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I Development of the nurse prescribing initiative

Joyce Green

Nurse prescribing is a comparatively new and exciting development for the nursing profession, the vision of community nurses and health visitors being able to prescribe for patients having begun in 1986. This chapter will incorporate a historical overview of the nurse prescribing initiative and include reference to relevant reports and legislation, a brief summary of the pilot sites and how the training for nurse prescribing developed. Issues relating to teamwork in primary health care, including community profiling and case load management, and circumstances in which a nurse may prescribe, will be addressed in order to illustrate how nurse prescribing fits in with the current role of nursing practice.

A historical overview of the legislative framework

According to Blatt (1997), nurse prescribing is not a new idea but was first recommended by the Royal College of Nursing (RCN) in 1980, and became part of the government's policy agenda in 1986 with the Cumberlege Report. A team, chaired by Julia Cumberlege, was appointed in June 1985, its terms of reference in the frontispiece being:

To study the nursing services provided outside hospital by Health Authorities, and to report to the Secretary of State on how resources can be used more effectively, so as to improve the services available to client groups. The input from nurses employed by general practitioners will be taken into account.

(DHSS 1986)

The Review Team were asked to report to the Secretary of State by the end of the year so had six months in which to gather and collate their evidence. During this period, district nurses

indicated that, based on a full nursing assessment of the patients' individual health care needs, they were constantly recommending to general practitioners (GPs) the need for particular dressings or appliances for patients. However, they had to get the GPs to sanction and sign the prescriptions, which was felt to be very time wasting. In addition, according to Cumberlege (DHSS 1986), many nurses had also become very skilled in managing pain relief for terminally ill patients.

The following recommendation was included in the Report:

that the DHSS should agree a limited list of items and simple agents which may be prescribed by nurses as part of a nursing care programme, and issue guidelines to enable nurses to control drug dosage in well-defined circumstances.

(DHSS 1986, p. 33)

This recommendation and its implications were subsequently reviewed by the Department of Health (DoH) advisory group chaired by Dr June Crown.

The Crown Report, published in 1989 (DoH 1989), recommended that suitably qualified nurses working in the community, defined as those nurses with a district nurse or health visitor qualification, should be authorised to prescribe in defined circumstances from a limited list of items to be included in the *Nurse Prescribers' Formulary* (NPF) (see Appendix 1). They also recommended that nurses should be able to supply medicines within group protocols or adjust their timing and dosage within patient-specific protocols. These protocol issues were not taken further at that time which, according to Jones and Gough (1997), was viewed 'as a lost opportunity'.

Subsequently, Mr Roger Simms, Member of Parliament for Chislehurst, introduced a Private Member's Bill making legislative provision for nurse prescribing; this received Royal Assent in March 1992. Since then, much work has been undertaken in order to ensure that nurse prescribing is implemented in an efficient and cost-effective way. The primary legislation that permits initial nurse prescribing is the Medicinal Products: Prescription by Nurses Act 1992, but, although this Act was passed in 1992, the necessary secondary legislation, Medicinal Prescription by Nurses etc. (Commencement No. 1) Order 1994, did not come into effect until 3 October 1994.

Developing the initiative: the demonstration sites

On 21 November 1993, Baroness Cumberlege announced the introduction of demonstration sites for nurse prescribing, the purpose of the demonstration sites being to explore how the clinical, managerial and financial aspects of nurse prescribing could be managed effectively. GP fundholders and community units who could demonstrate commitment to nurse prescribing submitted a proforma to the DoH giving information about their unit and the fundholding practice. This was jointly signed by the practice, the community provider, the Family Health Service Authority and the region. The selection criteria for the demonstration sites included:

- evidence of an established GP fundholding practice
- a well-established primary health care team
- a contract for community services with a provider unit
- practice computing systems to enable linkage of patient and prescribing data
- the adequacy of management information systems
- a willingness to participate in data collection/evaluation prior to, during and after implementation
- the provision of representation on an implementation group and modification of the existing contract if necessary.

Eight sites were chosen, one in each of the health regions in England. The sites included inner city, rural and urban practices, some with large elderly populations and some with large numbers of children, especially the under 5s. Implementation in the eight demonstration sites was achieved by April 1994. The whole project was subject to an independent, fully researched evaluation which began in May 1994, to enable 'before and after' comparisons to be made. The University of Liverpool was commissioned to provide a qualitative evaluation of patient, nurse and doctor satisfaction with the scheme, and an analysis of the cost-benefit aspects of the scheme was undertaken by the University of York.

Two colleges of higher education (one in the north and one in the south of England) were invited to provide the taught component of the nurse prescribing course, and each submitted a detailed course document for validation by the English National

Board for Nursing, Midwifery and Health Visiting (ENB) in August 1994. After completing the *Nurse Prescribing: Open Learning Pack* (ENB 1994), nurses and health visitors in the prescribing sites attended one of these ENB-approved courses during September 1994 in readiness for commencing their nurse prescribing role in October 1994.

According to Jones and Gough (1997) 'with only eight sites involved, data from the project were not of sufficient statistical significance to extrapolate to the outcome of a national expansion of nurse prescribing.' Therefore in 1996, Bolton, one of the original pilot sites, was expanded to include 60 more practices, and a further 150 community nurses were trained as nurse prescribers. Two pilot sites were designated in Scotland in the same year. In 1997, following publication of the White Paper *Primary Care: Delivering the Future* (DoH 1996), a further seven pilot sites in NHS trusts were inaugurated in England, and the Bolton site was further extended to include Wigan. A press release in July 1997 announced that 'plans to extend nurse prescribing to Wales were unveiled as part of a package of primary health care measures announced by Welsh Health Minister Win Griffiths' (Scott 1997). These plans came to fruition when the first cohort of nurses started prescribing in January 2001. Training of approximately 1,500 nurses in Wales should be completed by March 2002 (Association for Nurse Prescribing 2001).

Preparation for nurse prescribing: education and training

In July 1991, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) responded to the DoH's invitation to establish the standard, kind and content of educational preparation for nurse prescribing. It was recognised that the training should enable district nurses and health visitors to meet the learning outcomes set by the UKCC in order for them to prescribe safely and effectively from an appropriate knowledge base. According to the UKCC (1991, p. 1):

in order to complete the preparation for nurse prescribing, individuals will need to ensure that they have sufficient knowledge of relevant pharmacology and therapeutics to enable them to undertake the programme. The *Nurses' Formulary* would provide the basis for identification of requirements.

The previous education and training of the course participants would also influence the type and length of programme required, in particular the amount of pre-course preparation necessary. The kind of programme envisaged by the UKCC would fall into two categories:

A free standing module for district nurses and health visitors who are already qualified – and preparation which could be incorporated into the curriculum for district nursing and health visiting from a date agreed by the council.

(UKCC 1991, p. 1)

A newsletter for institutions of higher education, issued by the ENB on July 1992, outlined the progress made with regard to the educational requirements for nurse prescribing. The following statement was incorporated:

To ensure the availability of a suitable programme leading to the achievement of competence and authority to prescribe, the ENB has been given responsibility and funding for developing and delivering:

- an open learning pack
- a video
- guidance for the validation of programmes to be presented by institutions of higher education currently offering district nurse and health visitor courses.

(ENB 1992)

A Steering Group with DoH and higher education representation was set up in order to monitor and guide the preparation and development of the above. In order to ensure that the most effective strategies were employed, the Steering Group held a number of regional consultation days with district nurse and health visitor course leaders, formed a Working Group to plan and supervise the production of the open learning pack and appointed open learning consultants to advise the group and develop the materials. As stated in the ENB newsletter (1992), the Working Group represented:

the major stakeholders in the process of preparing district nurses and health visitors for prescribing: practitioners, managers, lecturers, ENB directorate and the Department of Health.

The Group provided a wide range of professional expertise and also knowledge and experience of open learning.

The learning outcomes defined by the UKCC (1991, Section 5, p. 2) are:

- the ability to prescribe safely, effectively and cost-effectively from the Nurses' Formulary;
- an understanding of the potential side effects of, and reactions to, the items in the Nurses' Formulary;
- an understanding of the team and individual roles of doctors, dentists and pharmacists in relation to prescribing;
- an understanding of the requirements of the legislation relevant to the practice of nurse prescribing and
- an understanding of accountability and professional responsibility in relation to nurse prescribing.

One of the Working Group's main tasks was, based on the UKCC learning outcomes, to devise more specific outcomes for the *Open Learning Pack*. These were considered further in the light of information received from colleagues on the consultation days and from practitioner profiles taken from telephone interviews. It was decided that, in order to ensure integration of the *Open Learning Pack* and the taught component of the course, most topic areas should be included in both, the *Open Learning Pack* forming the bridge leading from the individual's current experience into the taught component. This would enable course participants to apply their existing knowledge and practice to nurse prescribing issues and to identify their own individual learning needs, which could be addressed in the taught part of the course.

The *Open Learning Pack* is divided into the following areas of study: getting to grips with nurse prescribing; accountability; prescribing safely and effectively; ethical issues; prescribing in a team context; administrative arrangements; and evaluating effectiveness. These topics were further developed in the taught course using a variety of teaching methods, including the ENB video, to trigger much discussion and debate. In addition, the taught course includes relevant pharmacology and therapeutics based on the NPF, together with other legal, financial and practical aspects of nurse prescribing.

The necessary training for nurse prescribing was outlined in the UKCC's response to an invitation from the DoH in July 1991. At that time, a two-day taught course component was recom-

mended, but, following evaluations from the initial courses held in September 1994, the format of this part of the course was changed to three days, followed by an examination a week later. At present, nurses can only qualify by attending an ENB-approved course.

The UKCC (1991, p. 1) stated that:

a variety of assessment strategies should be employed to test knowledge and synthesis and the application of theory to practice. Assessment should focus upon the principles of nurse prescribing, and the professional accountability and responsibility of the nurse undertaking the role.

Several assessment strategies were considered, including written examination, self-assessment, case study analysis, peer assessment, keeping a reflective journal and a defined period of supervised practice. However, as a matter of expediency, partly due to the tight timescale and the need to identify quickly whether course members were competent to prescribe in practice, the written examination was chosen. Most educationalists, given the essentially practical nature of nurse prescribing, would have preferred a combination of the other options, but the written examination, which is divided into two parts, proved to be a satisfactory method of assessment, for the following reasons. First, the short answer questions, some of which are multiple choice, are a useful way of ensuring a wide coverage of the curriculum and testing the principles of nurse prescribing. Second, the context-dependent questions based on case study analysis test knowledge of the nurse's role in prescribing situations and the understanding and application of identifying an appropriate rationale for decision-making in respect of nurse prescribing.

Assessment strategies are changing as the nurse prescribing initiative continues to be developed and is now an integral part of district nurse and health visitor education. With legislation now changed to include other branches of nursing, the course content, length of training and assessment have been reviewed in order to ensure that all nurses are prepared for their nurse prescribing role in the most appropriate manner. Now that there is a nucleus of experienced nurse prescribers across the country, it is easier to adopt a method of assessment which more accurately reflects practice, as there are nurses and health visitors acting as mentors/supervisors for those undertaking training. Indeed, nurse prescribing training is

subject to ongoing evaluation and review and as stated in paragraph 3.3 of *Nurse Prescribing Guidance*:

In an effort to reduce infrastructure costs whilst maintaining the quality of training, further training models will be developed during the pilot trials and evaluated.

(NHS Executive HQ, April 1997)

The ongoing monitoring and evaluation of the examination procedure has enabled the strengths and weaknesses of the system to be identified and minor modifications to be made. This knowledge will also help to ensure that an informed choice is made as the assessment strategy is changed or modified.

Current examples of good practice now emerging from the recent developments in nurse prescribing education include a more integrated approach to assessment throughout the nurse prescribing module; the use of work books as part of the examination procedure; presentation of appropriate assignments and case studies which reflect integration of theory and practice. Many courses for qualified district nurses and health visitors now incorporate a pre-course study day and more formalised tutorials while students are studying the ENB *Open Learning Pack*. For those nurses undertaking nurse prescribing training as an integral part of their specialist practitioner programmes for district nursing and health visiting, most courses have incorporated a period of supervised practice.

Nurse prescribing and primary health care

Primary health care services are the first point of contact for most patients and their families, and are the most frequently used within the National Health Service. The skills, expertise, and knowledge base of all those who work in primary care have developed to meet challenges created by an increasingly more informed public, advances in technology, and better service outcomes.

(Poulton 1997, p. 1)

The role of nurses and health visitors in primary health care has developed to meet the changing health care needs of the population, and community nurses currently have a vital role to play in

a primary care-led NHS. Nurse prescribing has an important contribution to make in improving the service to patients and clients within the primary health care context. In fact, the potential advantages and benefits of nurse prescribing were clearly identified in the Crown Report (DoH 1989) and included improvement in patient care as nurses would be able to manage a patient's condition more effectively; a better use of patients' and nurses' time, thus enabling patients to receive treatment with the minimum of delay; and a clarification of professional responsibilities, which would strengthen professional partnership within the primary health care team.

The nurse, midwife or health visitor responsible for the programme of care for the patient or client is uniquely placed to make an accurate assessment of his or her needs based on a critical professional appraisal. For those nurses and health visitors who are trained as nurse prescribers, prescribing issues are an integral part of that assessment, and they utilise their clinical and professional judgement to decide when it is necessary to prescribe and which products from the NPF are the most appropriate to meet the needs identified. Community profiling and workload analysis will also enable nurses and health visitors to identify those patient/client groups and individuals most likely to require nurse-initiated prescriptions. Nurse prescribing will also impinge on the nurse's teaching and health promotion role. For example, patients experiencing problems with constipation may require advice about diet, fluid intake and variation in bowel habits, which will still be a first-line strategy in most cases; now, however, following a full clinical assessment, the nurse will be able to prescribe an appropriate laxative if this is necessary. The nurse is also in an ideal position to advise the patient on the action of the medication prescribed and to plan appropriate follow-up and evaluation of the situation for the care plan.

Have the potential benefits been realised in practice? It would appear so as, according to Luker et al. (1997a, p. 51):

the advantages patients identified coincided with the anticipated benefits, while the disadvantages that had been anticipated before the study were not confirmed.

From the results of the study undertaken, it would appear that patients did receive treatment more promptly, and this was of great benefit to themselves and their carers. Luker et al. (1997a, p. 54) also state that:

although it was anticipated that district nurses' patients would be the main beneficiaries of nurse prescribing, health visitor clients, in particular, were more likely to mention the increased convenience, practice nurses' patients, while benefiting overall, noted fewer changes.

These opinions reflected the relative ease or difficulty that each of these groups of patients had in obtaining a prescription before nurse prescribing. The reaction from patients and clients was extremely positive, and in some instances the nurse was cited as being the preferred prescriber. Patients quickly familiarised themselves with the nurses' remit, and there did not appear to be any undue confusion surrounding the nurses' and doctors' role in prescribing. According to Luker et al. (1997a, p. 54):

patients were conscious of the fact that in the past the nurse had made the decision but the prescription had to be obtained from the GP. For these nurses this anomaly has now been rectified.

According to the Executive Summary of the *Evaluation of Nurse Prescribing. Final Report* (Luker et al. 1997b, pp. 12–13):

There has been little reported change in professional relationships, between primary health care team members, with the notable exception of the pharmacist. District nurses reported a closer relationship with the pharmacist, HVs and PNs, who previously had very little, if any, contact now do have contact; this they have reported as being a positive aspect of nurse prescribing.

Also cited in this document is the fact that many professionals included in the evaluation indicated many advantages of nurse prescribing for patients and for the primary health care team. Time-saving was frequently mentioned; over half the GPs had noticed that nurse prescribing was saving them time and that they were signing fewer nurse-generated prescriptions, but in most cases this was not quantifiable. Luker et al. (1997b) also intimated that most nurses and health visitors participating in the demonstration sites had a positive reaction to nurse prescribing. The main benefits appear to be increased job satisfaction, time-saving

and improved patient or client care, while the main frustration is the limited nature of the *Nurses' Formulary*, some nurses wanting to see additional items added to the list.

According to the *Open Learning Pack* (ENB 1994), teamwork is an essential part of nurse prescribing, and even those nurses working independently will have to report back to their nurse manager and have the opportunity to discuss their workload with other nurses and health visitors. For some practice nurses, this may not be quite so easy, and therefore the importance of the advantages of an integrated primary health care team, whose members have common goals and understand and respect each other's role and function within the team, cannot be overemphasised. Communication and teamwork are essential for effective nurse prescribing, one way of ensuring clear communication being to use well-defined local policies and/or protocols. In the interests of good patient or client care, it is also important to maintain good relationships with those nurses in the team who are unable to prescribe and keep them informed of any developments in the nurse prescribing initiative. In fact the summary of conclusions in the final report of the *Review of Prescribing, Supply and Administration of Medicines* (DoH 1999) states that their consultation:

revealed considerable support for an extension of the groups of professionals who may prescribe, which would be expected to improve multidisciplinary team-work and make fullest use of professional skills

and also that:

the extension of prescribing to new professional groups, subject to safeguards which would be established by the professional regulatory bodies, would yield benefits to patient care, improved patient convenience and better team-working between professionals.

(p. 71)

Nurse prescribing: a changing role?

The future of nurse prescribing is a continuing and developmental process. A national roll-out of community nurse prescribing was announced in April 1998; however when there was prior indication of this, Bradley (1997) wrote:

The government intention, declared in recent white papers on primary care, is to roll out the nurse prescribing scheme to cover the whole country. All this would appear to imply that nurse prescribing has now arrived and is about to transform life for nurses, GPs and their patients. Well, don't you believe it. Unless the constraints currently operating on nurse prescribing are radically altered, the ability of nurses to prescribe will only ever have a very limited impact. The reasons for this are that nurse prescribing is confined to a restricted group of nurses (with district nursing or health visitor qualifications who have undergone further specific training) and to a fairly narrow formulary of drugs and appliances, most of which are available without prescription anyway. The result of these restrictions is that the majority of nurses who would like the power to prescribe *i.e.* practice nurses without the necessary qualifications, cannot do so. Furthermore, many of the items nurses would like to be able to prescribe, particularly those that enhance their role in chronic disease management, for example in asthma and diabetes, are precluded.

(p. 13)

However, although there are advocates for extending the NPF, there are also those who have expressed concern about nurses' knowledge of items already included in the *Formulary*. Some of these points are also borne out by Luker et al. (1997b) who state that since the publication of the first Crown Report (DoH 1989), considerable changes have taken place in the role of nurses working in the community. This particularly applies to practice nurses whose role is very diverse and has developed considerably since the implementation of the GP contract (DoH and Welsh Office 1990). Atkin et al. (1993) in a national consensus of practice nurses, identified that about 96% of practice nurses were involved in the provision of immunisations, almost 30% in family planning, 55% in diabetes management and 52% in asthma management. The extension of the practice nurse's role has led to much discussion as to whether the *Nurses' Formulary* is too restrictive especially in relation to chronic disease management, for example care of the asthmatic patient.

Luker et al. (1997c) point out that although the role of the practice nurse has expanded there is a diversity of expertise among this group and considerable variation in the qualifications they possess. Variations in preparation for practice, of which practice nursing is an example, will need to be considered when planning the future education of nurse prescribers. These concerns reinforce the point that it is essential for all nurses to be properly and appropriately trained before undertaking additional professional

responsibilities. Have recent developments suggested changes which may allay some of these fears?

The long-awaited *Final Report* (DoH 1999) of a Working Group chaired by Dr June Crown which was set up by the government to review prescribing, supply and administration of medicines (known as Crown II) was published in March 1999. In the accompanying letter to the Rt Hon Frank Dobson MP, then Secretary of State for Health, the following paragraphs were included:

The Review Team have considered carefully the extensive evidence that was submitted during the period of consultation. It is inevitable that we could not produce recommendations which would meet all the aspirations expressed to us, while at the same time meeting your requirements for a robust framework for an extension which safeguards patient safety.

The team believes, however, that its proposals, if implemented, will provide a secure means of increasing the range of health professionals who are authorised to prescribe. This will improve services to patients, make better use of the skills of professional staff and thus make a significant contribution to the modernisation of the health service.

This detailed report which includes many conclusions and recommendations, was presented to the professions for comment in March 1999 and a six-month consultation period was granted. Some of the conclusions and recommendations that have a particular relevance to nurse education and practice are highlighted as follows. One of the conclusions reached indicates that:

professional practice is changing in response to changing patterns of clinical care, professional education and patient expectations. These trends have not been fully reflected in the arrangements for the prescribing, supply and administration of medicines.

(DoH 1999, p. 71)

Increasingly, within the general practice setting, practice nurses who have undergone further specific training, for example a Diploma in Asthma Care, may be running nurse-led clinics and advising patients of the most appropriate medication to control and improve their medical condition but they are unable to prescribe this medication and currently have to generate a prescription from the GP. This is seen by some nurses to be very frustrating and potentially time wasting and, as Luker et al. (1997c) argue, practice nurses already influence the prescribing behaviour of GPs

in the areas of asthma and diabetes and the nurse's ability and practice have 'outstripped' the parameters of the NPE.

The Crown II Report (DoH 1999) which covers a much wider remit than community nurses with a district nurse or health visitor qualification, outlines in some detail the importance of appropriate professional training for all new prescribers. The recommendations have profound implications for professional training especially as other professions such as pharmacists, optometrists and podiatrists could be granted prescribing powers if the report is implemented. The recommendations also encompass other nursing groups, including those in specialist therapeutic areas such as asthma. One could argue that community nurses have had a head-start as far as training and prescribing practice are concerned, especially as some of the guidance for training in the Crown II Report replicates what is currently happening in the community nurse education field, for example:

training programmes for prescribing would need to be set up in the first instance for those health professionals who have already obtained the necessary specialist clinical qualification.

(p. 66)

However the recommendation that:

all training should include a period of supervised practice, and professional and regulatory bodies should take firm action against supervisors who fail to discharge their responsibilities

(p. 66)

may have implications for the assessment and curriculum design of future community nurse education nurse prescribing modules. This model is a familiar one that has been utilised for many years in health visitor and district nurse education but has not yet been incorporated into all of the current nurse prescribing programmes.

Current situation

In spite of its critics nurse prescribing is a major step forward for nurses and one which has, in the main, been met with a very positive and enthusiastic response, having been seen to have strength-

ened teamwork in primary care in some instances. Patients appear to have welcomed the initiative and GPs and pharmacists have been very supportive. According to Brooks et al. (2001) patients view nurse prescribing as a practical and responsive method of service delivery although some concern was expressed regarding the limitations of the *Nurse Prescribers' Formulary*.

Community nurses have pioneered the nurse prescribing initiative and for many this is now an integral and important part of their clinical care. The uniqueness of their role has been emphasised in that they are well versed with the needs of each patient/client and of the services and resources available to help meet those needs. This knowledge and experience enable them to provide a service tailored to individual needs and circumstances.

Nurse prescribing initiatives are moving on apace and it would appear that rolling out the nurse prescribing initiative to all those nurses with a health visitor or district nurse qualification and currently practising in their relevant fields is only the beginning. However, by April 2001 it was estimated that there were 23,000 qualified nurse prescribers.

In 1997, Jones and Gough stated:

For nurse prescribing to find full expression appropriate to the demands of today's health services and the expanding nature of nursing practice, the existing legislation needs urgent revision.

(p. 42)

They also advocated the lifting of restrictions on the type of nurse able to prescribe and the expansion of the *Nurses' Formulary*. The government announced on 13 March 2000, that it had accepted and would take forward the main recommendations of the *Review of Prescribing, Supply and Administration of Medicines*. This included extending the scope of nurse prescribing, which does not require primary legislation, and also extending prescribing rights to other health professionals when parliamentary time allows. The government consultation paper on extending independent nurse prescribing (DoH 2000) was welcomed by nurses as it outlines options for extending the *Nurse Prescribers' Formulary* and indicates a range of medical conditions which nurses could be trained to prescribe for. The consultation period ended on 10 January 2001 and on 5 May 2001 a press

release from the DoH gave information that a further 10,000 nurses will undergo training to become prescribers.

Conclusion

Nurses and health visitors currently able to prescribe acknowledge that nurse prescribing is very much an integral part of their role and hope that this aspect of their work will continue to develop as it increases job satisfaction and is enabling them to provide a more comprehensive service. With the advent of further developments in nurse prescribing, both in terms of the nurses who may prescribe and the expanded *Nurse Formulary*, this valued component of nursing should be further enhanced.

References

- Association for Nurse Prescribing (2001) *Nurse Prescribing Handbook*. Emap Healthcare, London.
- Atkin, K., Lunt, N., Park, G. and Hirst, M. (1993) *Nurse Count: A National Census of Practice Nurses*. Social Policy Research Unit, York.
- Blatt, B. (1997) Nurse prescribing: Are you ready? *Practice Nursing*, 8(12): 11–13.
- Bradley, C. (1997) Nurse prescribing – unlikely to transform our lives. *Prescriber*, 5 May 1997: 13.
- Brooks, N., Otway, C., Rashid, S., Kilty, L. and Maggs, C. (2001) Nurse prescribing: what do patients think? *Nursing Standard*, 15(17): 33–8.
- DHSS (1986) *Neighbourhood Nursing – A Focus for Care* (Cumberlege Report). HMSO, London.
- DoH (1989) *Report of the Advisory Group on Nurse Prescribing* (Crown Report). DoH, London.
- DoH (1996) *Primary Care: Delivering the Future*. HMSO, London.
- DoH (1999) *Review of Prescribing, Supply and Administration of Medicines. Final Report* (Crown II Report). DoH, London.
- DoH (2000) *Consultation on Proposals to Extend Nurse Prescribing*. DoH, London.
- DoH and Welsh Office (1990) *Terms and Conditions for Doctors in General Practice*. The NHS (General Medical and Pharmaceutical Services) Regulations 1974 Schedules 1–3 as amended. HMSO, London.
- ENB (1992) *Nurse Prescribing: Newsletter for Institutions of Higher Education*. ENB, London.
- ENB (1994) *Nurse Prescribing: Open Learning Pack*. ENB, London.

- Jones, M. and Gough, P. (1997) Nurse prescribing – why has it taken so long? *Nursing Standard*, **11**(20).
- Luker, K.A., Austin, L., Hogg, C., Ferguson, B. and Smith, K. (1997a) Patients' views of nurse prescribing. *Nursing Times*, **93**(17): 51–4.
- Luker, K.A., Austin, L., Hogg, C. et al. (1997b) Evaluation of Nurse Prescribing. Final Report: Executive Summary. Unpublished report.
- Luker, K.A., Austin, L., Willock, J., Ferguson, B. and Smith, K. (1997c) Nurses' and GPs' views of the *Nurse Prescribers' Formulary*. *Nursing Standard*, **11**(22): 33–8.
- NHS Executive HQ (1997) *Nurse Prescribing Guidance April 1997*. NHS Executive HQ, Leeds.
- Poulton, B. (1997) *Practice Nursing: A Changing Role to Meet Changing Need*. DoH, London.
- Scott, G. (1997) Welsh nurses elated as prescribing arrives. *Nursing Standard*, **11**(44).
- UKCC (1991) *The Council's Response to the Department of Health's Invitation to Establish the Standard, Kind and Content of Educational Preparation for Nurse Prescribing*. July 30th 1991. UKCC, London.

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