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Implementation across the United Kingdom

Policy Background

Molly Courtenay and Matt Griffiths

Recommendations were first made in 1986 for nurses to take on the role of prescribing. The Cumberlege Report¹ examined the care given to clients in their homes by district nurses (DNs) and health visitors (HVs). It was identified that some very complicated procedures had arisen around prescribing in the community and that nurses were wasting time requesting prescriptions from general practitioners (GP) for items such as wound dressings and ointments. The report suggested that patient care could be improved and resources used more effectively if community nurses were able to prescribe as part of their everyday practice, from a limited list of items and simple agents agreed by the Department of Health and Social Security (DHSS).

Following the publication of this report, the recommendations for prescribing and its implications were examined. An advisory group was set up by the Department of Health (DH) to examine nurse prescribing, which resulted in the first Crown Report.² Dr June Crown was the Chair of this group. The following is taken from this Report:

Nurses in the community take a central role in caring for patients in their homes. Nurses are not, however, able to write prescriptions for the products that are needed for patient care, even when the nurse is effectively taking professional responsibility for some aspects of the management of the patient. However experienced or highly skilled in their own areas of practice, nurses must ask a doctor to write a prescription. It is well known that in practice a doctor often rubber stamps a prescribing decision taken by a nurse. This can lead to a lack of clarity about professional responsibilities, and is demeaning to both nurses and

doctors. There is wide agreement that action is now needed to align prescribing powers with professional responsibility.²

The report made a number of recommendations involving the categories of items which nurses might prescribe, together with the circumstances under when they might be prescribed. It was recommended that:

Suitably qualified nurses working in the community should be able, in clearly defined circumstances, to prescribe from a limited list of items and to adjust the timing and dosage of medicines within a set protocol.²

Several groups of patients were identified that would benefit from nurse prescribing. These patients included: patients with a catheter or a stoma, patients with post-operative wounds and homeless families not registered with a GP. The Report also suggested that a number of other benefits would occur as a result of nurses adopting the role of prescriber. As well as improved patient care, this included better use of both nurses' and patients' time and improved communication between team members, arising as a result of a clarification of professional responsibilities.²

During 1992, the primary legislation permitting nurses to prescribe a limited range of drugs was passed.³ Secondary legislation with necessary amendments were made to this Act, which came into effect in 1994, and a list of products available to the nurse prescriber was published in the Nurse Prescribers' Formulary (NPF) for DNs & HVs. In 1994, eight demonstration sites were set up in England for nurse prescribing. By the spring of 2001, around 20,000 DNs and HVs were qualified prescribers, and training programmes for DNs and HVs included the necessary educational component qualifying them to prescribe.

At the time of writing, there are over 28,000 DNs and HVs qualified to prescribe from a list of appliances, dressings, pharmacy (P) medicines (those products sold under the supervision of a pharmacist), and general sales list (GSL) items (those that can be sold to the public without the supervision of a pharmacist), and thirteen prescription only medicines (POMs) included in the NPF. Following a Nursing and Midwifery circular (NMC) in October 2005 other first-level nurses have been able to train as V100 prescribers in order to prescribe from what has now become the *NPF for Community Practitioners*.⁴ In practice this means that,

provided that there is an NHS need, school nurses, children's community nurses, practice nurses and occupational health nurses can undertake such training.

Extending Prescribing

A second report by Crown, which reviewed the prescribing, supply and administration of medicines, was published in 1999.⁵ This review recommended that prescribing authority should be extended to other groups of professionals with training and expertise in specialist areas. During 2001, support was given by the government for this extension.⁶ Funding was made available for other nurses, as well as those currently qualified to prescribe, to undergo the necessary training to enable them to prescribe from an extended formulary.

This formulary included:

- ▶ a number of specified POMs, enabling nurses to prescribe for a number of conditions listed within four treatment areas that were, minor ailments, minor injuries, health promotion and palliative care;
- ▶ GSL items used to treat these conditions;
- ▶ P medicines used to treat these conditions.

Further Extensions

During 2003, proposals by the Medicines and Healthcare Products Regulatory Agency (MHRA)⁷ to expand the Nurse Prescribers' Extended Formulary (NPEF) were accepted and the NPEF was extended to include a number of additional conditions and medicines. In 2003, legislation was passed by the Home Office (HO) allowing nurses to prescribe six controlled drugs (CDs). These included:

- ▶ diazepam, lorazepam, midazolam (schedule 4 drugs) for use in palliative care
- ▶ codeine phosphate, dihydrocodeine and co-phenotrope (schedule 5 drugs).

Following further amendments to the Home Office Misuse of Drugs regulations and changes to the Prescription Only Medicines Order,

further CDs and additional indications for existing CDs were added on 6 January 2006 and the total list is now as follows:⁸

- ▶ diamorphine, morphine, diazepam, lorazepam, midazolam, oxycodone for use in palliative care
- ▶ buprenorphine or fentanyl for transdermal use in palliative care
- ▶ diamorphine or morphine for pain relief for suspected myocardial infarction, or for relief of acute or severe pain after trauma, including in either case post-operative pain relief
- ▶ chlordiazepoxide hydrochloride or diazepam for treatment of initial or acute withdrawal symptoms caused by the withdrawal of alcohol from persons habituated to it
- ▶ codeine phosphate, dihydrocodeine tartrate or co-phenotrope.

See Appendix 1 for routes of administration and indications.

Proposals to extend the NPEF to include medicines and conditions in emergency and first contact care were accepted in 2004.⁹

Current Situation

The prescribing powers of nurses have greatly increased since the introduction of the original NPF. By January 2006 there were around 6100 extended nurse prescribers. These prescribers were able to prescribe from a list of over 250 POMs (including CDs), GSL and P medicines for a range of over 100 medical conditions. Following the results of proposals set out in early 2005,^{10,11} Nurse Independent Prescribers (formerly extended nurse prescribers) are now able to prescribe any licensed medicine with the exclusion of CDs (except those listed earlier in this chapter). The prescribing powers of pharmacists have similarly increased, these health professionals are now able to train as independent prescribers.¹¹ Following the Medicines and Human Use (Prescribing) Order of May 2006, along with associated medicines regulations, nurses who have completed appropriate courses are able to prescribe any licensed medicine for any condition that falls within their competence.* At the time of writing this has been implemented in England and has been accepted in Scotland. Other devolved Governments of

*Improving Access to Medicines: A Guide to Implementing Nurse and Pharmacist Independent Prescribing within the NHS in England. Gateway reference 6429 (April 2006).

Northern Ireland and Wales are likely to implement the new legislation as they see fit. Legislation to allow pharmacists to become independent prescribers includes all licensed medicines but at the time of writing excludes prescription of CDs.

Supplementary Prescribing

The introduction of a new form of prescribing for professions allied to medicine was suggested in 1999.⁵ It was proposed that this form of prescribing initially called 'dependent prescribing' would take place after a diagnosis had been made by a doctor and a Clinical Management Plan (CMP) drawn up for the patient. The term 'dependent prescribing' has since been superseded by 'supplementary prescribing'.¹²

A close partnership between the doctor and the nurse, pharmacist or Allied Health Professionals (AHP) is essential for the successful implementation of supplementary prescribing. Access to the patient's medical records and to a prescribing budget are other necessary pre-requisites. There are no legal restrictions on the clinical conditions for which supplementary prescribers (SPs) are able to prescribe. They are able to prescribe any medicine including CDs (nurses and pharmacists, in England only at the time of writing) and unlicensed medicines.[†]

Supplementary prescribing provides an ideal mechanism for treating some long-term conditions, including mental health problems. Where a team approach to prescribing is clearly appropriate, a CMP provides an ideal framework for prescribing for all those involved with the patient. Supplementary prescribing also provides a method by which newly qualified prescribers are able to develop their confidence in areas in which they feel less confident to prescribe independently.

Training for supplementary prescribing was introduced in 2003 for nurses and pharmacists, and legislative changes enabling the extension of supplementary prescribing to some physiotherapists, radiographers, podiatrists and optometrists are now in place.¹³

At the time of writing, there are over 6000 qualified nurse supplementary prescribers and over 500 qualified pharmacist supplementary prescribers.

[†]England only.

Although the literature examining supplementary prescribing is largely anecdotal, a number of themes are emerging. It is evident that there has been some confusion amongst some GPs and hospital doctors surrounding roles and responsibilities within the independent/supplementary prescribing partnership. The purpose of patient group directions (PGDs), protocols and CMPs, patient diagnosis and patient review (with regard to CMPs) are areas in which a lack of understanding has been identified.¹⁴ Furthermore, the implementation of supplementary prescribing has been found to be time-consuming¹⁵ and agreeing CMPs with GPs has been a big hindrance. Difficulties have also been experienced explaining the nature of supplementary prescribing to patients.¹⁴ On a more positive note, people have confidence in the nurse having prescribed the best medicine for them, and say they would be willing to take it.¹⁶ Further benefits reported include more effective use of nursing skills and the management of more complex cases by doctors¹⁷ and a reduction in drug errors.¹⁵

The Benefits of Independent Prescribing

A small number of studies to date have been carried out to evaluate independent prescribing by nurses.¹⁸ Some of the benefits reported by patients include accessibility and approachability of the nurse, the nurses' style of consultation, specialist expertise and information provision, and timely, convenient and continuous cares.^{19–21} Benefits reported by nurses include more effective use of time, more convenient treatments and better information for patients, increased job satisfaction, status and autonomy, and the ability to deliver complete episodes of care.^{19,20,22,23} Benefits of independent and supplementary nurse prescribing as viewed by doctors include improved professional relationships, a means of refreshing doctors' own knowledge, fewer interruptions to sign prescriptions and reduced workload.²⁴

Influences on Independent Practice

A number of factors have been identified as influencing prescribing practice. These include inter-professional relationships, informal peer support gained through working in teams,^{25–27} and awareness of the non-medical prescribers' role.²⁸

Conclusion

Although the development of non-medical prescribing has been slow (prescribing by nurses first considered by the government during early 1980s), recent policy changes have meant that the role of the nurse, pharmacist and AHP with regard to prescribing has expanded dramatically over the last few years. The implementation of prescribing across the United Kingdom is discussed in the next part of this chapter with perspectives from Scotland, England, Wales and Northern Ireland.

References

1. DHSS. *Neighbourhood Nursing: A Focus for Care* (Cumberlege Report) (London: HMSO, 1986).
2. DH. *Report of the Advisory Group on Nurse Prescribing* (Crown Report) (London: DH, 1989).
3. DH. *Medicinal Products: Prescribing by Nurses Act* (London: DH, 1992).
4. NMC. V100 Nurse Prescribers. NMC Circular 30/2005SAT/lp (October 2005).
5. DH. *Review of Prescribing, Supply and Administration of Medicines* (Crown Report 2) (London: DH, 1999).
6. DH. *Patients to get Quicker Access to Medicines* (Press Release) (London: DH, 2001).
7. MHRA Consultation Document, MLX293, *NPEF* (2003).
8. Courtenay, M. Nurse prescribing update. *Journal of Community Nursing*, 2006, 20(2): 13–16.
9. MHRA. *Nurse Prescribers' Extended Formulary: Proposals to Expand the Range of POMs (MLX 320)* (2004).
10. MHRA. *Consultation on the Options for the Future of Independent Prescribing by Extended Formulary Nurses (MLX 320)* (2005a).
11. MHRA. *Consultation on Proposals to Introduce Independent Prescribing by Pharmacists* (2005b).
12. DH. *Supplementary Prescribing* (London: DoH, 2002).
13. DH. *Supplementary Prescribing by Nurses, Pharmacists, Chiropodists/Podiatrists, Physiotherapists and Radiographers within the NHS in England: A Guide for Implementation* (London: DH, 2005).
14. Baird, A. Supplementary prescribing: One general practice's experience of implementation. *Nurse Prescribing*, 2004, 2(2): 72–75.

15. Kinley, J. Nurse prescribing in palliative care: Putting training into practice. *Nurse Prescribing*, 2004, 2(2): 60–64.
16. Berry, D., Courtenay, M. and Bersellini, E. Attitudes towards, and information needs in relation to supplementary nurse prescribing in the UK: An empirical study. *Journal of Clinical Nursing*, 2006, 15: 22–28.
17. Hennell, S., Wood, B. and Spark, E. Competency and the use of CMPs in rheumatology practice. *Nurse Prescribing*, 2004, 2(1): 26–30.
18. Latter, S. and Courtenay, M. Effectiveness of nurse prescribing: A review of the literature. *Journal of Clinical Nursing*, 2004, 13: 26–32.
19. Brooks, N., Otway, C., Rashid, C., Kilty, E. and Maggs, C. The patients' view: The benefits and limitations of nurse prescribing. *British Journal of Community Nursing*, 2002, 6(7): 342–348.
20. Luker, K.A., Austin, L., Hogg, C., Ferguson, B. and Smith, K. Nurse-patient relationships: The context of nurse prescribing. *Journal of Advanced Nursing*, 1998, 28(2): 235–242.
21. Luker, K., Austin, L., Ferguson, B. and Smith, K. Nurse prescribing: The views of nurses and other health care professionals. *British Journal of Community Health Nursing*, 1997, 2: 69–74.
22. Rodden, C. Nurse prescribing: Views on autonomy and independence. *British Journal of Community Nursing*, 2001, 6(7): 350–355.
23. Latter, S., Maben, J., Myall, M., Courtenay, M., Young, A. and Dunn, N. An evaluation of extended formulary independent nurse prescribing. Executive summary of final report (London: DoH, 2005).
24. Avery, A., Savelyich, B. and Wright, L. Doctors' views on supervising nurse prescribers. *Prescriber*, 2004, 5: 56–61.
25. Humphries, J.L. and Green, E. Nurse prescribers: Infrastructures required to support their role. *Nursing Standard*, 2000, 14(48): 35–39.
26. Otway, C. The development needs of nurse prescribers. *Nursing Standard*, 2002, 16(18): 33–38.
27. Hay, A., Bradley, E. and Nolan, P. Supplementary nurse prescribing. *Nursing Standard*, 2004, 18(41): 33–39.
28. Pleasance, G. and Brownsell, M. Improving communication between nurse prescribers and community pharmacists. *Nurse prescribing*, 2004, 2(4): 171–173.

Further reading

Courtenay, M. and Griffiths, M. (eds). *Independent and Supplementary Prescribing: An Essential Guide* (Cambridge: Cambridge University Press, 2004).

Courtenay, M. Nurse prescribing update. *Journal of Community Nursing*, 2004, 20(2): 13–16.

Useful websites

www.doh.gov.uk/cno

www.npc.co.uk

www.mhra.gov.uk

Implementation in Scotland

Ishbel Rutherford and Anne Sherry

Jack McConnell, First Minister of the Scottish Parliament, referred to Scotland as ‘one of the most unhealthy countries in Europe’.¹ Life expectancy in Scotland is lower than for the rest of the United Kingdom, with Glasgow having the lowest life-expectancy in the United Kingdom.² In addition, the proportion of life years spent with long-term health problems is higher, particularly in areas of deprivation.³

The future delivery of health care is a matter of national priority, and in his foreword to the National Framework for Service Change in the NHS,⁴ Professor David Kerr summarises the Scottish context saying:

Given the extraordinary health pressures that we face from a rapidly ageing population, dwindling birth rate, imposed working time directives from Europe, changes in working patterns, evolving technology and an ever expanding health gap between rich and poor, it should be obvious to all that the status quo definitely cannot be an option.

This and other recent policy documents⁵ point to the development of a team approach to health care in Scotland, of which non-medical prescribing is one important aspect.

Nurse prescribing for DNs and HVs was introduced in Scotland in 1996,⁶ extended nurse prescribing began in 2002 and supplementary nurse prescribing in 2003. At the time of writing, there are seven institutions of higher education offering the Independent and

Supplementary Nurse Prescribing course. Course delivery varies from predominantly taught days to distance learning to suit individual need. The University of Stirling offers electronic distance learning to accommodate the needs of practitioners working in remote and rural locations. This has now become available to a national audience via Emap.

Pharmacist prescribing began at the Robert Gordon University in Aberdeen in October 2003, and currently this University and Strathclyde University are offering training for pharmacists. Around one-hundred and fifty pharmacists have completed the course, with approximately two-hundred students studying at the time of writing. Independent prescribing for pharmacists was announced by Health Minister Andy Kerr in November 2005 to be in place by the spring of 2006.⁷

Legislative change to facilitate supplementary prescribing by other professions (optometrists, radiographers, podiatrists and physiotherapists) has been approved, and indicative content set. As yet, however, no Scottish institution is offering training for these groups.

It is worth noting that supplementary prescribers in Scotland are not (at the time of writing) able to prescribe controlled drugs or unlicensed drugs unless they are part of a clinical trial which has a clinical trial certificate or exemption.⁸

Institutions and individuals are supported by NHS Education for Scotland (NES), which has produced an excellent website. This site provides up-to-date interactive learning materials, which underpin course content in areas such as influences on and psychology of prescribing, legal policy and ethical aspects. It also offers a wide variety of applied pharmacology scenarios and case studies. See end of this section for website.

Uniquely in Scotland, nurse prescribing programme leaders have formed a networking group which meets twice a year to review the educational issues of implementing nurse prescribing. Scottish policy has been more cautious than in England, where it was suggested the majority of nurses would be able to use either independent or supplementary prescribing by 2004.⁹ Two million pounds of central funding was allocated to train 1500 extended and/or supplementary prescribing nurses.¹⁰ The NES database indicated that by January 2005, fewer than 500 students had completed the extended (now known as 'independent') and

supplementary nurse prescribing course. At the time of writing, approximately two-hundred students are actively studying.¹¹

Evidently the uptake of training has been less than anticipated. Currently there is little evidence available to identify reasons for this, but the British literature highlights criticism and concerns on a variety of levels ranging from the conceptual¹²⁻¹⁴ to policy content and implementation.¹⁵⁻¹⁷ Anecdotally, it seems there were several emerging themes from nurse prescribers. These included the limitations of the NPEF which is no longer an issue. Others pointed to practical difficulties in implementing supplementary prescribing policy, based on unrealistic assumptions, for example, that diagnosis is undertaken by doctors, and that medical review annually for large numbers of patients with long-term conditions is unworkable. Whilst there is limited evidence that some forms of nurse prescribing have been received favourably by professionals and patients,¹⁸⁻²¹ the Scottish perspective is as yet unknown. Emerging evidence that many nurses may be underutilising²² or not using²² their prescribing powers is a cause for concern, and this aspect requires exploration.

The need for Scottish research is clear, and to this end the Scottish Executive has appointed a team at Stirling University to undertake a wide-ranging review of nurse prescribing in Scotland. This study will look at the impact of nurse prescribing on nurse prescribers, doctors, patients and other relevant groups. In addition the team aims to assess the learning experience of nurse prescribing students across Scotland and develop a typology of different curricular approaches.

In the meantime, existing nurse prescribers need to be supported in their new roles. This need has already been anticipated by the NES, which have launched a template for continuing professional development (CPD) that can be used by individuals or CPD providers.²³ The extent to which it has been used by nurses or health authorities, and therefore its value, is unknown at present.

Pharmacist supplementary prescribers are beginning to emerge, soon to be followed by pharmacist independent prescribers. The impact of this type of prescribing and how it will work in practice is yet to be seen. So is the impact of supplementary prescribing by AHPs.

There seems little doubt that Scotland has made good progress with the implementation of non-medical prescribing, though for

reasons as yet unclear, not as much as expected. The level of clinical practice support for prescribers is incompletely understood, and a clearer picture of the barriers to prescribing should be developed in order to produce the policy changes which will allow non-medical prescribing in Scotland to reach its full potential.

References

1. British Broadcasting Corporation (BBC). *Scots Smoking Ban Details Set Out*. <http://news.bbc.co.uk/1/hi/scotland/3999975.stm>, accessed 01.02.05.
2. Hanlon, P., Walsh, D., Buchanan, D., Redpath, A., Bain, M., Brewster, D., Chalmers, J., Muir, R., Smalls, M., Willis, J. and Wood, R. *Chasing the Scottish Effect* (Scotland: Public Health Institute for Scotland/Information and Statistics Division, 2001). <http://www.phis.org.uk/pdf.pl?file=pdf/chasing%20scottish%20effect.pdf>, accessed 28.01.05.
3. Clark, D., McKeon, A., Sutton, M. and Wood, R. *Healthy Life Expectancy in Scotland* (On behalf of the HLE Measurement in Scotland Steering Group, 2004).
4. SEHD. *A National Framework for Service Change in the NHS in Scotland* (Edinburgh: SEHD, 2005).
5. SEHD. *Partnership for Care: Scotland's Health White Paper* (Edinburgh: SEHD, 2003). <http://www.scotland.gov.uk/library5/health/pfcs-00.asp>, accessed 01.02.05.
6. SEHD. Statutory Instrument No.1504 (S.132). *The National Health Service (General Medical Services, Pharmaceutical Services and Charges for Drugs and Appliances) (Scotland) Amendment Regulations* (Edinburgh: SEHD, 1996).
7. Scottish Executive. *Nurses get Greater Prescribing Powers* (Press Release). www.Scotland.gov.uk/News/Release/2005/11/11104434, accessed 13.02.06.
8. Scottish Executive. *Framework for Developing Nursing Roles* (Edinburgh: SEHD, July 2005).
9. DH. *The NHS Plan: A Plan for Investment, A Plan for Reform* (London: Department of Health, 2000).
10. SEHD. *Extended Independent Nurse Prescribing within NHS Scotland: A Guide for Implementation* (Edinburgh: SEHD, 2002).

11. Waddington, C. Personal Communication. 27.01.05.
12. Barker, P. Prescribing: The great debate. *Nursing Standard*, 2002, 17(9): 23.
13. Horton, R. Nurse-prescribing in the UK: Right but also wrong. *Lancet*, 2002, 359: 1875–1876.
14. Skidmore, D. Will you walk a little faster...? In: Humphries, J. and Green, J. (eds) *Nurse Prescribing*, 2nd edition, Chapter 9, pp. 129–139. (Basingstoke: Palgrave Macmillan, 2002).
15. Pickersgill, F. Extending nurse prescribing. *Primary Health Care*, 2001, 11(4): 23.
16. Mazhindu, D. and Brownsell, M. Piecemeal policy may stop nurse prescribers fulfilling their potential. *British Journal of Community Nursing*, 2003, 8(6): 253–256.
17. Baird, A. Recent developments in prescribing. *Journal of Community Health*, 2004, 18(3): 4–6.
18. Luker, K., Austin, L., Hogg, C., Ferguson, B. and Smith, K. Patient's views of nurse prescribing. *Nursing Times*, 1997a, 93: 515–518.
19. Luker, K., Willock, J. and Ferguson, B. Nurses' and GPs' views of the nurse prescribers' formulary. *Nursing Standard*, 1997b (22): 1133–1138.
20. Brooks, N., Otway, C., Rashid, C., Kilty, L. and Maggs, C. Nurse prescribing: What do patients think? *Nursing Standard*, 2001, 15(17): 33–38.
21. While, A. and Biggs, K. Benefits and challenges of nurse prescribing. *Journal of Advanced Nursing*, 2004, 45(6): 559–567.
22. Timbs, O. What pharmacists prescribers can learn from those who have gone before. *Prescribing and Medicines Management*, 2003, 5: 5.
23. National Health Service Education for Scotland (NES). *A Template for Continuing Professional Development in Prescribing* (Edinburgh: NES, 2003).

Further reading

Scottish Executive Health Department (SEHD). *Our National Health: A Plan for Action, a Plan for Change* (Edinburgh: SEHD, 2005).

Scottish Executive. *Framework for Role Development in the Allied Health Professions* (Edinburgh: SEHD, July 2005).

Further reading cont'd

Scottish Executive. *Framework for Developing Nursing Roles* (Edinburgh: SEHD, July 2005).

Useful websites

NHS Education for Scotland	www.nes.scot.nhs.uk/nursing/prescribing/default.asp
Scottish Executive	www.scotland.gov.uk

Implementation in Northern Ireland *Carolyn Mason and Anita Glenn*

Northern Ireland is about the size of Yorkshire and has a population of 1.7 million. Given this relatively small area, it made sense to introduce non-medical prescribing consistently across the region. Prescribing by nurses is probably the most significant development in nursing since the inception of the NHS, testing ideas about 'which professionals do what' and ways of working that have become embedded over time.

Introducing nurse prescribing has been both challenging and rewarding. The challenge was led from the top by the then CNO Judith Hill. In 2001 a Project Officer was appointed to the government Department of Health, Social Services and Public Safety (DHSSPS) to carry out the work, under the leadership of one of the four Nursing Officers. In Northern Ireland, Health, Social Services and the Fire and Ambulance Services are combined into one government department, the DHSSPS. Protected project officer time was key to the success of implementation. An important feature of nurse prescribing is its interrelatedness with other aspects of health and social care, for example prescribing by nurses in primary care has an effect on practice-based prescribing budgets, and there are important implications for pharmacists who are legally accountable for ensuring the authenticity of prescriptions. This meant that a huge variety of detailed process issues had to be confronted, and a wide range of key stakeholders persuaded to commit to the change.

To drive the project, a senior level, multiagency, multiprofessional Steering Group was established, which included user representation as well as management, education and information computer technology (ICT) input. Although there was initially

some resistance from individuals within clinical areas such as general practice, pharmacy and microbiology, there was full support from the Chief Medical Officer. Those who supported the initiative saw the potential for better access for patients and more efficient service delivery. Those who were cautious tended to emphasise risks around indemnity, adverse incidents and records management. Given these legitimate concerns and the key priority of patient safety, advice and expertise were needed from across the spectrum of primary, secondary and tertiary care, as well as legal, civil service and technological help, and, at top level, ministerial backing. An Education Sub-Group and an Implementation Sub-Group were established to bring this forward.

The independent and supplementary prescribing course in Northern Ireland is comprehensive and demanding, and it has generally been the case that multiprofessional colleagues who were initially sceptical about nurses' education and competence have been impressed. The course is offered as a part-time programme at degree or postgraduate level, lasting one year and it contains four modules:¹

- ▶ Professional issues and patient empowerment
- ▶ Pharmacotherapeutics
- ▶ Health assessment
- ▶ Specialised assessment and prescribing.

A proportion of the programme consists of e-learning and students undertake 15 days of supervised practice.² Prerequisites to entry, as in other parts of the United Kingdom include support from a medical mentor and access to a prescribing budget. Northern Ireland has two universities and nurse prescribing is the first course ever to be offered jointly by these. From the outset, and in contrast to some other parts of the United Kingdom, the curriculum included both extended and supplementary prescribing and all students undertake both elements. Those who undertake the course come from a range of clinical areas and specialisms, including:

- ▶ nurse practitioners
- ▶ mental health nurses
- ▶ nurse specialists
- ▶ practice nurses

- ▶ midwives and
- ▶ accident and emergency (A&E) nurses.

Challenges for implementation have been, and continue to be, many. A distinct feature of Northern Ireland is the uncertain political situation. The disbandment of the NI Assembly in 2002 created a delay in passing the necessary legislation and amendments to associated regulations for nurse prescribing. In spite of this, the project has continued successfully and systems are in place to sustain expansion and development. Each of the four area Health and Social Services Boards has a designated Nurse Prescribing Adviser post, the education programme is well established and a nurse prescribing information system, NINA (Northern Ireland Nurse Analysis), has been built to capture information on nurse prescribing in primary care at individual, trust, board and regional levels.

There are still many challenges for non-medical prescribing in Northern Ireland. First, amongst these is the need to create a prescribing budget for these prescribers in primary care. Secondly, there can be a time lag between England and Northern Ireland in passing legislation and amendments to regulations to enable the prescribing. One such example is that of controlled drugs legislation which has only just been passed at the time of writing.³ Supplementary prescribers are not yet allowed to prescribe controlled drugs, unlicensed or 'off label' drugs in Northern Ireland.² It is therefore important that websites are designed to make it easy for nurses and others to know which rules apply to each country, at any given time. In common with the rest of the United Kingdom, the bit-by-bit expansion of the formulary did create difficulties for practising nurses in knowing exactly what could be prescribed at a given moment. Professional guidance documents still need to be updated regularly.

As prescribing by nurses grows, the way is being paved for developments in practice that, only a few years ago, would have been unthinkable. Pharmacy colleagues have started supplementary prescribing and in due course will be joined by the AHPs.

Collectively, this promises to change the face of health care. Extended and supplementary prescribing is opening up the routes for nurses to diagnose, care and treat, and is empowering them to tailor the management of medicines to the needs of patients in a way that is beginning to realise the full potential of the nursing as a profession.

References

1. Department of Health, Social services and Public Safety (DHSSPS). *Extending Independent Nurse Prescribing within the HPSS in Northern Ireland: A Guide for Implementation* (Belfast: DHSSPS, April 2004).
2. DHSSPS. *Supplementary Prescribing by Nurses and Pharmacists within the HPSS in Northern Ireland: A Guide for Implementation* (Belfast: DHSSPS, April 2004).
3. Statutory Rule. *The Misuse of Drugs (notification of and supply to addicts) (Amendment) Regulations (Northern Ireland)* (Crown Copyright, December 2005). www.opsi.gov.uk/sr/sr2005/20050564.htm, accessed 18.02.06.

Useful websites

Department of Health, Social Services & Public Safety
www.dhsspsni.gov.uk

Implementation in England *Molly Courtenay and Matt Griffiths*

Recommendations were first made in 1986 for nurses to take on the role of prescribing.¹ Eight years later (although limited to DNs and HVs, nurses in eight demonstration sites throughout England began to independently prescribe. At the time of writing, there are approximately 28,000 DNs and HVs qualified to prescribe from a list of appliances, dressings, Pharmacy (P), GSL items and POMs included in the Nurse Prescribers' Formulary (NPF). Other community specialist practitioners are now eligible to train for this type of prescribing.

The available research exploring nurse prescribing by DNs and HVs is positive.² Patients indicate that they are as satisfied, and sometimes more satisfied, with a nurse prescribing as they are with their GP.³ Nurses and doctors report that they are able to use their time more effectively and that treatments for patients are more conveniently provided.^{4,5} Nurses also report that they are able to provide patients with better information about their treatment and that they experience increased job satisfaction, status and autonomy.^{5,6}

During 2001, funding was made available for all nurses, who met the agreed criteria, to undergo the necessary training to enable them to prescribe from an extended formulary.⁷ Training for extended prescribing by nurses began in spring 2002. In 2003, proposals to expand the NPEF were accepted and the NPEF was extended to include a number of additional conditions and medicines.⁸ In 2003, legislation was passed by the Home Office (HO) allowing nurses to prescribe six CDs.⁹ Further CDs, included in the proposals set out by the MHRA,⁸ have recently been added following HO approval. Additional proposals to extend the NPEF to include medicines and conditions in emergency and first contact care¹⁰ were accepted in 2004 and came into effect in May 2005.

The result of recent proposals¹¹ to extend the NPEF yet further have been accepted, as have proposals to extend independent prescribing to include pharmacists.¹² These changes came into force on May 1st 2006.

Following DH approval in 2002,¹³ training for supplementary prescribing was introduced in 2003 for nurses and pharmacists, and legislative changes enabling the extension of supplementary prescribing to some AHPs, physiotherapists, podiatrists, radiographers and optometrists are now in place.¹⁴

The benefits reported following the implementation of supplementary prescribing include, improved interprofessional relationships and more effective use of the skills of the SP (enabling the management of more complex cases by doctors),¹⁵ reduction in drug errors,¹⁶ and standardisation of treatment across groups of patients.¹⁷

In England, at the time of writing, there are over 6000 independent/supplementary nurse prescribers and over 500 supplementary pharmacist prescribers.

References

1. DHSS. *Neighbourhood Nursing: A Focus for care* (Cumberlege Report) (London: HMSO, 1986).
2. Luker, K.A., Austin, L., Hogg, C., Ferguson, B. and Smith, K. Nurse-patient relationships: The context of nurse prescribing. *Journal of Advanced Nursing*, 1992, 28(2): 235–242.

3. Latter, S., Maben, J., Myall, M., Courtenay, M., Young, A. and Dunn, N. *An Evaluation of Extended Formulary Independent Nurse Prescribing: Executive Summary*. www.dh.gov.uk/publicationsandstatistics/pressreleases, accessed 29.06.05.
4. Brooks, N., Otway, C., Rashid, C., Kilty, E. and Maggs, C. The patients' view: The benefits and limitations of nurse prescribing. *British Journal of Community Nursing*, 2001, 6(7): 342–348.
5. Luker, K., Austin, L., Ferguson, B. and Smith, K. Nurse prescribing: The views of nurses and other health care professionals. *British Journal of Community Health Nursing*, 1997, 2: 69–74.
6. Rodden, C. Nurse prescribing: Views on autonomy and independence. *British Journal of Community Nursing*, 2001, 6(7): 350–355.
7. DH. *Patients to get Quicker Access to Medicines* (Press Release) (London: DH, 2001).
8. MHRA. Consultation Document, MLX293, NPEF (2001).
9. HO. 40/2003. *An amendment to the Misuse of Drugs Regulations 2001 – To Permit the Prescribing of CDs by Nurses in Restricted Circumstances, and the Supply of PGDs in Accordance with a PGD* (London: HO, 2003).
10. MHRA. *Nurse Prescribers' Extended Formulary: Proposals to Expand the Range of POMs* (MLX 320) (2004).
11. MHRA. Consultation Document, MLX 320, NPEF (2005a).
12. MHRA. *Consultation on Proposals to Introduce Independent Prescribing by Pharmacists* (2005b).
13. DH. *Supplementary Prescribing* (London: DH, 2002).
14. DH. *Supplementary Prescribing by Nurses, Pharmacists, Chiropodists/Podiatrists, Physiotherapists and Radiographers within the NHS in England: A Guide for Implementation* (London: DH, 2005).
15. Hennell, S.L., Wood, B. and Spark, E. Competency and the use of CMPs in rheumatology practice. *Nurse Prescribing*, 2004, 2(1): 26–30.
16. Kinley, J. Nurse prescribing in palliative care: Putting training into practice. *Nurse Prescribing*, 2004, 2(2): 60–64.
17. Baird, A. Supplementary prescribing: One general practice's experience of implementation. *Nurse Prescribing*, 2004, 2(2): 72–75.

Implementation in Wales

Fiona Irvine and Carol Kirkham

Historical Background

Following the Cumberledge Report of 1986¹, a review of community nursing in Wales in 1987 led to the production of 'Nursing in the Community – A Team Approach for Wales',² which recommended that 'legislative changes should be made to allow nurses to prescribe from a limited formulary agreed with the Medical profession' (p. 48). These recommendations finally came into force in Wales in January 2001 when the first cohort of community nurses (district nurses and health visitors) began prescribing.³

Supplementary Prescribing

Before the initiation of nurse prescribing in Wales, the concept of supplementary prescribing was already being considered and the second Crown Report⁴ recommended that prescribing powers be extended to nursing groups other than community nurses with a district nursing or health visiting qualification and to other professionals, such as pharmacists and therapists. A distinction was made between independent prescribers, who would be responsible for the initial assessment of the patient and subsequently drawing up a treatment plan, and supplementary prescribers, who would be authorised to prescribe for patients whose condition had been previously diagnosed by an independent prescriber, within the parameters of an agreed treatment plan. In May 2001 the Department of Health (DH) announced that prescribing authority would be extended to allow practitioners to prescribe treatments for a wider range of medical conditions from an expanded formulary. By March 2003 they published the implementation guide for supplementary prescribing by pharmacists and nurses, and in England training for supplementary prescribers began in 2003. Whilst the training in Wales was the same as that in other parts of the United Kingdom, nurses were not allowed to independently prescribe from the NPEF.

Overview of Supplementary Prescribing Education Programme in Wales

With the support of the Welsh Assembly Government, the decision was taken to develop a single All Wales Curriculum for *supplementary prescribing*, for pharmacists and nurses employed in Wales. An underpinning theme of the curriculum is that nurses and pharmacists are taught together and assessed using the same criteria. Thus the taught programme meets the relevant standards set by the Nursing and Midwifery Council (NMC) and the Royal Pharmaceutical Society. The programme is designed to develop the critical analysis and personal reflection skills of the students and to prepare them for continuous professional development.

The curriculum is normally delivered over a six-month period and comprises of 90 hours (15 days) taught contact, 72 hours (12 days) learning in practice and 218 hours of directed study. The module attracts 20 credits at level HE3.

The programme is developed around four main themes, namely: communicating, consultation and decision-making, therapeutics and clinical governance. Communicating seeks to prepare students to enhance their ability to communicate effectively across professional boundaries and to work in partnership with key individuals to achieve concordance. Consultation and decision-making prepare students to undertake assessment and diagnosis and to generate treatment options within a clinical management plan. The theme of therapeutics addresses safe and effective prescribing using an appropriate management plan. It also considers patient monitoring and referral. Finally, clinical governance prepares students to work within a clinical governance framework in relation to supplementary prescribing.

A rigorous assessment strategy underpins the programme and consists of an Objective Structured Clinical Examination (OSCE) and a practice portfolio comprising of:

1. A needs analysis, action plan and diagnostic essay
2. A clinical log and reflective critical analysis of cases from practice
3. Three clinical management plans.

Progress to Date

In Wales, it was agreed that a maximum of two cohorts per year would undertake the training with a maximum of 30 students entering the programme at each one of five educational providers in Wales. The first cohort of nurses and pharmacists commenced training as supplementary prescribers in March 2004. They completed the programme in December 2005 and successful students were awarded a Certificate in Supplementary Prescribing. They register with the NMC (nurses) or the Royal Pharmaceutical Society (pharmacists) as Supplementary Prescribers, before beginning to prescribe. The second student cohort commenced the programme in January 2005.

The success of supplementary prescribing in Wales is yet to be established since the first cohort of successful students is just beginning to prescribe. However, it is anticipated that the extension of supplementary prescribing to a wider range of nurses and pharmacists is a major step in ensuring that patients receive comprehensive and seamless care from the most appropriate professional.

A recent announcement by Health Minister Dr Brian Gibbons gave a commitment to introduce independent prescribing by pharmacists and nurses in Wales. This progression is eagerly awaited.⁵

References

1. DHSS. *Neighbourhood Nursing: A Focus for Care* (Cumberledge Report) (London: HMSO, 1986).
2. Welsh Office. *Nursing in the Community: A Team Approach for Wales* (Edwards Report) (Cardiff: Welsh Office, 1987).
3. Green, J. *Development of the Nurse Prescribing Initiative*. In: Humphries, J. and Green, J. *Nurse Prescribing*, 2nd edition. (Basingstoke: Palgrave, 2002).
4. DH. *Review of Prescribing, Supply and Administration of Medicines* (Crown Report 11) (London: DH, 1999).
5. Welsh Assembly. *Independent Prescribing Coming to Wales*. Press Announcement (19 January 2006). www.Wales.gov.uk/Servlet/PressReleaseByDate/Servlet?area_code, accessed 29.01.06.

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