MANAGEMENT CONUNDRUM

Grasping The Nettle Of Independent Prescribing

Janet Donit, Chief Pharmacist at Metropolis NHS Trust, Carey Whitecoat, Head of Medicines Optimisation at Riverdale Primary Care Organisation (PCO) (PCO) and Mr Silver, who represents Community Pharmacists in the PCO, were having one of their regular, quarterly meetings to discuss issues of mutual interest.

"It would be good to have more Community Pharmacists who are Independent Prescribers", said Mr Silver. "They could do a lot more in minor ailments and urgent care."

"You're not wrong," interjected Janet, "but I'd like to see Independent Prescribing pharmacists working across the interface. They could facilitate the flow of patients out of hospital. It would be good if they could target complex patients and frequent flyers and sort out their prescribing needs a bit more."

"The problem is", said Carey, "that we already have people qualified as Independent Prescribers but they have really just dabbled at the edge and are not embedded in the service in any sustainable way. It really is difficult to make a case for funding, at least from the PCO, to support the development of Independent Prescribing."

"Isn't that just it," said Mr Silver who was warming to his theme. "There doesn't seem to be any clear strategy about where Independent Prescribers fit and how many would be needed. Universities are ploughing on with courses that pharmacists are taking under their own steam but it then all comes to a dead halt!"

"That's right," said Janet, "there is a huge potential here but we're not tapping it properly. We do a little bit here and a little bit there but never really get to grips with things. We really need to grasp the nettle ."

"That's something we can all agree on," said Carey, "but what are we going to do about it?"

What advice would you give?

Commentaries

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I qualified as an independent prescriber in 2007. We still have not identified a budget and governance structure that will allow me to undertake the work that was originally envisaged!

That is a shame because community pharmacists have a lot to offer as independent prescribers. There is a school of thought, as championed by a speaker at a Pharmacy Management National Seminar, that doctors should diagnose and agree the drugs to be used, but that the dose titration and ongoing management should be in the hands of community pharmacists, freeing the GP to concentrate on more difficult cases. There are several examples of pharmacists who play a full part in medicines optimisation within practices, and recent encouragement to practices to employ pharmacists to improve their prescribing. All these are welcome, but as Janet notes there has been a failure to get to grips with independent pharmacist prescribing. Why is this?

First, some commissioners have had poor experiences of pharmacists operating (or failing to operate) services under Patient Group Directions. Too many pharmacies have not been able to ensure continuity of service and these commissioners say that if pharmacists cannot deliver under PGD, how could they possibly offer a reliable prescribing service? In fact, in one respect pharmacist prescribing gets over this problem. The barrier has usually been the result of a failure to accredit staff, but independent prescriber status avoids this need for accreditation – and it is national, rather than local. If every community pharmacist were to be an independent prescriber, we would not need the raft of PGDs that currently underpin services (and require accreditation processes).

Second, the old approach has usually been to specify services first, then think about how you might provide them. That will never justify the time and expense of developing independent prescribing.

Janet and Mr Silver both have ideas about how both have ideas about how independent prescribers could be used. If there were a pool of such prescribers, a large number of opportunities would present themselves – and NHS managers would save a lot of time currently spent writing PGDs and collecting accreditations.

I would suggest that they convene a meeting of interested parties to agree a plan to develop all pharmacists as independent prescribers within a challenging timeframe – perhaps three years. Community pharmacists cannot expect commissioners to meet the costs of doing this – those who seek work should equip themselves to take on that work – but there must be a commitment to commissioning services that will justify the expenditure involved. A plan to convert existing PGD-based services to prescriber services will be a start, but that involves no new income, so the meeting should be looking at all the possibilities. These will need costing, but if the considerable training costs do not need to be considered it is likely that a substantial number of patient-centred services could be offered within community pharmacy, and the PCO could have confidence that they would be delivered consistently.

A PCO that took a bold approach could negotiate with its local higher education partners to deliver training at a keen price, because currently HEIs do not know whether their next course will involve 5 or 55. An LPC that matched that boldness by persuading members to invest on the expectation of future commissioning would remove one of the big barriers. But as Janet notes, you cannot do a bit here and a bit there. Develop a big vision for the future, then think how you can get there.

Community pharmacists have a lot to offer as independent prescribers

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These colleagues seem to be in tune with the times; it appears that the NHS is, in general terms, recognising and championing the opportunities which independent prescriber pharmacists can offer. In some parts of the UK such as Scotland (Prescription for Excellence) and Wales (Our plan for a primary care service in Wales up to March 2018), explicit reference is made to the desirability and suitability of pharmacists to contribute to delivery of primary care and the optimisation of medicines use. The gap, as these colleagues identify, is translating this into roles and jobs. The key to success is in the planning to ensure that

roles are aligned to the delivery of local priorities and are clearly identified.

The three colleagues need to identify the specific needs and priorities of their organisations or local health economy that can be met by the deployment of their pharmacist independent prescribers. New independent prescriber roles need to be embedded and integrated with existing or new services to be sustainable.

The opportunities vary between settings; these could focus on a therapeutic area such as pain management, a chronic disease such COPD or a generalist approach e.g. 'in' or 'out'-of-hours services to support access to medicines, medicines optimisation or polypharmacy. Patients could be seen at home, in a care setting, at a hospital or at a GP surgery; or could be managed carefully across organisational boundaries. Where are the current work force gaps? What is both necessary and achievable? Who will pay for, or commission, these services? It is necessary to consider some practicalities such as access to prescriptions or the patient's record, using consulting rooms and who will book appointments and follow up patients when this is required.

There must be a clear governance and accountability framework in place for the independent prescribers to ensure they operate within clinical governance and financial parameters. There must a clear understanding of how the role fits with the roles of other pharmacists and the colleagues within the service in which they are working.

Currently, the number of independent prescribers is small and they have qualified with a competency in a defined disease area. They are not currently sufficient in numbers to deploy widely. To demonstrate success and embed these roles for the future, colleagues should evaluate the outcomes of using independent prescribers and should share their successes.

Declaration of interests

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- Member of the Editorial Board for the Pharmacy Management Journal
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