



Improving Patients' Access to Medicines:

A Guide to Implementing Nurse and Pharmacist Independent Prescribing within the NHS in England

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Introduction

1. This guide sets out the administrative and procedural steps needed to enable the following healthcare professionals in England to act as independent prescribers:
 - Registered nurses (first level)
 - Registered specialist Community Public Health Nurses
 - Registered midwives
 - Registered pharmacists
2. It provides information and advice on good practice for independent prescribers. This guide applies to all the professions listed above. [NB Where the term 'nurse' is used throughout the remainder of this document it includes midwives and specialist community public health nurses.
3. This guide is not directly applicable to Community Practitioner Nurse Prescribers (formerly known as District Nurse/Health Visitor prescribers) as their prescribing is limited to items from the Nurse Prescribers' Formulary for Community Practitioners.

Scope of this guidance and effect of devolution

4. This guide sets out the steps to implement independent prescribing in England. Medicines legislation permits the introduction of independent prescribing for the healthcare professionals named in paragraph 1 across the UK, but it is for the devolved administrations in Scotland, Wales and Northern Ireland to decide whether and how it is implemented for the NHS in their countries.

5. This guide has been produced to help promote safe and effective prescribing by Nurse and Pharmacist Independent Prescribers and is applicable to both the NHS and the Independent Sector.
6. When the Royal Pharmaceutical Society of Great Britain (RPSGB) is referred to in this guidance, please also take this to include 'The Pharmaceutical Society of Northern Ireland' where this is appropriate.

Nurse independent prescribing and pharmacist independent prescribing in England

Definition of independent prescribing

7. The Department of Health's working definition of independent prescribing is prescribing by a practitioner (e.g. doctor, dentist, nurse, pharmacist) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing. Within medicines legislation the term used is 'appropriate practitioner'.
8. In partnership with the patient, independent prescribing is one element of the clinical management of a patient. It requires an initial patient assessment, interpretation of that assessment, a decision on safe and appropriate therapy, and a process for ongoing monitoring. The independent prescriber is responsible and accountable for at least this element of a patient's care. Normally prescribing would be carried out in the context of practice within a multidisciplinary healthcare team, either in a hospital or in a community setting, and within a single, accessible healthcare record.

Legal basis of independent prescribing by nurses and pharmacists

9. The initial legal basis for the introduction of nurse prescribing was provided by the following regulations:
 - The Medicinal Products: Prescription by Nurses, etc. Act 1992 [which amended the National Health Service Act 1977 (section 41) and the Medicines Act 1968 (section 58)];
 - The Medicinal Products: Prescription by Nurses, etc Act 1992: (Commencement No 1) Order 1994.

10. Section 63 of the Health and Social Care Act 2001 enabled the Government to extend prescribing responsibilities to other health professions, including pharmacists. It also enabled the introduction of new types of prescriber, including the concept of a supplementary prescriber.

11. The Medicines and Human Use (Prescribing) (Miscellaneous Amendments) Order of May 2006 and associated medicines regulations enable nurses who have successfully completed a nurse independent prescribing course (formerly known as an extended formulary nurse prescribing course) to prescribe any licensed medicine, (i.e products with a valid marketing authorisation (licence) in the UK) including some Controlled Drugs, for any medical condition within their clinical competence. Independent prescribing for pharmacists is to be introduced on the same basis – the only difference being that Pharmacist Independent Prescribers will not, in the first instance, be able to prescribe any Controlled Drugs (community pharmacists can sell Schedule 5 Controlled Drugs). Changes to NHS (Miscellaneous Amendments Relating to Independent Prescribing) Regulations 2006 put these changes into effect in England from May 2006.

Aims of independent prescribing by nurses and pharmacists

12. It is government policy to extend prescribing responsibilities to non-medical professions to:-

- improve patient care without compromising patient safety;
- make it easier for patients to get the medicines they need;
- increase patient choice in accessing medicines;
- make better use of the skills of health professionals;
- contribute to the introduction of more flexible team working across the NHS.

13. Organisations should develop their strategic plan for the use of non-medical prescribing to include independent prescribing by nurses and pharmacists. Typically this would involve senior managers and clinicians (doctors, nurses, pharmacists) and the drug and therapeutics committee (or equivalent). The plan should be approved at Board level and would, for example:

- recognise the benefits to patients of non-medical prescribing;
- identify an initial range of clinical areas where patients could benefit;
- identify a way to support and sustain the transition of staff to extended roles and the services they currently provide;
- develop a communications plan aimed at informing both patients and all clinical and managerial staff;
- include timescales for implementation;
- identify a lead director to be responsible for implementation.

14. Nurse Independent Prescribers (formerly Extended Formulary Nurse Prescribers) will be able to prescribe any licensed medicine (i.e. products with a UK marketing authorisation) for any medical condition, including some Controlled Drugs (see Annex G). Nurse Independent Prescribers must only ever prescribe within their own level of experience and competence, acting in accordance with Clause 6 of the NMC's 'code of professional conduct: standards for conduct, performance and ethics'.

15. Pharmacist Independent Prescribers can prescribe any licensed medicine for any medical condition, with the exception of all Controlled Drugs, until such time as there are changes to the Home Office's Misuse of Drugs regulations. Pharmacist Independent Prescribers must only ever prescribe within their own level of experience and competence and in accordance with 'Medicines, Ethics and Practice – A Guide for Pharmacists', published by the RPSGB.

Implementation strategy

Which nurses, midwives and pharmacists can act as independent prescribers?

16. A Nurse Independent Prescriber must be a 1st level Registered Nurse, Registered Midwife or Registered Specialist Community Public Health Nurse whose name in each case is held on the Nursing and Midwifery Council professional register, with an annotation signifying that the nurse has successfully completed an approved programme of preparation and training for nurse independent prescribing.
17. A Pharmacist Independent Prescriber must be a registered pharmacist whose name is held on the membership register of the Royal Pharmaceutical Society of Great Britain, with an annotation signifying that the pharmacist has successfully completed an education and training programme accredited by the RPSGB and is qualified as an independent prescriber.

Selection of nurses, midwives and pharmacists to train

18. The selection of nurses and pharmacists who will be trained as independent prescribers is a matter for employing organisations who are best placed to assess local service and patient needs. All individuals selected for prescribing training must have the opportunity to prescribe in the post that they will occupy on completion of training. The therapeutic

area(s) in which they will prescribe should also have been identified before they begin training to prescribe. This will almost certainly be in the field in which they already hold considerable expertise.

19. In addition to fulfilling the legal criteria for eligibility to prescribe, applicants who are selected for prescribing training will need to meet the following requirements:

- Nurses should have the ability to study at Level 3 (degree level) and pharmacists the ability to study at a minimum of Quality Assurance Agency (QAA) for Higher Education level 3;
- Nurses should normally have at least three years' post-registration clinical nursing experience, of which at least one year immediately preceding their application to the training programme should be in the clinical area in which they intend to prescribe. Nurses must be assessed as being competent to take a history, undertake a clinical assessment and make a diagnosis. For example, they must be able to carry out a comprehensive assessment of the patient's physiological and/or psychological condition, and understand the underlying pathology and the appropriate medicines regime. It is:
 - the combination of expertise in the condition being treated
 - appreciation of the patient's particular manifestation of it and
 - the medicines which will be effectivethat make a proficient and competent prescriber.
- Pharmacists should have at least two years' experience practising as a pharmacist in a clinical environment, in a hospital or a community setting, following their pre-registration year after their graduation. Organisations who put forward pharmacists for independent prescribing should assure themselves that the pharmacist is competent to prescribe in the area in which they will prescribe following training.

- A medical prescriber willing and able to contribute to and supervise the nurse's 12 day learning in practice element of training. Final decisions have yet to be taken on training requirements for pharmacists;
- The support of their employer to confirm that:
 - their post is one in which they will have the need and the opportunity to act as an independent prescriber immediately upon qualifying;
 - there is a local need for them to prescribe – NHS Trusts and PCTs will decide whether there is a local NHS need for staff to access prescribing training. Nurses and pharmacists should not be able to undertake NHS funded training unless there has been prior agreement about the therapeutic area in which they will prescribe.
 - for nurses and pharmacists in primary care, they will have access to a budget to meet the costs of their prescriptions on completion of the course;
 - they will have access to continuing professional development (CPD) opportunities on completion of the course;
 - They will work within a robust clinical governance framework. [The RPSGB clinical governance framework for pharmacist prescribers is an excellent and helpful document. Organisations may want to use this framework as part of their clinical governance arrangements for pharmacist prescribers. See Annex F for details.]
They will be supported during their training and allowed some flexibility for self-directed study.

20. There are likely to be many nurses and pharmacists in any local health economy who meet these criteria. The three key principles that should be used to prioritise potential applicants are:

- patient safety;
- maximum benefit to patients and the NHS in terms of quicker and more efficient access to medicines for patients;
- better use of the professional's skills.

The individual practitioners must also understand and accept the higher level of clinical responsibility associated with prescribing.

21. The non-medical prescribing lead in each Strategic Health Authority (or Primary Care Trust) should liaise with NHS employers and Higher Education Institutions, to ensure that applicants and the number of course places can be appropriately matched. PCTs, other NHS employers and SHAs may find it helpful to work together to agree priorities for access to prescribing courses.

Commissioning services

22. Pharmacist and Nurse Independent Prescribers will give GP practices, hospital and primary care trusts, and all who commission services the opportunity to change the way they provide services to patients. A wider range of professionals who can act as independent prescribers provides a wider range of skills and expertise from which to draw, to meet patient needs. Using Nurse and Pharmacist Independent Prescribers can, amongst other things, help:

- fill geographical or skills gaps in services;
- meet the needs of patient groups who find it hard to access services, e.g. housebound people, people with busy lifestyles;
- manage long-term conditions;
- manage co-morbidities / complex medication regimes.

DH funding for nurse independent and pharmacist independent prescribing training courses

23. Central funding is being made available through Strategic Health Authorities to meet the direct costs of training. Guidance for Strategic Health Authorities will identify funding to support non-medical prescribing training for 2006/07. It is for SHAs to decide how this funding is best used, provided it is used for non-medical prescribing. SHAs may wish to draw up criteria for access to funds for training, based on local NHS need. For instance, some of this funding could be used to support Continuing Professional Development activities related to non-medical prescribing. NHS employers may also use their own training funds for this purpose.

Non-NHS staff

24. Nurses and pharmacists employed by non-NHS organisations, and who provide the majority of their clinical services to NHS patients (e.g. nurses and pharmacists working in hospices and pharmacists working in community pharmacy) may have their training funded and should be considered within the SHA-led planning process.

Conflicts of interest

25. In nominating for training any nurses or pharmacists whose posts are directly or indirectly funded by pharmaceutical and other companies, employers should be aware of, and take necessary steps to resolve, any conflicts of interests that may subsequently arise in the nurse's or pharmacist's practice.
26. Nurses are reminded of section 7.2 in the NMC Code of Professional Conduct which states that, in the exercise of his/her professional accountability, a registered nurse must 'ensure that your registration status is not used in the promotion of commercial products or services, declare

- any financial or other interests in relevant organisations providing such goods or services, and ensure that your professional judgement is not influenced by any commercial considerations’.
27. One of the key responsibilities of a pharmacist within the RPSGB code of ethics and standards is: ‘Pharmacists must ensure that they behave with integrity and probity, adhere to accepted standards of personal and professional conduct and do not engage in any behaviour or activity likely to bring the profession into disrepute or undermine public confidence in the profession.’
 28. If local organisations conclude that there is no conflict of interest, then the supported individual should openly declare and record this through local corporate governance mechanisms.
 29. Another key responsibility is that at all times a pharmacist must act in the interest of patients and other members of the public, and seek to provide the best possible healthcare for the community, in partnership with other health professions.
 30. NHS bodies should bear in mind issues of potential conflict of interest when they are considering commercial sponsorship of events aimed at prescribers.

Funding from other sources

31. If it so wishes, an NHS organisation or a private organisation may also pay for the training of nurses and pharmacists through other sources of funding.

Training and preparation for independent prescribing

Training programmes for independent prescribing

32. The Nursing and Midwifery Council (NMC) and Royal Pharmaceutical Society of Great Britain (RPSGB) have set out standards/curricula in respect of prescribing training for nurses and pharmacists, and will only validate new recordable courses against these (see www.nmc-uk.org and www.rpsgb.org.uk). Only successful completion of programmes approved by the NMC or RPSGB will lead to registration as a Nurse or Pharmacist Independent Prescriber.

33. Responsibility for the detail of the curriculum for prescribing training rests with the commissioner of the course (the Strategic Health Authority). DH expects course commissioners and validators to approve only those courses that demonstrate content that is consistent with published guidance and that the learning outcomes of the curricula are to be achieved.

34. Nurses training to become nurse prescribers will undertake a specific programme of preparation at a minimum of degree level (level three). This course enables a nurse to qualify as both a Nurse Independent Prescriber and as a Nurse Supplementary Prescriber. The programme comprises a minimum of 26 days at a Higher Education Institution plus 12 days 'learning in practice', during which a supervising designated medical practitioner will provide the student with supervision, support and opportunities to develop competence in prescribing practice. The programme of training and preparation may be spread over a period of 3 to 6 months. The nurse will also need to undertake an element of self-directed learning. For distance learning programmes, there must be a minimum of 8 face-to-face taught days (excluding assessment) plus 10 ten days protected learning time. In exceptional circumstances where this is

not practically possible, video-conferencing in which interaction between all participants is possible, will be acceptable.

35. Pharmacists training to be Pharmacist Independent Prescribers will undertake a specific programme of training at least at QAA level three (i.e. degree level), in accordance with the RPSGB curriculum. As with nurses, this will enable them to qualify as both a Pharmacist Independent Prescriber and as a Pharmacist Supplementary Prescriber. The length of the programme will be confirmed later this year.
36. The training programmes include an assessment of theory and practice that must be passed before the practitioner's entry on the NMC/RPSGB register is annotated, to indicate that he/she holds a qualification for prescribing.
37. Individual higher education institutions, where appropriate, may use approved prior learning (APL) or exemptions, to give credit for a nurse or pharmacist's previous learning.

Supervising/Designated Medical Practitioner (DMP)

38. Guidance entitled 'Training non-medical prescribers in practice – A guide to help doctors prepare for and carry out the role of designated medical practitioner' is available on the National Prescribing Centre website at www.npc.co.uk, and should help to inform the selection of Designated Medical Practitioners.
39. The period of learning in practice is to be directed by a DMP, who will also be responsible for assessing whether the learning outcomes have been met and whether the trainee has acquired certain competencies. Normally, these outcomes and competencies will be identified by the Higher Education Institution running individual courses.

40. The Designated Medical Practitioner (DMP) has a critical and highly responsible role in educating and assessing the non-medical prescriber and assuring competence in prescribing.
41. Before taking on the role of DMP, the doctor and the HEI should consider the implications of undertaking this role safely and effectively. It is then important that the DMP and the HEI running the prescribing programme should work closely together.
42. Training new prescribers will undoubtedly take up some time. The approach to teaching and learning should be developed on an individual basis, so it is difficult to predict how much time this will involve.
43. As described earlier, Department of Health funding is allocated to Strategic Health Authorities to meet the cost of training nurses and pharmacists in prescribing. It is, however, the responsibility of each SHA to determine the detail of how best to use the funds made available to it, to promote non-medical prescribing to and train healthcare professionals for it.

'Buddying' schemes during training

44. It is unlikely that a trainee will need to spend all of the period of learning in practice with their designated medical practitioner (DMP), as other clinicians may be better placed to provide some of the learning opportunities. However, the DMP remains responsible for assessing whether all of the learning outcomes have been met. Some form of 'buddying' link may also be valuable, for instance, with a current nurse or pharmacist prescriber, or with a senior and experienced pharmacist.

Continuing Professional Development

45. All nurses and pharmacists have a professional responsibility to keep themselves abreast of clinical and professional developments. This is no less true for prescribing. Nurse and Pharmacist Independent Prescribers will be expected to keep up to date with evidence and best practice in the management of the conditions for which they prescribe, and in the use of the relevant medicines.
46. Nurses may use the learning from this activity as part of their Post Registration Education and Practice (PREP-CPD) activity. The employer should ensure that the practitioner has access to relevant education and training provision. It is good practice for employers to support nurse prescribers in pursuing self-directed study. Details of additional training and updating will need to be incorporated by the individual into their personal professional profile, in order to renew their registration with the NMC.
47. For pharmacists, the RPSGB's new statutory requirements for CPD will require pharmacist prescribers to demonstrate CPD in their area of prescribing practice.
48. In addition, the National Prescribing Centre will publish "Maintaining Competency in Prescribing: An outline framework to help Pharmacist Independent Prescribers" (available at www.npc.nhs.uk / www.npc.co.uk) A similar competency framework is available for Nurse Independent Prescribers.
49. In addition to the time spent on the formal programme, it is important that employers of nurses and pharmacists undertaking the programme should recognise the demands of private study and provide support where

necessary. Employers may also consider providing mentoring opportunities for these nurses and pharmacists (see below).

'Buddying'/mentor post - qualification

50. Support from other professional colleagues is invaluable to non-medical prescribers, especially to those who are newly qualified. Many non-medical prescribers already have a buddy/mentor after qualifying to prescribe. This could be a doctor, nurse or pharmacist and is a sensible way of enhancing Continuing Professional Development. Supplementary Prescribing is also a useful mechanism to enable new non-medical prescribers to develop their expertise and confidence in prescribing.

Medicines prescribable under independent prescribing arrangements

Controlled Drugs

51. Nurse Independent Prescribers may prescribe any licensed medicine (i.e. products with a UK marketing authorisation) for any medical condition, including some Controlled Drugs. Nurse Independent Prescribers are able to prescribe independently the list of Controlled Drugs at Annex G solely for the medical conditions indicated. This list is also available in the Drug Tariff (part XVIIIB) and in the September 2006 edition (and beyond) of the BNF.
52. Pharmacist Independent Prescribers may prescribe any licensed medicine (i.e. products with a UK marketing authorisation) for any medical condition, with the exception, at present, of all Controlled Drugs. This does not affect pharmacists' ability to sell some Controlled Drugs.

Prescribing within competence

53. All Nurse and Pharmacist Independent Prescribers must work within their own level of professional competence and expertise, and must seek

advice and make appropriate referrals to other professionals with different expertise. Nurses and pharmacists are accountable for their own actions, and must be aware of the limits of their skills, knowledge and competence. Nurses must act within clause 6 of the NMC 'Code of professional conduct: standards for conduct, performance and ethics'. Pharmacists must act within the Royal Pharmaceutical Society of Great Britain's 'Code of Ethics and Standards'.

Prescribing licensed medicines for unlicensed uses, so-called 'off-label'

54. Nurse and Pharmacist Independent Prescribers may prescribe medicines independently for uses outside their licensed indications/UK marketing authorisation (so called 'off-licence' or 'off-label'). They must however, accept professional, clinical and legal responsibility for that prescribing, and should only prescribe 'off-label' where it is accepted clinical practice. A local policy for the use of off-licence medicines should be approved through mechanisms such as drug and therapeutic committees or the equivalent. The prescriber should explain the situation to the patient/guardian, where possible, but where a patient is unable to agree to such treatment, the prescriber should act in accordance with best practice in the given situation and within the policy of the employing organisation.

Unlicensed medicines (products without a UK marketing authorisation)

55. Nurse and Pharmacist Independent Prescribers are not permitted to prescribe unlicensed medicines.

Borderline Substances

56. All NHS prescribers will need to abide by any NHS terms of service under which they operate. For example, if operating under new GMS, borderline substances may be prescribed but the prescription will need to be marked 'ACBS'. A list of Advisory Committee of Borderline Substances (ACBS) approved products and the circumstances under which they can be

prescribed, can be found in part XV of the Drug Tariff. Although this is a non-mandatory list, Nurse and Pharmacist Independent Prescribers should normally restrict their prescribing of borderline substances to items on the ACBS approved list. They should also work within the guidance of their employing organisation.

Appliances / Dressings in Part IX of the Drug Tariff

57. Nurse and Pharmacist Independent Prescribers may also prescribe any appliances / dressings that are listed in Part IX of the Drug Tariff. Nurses and pharmacists prescribing in secondary care are not restricted to prescribing appliances/dressings from part IX of the Drug Tariff, but should take into account local formulary policies and the implications for primary care.

Clinical governance in independent prescribing

58. Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

59. Chief executives are legally accountable for the quality of care that patients receive and for securing patient safety.

60. The employing organisation must ensure that nurse and pharmacist independent prescribing is included within their overall clinical governance framework, to ensure that nurses and pharmacists practice safely and competently. It must include systems for:

- selection – all entrants to prescribing training must be selected according to criteria indicating their potential to prescribe safely in the area in which they will practice. This will usually include

evidence that they have appropriate specialist knowledge and an opportunity to prescribe within their work

- completion of accredited education programmes – the regulatory bodies provide and assess the standards for training and education programmes. Employers also have a duty to ensure that those training to prescribe are supported through their training programme
- ensuring that the names of prescribers are annotated on their professional register, before they begin to prescribe. This should be ascertained via the usual register checking arrangements that are undertaken for new employees
- ensuring arrangements are in place for assessment of practice, clinical supervision, audit, and continuing professional development for all Nurse Independent Prescribers and Pharmacist Independent Prescribers.
- developing a risk management plan – this will ensure that potential risks associated with extending clinical practice are recognised and minimised
- ensuring that the parameters of an individual's prescribing are agreed between the prescriber, their manager or local professional lead (e.g. the PCT Pharmaceutical Adviser in the case of a community pharmacist), and their employer
- ensuring that drug and therapeutic committees are aware of the medicines being prescribed by Nurse and Pharmacist Independent Prescribers

61. Nurses and pharmacists should use clinical supervision arrangements or equivalent as an opportunity for reflection on prescribing, as well as other aspects of practice. The model of clinical supervision should be agreed at local level, taking account of other staff support mechanisms and resources.
62. Peer review, support and mentoring arrangements should be established for pharmacists. Audits, clinical governance arrangements and their CPD requirements will allow pharmacists to reflect on their prescribing practice. The RPSGB has developed a clinical governance framework both for pharmacist prescribers and the organisations within which they work, which can be reflected in the employer organisation's overall clinical governance framework. The framework also details the prescriber's responsibility to engage in clinical governance activities. The framework is available at www.rpsgb.org.uk
63. A review of independent prescribing by nurses and pharmacists should be carried out as part of the overall prescribing monitoring arrangements and as a suitable area of practice for regular audit. This should include prescription and cost data available from the Business Services Agency (formerly the Prescription Pricing Authority) and from hospital internal systems.
64. Good practice examples of Non-Medical Prescribing Clinical Governance Frameworks can be found at Annex F.

Independent/Private sector

65. 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.

Good practice, ethics and issues for all independent prescribers

Responsibility for prescribing decisions

66. A Nurse or Pharmacist Independent Prescriber can only order a medicine for a patient whom he/she has assessed for care. In primary care, a nurse or pharmacist should only write prescriptions on a prescription pad bearing his/her own unique NMC/RPSGB registration number.

Informing patients

67. Nurse and Pharmacist Independent Prescribers must ensure that patients are aware that they are being treated by a non-medical practitioner and of the scope and limits of their prescribing. So there may be circumstances where the patient has to be referred on to another healthcare professional, to access other aspects of their care.

Prescribing for self, family and friends

68. Nurse and Pharmacist Independent Prescribers must not prescribe any medicine for themselves. Neither should they prescribe a medicine for anyone with whom they have a close personal or emotional relationship, other than in an exceptional circumstance. (See NMC's 'Standards of Proficiency to be Qualified to Prescribe' and the RPSGB's 'Code of Ethics and Standards'.)

Gifts and benefits

69. The advertising and promotion of medicines is strictly regulated under the Medicines (Advertising) Regulations 1994, and it is important that Nurse and Pharmacist Independent Prescribers, and indeed all health

- professionals, make their choice of medicinal product for their patients on the basis of evidence, clinical suitability and cost effectiveness alone.
70. As part of the promotion of a medicine or medicines, suppliers may provide inexpensive gifts and benefits, for example pens, diaries or mouse mats. Personal Gifts are prohibited, and it is an offence to solicit or accept a prohibited gift or inducement. Companies may also offer hospitality at a professional or scientific meeting or at meetings held to promote medicines, but such hospitality should be reasonable in level and subordinate to the main purpose of the meeting. Both PCTs and NHS Trusts should have local policies for working with the pharmaceutical industry which cover gifts and benefits, as well as, for example, access to prescribers and sponsorship. Prescribers should familiarise themselves with these policies and are expected to abide by them.
71. The Medicines and Healthcare products Regulatory Agency (MHRA) is responsible for enforcing the legislation on advertising and promotion of medicines. Any complaints about promotional practices should be referred to the MHRA or to the industry's self-regulatory body, the Prescription Medicines Code of Practice Authority.

Guidance on Controlled Drugs

72. The Home Office's Misuse of Drugs Act and associated regulations govern the prescribing of Controlled Drugs. For guidelines on the prescription of Controlled Drugs, healthcare professionals should refer to:
- Guidance from their respective professional bodies;
 - 'A guide to good practice in the management of controlled drugs in primary care' – Published by the National Prescribing Centre. See www.npc.co.uk ;

- Department of Health guidance available at www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/ControlledDrugs/fs/en
This website contains information on the post-Shipman changes to the legal framework around the use and management of controlled drugs. It signposts the user to the relevant legislation and guidance from Government, professional bodies and other agencies.
- The legal requirements for prescriptions for Schedule 2 and 3 Controlled Drugs are summarised in the British National Formulary, and the Royal Pharmaceutical Society of Great Britain's publication, 'Medicines, Ethics and Practice: a guide for Pharmacists'.
- See also part XVIIIB of the Drug Tariff

Patient records: Access and updating

73. All health professionals are required to keep accurate, legible, unambiguous and contemporaneous records of a patient's care. There is no single model or template for a patient record (although for guidance, staff should refer to the standards published by the relevant professional/regulatory body), but a good record is one that provides in a timely manner all professionals involved in a patient's treatment, with the information needed for them to care safely and effectively for that patient. It is a necessary way of promoting communication within the healthcare team and between practitioners and their patients/clients. Good record keeping is, therefore, both the product of effective team working and a pre-requisite for promoting safe and effective care for patients.
74. Best practice suggests that the details of any prescription, together with other details of the consultation with the patient, should be entered onto the shared patient record immediately, or failing that, as soon as possible after the consultation. **Only in very exceptional circumstances (e.g. the intervention of a weekend or public holiday) should this period**

exceed 48 hours from the time of writing the prescription. This information should also be entered at the same time onto the patient record and onto the nursing or pharmacy patient record (where a separate record exists).

75. It is recommended that the record indicates clearly:
- The date of the prescription;
 - The name of the prescriber (and that they are acting as a Nurse or Pharmacist Independent Prescriber);
 - The name of the item prescribed, together with the quantity (or dose, frequency and treatment duration).
76. To aid safe administration of medicines, the record should include:
- The name of the item prescribed, the strength (if any) of the preparation, the dosing schedule and route of administration, e.g. 'paracetamol oral suspension 120mg/5mls to be taken every four hours by mouth as required for pain, maximum of 20mls in any 24 hours'.
77. In the case of topical medicines the name of the prescribed item, the strength (if any), the quantity to be applied and the frequency of the application should be indicated. For dressings and appliances, details of how they are to be applied and how frequently changed, are useful. It is recommended that any advice given on General Sales List and Pharmacy medicines provided 'over the counter' is also recorded.

Adverse Drug Reaction Reporting

MHRA/CHM Yellow Card Scheme

78. The Yellow Card Scheme is a voluntary scheme, through which healthcare professionals notify the Medicines and Healthcare products Regulatory Agency (MHRA)/Commission on Human Medicines (CHM) of suspected adverse drug reactions. The MHRA/CHM encourage the

reporting of all suspected adverse drug reactions to newly licensed medicines that are under intensive monitoring/surveillance (identified by a ▼ symbol both on the product information for the drug and in the BNF and MIMS), and all serious suspected adverse drug reactions to all other established medicines, including herbal medicines. Serious reactions include those that are fatal, life threatening, disabling, incapacitating or which result in or prolong hospitalisation and/or are medically significant. The electronic Yellow Card provides a simple and fast way to report suspected adverse reactions. The electronic Yellow Card, together with instructions on how to use it, is available at www.yellowcard.gov.uk Health professionals are encouraged to report all suspected adverse drug reactions using this method, although hard copy Yellow Cards are also acceptable (and can be found bound to the back of the British National Formulary). Patients, parents, carers etc can also report suspected adverse drug reactions using the above methods and there is also a freephone number - 0808 100 3352, that can be used.

79. The bulletin “Current Problems In Pharmacovigilance”, issued by the MHRA/CHM, contains advice and information on drug safety issues. All prescribers are encouraged to routinely consult the bulletin and keep up-to-date with new information about safe use of medicines. Copies are also available from the MHRA’s website, www.mhra.gov.uk .

Role of the National Patient Safety Agency

80. If a patient suffers harm due to an adverse incident involving medicines, or if harm could have been caused to the patient by the medicine (a near miss), the incident or near miss should be reported by the Nurse or Pharmacist Independent Prescriber/Supplementary Prescriber using both local and national reporting systems. The National Patient Safety Agency (NPSA), a special health authority, was established in 2001 to improve the safety of NHS patient care, by promoting a culture of reporting and

learning from adverse incidents across the NHS. A new reporting system, the National Reporting and Learning System (NRLS), has been developed by the Agency to draw together information on adverse incidents. This will help the NHS to understand the underlying causes of patient safety problems, and to act to introduce practical changes to prevent mistakes.

81. All NHS organisations in England and Wales can now submit reports of patient safety incidents to the NRLS. These reports will enable the NPSA to build a clearer national picture of the problems affecting patient safety.

82. The National Reporting and Learning System allows NHS staff and independent contractors to report the incidents that they are involved in or witness, confidentially and anonymously. Two routes are available to enable them to report:
 - A direct reporting route to the NPSA using the electronic reporting form – known as the eForm – available on the NPSA website at www.npsa.nhs.uk/staffform/ .
 - Reporting through the local healthcare organisation’s established system.

83. Community pharmacy contractors are required to have an approved incident reporting system. The NPSA’s confidential National Reporting and Learning System is available to them.

84. The National Patient Safety Agency publishes statistics on trends and issues identified through the National Reporting and Learning System to promote a learning culture in the NHS. The Agency will also use the data to deliver effective, practical and timely solutions to the NHS, to help staff and organisations improve the safety of the patients they care for. Further information on the NPSA can be found on the Agency’s website www.npsa.nhs.uk .

Legal and Clinical Liability

Liability of prescriber/Professional indemnity

85. Prescribers are accountable for all aspects of their prescribing decisions. They should therefore only prescribe those medicines they know are safe and effective for the patient and the condition being treated. They must be able to recognise and deal with pressures (e.g. from the pharmaceutical industry, patients or colleagues) that might result in inappropriate prescribing.
86. All prescribers should ensure that they have sufficient professional indemnity insurance, for instance by means of membership of a professional organisation or trade union which provides this cover.
87. The RPSGB Code of Ethics states that all pharmacists who own a pharmacy, superintendent pharmacists, and pharmacist managers should ensure that all professional activities undertaken by them or under their control are covered by adequate professional indemnity insurance. The standard for prescribing within the Code also says that pharmacists must only prescribe within the limits of their registration and must comply with statutory requirements applicable to their prescribing.
88. The NMC recommends that every nurse/midwife prescriber should ensure he/she has professional indemnity insurance, by means of a professional organisation or trade union body. Prescribers must also be aware of the level of indemnity insurance offered by their insurer to determine whether it is sufficient for purpose. See clause 9 of the NMC code of professional conduct: standards for conduct, performance and ethics.
89. Both the employer and employee (or contractor) should ensure that the employee's job description (or contractor's agreed arrangements) includes

a clear statement that prescribing is required as part of the duties of that post or service.

Liability of employer

90. Where a nurse, midwife or pharmacist is appropriately trained and qualified and prescribes as part of their professional duties with the consent of their employer, the employer is held vicariously liable for their actions. In addition, Nurse Independent Prescribers are individually professionally accountable to the Nursing and Midwifery Council (NMC) for this aspect of their practice, as for any other, and must act at all times in accordance with the NMC Code of Professional Conduct. Pharmacist Independent Prescribers are individually accountable to the RPSGB and must at all times act in accordance with the RPSGB Code of Ethics and Standards.

Dispensing of prescribed items

Dispensing Doctors in primary care

91. Where a GP practice is a dispensing practice, prescriptions from Nurse and Pharmacist Independent Prescribers can be dispensed by the practice but only for the dispensing patients of that practice. Dispensing Doctors cannot dispense prescriptions written by Nurse and Pharmacist Independent Prescribers for patients of other practices.
92. When submitting prescription forms prior to sending them to the NHS Business Services Authority (formerly the Prescription Pricing Authority), dispensing practices should follow the sorting instructions on the prescription invoice.
93. Reimbursement for prescriptions written by Nurse and Pharmacist Independent Prescribers can be claimed by Dispensing Doctors; payment for the prescriptions submitted will be made to the senior partner.

Role of the pharmacist in dispensing Pharmacist Independent Prescribers' prescriptions

94. There should, other than in exceptional circumstances, be separation of prescribing and dispensing roles, in keeping with the principles of safety, clinical and corporate governance. The Royal Pharmaceutical Society of Great Britain's standard on prescribing within the Code of Ethics and Standards states that pharmacists should ensure that there is separation of prescribing and dispensing wherever possible. In exceptional circumstances, where a pharmacist is both prescribing and dispensing a patient's medication, a second suitably competent person should normally be involved in the checking process. The audit arrangements must allow checking for clinical appropriateness.
95. In such exceptional circumstances, prescribing and dispensing can be carried out by the same individual, provided that:
- clear accountability arrangements are in place to ensure patient safety and probity, and;
 - there are audit and clinical governance arrangements in place, which can track prescribing and dispensing by Nurse and Pharmacist Independent Prescribers. Where the two roles do co-exist, another person must carry out a final accuracy check. Where possible, a check for clinical appropriateness should also be carried out.

Verification of prescribing status

Role of the pharmacist on verification of prescribing status

96. The dispensing pharmacist will need to be sure that the prescriber has qualified as a Nurse or Pharmacist Independent Prescriber.

97. The prescription form will indicate whether a prescriber is a Nurse or Pharmacist Independent Prescriber. The dispensing pharmacist will, of course, need to use his/her professional judgement, just as he/she does for doctors' prescriptions, to assess whether a prescription is appropriate for a particular patient.
98. To enable pharmacists to check whether a prescription handed in for dispensing is bona fide, **all** NHS employers should keep a list of all nurse and pharmacist prescribers employed by them. It is also recommended that the employing authority (NHS or private) holds a copy of the prescriber's signature. Individuals should be prepared to provide specimen signatures to pharmacists, should that be required.

Nursing and Midwifery Council (NMC)

99. In the case of nurses, most enquiries from dispensing pharmacists will be resolved by telephoning the prescriber, the prescriber's employer or the PCT. However, for general queries about qualification (e.g. in the case of receiving a private prescription), the pharmacist can telephone the 24-hour NMC voice bank system (telephone number 020 7631 3200). Pharmacists should clearly state that they are checking the prescribing status of an individual. They should then be asked to give the nurse prescriber's NMC number and name. If the pharmacist fails to state that he/she is checking prescribing status, the NMC operator will assume the pharmacist is the nurse's employer and will ask a number of further questions to which the pharmacist will not have the answer.
100. Anyone can check the prescribing status of a nurse by accessing the NMC website www.nmc-uk.org and searching the Register. This can be done by simply entering a name and/or NMC registration number and will confirm if someone has live registration and what type of prescriber they are.

Royal Pharmaceutical Society of Great Britain (RPSGB)

101. The RPSGB has on-line web access www.rpsgb.org.uk/members/registration/mem.html , which provides a list of pharmacists registered either by name or registration number; the register is also annotated to indicate the pharmacist is a supplementary prescriber. It is expected a similar annotation will be recorded for Pharmacist Independent Prescribers. This enables 24-hour access and will incorporate an indicator of prescribing status.

Role of the Prescription Pricing Division of the NHS Business Services Authority

102. The Prescription Pricing Division of the NHS Business Services Authority (NHSBSA) checks only to ensure that a prescription written by a Community Practitioner Nurse Prescriber is restricted to items included in the Community Practitioners' Formulary. The NHSBSA does not check whether a nurse or pharmacist is prescribing as an Independent or Supplementary Prescriber. This is a more appropriate role for Primary Care Trusts.

Dispensing by appliance contractors

103. When a nurse or pharmacist becomes aware that the patient intends to have a prescription dispensed by an appliance contractor, he/she must ensure that the prescription does not contain medicinal preparations. Appliance contractors should follow the instructions on the Prescription Invoice – Form FP34A when sorting prescription forms prior to sending them to the PPA/BSA for pricing. NB Appliance contractors cannot dispense medicinal preparations.

Urgent dispensing

104. Occasionally a nurse or pharmacist prescription may require dispensing out of normal pharmacy opening hours. Many community pharmacies are

now open out-of-hours, and the local NHS Direct centre should have a list of those that do so. Hospitals and Out-of-Hours Services will have local arrangements for supplying medicines out-of-hours, which should be brought to the attention of all prescribers, including nurses and pharmacists.

Dispensing of items in Scotland, Wales and Northern Ireland

105. Prescriptions written by Nurse and Pharmacist Independent Prescribers in England will only be dispensable by pharmacists in Scotland, Wales and Northern Ireland when the devolved administrations amend their pharmaceutical regulations, to permit them to be dispensed at NHS expense.

Dispensing items against Nurse or Pharmacist Independent Prescriber's prescriptions in hospital pharmacies

106. An up-to-date list of all qualified Nurse and Pharmacist Independent Prescribers employed by the hospital will need to be kept in the hospital pharmacy. Pharmacy staff should check the prescriber against the list. The same process will apply for in-patient, outpatient and discharge prescriptions. In general, prescriptions written on forms intended for dispensing in the community, are not intended for dispensing by hospital pharmacies.

Independent prescribing monitoring information

107. The NHS Business Services Authority NHSBSA (formerly the Prescription Pricing Authority) reimburses costs to dispensing contractors and provides essential information electronically to authorised users. Prescribing by Nurse Independent Prescribers and Pharmacist Independent Prescribers will be identifiable in ePACT.net services and other NHSBSA Information Systems. PCTs will be expected to provide routine data analysis of all

prescribing which will include analysis of cost effectiveness and quality. Independent Prescribers can expect to receive information via their PCT, GP Practice, Walk-in Centre and Out-of-Hours Care Provider to monitor their prescribing.

108. Typically, the hospital pharmacy department will monitor prescribing, and provide feedback on all prescribing in hospitals to both clinicians and managers.
109. The route for accessing prescribing data for non-medical prescribers depends on where their prescribing costs are allocated.

Prescribers contracted to a GP practice

110. If a prescriber is prescribing on behalf of a GP practice, he/she can obtain prescribing data through electronic Prescribing and Financial Information for Practices (ePFIP) on the NHS Business Services Authority website. From November 2005, the paper PACT Standard report was replaced by the electronic Prescribing Analysis Report. Further details are available on the NHSBSA website: www.nhsbsa.nhs.uk
111. Information about the individual prescriber's prescribing is available through the Practice Detailed Prescribing Information, as part of ePFIP. This provides detail for individual prescribers, down to presentation and prescription quantity level. Further details are available on the NHSBSA website: www.nhsbsa.nhs.uk
112. The NHS Business Services Authority website provides information about ePFIP and how to access it. Practices which do not yet have access need to contact the IT Help Desk with their details by email at help@ppd.nhsbsa.nhs.uk or by telephone on 0191 203 5050.

Prescribers contracted to a PCT

113. If the prescribing costs are met directly by the PCT (i.e. if there is no GP practice code on the prescription form), prescribers can obtain their prescribing data through their PCT, via ePACT.net. Prescribers should in the first instance contact the PCT pharmaceutical or prescribing adviser for this information. ePACT.net provides the detailed prescribing data that would previously have been found in a PACT Catalogue. This system provides detail for individual prescribers, down to individual presentation and prescription quantity level.

Annex A – History

1. Following a successful pilot programme, the Department of Health introduced nurse prescribing nationally for District Nurses and Health Visitors in England from December 1998. The Nurse Prescribers' Formulary for Community Practitioners (until 2005 called the Nurse Prescribers' Formulary for District Nurses and Health Visitors) now enables Community Practitioner Nurse Prescribers to prescribe from a formulary of appliances, dressings and some medicines for patients in the community. Over 29,000 nurses in England are now qualified to do so.
2. In 1997, the Government set up a Review of Prescribing, Supply and Administration of medicines (under the Chairmanship of Dr June Crown CBE). In 1999, the second report of the Review recognised the potential benefits to patients of extending prescribing responsibilities to healthcare professionals other than doctors, dentists and the then small number of district nurse and health visitor prescribers. As a result, following public consultation, the Department of Health introduced a wider formulary for (independent) nurse prescribing in 2002: the Nurse Prescribers' Extended Formulary.
3. In April 2003, the Government enabled nurses and pharmacists to train to become supplementary prescribers. Supplementary Prescribing is defined as a voluntary partnership between the independent prescriber (a doctor or dentist) and a supplementary prescriber to implement an agreed patient-specific Clinical Management Plan, with the patient's agreement. Over 6,100 nurses and over 520 pharmacists have now qualified to become 'Supplementary Prescribers'.
4. Work to expand the Nurse Prescribers' Extended Formulary (NPEF) took place from 2003 to 2005. By May 2005, the NPEF included a list of around

240 Prescription Only Medicines (POMs), together with all Pharmacy and General Sales List medicines prescribable by GPs for these medical conditions. By March 2006, around 6,600 nurses in England had qualified as 'Extended Formulary Nurse Prescribers'.

5. The University of Southampton completed an evaluation of nurse prescribing for the Department of Health early in 2005. The evaluation concluded that the limits of the Extended Formulary were in some cases restricting benefit to patients and efficient NHS practice. Experience had also shown that updating the Extended Formulary was a long and resource intensive process, with proposed changes taking 12 to 17 months to put into effect. Furthermore, supplementary prescribing could not be used in all settings where patients would benefit, e.g. emergency care and first contact care, because it required the development of an individual clinical management plan agreed with a doctor.
6. A joint Department of Health/Medicines and Healthcare products Regulatory Agency consultation from February to May 2005 examined the options for the future of independent prescribing by nurses.
7. At the same time, a similar consultation examined options for the introduction of independent prescribing by pharmacists. These proposals aimed to benefit patients by providing greater access to pharmacists' knowledge and expertise, as well as a faster and more accessible service.
8. In October 2005, the Committee on Safety of Medicines considered the responses to both consultations and recommended to Ministers that suitably trained and qualified nurses and pharmacists should be able to prescribe any licensed medicine for any medical condition within their competence. These recommendations were agreed by Ministers and announced in a press release on 10 November 2005.

9. Changes to regulations from 1st May 2006 enable suitably trained nurses and pharmacists to qualify as independent prescribers, who will then be able to prescribe any licensed medicine (i.e. products with a valid marketing authorisation (licence) in the UK) including some Controlled Drugs for any medical condition they are competent to treat. At present Pharmacist independent prescribers cannot prescribe Controlled Drugs, although this could change in the future. Nurse Independent Prescribers can prescribe a limited range of Controlled Drugs for specific medical conditions.

Comparison with Nurse Prescribers' Formulary for Community Practitioners, and Supplementary Prescribing

10. Following training incorporated into their specialist practitioner programmes, Community Practitioner Nurse Prescribers (formerly District Nurse and Health Visitor prescribers) can prescribe from the Nurse Prescribers' Formulary for Community Practitioners (formerly the Nurse Prescribers' Formulary for District Nurses and Health Visitors). This Formulary includes dressings, appliances and a limited number of medicines relevant to community nursing and specialist community public health nursing practice.
11. Supplementary Prescribers (nurses, pharmacists, physiotherapists, radiographers, chiropodists/podiatrists and optometrists) can prescribe in partnership with a doctor (or dentist). Nurse and pharmacist supplementary prescribers are able to prescribe any medicine, including Controlled Drugs and unlicensed medicines that are listed in an agreed Clinical Management Plan. All supplementary prescribers may prescribe for any medical condition, provided that they do so under the terms of a patient-specific Clinical Management Plan (CMP) agreed with a doctor.

The Plan will be drawn up, with the patient's agreement, following diagnosis of the patient. Supplementary prescribing may well still be the most appropriate mechanism for prescribing, for instance where a nurse or pharmacist is newly qualified as a prescriber or where a team approach to prescribing is clearly appropriate, or where a patient's Clinical Management Plan includes certain Controlled Drugs (see section on 'Training and preparation for independent prescribing' for further information).

Annex B – Standards for Prescribing and outline curricula for training Nurse and Pharmacist Independent Prescribers

- **Nurses**

The revised Nursing and Midwifery Council's Standards for Prescribing will be available on their website from mid April 2006.

www.nmc-uk.org

- **Pharmacists**

Royal Pharmaceutical Society of Great Britain. The outline curriculum for pharmacists will be available from later in 2006.

www.rpsgb.org.uk

Annex C – Maintaining competency in prescribing – Outline frameworks

- **Nurses**

‘Maintaining competency in prescribing – an outline framework to help nurse prescribers’

http://www.npc.co.uk/non_medical/competency_frameworks.htm

- **Pharmacists**

‘Maintaining competency in prescribing – an outline framework to help pharmacist prescribers’ will shortly be available at

http://www.npc.co.uk/non_medical/competency_frameworks.htm

Annex D - Notification of prescriber details to the Prescription Pricing Division of the NHS Business Services Authority

1. The details of Nurse or Pharmacist Independent Prescribers employed by a Community NHS Trust, PCT, GMS/PMS/APMS contractor, Walk-in Centre or Out-of-Hours Care provider must be registered with the NHS Business Services Authority (NHSBSA) before prescriptions for that prescriber can be ordered. Hospital-based prescribers should refer to Annex E, paragraph 11.
2. Notification of required details by the prescribers' employer to the NHSBSA enables the setting up of automatic monitoring processes, as well as allowing the provision of prescriber details to the supplier (currently Astron) for the printing of prescription pads.
3. Employers of all Nurse and Pharmacist Independent Prescribers practising in primary care are therefore required¹ to inform the NHSBSA of the individual Nurse or Pharmacist Independent Prescriber's details - using the NHSBSA Annex form.
4. The NHSBSA Annex form should also be used to notify the NHSBSA of changes in circumstances (e.g. name) as they occur. This form is available on the NHSBSA website at www.nhsbsa.nhs.uk

In order to avoid transposition errors, and the subsequent problems incurred, the NHSBSA Annex form should be completed electronically by the relevant personnel within each Primary Care Trust and Community NHS Trust and then either:

¹ Paragraph 8 of Schedule 2 to the NHS Act 1990 provides that "an NHS trust shall furnish to the Secretary of State such reports, returns and other information, including information as to its forward planning, as, and in such form as, he may require". In this case the Secretary of State is intending to require NHS trusts to furnish information directly to the NHS Business Services Authority, in the manner prescribed on the official proforma.

emailed to Prescription.Information@ppd.nhsbsa.nhs.uk or

printed and sent to:

*Prescription Pricing Division
NHS Business Services Authority
Scottish Life House
Archbold Terrace
Jesmond
Newcastle upon Tyne
NE2 1DB*

6. The detail asked for on the NHSBSA Annex form has been kept to a minimum, to reduce work for the employer. Collecting and transmitting the information will, however, require co-operation between the employer and the prescriber, and this should ideally be discussed at the implementation stage, if such systems are not already in place. The details asked for on the NHSBSA Annex form include the:

- Nurse or Pharmacist Independent Prescriber's "personal identification number" – provided by the NMC or RPSGB
- Nurse or Pharmacist Independent Prescriber's name and profession
- organisation for which the Nurse or Pharmacist Independent Prescriber works (where relevant)
- organisation details

Changes to prescriber details

7. It is the responsibility of employers of Nurse and Pharmacist Independent Prescribers who are registered with the NHSBSA and who are working in GMS/PMS/APMS contractor organisations, PCTs, Walk-In Centres and providers of Out-of-Hours Care, to ensure that changes to the prescriber's

details are notified to NHSBSA as soon as they occur, e.g. change of name on marriage, change of telephone number. Failure to do this will mean that prescription forms will continue to be produced with the former (incorrect) details on them.

8. GMS/PMS/APMS contractors, Walk-in Centre or Out-of-Hours Care employers of Nurse and Pharmacist Independent Prescribers in primary care should pass the prescriber's details to the relevant Primary Care Trust within 48 hours (excluding weekends or Bank Holidays). The Primary Care Trust will then be responsible for passing these details to the NHSBSA, using the NHSBSA Annex form.

Prescriber ceases employment / prescribing.

9. The employer, or the PCT in the case of community pharmacists, should inform the NHSBSA as soon as possible when a prescriber is no longer carrying out prescribing duties (for example, because he/she has changed employer, been suspended from the relevant register or had his/her approval as a prescriber withdrawn for some reason). They should do this by submitting the NHSBSA Annex form. This includes circumstances where the employer is contracted to provide services for other commissioning organisations, e.g. nursing services through a Community Practitioner Nurse Prescribing Contract.
10. PCTs should annotate their lists of Nurse and Pharmacist Independent Prescribers with the reasons for any changes, to ensure that an up-to-date record exists.

Annex E – Prescription Forms

1. All prescription forms require information to be entered on them (by printing or writing or a combination of both). In addition to the correct dispensing of the items prescribed, this allows for prescribing information and costs to be attributed to the correct prescriber and / or organisation, as well as to the correct prescribing budget.

PRESCRIBING IN PRIMARY CARE

Ordering prescription forms

2. Employers should note that prescription forms are not sent out automatically. PCTs should order FP10 prescriptions from the supplier (Astron). Prescriptions should also be re-ordered from Astron as and when required.
3. Orders for a new prescriber's prescription forms should not be placed earlier than 42 days prior to the date the individual is scheduled to begin prescribing for your organisation, as Astron cannot access NHSBSA data before this point.
4. Allow at least 6 working days between notifying changes to the NHSBSA and ordering prescriptions. This will allow time for data input and transmission of updated data files to Astron. Details on orders must match NHSBSA data held by Astron. If you order too quickly after changing the details – the order may be rejected; any orders based on details which conflict with data held by Astron will be rejected for security reasons.
5. Prescriptions are normally sent to the address of the person who orders them (you can specify an alternative address for invoicing purposes).

Checks are made to ensure that FP10 prescriptions are only supplied to bona-fide NHS organisations. Difficulties with prescription orders should be addressed, in the first instance, to Astron.

Prescription forms FP10P pre-printed by Astron.

6. The top of the prescribing area will be overprinted to identify the type of independent prescriber eg:
 - NURSE INDEPENDENT/SUPPLEMENTARY PRESCRIBER
 - PHARMACIST INDEPENDENT/SUPPLEMENTARY PRESCRIBER

7. The address box will be overprinted to identify:
 - the Nurse or Pharmacist Independent Prescriber,
 - the organisation they are prescribing on behalf of, and
 - for those Nurse or Pharmacist Independent Prescribers who are directly employed by a PCT or prescribing through a Community Practitioner Nurse Prescribing Contract - a space for the relevant practice number to be added for each patient for whom they prescribe (Astron printed prescriptions only). If the prescription is printed by a GP system, the practice code will be printed in the relevant place.

8. Information about prescription overprinting and single sheet versions of the FP10P is available on the Department of Health web page www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/NHSEnglishPrescriptionForms/fs/en and the NHS Business Services Authority web page at www.nhsbsa.nhs.uk

9. Any prescriber who works for more than one employer or in more than one setting e.g.

- i) – PCT directly employed prescriber, providing services to patients in the PCT and
- ii) – the same prescriber providing services to patients outside the PCT area, through a contract

must have separate prescription pads for each organisation / or use FP10SS prescriptions, printed with the correct organisation details in the prescriber details area of the prescription form.

PRESCRIBING BY HOSPITAL-BASED NURSE AND PHARMACIST INDEPENDENT PRESCRIBERS

10. Nurse and Pharmacist Independent Prescribers prescribing for hospital in-patients or outpatients may use three methods to prescribe:

- Hospital in-patient prescription form or sheet – to be used for in-patients and discharge supplies only. A prescription charge is not levied for in-patients.
- Internal hospital prescription form – to be used for outpatients but only in cases where the hospital pharmacy will dispense the prescription. A prescription charge may be payable, unless the patient is exempt from prescription charges. **(NB internal hospital forms cannot be accepted for dispensing by community pharmacies).**
- FP10 type prescription forms, **where the medicine will be prescribed by a hospital prescriber and dispensed in a community pharmacy**. (Note: the Prescriber's employer should establish a local policy on the use of prescription forms in these circumstances.)

11. There is currently no requirement to notify the NHSBSA of details of hospital-based Nurse or Pharmacist Independent Prescribers, or changes to their details.

Ordering prescription forms

12. Managers of hospital-based Nurse and Pharmacist Independent Prescribers should order FP10 forms as required. **FP10** type prescriptions for a hospital-based nurse or pharmacist prescriber should conform to community pharmacy and NHSBSA processing requirements and be printed with prescribing account codes approved by the NHSBSA. Where possible, the prescription form should also identify the type of prescriber at the top of the prescribing area eg

- NURSE INDEPENDENT/SUPPLEMENTARY PRESCRIBER
NMC PIN or
- PHARMACIST INDEPENDENT/SUPPLEMENTARY PRESCRIBER
RPSGB No or

For further details of what should be stamped / printed on these forms prior to issue to the prescriber and the latest guidance on form use for hospital-based prescribers, see DH web site

www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/NHSEnglishPrescriptionForms/fs/en or the NHSBSA website at www.nhsbsa.nhs.uk

NON-NHS EMPLOYEES

13. A non-NHS Nurse or Pharmacist Independent Prescriber cannot issue an FP10 type prescription, i.e. one which will be dispensed in a NHS community pharmacy, unless the organisation they work for has an arrangement /

contract with an NHS provider (e.g. PCT) which allows the non-NHS organisation to use NHS community pharmacy dispensing services. The NHS provider should organise the supply of FP10 type prescription forms (and obtain the prescribing code(s) to be used) for their non-NHS organisation, if this is appropriate.

HOW TO COMPLETE THE PRESCRIPTION FORM

14. Detailed advice on prescription writing is contained in the British National Formulary (BNF) and the Nurse Prescribers' Formulary.

15. Details required on the front of the prescription form (to be entered by writing clearly and legibly using an indelible pen - preferably black or, where possible, by printing using a computer prescribing system) are as follows:

- the patient's title, forename, surname and address (including postcode) and if available the patient's NHS number.
- Age and date of birth (must be printed by computer prescribing systems; for hand written prescriptions - enter if known e.g. from patient notes - BUT it is a legal requirement to write the patient's age on the prescription when prescribing Prescription Only Medicines for a child under twelve years of age).
- for prescribing in primary care and in the community, the prescription should contain the name of the prescribed item, formulation, strength (if any) dosage and frequency, and quantity to be dispensed. The name should reflect the description in the 'NHS dictionary of medicines and devices (NHS dm+d), the NHS standard for naming medicines and devices. The NHS dm+d website address is www.dmd.nhs.uk The quantity prescribed should be appropriate to the patient's treatment needs, bearing in mind the need to avoid waste. Some medicines are only

available in patient packs (or multiples thereof)^{2 3} and special containers⁴ and the quantity contained should be prescribed, provided this is clinically and economically appropriate. The quantity should be specified for solid preparations as number of dose-units (number of tablets, capsules, lozenges, patches etc), for liquid measures in millilitres (mL or ml or litres), for topical preparations by mass (grams, g) or volume (millilitres, mL or ml). Terms such as “1 Pack” or “1 OP” should not be used. Alternatively, for preparations to be given at a fixed dose and interval, the duration(s) of treatment can be given in place of quantity to be dispensed.

- In hospitals, prescriptions for in-patients should contain the name of the prescribed item, formulation, strength (if any), dosage and frequency. Where a defined length of treatment is required, this should be stated. For outpatients and discharge prescriptions, the requirements are the same as those for primary/community care, whilst recognising local policies for example on the length of treatment provided for outpatients and patients who are being discharged.
- The names of medicines should be written clearly following NHS dm+d descriptions. **Nurses and pharmacists are recommended to prescribe generically, except where this would not be clinically appropriate or where there is no approved generic name** – see the Nurse Prescribers’ Formulary for Community Practitioners, the BNF and the Drug Tariff. Names of medicines and generic titles should not be abbreviated. Exceptions to this rule are for the prescribing of some dressings and

² A patient pack is a manufacturer's pack approved by the Licensing Authority which has a label and leaflet and contains an amount of medicine such that the pack is capable of being given whole to a patient to meet all or part of a treatment course. For some medicines, special packs containing smaller quantities will be available for starter/titration/trial purposes.

³ In the BNF, pack size is indicated as in this example "Net price 60-tab pack=£2.25". Wherever no pack size is indicated, as in "Net price 20=9p, the quantity is shown for price comparison purposes only.

⁴ A special container is a pack from which it is not practicable to dispense an exact quantity, or a pack with an integral means of application. This currently includes sterile preparations, effervescent or hygroscopic products, liquid preparations which are intended to be added to bath water, coal tar preparations, viscous preparations and all products packaged in casters, tubes, dropper bottles, aerosols, puffers, roll-on packs, sachets, sprays, shakers, squeeze packs.

- appliances, and of compound or modified release medicines which have no approved non-proprietary name.
- directions, which should be in English and not abbreviated.
 - where there is more than one item on a form, a line should be inserted between each item for clarity.
 - unused space in the prescription area of the form should be blocked out with, for example, a diagonal line (to prevent subsequent fraudulent addition of extra items).
 - Prescriber's signature and date.
 - on hospital prescriptions only: the Nurse or Pharmacist Independent Prescriber's name printed or hand written in the box provided - to ensure that the dispensing pharmacist is aware who to contact if s/he has a query.

Security and safe handling of prescription forms: good practice

16. The security of prescription forms is the responsibility of both the employing organisation and the prescriber. It is advisable to hold only minimal stocks of the prescription forms. This reduces the number lost if there is a theft or break-in, and also helps to keep prescription forms up-to-date - they are normally revised annually.
17. The prescriber's employer should record the serial numbers of prescriptions received and subsequently issued to an individual prescriber, surgeries, clinics etc.
18. Local policy should be established on monitoring the use of prescription forms to deter the creation of fraudulent prescriptions.
19. The prescriber should also keep a record of the serial numbers of prescriptions issued to him or her. The first and last serial numbers of pads should be recorded. It is also good practice to record the number of the first

remaining prescription form of an in-use pad, at the end of the working day. Such steps will help to identify any prescriptions that are either lost or stolen overnight.

20. Blank prescription forms must **NOT** be pre-signed, to reduce the risk of misuse should they fall into the wrong hands. In addition, prescription forms should only be produced when needed, and never left unattended. Prescription forms should not be left on a desk, but rather placed in a locked drawer.
21. Best practice recommends that where possible, all unused forms should be returned to stock at the end of the session or day. It is strongly recommended that this happens in practice. Blank prescription forms should not be left in cars, desks or bags, to help ensure their security. Prescriptions are less likely to be stolen from (locked) secure stationery cupboards than from desks, bags or cars.

Loss of prescription forms

22. Astron (not the NHSBSA) should be contacted about prescriptions ordered, but not received. The NHS Counter Fraud and Security Management Division of the NHSBSA should only be notified if missing items are not found.
23. All prescribers working in primary care should report any loss or theft of prescription forms to the local counter-fraud specialist at the PCT, as soon as possible after the theft/loss is confirmed. The prescriber should give details of the approximate number of prescriptions stolen, their identification numbers, and where and when they were stolen.
24. In consultation with regional or national counter-fraud operational teams where appropriate, the PCT/NHS local counter- fraud specialist at the trust should notify local pharmacists and decide upon any necessary action to

minimise the abuse of the forms. The local counter-fraud specialist at the PCT/NHS trust should also inform the Compliance Unit at the NHS Counter Fraud and Security Management Division of the NHSBSA.

25. Following the reported loss of a prescription form, the PCT will normally tell the prescriber to write and sign all prescriptions in a particular colour (usually red) for a period of 2 months. The PCT will inform all pharmacies in their area and adjacent PCTs of the name and address of the prescriber concerned; the approximate number of prescription forms stolen and the period within which the prescriber will write in a specific colour. This will normally be put in writing within 24 hours - with the exception of weekends.

26. In the event of a loss or suspected theft, an NHS trust-employed prescriber should also report this immediately, to whoever issued the prescription forms (normally the hospital pharmacy). They will inform the local counter-fraud specialist at the trust. The prescriber should give details of the number of prescription forms stolen, their serial numbers, and where and when they were stolen. Thereafter, hospital-based prescribers should follow local instructions following the loss or theft of prescription forms - this may also include writing and signing all prescriptions in a particular colour (usually red) for a period of two months.

27. It is the responsibility of the employer to ensure that:

- prescription pads are retrieved from prescribers who leave their employment for whatever reason. NB Prescription pads should be securely destroyed, e.g. by shredding and putting into confidential waste. It is advisable to record first and last serial numbers of the pads destroyed. Failure to recover prescription forms may potentially incur a cost, as any item prescribed on forms after prescribers have left employment would still be charged to the appropriate budget.

- no further prescription pads are ordered for a prescriber who has left his/her employment or who has been suspended from prescribing duties, and all unused prescription forms are recovered, recorded and securely destroyed relating to that prescriber.

NB All of the above requirements highlight the need for clear channels of communication, particularly between GP practices/PMS pilots and PCTs.

Annex F – Good Practice Examples of Non-Medical Prescribing Clinical Governance Frameworks

1. The Royal Pharmaceutical Society of Great Britain's document entitled 'Clinical governance framework for pharmacist prescribers and organisations commissioning or participating in pharmacist prescribing (GB wide)' is available at:

<http://www.rpsgb.org/pdfs/clincgovframeworkpharm.pdf>

2. Trent Strategic Health Authority's 'Non-medical Prescribing Clinical Governance Framework' (see pages 54 - 56)
3. North and East Yorkshire and Northern Lincolnshire's 'Non-Medical Prescribing - An Outline Governance Framework for Local Organisations' (see pages 57 - 64)

Non-medical Prescribing Clinical Governance Framework

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Trent Multi-Professional Deanery

Chris Orme
Head of Clinical Governance
Trent SHA

Patient Experience and involvement

The Trust should demonstrate:

- Patient information is available outlining Non-medical prescribing.
- Patient forums have been informed about the development of Non-medical Prescribing.
- Mechanisms are being developed to support concordant consultations
- Increased patient choice and access to appropriate health professionals.

Use of information

The Trust should demonstrate:

For Non-medical prescribers that:

- Co-ordinated systems are in place to ensure all non-medical prescribers are kept informed of all the relevant clinical information, i.e. changes with immediate effect, Drug alerts. Hazard warnings
- Information is available to individuals regarding their prescribing practice (PACT data).
- Prescribers are aware of the importance of using the yellow card system to report Adverse Drug Reactions. (ADRs)
- Prescribers are aware of the importance of reporting untoward incidents to the PCT and to the NPSA.
- Information is disseminated on the Trust policy regarding involvement with the Representative of the Pharmaceutical Industry.

For the Trust

- A co-ordinated system/ database is kept listing all prescribers and their status

- Health Visitor/District Nurse HV/DN,
- Extended Formulary Nurse Prescriber/Nurse Supplementary Prescriber EFNP/NSP,
- Pharmacist Supplementary Prescriber, PSP,
- Extended Formulary Nurse Prescriber, EFNP
- Allied Health Professional Supplementary Prescriber
- Optometrist Supplementary Prescriber
- Systems are in place to inform Non-Medical Prescribing lead in the Trust when new prescribers are employed and prescribers leave.
- A system is in place for the ordering and safe distribution of prescription pads to prescribers.
- A system is in place to retrieve prescription pads when staff leave the organisation
- A contact point within the Trust for any queries on the prescribing status of staff. i.e. from dispensing pharmacists
- Structures for organisational use of PACT data to monitor prescribing trends.

- System for receipt of information from the Education Development Manager (Non-medical Prescribing) and the University about the status of Trusts applicants to the course and results.

Processes for Quality Improvement

The Trust should demonstrate:

- A Trust Non-medical Prescribing Policy exists and is available to all Non-medical prescribers. The policy needs to include;
 - Writing prescriptions,
 - Record keeping,
 - Accountability and liability,
 - Security and safe handling of prescription pads
- The organisation has considered the impact of Non-medical Prescribing on other policies such as incident reporting, drug errors and near miss major incidents.
- Non-medical prescribing/CNST standards.
- Promotion of evidence based practice.
- Procedures are in place for ordering and distributing the latest available copy of the BNF/NPF to Non-medical prescribers
- Raise awareness of Non-medical prescribing within the organisation to Doctors, Nurses, Pharmacists and Managers by means of briefings, bulletins.
- Review the need for Trust Prescribing guidelines/protocols with regard to Clinical Management Plans for supplementary prescribing, i.e. Chronic Disease Management, Wound Care.
- Provide evidence of monitoring the implementation of Clinical Management Plan development.

- Assessment of the potential need for Non-medical prescribing within the Trust.
- Reduction of semi-legal or illegal practices involving prescribing medications, i.e. pre-signed prescriptions, issuing stock supplies.
- Evidence of how the organisation will address competency issues.
- Clinical Audit of Non-medical Prescribing.

Staff Management

The Trust should demonstrate:

- Effective infrastructures to develop, implement and monitor non-medical prescribing.
- Job descriptions are amended to account for prescribing responsibilities.
- An SLA or written agreement for staff employed or contracted to work in the Trust that they will follow Trust guidelines and Clinical Governance requirements.
- All non-medical prescribing staff receive an annual appraisal with reference to prescribing.
- Effective systems are in place to provide Continuous Professional Development – Multi-professional might be an option in the future.
- Ethical consideration of pharmacist prescribing and dispensing activity for Community Pharmacists.

Leadership Strategy and Planning

The Trust should demonstrate that:

- A Non-medical Prescribing lead in each Trust, regularly attends steering group meetings held in each locality with the Education Quality Manager (Non-medical Prescribing) from the Multi Professional Deanery.
- A clear organisational structure exists with the Trust Non-medical Prescribing lead reporting directly to the Professional Executive Committee and to the Board.
- Local Delivery Plans reflect the development of Non-medical prescribing.
- Consider Non-medical prescribing within service development in response to the GMS contract.
- An assessment of the suitability of those wishing to access the course takes place, i.e. are they working in a position that requires them to be a prescriber? Are they willing to prescribe once qualified?

Non-Medical Prescribing An Outline Governance Framework for Local Organisations

Michele Cossey- Clinical Development Manager Pharmacy & Prescribing
NEYNL WDC

The development of non-medical prescribing (NMP) is a key policy initiative that aims to maximise benefits to patients and the NHS by:

- Providing better access to medicines and
- Better, more flexible use of the workforce skills

As NMP is rolled out nationally and locally it is important that all those involved understand the responsibilities of individual practitioners, managers and organisations in ensuring safe and effective implementation and practice of NMP.

Ensuring patient safety is an integral part of all healthcare providers' clinical governance arrangements⁵.

The Department of Health (DH) have set out key steps for NHS organisations to have in place to ensure the implementation of clinical governance^{6 7 8}.

These include:

- Clear lines of responsibility and accountability for overall quality of clinical care
- Development of quality improvement programmes
- Management of risk
- Clear procedures to identify and remedy poor performance.

This NEYNL wide ***Non-medical Prescribing Governance Framework*** sets out the key elements that organisations and individual practitioners should have in place or be in the process of addressing, in order to ensure that the development of NMP is implemented within a mechanism that develops safe and effective practice.

The Framework should be read in conjunction with any policies and procedures that local organisations have in place for implementing NMP or any general policies related to prescribing and medicines management. It

⁵ Building a safer NHS for patients: implementing an organisation with a memory. DoH 2001

⁶ Clinical Governance: Quality in the new NHS. HSC 1999/065

⁷ Clinical Governance Guidance WHC(99)54

⁸ Clinical Governance MEL(98)75

should also be read in conjunction with any national or professional guidance issued by regulatory bodies for any of the non-medical professions eligible to train as prescribers. (Nurses, Pharmacists, Optometrists, Allied Health Professionals (AHPs) – currently physiotherapists, podiatrists, and radiographers).

1.Organisational Leadership and strategy for Non-medical Prescribing (NMP)

<p>Overarching statement:</p> <p><i>Clear lines of responsibility and accountability exist for all organisations in relation to the leadership, planning and implementation of NMP</i></p>	
<p>Governance arrangements required by organisations:</p>	<p>a) All organisations have a nominated named lead (or leads) for overseeing the development and implementation of NMP. Where different professional leads are in place co-ordination / networking between these leads is required to ensure consistency of approach to implementation and monitoring. NMP should be linked into organisation prescribing and medicines management arrangements within the organisation where appropriate.</p>
	<p>b) Organisations should have in place an integrated policy around the strategic development and implementation of NMP. This should include: named leads for NMP, stakeholder and patient/public awareness initiatives, implementation plans for NMP, advice about training, internal arrangements for monitoring, mechanisms for application and training, processes for obtaining prescription pads, signposting to any relevant policies and procedures and any other relevant local information.</p>

Overarching statement:

Clear lines of responsibility and accountability exist for all organisations in relation to the leadership, planning and implementation of NMP

	<p>c) A co-ordinated database or register of all trained non-medical prescribers should be maintained within all organisations. (For PCTs this should cover PCT employed and independent contractor employed staff). This database record all newly qualified prescribers; those employed by the PCT/Trust and should note those NMPs who leave the organisation. It should also note the designated status of all NMPs (e.g. Community Practitioner Formulary, Extended Formulary, Supplementary Prescriber) and the profession of the prescriber i.e. nurse, pharmacist, physiotherapist, radiographer podiatrist or optometrist.</p>
<p><i>Governance arrangements required by organisations (cont):</i></p>	<p>d) Non-medical prescribing is an integrated part of organisational clinical governance arrangements and relevant Action Plans. Organisations must consider the impact of NMP on other related policies and procedures e.g. drug error reporting.</p>
	<p>e) All planned developments for NMP should be linked to strategic service development within the organisation For example: Long term conditions, improved access to medicines and services, practice based commissioning; service modernisation and redesign.</p>

Overarching statement:

Clear lines of responsibility and accountability exist for all organisations in relation to the leadership, planning and implementation of NMP

	<p>f) Decisions to train individuals as NMPs should be linked to Personal Development Plans and candidates should be assessed for competency related to knowledge and skills in their area of potential prescribing practice. Competency Frameworks for NMPs are available from the National Prescribing Centre at www.npc.co.uk/</p> <p>*(Note: it is not intended that individuals are competent to “prescribe” prior to training but organisations should be assured that practitioners have the necessary clinical skills and knowledge in their area of practice which will enable them to prescribe safely and effectively once trained OR that CPD and additional training is planned to ensure these can be met. Organisations should also check that individuals would meet the necessary Higher Educational Institute (HEI) entry requirements).</p>
	<p>g) All plans to train NMPs should also include an assessment of: service specification, access to a prescribing budget (or equivalent in acute Trusts / secondary care), development of necessary policies or documentation e.g. Clinical Management Plans (CMP)</p>
	<p>h) Links should exist between NHS organisations, HEIs and commissioners of training (SHA/WDCs) to ensure effective monitoring of applications, funding, quality of training and monitoring of numbers and professions trained and attrition rates from modules.</p>
	<p>i) Ongoing support and network arrangements are in place for all NMPs including access to relevant CPD.</p>

2. Information governance and risk management of NMP

Overarching statement:	
Clear policies exist or links to existing policies are explicit for all manager and NMPs in relation to information governance and risk management of NMP.	
Governance arrangements required by organisations: (See also 1c above)	a) All NMPs should be linked to all organisational or local systems to ensure prescribers are kept informed of relevant clinical, therapeutic and prescribing information e.g. MHRA alerts, Adverse Drug Reaction reports etc.
	b) NMP practice is monitored through the same routes as medical prescribing (e.g. PACT data systems, audit and feedback in primary care, local mechanisms in acute Trusts) and that information is available to individual practitioners and managers where appropriate and in line with internal arrangements.
	c) All NMPs are aware of the importance and know how to report ADRs via the national Yellow Card system
	d) All NMPs understand the importance of reporting Serious Untoward Incidents (SUIs) and are aware of the local mechanisms for doing this as well as the NPSA systems of reporting.
	e) NMP should be aware and adhere to the PCT/Trust policy regarding relationships with the Pharmaceutical Industry
	f) All record keeping guidance and protocols/templates for prescribing practice are updated regularly as detailed within PCT/Trust policies e.g. CMPs should be revisited and amended where necessary at least annually
Governance arrangements required by organisations (cont):	g) All medical prescribers should be aware of NMPs within the organisation and when and how they may interact with patients to ensure consistency of record keeping and continuity of patient care.

Overarching statement:	
Clear policies exist or links to existing policies are explicit for all manager and NMPs in relation to information governance and risk management of NMP.	
	h) Organisations should keep records of prescription pad numbers linked to prescriber name for tracking any lost or stolen prescriptions, where prescription pads are used (Acute Trusts use prescription charts). This includes for any OOH services or Walk-in-Centres. (GP practices should do this for practice nurses as they order them directly).
	i) Organisations should review their policies related to medico-legal accountability and information made clear to NMPs regarding accountability, vicarious liability and personal indemnity. (Practitioners should also be advised to contact their professional regulatory bodies).
	j) Organisations should have systems in place for identifying poor professional performance (as for other prescribers) and prescribing should be considered as part of this process and effective action taken.

3. Audit and Quality Improvement

Overarching statement:	
Mechanisms should be in place to include NMP in relevant audit. Audit cycles and review processes should be employed to ensure that the implementation and development of NMP is progressing in a safe and effective manner that is benefiting patients and services.	
Governance arrangements required by organisations:	a) All review and updating of PCT/Trust prescribing and medicines supply policies include an impact assessment of NMP and are revised accordingly.
	b) All CMPs used by Supplementary Prescribers are reviewed (at least annually but more frequently where changes to policy or evidence dictate) to ensure they are based on sound clinical evidence and are safe and cost effective.

Overarching statement:	
Mechanisms should be in place to include NMP in relevant audit. Audit cycles and review processes should be employed to ensure that the implementation and development of NMP is progressing in a safe and effective manner that is benefiting patients and services.	
	c) All NMP practice should be integral part of prescribing policy audit including adherence to NICE Guidance, National Clinical Guidelines and any relevant local or national prescribing and medicines management policies.
	d) Evidence of tracking and monitoring arrangements should be in place to ensure the continuing competency of NMPs and their access to relevant, appropriate CPD.

4. Patient and Public Involvement

Overarching statement:	
<i>There should be mechanisms in place in organisations to ensure patients and public are aware of NMP practice and have a say in any related developments or audit of NMP services.</i>	
<i>Governance arrangements required by organisations:</i>	a) Patients and the public should be made aware of any developments in NMP which may alter services in order that they can make informed choices and understand what NMP means for them and the delivery of their care. E.g. nurses / pharmacists/ AHPs, providing prescriptions and prescribing in the community or GP Practices.
	b) Methods to include patient and public comments in any NMP service review should be standard practice within all PCTs/Trusts
	c) Patient / Public information should be available in all PCTs/Trusts outlining what NMP is, what it means for patients and any specific services where NMP is being used in that area.
	d) Patient Public Involvement forums should be briefed about NMP where relevant and

Overarching statement:

There should be mechanisms in place in organisations to ensure patients and public are aware of NMP practice and have a say in any related developments or audit of NMP services.

appropriate and information provided in a useable format.

5. Responsibilities of Individual NMP Practitioners

Whilst it is understood that organisations need to have robust governance arrangements in place for their NMP staff, individual practitioners have responsibility for ensuring they are clinically competent for their role, undertake appropriate CPD, practice within the law and any agreed local policies and abide by their relevant professional regulatory body's Code of practice or ethics.

Guidance for prescribing practice and relevant standards are outlined by the NMC (for nurses) and the RPSGB (for pharmacists) and can be accessed via the following web addresses below.

<http://www.nmc-uk.org>

<http://www.rpsgb.org/pdfs/clincgovframeworkpharm.pdf>

The National Prescribing centre (NPC) has published competency frameworks for NMPs, which should be used by organisations, managers and individuals) to assess competence to prescribe. They also publish useful information for NMPs and regular therapeutic updates. These documents and other information can be accessed via the web link below.

http://www.npc.co.uk/non_medical.htm

The Department of health (DH) has also published guidance on implementing NMP for organisations as well as Frequently Asked Questions (FAQs) related to specific enquiries and this information can be found via the web link below:

<http://www.dh.gov.uk/nonmedicalprescribing>

Annex G – Controlled Drugs

Nurse Independent Prescribers can prescribe any licensed medicine for any medical condition, including some Controlled Drugs. Nurse Independent Prescribers are able to prescribe the following list of Controlled Drugs, solely for the medical conditions indicated:

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

Details of the appropriate route of administration for these Controlled Drugs can be found in the table below:

Substance	Route of administration
Buprenorphine	Transdermal administration in palliative care
Chlordiazepoxide hydrochloride	Oral
Codeine phosphate	Oral
Co-phenotrope	Oral
Diamorphine hydrochloride	Oral or parenteral
Diazepam	Oral, parenteral or rectal

Substance	Route of administration
Dihydrocodeine tartrate	Oral
Fentanyl	Transdermal administration in palliative care
Lorazepam	Oral or parenteral
Midazolam	Parenteral or buccal
Morphine hydrochloride	Rectal
Morphine sulphate	Oral, parenteral or rectal
Oxycodone hydrochloride	Oral or parenteral administration in palliative care

Annex H – Prescribing Information and Advice

Nurse Independent/Supplementary Prescribers

1. DH purchases regular supplies of the British National Formulary and the British National Formulary for Children. Access to these resources is also available via the National Electronic Library for Health and the internet. Not all prescribing professionals may need their own hard copy and many may find electronic access more convenient, especially as NHS IT systems develop further.
2. The NHS Business Services Authority currently issues all nurse prescribers with a copy of the six-monthly **Drug Tariff** every six months – usually the May and November editions. See particularly Parts XVIIa and XVIIb for nurse prescribing.

N.B. The Drug Tariff is also available electronically on the internet at:

www.ppa.org.uk

Annex I - Web links for further information

- The Department of Health
www.dh.gov.uk
- The National Prescribing Centre
www.npc.nhs.uk
www.npc.co.uk
- The Medicines and Healthcare products Regulatory Agency
www.mhra.gov.uk
- The National Patient Safety Agency
www.npsa.nhs.uk
- The Nursing and Midwifery Council
www.nmc-uk.org
- The Royal Pharmaceutical Society of Great Britain
www.rpsgb.org.uk