1 Non-Medical Prescribing: An Overview

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

Following the publication of this report, the recommendations for prescribing and its implications were examined. An advisory group was set up by the Department of Health (DH) to examine nurse prescribing (DH 1989). Dr June Crown was the Chair of this group.

The following is taken from the Crown report:

> Nurses in the community take a central role in caring for patients in their homes. Nurses are not, however, able to write prescriptions for the products that are needed for patient care, even when the nurse is effectively taking professional responsibility for some aspects of the management of the patient. However experienced or highly skilled in their own areas of practice, nurses must ask a doctor to write a prescription.
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> It is well known that in practice a doctor often rubber stamps a prescribing decision taken by a nurse. This can lead to a lack of clarity about professional responsibilities and is demeaning to both nurses and doctors. There is wide agreement that action is now needed to align prescribing powers with professional responsibility. DH (1989)

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

> Suitably qualified nurses working in the community should be able, in clearly defined circumstances, to prescribe from a limited list of items and to adjust the timing and dosage of medicines within a set protocol. DH (1989)

The Crown report identified several groups of patients that would benefit from nurse prescribing. These patients included: patients with a catheter or a stoma; patients suffering with postoperative wounds; and homeless families not registered with a GP. The report also suggested that several other benefits would occur as a result of nurses adopting the role of prescriber. As well as improved patient care, these included improved use of both nurses' and patients' time and improved communication between team members arising because of a clarification of professional responsibilities (DH 1989).

During 1992, the primary legislation permitting nurses to prescribe a limited range of drugs was passed (Medicinal Products: Prescription by Nurses etc. Act 1992). The necessary amendments were made to this Act in 1994 and a revised list of products available to the nurse prescriber was published in the Nurse Prescribers' Formulary (NPF). In 1994, eight demonstration sites were set up in England for nurse prescribing. By the spring of 2001, approximately 20 000 DNs and HVs were qualified as independent prescribers. Later extensions (Nursing and Midwifery Council (NMC) 2005; 2007a) enabled any community nurse (including those without a specialist practitioner qualification) to prescribe from this formulary. Training for nurses with a specialist practitioner qualification (V100) is typically 4 days in duration and integrated into the qualifying programme for specialist community practitioners, that is DNs, public health nurses (previously known as HVs) and school nurses. Training for community staff nurses without a specialist qualification in community nursing (V150) comprises a stand-alone course of 10 days' duration (NMC 2018), requires no qualified experience and can be accessed by any first-level registered nurse (NMC 2018). Products available in the NPF include: laxatives; antifungal preparations; emollients; some analgesics, for example aspirin, paracetamol and ibuprofen; nicotine replacement products; anthelmintics and insecticides; catheter management preparations; stoma appliances; and wound dressings and management products (Joint Formulary Committe 2021).

Most studies that have explored prescribing by DNs and HVs were undertaken over a decade ago. The available research indicates that patients are as satisfied, and sometimes more satisfied, with a nurse prescribing as they are with their GP (Luker et al. 1998). The quality of the relationship that the nurse has with the patient, the accessibility and approachability of the nurse, the style of consultation and information provided and the expertise of the nurse are attributes of nurse prescribing viewed positively by patients (Luker et al. 1998). Nurse prescribing enables doctors and nurses to use their time more effectively and treatments are more conveniently provided

(Brooks et al. 2001). Time savings and convenience (with regards to not seeing a GP to supply a prescription) are benefits reported by nurses adopting the role of prescriber (Luker et al. 1997). Furthermore, nurses are of the opinion that they provide the patient with better information about their treatment and have reported an increased sense of satisfaction, status and autonomy (Luker et al. 1997; Rodden 2001). More recent evidence (Courtenay et al. 2018) has identified that community nurses value prescribing as an important element of their role, with nurses managing a range of chronic and more acutely focused conditions and health promotion activities for which they consider it is important that they can prescribe. An array of factors has also been shown to influence community nurses' decisions to prescribe (Chater et al. 2019), including knowledge and skills, professional confidence and identity as a prescriber, cost and time allocated to consultations.

Apart from community nurse prescribing, medication legislation in the United Kingdom (Medicines Act, 1968, c.67) meant that medication provision was predominantly restricted to medical doctors until 2001. However, the introduction of patient group directions (PGDs) in 2000 (DH 2000) permitted appropriately trained non-medical healthcare professionals to independently supply and/or administer specific medication for patients who present with predetermined medication requirements. Patient group directions, which are less flexible than independent prescribing, allow pre-specified groups of locally trained and assessed healthcare professionals to autonomously provide medication in specific circumstances.

Independent Prescribing

It was not until 2001, following a further report by Crown (DH 1999), that, in addition to community nurses, other appropriately qualified non-medical healthcare professionals were able to adopt independent prescribing capability. Independent prescribing, in contrast to PGDs, requires healthcare professionals to be responsible for the assessment, diagnosis and decisions about the clinical management of patients' health-related conditions (DH 2001).

In 2001, funding was made available for other nurses, as well as those currently qualified to prescribe, to undergo the necessary training to enable them to prescribe from an extended formulary.

This formulary included:

- one hundred and twenty prescription-only medicines (POMs) enabling nurses to prescribe for a number of conditions listed within four treatment areas: minor ailments, minor injuries, health promotion and palliative care;

- general sales list (GSL) items, i.e. those that can be sold to the public without the supervision of a pharmacist, used to treat these conditions; and
- pharmacy (P) medicines, i.e. those products sold under the supervision of a pharmacist, used to treat these conditions.

A number of medicines and conditions were added to this formulary between 2003 and 2005 (including medicines for emergency and first-contact care) until, in 2006, legislation was passed (DH 2005a) enabling nurses to independently prescribe any licensed medicines for any condition within their area of competence and a number of controlled drugs.

Independent prescribing for pharmacists was introduced in 2006 (DH 2005a) and, in 2009, further changes in legislation enabled nurse and pharmacist independent prescribers to prescribe unlicensed medicines for their patients and also to mix medicines themselves or direct others to do so (Medicines and Healthcare products Regulatory Agency (MHRA) 2009). Independent prescribing was later extended to include optometrists (DH 2007), physiotherapists, podiatrists/chiropodists (DH 2013), therapeutic radiographers (National Health Service (NHS) 2016) and paramedics (NHS 2019). Restrictions around controlled drug (CD) prescribing for nurses and pharmacists were lifted in 2012 (NMC 2012) enabling nurses and pharmacists to prescribe virtually any CDs.

Supplementary Prescribing

The introduction of a new form of prescribing for professions allied to medicine was suggested in 1999 (DH 1999). It was proposed that this new form of prescribing, i.e. 'dependent prescribing', would take place after a diagnosis had been made by a doctor and a clinical management plan (CMP) drawn up for the patient. The term 'dependent prescribing' has since been superseded by 'supplementary prescribing'.

Supplementary prescribing is 'a voluntary prescribing partnership between an independent prescriber (doctor or dentist) and a supplementary prescriber (SP) (e.g. nurse or pharmacist) to implement an agreed patient-specific CMP with the patient's agreement' (DH 2002). Patients with long-term medical conditions such as asthma, diabetes or coronary heart disease, or those with complex pharmacological needs such as those on psychiatric medication, are most likely to benefit from this type of prescribing.

Supplementary prescribers are able to prescribe:

- all GSL and P medicines, appliances and devices, foods and other borderline substances approved by the Advisory Committee on Borderline Substances;
- all POMs (including CDs);
- 'off-label' medicines (medicines for use outside their licensed indications);

- 'black triangle' drugs and drugs marked 'less suitable for prescribing' in the British National Formulary (BNF); and
- unlicensed drugs.

Training for supplementary prescribing was introduced in 2003 for nurses and pharmacists (DH 2002), in 2005 for optometrists, physiotherapists, podiatrists/chiropodists and radiographers (DH 2005), 2016 for dietitians (NHS 2016) and 2019 for paramedics (NHS 2019). Training is based on that for independent prescribing (see below).

Educational Preparation for Independent/Supplementary Prescribers

The independent and supplementary prescribing training programme can be accessed by first-level registered nurses with 1 year's qualified experience (NMC 2018), by pharmacists with 2 years' qualified experience (General Pharmaceutical Council (GPhC) 2019) and allied health professionals (AHPs) with 3 years' qualified experience (Health and Care Professions Council (HCPC) 2018). Some prescribing knowledge and skills have now been moved into nurse undergraduate education programmes (NMC 2018) and, if reforms in pharmacy take place (GPhC 2020), new pharmacist registrants will be independent prescribers (see Chapter 15 for further information).

The prescribing programme comprises at least 26 days in the classroom (for distance learning programmes, 8 taught days must be included in the programme) and 12 days in practice with a designated prescribing practitioner. Courses generally run over 3–6 months, but must be completed within 1 year. Topics taught include:

- consultation skills;
- influences on the psychology of prescribing;
- prescribing in a team context;
- clinical pharmacology;
- evidence-based practice;
- legal, policy and ethical aspects;
- professional accountability and responsibility; and
- prescribing in the public health context.

Conclusion

The initial development of non-medical prescribing was slow. It was first considered by the Government for nurses in 1986 with community nurses now able to

independently prescribe from a restricted formulary. Between 2002 and 2016 policy changes were rapid with a range of non-medical healthcare professionals now able to independently prescribe virtually the same medicines as medical prescribers.

The delivery of healthcare within the United Kingdom is constantly changing. In order to ensure the survival of the NHS, and the development of future services, the skills of practitioners must be used appropriately. This means that where practitioners have the knowledge and skills with regards to the adoption of roles such as prescribing, and patients are happy with the services these practitioners are able to provide, they must be given the opportunity to do so.

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