

## What is the Profession Aspiration that has been Realised since the Extension of Prescribing Rights to Pharmacist on UK?

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### Short Communication

For decades there has been a clear demarcation of roles within the National Health Service (NHS) with respect to the prescription of medications for patients. General practitioners, hospital doctors and dentists as well as being responsible for diagnosis of illnesses and ailments were the sole parties able to prescribe appropriate treatment. It has always been abundantly clear that this is a heavy burden that was clearly not shared. The NHS encompasses a wide range of professionally trained and qualified staff, not only doctors and dentists but nurses, pharmacists, podiatrists, chiropodists, optometrists, physiotherapists and radiographers. It has long been apparent that by devolving some of the prescribing responsibilities and activities from doctors and dentists to these other professionals, increased efficiency and a more streamlined health system could evolve. Not only would this step distribute the workload of doctors and dentists but importantly reinvigorate the other professions with an added level of professional responsibility and sense of achievement. This assignment examines the timeline of the advances made in the incorporation of registered pharmacists as firstly supplemental prescribers, and then as independent prescribers and the additional responsibilities added at each key point. It also attempts to answer whether the profession's aspirations have been met within these changes.

In March 2003, the first official step was made to extend the prescribing rights of pharmacists [1]. The new enablement followed from proposals firstly made in a Crown report issued by the Department of Health in 1999. This report reviewed every aspect of the prescribing, supply and administration of medicines. Two definitions of prescribers were advanced. Firstly, the independent prescriber: essentially being a doctor or dentist, being a professional responsible for the clinical assessment of patients and the generation of a treatment plan. Secondly, the dependent prescriber (this descriptor was later changed to "supplementary prescriber"). In the first instance, professionals recognised as being potential supplementary prescribers were nurses and pharmacists. This supplementary prescriber role included the ability to be able to prescribe, issue repeat prescriptions and to change medication dose and dosage form if required. The caveats were that there was a need for an initial diagnosis from a general practitioner or a hospital doctor. This was followed by the drawing up of a clinical management plan agreed between the doctor, the patient and the registered pharmacist supplementary prescriber. The supplementary prescriber could then implement the plan with clear agreed steps for monitoring the progress of the patient with regular reviews by the clinician. The supplementary prescriber would also be responsible for maintaining their prescribing and monitoring activities in the patient's records, with this data -being transparent to the clinician.

From 2003, registered pharmacists who had undergone appropriate training (described below) were now able to act as supplementary prescribers. Those professionals eligible for training were required to have support from a primary care organisation or NHS trust and to have a named independent prescriber who would be responsible for the clinical training and supervision component. The programme for training involved about 25 days of teaching at an appropriate establishment, for example a school of pharmacy, followed by a period of about 12 days of "learning in practice". These two facets would develop the key theoretical and practical competencies required for successful transition to the role of supplementary prescriber and would be assessed by a range of methods including examination and the uniformly recognised technique amongst health care professionals of reflection. This new categorisation of supplementary prescriber enabled the professional pharmacist to prescribe all medications except for controlled drugs and unlicensed medications (i.e. those without a current marketing authorisation). However, some unlicensed drugs that were part of a clinical trial that fulfilled certain criteria could be prescribed (appropriate certification or exemption documentation for the drug would be required).

The next major advance for pharmacists occurred in April 2006 when the Department of Health issued guidelines for the implementation of independent prescribing for nurses and pharmacists in the NHS in England [2]. The role of an independent prescriber has been defined above and the new legislation incorporated doctors, dentists, nurses and pharmacists under this umbrella (also called "appropriate practitioner"). Clearly again there were certain prerequisites for a pharmacist to become accredited as an independent prescriber. Along with the statutory need to be registered with the Royal Pharmaceutical Society of Great Britain and to have a defined minimum period of experience, a period of additional training had to be successfully completed. The curriculum for training was established by the Royal Pharmaceutical Society of Great Britain and as with supplemental prescribers incorporates theory developed by attendance at a recognised course and a period of learning in practise conducted under the auspices of a clinician called the designated medical practitioner (DMP). The later professional needs to have experience of supervising non-medically qualified trainees in a clinical environment. There is an expectation of a consistent positive interaction between the DMP and the institution offering the training programme to ensure that the candidate independent prescriber is monitored, mentored and essentially set up for success by this supportive environment. The guidelines did leave some room for manoeuvre as it was accepted that the DMP may not always be available. There was built in capacity within the new remits to transfer some of that responsibility from the DMP by the adoption of a "buddy" system whereby an alternate independent prescriber could fulfil some of the training requirements. Clearly success here is defined by the ability of the pharmacist to satisfy

all necessary criteria. Criteria and curriculums were also established for those already registered as supplementary prescribers to take this next step to become an independent prescriber. Other essentials before practise as an independent prescriber were the recognised need and opportunity for immediate post-qualification application of the training (this requires a mandate from the pharmacist's employer), a defined need within a local PCT or NHS trust for expertise in the particular therapeutic area and the necessity for operating within what is called a "robust clinical governance framework". Having attained this new mode of freedom of operation within these new expanded boundaries, an independent prescriber however was still not able to prescribe controlled drugs.

In 2008 a thorough review of the impact of implementation of supplementary and independent prescriber roles was conducted by Hobson [3]. Her review, as part of her doctoral thesis from one of the premier UK schools of pharmacy is particularly pertinent reading. She provides detailed background for each newly unveiled initiative and the impact on the pharmacy profession.

Most recently, in April 2012, potentially the most important change in the increasing assimilation of pharmacists' responsibilities occurred [4]. The announcement from the Home Office was an acknowledgment that with the accelerated responsibilities from registered pharmacist to supplementary prescriber to independent prescriber and nearly a decade of successful experience with these changes allowed legislative changes with respect to controlled drugs to be unveiled. The main issue prior to this change in responsibilities was that there was concern that controlled drugs, covered by the misuse of drugs act, were subject to "diversion and misuse". There has been no evidence to suggest that an increase in pharmacist independent prescribers' responsibilities to encompass the prescribing of controlled drugs would contribute to an increase in diversion and misuse. Accordingly, new regulations now allowed pharmacist independent prescribers to prescribe Schedule 2 to Schedule 5 controlled drugs as part of their remit. The only exceptions were for prescribing cocaine, diamorphine and dipipanone for the treatment of addiction. However,

the independent prescriber is able to prescribe and dispense other appropriate medications for addiction. The key acknowledgement by the Government in the legislation is that it was inappropriate to distinguish between appropriately qualified nurse and pharmacist independent prescribers and doctors in their ability to prescribe medications appropriately.

After well over a decade of lobbying from the pharmacists' professional body and other advocates within the health system in the UK, it is apparent that within the last nine years significant changes have been made. The initiative has been directed by the involvement of professions within the health care system as well as the government itself to construct a more fluent and efficient system of care that plays to the strengths of qualified professionals. These changes represent the enablement of professional pharmacists to encompass ever increasing roles of responsibility and diversity to achieve more significant, challenging and rewarding personal and career goals. Thus in these respects professional aspirations of never ending improvement, continuing professional development and role expansion have been met. Before the April 2012 change, there was still a feeling of disenfranchisement from true involvement within a prescribing fraternity. However, with the recent legislative change and the huge positive change that has made, the next question to ask is – where next for the pharmacy profession and ongoing professional development?

## References

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