

Opportunities and risks in prescribing

Non-medical prescribing was discussed at a conference held in London in October. **Clare Bellingham** reports

Improving access to care and managing long-term conditions are two of the areas where there are opportunities for non-medical prescribers, according to Alison Smith, chairman of Adur, Arun & Worthing Primary Care Trust's professional executive committee.

"Access is a great thorny issue for many of us but the Government isn't going to let go of its access targets," she said. These are access to a GP within 48 hours and to a nurse, health care assistant or pharmacist within 24 hours, she explained. "So there is an opportunity here for non-medical prescribers in triage and first contact care."

Turning to long-term conditions, Dr Smith said: "We know that 5 per cent of the population uses 42 per cent of hospital resources. The question is how we can rechannel these resources to provide better care for patients," she said. "It is perfectly possible for care to be monitored by someone other than the doctor." Using other health professionals to manage long-term conditions frees GPs to do what they are trained for: "To manage uncertain situations when a patient presents and it isn't know what is happening to them," she said. "Other professionals' skills are in the management of more certain, long-term conditions, but mine are not."

This point was supported by Barbara Stuttle, chairman of the Association of Nurse

Prescribing. "Some nursing colleagues found learning to cope with uncertainty hard when they first started prescribing," she said, particularly in the care of children where deterioration could be rapid. Beth Taylor, specialist principal pharmacist at Southwark PCT, added that pharmacists are good at managing certainties. "This is a generalisation, but pharmacists tend to like things to be clearly set out and understandable," she commented.

Dr Smith pointed out an omission in the new GP contract is health promotion. Yet health promotion is the plinth underneath the chronic disease management pyramid: in other words, stopping people getting a disease in the first place.

Managing new risks

New prescribers bring new risks. "I worry a lot about who is managing the natural history of the disease," Dr Smith said. If a person is managed "in bits", it has to be ensured that everything is picked up.

This was discussed by Clare Mackie, head of the Medway School of Pharmacy, who said that as more health professionals became prescribers, there was a danger of fragmenting care. But she pointed out that under the old model of doctor-only prescribing, different doctors could see a patient and, if they wrote inadequate notes in the patient's record, this could lead to a breakdown in seamless care.

Supplementary prescribing is a new model of care and an evidence base for it needs to be developed, said Professor Mackie. She said that the nearest equivalent for which research exists is medication review resulting in an agreed management plan that is implemented by someone other than the reviewer. A systematic literature review found fewer than 10 robust studies examining this type of review. Some of Professor Mackie's work in the area had shown that eight out of 10 people taking four or more medicines required a medicine change. Addressing these problems resulted in substantial health gain.

The introduction of supplementary prescribing brings other challenges. Professor Mackie suggested that one of the biggest is how to maintain competency after qualifying as a prescriber. "There is no national structure to reassess competency," she said. The National Prescribing Centre's framework for the competent prescriber could be used to find examples of ways to demonstrate competence, but she added that all supplementary prescribers have different areas of specialty.

Another challenge concerned intra-professional deskilling: for example, a GP becoming so reliant on an asthma practice nurse that the GP can no longer manage asthma alone. "So supplementary prescribing must be something that is done in partnership, not isolation," she warned.

Legal issues in supplementary prescribing

Jane Lynch, a solicitor at Bond Solon, talked about legal issues around supplementary prescribing. "Good communication is the cornerstone of extended prescribing powers," she said. "One of the major causes of medical accidents is a breakdown in communication."

With the cost of clinical negligence claims against the NHS reaching £5.89bn in April 2004, she warned conference participants that one in three of them would be involved in litigation at some time. "Your employer is responsible for your actions but if you act outside your prescribing powers then your employer may not support you," she said.

A supplementary prescriber may not write a prescription and ask a GP to sign it retrospectively, she explained. The clinical management plan (CMP) should be kept as simple as possible but it must contain all the relevant information. Patient consent to be treated should be recorded, along with details of who

the prescribers are, who made the diagnosis, what the medication is, and a description of the circumstances in which the dosage, frequency or formulation can be changed.

It is essential that the independent and supplementary prescriber share access to a common patient record. "Where information becomes fragmented there is a real risk of a breakdown in communication," she said. Records have to be kept in addition to the CMP. "You have a legal and professional duty to maintain records; it is not something you fit in, time permitting," she said.

Entries in records should be made contemporaneously, or at most within 24 hours of a consultation. Records should provide enough information for another professional to be capable of taking over a patient's care, she said. Entries should be clear, meaningful and unambiguous. All tick boxes should be completed and gaps should not be left in records to fill in later. If following a protocol, a copy of the protocol should be attached to the notes. "If something is not recorded, then there may be the assumption that it did not happen, was not considered, or was not said."

Evidence-based care

It is important for new prescribers to know about the evidence about the efficacy, safety and cost-effectiveness of medicines, according to Neal Maskrey, medical director at the National Prescribing Centre.

First, prescribers need to understand the hierarchy of evidence. Dr Maskrey said that large well-designed randomised controlled trials and meta-analyses of smaller randomised controlled trials rank at the top.

Differences in clinical studies are described in different ways, he commented. Relative risk reductions stay constant in different populations but absolute risk reductions alter in different populations.

The size of the study matters since more consistency in results is found in larger studies, Dr Maskrey explained. The *P* value depends on how large an effect was, how consistent it was and how many patients were studied. He pointed out that in medicine, it has been arbitrarily set at $P < 0.05$, but asked "are you happy with a one in 20 risk".

Dr Maskrey commented that in medicine, a one in 20 risk is accepted but this level of risk is not acceptable in astrophysics.

The non-medical prescribing conference was held in London on 14 October by Surrey & Sussex and Kent & Medway Strategic Health Authorities