What is the value of supplementary prescribing in the 2020’s? – a dietitian’s perspective.

Introduction

Supplementary prescribing (SP) is one of two models of non-medical prescribing (NMP) currently used in the United Kingdom (UK): the other being independent prescribing IP). NMP describes prescribing that is undertaken by healthcare professions other than doctors or dentists. Completion of a recognised qualification is required to allow the healthcare professional to work with the additional responsibility. In the UK, the NMP workforce comprises nurses, pharmacists, and other allied health professionals (AHPs) (Beckwith and Franklin 2011)

NMP began in 1992 with nurses, but since then it has evolved to incorporate a wider group of healthcare professions. The scope of practice has become more autonomous, allowing many of the early NMP healthcare professions to progress from SP to IP, as NMP has become more embedded in healthcare culture. Consequently, IP is the predominant model in the 2020’s (Cope, Abuzour, Tully 2016).

NMP in the 2020’s is fundamentally different to when supplementary prescribing was first introduced in 2003, when it was an unknown entity. Independent prescribing is now well-evidenced and established in healthcare, as is the form undertaken by most of the NMP workforce. Consequently, it is important to question whether new professions becoming NMPs need to begin with supplementary prescribing. This paper will describe the models of NMP, outline how NMP has evolved and evaluate the current models in use, to enable discussion on the value of supplementary prescribing for dietitians in the 2020’s.

Models of prescribing

Supplementary prescribing involves a voluntary partnership between an IP (a doctor or dentist) and an SP to implement an agreed, patient specific clinical management plan (CMP), with the patient’s agreement. Within this partnership, the IP is responsible for making the diagnosis, indicating which medications can be prescribed within the CMP, setting the parameters for its use, and monitoring (Beckwith and Franklin 2011).

The SP is responsible and accountable for their prescribing practice within the limits of the agreed CMP, which is the foundation stone of supplementary prescribing and provides the legal framework. It can be used to prescribe licensed medicines, unlicensed medicines, mixed medicines, but the SP will be limited to the medications indicated in the CMP. Any issues that arise need to be referred back to the IP (Department of Health 2005).

In contrast, independent prescribing allows the practitioner to prescribe independently without any direct supervision. This involves making their own assessments and diagnosis to inform their prescribing decisions and they can prescribe any medication that is within their clinical competence (Beckwith and Franklin 2011). Those working as IPs are still able to use the SP model, but for many their independent prescribing rights has diminished the need. The ability to prescribe controlled drugs (CDs) varies between professions and is not automatic to IPs therefore, some IPs may use the supplementary prescribing model to be able to prescribe medications outside their permissions using a CMP.

Development of NMP

NMP was introduced in the UK in 1992, in response to recognition that care could be enhanced if nurses were able to prescribe directly, rather than needing to seek prescriptions from doctors. Its purpose was to be more patient-centred and develop multidisciplinary teamworking (Beckwith and Franklin 2011). Following a variety of amendments to the scope of nurse prescribing, supplementary prescribing was introduced for nurses, pharmacists and some AHPs in 2003. This was a significant advance as it permitted any medicines to be prescribed in comparison to the previous limited formulary (although limited to those indicated in the CMP), but scenarios quickly arose where the practicalities of partnership with a doctor became challenging. This was especially evident in more acute care environments or where the doctor and SP did not work in proximity.(Graham-Clarke et al. 2019).

Consultation resulted in legislation changing in 2006, to permit nurses and pharmacists to prescribe independently. By 2012, all the other supplementary prescribing professions had progressed to independent prescribing, except for radiographers. In 2016, dietitians were permitted SP status (AHP Medicines Project Team 2016; British Dietetic Association 2016) and therapeutic radiographers progressed to IP within the same legislative change. A recent registrant snapshot in September 2021 showed that 161 dietitians had SP annotation on their registration: approximately 2% of registered dietitians. More recently, ADD DATE paramedics have been granted independent prescribing rights without any prior NMP capabilities in response to recognition that their roles involve more urgent care, rendering SP status as impractical (College of Paramedics 2021; NHS England 2015)

Evaluation of NMP models

*Supplementary prescribing*

As supplementary prescribing began with nurses and pharmacists, most understanding is derived from research of these healthcare professions. A large survey undertaken in 2005 explored the prescribing practices of independent extended prescribers (a pre-2003 model) and SPs. It found that a majority were prescribing in primary care (82%), independent extended prescribing was undertaken more than supplementary prescribing (87% v 35%) and the three conditions most frequently prescribed for were asthma, diabetes and hypertension. Factors most likely to prevent prescribing were inadequate formulary, for those working as independent extended prescribers, and implementation of the CMP (Courtenay, Molly, Carey, Burke 2007).

While SP was considered to benefit from the safe framework that the CMP provided, it was noted that the CMP led to inflexible prescribing due to its restrictive nature. Further, it did not acknowledge the complexity of some patients with multiple comorbidities and was not a holistic approach to patient care (REF). It was acknowledged that moving toward independent prescribing would be more flexible, but that SP may still have a role as an introductory model for those with no experience, to build confidence (Cooper, Richard et al. 2008)

A qualitative study exploring pharmacists’ views before and after implementation of supplementary prescribing highlighted the anticipation of what the new role would involve. They felt that it would supersede the advisory role to doctors’ prescribing decisions, by being able to undertake this themselves. Once implemented, many felt more involved and respected by their medical peers and that the risk of errors was minimised. However, the CMPs offset this positivity, as they were seen as cumbersome, timewasting(Tully et al. 2007). Nonetheless, a survey of UK pharmacist SPs indicated that they were confident in their extended role and felt it contributed to job satisfaction. They perceived that their patients were satisfied with their care and benefitted from better therapeutic management (George et al. 2007).

A mixed methods study evaluating both nurse and pharmacist supplementary prescribing found SP was difficult to implement, given the unwieldy use of CMPs, difficult access to medical records and information technology, as well as lack of funding for SP training. In terms of prescribing practice, SPs felt confident and competent to prescribe safely and this was supported by feedback from doctors. Patients indicated positive experiences of nurse and pharmacist SPs, considering them easier to talk to compared with doctors. Their consultations were longer, but they ? patients did not understand either the concept of supplementary prescribing or CMPs (Bissell et al. 2008). A further study indicated that the practical difficulties identified resulted in delays to SPs taking their new role forward once trained (George et al. 2006).

The smallest body of evidence arises from patient perspectives, which is disappointing given that NMP was designed to improve patient care. Patient perspectives contributed to a wider study exploring experiences of mental health nurse supplementary prescribing. Of the eleven patients interviewed, ten found the nurse prescribing to be person-centred, incorporating information giving, partnership working, offering choice and minimising risks, and felt it to be a positive experience overall. Additionally, more than half reported that the nurse prescriber provided more detailed explanations than the psychiatrists and gave more choice on treatment options (Jones et al. 2007)IS THIS SP OR IP?

Patients attending a pharmacist SP-led hypertension clinic were surveyed to explore a perceived positive response. 57% of patients felt their care was better than previously and a further 32% found it comparable. 86% felt their understanding of their condition had improved since attending the clinic and felt more involved in treatment decisions. 86% indicated it was easier to make appointments, supporting the government’s aim to improve access to medicines. However, it is important to note that appointment times in this clinic were purposefully set at 20 minutes rather than the standard 10 minutes to allow a prescribing partnership to develop. This may have been a key factor in its success (Smalley 2006).

A patient survey in Scotland found high satisfaction with their consultations with pharmacist SPs and the medication information they were provided with. They trusted the SP and felt comfortable during their consultations. However, many still indicated they would prefer to see a doctor. It was suggested that this may have been related to long-established confidence in their doctors’ support of their chronic conditions rather than there being specific issues associated with the pharmacist SP. This was also early in terms of pharmacist prescribing , so this was not widely established (Stewart et al. 2008).

*Independent prescribing*

The research literature on independent prescribing is far more comprehensive with all stakeholder perspectives being evaluated in addition to its impact on outcomes. Nonetheless, limited research has been conducted in professions other than nurses and pharmacists (Cope, Abuzour, Tully 2016). An evaluation of nurse and pharmacist IP indicated that most were using their qualification (93% of nurses and 80% of pharmacists), largely driven by the individuals themselves rather than re-design of services (Latter et al. 2010). This contrasted with an earlier study of SPs, where only a small proportion of those trained were prescribing (28% of nurses and 51% of pharmacists), attributed to the cumbersome use of the CMP (Bissell et al. 2008). Additionally, independent prescribing was evaluated as being safe and clinically appropriate, highly acceptable to patients and most patients within this study had no preference for either a doctor or NMP (Latter et al. 2010).

Patient perspectives often related to practical benefits, in addition to positive relationships with the prescribers. They indicated more flexibility with appointments, ease of access and were supplied with more relevant and comprehensive information (Courtenay, M., Stenner, Carey 2010; Courtenay, M. et al. 2011; McCann et al. 2015; Tinelli et al. 2015). Strong relationships with the prescribers were described, related to establishing good rapport which had developed as a result of feeling listened to, promoting trust and openness (Deslandes, John, Deslandes 2015; Stenner, Courtenay, Carey 2011). These strong relationships had positive effects on shared decision-making, increasing confidence levels which further impacted on concordance and self-management (Courtenay et al. 2011; Deslandes, John, Deslandes 2015; Ross 2015; Stenner, Courtenay, Carey 2011).

A 2016 Cochrane review examined NMP versus medical prescribing for acute and chronic disease management in primary and secondary care. Key findings suggested NMP was being undertaken in various settings, with comparable outcomes: management of systolic blood pressure, glycated haemoglobin, low-density lipoprotein, medication adherence, patient satisfaction, and health-related quality of life. The findings supported NMP roles in the UK healthcare systems and workforce (Weeks et al. 2016).

In summary, independent prescribing has all the benefits associated with supplementary prescribing and has demonstrated that the close governance of the CMP is not necessary to support proficient prescribing practice.

Discussion

24 years after nurses began prescribing, dietitians have joined the NMP community as SPs. This has been a long-awaited development for the profession, acknowledging dietitians’ capabilities, and has the potential to better meet patients’ needs. Dietitians are in a unique position to prescribe medications that are dependent on food knowledge to maximise their efficiency e.g., phosphate binders, pancreatic enzymes, insulin etc.

NMP training involves the same course content for both SPs and IPs, often learning alongside each other, so those qualifying at the end of the course have equivalent skills and knowledge to support their prescribing practice. It is solely the legislation, specific to individual healthcare professions, which governs the model with which they can work, and this difference is acknowledged in competency assessment on completion of training. If legislation changes in the future for SPs to be able to work as IPs, an additional conversion course will be required despite undertaking the same course initially, and will necessitate cost, additional competency assessment and further time commitment from the SP.

It is now common practice to be prescribed for by a healthcare professional other than a doctor and the benefits observed by patients are consistent and irrespective of the model of NMP used. Confidence in NMP has grown and its value has been extensively supported by research establishing it to be safe and clinically appropriate, acceptable to patients and has demonstrated non-inferiority to prescribing undertaken by doctors (Gielen et al. 2014; Weeks et al. 2016). Although currently unproven due to a lack of research, these benefits may also be observed with dietitian prescribing.

Dietitians who work as SPs tend to work within close multidisciplinary teams (MDTs) caring for people who have long term conditions where diet and medication treatment strategies are interlinked: diabetes, chronic kidney disease, cystic fibrosis, inflammatory bowel disease and intestinal failure. Shifting the prescribing from the doctor to the dietitian has provided the potential to minimise duplication and avoid mixed messages for patients. The dietitian can now advise on diet and medication together, whilst relinquishing the additional direct involvement of the doctor. It has also allowed the dietitian to develop prescribing competency which is invaluable.

In theory, the model of supplementary prescribing should be ideal for use within MDTs due to the close supervision required, however, for prescribing to be undertaken, a patient-specific CMP needs to be in place. It is not always clear before a dietetic consultation if medication changes will be required as diet is often assessed initially to identify this. This may result in delays to prescribing if a doctor is not contactable to agree a CMP as working closely within MDTs does not always necessitate working in the same location. This delay will not differ greatly from practice without supplementary prescribing i.e. liaising with a doctor once a prescribing need is identified, and changes are then made by the doctor.

At its inception in 2003, supplementary prescribing was considered quite radical, permitting healthcare professionals without traditional medical training to prescribe any medications. It provided a pathway to delegate prescribing responsibilities within a safety net and was appropriate for the healthcare climate at that time.However, the CMP, the underpinning regulatory document, can be a barrier to efficient supplementary prescribing in practice, as documented in studies from other clinical fields (Bissell et al. 2008; Tully et al. 2007). (Courtenay, Carey, Burke 2007; George et al. 2006).

This issue was also raised within a scoping project which was undertaken to support the extension of prescribing and medicines supply by AHPs (Department of Health 2009). It suggested that implementation difficulties arise when there is incompatibility between necessary mechanisms and the needs of patients. The main issue being doctor availability for CMP agreements. In addition, the report highlighted that there are often situations when the AHP is the expert in a clinical condition / intervention, or the professional most familiar with the clinical case, yet the SP needs an IP to validate their expert opinion.

Both issues affect dietitian prescribing, where many of the relevant medications are dependent on food knowledge, and access to doctors cannot always be instantaneous. Reassuringly, once the CMP is in place and prescribing follows, patients are generally positive about their experiences with both SPs and IPs and the value of NMP is realised from this point forward (Courtenay, Stenner, Carey 2010; Courtenay et al. 2011; Deslandes, John, Deslandes 2015; Jones et al. 2007; McCann et al. 2015; Smalley 2006; Stewart et al. 2008; Tinelli et al. 2015).

In the 2020s, supplementary prescribing has been almost entirely replaced with independent prescribing for most of the NMP healthcare professions, bypassing the need for a CMP. Dietitians and diagnostic radiographers are the exception to this and are currently permitted to work as SPs only. Most professions have begun with SP status, with the exception of paramedics, who were granted IP status without prior NMP experience. This was because they were able to justify the incompatibility of the SP model with how they work (College of Paramedics 2021).

Considering that NMP was introduced to improve patient access to treatment and to make better use of resources, the supplementary prescribing model can be seen as potentially outdated in the 2020s. Although there appear to be no differences to how prescribing is perceived by patients, the practicalities of implementing the supplementary prescribing model cannot continue to be ignored. Discontinuing supplementary prescribing in favour of independent prescribing will not cease supervision between doctor and non-medical prescriber, but will foster effective team working for more complex prescribing decisions.

Dietitians are already embedded within MDTs providing the opportunity for case discussions and so the need for the close supervision required to agree a CMP is becoming increasingly redundant. It would permit smoother and more timely prescribing in practice if it were no longer necessary. Plans are underway to propose changes to legislation to permit dietitians to work as IPs but without supporting evidence, the case will be difficult to make. Where healthcare professions have previously progressed to independent prescribing, the time taken for legislation to allow this to happen has been lengthy and success has been dependent on credible supporting information.

Of course, research to explore the role of dietitian SPs is necessary to determine need and provide momentum to this development for dietitians. Many dietitians may now wait to see if independent prescribing becomes a reality for the profession before training, as they are starting to understand the limitations of the supplementary prescribing model as described by colleagues. As an unintended consequence, this may further delay gathering robust evidence to support IP for the profession.

Conclusion

NMP is well established in current healthcare practice, however, the need for two models of NMP in the 2020’s is now questionable. Supplementary prescribing has been a useful model of NMP to introduce the non-medical healthcare professions to prescribing practice and is evaluated positively by patients. However, the conditions of supplementary prescribing associated with use of a CMP, still present the same challenges that were identified many years ago and can impact efficiencies and cause frustration. Most professions have progressed to independent prescribing as confidence and competence in NMP has been achieved, demonstrating that the close supervision is not necessary. Independent prescribing for all non-medical prescribers may be the optimum model of future prescribing. Where the SP model is necessary to support prescribing of certain medicines not permitted within a professions IP status, alternative mechanisms may need to be developed.

Recommendations

More debate about the future of NMP and the best way forward for small professions to demonstrate clinical service needs in the context of prescribing.

Further research exploring dietitian supplementary prescribing is required to support this debate. It may also strengthen the case for other healthcare professions wanting to extend their roles in the future to prescribe by promoting independent prescribing as the way forward for all non-medical prescribers.

Key words

- non-medical prescribing, supplementary prescribing, independent prescribing, dietitian

Key points

- Non-medical prescribing is well-established in the NHS and accepted by both patients and healthcare staff

- Two models exist in practice – supplementary prescribing and independent prescribing

- Dietitians and diagnostic radiographers are the only healthcare professions limited to supplementary prescribing although its framework can be used by IPs.

- The CMP required for supplementary prescribing is cumbersome and may limit prescribing due to its restrictive governance.

- Use of the supplementary prescribing model in the 2020’s is becoming a debatable model of NMP

CPD reflective questions

What are the benefits of supplementary prescribing?

What are the drawbacks of supplementary prescribing?

Are both models of NMP necessary in the 2020’s?

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