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Can we learn from nurse prescribing?

By **Jason Hall**, clinical teaching fellow at the school of pharmacy, University of Manchester

Since the first pharmacist prescribers are about to issue their first prescriptions, it is worth pausing to consider if there are any lessons that can be learnt from our knowledge of the introduction of nurse prescribing that would help smooth the path for the novice pharmacist prescriber.

It is 17 years since nurse prescribing was first recommended in a Government report and we now have almost 10 years' experience of nurse prescribing. The first nurse prescribers were community nurses and they included district nurses, health visitors and a much smaller number of practice nurses. These nurses prescribe from a limited list of medicines and appliances termed the Nurse Prescribers' Formulary. More recently, all registered nurses have been eligible to be trained as prescribers and prescribe from a wider range of items known as the Nurse Prescribers' Extended Formulary. However, Prescription Pricing Authority figures indicate that community nurses account for 95 per cent of all nurse prescribing costs.

Pharmacist prescribers must have sufficient confidence to take on the role

Looking back at the delayed introduction of nurse prescribing following its first recommendation, it appears that the Government's greatest concern was the impact that this might have had on an already increasing drugs bill. These fears subsided following reports that nurse prescribing did not add to prescribing costs. Nurse prescribing costs may be lower than was once expected because some nurses are not making use of their prescribing rights, with around a quarter of trained prescribers not regularly prescribing according to one study.[1]

This lack of a cost pressure has meant that many primary care trusts have not made the monitoring of nurse prescribing a priority. It is perhaps not surprising, given the financial pressures on the National Health Service, that their focus has been actual and potential overspends due to GP prescribing.

However, the targeting of prescriber support should not just be determined on the basis of financial risk but should also consider the prescribers' needs. Therefore their level of prescribing should be reviewed, in addition to performance against prescribing indicators. One could argue that the needs of a prescriber are greatest at the start of their prescribing career and a lack of support during this period could prevent their development into confident prescribers, resulting in a lost opportunity for improving patient care. Prescriber support can take a variety of forms that include targeted information, training, access to help and advice, user-friendly administrative systems, peer review and performance feedback.

Targeted information and training can help address confidence problems and several studies suggest that community nurse prescribers lack confidence in prescribing. There are a number of possible explanations. Having to wait up to 18 months to receive a prescription pad following qualification, as has happened, does not help their confidence, and this could be avoided provided there is collaboration between those responsible for training, registration and issuing prescription pads. One could point to the relatively brief period of training (two days plus a distance learning package) compared to supplementary prescribers (26 taught days and 12 days learning in practice) and claim that this is less likely to be a problem for supplementary prescribers. However, most of the community nurses interviewed[1] believed that their original training was satisfactory but they lacked ongoing training. It has been reported that support mechanisms for prescribers are weak and some nurse prescribers uncertain whom to consult for support.

Research carried out within my department has identified that prescribing administrative systems vary. In those places with higher levels of prescribing, the systems appear to have evolved and the nurses consider them to be user-friendly. But in places with low levels of nurse prescribing, the systems appear cumbersome and were perceived by nurses to be a barrier. Since both supplementary and independent prescribers are required to share a common record there is less need for separate communication channel which should simplify the administrative systems. It is also hoped that the supervised learning in practice component of the training will provide supplementary prescribers with the opportunity to become confident in such procedures. However, supplementary prescribing will have its own administrative systems and central to these are the clinical management plans. It is rare for administration systems to be perfect at the first attempt so it is important that trusts reflect on prescribers' experience with such systems and also work with other trusts to share good practice.

Many nurses claim that they have not received feedback on their prescribing and complain that they have little knowledge of their performance. Systems have developed to allow GPs to review their prescribing, but as yet it appears that many places have not developed systems for nurses. It is likely that the bulk of prescribing costs will remain with doctors for the foreseeable future and therefore pharmacist prescribers could well receive as little feedback as nurse prescribers. However, if little attention is paid now to encouraging good practice then it may be more difficult in the future.

The area of prescribing where community nurses are most active is in wound management and it was acknowledged before the introduction of nurse prescribing that GPs were simply endorsing nurses' clinical decision making in this area. It could be argued that nurse prescribing has been most successful where it has involved little change to their clinical practice and areas that involved role development, such as smoking cessation, have not taken off to the same extent. This could reflect a resistance to change or that the training addressed how to prescribe rather than what to prescribe. Trusts considering the therapeutic areas in which they wish pharmacists to prescribe should consider the extent to which it represents a development of their role and tailor their support accordingly.

The Department of Health has said that supplementary prescribing aims "to provide patients with a quicker and more efficient access to medicines" and over time it is "likely to reduce doctors workloads". There have been reports that time is saved for patients as nurses can write the prescription there and then, rather than chasing doctors to write prescriptions. It was also hoped that nurses would save time but the time required for administration related to nurse prescribing and discussing medicine usage with patients appears to offset any time saved elsewhere. It may be that this different use of time represents a more effective use of time that pharmacist prescribers will relish. However, both pharmacists and their managers will need to consider what aspects of their current role they will no longer be able to perform in order to ensure that they have sufficient time to prescribe.

Supplementary prescribing should benefit patients by improving their access to prescribers but pharmacist prescribers must have sufficient confidence to take on the role. Trusts can facilitate this by ensuring pharmacists work in areas where they have the opportunity to prescribe with protected time to enable them to do so, by developing systems for the routine monitoring of supplementary prescribing, by engaging in discussion with prescribers and other trusts and by providing ongoing support and feedback that meets the needs of prescribers.

Reference

1. Luker K, McHugh G, Nurse prescribing from the community nurse's perspective. Interntional Journal of Pharmacy Practice 2002;10:273–80.

Why choice is the good news for 2004

By **Beth Taylor**, member of the NHS modernisation board and primary care task group that consulted on choice, responsiveness and equity

Some are predicting that 2004 may mark a step change for the better for pharmacists. One of the good reasons for this optimism, perhaps not yet widely recognised, is the report of the Department of Health's latest consultation on choice, responsiveness and equity, which was published in early December 2003. The report, "Building on the best" (available at www.doh.gov.uk/choiceconsultation/index.htm), makes encouraging reading for those who would like to see a more radical, patient-centred approach to managing medicines in the future. It quotes a *PJ* editorial on concordance, and has been welcomed by pharmacy organisations (*PJ* 13 December 2003, p802).

This is not mainly about choice of hospital for elective care. "Building on the best" is about a far wider interpretation of what choice can mean for health care, and both primary care and medicines are central in this vision. Many responses from patient organisations featured medication as an issue, and pharmacy organisations were well represented. As a member of the primary care task group, I had the opportunity to listen to patients' views and contribute directly to the debate, and it has been both a refreshing and encouraging experience.

So how did this report arise, and what were major themes to emerge from the consultation, from which the profession can learn? The new Secretary of State, John Reid, highlighted early on his ambition to put patient voices at the centre of policy making, and move away from a "one size fits all" culture in the NHS. Modernisers were also debating the need for cultural change in the NHS. The result was the choice, responsiveness and equity consultation, which ran from August until November last year. There were four strands: a public consultation involving patient and health care organisations, local consultations with patient representatives and the NHS, eight national task groups on major themes, and direct contributions from individuals. The eight themes for national task groups were primary care, maternity services, planned care, older people, children's services, mental health, emergency care, and people with long-term conditions.

The key questions posed were concerned with patient choice, information and support needed and changes in the system required.

At the start, I was aware of a great deal of scepticism from within the NHS generally about choice in primary care. Comments along the lines of "It's not relevant because we have a GP system in place" and "It's bound to be more expensive if we duplicate services" were common. It has been heartening to see how quickly these views have turned around in a short time, and the final report places great emphasis on offering wider options to patients about how, when and where they can access primary care services in future. The major reason for this, in my view, has been the enlightening responses from the public and their representatives on what choices they would like to see in a modern NHS. People wanted: more opportunity to share in decisions about health and health care and to make choices about that care where appropriate; more information in order to make decisions and choices about their treatment or care; and services to be shaped around their needs instead of being expected to fit the system.

Medicines and pharmacy are centre-stage, patient-focused

All these points are highly relevant in primary care. The primary care task group advocated more flexibility and choice in how people access medicines, and direct access to a wider range of primary care practitioners, including pharmacists, where appropriate. Another interesting theme was the need for a possibly non-clinical "navigator" role in primary care, to help people make informed and personal choices about services available, and to avoid unnecessary referrals and treatments.

What does all this mean for the NHS and for pharmacists? This report does not contain a list of targets for NHS managers to be measured against but, instead, marks the start of an important change in culture and direction for the NHS. John Reid has made it clear that the themes of the report will impact on all future national policy developments, and must also be taken into account more locally. It is clear from modernisation board meetings that the leaders of national patient organisations are becoming much more influential in many ways, as signalled by Harry Cayton's role as director of patients and the public within the Department of Health. I believe this is hugely welcome, and that such people are some of the most effective advocates we as a profession could wish for.

They can be vocal about making greater use of pharmacists and pharmacies, reflecting views from their members. As a result, medicines feature prominently in the final report, which includes the following priorities for action:

Increased choice of access to a wider range of services in primary care, helping people get access to health care on their own terms. This will include not only developing traditional primary care services but also encouraging innovative new providers, particularly in deprived areas where primary care has traditionally been weak. It will also mean extending the ways in which people can get advice in other ways and new arrangements to help people access care away from home.

Increase choice of where, when and how to get medicines. The Department will continue to ease the bureaucracy around repeat prescribing, free restrictions on the location of new pharmacies, expand the range of medicines pharmacies can provide without a prescription, promote minor ailments schemes where pharmacies can help patients manage conditions like coughs, hay fever and stomach upsets without involving their GP and increase the range of health care professionals who can prescribe.

Cynics may point out that some actions within the Department's response are ones that were in progress already, and do not represent new thinking. This may be partly true, but what is new is the emphasis on personally relevant choices, convenient and timely access to wider service options in primary care, and a shift in the type of information required to support this.

So how should we be responding? There is specific mention of the valuable role of pharmacists in monitoring chronic diseases, and clear support for pharmacy-based minor ailment services. There is mention of mail order and internet pharmacies, but we must accept that this accurately reflects the public's views. What we have to ensure is that such views are not allowed to close down choices for other groups of patients such as those who wish to use local pharmacy services, because this would go against the key principle of equity and could impact disproportionately on disadvantaged groups.

The themes will support those developing many different community pharmacy services that people can directly access without visiting a GP first. GPs are sometimes divided on this issue, but my perception is that provided information is fed back to them appropriately, many are supportive of direction of travel, particularly if IT developments can help. Certainly, patients are fed up with wasting GPs' time on visits made solely in order to get referrals elsewhere.

So 2004 has started with a national policy development in which medicines and pharmacy are centre stage, patient-focused and fit well with the profession's aspirations. Let us make sure that as a profession we can build on the best I know we can offer.

Feedback on local examples of good practice is welcome and can be e-mailed to beth.taylor@southwarkpct.nhs.uk.