skills, such as those employed full time as prescribers in GP surgeries. However, this would be a matter for the Turning Point clinicians to consider and weigh up against the benefit of nurse NMPs who already have the skills in place.

It was also highlighted that the nurse NMPs are key workers, working with a caseload and having a prescribing component as part of their role. In terms of investment in development on NMPs and support, it was considered more prudent for Turning Point to focus on these full time members of staff rather than sessional workers such as pharmacist NMPs. The need for a full time pharmacist within Turning Point was not identified. However as more pharmacist NMPs become trained there will potentially be a greater number of experienced ones available for sessional work.

'If it weren't for him would I generally want to be having more and more pharmacy prescribers or pharmacy NMPs in err in the service? No [pause] *not because there is anything the matter with them at all my experience of XX2 has been nothing but positive, I don't regard him as being any better or any worse err in anyway less or more useful than the nurse prescribers that we have, it's just that the nurse prescribers that we are employing full time umm they are part of our team all the time'*

The clinicians talked of how people who work in addictions need to have empathy and understanding and naturally care about people. Pharmacists were recognised as not traditionally having some of the skills that are needed for effective drugs work such as motivational interviewing skills. However this is now introduced at undergraduate level. Good interpersonal skills were considered vital. They thought for many pharmacists, working in addictions would be a new dimension of learning, as the key aspect is understanding the complexities of drug dependence and the role it plays in people's lives,

as opposed to complex therapeutics. However, it is argued that community pharmacists who provide services to large numbers of drug users over considerable periods of time also develop an understanding of the complexities of drug dependence, perhaps to an extent greater than the clinicians recognised.

The development of consultation skills was considered an important learning point for pharmacists, a quality which nurse NMPs were said to have. The pharmacist NMP had also recognised this. This will however in part depend on the background of the pharmacist concerned, as some pharmacy roles require developed consultation skills, such as the provision of cardiovascular disease clinics by practice pharmacists. Other traditional roles such as counter prescribing utilise basic consultation skills, which can be built upon. The key issue appears to be that many nurses who work in addictions have been doing so for some time and therefore on completion of the NMP course may be seen by the clinician as a more 'off the shelf' option as opposed to a pharmacist that may require more mentoring to develop clinical examination and consultation skills. However, the nurses who took part in the focus group identified that they do not have as extensive clinical pharmacology training as pharmacists and therefore saw this as a key area within nurse NMP training that has to be developed. This highlights the 'different beast' that is the pharmacist NMP from the nurse NMP.

5.3.2.2 Governance of NMPs

Governance was an important issue to the clinicians with respect to NMP. There was a lack of awareness that pharmacists are legally required to undertake Continuous Professional Development (CPD) which is assessed in order to retain professional registration. This is moving to a system of revalidation in the near future. CPD was seen as vital and part of the responsibility that goes with the added professional status of being an NMP. In return it was felt that NMPs should be remunerated for the increased responsibility that they take on. Adequate supervision and peer support for prescribers was recognised as important. It was felt that this need will increase when IP status for controlled drugs is passed and a suggested structure was given:

'I mean I'm very clear in my mind about what governance is going to be needed around our nursing NMPs umm ..... I don't suppose [pharmacist NMP] would be any different really umm we'd be wanting him to attend a certain amount of continuous training which we would presumably pay for umm we'd want him to be part of the peer supervision group as well as having one to one supervision from myself or a colleague periodically as well so [pause] and then having a little sort of mini cut down appraisal as well each year'

The issue of expansion of the NMP model into shared care was discussed extensively under governance, as was the future of NMPs within addiction. This is considered in section 6.0 where the 'next steps' are considered.

5.3.3 The staff team view

The staff team were without exception positive about having a pharmacist prescriber within their team. They gave several reasons for this, some which can be described as 'generic' and some which are 'role specific':

5.3.3.2.1 Generic benefits

The team recognised that an additional prescriber had reduced waiting times by increasing capacity in the Limbo clinic and reducing the pressure from other prescribers taking leave or being off sick. This was felt to be of benefit to clients who could be seen quicker, of benefit to nurse NMPs by reducing pressure on them and of benefit to doctors by freeing up their time to focus on more complex cases.

5.3.3.2.2 Role specific benefits

Most staff had extensive experience of contact with pharmacists, both in their current role liaising with pharmacists who dispense for their clients and in past roles. For example staff from nursing backgrounds had worked on hospital wards with pharmacists. This gave them confidence in the ability of pharmacists to prescribe about which no concerns were expressed. It also gave them an understanding of the knowledge and expertise of pharmacists. The staff team identified where pharmacists could contribute in a unique capacity to the team, which includes people from a range of nursing and non healthcare backgrounds. They had utilised the pharmacist prescriber to provide such expertise:

'[Pharmacist NMP] *is a specialist working with us you know. And amongst the prescribing team however I suppose he brings different angles in a multi-disciplinary if you like background - he can bring a lot of pharmacology'* FG1

'[Pharmacist NMP] *will know much more detail about that and he's got a bit more time to look into it …. you know certain aspects of pharmacology so I do think he definitely brings that I mean I had a couple of questions that I've emailed him about -methadone specifically and normally I'm like 'email* [Dr]' *but now I think 'no I'll lean on* [Pharmacist NMP]' *cause I know that he'll be interested in looking that up he'll have the time to do it and he'll have that kind of detail'*. FG2

'I think he has got something fairly unique over and above our nurse prescribers - as they have as well. I think it would be a loss if we lost him……cause we find him a huge valuable resource' FG3

Difficulties with the pharmacist NMP post

In terms of difficulties with the post, the staff team identified one issue which was explaining the role to clients. Contrary to nurse prescribers, which the team felt clients readily accepted, they found more time was needed to explain the pharmacist prescriber role and distinguish it from a dispensing role. This may explain why the clients who were interviewed had not recognised that they were seeing a pharmacist prescriber before their first appointment. The team reported that once this was done they had had no client difficulties with the post.

Expansion of pharmacist prescribing within addiction

The staff team were positive about pharmacist prescribing expanding, although they doubted whether the benefits could be expanded to shared care. This was mainly because they felt surgeries not currently in shared care had resource difficulties, which a pharmacist or other NMP would not resolve. The staff team were more positive about the idea of community pharmacy based prescribing. They felt community pharmacists were well placed to prescribe for stable clients, although they identified locum staffed pharmacies may be a barrier. The team also recognised that the community pharmacist's

role could expand to include BBV testing and HBV vaccinations, as demonstrated in recent pilot studies. It was suggested that pharmacist prescribers would benefit from safer injecting training.

Personal qualities of the pharmacist NMP

The staff team recognised and emphasised the importance of the personal qualities of the pharmacist, who held the post, in making this post successful. They felt without enthusiasm, empathy, good communication skills and the ability to relate to clients the benefits to both the clients and the team from this post would have been lessened.

5.3.4 The nurse NMP view

The nurse NMP described the importance of teamwork within the non medical prescribing framework. The nurse also recognised the contribution of specialist advice on drug interactions that the pharmacist NMP post could bring to this team.

The nurse gave several suggestions regarding the development of NMP within the service and shared care, which are included in section 6.0.

5.3.5 The external expert

The external expert was mainly used to explore and inform the future potential of the pharmacist NMP role, which is discussed in section 6.0. Key points specific to the introduction of pharmacist NMPs in addiction were raised:

The expertise and 'added value' of pharmacist NMPs will be largely unknown to doctors, who are much more familiar with working with nurses. Pharmacists may be perceived as 'shop keepers' and therefore pharmacists need to do some 'selling' of their skills in order to promote understanding of what they can contribute. The contribution that pharmacists can make to managing complex cases such as co-prescribing to individuals on multiple medicines and giving advice on drug interactions, prescribing in pregnancy and lactation, prescribing in renal failure and managing prescribing budgets needs to be demonstrated.

There is a belief that pharmacist NMPs will be less 'hands on' than nurses, because nurses are trained at undergraduate level in skills, for example, such as measuring blood pressure[4]. However, pharmacists have demonstrated that they can gain such necessary skills at post graduate level. An example given was of a pharmacist NMP undertaking the RCGP training in alcohol problems in order to be able to manage alcohol patients. With appropriate training, skills development and referral for concerns, this pharmacist has begun prescribing community alcohol detoxes as part of a multidisciplinary team.

On the topic of shared care, the external expert believed that 'dual role' pharmacists could contribute significantly to the work of GP practices. This role was seen to be of particular benefit to those that have a *high drug user case load* as opposed to ones where there is a need but GPs are reluctant to get involved. It was suggested that this 'dual role' pharmacist could act:

(i) as an NMP within drug treatment, managing the prescribing for patients on multiple medicines, and

[4] This is now also taught at pharmacist undergraduate level.

(ii) as a regular practice pharmacist, conducting medication reviews and developing initiatives for cost savings on the overall surgery prescribing budget and meeting targets.

The dual role pharmacist could either be employed by the PCT or practice, as is the model with primary care medicines management pharmacists. The value of this dual role would become evident in the same way that the value of practice pharmacists has come to be realised by busy GP surgeries. A further potential role could be co-ordinating community pharmacy aspects of shared care and needle exchange, for example local audits and offering peer support to community pharmacists with respect to addiction client care.

5.3.6 The NMP post holder view

The NMP post holder was interviewed twice for this evaluation, three months and six months into his post. The first interview was largely to establish background, gather his views on the training he had undertaken and to reflect on his development to date. This was felt to be useful information for any future expansion of pharmacist NMPs.

The post holder had developed an interest in working with people with drug problems through his experience as a community pharmacist. He described being interested in people and enjoying getting to know them, which had led to a good rapport with his drug user patients. This he felt had provided a good background for the post.

The post holder described how he had found the university course intense, very time occupying but rewarding. He described a change of mind set being part of his development, with more advanced and thorough consultation skills being an important part of his learning. This had influenced his pharmacy practice as well as his prescribing role. He recognised a shift from the traditional ‘drug focus’ of a pharmacist to a ‘person focus’ of a prescriber. He had a good rapport with his practice based mentor and felt supported. He described an attitude that was willing to learn from the whole team, which probably contributes towards the acceptance and support for the pharmacist NMP demonstrated by the team in the focus group. The pharmacist recognised that community pharmacists are used to working in isolation and had therefore found team work a personal learning point.

In terms of suggested changes for future training of pharmacist NMPs, he suggested motivational interviewing could be a generic skill taught within the University component of the course. He also recognised the difficulty for NMPs based in substance misuse to get experience of the range of ‘hands on’ diagnostic skills. This could be planned in advance for any future trainee, with perhaps a GP surgery based component to the training.

At the second interview the post holder had clearly developed more confidence in his role, which he identified. This was also identified by his mentor in his second interview. The pharmacist’s contact with his mentor had reduced, evidence of his growing independence and confidence. As his confidence had grown he had found himself bringing more pharmaceutical care into his consultations. He described cases where he had, for example, checked inhaler technique, recommended over the counter medication and given advice on prescribed medicines for other conditions.

The pharmacist NMP had now developed a greater understanding of substance misuse treatment in Somerset and a considerable amount of time was spent in the interview

discussing the potential for his role to develop and also for the role of community pharmacists to develop. This is covered in section 6.0.

5.4 Reflection on the aim and objectives of this evaluation: have the key performance indicators and the core purpose of the post been fulfilled?

One of the most important factors that must be considered in this evaluation is that this was a training post, which took a pharmacist from a generalist community pharmacy background and developed this person into a non medical prescriber in addictions. Hence the evaluation was looking at someone new to the area in a role new to the specialist service, as opposed to someone who has been qualified as a pharmacist NMP specialising in addiction for some time. This is not meant to be seen as detrimental to the pharmacist but to set in context what is being assessed.

5.4.1 Key performance indicators

The key performance indicators will be summarised against the findings described above:

- **Numbers of clients seen**

One hundred and four appointments were attended by 88 different clients, with a non attendance rate of 33%. Of the attended appointments, 82 (79%) were with male clients and 22 (21%) with female (2 not recorded). The mean age of clients who attended was 32, with a range of 19 to 60 years.

One hundred and eight prescriptions were issued in 97% (n=101) of attended appointments, all for items indicated in the management of addiction. Although it was not a requirement of this evaluation to review the appropriateness of the prescribing, it is noted from the commentary made by the pharmacist NMP on the data collection form that this all appears to be within the national guidelines. The pharmacist also noted responding to symptoms in a similar way as would be done ‘over-the-counter’ giving assistance with minor ailments and giving advice on drug interactions. This was noted and valued by some clients in their feedback.

The pharmacist documented contact with community pharmacists with respect to 34 attended appointments (34%). As no comparison data was collected it is not known how this compares with doctors or nurse NMPs.

The pharmacist sought advice from a doctor in 38% of cases, however no data is available to compare this to nurse NMPs within the first six months of their prescribing post. The frequency of contact reduced over time. Additionally, from the notes made by the pharmacist NMP in the majority of cases these referrals were deemed necessary in line with legal and clinical requirements e.g. to have CMP signed or a dose outside the CMP given.

- **Client Feedback**

The majority of client feedback given via the questionnaire (n=29) on their experience of being seen by a pharmacist NMP was positive. The level of care received was rated as

'average' by two people (7%), 'good' by 11 (38%) and 'excellent' by 16 (55%). No one rated the level of care as 'poor' or 'below average'. Information received was rated as 'average' by three people (10%), 'good' by 10 (35%) and 'excellent' by 16 (55%). No one rated the information received as 'poor' or 'below average'. When asked to rate the level of knowledge the pharmacist prescriber has about addiction treatment, two (7%) considered this to be 'average', eight (28%) considered it to be 'good' and 17 (59%) said 'excellent'. In terms of involvement that the client felt they had in their care, one person (3%) felt 'involved a little bit'. Six (21%) felt 'quite involved' and 22 (76%) felt 'very much involved'. When asked if they would accept the option of seeing a pharmacist prescriber in the future one person (3%) said 'No' and the remaining 28 (97%) said 'Yes'.

Those who took part in interviews (n=6) identified that pharmacist NMPs could reduce waiting lists and improve access to treatment. They had no concerns about seeing a pharmacist or nurse NMP, describing trust in Turning Point to put appropriately trained and competent people into such posts. Some cited examples of healthcare issues where they would rather see a GP than a NMP but all were happy with their addiction treatment to come via NMPs. Some described the benefit of a pharmacist as understanding other medication that they may be taking and managing interactions. Seeing the same prescriber each time was considered important and it was felt that NMPs were more likely to provide this. In terms of their own experience with the pharmacist NMP, they talked extensively of their positive therapeutic relationship. This included personal qualities of the pharmacist NMP that were liked, feeling that their opinion was valued and feeling involved in their treatment decisions.

- **Key worker feedback**

The key workers all talked positively of the pharmacist and identified personal qualities that had enabled effective team working and relationships. In terms of their opinion of pharmacist NMPs they clearly identified a benefit to the team of having pharmacological expertise on which they could draw. This was cited by workers from both healthcare and non healthcare backgrounds. It was felt that removal of the pharmacist NMP post would leave a gap in terms of access to pharmacological information, which would be detrimental.

- **Lead and deputy lead clinician feedback**

The lead and deputy lead clinicians were positive about the pharmacist NMP post. They also identified the abilities of the pharmacist to advise on drug interactions and safe use of medicines. They recognised that pharmacists are less 'hands on' in terms of clinical examination skills and therefore this has to be developed in the pharmacist NMP when training. This was felt to be a negative aspect compared to nurse NMPs who are trained in examination skills prior to training to become NMPs. Another issue was around the investment of Turning Point time and money in training NMPs. As nurses are permanent members of staff it was felt that investment is more likely to be made in their training as NMPs. There was some feeling that pharmacist and nurse NMPs should not prescribe for alcohol patients as this client group require medical assessment. There was some suggestion that these assessment skills could be learned, but opinion tended towards this remaining a medical function.

- **Cost effectiveness**

Cost effectiveness is defined as the cost of a health gain divided by some measure of the gain in health. Commonly, cost utility analysis is calculated. This is the ratio between the cost of a health-related intervention and the benefit it produces.

The pharmacist NMP appointments were 30 minutes, which is the same as for the doctors and nurse NMP, hence the pharmacist can carry the same client load. If it is assumed that DNA rates are the same and that the benefit to the client of being seen by a doctor, a pharmacist NMP or a nurse NMP is the same – in terms of the provision of a safe and effective prescription to manage their substance misuse, then the cost utility of the pharmacist NMP is better compared to a doctor but may be less cost effective than a nurse NMP. This is because typically NHS nurse prescribers appear to be on at least *'Agenda for Change'* band 6 (£25,472 - £34,189) but more commonly band 7 (£30,460 - £40,157). NHS Pharmacist NMPs tend to be on band 7 or 8a (£38,851 - £46,621) or above, depending on their other management and clinical responsibilities.

However the above is an over simplification and it would be false to make the assumptions stated for the following reasons. The clients identified that DNA rates may be influenced by interpersonal relationships with the prescriber, which cannot be readily measured and appear to be independent of professional status. The data also suggests that making direct comparisons of costs of the different post holders is inaccurate because a nurse NMP, pharmacist NMP and doctor cannot be directly compared. This evaluation has identified that the skills and contribution to the team from each post is different. It is therefore an over simplification to say all prescribers do the same thing or achieve the same benefits. They may ultimately achieve the same outcome of safe and effective prescribing but the route to doing so may depend on the complexity of the case to begin with, their unique professional contribution e.g. preventing drug interactions and the extent to which they utilise each other and other members of the multidisciplinary team to achieve the outcome.

The National Prescribing Centre suggest that investing in NMP is an example of invest to save[3]. NMP costs include employment, training, mentoring and supervision costs as well as clinical governance, practical and CPD support. It is suggested that NMP can represent value for money if these costs are compared against the employment costs of using and supporting medical prescribers of equivalent experience, costs in health service inefficiencies from duplication, time or medicines wasted, and lost organisational savings or income from payment by results. This however assumed that NMPs are trained up within organisations. However as the numbers increase there will be more opportunity to recruit trained, qualified and experienced NMPs.

- **Future costs**

Future costs of the post would depend on how the post was configured and the grade of pharmacist employed. Employment on a sessional basis to provide clinics is likely to be the cheapest but not necessarily provide the greatest return in terms of additional work that could be done to improve cost efficiency of community pharmacy and GP substance misuse services. Pharmacist NMP sessional employment rates would typically be higher than locum pharmacist rates, which are circa £25 per hour daytime weekdays. Further consideration of future costs are given in section 6.

5.4.2 Core purpose of the post

The question of whether the core purpose of the post has been fulfilled will now be considered.

1. *To improve patient care without compromising their safety*

The pharmacist NMP post facilitated quicker throughput in the specialist service by reducing waiting times through the provision of the Limbo clinic. This may be defined as an improvement in patient care. There was no evidence to suggest that patient care was lacking in any way prior to the introduction of the pharmacist NMP, but there was sufficient evidence from several sources to suggest that the pharmacist's contribution of knowledge on pharmacology, drug interactions and over the counter medications has benefited both the team and clients. There were no safety incidents raised by the clinical lead or pharmacist NMP to the researchers and nothing identified to suggest that the pharmacist NMP post compromised safety in any way.

2. *To improve patient access to the medications they need*

The reduced waiting list and the ability of the pharmacist to respond to prescription issues in the absence of a doctor has improved patient access to the medication they need.

3. *To increase patients choice in accessing medications*

All clients were happy to be seen by a pharmacist NMP and 97% said they would wish to see a pharmacist NMP again. In theory this provides patients with a greater choice of who prescribes for them. However, the nurse NMP suggested more could be done to provide patients with choice as it was felt that availability of the prescribers and the needs of the service often dictated who saw which client. Professional guidance requires clients have the freedom to refuse to see a NMP instead of a doctor. The client interviews however suggested that clients were happy with the system in place and as long as they received their appropriate care and prescribing had no particular wish to be seen by a medical prescriber as opposed to a non medical prescriber. As the pharmacist NMP post was based within the specialist service for the whole duration, there was no facilitation of greater choice of where to access medications. However suggestions regarding this in the future are made in section 6.0.

4. *To better utilise health professional skills*

The pharmacist post holder felt his skills were being utilised well within the post. He described it as challenging and a learning curve. Whether his skills are being better used than they would be in community pharmacy environment is difficult to compare, as the skill set for prescribing does vary to some extent. In particular the consultation skills need to be deeper and more extensive.

The pharmacist NMP post allows doctors time to see more complex cases, something that was recognised by several sources including clients, doctors and the team. Hence it may

be argued that the post allows better utilisation of doctor's skills by reserving their clinic time for new and more complex cases.

5. To contribute to the introduction of more flexible team working across the NHS

Turning Point already had nurse NMP posts in place before the pharmacist NMP post was introduced. Flexible working appeared from the staff team data, nurse NMP data and clinician input to already be part of the fabric of the service. The pharmacist NMP post has added to flexible working in that it has broadened the NMP contribution to Turning Point services. However, because the post did not move out of the specialist service there is no opportunity to consider flexible working across the NHS. There are however examples of other pharmacist NMP posts within the South West that have developed very flexible working patterns within the NHS. For example Rachel Hall, who is cited in the government white paper on pharmacy published in 2008[7], progressed from being a PCT practice pharmacist to clinical manager within the Old School GP Surgery in Bristol. A secondary care example is that of Vicki Clarke who progressed from ward pharmacist specialising in oncology to oncology clinic prescriber, managing a case load alongside the consultants at the RUH in Bath[8]. Flexible working is one of the outcomes of NMP described by the National Prescribing Centre[3].

6. Cost efficiency

Cost efficiency is defined as the cost of a service divided by the number of recipients. This does not consider outcomes. If the service is taken to be delivery of a service based on the model of the Limbo clinic then, taking the salary information in 5.4.1 (p33) shows that nurse NMPs could be more cost efficient than pharmacist NMPs who in turn are more cost efficient than doctors. A network of limbo clinics could in theory be overseen by one doctor and provided by a team of nurse NMPs at greater cost efficiency than a doctor led service. However, as the information in 5.4.1 shows, to consider cost efficiency in isolation is misguided. The 'added value' to the team of the pharmacist NMP post was specialist pharmacological input, advice on preventing drug interactions and over the counter medicines. Each of these may avoid costs to the NHS e.g. cost of managing a drug interaction or cost to primary care of treating a self limiting illness that can be treated OTC. This raises the difficult to measure issue of how much this contribution is worth, which would require a more extensive health economic study.

When considering the cost difference between nurse NMPs and pharmacist NMPs the configuration of the posts also needs to be considered. If the 'cost of a service' is taken to be 'cost of providing a prescribing clinic' then as said the pharmacist NMP is more cost efficient than a doctor and the nurse NMP is more cost efficient than the pharmacist at face value. However if the 'cost of a service' is taken to be the cost efficiency of drug treatment in Somerset then there are wider issues for future consideration:

Nurse NMPs within Turning Point appear to have three roles – key worker, NMP and manager. The pharmacist NMP post was based on a locum model with the provision of sessional prescribing work. The difference in cost therefore has to be reconciled with the difference in contribution to patient care and other aspects of service delivery that the pharmacist could make if the post were full time equivalent. The pharmacist NMP can take referrals from both nurse NMPs and doctors. The contribution of the pharmacist to managing poly-pharmacy cases and drug interactions, both within the specialist service

and for shared care GPs, has to be considered in terms of improved clinical outcome and client safety. Also, the potential for the pharmacist to contribute to liaison with community pharmacists, review the appropriateness of supervised consumption and audit community pharmacy to improve overall cost efficiency of drug treatment in Somerset (discussed in section 6) has to be considered. That is, alongside the fact that investment in qualification training has already been made for the individual current post holder.

6.0 The future of the pharmacist NMP post

It is clear from the evaluation data that the post has been well received within Turning Point. It has proved successful in terms of fulfilling its core purpose and meeting the key performance indicators, echoing the findings of research studies cited by the National Prescribing Centre[3]. However, when considering the future of the post, the current political and financial climate for drug treatment has to be considered, as well as the outcomes demonstrated to date.

This section will bring together the opinions gathered on the future of the post and also add some additional thoughts from the research team.

6.1 The current commissioning context

The interviews with the commissioners and shared care co-ordinator identified a belief that pharmacists are an under utilised resource in Somerset. There was clear political will to develop the contribution of pharmacists within primary care. It was felt that providing more varied and challenging roles for community pharmacists may help with the recruitment problem that community pharmacy has within the south west. It was also recognised that community pharmacists are usually single handed practitioners and therefore the provision of peer support to facilitate their involvement in more varied and challenging roles was important, especially from a governance point of view.

It was also clear that improved quality and efficiency of services will no longer be enough to facilitate commissioning. Although these issues will remain key, new services will have to save money somewhere within the overall drug treatment system to be considered.

6.2 The development of the pharmacist NMP post within primary care

6.2.1 Providing shared care for clients registered with GP practices not in the scheme or busy practices

An early anticipated role for this post was to utilise a pharmacist NMP to provide prescribing services to clients who are not registered at a GP practice within the shared care scheme. Some GP practices are not involved because they do not wish to provide services to drug users but others do not have the capacity or space to do so, for example some may be single handed practices in small buildings.

Although the pharmacist NMP post has been shown to be able to deliver prescribing care to people in drug treatment within the specialist service, consideration needs to be given as to an appropriate model that could be used in primary care.

An essential component of NMP identified both in this study and from discussions with practitioners in other localities is the provision of adequate support and governance structures. This takes both professional and legal forms.

At present support is legally required from a doctor in the shared responsibility of prescribing within an agreed CMP. This raises an issue for shared care. If a GP is unwilling or unable to provide shared care themselves, it is unlikely from a governance point of view that they should be the named independent prescriber on a CMP. The model that could be utilised instead would be one where the independent prescriber is either a GPwSI or the clinical lead at the specialist service. Both would require access to shared case notes by both the IP and pharmacist NMP. However, the legislation to allow independent prescribing of controlled drugs is likely to be passed soon, removing the legal requirement for CMPs.

However support is also professionally required in that the framework for both supplementary and independent prescribing requires that the NMP has access to support from a medical doctor. The patient also has to be reassured that advice from a doctor can be sought. This does not mean they all have to physically be in the same building but that a system of referral for advice and support has to be in place. This requirement was also echoed by both the pharmacist and nurse NMPs when interviewed. Consultation with NMPs in other areas also identified the dangers of professional isolation. In areas where pharmacist NMPs are working in shared care, they have done so successfully with access to support and supervision to ensure a robust governance process.

This would suggest that input from a GPwSI or the clinical lead would be essential and that the best model for a shared care pharmacist NMP would be as an outreach service attached to the core team but working in locations around the county where needed. Clients could be seen in GP practices, community pharmacies that have enough space to provide a private room or other locations that may traditionally be used for outreach drugs work such as community halls and youth centres. In terms of case notes, wireless network access to the Turning Point system would be essential and the client's case notes kept up to date on that system, with copies of clinic notes sent to GPs for information. This essentially reflects the current Turning Point model but basing the NMP in outreach locations. The benefit is stable clients could be seen in locations that are more convenient to them and mean they do not have to occupy a clinic slot in the specialist service.

In terms of key work, clients would either be so stable that they would not require significant key work input or they would access the new Turning Point Models of Psychosocial Interventions (MoPSI) system either remotely (e.g. computer based CBT) or intermittently by attending the TP office or through outreach key working.

In terms of cost, this would depend on whether the pharmacist was employed on a sessional basis or in a full time equivalent post. As well as staff costs there would be travel costs and room rental for consultations. Costs would be saved in that the payment made to GPs for shared care would not be made.

A further suggestion welcomed by the clients is that of community pharmacists prescribing for shared care clients. The points made about adequate support and governance apply equally here. They would also benefit from PwSI support as well as a medical mentor. One potential model would be for very stable shared care clients to receive their care along a similar model to 'repeat dispensing'. The community pharmacist would prescribe regularly and the GP undertake intermittent reviews (90 days). This would require significant

investment in training as there are unlikely to be many community pharmacists qualified to prescribe. They would also ideally need access to shared records and the logistics of how this would be arranged would require investigation. For the Turning Point system this would potentially be easy to arrange but for GP records this would be considerably more challenging. It is questionable as to whether this model would be cost efficient, given the rural nature of Somerset and the widespread gaps in shared care. It is unlikely that any one community pharmacist would have ample number of clients to justify the costs. Although such a model has been utilised in another part of the south west, this has been in an urban area where the pharmacists were able to take on a case load from the specialist service.

An additional suggestion made was that busy GP practices with a high shared care load may be willing to employ pharmacist NMPs to manage some or all of their case load. Financially this may be worthwhile for the practice. In such cases a GP who had completed the RCGP part 1 certificate would provide the clinical support discussed above.

All these models may detract from the potential holistic benefit of shared care where the GP has oversight of all the health needs of the individual. However, specialism within General Practice is increasingly happening so passing the shared care prescribing case load to a pharmacist NMP fits with this increasing specialism.

The question as to why pharmacist NMPs would be advocated over nurses in shared care has to be addressed. The main reason is that one part of the shared care team is the community pharmacist. A pharmacist NMP it is felt would be best placed to liaise with community pharmacists to improve the contribution of the community pharmacist into the shared care process (see below). The additional benefit is advice on drug interactions and managing co-prescribing for other conditions that could be given to GPs.

6.3 Providing support to the DAAT to reduce costs of drug treatment in Somerset

It was widely suggested that the pharmacist NMP post could develop into PwSI type post. There are many examples of this type of post around the UK (e.g. V Hayward, Oxfordshire, C Hunter, Glasgow Addictions Service, G Parsons, Plymouth PCT, T Schofield, South Tyneside) and in many cases the origins of such posts comes from grass roots development of individuals with an interest in addictions. Broadly it was envisaged that this post would be split between a prescribing role and a DAAT support role. The prescribing role could potentially take the form already in place or one of those described in 6.2. There were a variety of roles that this PwSI could fulfil in terms of DAAT support, which will now be considered.

6.3.1 Troubleshooting, audit and commissioning support

There were two components to this role suggested. One was a support role for the practice reviews that are undertaken in shared care GP surgeries. The pharmacist post could support practices in improving their success in meeting audit standards. This has been successfully demonstrated in other therapeutic areas such as cardiovascular health (e.g. A Docherty, GP practice prescribing pharmacist in Weston-super-Mare).

The second was expanding practice review to community pharmacy. It was identified that there are currently no audit standards for community pharmacy with respect to their shared

care role. This raises concern as it means pharmacists will be paid equally for providing shared care services regardless of the level of input they make for the client, the level of feedback they give to the prescriber or the extent to which they are asked to make a contribution to care decisions. The 'pay per swallow' model, although restrictive because it focuses only on administration of medicines, could be expanded to include audit standards and improved liaison with prescribers. The PwSI could therefore have a fixed term role in developing these audit standards and an ongoing role in auditing and providing support to failing and thriving pharmacies. Models of best pharmacy practice could be developed and rolled out across the county. There is evidence of pharmacists undertaking similar roles elsewhere (e.g. Oxfordshire, Northumberland).

This shared care support role would feed into decisions about commissioning and decommissioning of pharmacies and GP surgeries, in order to maximise the cost return for investment in terms of improving the service given to clients. Surgeries and pharmacies not meeting standards could potentially be replaced with others that could, although such decisions would only be after a package of support from the PwSI had failed to achieve improvements.

6.3.2 'Pulling clients through the system'

There is considerable focus on the 'recovery' agenda at the moment and hence consideration was given as to the PwSI role within this. Costs can be saved in two aspects: firstly getting people off supervised consumption as a step towards moving on in the treatment system and secondly, supporting stable shared care clients to detoxify from substitute medication.

6.3.2.1 Getting people off supervised consumption –enhancing community pharmacist involvement

At present there are no standardised criteria to assess when a client is ready to stop supervised consumption. The decision is largely made by the prescriber considering factors such as urine screen evidence of no or controlled illicit drug use, length of time in treatment and employment and family circumstances. It is good practice to involve the community pharmacist in the decision to stop supervised consumption as they can provide information on compliance in terms of daily attendance and often will have an insight into the client that is different to that of the key worker or prescriber.

However, there is anecdotal evidence that some prescribers and key workers may be more hesitant than others to stop supervised consumption. Although the UK clinical guidelines advocate supervision for periods of at least three months and during times of instability[6], some clients even within shared care remain on supervision for long periods of time. There may not always be a clinical need for this.

It is suggested that the PwSI could develop local standards to support the decision to end supervised consumption then liaise with community pharmacists, prescribers and key workers to identify clients suitable for cessation of supervision. If this was done on a regular basis potentially clients may be pulled towards take home dosing more quickly.

6.3.2.2 Providing a specialist primary care mobile detox service for shared care clients

This suggestion comes from a nurse model in Bournemouth where a designated practitioner supports GP surgeries to provide focused detoxification plans for clients in shared care. This service developed after it was identified that some clients in shared care would be willing to detox when they were given encouragement to do so and felt adequately supported. GPs also felt more comfortable with detox if it was done in conjunction with specialist support. The PwSI could again liaise with key workers, clients, shared care GPs and community pharmacists to systematically identify clients who may be suitable for supported community detox and then provide the enhanced detox service, possibly in conjunction with the key worker and GP. A package of aftercare would follow, in conjunction with Turning Point. This role could be undertaken by a nurse or pharmacist NMP.

6.4 Providing specialist pharmaceutical support to medical and non medical prescribers within Turning Point and shared care

The PwSI would be expected to have enhanced pharmaceutical knowledge and skills compared to other NMPs and shared care GPs. This could be used to provide support in relevant pharmaceutical decision making, for example developing pharmaceutical care plans for patients with coexisting health issues that require complex medication regimens e.g. schizophrenia, HIV, epilepsy. This could be provided to both the specialist service and shared care GPs.

6.5 Developing the contribution of community pharmacy to drug treatment

Two areas where pilot work is showing emerging evidence of cost: benefit contribution of community pharmacists are (i) the provision of dry blood spot testing and vaccination for blood borne viruses and (ii) the provision of naloxone to prevent overdose. It is suggested that the PwSI would have a niche role in liaising with community pharmacists to develop their skills and to spearhead the development of these services.

At present BBV screening is done in primary care and by specialist nurses within the specialist service. Pharmacies that provide needle exchange may be able to reach newer and younger users, the key group that need to be targeted for effective BBV control. It is suggested that the first stage in exploring this option would be pilot work to establish the cost efficiency of configuring services from community pharmacies and compare this against current service provision. There are published accounts of similar pilot studies e.g. on the Isle of White and in Sandwell[9,10]. The audit tools and PDGs for the Isle of White service can be found online:
http://www.hampshirelpc.org.uk/index.asp?type=newsletter&id=74&m=300

At present there are naloxone trials going on across the UK, showing positive results in preventing drug related deaths. There is currently no pilot in Somerset. If this was to be done, the inclusion of community pharmacists in naloxone provision could widen the supply net as they may have contact with needle exchange clients not in contact with specialist services. Again the PwSI could lead on the development of the pharmacy in this area.

7.0 Conclusion

This evaluation examined the post of the first pharmacist NMP in addictions in Somerset. The data gathered has shown that the post fulfilled its specified purpose and that the relevant key performance indicators were met.

Experience of seeing the pharmacist NMP was rated highly by the majority of clients with no concerns raised by clients over safety. Most would happily be seen by a pharmacist NMP in the future. The interpersonal skills of the pharmacist were valued highly and in many ways more important to the clients than whether their prescriber was a doctor or not, as implicit trust in the specialist service was identified.

The pharmacist NMP post was shown to have added value to the staff team by providing a specialist source of pharmaceutical knowledge which could be utilised by key workers and clinicians to inform patient care decisions.

Waiting times for treatment were reduced because of the configuration of the Limbo clinic, where prescribing was undertaken by the pharmacist NMP and a nurse NMP. This freed up doctor time to see additional and potentially more complex clients.

Limits to pharmacist NMPs identified by the doctors were their less 'hands on' experience in clinical examination skills. This meant the post did not include prescribing for alcohol patients where it was felt that doctor input is necessary. Although nurse NMPs were deemed to have more hands on clinical examination skills there was still some hesitation as to whether these skills were extensive enough for alcohol patient prescribing.

In terms of costs, pharmacist NMPs are cheaper than doctors but more expensive than nurse NMPs. However there needs to be caution in making direct comparisons as the three posts are not equal in terms of their input to client care. A full health economic comparison was beyond the scope of this evaluation as it would require a much more extensive study. Instead the pharmacist NMP post must be seen as a unique entity within the addictions team and how it can be best utilised comes down to comparing the various suggested options for future development given in section 6.0 with the various costs and benefits attached. Detailed economic costing of this is outside of the remit of this evaluation and needs to be considered more fully by commissioners.

8.0 References

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Appendix 1: Pharmacist real time activity data collection tool

Pharmacist NMP Data collection form

To be completed by NMP after each session for each client scheduled to attend.

Session date: _____

Client ref code	Gender	Age	Attended	Summary of appointment key issue(s) & recommendation(s)	Prescription* (drug(s), dose(s); new/continued)	Supervised consumption?	Refer to Clinical Lead?
Relevant notes: e.g. liaison with community pharmacist/ advice on medicines etc							
Client ref code	Gender	Age	Attended	Summary of appointment key issue(s) & recommendation(s)	Prescription* (drug(s), dose(s); new/continued)	Supervised consumption?	Refer to Clinical Lead?
Relevant notes: e.g. liaison with community pharmacist/ advice on medicines etc							
Client ref code	Gender	Age	Attended	Summary of appointment key issue(s) & recommendation(s)	Prescription* (drug(s), dose(s); new/continued)	Supervised consumption?	Refer to Clinical Lead?
Relevant notes: e.g. liaison with community pharmacist/ advice on medicines etc							

Appendix 2:

~ Questionnaire on client views ~

The University of Bath have been asked by Somerset Drug & Alcohol Team to find out what clients think about the new pharmacist prescriber post that they are funding at Turning Point.

You are being given this questionnaire because you had an appointment with Andrew Harker, the pharmacist prescriber. We would be grateful if you would fill it out to tell us what you think, however there is no obligation to do so and no one will mind if you choose not to fill it out. The questionnaire is anonymous. We do not want your name on it and you cannot be traced from it. If you do fill it out please put the completed questionnaire into the envelope you have been given and seal it, before posting it into the box provided.

If you have any questions about this questionnaire or the evaluation, please contact Dr Jenny Scott at the University of Bath on 01225 385775 or email: *Thank you for your time.*

Question 1: How would you rate your consultation with the pharmacist prescriber today? (please tick)

Worse than I expected	About what I expected	Better than I expected

Question 2: How would you rate the level of care you have received today from the pharmacist prescriber? (please tick)

Poor	Below average	Average	Good	Excellent

Question 3: How would you rate the information you have received today from the pharmacist prescriber? (please tick)

Poor	Below average	Average	Good	Excellent

Question 4: How would you rate the level of knowledge the pharmacist prescriber has about addiction treatment? (please tick)

Poor	Below average	Average	Good	Excellent

Question 5: How would you describe the level of involvement you had in your care today? (please tick)

I was not involved at all	I was involved a little bit	I was quite involved	I was very much involved

Question 6: If you were given the option of seeing a pharmacist prescriber in the future would you want to? (please tick)

Yes ☐ No ☐

Your comments are welcomed, please add them on the back of this page >>>> *Thank you*