Supplementary nurse prescribing – how will it affect diabetes care?

Robert Hallworth

ARTICLE POINTS

1 Through the increased flexible use of workforce skills, supplementary prescribing aims to maximise the benefit to patients and the NHS.

2 There are many roles in which nurses can function as supplementary prescribers in the care of people with diabetes.

3 Some of the skills necessary to be a supplementary prescriber will be new and and these will need to be learned and maintained.

4 Supplementary prescribing can build on the currently available services in both primary and secondary care and better utilise the skills of nursing staff.

5 Supplementary prescribing must be underpinned by good strategic vision and planning.

KEY WORDS

- **Diabetes services**
- **Service delivery**
- **Nurse prescribing**
- **Supplementary prescribers**
- **Clinical management plans**

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Introduction

***The NHS Plan* (Department of Health [DoH], 2000) identified the need for the organisation and delivery of NHS services to be patient centred, while the *National Service Framework (NSF) for Diabetes: Delivery Strategy* (DoH, 2002a) focused on structured, proactive care to support people with diabetes in managing their condition. The *NSF for Diabetes* also includes education and training for health professionals involved in the care of people with diabetes. Supplementary nurse prescribing is one way of ensuring that structured supportive care is provided to people with diabetes in secondary care and, increasingly, in primary care.**

Supplementary prescribing aims to maximise the benefit to patients and the NHS, through the increased flexible use of workforce skills (Department of Health [DoH], 2003). It is defined as:

> ***'A voluntary prescribing partnership between the independent prescriber and a supplementary prescriber, to implement an agreed patient-specific clinical management plan with the patient's agreement.' (DoH, 2003)***

Supplementary prescribing was introduced through a Prescription Only Medicine (POM) Order amendment and changes to the NHS regulations in April 2003. Currently, only nurses and pharmacists can train as supplementary prescribers. Indeed, the DoH has set a national target for 1000 pharmacists and 10 000 nurses to be trained as supplementary prescribers by the end of 2004 (DoH, 2002b).

Several important criteria must be fulfilled before supplementary prescribing can take place (*Table 1*). Clinical management plans (CMPs) are the foundation stone of supplementary prescribing, and must be agreed between the independent and supplementary prescribers. Draft templates for CMPs, which may be individualised to meet the patient's needs, can be downloaded from the DoH website (DoH, 2004a).

Opportunities

There are many roles in which nurses can function as supplementary prescribers in the care of people with diabetes. In primary care, for example, they could provide chronic disease management clinics or

Table 1. Criteria for supplementary prescribing

- The independent prescriber must be a doctor (or dentist).
- The supplementary prescriber must be a registered nurse, registered midwife or registered pharmacist.
- There must be a written clinical management plan relating to a named patient and to that patient's specific conditions. Agreement to the plan must be recorded by both the independent and supplementary prescribers before supplementary prescribing begins.
- The independent and supplementary prescribers must share access to, consult and use the same common patient record.

Source: Department of Health, 2004b

medication review/repeat prescribing clinics, and in secondary care they could work with consultant teams, adjusting medication dosage (such as insulin) or prescribing for patients on discharge from hospital.

Involvement in initiatives such as these will be challenging and, in the author's opinion, increase job satisfaction. However, when nurses apply to study on a supplementary prescribing course, the higher education institutes (HEIs) will wish to know what impact the qualification will have on patient care.

Benefits of the supplementary prescriber role can be indentified, for example:

- Improving access to treatment and/or reducing delays in accessing treatment: patients can be seen by a nurse more quickly than by a doctor.
- Helping to address a shortage of GPs by service redesign: nurses can provide a prescribing service for patients.
- Reducing waste from current prescribing mechanisms: duplication of prescribing activity by different healthcare professionals is reduced.
- Supporting the delivery of the national General Medical Services contract: helping to achieve quality targets. Nurses can help by prescribing towards these targets.

It is also important to consider the possibility that the service may be provided more quickly by other means, such as a patient group direction (PGD), which does not require the nurse to be a supplementary prescriber.

A PGD is defined as:

> ***'A written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.'***

Nurses are one of the groups of health professionals who can supply medicines on a PGD, but this mechanism is designed to provide emergency care (e.g. administration of glucagon injection) and one-off episodes of care (e.g. administration of influenza vaccine) and is not intended for continuing care.

A PGD is therefore unsuitable for chronic disease management and cannot be used for dosage adjustment of insulin or oral hypoglycaemic agents, for example. In the latter case, supplementary prescribing is the most suitable mechanism for improving patient care.

Training

Supplementary prescribers are able to prescribe any product (available on NHS prescription) except controlled drugs or unlicensed medicines (with the exception of paediatric care). During the taught sections of the training course, it is not possible to cover the entire contents of the *British National Formulary* (BNF). The English National Board (ENB) outline curriculum for supplementary prescribing can be accessed from the DoH website (DoH, 2004c). This will provide the underpinning knowledge for all supplementary prescribers, irrespective of their specialist area, but time for private study on the prescriber's chosen therapeutic subject area will need to be built into training plans.

Before embarking on the course, aspiring supplementary prescribers will need to ensure that adequate cover has been provided for their current role while they are studying.

Courses vary in composition, but usually involve at least 26 taught days and 12 in-practice days with a designated medical practitioner (DMP) over six months (DoH, 2004d). The taught element has generally featured face-to-face contact; however, organisations have experienced problems in releasing staff, and there is now some provision for open/distance learning, and some HEIs have developed e-learning. It is, therefore, important to check how the course is delivered by the various organisations before committing to a course.

Course fees are funded by the DoH, but there is no funding available for staff replacement costs, which must be found by the employing organisation.

The importance of the DMP's input to the success of the supplementary prescribing process cannot be over-emphasised, as so many of the practical and therapeutic issues are learned and perfected in practice rather than during the taught days. This input must therefore be present post-qualification to ensure that, for sound clinical governance reasons,

PAGE POINTS

1 The role of supplementary prescriber has proven benefits for patients.

2 The service may be provided more quickly by other means, such as a patient group directive (PGD), which does not require the nurse to be a supplementary prescriber.

3 Before embarking on the training course, aspiring supplementary prescribers will need to ensure that adequate cover has been provided for their current role while they are studying.

4 Courses vary in composition, but usually involve at least 26 taught days and 12 in-practice days with a designated medical practitioner (DMP).

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Table 2. New skills required by supplementary prescribers

Process skills

- Prioritising
- Organisation
- Empathy
- Problem solving
- Team working
- Assertiveness
- Influencing
- Budget management
- Working knowledge of NHS structure, local and national guidelines, e.g. NICE, NSFs
- Data interpretation and information searching
- Critical appraisal
- IT technology skills, e.g. use of GP computer systems and templates

The consultation

- Physical examination
- Interpreting monitoring and diagnostic tests
- Negotiation
- Analysis of risk/benefit and application of the 'no-treatment' option
- Communication with patients and healthcare professionals
- Active listening
- Consultation skills, e.g. successfully ending a consultation
- Clear documentation
- Concordant approach, providing informed choice and an agreed treatment outcome

Essential skills

- Knowing limitations – being aware of referral pathways and procedures
- Patient confidentiality
- Awareness of responsibility and accountability
- Continuing professional development – underpinned by good reflection, planning and networking skills

competence to practise is maintained at all times.

Again, there is no funding for DMPs, who are likely to be consultant physicians and GPs. As a result, some flexibility for 'learning in practice' may be permitted – not all the time has to be spent with the DMP. Although an experienced qualified nurse can act as a mentor during training, a doctor must still undertake the overall competency assessment.

Skills

A supplementary prescriber has to be able to prescribe safely, effectively and in an evidence-based manner within his/her knowledge and competence. While nurses possess many of the skills required to be a supplementary prescriber, many of the necessary skills will be new and different and these will need to be learned and maintained. *Table 2* lists some of these diverse skills.

The National Prescribing Centre (NPC) has produced a competency framework for nurse prescribers (NPC, 2001, 2003). This can be used as a basis for reflective practice in order to identify learning needs and gaps in competency to carry out a prescribing role.

The present and future

The first nurses commenced supplementary prescribing training in January 2003. Pharmacists began training as supplementary prescribers in September 2003, and the first cohort qualified in March 2004.

Work has now started on extending supplementary prescribing to some allied health professionals (DoH, 2004e). On 10 May 2004, a 12-week consultation period between the DoH and the Medicines and Healthcare Products Regulatory Agency (MHRA) commenced, regarding the addition of physiotherapists, podiatrists,radiographers and optometrists to the list of professionals able to train as supplementary prescribers. The consultation has now closed and the MHRA is considering the responses before putting them to the Committee on Safety of Medicines in the autumn.

It is possible, therefore, that people with diabetes may receive prescriptions for their foot and eye care from supplementary prescribers other than nurses in the future.

Conclusion

Nurses involved in the care of people with diabetes already have regular patient contact and are familiar with the evidence base underpinning the treatment of diabetes. Since diabetes is a chronic condition, supplementary prescribing can build on the currently available services in both primary and secondary care to have a positive impact on patient care and better utilise the skills of nursing staff.

However, good support for the supplementary prescriber needs to be in place before, during and after training. The

Table 3. Support required for supplementary prescribing

- Workforce planning processes to identify a future role and provide backfill during training
- Independent prescriber(s), who perceive the need for supplementary prescribing, with whom the nurse can work after qualification
- Designated medical practitioner to act as a mentor. This person receives no remuneration but must be prepared to provide 12 days of supervised protected practice time during the course, and half a day per month after qualification. Also required to assess and confirm that the nurse is competent to prescribe (in conjunction with the higher education institution)*
- Location for supervised protected time
- Infrastructure to allow prescribing to take place – location, access to notes, referral procedures, provision of prescription pads, budgetary arrangements, etc
- Clearly defined, robust clinical governance framework within which to work
- Method of identifying post-qualification training and development needs
- Processes for monitoring the success of supplementary prescribing – quantitative, qualitative, appraisal, etc

* it is possible for the independent prescriber and the designated medical practitioner to be the same individual

main areas of support required are listed in *Table 3*. This organisation is essential as already stretched diabetes services can ill afford to release staff to attend courses that train them for a role that may be poorly defined. In addition, the DMP will need to devote time to the mentoring of the nurse to adopt this new role, possibly affecting service delivery. Supplementary prescribing provides an ideal opportunity to enhance the care of people with diabetes, but it must be underpinned by good strategic vision and planning within the organisation. ■

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PAGE POINTS

1 The supplementary prescriber requires good support before, during and after training.

2 Supplementary prescribing provides an ideal opportunity to enhance the care of people with diabetes.

3 Good strategic vision and planning within the organisation are crucial to its success.