Non-medical prescribing: The road less travelled?

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Are you are a recently qualified non-medical prescriber (NMP) or are you on the brink of undertaking the course to become either an independent or supplementary prescriber? Then this editorial is intended for you… Alternatively, if you are bewildered by the arrival of NMPs and are intrigued after reading the recent *Daily Mail* article condemning us (Martin, 2007) then please read on.

What is non-medical prescribing?

The various mechanisms for non-medical prescribing, supply or administration of medicines are defined by the DoH (2006) as:

- patient group directions
- patient specific directions
- nurse independent prescribing
- pharmacist independent prescribing
- optometrist independent prescribing
- supplementary prescribing by nurses, pharmacists, optometrists, physiotherapists, podiatrists and radiographers.

This editorial focuses on the potential role of supplementary prescribing as a mechanism of enhancing the care of people with diabetes-related foot complications. To date, it only exists in England. Both authors write this editorial as qualified supplementary prescribers (SPs) involved in actively championing the management of people with diabetes-related foot complications across both primary and secondary care settings.

Supplementary prescribing represents a tripartite voluntary partnership between the independent prescriber (IP) and the SP, with the patients' agreement. In May 2005, supplementary prescribing was extended to include physiotherapists, podiatrists, radiographers and optometrists. Previously, only nurses and pharmacists could use this mechanism of prescribing (DoH, 2005).

Supplementary prescribing is deemed most useful for managing individuals with long-term conditions. The SP competent to manage a condition is responsible for prescribing for a person within an agreed clinical management plan (CMP) between reviews by the IP (a doctor). In such an arrangement there is a requirement for a partnership between the IP and the SP where both have access to the same patient record (DoH, 2006).

Those practitioners involved in managing diabetes-related foot disease within multidisciplinary teams (MDTs) offer a prime potential for such a working partnership. Back in 1995, the work of the St Vincent's Taskforce defined the individual roles of the MDT on the diabetes foot clinic (St Vincent Declaration Meeting, 1995). However, just 12 years on there is now quite a different hybrid of skills across these teams. *The National Minimum Skills Framework for Commissioning of Foot Care Services for People with Diabetes* (Diabetes UK, 2006) clearly defines the skills required to manage the complicated foot in diabetes and is not profession specific. We would argue that the MDT is evolving towards care defined by competence rather than the traditional discipline-defined model of practice. For example, some podiatrists can measure and prescribe footwear; increasingly nurses in England are undertaking debridement courses at Masters level; and many healthcare professionals use patient group directions to dispense protocol-driven antibiosis. More recently, SPs are able to prescribe antibiotics along with other medicines under a defined CMP.

The demand for high-quality services in which the roles of healthcare professionals extend outside of traditional boundaries has led to prolific changes in the roles of non-medical professionals. Diabetic foot problems are quite frequently assessed and reviewed in isolated settings outside the multidisciplinary clinic where prescribing decisions often need to be made by practitioners with limited specialist knowledge (Stuart and Baker, 2007). In such well-recognised circumstances, surely non-medical prescribing for diabetic foot specialists has much to offer?

The role of NMP sits well within a competence-defined practice where nurses or allied health professionals (AHPs) prescribe within a clearly defined governance structure

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initially overseen by a doctor. NMPs will only prescribe items they can demonstrate they are competent to. Failure to abide by such practice will compromise their career in the event of an error.

A time to take the road less travelled?

Non-medical prescribing opens doors to utilise nursing and AHPs specialist knowledge in chronic disease management inclusive of diabetes.

It is, admittedly, early days for NMP and people with foot complications. To the best of our knowledge, while there appears to be evidence of supplementary prescribing working in secondary care diabetic foot clinics, few AHPs are prescribing as SPs in primary care (as can be seen in discussions on the FDUK forum: www.footindiabetes.org [accessed 07.09.2007)). There are now more than 10 000 nurse prescribers, 82 % of whom work in primary care (Courtney et al, 2007).

Clearly, AHPs have lessons to learn from these nurses who have been prescribing since 2002. However, nurses too have acknowledged that implementation of supplementary prescribing is fraught with difficulty (James, 2006; Courtney et al, 2007). The controversy of non-medical professionals prescribing has more recently provoked much debate (Avery and James, 2007; Martin, 2007).

Regardless of location, effective prescribing can only occur when all professionals involved are working closely together. Surely the multidisciplinary diabetes foot clinic can provide an ideal environment for supplementary prescribing to effectively impact where doctors, nurses and podiatrists work collaboratively to achieve best possible outcomes. Such a model underpins the notion of seamless care.

Realistically, NMPs will also be working outside of the multidisciplinary foot clinic and will be locating individuals with immediate prescribing needs in places and times that do not match the availability of these clinics. Clearly, stretching the concept of integrated care here across primary and secondary care settings poses a considerable challenge. The dilemma of what to do with the Friday afternoon domiciliary individual with diabetes and other co-morbidities, presenting with a mild foot infection is one that NMPs will face and struggle with in relation to prescribing as either an IP or an SP. We do not have the answers at the time of writing this editorial.

For SPs in particular, the need to have a CMP signed by the IP in place prior to prescribing is both a safety net for shared responsibility and a logistical obstacle when not having timely access to the IP (Courtney et al, 2007).

This editorial takes place at an early stage of the evolutionary journey of NMP in England but if supplementary prescribing is to improve the delivery of care in diabetes we reiterate the DoH (2006) guidance that SPs ensure the following benchmark standards are met before prescribing:

- NMPs must be rooted in robust, well-defined clinical governance structures, which requires consultation with key stakeholders.
- NMPs must not compromise the patient or themselves by working outside their defined area of clinical competence regardless of their prescribing status.
- NMPs must ensure that they can demonstrate access to shared clinical records.
- SPs must never prescribe without having a signed CMP in place, with clearly defined prescribing limits included.
- NMPs must ensure that they are supported with appropriate CPD to underpin their prescribing practice.

It is interesting to note that although independent nurse prescribing has been around for the last 12 months that up to 40 % of IPs still choose to continue the SP prescribing route. This may be because it offers protected prescribing within defined areas and assists the development of competence and trust between medical and non medical prescribers. A wise first step on this particular road less travelled?

Conclusion: early days for NMP

Does NMP have a key role to play in prescribing for the foot in diabetes? We suggest the answer is a resounding *yes*, once the elements listed above are in place. From appropriate, timely antibiotics to optimising glycaemic control, reducing cardiovascular risks and managing pain caused by neurovascular complications, the applications are obvious.

For both IPs and SPs working in diabetes, the time is now to build governance frameworks to prescribe within. Only when you have ensured these are in place is it safe for you to pick up your pad and write that first prescription. ■

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