Pharmacist Prescribing in England: Acting on History to Address Current Challenges in Pharmacy Practice

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Abstract

Historically doctors prescribe and pharmacists dispense, but these clear lines are rapidly eroding. The view that pharmacists should work closely with general practitioners and hospital doctors is a reality. It is encouraged by surveys and major reports such as that of Lord Carter. This shift is mediated by the need to balance the authority of doctors and patient safety with a shortage of doctors and a need to use the skills of pharmacists appropriately. As the population ages, more pharmacists, with the necessary skills and knowledge, will be required.

Introduction

In 1670, a London physician, Goddard, wrote that only doctors should prescribe, as he railed against the apothecaries for apparently diagnosing and prescribing, which was the physician's prerogative.[1] The debate now is more about doctor shortages and how the National Health Service (NHS) in England can run a full seven day service to include elective surgery as well as emergency admissions, yet still use the same number of doctors on guaranteed 'reduced' hours. As the population ages, there is greater need to offer prescription services for these conditions so they are readily accessible outside of the hospital.[2,3] This need has been

addressed by extending prescribing privileges firstly to community practice nurses, initially with a restricted formulary, then to pharmacists and allied healthcare professionals including podiatrists, physiotherapists and optometrists. These healthcare professionals, based in primary and secondary care, have been demonstrated to be as safe and effective as doctors in prescribing medications for patients[4]. Non-medical prescribers are also widely accepted by the patient population, in some instances associated with a higher levels of patient satisfaction[5]. Despite, these obvious advances in the role of pharmacists in healthcare system, there remain further opportunities to optimise the knowledge and skills of these professionals, particularly in primary care. This paper will review the history of pharmacist prescribing in England and examine the extent to which this expanded role meets the current demands within the primary care system.

Institutional constraints on prescribing

In the UK, the separation of prescribing from dispensing was institutionalised by the National Health Insurance (NHI) scheme in 1913. When reviewing the arrangements for the NHI, the Chancellor of the Exchequer, Lloyd George, feared that doctors would increase their prescribing as a means of inflating their incomes. [6]

During the 1940s, most medicines supplied to patients were compounded within the pharmacy premises.[6] With the expansion of the pharmaceutical industry, the prescription of branded medicines rapidly increased and the role of compounding virtually disappeared.

Political necessity for change

Following the introduction of the Medicines Act in 1968[7] a series of major political changes coalesced to create a fertile environment for change. While the political changes were

occurring, pharmacists were evolving from a purely service support profession to that of clinical scientists.

In 1955 Sir Hugh Linstead[8] chaired a committee on the hospital pharmaceutical service from which the recommendations to try to help recruitment and retention of hospital pharmacy staff were developed. Two main principles were stated, pharmacy was a science and an art and that effective advice and decisions about pharmaceutical matters should be in the hands of pharmacists.

A rapid increase in the output and research from the pharmaceutical industry and universities following the introduction of the NHS in 1948 led to a proliferation of potent active medicines. The impact of these potent medicines, with their potential for serious adverse effects, led to a further review of pharmacy activity.

The Noel Hall report, published in 1970, changed the face of hospital pharmacy.[9] Ward pharmacy emerged , that is pharmacists having a presence on the ward. The report recommended greater remuneration of pharmacists, an attractive prospect for new graduates which would be likely to retain them in the hospital service.

The Nuffield Foundation report [10] was published in 1986 in which recommendation 43 stated:

> …it should be possible for specialists (such as in drug information, quality assurance and the newly developing clinical areas within paediatrics and oncology) to obtain promotion while remaining within their specialty and without undertaking solely managerial responsibilities.

Instead of the need to rise to the top of a career pyramid, with management at the top, the pharmacy service was now a series of columns that could all be climbed.

New activities recommended for hospital pharmacists were taking patient medication histories, interpreting laboratory results and working in teams with doctors and nurses.

The Crown reports and the Health and Social Care Act 2001.

Pharmacists' prescribing rights have evolved over many decades in accordance with policy and legislative changes. Two major reports, both entitled 'review of prescribing supply and administration of medicines' were published at the end of the 1990s soon after a new Labour Government had been elected [11,12]. The final report of 1999[12] stated:

'The legal authority in the United Kingdom to prescribe, including authorising NHS expenditure should be extended beyond currently authorised prescribers.'[11]

The recommendations of the Crown reports [11, 12] were enacted through the 2001 Health and Social Care Act.[13] These recommendations led to the introduction of supplementary (dependent) and independent prescribing as well as a new route for supplying medicines without the need for a prescription, namely Patient Group Directions. In addition, the European Working Time Directive was incorporated into UK legislation.[14] For junior doctors, their working hours would be reduced from an average of 56 per week to 48. This meant there was a potential reduction in the number of doctors available to see patients, to prescribe and sign prescriptions at any time. Inevitably this could lead to longer waiting for prescriptions at discharge or on the ward.

Identifying the barriers such as fear of role erosion by medics, scepticism about the depth of knowledge or skills of other healthcare professionals and a feeling that this was getting medicine on the cheap were voiced.

Latter and Blenkinsopp[15] concluded nurse and pharmacist prescribing was safe and appropriate. With the EU working time directive[16] applied to doctors; the increase in the number and complexity of consultations and the claims that numbers of family doctors were falling significantly and were not being replaced, meant there was an obvious need for additional prescribers in hospital and the community. Latter and Blenkinsopp [15] reported that,

there was no evidence that patient safety had been compromised by the introduction of prescribers other than doctors.

General Practice: Crisis and Solution

In 2000, the Royal College of General Practitioners published a document on the workforce in general practice. In it, Anthony Mathie succinctly summed up the problems 17 years ago:[16]

> 'Expectations on general practitioners are ratcheted up. We're being asked to be more accessible, to audit our care, to undertake continuing professional development, to appraise each other and to be revalidated.'

In 2011, the Kings Fund reported some of the key facts that related, at least in part, to what is now considered yet again a crisis.[17] These factors were said to be the number of salaried GPs employed in practices, which the report said had risen from 786 in 1999 to 7,310, 10 years later in 2009. Because of the general expectation that health would be dealt with more in primary care than in secondary care, general practice would become increasingly involved and responsible for the health of local populations.

The major report that brought the issues together in 2014 was the Review of GP Workforce from the Centre for Workforce Intelligence (CfWI). [18] They considered the service looking ahead to 2030 and concluded that the current level of GPs being trained was inadequate. They suggested that 50% of medical training specialties should be in general practice.

The workforce was said to be under considerable strain and unable to keep up with patient demands. All models carried out by the CfWI showed a large supply-demand gap. A 20%

increase was required in training posts for GPs to meet the demand and it was estimated that the GP workforce would increase by only 9%.[18]

In early 2015 the Royal College of General Practitioners commented on the impending chaos that would ensue if GP numbers were not addressed. [19] In October 1995, Roger Dobson writing in the Independent titled his brief article 'a health crisis'.[20] The avalanche of paperwork, poor working conditions and a climate of uncertainty was blamed for shortfalls in recruitment.

In June 2016, Civitas produced a short report to examine the supply and demand for doctors.[21] The obvious conclusion was that we need a far larger pool of medics from which we can have a stable permanent workforce. It is also imperative to ensure that doctors continue to work for the NHS after they graduate.

Pharmacists could also be further utilised to mitigate the crisis. Graduate pharmacists could be trained as prescribers in 6 months, after 2 years on the register, then run clinics and common ailment schemes in GP surgeries. Conversely the clinical pharmacist in practice could deal more with chronic illness and long term conditions, leaving the GP and advanced nurse practitioner to deal with acute consultations.

So where are we now with prescribing pharmacists?

In 2013, a review of GPhC registrants was prepared by NatCen.[22] The results included a chapter on pharmacist prescribers in the UK. Of the 45,000 pharmacists registered with the GPhC with an address in Great Britain, there were approximately 3,000 (6%) annotated as prescribers. Of these, 74% had prescribed at some point since their annotation.

The GPhC undertook a further prescribers' report published in May 2016.[23] Numbers of pharmacist prescribers had increased by November 2015 to almost 4000 or 8% of the registered pharmacists. Of these prescribing pharmacists, 61% were in secondary care, 30%

were in primary care organisations and 13% were in the community. Comments in the 2016 report showed the main area of continued concern was the lack of diagnostic skills in many clinical areas, which meant the majority of pharmacists were prescribing after diagnosis by another healthcare professional. Two other areas of concern were the lack of access to patients' medical records in the community and the need for a second pharmacist to provide a clinical check in hospital. It is widely acknowledged that pharmacists in primary care are a valuable untapped resource[24]. Within this setting, pharmacists would have access to patient records which would enable them to offer patient facing consultations, run clinics for patients with chronic diseases, work with multidisciplinary teams in the provision of domiciliary and care home support and work with community pharmacy colleagues to resolve issues with prescriptions. These activities would greatly alleviate the existing pressures on GPs.

Where we are in 2017

In April 2016 NHS England published *General Practice, forward view.* [25] In this document, the statement was made that the government was aiming to add a further 5000 GPs in the next five years. There is no clear discussion about how this will happen or how medical students currently studying will turn to general practice in this country.

General practice is changing with an increasing elderly population with complex health needs and the general trend to treat more patients in the community and outside hospital. In chapter 2 of General Practice: forward view, the workforce is discussed. The Government's response to the issues outlined is to include clinical pharmacists:

> Current investment of £31 million to pilot 470 clinical pharmacists in over 700 practices to be supplemented by new central investment of hundred and £12 million to extend the programme by a pharmacist per 30,000 population for all practices when not in the initial pilot.[25]

This will lead to a potential further 1500 pharmacists working in general practice by 2020. There will also be the introduction of a new pharmacy integration fund, which will be worth £20 million in 2016/17 rising by a further £20 million each year to help further transform how pharmacists and their teams and community pharmacy work as part of wider NHS services.[25] As this scheme is in it's infancy, it is likely to be some time before an appreciable benefit to the workload of GPs will be observed.

A note from the Carter Review [26] Recommendation 3:

> Trusts should, through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, by April 2020,

This may allow for a more complete use of clinical skills to be distributed more appropriately where needed. This collaborative practice model is an efficient way to facilitate safe and effective access to medicines.

Other ideas being considered are to use existing prescribing pharmacists to become 'designated prescribing practitioners' to supervise the pharmacists and possibly the nurses, on prescribing courses. This would support the existing designated medical practitioners as the number of prescribing students increases. The other possibility which is being considered now is to increase the amount and level of prescribing information provided on undergraduate courses. This could be coupled with the requirement for all practising community based pharmacists to become accredited prescribers, an ambition proposed by NHS Scotland to improve the provision of pharmaceutical care by 2023.[27] The Murray Report identified that a similar initiative in England would greatly enhance the number of prescribing pharmacists as approximately 70% of registered pharmacists work in community pharmacies.[28] While it would be advantageous for community pharmacists to make a greater

contribution to patient care, the community pharmacy workforce, consisting of pharmacy technicians, dispensers and checkers needs to be used more effectively to release pharmacists from their traditional dispensing roles.

Conclusion

In England pharmacists have developed from compounders to experts on potent drugs and to consultant pharmacists within the hospital sector and prescribers in all sectors. Clinical pharmacists are working closely and collaboratively with their colleagues in general practice and hospital and the number of pharmacists working in GP surgeries has increased significantly and continues to increase steadily. However with the ageing population and the shortages particularly with regard to general practitioners, the need for the rapid integration of community and primary care pharmacists into general practice is an urgent necessity. The skills and education of the health professional will be used to give the patients a better experience, and could help contribute to flexible working in both general practice and in hospital by running clinics in their specialty areas and ensuring patients' received appropriate medicines as necessary at the end of the consultation.

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