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Royal Cornwall Hospitals NHS Trust

Non-Medical Prescribing Strategy

V3.0

March 2019

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1. Executive Summary

1.1. It is Department of Health policy to extend prescribing responsibilities to a range of professions to:

- Improve patient care without compromising patient safety
- Make it easier and quicker 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

1.2. Non-Medical Prescribing (NMP) helps organisations to deliver high quality care and respond to the Quality, Innovation and Productivity agenda. It offers a strategic, innovative solution to address capacity, quality, efficiency and effectiveness if used more widely within pathway redesign – this fits within the Trust's 'Our Plans 2012-17'.

1.3. This Strategy identifies here four broad priority areas for which over the next three years the Trust aims to concentrate the development of NMP roles:

- **Emergency and Urgent Care**
- **Out-of-Hours Care**
- **Care Pathways for Long Term Conditions**
- **Supporting patient flow and discharge**

1.4. The NMP Lead for the Trust is responsible for the delivery and reporting on the outcome of the strategy's implementation.

1.5. This is reported to the RCHT Medicines Practice Committee.

2. Context / Background

2.1. It is Department of Health policy to extend prescribing responsibilities to a range of professions to:

- Improve patient care without compromising patient safety
- Make it easier and quicker 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

2.2. Non-Medical Prescribing (NMP) helps organisations to deliver high quality care and respond to the Quality, Innovation and Productivity agenda. It offers a strategic, innovative solution to address capacity, quality, efficiency and effectiveness if used more widely within pathway redesign.

2.3. Non Medical prescribing provides a mechanism to meet demands for increased workforce capacity to drive increased productivity in the face of decreased resourcing.

2.4. Non-Medical Prescriber roles can increasingly be used within all clinical pathways and this is in line with the Trust's strategic direction – Our Plans 2012-17

2.5. This version supersedes any previous versions of this document.

2.6. Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The DPA18 covers how the Trust obtains, hold, record, use and store all personal and special category (e.g. Health) information in a secure and confidential manner. This Act covers all data and information whether held electronically or on paper and extends to databases, videos and other automated media about living individuals including but not limited to Human Resources and payroll records, medical records, other manual files, microfilm/fiche, pathology results, images and other sensitive data.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the 'information use framework policy', or contact the Information Governance Team rch-tr.infogov@nhs.net

3. Purpose / Objectives of this Strategy

3.1. The use of Non-Medical Prescribers allows a range of healthcare professionals to contribute to service improvement and efficiency in many ways:

- Improving access to services
- Extending patient choice
- Making it easier for patients to access medicines they need

- Improving quality and care, especially across the range of long term conditions
- Improving productivity
- Reducing waiting times
- Reducing hospital admissions
- Responding to reduced junior doctor hours and EWTD
- Delivering cost savings

3.2. This strategy will identify a clear framework for the development of non-medical prescribing (NMP) within the Trust.

4. Scope

4.1. This Strategy applies to all those involved in service redesign, from Executive level, through Divisional Management Teams to staff members working directly in clinical services who involved in looking at their own service redesign.

4.2. The RCHT Non-Medical Prescribing lead will be supported by the RCHT Medicine Practice Committee in implementing the Strategy.

5. Definitions / Glossary

5.1. There are three types of Non-Medical Prescribing:

- **Independent prescribing**
  Independent prescribing by nurses, pharmacists, physiotherapists, physician's associates, podiatrists, optometrists, orthoptists and therapeutic radiographers. (see 5.3 to 5.9 below). Independent prescribers are responsible and accountable for the assessment of patients with undiagnosed and diagnosed conditions and for decisions about the clinical management required, including prescribing.
- **Supplementary prescribing**
  Enables trained and registered nurses, pharmacists, physiotherapists, dieticians, chiropodists or podiatrists, radiographers and optometrists to prescribe any medicine including controlled drugs, within the framework of a patient- specific clinical management plan, agreed with a doctor.
- **Nurse Prescribers' Formulary for Community Practitioners**
  Community Practitioners, formerly known as District Nurses and Health Visitors, are able to prescribe independently from a more limited formulary comprising a limited range of medicines, dressings and appliances suitable for use in community settings.

5.2. To ease the burden on doctors and improve access to medicines, the Department of Health has enabled nurses, pharmacists, optometrists, physiotherapists, podiatrists and therapeutic radiographers to train as supplementary prescribers so that they can prescribe medicines, within an agreed Clinical Management Plan for a patient.

5.3. Qualified and registered **Nurse Independent Prescribers** can prescribe any medicine for any medical condition within their competence

5.4. Qualified and registered **Pharmacist Independent Prescribers** can prescribe any medicine for any medical condition within their competence

5.5. Optometrist Independent Prescribers can prescribe any licensed medicine (except for controlled drugs or medicines for parenteral (injected) administration) for conditions affecting the eye, and the tissues surrounding the eye, within their recognized area of expertise and competence.

5.6. Qualified and registered **Physiotherapy Independent Prescribers** can prescribe any medicine for any medical condition within their competence.

5.7. Qualified and registered **Podiatry and Therapeutic Radiographer Independent Prescribers** can prescribe any medicine for any medical condition within their competence.

5.8. Qualified **Physician's associate independent prescribers** can only prescribe whilst they hold and maintain registration with a regulatory body, such as, NMC/HCPC. If registration lapses then the ability to prescribe within the Trust will be revoked.

5.9. Independent Prescribers can prescribe all Licensed and Unlicensed Medicines including controlled drugs within a Clinical Trial however it must be confirmed that the trial sponsor permits this within the trial protocol. Independent Prescribers must have undergone Good Clinical Practice (GCP) training in accordance with RD&I guidance and be identified on the Delegation Log by the principal Investigator. They are also required to have undergone appropriate training regarding the trial protocol and reportable adverse events.

6. Ownership and Responsibilities

6.1. This Non-Medical Prescribing Strategy requires approval at Board level. The Accountable Director is the Executive Nurse, although the recommending committee is the RCHT Medicines Practice Committee chaired by the Medical Director.

6.2. This section defines the operational responsibilities of individuals and groups within the organisation for the Strategy to be implemented.

6.3. The **Executive Nurse** has overall responsibility for delivering the strategy and enabling its implementation.

6.4. The **RCHT Non-Medical Prescribing Lead,** reporting to the responsible Executive Director, will ensure the Strategy is championed, implemented and that its impact is monitored and reported.

6.5. The **RCHT Chief Pharmacist** has a role to support the NMP Lead in championing and implementing the strategy. Providing access to medicines expertise to support the Strategy's implementation is one key element of this support.

6.6. Divisional Management Teams are responsible for ensuring the strategy is promoted and disseminated to inform clinical teams of the opportunities NMP gives services as they are reviewed and redesigned.

6.7. Service Improvement Teams will ensure the Strategy is considered in all service redesign and development work.

6.8. Individual Non-Medical Practitioners will use the Strategy to inform their personal and professional development opportunities.

6.9. The **RCHT Medicine Practice Committee** will support the approval of the Strategy and monitor its implementation and impact

6.10. The **RCHT Non-Medical Prescribing Group** will contribute to the development and review of the Strategy and champion the strategy where they can to promote the benefits of NMP and to identify opportunities for service improvement through NMP.

7. Benefits

The following bullet points are seen as benefits to NMP:

- Improving access to services
- Extending patient choice
- Making it easier for patients to access medicines they need
- Improving quality and care, especially across the range of long term conditions
- Improving productivity
- Reducing waiting times
- Reducing hospital admissions
- Responding to reduced junior doctor hours and EWTD
- Delivering cost savings

8. Risks

The following bullet points are seen as risks to NMP:

- Inappropriate staff trained so qualifications are not maximised
- NMP role changes / promotions so qualifications are not maximised
- Staff training release time impacting on services today (student and medical supervisor)
- Historical lack of succession planning within service developments jeopardising continuity of services over time
- Services change so NMP role not required

9. The Strategy

9.1. *Non-Medical Prescribing Priorities*

9.1.1. RCHT is resolutely focused on further improving the quality and effectiveness of the care and services given to patients and it acknowledges through this Strategy that NMP can be facilitative as part of multi-professional service redesign to develop an increased range of services and clearer pathways of care for the patients we serve.

9.1.2. This Strategy identifies here four broad priority areas for which over the next three years the Trust aims to concentrate the development of NMP roles:

- **Emergency and Urgent Care**
- **Out-of-Hours Care**
- **Care Pathways for Long Term Conditions**
- **Supporting patient flow and discharge**

9.1.3. The development of these services will be supported by the latest technology e.g. electronic health care records and electronic prescribing

9.1.4. To support local teams in understanding the scope of NMP in service redesign. Appendix 3, presents a range of care pathway focused proven opportunities for NMP to stimulate thinking and challenge current practice.

10. Implementation and Action Plan

10.1. The Strategy will be disseminated by the NMP Lead to Divisional and speciality leads for staff groups linked to prescribing opportunities and to the Divisional Management Teams.

10.2. The NMP Lead has established an internal recruitment and selection process involving the Chief Pharmacist, The Head of Learning and Development, the Deputy Chair of the NMP Group and the NMP Group's Educational Lead.

10.3. Twice a year the process commences to scope services and individuals and to call for internal applications. Internal application are scrutinise by the group and evaluated against the strategic aims set out in this paper and a range of other identified individual contributory success factors to course completion.

10.4. In partnership with course providers individuals who have been prioritised are put forward for course places.

10.5. Senior nurses responsible for registered practitioners for these priority areas are required to review job descriptions and person specifications reflecting NMP as desirable / essential criteria.

10.6. Allied Health Professional (AHP) leads are required to scope their workforce developments needs in line with this strategy and liaise with the NMP Lead to promote and further develop and enhance NMP within the AHP workforce tier.

10.7. New non-medical employees to the Trust who possess an independent or supplementary prescribing qualification should be identified and support to maintain competence and effectively utilise their prescribing skills where ever they can.

11. Monitoring compliance and effectiveness

Element to be monitored	The impact of this strategy will be measured by the growth of NMP in the organisation that are effectively prescribing and that the growth of NMP is in line with the three broad priority areas (section 9.1.2)
Lead	RCHT NMP Lead
Tool	The following will be reported annually: • Recruitment profile of each NMP student intake in line with Strategy priority areas • Profile of all active NMP in RCHT
Frequency	Annual report at the end of each financial year (minimum)
Reporting arrangements	Formal report to the Medicine Practice Committee
Acting on recommendations and Lead(s)	Recommendations will be acted upon by the RCHT NMP Lead
Change in practice and lessons to be shared	The NMP Lead will use established group and forums to disseminate and share good practice.

12. Updating and Review

12.1. The NMP Lead will undertake a formal review of this Strategy every three years

12.2. The NMP lead will consider minor amendments and alterations in line with National policy and any legislative changes to the role and scope of the NMP at the appropriate time.

12.3. The NMP Group and Medicine Practice Committee will be consulted on any changes to the Strategy

12.4. The version control table will note and track Strategy changes

13. Equality and Diversity

13.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

13.2. *Equality Impact Assessment*

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1: Governance Information

Document Title	Non-Medical Prescribing Strategy V3.0					
Date Issued/Approved:	1st October 2018					
Date Valid From:	March 2019					
Date for Review:	March 2022					
Directorate / Department responsible (author/owner):	Corporate Nursing Karen Cock, Colorectal Consultant Nurse/ NMP Lead					
Contact details:	01872 255021					
Brief summary of contents	Sets out the strategic framework for the Trusts Non-Medical Prescribing workforce development in the context of National and Trust priorities					
Suggested Keywords:	Strategy; Non- Medical Prescribing; Prescribing: Service Improvement					
Target Audience	RCHT	KCCG	CFT			
	✓					
Executive Director responsible for Policy:	Executive Director of Nursing, Midwifery and AHPs					
Date revised:	1st October 2018					
This document replaces (exact title of previous version):	RCHT Non-Medical Prescribing Strategy V3.0					
Approval route (names of committees)/consultation:	Consultation: RCHT Non-Medical Prescribing group. AHP lead. Chief Pharmacist Approval: RCHT NMP Group and RCHT Medicine Practice Committee					
Divisional Manager confirming approval processes	Heather Newton Consultant Nurse Tissue Viability					
Name and Post Title of additional signatories	Iain Davidson, Chief Pharmacist					
Signature of Executive Director giving approval	{Original Copy Signed}					
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only			
Document Library Folder/Sub Folder	Clinical / Pharmacy					
Links to key external standards	CQC Outcome:					

Related Documents:	Our Plans 2012-2017 RCHT Non- Medical Prescribing Policy RCHT The Medicine Policy
Training Need Identified?	No

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
01-05-12	V1.0	New document	Frazer Underwood, Consultant Nurse / Associate Director of Nursing
01-05-15	V2.0	Tri-annual update of strategy. Minor changes made to section 5 to reflect the increasing variation of health professionals undertaking NMP training. NMP lead details updated Addition of NMP in clinical trials and Paediatric oncology	Heather Newton Consultant Nurse Tissue Viability
01-10-18	V3.0	Tri-annual update of strategy. Minor changes to add in a forth priority and including physician's associates. NMP Lead details updated.	Karen Cock Colorectal Consultant Nurse

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Initial Equality Impact Assessment Form

<table>
<tr><td colspan="6">Non-Medical Prescribing Strategy V3.0</td></tr>
<tr><td colspan="3">Directorate and service area:
Corporate</td><td colspan="3">Is this a new or existing Policy:
Existing</td></tr>
<tr><td colspan="3">Name of individual completing assessment:
Iain Davidson, Chief Pharmacist</td><td colspan="3">Telephone:
01872 255043</td></tr>
<tr><td>1. Policy Aim*

Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="5">To aid the development of Non-Medical Prescribing (NMP) across the Trust’s services.</td></tr>
<tr><td>2. Policy Objectives*</td><td colspan="5">To aid the development of Non-Medical Prescribing (NMP) across the Trust’s services.</td></tr>
<tr><td>3. Policy – intended Outcomes*</td><td colspan="5">To grow active NMP within the organisation as part of service reviews and redesign.</td></tr>
<tr><td>4. *How will you measure the outcome?</td><td colspan="5">The following will be reported annually:
Recruitment profile of each NMP student intake in line with Strategy priority areas.
Profile of all active NMP in RHCT.</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="5">Patients and staff.</td></tr>
<tr><td rowspan="3">6a Who did you consult with

b). Please identify the groups who have been consulted about this procedure.</td><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr>
<tr><td>X</td><td></td><td>X</td><td></td><td></td></tr>
<tr><td colspan="5">Please record specific names of groups

Medication Practice Committee
Non-Medical Prescribing Group</td></tr>
<tr><td>What was the outcome of the consultation?</td><td colspan="5">Strategy approved.</td></tr>
</table>

7. The Impact
Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		**X**		
Sex (male, female, trans-gender / gender reassignment)		**X**		
Race / Ethnic communities /groups		**X**		
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		**X**		
Religion / other beliefs		**X**		
Marriage and Civil partnership		**X**		
Pregnancy and maternity		**X**		
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		**X**		

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this excludes any *policies* which have been identified as not requiring consultation**. or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**		**No**	**X**

9. If you are **not** recommending a Full Impact assessment please explain why.

This assessment has shown no impact on equality.

Signature of policy developer / lead manager / director 		Date of completion and submission October 2018
Names and signatures of members carrying out the Screening Assessment	1. Iain Davidson, Chief Pharmacist 2. Human Rights, Equality & Inclusion Lead	

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust's web site.

Signed: 

Date: October 2018

Appendix 3: Examples of How Non-Medical Prescribing Is Being Used: The Impact and Benefits

Care Pathway	Examples Of How Non-Medical Prescribing Is Being Used: the Impact or Benefits	
	Example	**Impact or Benefit**
Staying Healthy	●Community pharmacists prescribe for minor ailments ●Community pharmacists run obesity, smoking cessation, sexual health, men's health and travel clinics ●Pharmacist prescribers run clinics for hepatitis B ●Nurses and pharmacists prescribing in substance misuse and rapid access services ●Sexual health services using nurse prescribers ●Contraception and sexual health services use nurse prescribers. Nurse-led clinics use prescribing where necessary to complete an episode of care ●Nurse prescribers run open access services for Chlamydia and other STIs ●Nurse prescribers working with the homeless and intravenous drug users cater for their health needs ●Nurses prescribers within weight management services use prescribing ●Family planning services use nurse prescribers	►reduce A&E attendance and unnecessary GP visits ►increase GPs' time to use their skills more effectively on complex cases ►promote adherence to treatment regimes and the uptake of screening. This helps reduce disease progression and transmission, by increasing awareness and understanding amongst patients, families and communities ►improve patient access and provide continuity of care, deliver services previously provided by doctors ►increase capacity, reduce waiting times and improve patient access ►allow women greater choice of service for fertility control and hormone replacement therapy, whilst improving access and reducing waiting times. Also helps prevent doctors' and nurses' time being used inappropriately ►ensure rapid treatment and reducing risk of further spread of infection ►prevent admission to hospital by prescribing for minor ailments, wound infections, sexually transmitted infections and also offer needle exchange services ►manage a holistic approach and extend patient choice

		►target and reduce teenage pregnancies
Maternity and Newborn	●Neonatal nurse practitioners use prescribing ●Advanced neonatal nurse practitioners as prescribers ●Liaison midwives in integrated substance misuse services prescribe 'on the spot' ●Diabetes nurse prescribers in antenatal services ●Specialist nurse prescribers in smoking cessation	►roles developed in line with the European Working Time Directive and operate at Senior House Officer level ►assess, plan, manage and prescribe for new admissions and discharges on the neonatal unit ►run the Respiratory Syncytial Virus clinic over winter and prescribe for those babies attending ►prescribe common neonatal drugs required such as vitamin K, dextrose infusions, antibiotics and iron supplementation. This makes it easier for babies to get the medicines they need in the absence of medical staff from the unit, makes better use of the skills of health professionals available and contributes to more flexible teamwork ►provide prescriptions and information to support a vulnerable and challenging caseload in both pre- and postnatal care, which includes prescribing for babies where necessary ►can initiate insulin therapy outside clinic hours which provides a specialist and timely service to protect pregnant women and their babies ►support pregnant women to stop smoking by increasing capacity and access to cessation services
Children	●Paediatric nurse prescribers in A&E ●Eczema nurse specialists provide clinics ●Children's community nurses assess those with complex health needs at home and prescribe ●Nurse specialists in CAMHS prescribe ADHD medication for children and young people ●Child health specialist nurses for epilepsy management ●Prescribing for children in palliative care ●Prescribing for treatment / chemotherapy and supportive care of paediatric oncology patients.	►Trust reconfiguration and service centralisation ensures prompt systematic paediatric assessment to allow access to appropriate timely treatment with subsequent discharge or admission ►treat and advise on the use of emollients and steroids. Reduced waiting times and better access to manage acute flare-ups has reduced the number of dermatology and GP admissions for in-patient stay. Those admitted from elsewhere are discharged quicker and followed up by nurses which avoids using GP and dermatologist

	●Nurses prescribing for asthma ●Paediatric nurse practitioners and pain management specialists prescribers	appointments ►prompt diagnosis and instigation of treatment avoids GP visits. Children with long term conditions are also seen which allows their care to be monitored and treatment modified to avoid delay in optimising treatment ►previously a service where there was reluctance from GPs to use shared care guidelines. This has increased access to services by providing community clinics, and reduced the DNA (do not attend) rates. Quality of care has improved by helping educate and support parents to improve medication compliance ►complies with NICE recommendations. Nurses help to reduce hospital admissions through telephone management and home visits, instigate timely emergency treatment on the wards to manage seizures when no doctor is present, and run clinics to increase service capacity. Reducing doctors' workload and waiting times ►allows timely access to start or modify end-of-life drug treatment. Complex symptom control is managed by clinical nurse specialists instead of GPs. Care can be continued at home. Parent education provides additional support for care ►increase capacity, increase access to medicines and reduce patient waiting times. Simultaneously consultant input to clinics has been reduced, quality of care has improved and nurse-led clinics have no DNAs ►improve the timeliness of prescribing, avoid unnecessary delays in treatment and facilitate early discharge
Planned Care	●Pharmacist prescribers ●Pharmacist and nurse prescribers in anticoagulation	►increase the speed of admission and discharge e.g. following surgery

	treat deep vein thrombosis and pulmonary emboli ●Pharmacist prescribers optimise antimicrobial use ●Physiotherapist Supplementary Prescribers in intermediate care ●Nurse prescribers support long term care of women with breast cancer ●Specialist nurses prescribing in ENT see the majority of patients with aural problems ●Haemophilia nurse prescribers manage and adjust treatment regimes ●Nutrition nurses and pharmacists as prescribers	►reduce hospital admissions or length of stay ►reduce the incidence of MRSA and clostridium difficile and reduce length of stay ►admit and discharge patients. Reduced use of call-out services to get a doctor to prescribe saves time and money, while also improving concordance ►post-operatively they ensure treatment is tailored to patient need which is monitored and managed over time in line with national guidance. In addition, women have better access to education. Greater capacity and reduced consultant input to clinics and service provision ►this allows ENT consultant time to be used for more serious conditions. Faster access to treatment relates to quicker recovery times. Previously, delays occurred which also required an additional doctor's appointment for a prescription to be issued ►this reduces consultant appointments, ensures fast access to treat bleeds, and allows treatment plans to be individualised to manage planned care and reduce in-patient stay ►take responsibility for Total Parenteral Nutrition and fluid support and will also prescribe prophylactic treatments
Long Term Conditions	**Stroke** ●Pharmacists prescribing within a stroke team, initiate treatment and support admission and discharge processes on a stroke unit ●Nurse prescribing within a stroke unit and nurse-led stroke clinic **Diabetic, Respiratory, Dermatology, Rheumatology** ●Respiratory, Diabetic and Dermatology specialist nurse prescribers	►faster access to treatment so that medication can commence immediately following diagnosis, in line with NICE guidance ►speeds up access to treatment and discharge planning. Patient and carer knowledge and understanding of medicines is improved, which encourages compliance and controls risk factors. Availability of telephone advice for patients in community for medication queries help prevent complications or readmission

	●Practice nurses and pharmacist prescribing for diabetes services, hypertension and hyperlipidaemia ●Podiatrist supplementary prescribing for diabetic patients ●Nurse prescribers facilitate in-patient management of diabetics, including those newly diagnosed ●Nurse and Pharmacist prescribers for renal patients ●Rheumatology Nurse Specialist prescribing ●Respiratory nurse prescribers **Cardiovascular** ●Community heart failure nurse or pharmacist specialists ●Pharmacist prescribers in cardiovascular or heart failure clinics **Pain Management** ●Nurse prescribers specialising in chronic pain management ●Community chronic pain services include pharmacist prescribers ●Physiotherapist supplementary prescribers **Other** ●Pharmacist-led clinics monitor treatment for stable patients with long term conditions e.g. anticoagulant and cardiovascular clinics ●Pharmacist prescribers in HIV clinics ●Tissue viability services transferred from secondary care into the community using nurse prescribers ●Intermediate care nurse practitioners and pharmacist prescribers (acute or PCT-led) offer a one-stop clinic ●Community Matrons as prescribers ●Optometrist-led clinics for glaucoma and ocular hypertension	►Timely prescribing and increased patient education avoids using additional consultant appointments. These can then be used for diagnosis and treatment of complex patients ►reduce GP waiting times, improve patient access to services, increase prescription review and reduce drug wastage. All patients are monitored in line with the national diabetes guidance ►faster access to treatment, avoids a separate GP visit to get a prescription and improves patient concordance ►faster optimisation of treatment regimes reduces length of stay. Ability to follow up post discharge ensures seamless transition to primary care and reduces prescribing errors ►reduce doctors hours to meet EWTD, identify medication errors, and save costs by reducing drug wastage ►increase service capacity as rheumatology consultants are able to focus on newly diagnosed, acutely unwell and unstable patients ►initiate and titrate medication to provide faster access to treatment and improve the quality of patient care ►titrate medication, monitor and manage care and patient education to facilitate earlier discharge, or work in A&E and the medical admissions unit to prevent hospital admissions ►reduce COPD admissions and enable earlier discharge ►initiate and titrate medication, provide faster access to treatment, reducing consultant input and readmission to hospital ►optimise treatment to increase quality of life,

		improve QOF indicator achievement and reduce admissions ►allow more rapid access to medicines to begin treatment in hospital or out-patients and help to reduce workload of doctors ►locality reinvestment of freed up resources has paid for additional pharmacist time to run medication reviews and hypertension clinics using their prescribing skills ►for orthopaedics reduce secondary care referrals and orthopaedic consultant input ►diagnose those referred for assessment by GPs or physiotherapists. This improves the quality of care by optimising medication management more quickly and avoiding use of a pain management consultant or further GP time ►allow consultants, senior registrars or GPs to concentrate on unstable and complex patients ►increase service capacity and allow medical staff to focus on newly diagnosed, acutely unwell or unstable patients who require more intensive input ►reduce patient waits, increase patient choice and reduce referral rates into secondary care ►reduce doctors hours to meet EWTD, adhere to local and national guidance, identify medication errors and save drug wastage costs ►improve service access and help prevent avoidable admissions ►enable faster diagnosis, monitoring and treatment initiation. Also allow consultants to concentrate on complex cases
Acute Care	●A&E nurse and pharmacist prescribers ●Walk-in Centre nurses offer prescribing services ●Use of nurses prescribers for chest pain assessment ●Nurse prescribers in diabetes	►increase the throughput for treating minor illness cases and discharging patients. Both allow doctors to concentrate on more complex cases ►treatment provision avoids an additional GP visit to

	●Emergency cardiac nurse practitioners based in A&E use prescribing ●Emergency care nurse consultants and other nurses prescribe analgesia and antibiotics both for minor injury and major trauma such as fractured femur, and widely use prescribing for respiratory disease, cardiac pain, management of allergic reaction or epilepsy, initiation of IV fluids and alcohol withdrawal ●Nurse consultants as prescribers lead 'nurse led' units ●Clinical nurse specialists work with advanced nurse practitioners to see acutely ill patients, carry out a full clinical assessment and examination, order investigations ●Nurse practitioners and pharmacists involved in unscheduled care	obtain a prescription ►reduce admission to hospital and allows discharge with medication ►prevent hospital admissions and allow timely treatment to start for those presenting with diabetes. This allows follow-up to achieve quicker stabilisation and return to normal lifestyle. Support to achieve good control prevents long term health problems which helps prevent hospital admission ►achieve door to needle times for thrombolysis, prompt management of other heart conditions to reduce the risk of arrest, and conduct chemical cardioversion of arrhythmias ►faster access to treatment initiation without delay in a role previously done by doctors ►diagnose patients and allow treatment to be initiated without delay ►diagnose and prescribe appropriate treatment in A&E ►prevent unnecessary hospital admission through work in nursing homes, palliative care and out of hours services
Mental Health	●Use of nurse prescribers offers prompt assessment and prescription review ●Nurse and Pharmacist prescribers in nursing homes and mental health services ●Pharmacist prescribers in a personality disorder unit rationalise prescribing in agreement with the GP, psychiatrist and patient ●Nurse and pharmacist prescribers in drug dependence ●Nurse prescribers in substance misuse services provide care for vulnerable patients or those finding difficulty engaging with primary and secondary care ●Alcohol treatment teams use nurse prescribers to	►faster access to medicines, particularly to vulnerable clients. This supports improved clinical outcomes, concordance, continuity of care and reduced use of on-call doctors ►optimise prescribing and reduce drug wastage ►allows implementation of a care plan supporting the patient to optimise or withdraw medication ►ensure accurate titration of maintenance doses, timely reviews and individualised detoxification regimes ►reduce GP workload which has allowed service capacity to increase by a third whilst reducing waiting times for appointments and eliminating waiting times

	provide detoxification and relapse prevention medication within their care package ●Nurse prescribers manage eating disorders in outreach clinics	for treatment ►reduce GP workload and hospital admissions through focusing on prevention ►reduce referrals into secondary care, increase appropriate and timely prescribing. This improves the quality of care for individuals to manage aspects of both physical and mental health
End of Life	●A pharmacist chemotherapy consent clinic ●Therapy Radiographers prescribe in oncology out-patients ●Prescribing key palliative care drugs by Macmillan Nurse Independent Prescribers ●Community Palliative Care nurse prescribers ●Specialist Palliative Care and MacMillan Clinical Nurse Specialists independently prescribe in acute Trust Palliative Care Teams ●Clinical Nurse Specialists as prescribers ●Clinical nurse specialists prescribe for children in palliative care instead of GPs	►avoids drug wastage which saves costs, and prevents drug errors. This helps to reduce the time to diagnosis and treatment ►timely prescribing to manage acute symptoms during treatment, reduces treatment or waiting time, and avoid ambulance or transport delays. In addition clinic capacity increased, patient distress prevented and the need for doctors to attend the clinic ad-hoc eliminated ►reduce the rate of admission to hospital through symptom management and increase the ability to meet patient choice to die at home ►adjust medication and explain changes to patients and carers which reduces concern and risk. They advise patients and GPs on the dosage and adjustment of symptomatic care, to improve the appropriateness of patient care and avoid use of doctors out of hours. Faster access to medicines significantly increases the timeliness of care particularly when GPs are unavailable or surgeries are shut ►patients' medication is rationalised and adjusted as the condition worsens, new symptoms occur, or side effects require management. This allows systematic symptom control more quickly, allows patients to get on with their lives, and reduces GP visits and hospital admissions ►reduce delays in prescribing and improve patient

		access to medication and symptom management. This eases the workload of the medical team, improves safety and can improve the speed of discharge ►timely access and change of medication from the oral to injectable route when required, to maintain symptom control and reduce patient or carer distress. ►timely access to start or modify end-of-life drug treatment. Care can be continued at home. Parent education provides additional support for care

Taken from **Making the Connections**: **Opportunities to Innovate, Increase Productivity and Drive Efficiency By Using Non-Medical Prescribing when Commissioning For Service Delivery** by. Alison Dale Clinical and Education Development Lead, Non-Medical Prescribing and Pharmacy Yorkshire and the Humber, November 2009 [updated May 2010] reproduced on the Department of Health Website

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