



# Pharmacist Independent Prescribers

Greater use of Pharmacist Independent Prescribers will increase patient access to pharmaceutical care and support in a timely manner. Pharmacist Independent Prescribers must be considered an essential part of the multidisciplinary team to improve patient care and overcome some of the challenges in today's NHS.

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Pharmacists have a unique and in-depth education in all aspects of medicines and medicines use, essential to the safe on-going monitoring, support and treatment of patients. The Royal Pharmaceutical Society (RPS) is committed to ensuring that patients benefit from this expertise to improve health outcomes.

All pharmacists in direct patient care roles must have access to independent prescriber (IP) training and be enabled to fully utilise these skills to enhance patient care as part of a multidisciplinary approach.

## Key Recommendations

- 1. Patient access to safe and effective healthcare must be enhanced through new models of care and services that enable pharmacist independent prescribers to routinely use their skills and knowledge in practice.**
  - 1.1 Patients should benefit from access to pharmacist independent prescribers (PIPs) in their communities. Structured services need to be in place to enable PIPs to have the capacity to fully utilise their skills depending on the needs of their population.
  - 1.2 Workforce planning must take into account the new and emerging roles of PIPs. More resources are required for the existing pharmacist workforce to undertake advanced clinical skills training and qualify as PIPs.
  - 1.3 In the interest of delivering high quality, safe and effective patient care, all PIPs should have appropriate access to, and be able to input into, the patient health record.
- 2. Develop a clear pathway for pharmacists to become qualified PIPs.**
  - 2.1 The underpinning knowledge base for independent prescribing must be included in the MPharm undergraduate degree and pre-registration training year.
  - 2.2 Pharmacists applying to undertake an IP programme should already have completed the RPS Foundation framework to assess clinical competency.
  - 2.3 Experienced non-medical prescribers should be able to take on the role of designated practitioner as part of a multidisciplinary team (MDT) approach to clinical learning.
  - 2.4 PIPs in training should also receive formal input and mentoring from medical colleagues and the wider MDT to benefit from a range of professional skills and knowledge.

## Context for change

The NHS must adapt in order to deal with the progressive demands of an increasing and ageing population. With an estimated one in three people living with at least one long term condition<sup>1</sup>, demand for services is predicted to continue to rise<sup>2</sup>. Financial constraints and challenges with recruitment and retention of health practitioners<sup>3</sup>, including general practitioners and nurses<sup>4</sup> are well publicised. There is therefore mounting pressure to find new ways to increase efficiency whilst not compromising quality, ensuring the NHS is making the most effective use of all available skills and resources and that all healthcare practitioners are empowered to work at the height of their clinical competence.<sup>5</sup>

Caring for the health needs of patients and the public is a multidisciplinary process. Medicines are the most common intervention in the NHS; they can be life-prolonging and life-saving but, if used incorrectly, can also cause harm.<sup>6</sup> Patients must therefore benefit from routine access to expert advice from a pharmacist as part of MDT approaches to the prescribing of medicines.

The legislation governing independent prescribing was amended in May 2006 when nurse IP and PIP was introduced. Since this time further changes in legislation have been introduced to extend prescribing rights to other registered healthcare professionals.

Once qualified, a PIP can autonomously prescribe any medicine for any medical condition within their competency, including controlled drugs (with the exception of the prescribing of diamorphine, dipipanone or cocaine for treatment of addiction).

### **1. Patient access to safe and effective healthcare must be enhanced through new models of care and services that enable pharmacist independent prescribers to routinely use their skills and knowledge in practice.**

Where there is a clear opportunity for improving access to care, local planning arrangements must integrate PIPs into core models of care. This will contribute to improved patient flow and efficiencies, ensuring patients are able to see the right health professional at the right time and in the right place, from specialist clinics in secondary care through to prescribing for patients in their own home.

The skills of PIPs can help to build greater capacity and capability within the NHS workforce and ease pressure in areas such as acute and emergency care and primary care, including out of hours services. Current barriers which inhibit these developments must be addressed to ensure the investment in producing more pharmacist prescribers is a positive addition to patient care.

The development of the health and social care workforce should be based on the needs of patients, with a focus on disease prevention and new, flexible service models tailored to local population needs. Services and care settings require to be integrated with consistent leadership across the health and social care system.<sup>7</sup>

# Case study 1

## The Northumbria NHS Integrated Pharmacy Service

The Northumbria NHS Integrated Pharmacy Service<sup>1</sup> supports patients with medicines across care settings, with pharmacists working with the multidisciplinary team and patients, optimising medicines wherever the patient presents. Northumbria Healthcare NHS Foundation Trust has embraced pharmacist prescribing across generalist and specialist areas. All services allow for pharmacists to autonomously prescribe (or deprescribe), increasing quality, reducing risk and saving healthcare resources.

Enabling pharmacists to prescribe in an integrated system has demonstrated benefits in a variety of care settings. In care homes, the medicines burden was reduced by an average of 1.7 medicines for every resident reviewed.<sup>2</sup> The most common reasons for stopping medicines were no current indication (57%) and residents not wanting to take the medicine after risks and benefits were explained (17%). Forty-one medicines (6%) were stopped because of safety concerns.

In the hospital setting, pharmacists prescribed 1 in 8 items for over 40% of patients, with a very low error rate of 0.3%.<sup>3</sup> Pharmacists prescribed a wide variety of medicines from 12 out of the 15 BNF therapeutic categories. The majority of prescribing was for central nervous system, cardiovascular and respiratory medicines. 13% of the medication orders prescribed by pharmacists were for new therapy, suggesting that pharmacists are not just using their prescribing rights to correct errors, but are actively managing patients.

A key feature of the Northumbria prescribing model is patient centred care; by working within a shared decision making framework, Northumbria pharmacists are making a positive impact on patient outcomes, through prescribing.<sup>4</sup>

1. <https://www.pharmaceutical-journal.com/research/perspective-article/impact-of-an-integrated-pharmacy-service-on-hospital-admission-costs/20204550.article>
2. <http://bmjopenquality.bmj.com/content/3/1/u203261.w2538>
3. <http://ejhp.bmj.com/content/22/2/79.info>
4. <http://ejhp.bmj.com/content/24/1/30>

- 1.1 Patients should benefit from access to PIPs in their communities. Structured services need to be in place to enable PIPs to have the capacity to fully utilise their skills depending on the needs of their population.

As community pharmacy practice evolves, the number of patient facing services available continues to increase. A commitment to making community pharmacy the first point of contact for people with common ailments has increased the opportunities for patients to access medicines and advice throughout Great Britain; the introduction of common/minor ailment services has supported this commitment.

A community pharmacist with an IP qualification can deliver beyond a common/minor ailment service, managing an extended range of common and long term conditions. For example, they could help people access treatment and expertise in a timely manner whilst also supporting the capacity of local GP practices.

- 1.2. Workforce planning must take into account the new and emerging roles of PIPs. More resources are required for the existing pharmacist workforce to undertake advanced clinical skills training and qualify as PIPs.

Over 1 billion prescription items are written each year in primary care in Great Britain.<sup>8</sup> The vast majority are written by GPs. As pharmacists take on ever more clinical roles, the pharmacy workforce will need the right skills to meet these challenges.

Whilst not all existing pharmacists will need to become prescribers, the opportunity should be available to all. For existing pharmacists, accreditation of prior learning, for example, their portfolio, showing completion of the RPS Advanced Practice Framework, should provide evidence of suitability to embark on IP training. Ongoing funding will be essential to ensure wider access to the non-medical prescribing course for pharmacists. Employers and the NHS will need to resource backfill and protected learning time.

- 1.3 In the interest of delivering high quality, safe and effective patient care, all PIPs must be able to have appropriate access and be able to input into the patient health record.

Access to relevant sections of the patient health record, including medical history and laboratory test results, will allow pharmacists to make more informed clinical decisions on the use of medicines in partnership with patients and other health and social care professionals. This will support improvements in the safe and effective treatment of individual patients and help the NHS to secure best value from the significant investment it makes in medicines.

All pharmacists, directly involved in providing patient care, must have access to appropriate IT systems that are interoperable with other primary and secondary care IT systems. In order to optimise the use of medicines and deliver more integrated patient care, the ability to access and share essential patient information electronically will reduce risk and improve patient safety across all care sectors.

# Case study 2

## Community Pharmacy based IP service

To help ensure GP sustainability and increased patient access to a prescriber, Powys THB developed and implemented a new enhanced pharmacy service that utilised the already commissioned Common Ailment Scheme but also went a step further to make full use of PIP skills.

Communication between the community pharmacists, GP practice and patients are key enablers underpinning the service. Secure access to GP held patient records from within the pharmacy was facilitated, ensuring a robust process that enables safe prescribing and continuity of care.

Utilising the IP qualification ensures that patients are able to access support and treatment for a wide range of conditions (see graph below), this has proven to be particularly important on Saturdays, when the GP surgery is closed. The service has also helped to ensure that GPs are focusing on more serious conditions.

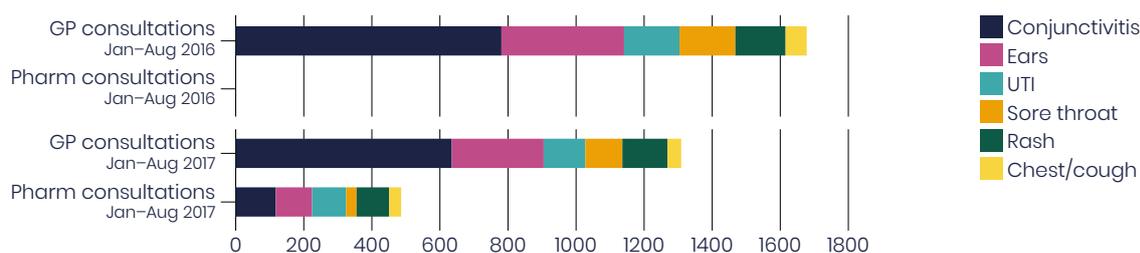
The diagnosis skills developed during the IP course has also enhanced the care provided:

One example of this was a 30 year old male who presented at the pharmacy on a Saturday morning requesting antibiotics for a chest infection. He'd been unwell for 5 days with pain on breathing, painful cough and shortness of breath on exertion. He'd been working that morning on a local farm. Upon examination, there were a number of concerns including: clear variance in sound between both sides of the chest, left side had reduced inflow of air (identified through chest auscultation) and respiratory rate was high. The patient was sent directly from the pharmacist to hospital where they received lung re-inflation and treatment.

This evaluation demonstrates that pharmacist prescribers working in community settings are effective, accessible and can integrate successfully with existing services to support the sustainability of primary care. Patient feedback indicated overwhelming satisfaction with the service.

### Top 6 conditions: impact of pharmacy services

Jan–Aug 2016 v Jan–Aug 2017



Dylan Jones, principal pharmacist at Dudley Taylor's Llanidloes Pharmacy

Jason Carroll, medicines management pharmacist in Powys

## 2. Develop a clear pathway for pharmacists to become qualified PIPs.

Pharmacists' unique clinical and scientific training in all aspects of medicines and their use equips them to treat people holistically. The pharmacist's skills are a vital component of healthcare delivery, ensuring new medicines are compatible with existing patient treatment plans, and that inappropriate polypharmacy is avoided. As part of a multidisciplinary approach to care, PIPs can optimise patient medication regimens to ensure the appropriate medicines are used to best effect. This includes de-prescribing and non-pharmacological treatment options for patients.

In order to qualify as an IP, pharmacists must successfully complete a General Pharmaceutical Council (GPhC) accredited IP programme operated by an accredited training institution. Pharmacists must meet the GPhC entry requirements<sup>9</sup> which include: identifying an area of clinical practice in which to develop their prescribing skills, having clinical or therapeutic knowledge relevant to their intended area of prescribing practice, identifying a supervisor to supervise their learning in practice and sign off on their competency. Finding a suitable practitioner for this role can be problematic and can cause difficulties in eligibility for courses, limiting the entrance numbers.

Once they have demonstrated that they have the knowledge, skills and attributes required of an independent prescriber, they are awarded a practice certificate in independent prescribing which makes them eligible to apply for annotation on the GPhC register.

Expanding the number of PIPs who see patients in a range of care settings, taking responsibility and accountability for their pharmaceutical care, is one way to improve patient access to healthcare. This is already happening in some areas but only 7% of pharmacists were registered as PIPs on the GPhC register in 2015.<sup>10</sup> It is clear that more still needs to be done if we are to have PIPs working universally across Great Britain.

### 2.1 The underpinning knowledge base for IP must be included in the MPharm undergraduate degree and pre-registration training year.

With healthcare changing and evolving over time there is a requirement for the five year masters level training of undergraduates and preregistration trainees, which enables individuals to enter into the pharmacy profession, to be continually reviewed and revised to ensure that newly qualified pharmacists are fit to practice in the NHS of today. The underpinning skills and knowledge needed for new roles are incorporated into teaching, learning and assessment. It is therefore logical that the core content of the IP course be incorporated into the MPharm curriculum.

## 2.2 Pharmacists applying to undertake an IP programme should already have completed the RPS Foundation framework to assess clinical competency.

It is recognised that post registration experience is essential for pharmacists to apply the knowledge and skills they have acquired during their undergraduate and pre-registration education. The behaviours and competence they need to demonstrate during this post registration period can be gained during their Foundation training years where core skills around consultations, clinical assessment, clinical decision making and therapeutic management should be further enhanced and demonstrated, in line with the RPS Foundation Framework<sup>11</sup> and under the guidance of a tutor.

All newly qualified pharmacists should have access to Foundation training to enable, guide and quality assure their professional development during their early career. Rather than focusing on a set amount of time before undertaking a prescribing course we believe the focus should be on identifying the right knowledge, skills, experience and level of competence that the individual can work towards during their Foundation training, using the RPS Foundation Framework and then consolidating this post-Foundation training using the Prescribing Competency Framework.<sup>12</sup>

## 2.3 Experienced non-medical prescribers must be able to fulfil the role of designated practitioner as part of a multidisciplinary team (MDT) approach.

PIPs, like other prescribers, will prescribe within their areas of competence in line with the competency framework for all prescribers. It is important that trainees have access to a suitable prescribing supervisor and therefore regulations should be changed so that the designated prescribing practitioner could be either a medical or non-medical prescriber provided they have the necessary skills and experience. Having a larger number of designated clinical practitioners available would ensure there is an improved supply of IPs.

Ideally the prescribing supervisor should have experience of working in a similar area of practice to that of the PIP in training. It is important however that PIPs have opportunities to develop generalist prescribing competence as well as specialising in a clinical area as it is vital to be able to consider the patients' needs holistically in practice.

Designated supervision rights for pharmacists would provide additional capacity for more pharmacists to become prescribers. We believe that an increase in the number of pharmacist prescribers is essential to enable pharmacists to contribute more actively, achieving positive patient outcomes, particularly for those individuals with long term conditions.

Additional investment may also be required to support the ongoing development of current PIPs to ensure they are equipped to undertake the role of a designated clinical practitioner for pharmacists and possibly other health care professionals.

2.4. Pharmacists should also receive training and mentoring from medical colleagues and the wider MDT to benefit from a range of professional skills and knowledge.

PIPs in training must continue to have the opportunity to work alongside medical and other healthcare practitioners, particularly when the final sign off for an individual is by a non-medical prescriber. The prescribing supervisor should demonstrate an understanding of and competency in educational supervision to ensure patient safety. In addition, we advocate that trainees should have as much opportunity as possible to gain experience working as a 'prescriber in training' within a multidisciplinary team.

## Case study 3

### Community pharmacy Warfarin clinic

A community pharmacist based in Hywel Dda LHB, West Wales has established a Warfarin clinic where she utilises her IP status routinely to ensure patients anticoagulant therapy is managed close to home.

Previously, patients would have attended an INR Clinic at a hospital for monitoring. For one gentleman, who is a regular patient at the pharmacy, this involved driving over 30 minutes each way and spending up to 2 hours at the hospital depending on the number of patients waiting at the clinic.

On one occasion, three attempts were made to draw blood via a venous sample. Even after these attempts, there was insufficient blood for the laboratory to test and the patient had to travel back to the hospital again. The patient had found the episode extremely upsetting.

The patient was offered the pharmacy based INR service. Testing is done via a finger prick test and the result is immediate. During the 7 months that he has been attending the pharmacy for testing, the frequency of his INR monitoring has reduced from weekly to every 8 weeks.

This service has made a dramatic difference to patients and ensures that they have continuity of care from their already trusted community pharmacist.

Rachel Davies, Burry Port Pharmacy Ltd

# Case study 4

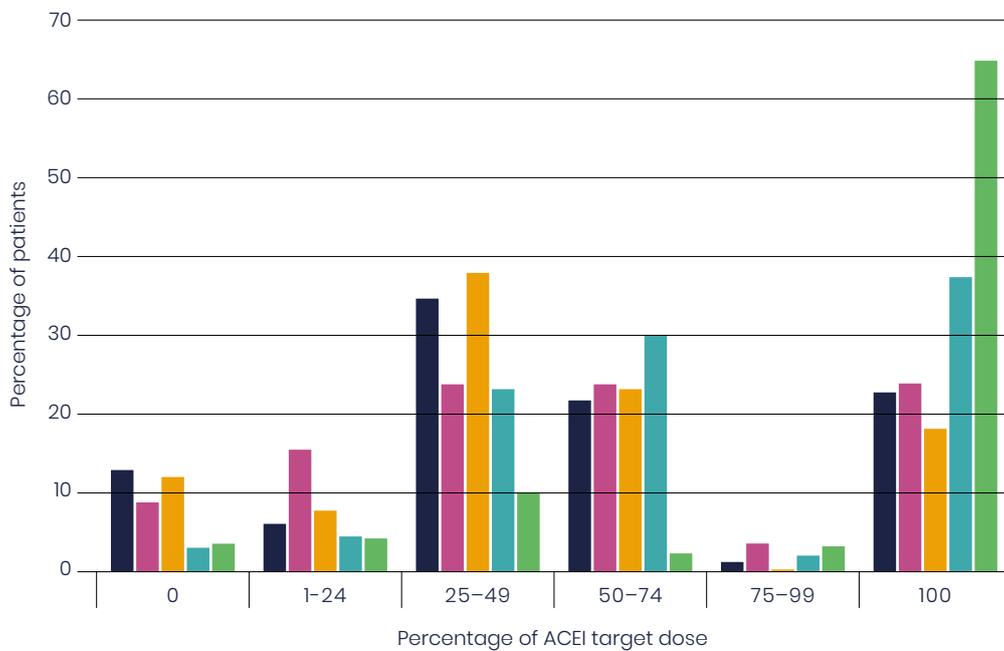
## Pharmacist led cardiology clinics

SIGN Guideline 148 and NICE CG172 recommend treatment with Angiotensin Converting Enzyme Inhibitors (ACEI) in patients with post-myocardial infarction (Post-MI) left ventricular systolic dysfunction (LVSD)

Figure 1 below shows an example of the improvement in the use and target dosing following the introduction of pharmacist-led clinics within cardiology in NHS Greater Glasgow & Clyde.

### Achievement of ACEI dosing of baseline hospital audits vs pharmacist-led clinics for post-MI LVSD patients fit enough to return to cardiac rehab

- Historic Royal Alexandra Hospital (n=133)
- Historic Glasgow Royal Infirmary (n=58)
- Historic New Victoria Hospital (n=76)
- Historic Southern General Hospital (n=64)
- Pharmacist-led clinic (n=849)



Courtesy of Paul Forsyth MRPharmS, Lead Pharmacist, Clinical Cardiology (Primary Care) / Heart Failure Specialist

## Next steps

Implementation of each of the recommendations within this document will help to drive quality improvement in the delivery of care; it will positively contribute to the changes needed to increase health care provider capacity, to reduce demands right across our health and social care system, from primary care and community services to acute and emergency care.

Action will be required across the NHS to review current care models to ensure the inclusion of pharmacists, including PIPs, which will lead to more effective models of care for the public.

All prescribers are expected to prescribe only within their levels of competence. The RPS led the development of the competency framework for all prescribers which was published in July 2016. This prescribing competency framework applies to all prescribers regardless of their professional background. This prescribing competency framework was developed with the backing of NICE and in collaboration with all the prescribing professions UK wide. The framework has been endorsed by professional bodies representing a number of other professions. In future, the RPS will continue to publish and maintain the updated competency framework in collaboration with the other prescribing professions.

The Royal Pharmaceutical Society is committed to continue working with the NHS and its other partners to drive this important agenda forward and to evaluate its effectiveness in improving patient care across all pharmacy sectors.

## References

- 1.** Department of Health. 2012. Long Term Conditions Compendium of Information – Third Edition. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216528/dh\\_134486.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf) (Last Accessed: October 2016)
- 2.** Roberts, A. and Marshall, L. and Charlesworth, A. 2012. The funding pressures facing the NHS from 2010/11 to 2021/22 – A decade of austerity? NuffieldTrust. Available at: <https://www.nuffieldtrust.org.uk/files/2017-01/decade-of-austerity-full-web-final.pdf> (Last Accessed: October 2016)
- 3.** Kings Fund 2015. Workforce Planning in the NHS. Available at <https://www.kingsfund.org.uk/publications/workforce-planning-nhs>
- 4.** The Health Foundation 2017: In short supply: pay policy and nurse numbers. Available at [https://www.health.org.uk/sites/health/files/Workforce%20pressure%20points%202017%20FINAL\\_0.pdf](https://www.health.org.uk/sites/health/files/Workforce%20pressure%20points%202017%20FINAL_0.pdf)
- 5.** Welsh Government. 2015. A Planned Primary Care Workforce for Wales. Available at: <http://gov.wales/topics/health/nhswales/plans/care/?lang=en> (Last Accessed: April 2018)
- 6.** Davies, M. and Tranter, B. 2015. Maximising fresh opportunities through prudent pharmaceutical care. Available at: <http://www.prudenthealthcare.org.uk/pharmacy/> (Last Accessed: April 2018)
- 7.** Transforming the Pharmacy Workforce in Great Britain: The RPS Vision. Available at <https://www.rpharms.com/resources/reports/transforming-the-pharmacy-workforce>
- 8.** NHS Business Services Authority prescription data. Available at <https://www.nhsbsa.nhs.uk/prescription-data/prescribing-data/volume-and-cost-prescribing-charts>
- 9.** GPhC standards for education and training for Pharmacists Independent Prescribers 2018. Available at <https://www.pharmacyregulation.org/education/pharmacist-independent-prescriber>
- 10.** Prescribers Survey Report, May 2016. Available at [https://www.pharmacyregulation.org/sites/default/files/gphc\\_prescribers\\_survey\\_report.pdf](https://www.pharmacyregulation.org/sites/default/files/gphc_prescribers_survey_report.pdf)
- 11.** Royal Pharmaceutical Society Foundation Pharmacy Framework. Available at <https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Frameworks/RPS%20Foundation%20Pharmacy%20Framework.pdf> (Last accessed 30th April 2018)
- 12.** Royal Pharmaceutical Society, A competency Framework for all Prescribers. July 2016. <https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Prescribing%20competency%20framework/prescribing-competency-framework.pdf>