

Chapter 1

Prescribing in Context

Dilyse Nuttall

Learning objectives

After reading this chapter and completing the activities within it, the reader will be able to:

- 1 Identify the development and current context of non-medical prescribing in the UK.
- 2 Critically analyse the implementation of non-medical prescribing in relation to the different professional groups.
- 3 Evaluate the different types of prescribing and identify their appropriate application to practice.

Non-medical prescribing has been subject to ongoing development ever since its inception. This has resulted in changes in both the types of prescribing possible and the related terminology. This chapter explores the different qualifications available in non-medical prescribing and discusses their application in the practice of various professionals, including nurses, midwives, pharmacists and allied health professionals. The discussion incorporates explanation of independent prescribing and supplementary prescribing, differentiating between specific prescribers and making comparisons to highlight their individual benefits and restrictions.

The prescribing journey

The current position of prescribing has evolved from its origin in district nursing and health visiting to a well-established element of everyday practice for a range of health professionals. This journey has not been as straightforward as many would have hoped, with individual professions having to undertake a period of limited prescribing before being able to use it in a manner that best supports their practice. The introduction of prescribing to the nursing profession was, in many ways, tentative, with the 1992 Medicines Act enabling only a small group within a very large workforce to undertake the necessary programmes of education. Furthermore, the limited formulary imposed a controlled and constrained introduction of prescribing. Nevertheless, this was a welcome development, the

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benefits of which became increasingly apparent and, ultimately, led to prescribing becoming available to more nurses and more professions.

The caution employed in the introduction of prescribing in nursing was, in part, due to the lack of a robust evidence base to support this new element of practice. Although many nurses' interpreted this cautious approach as concern that they were more likely to make mistakes, a view unfortunately held by some medical colleagues (Day 2005), the profession has been able to develop an increasing evidence base to support the expansion of prescribing. Supported by government-led consultations and evidence gathering from other professional groups and professional bodies, the necessity to introduce prescribing to other professional groups dictated the change in terminology from nurse prescribing to non-medical prescribing.

Defining non-medical prescribing

The issue of terminology in prescribing has often caused discord and confusion. The term 'nurse prescribing' remains an accurate description for nurses, with prescriptions continuing to identify nurses as such. Similarly, the terms 'pharmacist prescriber' and 'allied health professional prescriber' are used by the professional bodies governing these groups (General Pharmaceutical Council (GPhC) 2013, Health and Care Professions Council (HCPC) 2014). Although the government health departments in England, Scotland, Wales and Northern Ireland (Department of Health (DH) 2006a, 2011a, Scottish Government (SG) 2009, 2013, National Health Service (NHS) Scotland 2010, Welsh Government (WG) 2013, Department of Health, Social Services and Public Safety (DHSSPS) 2014) utilise the term 'non-medical prescriber', they continue to differentiate between prescribers to acknowledge the differences in prescribing rights and professional registration. As a result, these terms are reiterated in the names of education programmes and in the evidence base supporting prescribing. There is much benefit in this differentiation, from both a safety and a professional development perspective, but it should be recognised that these individual practitioner titles are components of the broader context of prescribing by those health professionals who are not doctors or dentists. The inclusive term 'non-medical prescribing' is now widely used to represent these prescribers, the advantage of which is that it promotes the multidisciplinary approach required for safe and effective prescribing, highlighted in Chapter 6.



Activity box 1.1

Go to the government website relevant to your practice area and search for documents that outline the implementation of non-medical prescribing for your professional group. Consider their content in relation to your practice:

- <http://www.gov.uk/government/organisations/department-of-health>
- <http://www.scotland.gov.uk>
- <http://www.wales.gov.uk>
- <http://www.dhsspsni.gov.uk>

The non-medical prescribing vision

In considering the context of non-medical prescribing, it is of benefit to revisit the origins of nurse prescribing to consider its early ethos and vision. The *Review of Prescribing and Administration of Medicines: Final Report* (DH 1999a) identified five key principles within the terms of reference (Table 1.1). On examining these principles and making comparison to policy and guidance supporting the current position of non-medical prescribing, it is evident that these principles remain steadfast. The Department of Health (DH) (2008), in the document *Making the Connections: Using Healthcare Professionals as Prescribers to Deliver Organisational Improvements*, clearly identified the benefits of non-medical prescribing and the opportunities for healthcare professionals to enhance their practice by making effective use of prescribing. The benefits of non-medical prescribing presented for patients included increased access, increased capacity and improved choice for patients. This was supported by the professionals' ability to manage and complete episodes of care for patients, in a variety of settings, reiterating the messages from *Medicines Matters* (DH 2006b). Although the terminology and focus may have shifted slightly, the underpinning principles remain the same: safe and effective prescribing. In our current healthcare climate, there is a clear focus on the need to ensure services effectively support the needs of individuals, families and communities (DHSSPS 2011, HM Government 2012, WG 2012, SG 2014) and prescribing is recognised as a valuable tool in this process.

The complex nature of good prescribing was identified by the National Prescribing Centre (NPC) when they released their first *Nurse Prescribing Bulletin* (NPC 1999). The seven principles of good prescribing identified within this bulletin have provided a core framework for prescribers in their education and development for the past decade. However, it is important to recognise that, although these remain relevant, non-medical prescribing has moved forward significantly, in terms of both the range of treatments prescribers are able to prescribe and the range of expertise and settings in which prescribing can now take place. As such, the seven principles should be seen as a foundation on which to build rather than as a measure on which to base effectiveness. The NPC (2012) and the professional bodies (HCPC 2006, Nursing and Midwifery Council (NMC) 2006, GPhC 2010a) have all identified the need to develop and maintain competency in prescribing beyond qualification, developing relevant frameworks and continuing professional development (CPD) strategies. These are discussed further in Chapter 9.

Attitude shifts

The evolution and success of non-medical prescribing should not be measured just by the increase in numbers of prescribers. It is recognised that the process has required many legal, professional and ethical changes, as discussed in Chapter 2. Fundamentally, the increase in non-medical prescriber numbers and the strategies employed to support this development have relied on a change much more difficult to measure. It would, therefore, be inappropriate to consider the context of

Table 1.1 Key principles of the Crown Report

Patient safety
 Effective use of resources
 Skills and competencies of various health professionals
 Changes in clinical practice
 Public expectations

Source: Department of Health (1999a).

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non-medical prescribing without addressing the significant and ongoing shifts in attitude that have enabled non-medical prescribing to flourish. The processes involved in enabling legal and professional changes have often highlighted the concerns and objections of individuals and groups from both the medical profession and colleagues in other health professions. These concerns have ranged from questions of safety to issues of boundaries within professional roles (Day 2005). Importantly, the evidence base developed has addressed many of these concerns. Data from the National Patient Safety Agency (National Patient Safety Agency (NPSA) 2009, 2010) identified that, although prescribing errors occur, the most medication errors arise from administration. There is no indication that non-medical prescribing activity results in an increase in prescribing errors.

Many of the prescribing errors reported have been attributed to junior doctors, but the cause of these errors has been found to be multifactorial in nature (Velo and Minuz 2009, Ryan et al. 2014). It is unproductive to utilise the junior doctor as a diversion from the concerns raised regarding non-medical prescribing, but it does highlight issues that should provide some reassurance to those raising the concerns. Significantly, a need for specific education for all prescribers has been identified by Schachter (2009), and the content of this education, suggested by Likic and Maxwell (2009), reflects that already undertaken by non-medical prescribers. Health Education England in partnership with the Academy of Medical Royal Colleges, in recognition of the importance of the principles of safe prescribing, now provides a resource for doctors undertaking foundation training, which includes safe prescription writing and risk awareness (E-Learning for Health Care 2014). It is important to recognise this as evidence of good practice from which others may learn.

Attitudes towards prescribing are becoming increasingly positive, with the benefits brought to specialist roles being recognised (Avery and Pringle 2005, DH 2011a). The role of doctors has not diminished as a result of non-medical prescribing, but instead, there are numerous examples of how non-medical prescribing can be used by professionals to work alongside doctors to improve the patient experience (Courtney and Carey 2008, DH 2011a). The health professional case studies provide some clear examples of this issue.

It is important also to consider the attitudes of those practitioners undertaking non-medical prescribing and the impact on the team (both the immediate healthcare team and the wider organisation). Prescribing can increase a practitioner's confidence and result in greater job satisfaction, but any change in role and attitude of an individual within a team can have an impact on the team dynamics as a whole (Bradley and Nolan 2007). Although this can often be a positive change in dynamics, it is important to recognise that the journey is not always straightforward and change should be supported by ensuring that the team is informed and involved.

The success of non-medical prescribing has not only required an attitude shift by professional colleagues but, possibly more importantly, has also been reliant on its acceptance by patients. A study investigating the views of the Scottish general public found that there was a significant awareness of non-medical prescribing (Stewart et al. 2009). Interestingly, respondents from Stewart et al. (2009) study reported that they were more comfortable with pharmacist or nurse prescribing than with other non-medical groups, a finding that could, at least in part, be due to familiarity with, and experience of, the public with those professionals. The study identified that the public required reassurance regarding clinical governance issues, reiterating the need for both a strong evidence base and effective channels of communication, to ensure that the public develop an awareness of advancements in non-medical prescribing.

Non-medical prescribing, medical prescribing or prescribing

As acknowledged above, safety and efficacy have remained the key objectives for non-medical prescribing, an ethos that has been fundamental to its success. However, all health professionals would surely argue that these are essential principles that underpin their practice as a whole. The professional

and ethical codes that serve to regulate the practice of health professionals (NMC 2015, GPhC 2010b, HCPC 2012) remain as relevant to prescribing as they do to other aspects of their practice.

Therefore, the debate should perhaps focus on the need to differentiate prescribing from any other element of healthcare practice. However, prescribing does present specific challenges and potential problems that require specific guidance and standards. As such, all relevant professional bodies have developed curricula and standards to ensure that education programmes prepare students to practise as non-medical prescribers within the boundaries of their professional ethical code (NMC 2006, 2009, GPhC 2010b, Allied Health Professions Federation 2013).

In recognising that prescribing requires specific consideration, the relationship between non-medical prescribing and medical prescribing must be considered. It has been established that the concepts of safety and efficacy are pertinent to all healthcare practice, including medical prescribing. It is logical to consider that some practices that support safety in prescribing, such as standards for writing prescriptions (British Medical Association (BMA) and RPSGB 2015), were originally developed for medical prescribing, before the advent of non-medical prescribing.

Therefore, it is reasonable to question the necessity to even differentiate between medical and non-medical prescribing. The potential for medicines to result in harm to patients is well acknowledged by the existence of agencies responsible for monitoring this throughout the UK (see Activity box 1.2). The data collected by these agencies reiterate the message that patient safety must be paramount, regardless of who is prescribing. The strategies, used to support patient safety and efficacy, are explored throughout the chapters of this book and adopt a holistic approach to prescribing.

This approach requires non-medical prescribers to consider all factors influencing their prescribing practice, including consultation skills, patient expectations, the clinical evidence base and CPD, in order to achieve the safest and most effective outcomes possible for the individual patient. This approach is reflected in non-medical prescribing education programmes throughout the UK. However, although the objectives of medical and non-medical prescribing are fundamentally consistent, until recently, there has been a stark difference in the standardisation of education with regards to prescribing between these two groups. The medical profession has shared a wealth of knowledge and skills with other health professionals as designated medical practitioners, to support them through their education and beyond. This has been invaluable in moving non-medical prescribing forward. It is therefore reassuring to see that current resources for doctors in foundation training (E-Learning for Health Care 2014) recognise that the benefits of the formalised and structured approach to providing education focused on prescribing are relevant and valuable to all prescribers.



Activity box 1.2

The UK has dedicated agencies to address patient safety. Go to the appropriate agency website and, by accessing their resources, identify the recommendations for promoting patient safety in relation to your prescribing practice. Critically reflect on your practice and identify strengths and weaknesses in relation to patient safety:

National Patient Safety Agency (England, Northern Ireland and Wales): <http://www.npsa.nhs.uk>

Scottish Patient Safety Programme: <http://www.scottishpatientsafetyprogramme.scot.nhs.uk/>

Healthcare Inspectorate Wales: <http://www.hiw.org.uk>

Health and Social Care Safety Forum (N. Ireland): <http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/hsc-safety-forum>

Changes in clinical practice

One of the major drivers behind the increasing development of non-medical prescribing has been the significant changes that have taken place in clinical practice. These changes have been a direct response to the recognition of the changing health needs of the population. The DH (2011b), in its Operating Framework, identified priorities for 2012–2013, many of which reflect the increase in the number of people with long-term conditions, such as dementia. In order to address the demands on services, healthcare must aim to reduce both hospital admissions and the subsequent lengths of stay. The priorities set by the DH (2011b) maintain the public health approach and include measures to ensure people have a positive experience of care and are protected from avoidable harm. The workforce continues to be subject to significant changes in response to these priorities, resulting in new challenges and demands. Implementation of current health policy involves a fundamental shift of care into the community arena (DH 2010, HM Government 2012) with both primary and secondary care evolving in response. Non-medical prescribing has long since ceased to be a primary care phenomenon, with independent prescribing developing rapidly in the hospital setting, responding to reductions in the working hours of junior doctors and emerging new and specialist roles. The expansion of non-medical prescribing into new areas brings not only many benefits and opportunities (Goswell and Siefers 2009, DH 2011a) but also new challenges for all those involved (Cooper et al. 2008a, Pontin and Jones 2008, SG 2009, Downer and Shepherd 2010).

The role of non-medical prescribing

The skills and expertise of health professionals have been recognised as a valuable resource that could be used more effectively to support the development of healthcare services (DH 2006a, SG 2009, 2013, HM Government 2012). This has resulted in the development of new roles throughout the healthcare professions, including advanced practitioners, pharmacists and allied health professionals with specialist roles, community matrons and specialist midwife roles. This, in turn, has required a redefinition of many existing roles. Non-medical prescribing has not only proved useful in these developments but, in some cases, has been identified as an essential component of the health professional's role, clearly indicated within the job description. In considering the vision for modern UK healthcare in providing an equitable service, which meets the needs of service users and staff, it is clear that the ability for individual practitioners to complete episodes of care is paramount. It is important to acknowledge that it would be unrealistic to suggest that prescribing, as an isolated skill, would enable practitioners to complete every episode of care. However, in the context of prescribing representing an additional skill possessed by experienced and competent practitioners, it is fair to suggest that it would enable a significant number of consultations to be successfully concluded. The principles of prescribing (NPC 1999) and subsequently the competency framework supporting prescribing (NPC 2012) have reiterated the message that writing a prescription is only one aspect of the multifaceted process of prescribing practice. As such, the skills acquired by health professionals in enabling them to reach a prescribing decision, whether or not it results in the writing of a prescription, mean that those consultations that require referral can proceed in a more efficient and appropriate manner. Therefore, it is clear that, in an evolving healthcare service, non-medical prescribing is, and will continue to be, an essential component.

The 6 Cs

It would not be appropriate to consider changes in clinical practice without acknowledging the Francis Report (Francis 2013) and the failings in care that were identified. A key strategy introduced to empower healthcare practitioners to advocate compassion, provide excellent care and eliminate poor practice was introduced in *Compassion in Practice: Our Vision and Strategy* (NHS Commissioning Board 2012) that identified six core values, known as *the 6 Cs*: care, compassion, competence, communication, courage and commitment. As with all aspects of care, the 6 Cs are directly relevant to prescribing practice.

It is important that the prescriber makes effective use of the holistic approach integral in the principles of prescribing practice (NPC 1999) in order to ensure that, as Francis (2013) considered crucial, the patient is at the centre of *care* provided for them. In support of this, taking time to establish the patient's expectation and negotiate a plan of treatment, using sensitive *communication*, will go some way to demonstrate *compassion* within the prescribing consultation. This of course is reliant upon the prescriber being competent to establish a diagnosis and identify an appropriate treatment plan. As health professionals and prescribers, the maintenance of *competence* is a professional requirement and one that is supported by the Single Competency Framework (NPC 2012). However, this responsibility needs to be supported by a *commitment* to ensure that prescribing meets the individual needs of the patient. This will often require effective use of a multidisciplinary approach to care provision and at times will require the prescriber to have the *courage* to challenge their own and others practice.

The economic context

The majority of prescribing activity undertaken by non-medical prescribers in the UK is undertaken by National Health Service (NHS) employees, with the cost of the treatment met by the NHS budget. The extent of spending on prescription items can be demonstrated by making reference to the document *Prescription Cost Analysis for England 2012* (Health and Social Care Information Centre 2013). In 2012, 83 million prescription items and £710 million worth of payments were processed per month. The magnitude of this is compounded by the knowledge that this related only to prescriptions written within the community.

The NHS prescribing budget, as with all areas of NHS provision, is a finite resource. As such, non-medical prescribing exists within the context of a service where resources must be used appropriately, efficiently and effectively in order that patients benefit from the full potential of the service. The consequence of this is that, in order for prescribing practice to be safe and effective, prescribers must consider issues of cost-effectiveness as part of the decision-making process. The issue of cost-effectiveness must be regarded in relation not only to the use of treatments but also to the many associate resources that compliment and support prescribing practice.

The achievement of an appropriate balance between cost-effectiveness and clinical effectiveness is an aspect with which many non-medical prescribers struggle. The reasons for this are numerous, influenced by professional, legal and ethical issues. Concordance issues, patient expectations, media influences and practitioner professional development issues are just a small selection of the factors that might impact on the choice of treatment and the balance of cost-effectiveness against clinical effectiveness. Case study 1 provides an example of how local formularies have been used effectively to address some of these issues.

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Local formularies and guidelines (e.g. antimicrobial guidelines) can provide clear frameworks for non-medical prescribers and are often an important consideration in aiding decision-making about treatments. However, it has been identified that for some non-medical prescribers, they can be restrictive (Royal College of Nursing (RCN) 2012). Unfortunately, the drive for cost-effectiveness can easily be mistaken by an inexperienced prescriber as a necessity to always prescribe the cheapest treatment available. It is important that local formularies are not unfairly perceived as tools to limit prescribing to the cheapest options available. An engagement with national and local medicine management processes will support the non-medical prescriber in developing an understanding of the benefits of these formularies. It is worth noting that, within individual trust policy, there is usually an option to prescribe outside the formulary (where there is a clear rationale for doing so). Maintaining knowledge and competence in relation to their specialist field, particularly in relation to national guidelines and treatment options, is essential in enabling non-medical prescribers to work effectively with local formularies, while having the expertise to challenge them when appropriate.



Activity box 1.3

- Access and summarise national guidelines for a condition for which you could prescribe.
- Access your local formulary and guidelines and compare these to the national guidelines.
- Answer the following questions:
 - 1 Are there any differences?
 - 2 Is there a rationale for the differences?
 - 3 Do you know the protocol for prescribing outside your local formulary?

The private sector

Although most non-medical prescribers practise within the NHS, there are a significant and increasing number of prescribers who work within private or independent practices. Each individual practitioner is responsible for ensuring that they practise in accordance with the regulations of their professional body and, of course, this includes a requirement to practise within, and to maintain, one's own competence. This remains the case, regardless of the sector in which they are employed. In order to provide and maintain quality and standardised care, the NHS requires that nationally determined standards are adopted and implemented within individual trusts and that these in turn are implemented within individual practices. Although many private sector practices ensure that comprehensive policies and protocols are in place, others have limited and/or inadequate governance procedures in place. The DH (2006a, p. 19) recognised the potential for differences in clinical governance systems and therefore made the following statement to promote safety, regardless of the setting in which non-medical prescribing is undertaken:

Nurse and Pharmacist Independent Prescribers who work outside NHS settings where clinical governance systems may be different or may not be applied in the same way, must ensure they comply with requirements to demonstrate their competence to practice. For example, they must

be able to show how they audit their practice, keep up-to-date with current guidance, and how they safeguard the patients in their care.

One related concern has been identified in relation to injectable medicines, such as Botox® and Vistabel®, used in cosmetic procedures. The receipt of wholesale supplies of these medicines by nurses and remote prescribing by doctors are just two issues that have prompted the need for guidance. The NMC (2007) acknowledged that some nurses were also moving into this area of practice after completion of a non-medical prescribing programme that prompted the identification of additional content for programmes to ensure that issues relevant to this area of practice are addressed. The Medicines and Healthcare Products Regulatory Agency (MHRA) (MHRA 2014) provides clear direction that also incorporates the position of the NMC in relation to nurses. This is based on advice produced in partnership with the Royal College of Nursing, *Remote Prescribing and Injectable Cosmetic Medicinal Products* (NMC 2011) and *Standards for Medicines Management* (NMC 2008) and *The Code – Standards of Conduct, Performance and Ethics for Nurses and Midwives* (NMC 2015). In undertaking a non-medical prescribing programme, health professionals are required to analyse their practice and become aware of their responsibility and accountability. This can be seen only as a positive outcome that will support safe and effective practice.

The public health context

Public health was determined as a core theme of this book, due to its significance in modern UK healthcare. Addressing public health issues was clearly intended to be one of the key functions of non-medical prescribing, with health promotion being identified as one of the four original areas suitable for prescribing from the extended formulary (DH 1998). Although this categorisation has long ceased to be used, the need to consider health promotion and public health in non-medical prescribing practice remains essential.

UK public health policy

Current UK public health policy incorporates strategies to meet targets rather than simply addressing specific diseases and significantly focuses on tackling inequalities. This is due in part to the recognition that poverty and its associated health inequalities originally identified in the Black Report (Black et al. 1980) and reiterated by Acheson (1998), Wanless (2004) and Marmot (2010) remain a key factor in the health of the population. As such, tackling health determinants has consistently been identified as an essential concept in UK health policy (Scottish Government 2008, 2010, DH 2013, 2014). The health agenda described by the DH (2004) identified long-term key target areas with the objective of supporting and empowering the public to make healthier and informed choices, and these continue to be reflected in today's public health targets (DH 2013) (Table 1.2).

This approach is reflected in the definition of public health provided by Acheson (1998):

The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society ...

It is significant that this definition recognises the organised, multi-agency partnership approach necessary for tackling health determinants. This reflects the messages in Chapter 6, supporting the

Table 1.2 Public Health Outcomes Framework indicators

Accidents, falls and injuries
 Alcohol
 Cancers
 Cardiovascular disease
 Communicable diseases
 Diabetes
 Diet, weight and physical activity
 Domestic abuse
 Liver disease
 Mental health including dementia
 Respiratory disease inequalities
 Sexual health and teenage pregnancy
 Substance misuse
 Tooth decay
 Smoking

Source: Department of Health (2013).

need for a team approach to prescribing, in order that safety and efficacy are maximised. Acheson (1998), Wanless (2004) and Marmot (2010) stress that we all have a responsibility for our public health. This responsibility is both personal and professional, as individuals with responsibility for our own health and as health professionals with responsibility to provide services that support public health.

It has been argued that every prescribing situation has a potential opportunity to promote health and address public health issues but relies on individual practitioners developing an awareness of the current health issues, national and local targets, and factors determining health. Furthermore, it requires non-medical prescribers to recognise and embrace the opportunities to impact on public health targets elicited within the prescribing situation (Nuttall 2008).

Need and expectations

The public health focus of modern healthcare requires that the needs of the population are clearly identified and met. *Bradshaw's Taxonomy of Needs* (Bradshaw 1972, cited in Bradshaw 1994) considers the categories of need that, although rudimentary, provide a useful framework for consideration. In relating this categorisation to both the health needs of the UK population and non-medical prescribing practice, links to policy developments, health provision and public expectation can be clearly identified. The first category of 'felt need' relates to issues or factors that members of the population feel to constitute a need. These needs are felt but not articulated. Once these needs are articulated, they fall in to the second category of Bradshaw's taxonomy: 'expressed need'. The third category of 'normative needs' refers to issues and factors that health professionals have identified as needs within the population. These needs are usually based on epidemiological data and population profiles that identify key health issues in the population as a whole but also in specific communities within the wider population. The final category of 'comparative need' refers to the needs that are determined by making comparisons between individuals within the same community or

population. In a health service where the philosophy is to ensure that the patient and his or her individual needs are placed at the centre of the care provided (DH 2010, 2014), it is essential that all these needs be considered.

Current national health targets are largely based on normative needs, which are targeted more specifically at local level. However, although normative needs are generally an accurate representation of broad health needs, they can often differ from those felt and expressed by users of the health service. The disparity may in part be due to differences in prioritisation between service users and service providers. To ensure that non-medical prescribing is meeting the needs of the population, it must not only target public health issues previously identified but also ensure that patients and carers have the ability to express their felt needs.

The DH commissioned a study by the University of Southampton in 2005 to evaluate extended formulary independent nurse prescribing. This study did seek the views of patients, as well as those of nurses and doctors. However, the number of patients involved was unclear and the summary of their responses was broad. A more recent study commissioned by the DH (2011a) that evaluated nurse and pharmacist independent prescribing again had an element of patient focus. Patient surveys were used to determine patient views, and it was clear that patient need was implicit in the data provided. However, it was worthy of note that although other participants within the study were interviewed or involved in focus group discussions, patients were not. Although there is clearly a positive move to seek patient opinion in large-scale DH-commissioned studies, there remains an opportunity to ensure that subsequent research and consultation explores the needs of service users by incorporating more qualitative methodology.

On an individual level, non-medical prescribers have a responsibility to ensure that the processes and strategies used with individuals enable the patient and carers to receive a service that meets their needs. This may be achieved through a number of measures, not least through the strategy fundamental to safe and effective prescribing – that of the holistic assessment. Concordance, which is discussed in depth in Chapter 5, relies on negotiation between the patient and the non-medical prescriber. For any negotiation to be effective, it must take into account the needs and views of the individuals involved, and there is an expectation that these needs will be adequately considered.



Activity box 1.4

Take time to reflect on your practice and consider the following questions:

- 1 Do you allow patients to express their needs?
- 2 Are there any barriers to this?
- 3 What strategies could you employ to improve the ability of patients to express their needs?

Differentiating between prescribers

The first part of this chapter explored the wider context of prescribing in the UK. However, it is important to identify how individual practitioners apply non-medical prescribing within the context previously examined. The terms 'independent' and 'supplementary' used in relation to prescribing

cover a range of professions and a range of prescribing activity. Therefore, the latter part of this chapter differentiates between independent prescribing and supplementary prescribing. It also explores the application of both types of prescribing within the practice of different health professionals.

Independent prescribing

The term 'independent prescribing' has been (and still is) used in a variety of contexts, all presenting differences in its meaning and application. This may cause confusion to those new to the concept of non-medical prescribing, not least because of the use of the term both as a title identifying prescribing activity by a particular type of prescriber and as a method of prescribing in itself. It is important to clarify these issues, recognising that independent prescribing is a core concept that underpins prescribing practice by many professional groups.

Independent prescribing was identified as one of the two types of prescribing recommended in the final report of the *Review of Prescribing, Supply and Administration of Medicines* (DH 1999a). It was originally anticipated that independent prescribing would address undiagnosed conditions. However, the current working definition has evolved beyond this.

Independent prescribing is defined by the DH (2006b, p. 2) as

... prescribing by a practitioner responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing ...

This definition is clearly underpinned by legal, professional and ethical principles, with responsibility and accountability at its centre. It identifies a method of prescribing where the individual professional undertaking prescribing practice must be able to make a prescribing decision and support this with a clear rationale. This, of course, reflects professional practice requirements while recognising the specific factors supporting safe and effective prescribing. The DH (2006b) definition is significant in that it recognises three important factors in relation to independent prescribing:

1. Assessment is fundamental to safe and effective prescribing.
2. Practitioners who prescribe independently may do so for undiagnosed and/or diagnosed conditions.
3. Independent prescribing involves making a decision about clinical management, which may or may not require a prescription to be generated.

Assessment

A deeper exploration of these factors highlights fundamental practice issues that are frequently identified by both training and practising prescribers. The key elements of assessment are considered in depth in Chapter 4 of this book, with the link to safe and effective prescribing clearly identified. Indeed, independent prescribing requires that assessment is a key component of the process, with the prescriber responsible and accountable for this. Essentially, independent prescribing is a process that relies on the information gathered from an assessment in order that a diagnosis and/or clinical management decision can be reached. In most instances, the assessment will be an integral element of the consultation process, raising the question of whether or not prescribers must undertake the assessment themselves.

One of the issues highlighted by *Saving Lives: Our Healthier Nation* (DH 1999b) was that nurses were undertaking assessments and making decisions about clinical management of patients' conditions. Doctors were then issuing prescriptions based on the judgement of these nurses. Not only did this highlight the often unrecognised knowledge and expertise of many nurses, but it also identified safety issues in relation to these practices. One of the main advantages of non-medical prescribing was that it enabled the same practitioner who had undertaken the assessment, and who was in possession of all the relevant information, to prescribe treatment if necessary. However, some practitioners will argue that this is not always possible or indeed necessary, raising further issues relating not only to the individual prescriber's practice but also to the expectations of colleagues.

Ultimately, the independent prescriber is responsible and accountable for the assessment of the patients for whom he or she will make a decision about clinical management. There may be an expectation by some health professionals that their prescribing colleague will issue prescriptions on their request. Of course, in some instances, non-medical prescribers may work alongside colleagues who are competent in assessment and diagnosis of specific conditions and in whose ability they are very confident. However, the NMC (2008) has considered the issue of remote prescribing and has determined that it is only acceptable in exceptional circumstances. Practice issues such as these often highlight other areas that need to be addressed. Although many health professionals may be competent in assessment in order to reach a diagnosis, it is possible that their assessment does not address all issues relevant to making a safe prescribing decision. Furthermore, if these practitioners are competent, there is an expectation that they should be identifying, within their own practice, the need to prescribe themselves and as such should endeavour to undertake the appropriate programme of education.

Diagnosed and undiagnosed conditions

The DH's (2006a) definition of independent prescribing significantly included diagnosed conditions within its remit, an element missing from previous definitions. This change recognised the fact that non-medical prescribers who prescribed independently may do so in a variety of situations, treating a wide range of patients and conditions. As such, some non-medical prescribers will treat only patients who have been previously diagnosed, whereas others would be making the initial diagnosis and prescribing for that condition. Many non-medical prescribers will prescribe for both previously diagnosed and undiagnosed conditions. As practitioners preparing to undertake a non-medical prescribing education programme, individuals will have a clear indication into which category they fall. However, in reality, the boundaries are arguably more difficult to define, for example, the practitioner whose caseload includes only patients who have previously been diagnosed may find that they present with side effects of treatments that may require short-term treatment. Equally, patients may also present with an unrelated complaint for which the non-medical prescriber is still competent to prescribe.

The prescribing decision

In considering the context of independent prescribing, it is important to reiterate the message set in the prescribing principles (NPC 1999), reinforced in the Single Competency Framework (NPC 2012) and embedded in the DH's (2006a) definition that prescribing a drug is only one option available to the practitioner prescribing independently. Indeed, it would be inappropriate to prescribe a drug without providing some health promotion, whether that be advice on physical measures to be taken to support the drug treatment, for example, dietary advice when prescribing cholesterol-reducing drugs, or preventing accidents such as overdose by giving clear instructions for taking the

drug. Strategies used to reach a prescribing decision are discussed at length in Chapter 4, but the key message is that it is not a requirement that independent prescribing results in a prescription. The processes and strategies used will enable an appropriate prescribing decision to be made, which may mean that only health promotion advice is necessary or that referral is needed, either in isolation or in support of a drug treatment. The practitioner trained as an independent prescriber will have developed skills that reach far beyond simply being able to write a prescription. The decision to prescribe or not will be made within the context of a holistic and multidisciplinary approach to consultation and treatment options.

Who are independent prescribers?

Non-medical independent prescribers must hold a recognised qualification, which is annotated on the relevant professional register, and must continue to demonstrate competence in assessment, diagnosis, decision-making and treatment of specific conditions (DH 2006b). The range of conditions for which they prescribe may be limited to one or may be wide ranging. These professionals are referred to as *independent prescribers*. Unfortunately, the terminology does not lend itself to a simplistic interpretation of the role. Not only is the term 'independent prescriber' used to describe the professional undertaking independent prescribing, but it is also a title given to specific prescribers, recorded as such by their professional bodies. This, in essence, means that although a range of professionals undertake the processes highlighted within the DH (2006a) definition and as such undertake independent prescribing, they would not necessarily be referred to as independent prescribers. Supplementary prescribing is more distinct and understanding the differences between supplementary and independent prescribing will provide further clarity when considering the role of prescribers within individual professional groups.



Activity box 1.5

Look at case study 1 at the back of this book and consider the following questions:

- 1 Is non-medical independent prescribing the appropriate method for this patient to access medicines?
- 2 What is your rationale for your answer?
- 3 Would there be any potential barriers to you undertaking non-medical independent prescribing for this particular patient?

Supplementary prescribing

Supplementary prescribing, in common with independent prescribing, has evolved from the recommendations made in the final report of the *Review of Prescribing, Supply and Administration of Medicines* (DH 1999a). The original reference was to 'dependent prescribing' where a dependent prescriber would be responsible for the continuing care of patients who had initially been assessed by an independent prescriber. Although the terminology and, indeed, the definition have altered, the core principles have remained very much the same. The current definition of supplementary prescribing is

... a voluntary partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber to implement an agreed patient-specific clinical management plan (CMP) with the patient's agreement ...

DH (2005, p. 8)

Undertaking supplementary prescribing therefore requires application of the key principles underpinning it. One key principle of supplementary prescribing is that of partnership. The dynamics of supplementary prescribing are different to those of independent prescribing in that the non-medical prescriber takes on the role of supplementary prescriber, with a doctor (or dentist) adopting the role as independent prescriber. This means that the doctor (or dentist) takes responsibility for a diagnosis, or a decision relating to the review of an existing diagnosis, at the time of the development of a clinical management plan (CMP). The supplementary prescriber is then able to review the patient and manage the longer-term care of the patient. This crude interpretation is not a complete reflection of supplementary prescribing because it understates the partnership context that is crucial to its success.

The role of partnership

Partnership in supplementary prescribing is essential in order to effectively achieve the following fundamental requirements of supplementary prescribing:

- Agreement on which patients will be suitable for supplementary prescribing
- Obtaining the patient's agreement to being treated under a CMP
- Agreement of an individual CMP
- Maintenance of communication in relation to review and prescribing

However, the necessity for partnership extends beyond this. In addition to the responsibility for the diagnosis, the independent prescriber is responsible for the boundaries of the CMP (DH 2005). To effectively set boundaries within which the supplementary prescriber will prescribe, it is crucial that there is an honest exchange to determine the competence of the supplementary prescriber and to ensure that the expectations of the independent prescriber remain within the parameters of that competence. Furthermore, the independent prescriber has a responsibility to provide support and advice to the supplementary prescriber as required (DH 2005). Arguably, this relies in part on the confidence of the supplementary prescriber's ability to seek and receive this support as necessary. Equally, the independent prescriber will have expectations that the supplementary prescriber accepts responsibility, and is accountable, for his or her own prescribing practice (see Chapter 2).

The concept of partnership in supplementary prescribing extends beyond the relationship between the independent prescriber and the supplementary prescriber. In actual fact, the whole concept of supplementary prescribing relies on a three-way partnership, with the patient completing the tripartite collaboration. The patient must be aware of, and agree to, the intention to facilitate his or her care through a CMP, and his or her agreement to receive care via supplementary prescribing must be documented (DH 2005).

The CMP

As already stated, the CMP is an essential component of supplementary prescribing and as such must be drawn up before prescribing begins. The CMP may be handwritten or completed electronically but must be relevant to the specific patient and his or her specific condition(s) (DH 2005). Table 1.3

Table 1.3 Essential information to be included on a clinical management plan (CMP)

Patient's name
Condition(s) for which the supplementary prescriber may prescribe
Start date for CMP
Date for review by the independent prescriber
Identification of medicines or appliances that may be prescribed under the CMP ^a
Identification of limitations or restrictions of identified medicines, including strength, dose, period of use ^a
Indications for referral back to the independent prescriber
Allergies, sensitivities and difficulties relating to medicines or appliances
Arrangements for notification of adverse reactions and incidents of potential or actual serious harm from appliances

Source: Department of Health (2011b).

^aReference to relevant parts of published guidelines may be made instead provided that they clearly identify the required information and are easily accessible.

identifies the information that the DH (2011c) determines must be included within a CMP, and an example of a completed CMP can be seen in case study 9.

So that supplementary prescribing is utilised efficiently and safely, CMPs need to be relatively quick and simple to complete (NPC 2007). However, there is often confusion about their completion and this has contributed to the notion that their development can be time-consuming. Although the information that must be included may seem extensive at first glance, there are acceptable methods of reducing the magnitude of this information on the CMP, provided that the full details are easily accessible, for example, as indicated in Table 1.3, it is not necessary to list every medication and every possible regimen on the CMP if it directly reflects that stated in a recognised published guideline. Instead, it is perfectly acceptable to indicate that treatment will be given in line with the guidelines (identifying specific sections where appropriate) named on the CMP, provided that they are readily available to both the independent prescriber and the supplementary prescriber. Similarly, detailed patient information, available to both prescribers in shared records, does not need to be recorded on the CMP unless there is a specific need to do so.

In addition to the information necessary on a CMP, there is a need for clarity about the responsibility for its completion and the signatures required. Although the CMP must be agreed by both prescribers, either may take responsibility for composing it. A CMP that contains the signatures of both the independent and supplementary prescribers provides clear evidence that it has been agreed and, therefore, could be considered preferential. However, it is not always possible for the CMP to be signed by both prescribers and, as such, it is not an essential requirement. However, agreement to the CMP must be recorded in the patient's record (DH 2005). Similarly, although the patient's agreement must be obtained if he or she is to be cared for using a CMP, it is not necessary for the patient to sign it. However, a record that a discussion has taken place and that the patient has agreed must be recorded in the patient's records (DH 2005).

A further consideration in relation to CMP use is the potential for more than one supplementary prescriber to be involved in the patient's care. If more than one health professional, who is able to prescribe as a supplementary prescriber, is involved in the care of the patient

Table 1.4 Circumstances for termination of the clinical management plan

At the request of the independent prescriber (IP), the supplementary prescriber (SP) or the patient
 If the named SP is unable to continue in this role and is the only named SP
 At the set review date (unless agreement has been made to continue)

Source: Department of Health (2005).

in direct relation to the condition(s) indicated on the CMP, then he or she is able to prescribe from it, provided that (DH 2005):

- They agree to the CMP.
- They are named on the CMP.
- They have agreed strategies of communication between all prescribers.
- They have access to consult and use the same part of the common record.

Termination of supplementary prescribing

Partnership working and agreement are fundamental throughout the process of supplementary prescribing, and this extends to the point at which a CMP may be terminated. As supplementary prescribing relies on the three-way agreement previously discussed, the CMP must be terminated in the event of any circumstances that compromise this partnership (Table 1.4). The DH (2005) determines that an existing CMP could be used by a replacement supplementary prescriber, provided that he or she agreed to the CMP and was then named on it.

The initial development of a CMP requires an agreement to be made about a date for a joint formal review. This should generally be within a maximum of 12 months unless the stability of the patient's condition indicates otherwise (DH 2005). Essentially, the date of review must be appropriate to the needs of the patient and his or her presenting condition(s). The CMP will be terminated at the set review date unless it is agreed at the review that the CMP is to continue.

Who are supplementary prescribers?

Supplementary prescribing was enabled by changes in legislation in 2003. These changes allowed first-level registered nurses, registered midwives and registered pharmacists to undertake supplementary prescribing, following a recognised programme of education. Subsequently, in 2005, further changes in legislation enabled defined professions from the allied health professions to undertake supplementary prescribing. The identified professionals were radiographers, podiatrists, physiotherapists and optometrists. Although legislative changes in 2006, 2008 and 2013 now mean that all these health professionals (with the exception of radiographers) are now able to train as independent prescribers, supplementary prescribing continues to be part of their prescribing course. For detailed explanation of the law in relation to non-medical prescribing, see Chapter 2.

Resistance to supplementary prescribing

The introduction of supplementary prescribing brought with it the expectation that its use would be in the management of long-term conditions, with the inclusion in some instances of acute episodes within these long-term conditions (DH 2005). There is much evidence of its usefulness in this area of healthcare (Carey and Courtney 2008) and is successfully embedded in a range of clinical setting (Cooper et al. 2011). Although having distinct characteristics, the aim of supplementary

prescribing reflects the ethos of non-medical prescribing as a whole, in that its intention is to use the skills of health professionals more effectively and enable patients to access medicines more efficiently (DH 2005). The benefits of supplementary prescribing were arguably much clearer at its inception when independent prescribing was limited to a formulary. Supplementary prescribing enabled health professionals to prescribe drugs within the boundaries of a CMP, who, although competent to do so, were legally unable to prescribe as an independent prescriber. The evolution of independent prescribing has eliminated this as a rationale for supplementary prescribing. Many qualified, and even training, non-medical prescribers would argue that, as they would only prescribe for conditions for which they are competent to do so, they would be competent to prescribe for these same conditions independently. However, in many ways, this has clouded the benefits of supplementary prescribing, which always extended beyond simply enabling a broader range of medicines to be prescribed.

In attempting to highlight the continued benefits of supplementary prescribing, it is useful to deconstruct the actual and perceived purposes of its introduction. Supplementary prescribing was introduced to treat long-term conditions. This aspect remains unchanged because it would rarely be an efficient use of resources to develop a CMP for a condition that would respond to a short-term, and often simple, programme of treatment. However, the argument remains that, even in the care of long-term conditions, non-medical prescribers are able to make independent prescribing decisions. It is perhaps this argument that has had the greatest impact on the perceived usefulness of the CMP. Yet, in making the case for independent prescribing in long-term conditions, there could be seen to be an assumption that all patients are relatively typical, that the progress of the condition is predictable and that the response to treatment is generally straightforward. Similarly, it also suggests that all non-medical prescribers would be confident and competent to treat any patient provided that they presented with a condition for which they were competent to prescribe.

In reality, many new non-medical prescribers find the prospect of prescribing very daunting. It is recognised that, for some practitioners, supplementary prescribing is a useful method of allowing them to develop their skills in prescribing and, in turn, increase their confidence (DH 2005). Of course, some patients have a simple medical history and respond well to the routine treatments indicated for their long-term condition. However, many others are much more complex, with multiple medical conditions and/or polypharmacy issues that increase the likelihood of complications. In such instances, the supplementary prescriber may feel that the ability to discuss the patient's needs and to determine a suitable plan of management within predetermined boundaries enables him or her to prescribe more safely and more confidently.

Considering the current UK context of non-medical prescribing, there are limitations that serve to maintain the need for supplementary prescribing. Physiotherapists, for example, have restrictions on their independent prescribing in relation to controlled drugs. They are only able to prescribe from a limited list of controlled drugs. In instances where a controlled drug that is not on the list is required, the CMP enables the non-medical prescriber to meet the patient's needs. It is anticipated, however, that, even without any legal limitations relating to controlled drugs, some non-medical prescribers would choose to use supplementary prescribing as a safety mechanism.

The development of supplementary prescribing and CMPs has been hindered by medical apathy and implementation problems (Cooper et al. 2008b). Indeed, it has been perceived as a time-consuming process, an issue that for some outweighs any benefits of supplementary prescribing. CMPs do involve an initial outlay of time in their development, but when used appropriately, this is reimbursed through the time saved by enabling the supplementary prescriber to undertake

subsequent reviews. In settings where supplementary prescribing is implemented well, it has become well accepted by all those involved (Cooper et al. 2011). Although CMPs must be relevant to individual patients, it is acceptable for prescribers to develop CMPs for specific conditions provided that they are refined for each patient in order to meet their individual needs.

Difficulties in accessing records have also proved problematic for some non-medical prescribers. The DH (2005, p. 19) stated that in supplementary prescribing:

The independent prescriber and the supplementary prescriber must share access to, consult, keep up to date and use the same common patient record ...

This has often been misinterpreted to mean that only supplementary prescribers who use the same patient records as the independent prescriber can undertake prescribing. This would eliminate a large number of non-medical prescribers, particularly those who work in areas with limited direct medical input. The requirement in relation to records is that there must be a common record where prescribing is documented. The mechanisms for enabling this must be agreed by the independent prescriber and the supplementary prescriber, so that both prescribers remain aware of the current status of the treatment plan.

A further challenge experienced by practitioners in relation to supplementary prescribing is that of responsibility of diagnosis. Podiatrists, for example, often see patients who have been referred to them by a doctor, in order that they, as the specialist, make a diagnosis and often a decision about treatment. Developing supplementary prescribing partnerships within these circumstances enables effective use of specialist knowledge and skills in a shared decision-making context.

Although it is important to recognise the limitations of supplementary prescribing in an evolving context of non-medical prescribing, it is equally important not to lose sight of the many benefits that remain. To promote an understanding of these benefits, it is pertinent to provide clear examples of when it might be utilised effectively.



Activity box 1.6

Look at case study 9 at the back of this book and consider the following questions:

- 1 Is non-medical supplementary prescribing the appropriate method for this patient to access medicines?
- 2 What is your rationale for your answer?
- 3 Would there be any potential barriers to you undertaking non-medical supplementary prescribing for this particular patient?

Nurse non-medical prescribers

The NMC currently validates courses to train three different types of non-medical prescriber (V100, V150 and V300), all of whom have fundamental similarities, yet some distinct differences.

V100 non-medical prescribers

The history of non-medical prescribing identified that health visitors and district nurses were the first groups of professionals to undertake non-medical prescribing. This prescribing was, and still is, limited to a defined formulary. This limited formulary is known as the Community Practitioner Nurse Prescriber Formulary and contains items felt to be relevant to community practitioner practice. Although some prescribers have found the formulary to be limiting (Hall et al. 2004) with a desire for a wider formulary expressed (SG 2009), the extent of prescribing undertaken from this formulary and the limited number of health visitors and district nurses who go on to extend their prescribing role would suggest that, in the main, this is an appropriate formulary. However, V100 or community practitioner nurse prescribing is an extended role available to all community practitioners, including school nurses, community mental health nurses, community children's nurses and general practice nurses, provided that they have undertaken and successfully completed a specialist community practitioner programme. The V100 education programme is incorporated into many specialist community public health nursing and community specialist practice programmes as a core component, although the requirement for specific groups within these programmes to undertake the V100 element varies. However, when V100 is not a compulsory element, dictated by either programme specification or local trust requirements, few of these other nursing groups have chosen to undertake V100 prescribing education. The limitations of the formulary are no doubt a significant reason for this apparent lack of interest in prescribing, with its contents still very much relevant to health visitors and district nurses. However, there are also other possible explanations that must be recognised.

Competence is a crucial element in nursing practice and one that is equally important in prescribing. Interestingly, although some practitioners would consider themselves competent to make a decision about a need for treatment with many drugs within the *British National Formulary* (BNF), they would not do so in relation to the drugs within the community practitioner nurse prescribing formulary. For example, a community mental health nurse may assess the patient and be competent to decide that an increase of his selective serotonin reuptake inhibitor (SSRI) is necessary (and prescribe the treatment, if appropriately trained, from the BNF). However, the same nurse may not feel competent to make a diagnosis of constipation and so would not prescribe, even though there are drugs available to treat constipation within the community practitioner nurse prescriber formulary. Other legal and ethical issues may also impact on the decision by some specialist community practitioners not to undertake the V100 education programme. Consent is often problematic, for example, for school nurses. Although they may feel that, with further education, they would be competent to prescribe from the formulary, they may argue that the legal and ethical constraints of prescribing for children within the school environment would make it impossible. However, it is worth noting that changing roles for school nurses mean that there is potential to prescribe in other settings where the issues are different from those within the school. Day (2007) identified clear benefits of non-medical prescribing within a school nursing role.

V100 prescribing requires the nurse to make an assessment, diagnose or review an established diagnosis and decide on the appropriate treatment (which may include prescribing). As such, V100 prescribing can be seen to be representative of independent prescribing. Case study A provides an example of V100 prescribing in practice.

V150 non-medical prescribing

V100/community practitioner nurse prescribing has become well established since it was introduced throughout the UK and, overall, has confirmed the benefits suggested at its introduction. However, the service provided by community nurses has evolved, and as such, the adequacy of V100 prescribing to meet current service needs has been in question. Indeed, it has become evident that, in many areas, developments in community nursing have, unintentionally, had an adverse impact on prescribing. This impact has included limitations on practice caused by the lack of available non-medical prescribers and, as a result, has also often supported poor prescribing practice. Changing roles in district nursing has meant that many experienced nurses have moved to newly developed roles, and teams that once had a number of nurses with a community specialist practitioner qualification now often have only one. These nurses are responsible for leading a team of staff nurses who generally do not hold the V100 qualification and so are unable to prescribe. The obvious impact of this change is a significant reduction in the number of non-medical prescribers within district nursing teams. This, in turn, has meant that, overall, fewer episodes of care can be completed by district nurses. The consequence of this is that alternative strategies have been employed to address the limited numbers of available prescribers within a service that has maintained a need for non-medical prescribers. Although no doubt well intentioned, these strategies have often involved practice that does not conform to the standards supporting safe and effective prescribing. In effect, practices that V100 prescribing aimed to replace have now re-emerged in a new guise.

In recognition of these problems and of the obvious need for more prescribers, a study of the education needs of community nurses was undertaken by Fitzpatrick et al. (2007). The findings from their work led to the introduction of V150 community practitioner nurse prescribing. The V150 prescriber is able to prescribe from the same formulary as the V100 prescriber but undertakes the education programme as a stand-alone module of study rather than as part of a community specialist practitioner or specialist community public health nursing programme. The differences in context of the education programmes for V150 and V100 have determined the differences in the content of the courses. The V150 education programme incorporates additional study days that aim primarily to consider leadership and related issues that V100 students receive within the wider specialist nursing programme. The requirement for the nurse to assess the patient, reach a decision about diagnosis or outcome of a review and negotiate treatment means that, as with V100, V150 prescribing can be seen to be representative of independent prescribing.

The uptake of V150 prescribing varies throughout the UK. The north west of England has trained significant numbers of nurses, and numbers are slowly increasing in other areas of England. V150 education programmes are becoming available in other areas of the UK, subject to the identification of a service need. Hogg and Schelowok (2009) recognise that V150 can be a useful tool in meeting the needs of services where there is a need for more prescribers but where V300 prescribing is not indicated. Case study C provides an example of how V150 prescribing has improved services for patients.

V300 independent/supplementary nurse prescribers

Nurses and midwives who wish to undertake education to prepare them to prescribe as independent prescribers will now access programmes that incorporate both independent and

supplementary prescribing. It is worth clarifying at this juncture that V200 extended formulary nurse prescribers were trained as independent prescribers but were able only to prescribe from a specific formulary known as the 'extended formulary'. This has now been replaced by the V300 programme. V200 prescribers are no longer limited to this formulary but may or may not have accessed further education in supplementary prescribing. Supplementary prescribing is considered in detail later.

As with all the aforementioned types of nurse prescribers, V300 independent prescribing incorporates all the elements of independent prescribing previously determined but allows a much more extensive range of medicines to be prescribed. Unlike V100 and V150 prescribers, who are limited to the community practitioner formulary, V300 prescribers can prescribe any drug for any condition (including controlled drugs schedule 2–5 with the exception of diamorphine, cocaine and dipipanone for the treatment of addiction). However, despite the differences in the range of medicines available to the V100, V150 and V300 prescribers, there remains a common restriction that limits the range of medicines actually prescribed. That restriction is enforced by the NMC in its standards for prescribing, which reinforce the need for individual practitioners to prescribe only within the limits of their competence. Furthermore, restrictions may be set locally to address concerns relating to specific areas of practice, for example, a study conducted in Wales by Jones (2008) identified a view among health professionals that a cautious approach was needed in the implementation of independent prescribing in mental health settings. Studies in both Scotland (Snowden 2008) and Ireland (Wells et al. 2009) reflected this, albeit within differing contexts.

The term 'independent prescribing' has been used consistently in relation to V300 prescribing for many years. As a result of this, many people would use the terms 'V300' and 'independent prescriber' synonymously. However, as previous discussion identified, supplementary prescribing is a key strategy in V300 prescribing, the benefits of which are commonly overlooked.

Although it is intended that, when using the term 'nursing' within this book, reference is also being made to midwifery and health visiting, it is important to recognise that the uptake and prescribing needs of these specific professions do not necessarily match those of the wider nursing profession. Non-medical prescribing qualifications recorded by the NMC show that access to V300 education programmes by both midwives and health visitors has been significantly lower than for other nursing professions. The reasons for this vary but may include both service need and benefit-awareness issues. Many health visitors may argue that, although the community practitioners' formulary does not enable them to prescribe everything that they require, the service need does not warrant them undertaking the V300 education programme. However, some health visitors do have specialist skills that would be better used if they were able to prescribe a wider range of medicines. Case study A at the end of the book provides an example of how V300 prescribing can improve the service offered by health professionals and make best use of their skills.

Similarly, midwives have specific exemptions in medicines legislation, which enables them to supply and administer specific medicines in specified circumstances (NHS Scotland 2011, MHRA 2012). Many midwives would suggest that this negates the need for undertaking non-medical prescribing. However, many of the exemptions relate to the period around labour and the childbirth situation and do not cover many of the situations encountered in the postnatal period in the home. Case study B provides an example of the application of V300 prescribing in midwifery practice.



Activity box 1.7

Consider the following examples of nursing practice. Decide which type (V100, V150, V300) of prescribing would be most appropriate:

- 1 Zoe is a nurse on a rehabilitation ward. She currently has to wait for a doctor to prescribe medicines for conditions that she is competent to treat.
- 2 David is a community staff nurse who has undertaken extensive training in wound care. In order to change a treatment, he has to request a prescription from the GP or ask his team leader to review the patient.
- 3 Sam is a health visitor. He trained 15 years ago but gave up work for 5 years to care for his child. He completed a return to practice course 3 years ago. He is the only health visitor in his team without a prescribing qualification.

Pharmacist non-medical prescribers

The GPhC, in response to the legislative restrictions and subsequent changes, has validated programmes of study to train pharmacists as supplementary prescribers and independent and supplementary prescribers and to enable those trained as supplementary prescribers to become independent prescribers.

Pharmacist supplementary prescribers

Pharmacists who undertook a programme of education in non-medical prescribing before the legislative changes of 2008 were able to train and subsequently practise only as supplementary prescribers. This enabled pharmacists to prescribe any medicine identified within a CMP under the criteria of supplementary prescribing discussed earlier. Pharmacist supplementary prescribers do not have any restrictions on the drugs that they may prescribe or on the conditions for which they may prescribe. This enables pharmacists to prescribe controlled drugs and unlicensed drugs where there is a patient need and has been agreed by the independent prescriber and the supplementary prescriber within the CMP.

Some pharmacist supplementary prescribers have found that supplementary prescribing has improved patient management and their role within it (Johnson et al. 2006). However, many pharmacist supplementary prescribers identified that the ability to prescribe independently would enhance their role further by enabling them to prescribe in situations where supplementary prescribing is inappropriate. These pharmacists have undertaken additional education on conversion courses that focus on the elements particularly significant in achieving safe and effective independent prescribing. Pharmacists undertaking courses validated to encompass the 2008 legislative changes receive education in supplementary prescribing as part of the independent prescribing programme. It is important again to reiterate the advantages of supplementary prescribing as the perceived superiority of independent prescribing can detract from the benefits of pharmacist supplementary prescribing (Cooper et al. 2008a). Case study D provides an example of pharmacist

supplementary prescribing. Pharmacist prescribers may choose to use a CMP as a developmental tool or to afford the support of the independent prescriber in more complex cases.

Pharmacist independent prescribers

Pharmacist independent prescribing incorporates all the elements of independent prescribing previously identified. Pharmacists who have successfully completed a recognised programme of education are able to prescribe any licensed or unlicensed medicine within their clinical competence. Legislative changes in 2012 enabled pharmacist independent prescribers to prescribe any controlled drug (schedule 2–5) for any medical condition within their competence (with the exception of diamorphine, cocaine and dipipanone for the treatment of addiction). Case studies E and F provide examples of pharmacist independent prescribing.



Activity box 1.8

Consider the following examples of pharmacist practice. Decide which type (independent or supplementary) of prescribing would be most appropriate:

- 1 Beth is a community-based pharmacist who reviews patients in a busy GP practice. She sees patients already diagnosed with hypertension and advises on any necessary changes in medication.
- 2 William is a hospital-based pharmacist who works in a specialist drug dependency unit. He reviews patients on a methadone programme.
- 3 George is a pharmacist specialising in heart failure. He reviews a range of patients who are receiving medicines to treat chronic cardiac failure.

Allied health professional non-medical prescribers

The HCPC, in response to the legislative changes in 2005, validated courses to train eligible allied health professionals as supplementary prescribers, available only to physiotherapists, radiographers, podiatrists/chiropractors and optometrists. Subsequent legislative changes in 2013 allowed existing physiotherapist and podiatrist supplementary prescribers to undertake a conversion course to become independent prescribers and those not yet trained as prescribers to undertake independent and supplementary prescribing. HCPC (2013) developed prescribing standards to reflect these legislative changes. As optometrist training includes specific requirements not indicated for other allied health professions, they are considered separately.

Radiographer, physiotherapist and podiatrists/chiropractors supplementary prescribers

Radiographers, podiatrists/chiropractors and physiotherapists are able to train and prescribe as supplementary prescribers. This enables them, in line with other supplementary prescribers, to prescribe any medicine identified within a CMP under the criteria of supplementary prescribing discussed

earlier. Allied health professional supplementary prescribers also have no restrictions on the drugs they may prescribe as long as it falls within their individual area of competence and scope of practice. This enables physiotherapists, radiographers and podiatrists/chiropractors supplementary prescribers to prescribe controlled drugs and unlicensed drugs where there is a patient need and where it has been agreed by the independent prescriber and the supplementary prescriber in a CMP (DH 2006b).

The HCPC (2012), in line with the NMC (2015) and GPhC (2010b), have encompassed non-medical prescribing in their ethical and professional codes. This ensures that physiotherapists, radiographers and podiatrists/chiropractors restrict their prescribing practice to those conditions for which they are competent to prescribe.

The benefits of supplementary prescribing remain evident for this professional group, and it is important that this continues to be recognised, even with the event of independent prescribing for physiotherapists and podiatrists.

Physiotherapist and podiatrists/chiropractors independent prescribers

As identified in pharmacist prescribing, supplementary prescribing does not meet the needs of all allied health professional non-medical prescribers. Patient group directions (PGDs) continue to meet the needs of some patients, and there are others where independent prescribing would be the most appropriate option. The scoping exercise undertaken by the DH (2009) recommended that independent prescribing should be introduced for physiotherapists and podiatrists and this has since been introduced, with the HCPC (2013) producing related standards. Physiotherapist and podiatrist, as independent prescribers, can prescribe any licensed medicine (with the exception of controlled drugs) as long as they are limited to the individual's scope of practice and area of competence. NHS England (2013) defines these limits in scope of practice and competence for physiotherapists as prescribing relating to 'human movement, performance and function' and for podiatrists 'disorders affecting the foot, ankle and associated structures'.

The Allied Health Professions Medicines Project has undertaken further scoping and consultation in 2014 to identify if there is a need to implement the other recommendations from the DH (2009) report that included independent prescribing for paramedics and for therapeutic and diagnostic radiographers. Therefore, it is likely that further developments will be forthcoming.

Case studies G, H and I provide practice examples of allied health professional prescribing.



Activity box 1.9

Consider the following examples of allied health professional practice. Decide which type (independent or supplementary) of prescribing would be most appropriate:

- 1 Darren is a hospital-based physiotherapist, specialising in musculoskeletal conditions.
- 2 Yvonne is a podiatrist, specialising in diabetic foot conditions, who regularly has to prescribe long-term antifungal preparations.
- 3 Frances is a radiographer who is lead for her hospital's lower gastrointestinal endoscopy unit. Patients often require 'one-off' prescribing of bowel preparations.

Optometrist prescribers

Optometrist prescribing programmes are validated by the General Optical Council (GOC) and are currently limited to three university courses in the UK. Non-medical prescribing education for optometrists is somewhat different to the generic programmes offered to other professions, focusing very much on the speciality of optometry. All registered optometrists are able to administer and supply using specific exemptions, but these are limited. Those optometrists wishing to administer, supply or prescribe beyond those exemptions must undertake specialist training that must be registered with the GOC (College of Optometrists 2010). In order to achieve this, legislative changes have now enabled optometrists to undertake three routes: additional supply, supplementary prescribing and/or independent prescribing. Additional supply has enabled appropriately qualified optometrists access to an extended list of exemptions. Supplementary and independent prescribing is undertaken using the same criteria identified for other non-medical prescribing professions. Case study J provides an example of optometrist prescribing in practice.

PGDs

It is important that clarification is provided in relation to the differences between prescribing and the use of PGDs. Prescribing is undertaken on an individual basis, taking into account the individual needs of a patient, based on a thorough and holistic assessment, resulting, where appropriate, in the generation of a prescription. The use of PGDs does not constitute prescribing, although it could be argued that the processes leading up to both the generation of a prescription and the use of a PGD are similar.

The preferred method by which patients receive medicines is to have them prescribed, on an individual basis, by a health professional who has been trained to do so (National Institute for Health and Care Excellence (NICE) 2013). An alternative to this is the use of a PGD. It is not the intention of this discussion to provide a detailed account of the application of PGDs. Instead, the focus is on the differences between the two and the appropriateness of their use.

A PGD is defined as

... a written instruction for the sale, supply and/or administration of medicines to groups of patients who may not be individually identified before presenting for treatment. (NHS 2011)

The PGD therefore allows a healthcare professional to supply and/or administer a medicine directly to the patient. This can be done without the patient being required to see a prescriber, although a prescriber may have referred the patient in some instances. The health professional using a PGD is responsible for assessing the patient, just as a prescriber would in order to reach a decision about treatment. The difference in this assessment is that the health professional using a PGD undertakes the assessment against set criteria that determine if the PGD is appropriate (NPC 2009). In the same situation, the prescriber's assessment would no doubt incorporate many of the criteria used for the PGD but would also incorporate information that is individual to the patient.

As the definition of a PGD states, the medicines are predetermined for an identified clinical situation. Prescribing, on the other hand, enables the health professional to take into account the individual needs of the patient, using these to decide on an appropriate treatment, which may or may not be the same as indicated in the PGD. The prescriber may also support this by tackling the long-term implications of the presenting clinical situation.

The necessity to determine whether the PGD or prescribing is most appropriate highlights the reality that many services will function most effectively using a combination of both. Case study 9 provides an example of how the same clinical situation may be dealt with promptly and effectively by both methods, demonstrating a situation where prescribing would be preferable but where a PGD would enable a satisfactory outcome.

Although it is acknowledged that prescribing is the most appropriate option in most instances, it is also recognised that the use of PGDs, in a limited number of situations, can be advantageous for patient care, provided that it does not compromise patient safety (NICE 2013). Immunisation is an example of such a situation. The criteria set within the PGD to determine if a vaccine is appropriate enable health professionals to administer vaccines safely and efficiently within busy clinics, without the necessity of every health professional being a prescriber.



Activity box 1.10

Access the following websites for in-depth information on PGDs:

PGD website: <http://www.medicinesresources.nhs.uk/en/Communities/NHS/PGDs/>

MHRA: <http://www.mhra.gov.uk/index.htm>

Patient-specific directions differ from PGDs in that they are specific to a named patient. It is important to briefly clarify the link between prescribing and patient-specific directions because many non-medical prescribers will use them within their prescribing role. A patient-specific direction is defined by the MHRA (2014) as

... the traditional written instruction, from a doctor, dentist, nurse or pharmacist independent prescriber, for medicines to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis...

Independent non-medical prescribers may direct a relevantly qualified person to administer or supply a medicine. This direction will be based on the independent prescriber's assessment and decision about diagnosis and treatment. An example of this in secondary care would include an instruction given on a patient's ward drug chart.

Access to education programmes

Although many professionals reading this book will either be currently undertaking or will have completed a recognised programme of education in supplementary and/or independent prescribing, it is recognised that others will be using it to acquire information to help them to decide whether or not non-medical prescribing is appropriate for them. In many ways, the professional bodies governing the relevant professions have determined criteria that have simplified this decision. It is recommended

that any professional considering undertaking an education programme in non-medical prescribing accesses the standards set by their own professional body, the links for which are:

- GOC: <http://www.optical.org/en/Education/core-competencies--core-curricula/index.cfm>
- HCPC: <http://www.hpc-uk.org/assets/documents/10004160Standardsforprescribing.pdf>
- NMC: <http://www.nmc-uk.org/documents/standards/nmcstandardsofproficiencyfornurseandmidwife-prescribers.pdf>
- GPhC: <http://www.pharmacyregulation.org/education/pharmacist-independent-prescriber>

However, a brief explanation of the criteria used in determining access to education programmes is provided below.

Criteria relevant to all

Health professionals must:

- Be in a post in which prescribing will enhance their role and make better use of their skills
- Be able to identify that the introduction of non-medical prescribing within their role will improve the quality of patient care
- Be able to identify that the introduction of non-medical prescribing within their role will enable quicker and more efficient access to medicines for patients
- Be able to prescribe within their practice area once the education programme is successfully completed
- Have the ability to study at a minimum of degree level
- Have the support of their employer
- Have access to a budget from which the cost of their prescriptions will be met
- Have access to CPD
- Be able to identify an appropriate doctor who has agreed to act as their designated medical practitioner (note that for nurses, midwives and health visitors undertaking the community practitioner prescribing V100/150 programmes must *instead* be able to identify a practising prescriber who has agreed to act as their practice supporter; this may be another non-medical prescriber)

Nurse, midwife and health visitor-specific criteria

Nurses, midwives and health visitors must do the following.

V100

- Undertake a specialist community public health nurse or community specialist practitioner programme or already hold these qualifications

V150

- Have practised for a minimum of 2 years in the area in which they intend to prescribe

V300

- Have at least 3 years of post-registration clinical experience, with the last year being in the speciality/area in which they intend to prescribe

Allied health professional-specific criteria

Allied health professionals must:

- Have at least 3 years relevant post-qualification clinical experience in the clinical area in which they will be prescribing
- Be working at an advanced practitioner or equivalent level

Pharmacist-specific criteria

Pharmacists must:

- Have a minimum of 2 years appropriate patient-orientated experience in addition to the pre-registration year after graduation
- Be on the practising register

Optometrist-specific criteria

Optometrists must have been practising in the UK for 2 full years before they are eligible to start training for the therapeutic specialty qualifications.

Summary of the context of prescribing

This chapter has examined the context in which non-medical prescribing continues to develop in the UK. It is apparent that, although evolving, non-medical prescribing maintains its original vision of improving patient access to medicines through safe, effective and efficient prescribing. The achievement of this vision has relied on appropriate responses being made to the pressures placed on it. Figure 1.1 serves to highlight that the achievement of safe, effective and efficient prescribing results from a balance between these pressures and responses.

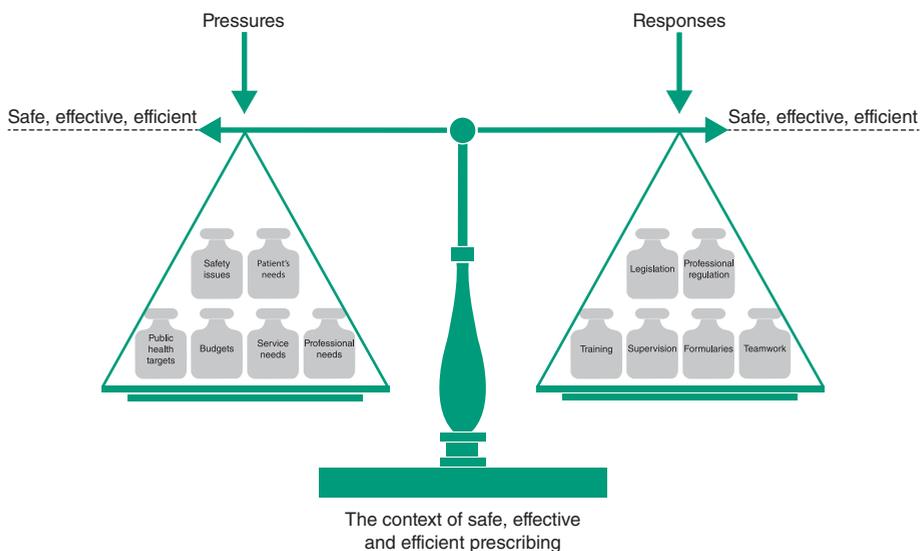


Figure 1.1 The balance between pressures and responses.

The pressures on prescribing are multiple. The identification of emerging safety issues, new public health targets and the resultant needs of the patient, professional and service all require response within a limited budget. To ensure that prescribing is able to form an effective element of the health services' response to these pressures, a teamwork approach is important. CPD, which incorporates not only relevant education but also appropriate and effective supervision, is essential in order to promote evidence-based and cost-effective practice. As the context of prescribing continues to evolve, so must the support provided to prescribers by legislation and professional regulation.

Key themes: conclusions and considerations

Public health

Public health has been shown to be a responsibility of all health professionals. So that inequalities in health in the UK are addressed, public health targets must remain a consideration in all areas of practice. Non-medical prescribing provides an appropriate setting for considering public health issues

Consider how you, as an individual practitioner, can impact on public health targets. Evaluation of your own practice will highlight areas that can be developed to ensure that public health becomes an integral part of non-medical prescribing practice

Social and cultural issues

The current context of non-medical prescribing has evolved from a position where prescribing was seen as the domain of doctors. The process of change has involved social and cultural shifts on the part of both patients and health professionals. Much of this process has relied on effective communication and the development of a sound evidence base

Consider what measures you can take to further reduce the barriers to non-medical prescribing and to promote it as an effective tool in meeting the needs of the patient and the health service

Prescribing principles

The prescribing principles have continued to support safe non-medical prescribing for over a decade

Consider each principle individually in order to evaluate how effectively you address them in practice. Dependent upon your experience as a prescriber, the consideration given to the individual principles on a daily basis is likely to differ. Reflecting on and revisiting the prescribing principles will aid both the novice and the experienced prescriber to ensure that their practice remains safe

Continuing professional development (CPD) and competence

CPD is an essential undertaking to ensure prescribers remain safe and effective, as well as enabling the most efficient use of this valuable skill. The Single Competency Framework (NPC 2012) provides a structure through which to consider areas for development

The following activity can be linked to *Competency Dimension 8: Information of the Single Competency Framework (NPC 2012)*

Considering the context of your prescribing activity in a changing NHS, reflect upon how you might utilise prescribing to develop your specific professional role. You should consider how access to information could support this transition

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