

Support for non-medical prescribers

As Government policy to extend prescribing responsibilities takes effect, the number of non-medical prescribers will increase. Around 200 of these new practitioners (pharmacists and nurses) attended a conference designed to support their practice. Lin-Nam Wang reports

These are exciting times for new prescribers across the non-medical professions, Clive Jackson, chief executive of the National Prescribing Centre, said. "Increasing numbers of individuals with more prescribing flexibility are opening up new ways of delivering health care to patients," he added. The further expansion of prescribing mechanisms to include nurse and pharmacist independent prescribing plus the White Paper, which is imminent, is further going to radicalise the way care, particularly in primary care, is delivered, Mr Jackson predicted.

Department of Health figures indicate that there are now about 5,700 nurse supplementary prescribers and 450 pharmacist prescribers qualified in England. In terms of all nurse prescribers (18,900 are trained), Dave Roberts, manager at the Prescribing Support Unit, reported that although half are actively prescribing, the number of items prescribed by nurses is small. Of the qualified pharmacist supplementary prescribers, around 200 are actively prescribing. From July to September 2005 the top 10 drugs (in terms of number of items) prescribed by pharmacists were: bendroflumethiazide, warfarin, ramipril, atenolol, aspirin, felodipine, simvastatin, amlodipine, paracetamol and nicotine replacement therapy. Atorvastatin held the number one spot as the most costly pharmacist-prescribed drug.

According to Mr Jackson, qualified non-medical prescribers need to know the legal and regulatory frameworks but, increasingly,



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they need to understand where they are going to fit into the radical NHS reforms in order to grasp all the opportunities potentially available. In addition, non-medical prescribers need the support to ensure that they are delivering high quality care to patients and cost-effective care for their employers and the health service. Continuing professional development, with the ultimate move towards revalidation of non-medical prescribers, is another emerging issue and Mr Jackson announced that the NPC and its NPC plus arm will be delivering increased levels of support to non-medical prescribers over the next 12 to 18 months.

An issue raised by Jackie Smith, pharmaceutical adviser at Bedford Primary Care Trust, was that although there is a need for community pharmacist prescribers, there is a lack of money to get such services up and running. GPs are reluctant to "use their wedges of cash to put into pharmacist prescribing", she claimed. In response, Mr Jackson said the NPC will be looking at whether or not it can support practice-based commissioning. "Clearly [practice-based commissioning] could be one option to promote non-medical prescribing as an additional option to deliver health care effectively within a locality," he said.

What does it take to be a good practitioner?

Ideally, treatments should be based on the best available evidence but with around 40,000 new articles in journals to read each week, evidence-based practice can be difficult to achieve. Even those who have been trained in critical appraisal and who have access to IT can find it difficult, according to Neal Maskrey, medical director at the National Prescribing Centre. For example, although the National electronic Library for Health provides links to most trusted sources of summaries of evidence, the user is not given any help to choose the most useful site. "It's like a Woolworth's pick and mix," Dr Maskrey said — "no-one talks about how to find what we want, fast."

In a clinical setting, evidence-based practice can be even more difficult. Quoting ex-

isting research, Dr Maskrey said that guidelines are unlikely to be read and expert computer systems are rarely used. Largely, information from tacit sources — what practitioners see and what others tell them — is what changes clinical practice.

Dr Maskrey acknowledged that although evidence-based practice was important, "there is a lot more to a consultation than knowing the number needed to treat". Caring is also important. "You can be low on competence but quite caring and people will like you, and you can be good [competent] and get respect, but you need both to get trust, and you need trust to be a good practitioner," he said.

Although there is a need for both original research and clinical experience, neither can be relied on alone. People would rather be treated by a practitioner who has lots of experience than one who has read lots of books. On the other hand, the experienced practitioner's behaviour can be skewed because he

or she has seen lots of people and has collectively constructed "mindlines". For example, the top three most important interventions for people with type II diabetes are stopping smoking, tight control of blood pressure and taking a statin. Tight control of blood glucose comes sixth. A key message from the UK Prospective Diabetes Survey was that although blood glucose control should not be ignored, benefits were microvascular and strokes and myocardial infarctions were not reduced. However, an analysis of 35 expert reviews on the treatment of type II diabetes found that only six reported that tight control of blood glucose had no effect on diabetes-related death or total mortality. "Experts tend to see more people with type I diabetes so when they see type II, that is where the mindlines lie. Type II needs to be seen as a vascular disease not an endocrine disease," Dr Maskrey explained. "So you want an expert to diagnose or do a procedure, but not to interpret the evidence base," he concluded.

The Non-medical prescribing in 2006 conference organised by the National Prescribing Centre took place at the Thistle Tower Hotel, London, on 24 January