Why pharmacist prescribing appears to be floundering

Not all pharmacists who train as prescribers go on to make the most of their skills. In this commentary, Wasim Baqir and Jim Smith discuss the findings of a recent study of pharmacist prescribing in the north east of England.

Launching the Pharmacy
White Paper last year, Dawn Primarolo, Minister for Public Health, said: “We need to ensure that pharmacists’ clinical skills and expertise are an integral part of delivering better services to patients. The development of pharmacist prescribing is central to achieving that goal.”

While it is undoubtedly encouraging that a UK government policy recognises the potential of pharmacist prescribing, the early results from an extensive survey of pharmacists who have undertaken prescribing training in the north east of England suggest that, in many cases, this potential is far from being realised (see p147).

Current situation
Over two hundred pharmacists have undertaken a prescribing course in the north east of England since 2003, when supplementary prescribing first became a reality. Our survey showed that most of them (87%) have registered with the Royal Pharmaceutical Society as prescribers following successful completion of the course. A large proportion (67%) then go on to use their prescribing qualification to some extent.

Over 60% of pharmacist prescribers in our evaluation are prescribing in secondary care. A more detailed study to quantify prescribing by hospital pharmacists is under way. Early data suggest that, on the positive side, most trusts have some pharmacist prescribing and hospital pharmacists are prescribing across a diverse range of clinical areas, including wards, admissions units and specialist clinics (e.g. rheumatology, oncology and those managing patients with hypertension). Less encouraging is that the number of prescribers and the volume of prescribing are low.

In primary care, the situation is worse. Not only are there fewer prescribers (only a quarter of the pharmacist prescribers in the north east of England evaluation were working in this setting) but the actual level of prescribing is minimal. Total prescribing on NHS prescriptions in 2008–09 amounted to less than 5,000 items, costing £39,000. In the same period, nurses from the north east of England prescribed about one million items, costing just under £10 million. Again, if there is any comfort to be drawn, it is that those pharmacists who prescribe in primary care do so across a variety of clinical areas, ranging from medication review clinics to more specialist clinics, such as those managing patients with hypertension and chronic obstructive pulmonary disease.

This situation is mirrored in England as a whole, with 70% of primary care organisations having some pharmacist prescribing.

Among community pharmacists in the north east of England, the situation can only really be described as dire, with only those pharmacists based at the innovative First Contact service, who assess and prescribe for patients with substance misuse problems, actively prescribing.

Barriers to prescribing
So, why has pharmacist prescribing not taken off? And why is there such a difference between secondary care and other settings?

Pharmacists working in all areas cite organisational barriers, such as a lack of strategic implementation, as the main reason why prescribing has not flourished among their ranks in the north east of England. This is particularly the case in primary care and community pharmacy, where there appear to be no defined prescribing roles for pharmacists. Hence, pharmacists who currently prescribe in these settings usually do so because of the time and effort they have put into identifying a need, obtaining funding and developing their prescribing role.

While some hospitals have implemented trust-wide policies to allow their ward pharmacists to prescribe within their competencies (see later), most seem to have developed an approach not dissimilar to that in primary care, where individual pharmacists have developed services and clinics. There is always a risk that such ‘person dependent’ services will fall by the wayside if the circumstances of the current postholder change.

Lack of funding is another key barrier to pharmacist prescribing. Healthcare organisations are under pressure to make financial savings, with clinical roles for pharmacists appearing to be particularly vulnerable in primary care. The success of nurse prescribing seems to contribute to this. Chronic disease management has, for many years, been the realm of practice nurses, making them an obvious, and comparatively inexpensive, choice for those looking to develop non-medical prescribing roles. Of course, pharmacists would argue that they are able to bridge the gap between nurses and doctors and offer a holistic approach, not only managing the condition responsible for a patient’s attendance at a particular clinic, but also reviewing all of the medicines that he or she is taking. However, this argument has found little resonance with the vast majority of GPs. This is particularly regrettable, given that those pharmacists who are directly employed by GP practices and are prescribing from the practice budget are invariably highly thought of by their medical colleagues.
Issues around the expense of indemnity insurance and not being permitted to independently prescribe controlled drugs are also cited as barriers. For community pharmacy, poor access to clinical records and issues surrounding the separating of the supply and prescribing processes also contribute to the virtual absence of prescribing. Peer support and opportunities for continuing professional development are also few and far between when so few pharmacists in a particular setting perform a prescribing role.

Moving forward
Although we would encourage pharmacists to continue seeking out and developing new prescribing roles, we warn that the only real and sustainable solution is a ‘top-down’ approach, with generic prescribing roles being developed by organisations and not specific roles being developed by individuals.

Some secondary care trusts have adopted this strategy, with policies and procedures being in place to underpin prescribing by pharmacists. For example, in Northumbria Healthcare NHS Foundation Trust a decision was made to introduce pharmacist prescribing across all wards following the success of prescribing by pharmacists on the emergency care wards. This initiative was supported by hospital management and consultants. Ward-based pharmacists now prescribe across a number of clinical areas to inpatients, ensuring that medicines are stopped, started or doses changed in a timely fashion.

As well as widely disseminating this and other examples of good practice, research assessing the impact of ward-based pharmacists on contributing to the NHS agenda of reducing risk, improving quality and productivity should be performed. This would give organisations an evidence base for further developing pharmacist prescribing. NHS commissioners need to identify and support the potential benefits of pharmacist prescribers in primary care and community pharmacy.

Legal changes to permit the independent prescribing of controlled drugs are, of course, welcome but, with most organisations seeming reluctant to make the most of pharmacist prescribing within the current framework, they are unlikely to have a major impact.

In short, pharmacist prescribing needs to be seen as a viable and innovative way of dealing with the huge demands placed on the NHS. In our view, pharmacist prescribers not only offer an additional pool of prescribers for the NHS but can also capitalise on the unique training that equips pharmacists to prescribe in a particularly safe and cost-effective manner.

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References