

# Investigation of Employers’ and Commissioners’ Approach to Non-Medical Prescribing Education in the South of England

July 2020

Sally Jarman

Clinical Fellow (Independent Prescribing Review)

## Contents

1. Introduction .....	3
2. Aims and Objectives.....	4
3. Method .....	4
4. Results .....	4
4.1 Survey Respondents.....	4
4.2 Non-Medical Prescribers.....	5
4.3 Funding for NMP Education .....	6
4.4 NMP Courses: What Matters to Employers? .....	8
4.5 Managing applications for the NMP course .....	9
4.5.1 Pre-application processes .....	9
4.5.2 Clinical Skills as a pre-requisite to the NMP course .....	10
4.5.3. Prioritisation of applicants .....	12
4.5.4 Access to training .....	12
4.6 Designated Prescribing Practitioners .....	13
4.7 Organisational governance .....	15
4.7.1 Assessment of Competence .....	16
4.7.2. Continuing Professional Development .....	16
4.8 Implementation of Non-Medical Prescribing .....	17
5. Discussion.....	21
6. Conclusion.....	25
7. References .....	25
Appendix 1 .....	27

## 1. Introduction

Non-medical prescribing can be defined as a prescribing decision by an appropriately trained health professional other than a doctor or a dentist. It is safe (Black, 2013), effective (Weeks et al, 2016), and can facilitate quicker patient access to treatment (Carey et al, 2014). It was first introduced to the UK in 1992 and subsequent legislative changes have broadened both the scope and the professions who are able to undertake training as prescribers (Cope et al, 2016). In the UK, there are three types of non-medical prescriber (NMP) as follows:

- Independent prescribers (IPs) are able to prescribe any medicine within their scope of practice and professional limitations (for example, podiatrists and physiotherapists are only able to prescribe a limited number of controlled drugs). Eligible professions currently include nurses, pharmacists, physiotherapists, podiatrists, paramedics, optometrists and therapeutic radiographers.
- Supplementary prescribers (SPs) are able to prescribe any medicine within their scope of practice (including controlled drugs and unlicensed medicines) providing they do so under the terms of a patient-specific clinical management plan (CMP) agreed by a doctor or a dentist. Many training courses will train eligible professionals to become both IPs and SPs, however dietitians and diagnostic radiographers can only undertake training to become SPs.
- Community Nurse Practitioner Prescribers (CPNPs) are able to prescribe from a limited formulary known as the Nurse Prescriber Formulary (NPF). This consists of dressings, appliances, pharmacy (P), general sales list (GSL) and thirteen prescription only medicines (POMs).

In order to become a NMP, it is necessary for an individual to undertake a NMP course, provided by a higher education institute (HEI) that has been accredited by the relevant professional regulator. Part of the course involves a period of learning in practice and recent regulatory changes have mandated that the role of assessor, also known as the Designated Prescribing Practitioner (DPP), can now be undertaken by an NMP rather than just by a doctor (which has been the case in the past).

Health Education England (South) has historically funded the provision of NMP courses across the region. The mechanism of funding courses is different in the four local offices; the Southwest (SW), Wessex, Thames Valley (TV), and Kent, Surrey and Sussex (KSS).

A project was commissioned by Health Education England (South) to review how non-medical prescribing training is accessed and run across the area, with an aim of reducing unwarranted variation. As part of this project, the views of employers and commissioners has been sought. This report sets out the results and a discussion of those results.

## 2. Aims and Objectives

1. Understand any barriers that exist with regard to accessing NMP courses
2. Identify whether current funding for NMP training is adequate for service need
3. Identify the factors that are important to employers and commissioners regarding NMP education
4. Scope the NMP pre-course process and pre-requisites within organisations
5. Understand what preparation has been made for the new DPP role within organisations, and identify any barriers to implementation of this.
6. Scope the ongoing assessment of competence for NMPs within organisations

## 3. Method

A set of survey questions was developed by the project lead, based on a set used in a similar IP review project conducted in the North of England in 2018. This was in order for responses to be compared across the regions. Feedback on the survey was sought from a range of HEE staff covering Wessex, SW, TV and Wessex. The survey was distributed using a range of distribution lists including Directors of Nursing for hospital trusts and clinical commissioning groups (CCGs), Directors of Pharmacy and NMP Leads.

Participation in the survey was voluntary.

Interview questions are included in Appendix 1.

## 4. Results

### 4.1 Survey Respondents

A total of 82 responses were received from across Southern England. The SW provided the highest number of responses closely followed by KSS. There were fewer responses received by Wessex and TV (see Table 1). The most common role of the respondents was Consultant Nurse/Clinical Nurse Specialist, followed by Chief Nurse/Lead Nurse (see Table 2).

**Table 1. Geographic distribution of respondents**

Region	SW	KSS	Wessex	TV	Unknown
<b>Number of respondents</b>	31	30	14	7	5

Table 2. Job title of respondents	
Job Title	Number of respondents
Consultant Nurse/Clinical Nurse Specialist	27
Chief Nurse/Lead Nurse	24
Education/Workforce Development	11
Chief Pharmacist/Lead Pharmacist	6
Clinical Governance	5
Practice Nurse	4
Advanced Nurse Practitioner	3
Advanced Paramedic	2

Respondents worked in a range of organisations, most commonly Clinical Commissioning Groups/Primary Care and NHS Acute Trusts (see Table 3). There were five respondents who worked across more than one sector/organisation.

Table 3. Respondents by organisation type	
Organisation	Number of respondents
Primary Care/CCG	30
NHS Acute Trust	27
NHS Community Trust	12
Independent Sector (including hospices)	9
NHS Mental Health Trust	4
Community Interest Company	3
NHS Ambulance Trust	2

Several respondents commented on the lack of national/regional NMP leadership and the issues that this caused, for example,

*“I believe that NMP requires visible clinical leadership; the networking that was once facilitated by the region, between NMP Leads, no longer exists. National and regional support for NMP leads would be welcomed.”*

*“Additional support and guidance for Prescribing Leads would be beneficial. Also support for ongoing CPD and supervision of NMP's would be useful. Currently more clarity around system alignment and role definitions in relation to NMP Leads required.”*

## 4.2 Non-Medical Prescribers

There were a wide range of professions employed as NMPs across Southern England by respondents' organisations (see Table 4). The majority employed nurses as NMPs, with the second-most common profession employed being pharmacists.

**Table 4. Number/Professions of Non-Medical Prescribers**

	<b>Total number of NMPs</b>	<b>Number of organisations employing this profession</b>	<b>Range</b>	<b>Mean Average</b>
<b>Nurse IP/SP</b>	4052	77	1-250	50.02
<b>Pharmacist IP</b>	601	53	1-100	7.42
<b>CPNP</b>	523	24	1-113	6.46
<b>Physiotherapist IP</b>	103	42	1-9	1.27
<b>Paramedic IP</b>	39	20	1-5	0.48
<b>Optometrist IP</b>	34	13	1-10	0.42
<b>Therapeutic radiographer IP</b>	28	10	1-10	0.35
<b>Podiatrist IP</b>	22	14	1-3	0.27
<b>Dietitian SP</b>	6	5	1-2	0.07
<b>Podiatrist SP</b>	3	3	1	0.04
<b>Therapeutic radiographer SP</b>	2	1	2	0.02

### 4.3 Funding for NMP Education

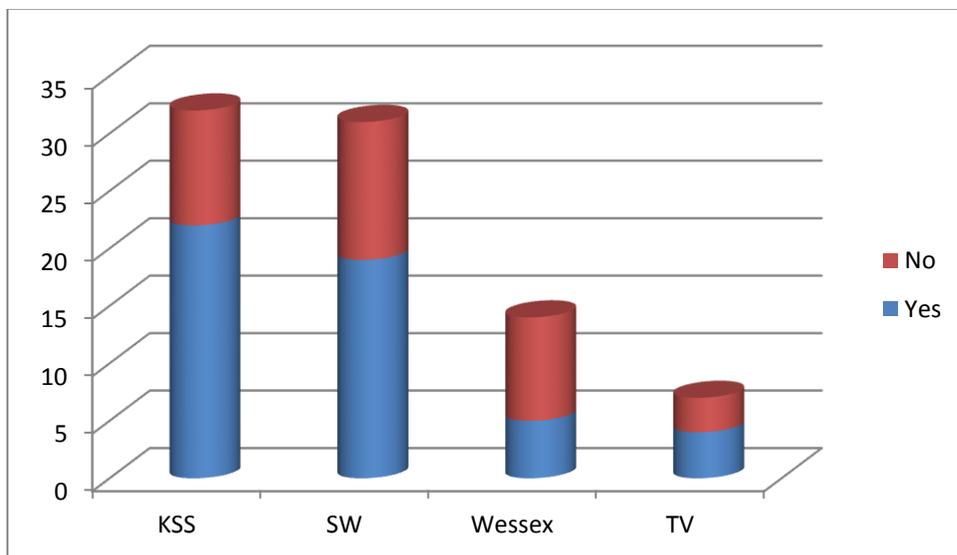
Respondents indicated that they accessed funding via a combination of different routes (Figure 1). Although 58 (70.7%) respondents stated that they had access to HEE commissioned places and a further 22 (26.8%) stated that they had access to HEE funded places via locally spot-purchased places, there were still significant levels of alternative funding sources being used for NMP training. As an example, 38 (46.3%) said that they also used internal organisational funds for training and 14 (17.1%) reported that they used charitable funds.

**Figure 1. Funding for NMP education**



Whilst 50 (61.0%) of respondents felt they currently received enough funding to support their staff through the NMP course, there was some regional variation (see Figure 2).

**Figure 2. Is there enough funding for NMP training (regional breakdown)**



Those who stated that they did not have adequate funding were asked how many additional places were required within this financial year. Table 5 shows the number of respondents, range and median for the number of additional places required.

**Table 5. Summary of additional NMP places required**

Profession requiring training	Number of respondents	Range	Median
Nurse IP	27	1-12	6
Pharmacist IP	15	1-5	2
Physiotherapist IP	9	1-5	2
Paramedic IP	8	1-40 (two organisations stated 30 and 40 extra places needed)	2
Podiatrist IP	4	2-5	3
Therapeutic Radiographer IP	3	2	2
Community nurse practitioner prescriber	2	6-15	10
Dietitian SP	2	2	2
Optometrist IP	1	3	3
Diagnostic Radiographer SP	1	2	2

#### 4.4 NMP Courses: What Matters to Employers?

Respondents were asked to rate how important various factors were in relation to the NMP course, using a 5-point Likert scale with 1 being the least important and 5 being the most important. The course content, location and supervision requirements were rated as the most important factors and availability of uni-professional cohorts was rated as the least important (see Table 6).

Additional comments given by respondents on the importance of various NMP course factors can be divided into three broad themes: practical factors, previous feedback/knowledge about the course and communication/support factors.

- **Practical Factors:** location of the course, timing of the course (e.g. “April is not a good time as we rarely have funding secured”) and the number of cohorts run each year.
- **Previous Feedback/Knowledge about the Course:** Experience and feedback from previous students, the reputation of the university and a history of successful outcomes for those undertaking the course.

- Communication and Support:** Communication between the university/programme lead and the organisational lead, the amount of support that students are given by the university as an institution and by individual tutors.

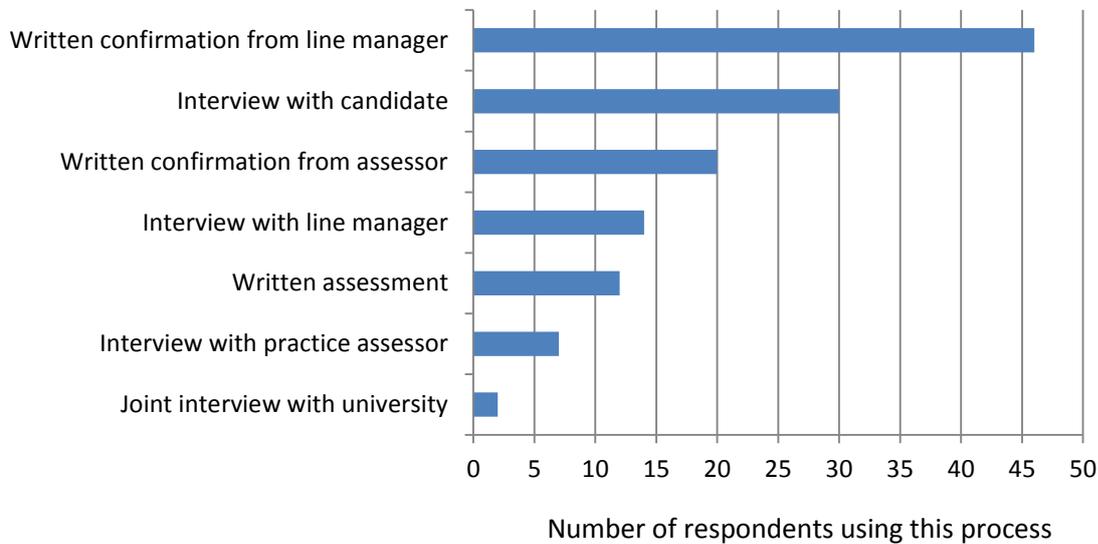
Table 6. Importance of NMP course factors to employers	
Course Factor	Mean Average
Course content	4.70
Supervision requirements	4.42
Location of university	4.39
Cost	4.01
Number of university study days	3.81
Local networks with university	3.78
Flexibility of course (e.g. making allowances for part-time students)	3.74
Availability of multi-professional cohorts	3.51
Days of the week the course is offered (e.g. weekends)	3.15
Availability of uni-professional cohorts	2.61

## 4.5 Managing applications for the NMP course

### 4.5.1 Pre-application processes

The majority of respondents (72%) stated that they undertook pre-application processes with prospective candidates; often using a combination of several different methods (see Figure 3).

**Figure 3. Pre-application processes**



In addition to the processes listed within the survey itself, respondents were asked whether they used any other pre-application processes. Comments included confirmation the NMP course is part of the candidates job role, approval by NMP lead, NMP committee and/or workforce, completion of eligibility checklist, completion of numeracy test and confirmation that candidate would repay a percentage of training fees if they left their organisation within a certain period of time.

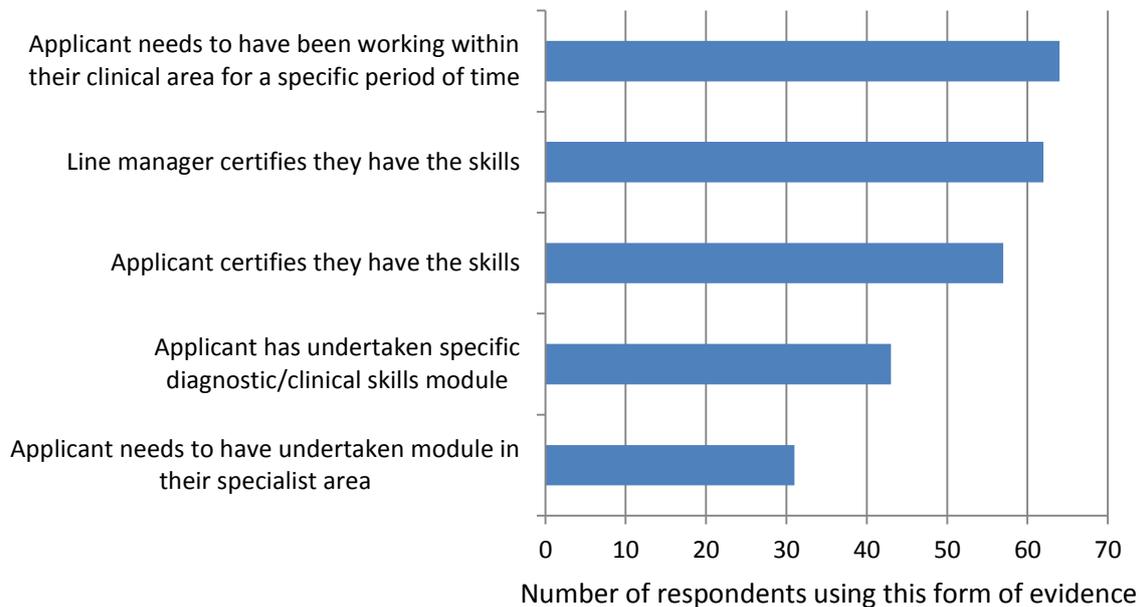
One of the respondents gave the following warning,

*“While I am a strong believer in NMPs and think it is the future of the NHS in many ways, I would caution the speed at which some professions are thinking of implementing it within the existing training structure. Currently NMPs make fewer prescribing errors than Doctors, at least within our trust, but this trend might not continue if we lower requirements for entry.”*

#### 4.5.2 Clinical Skills as a pre-requisite to the NMP course

All of the professional regulators state that NMP students must have appropriate clinical skills and/or experience prior to undertaking the course. Many respondents reported using a combination of several different methods to ensure that this requirement was met (see Figure 4).

**Figure 4. Evidencing clinical skills**



In addition to the areas listed above, several respondents made additional comments about the evidencing of clinical skills. These included the need for the candidate to have clinical assessment and examination skills (with or without a specific course to evidence their competence in this area), the need for specialist knowledge/skills in their clinical area, evidence of recent study, working at an advanced level and meeting the relevant regulatory requirements (such as time since qualification).

There was a range of opinions expressed regarding the need for a specific diagnostic/clinical skills module prior to undertaking the NMP course. Whilst some felt this should be absolutely mandatory, others expressed alternative views, for example,

*“It is possible to undertake the prescribing course with specialist knowledge in a specialist clinical area without the broader more generic clinical examination skills course”*

*“Clinical/diagnostic skills should be relevant to the post. These may have been acquired through practice or specialist modules. A generic module is not necessary for all practitioners in all cases”*

Some respondents felt that although a diagnostic/clinical skills module would be useful, it should not be a barrier to accessing the course;

*“It is preferred that they have the clinical examination module but currently it is not available at the local university”*

*“Acceptable if not overly expensive - it shouldn't be a barrier for experienced practitioners”*

## 4.5.3. Prioritisation of applicants

Respondents were asked to rate how important various factors were in relation to prioritising candidates for the NMP course, using a 5-point Likert scale with 1 being the least important and 5 being the most important. Local service need and the proposed impact on patient experience were rated as the most important factors and employee satisfaction was rated as the least important (see Table 7).

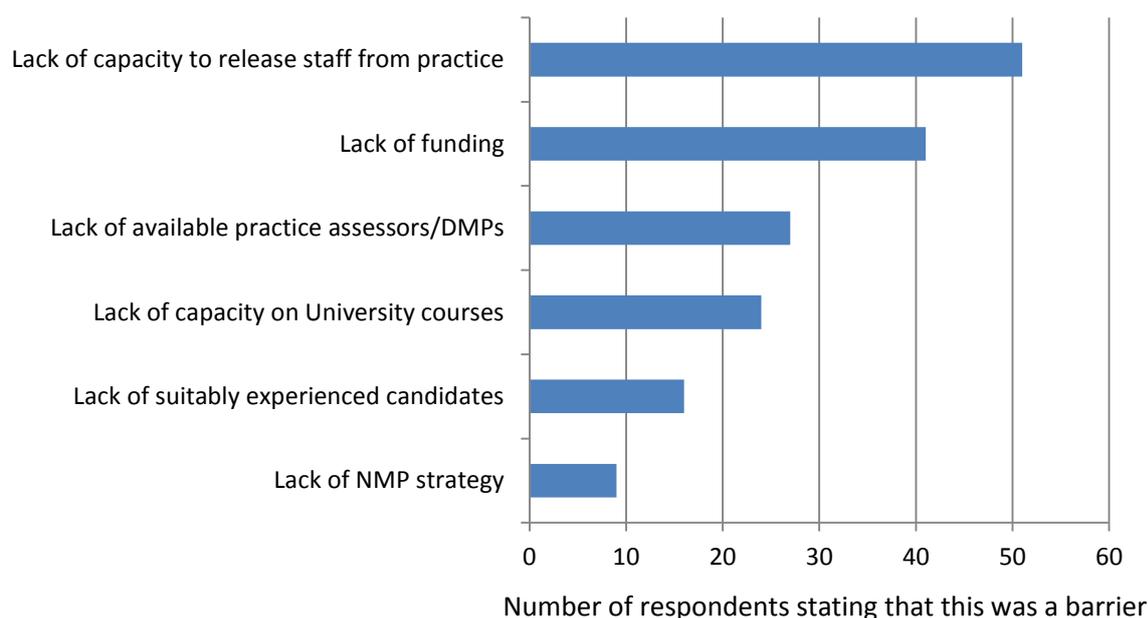
Table 7. Prioritisation of candidates for the NMP course	
Course Factor	Mean Average
Local service need	4.78
Proposed impact on patient experience	4.77
Knowledge/experience of staff	4.72
New service requirement	4.41
Part of workforce development plan	4.38
Link to national priorities	4.12
Employee progression	4.10
Proposed impact on organisational targets	4.05
Employee satisfaction	3.89

Additional factors not included in the above but highlighted as important by respondents included an assessment of the impact on the team (e.g. “*Capacity of the service to release staff for the course and its attendant study requirements*”), ensuring the candidate is aware of the time commitment/content of the course and, finally, that it is included as an essential part of their job description.

## 4.5.4 Access to training

Although 10 (12.2%) respondents reported no current barriers to individuals accessing the NMP course, the remainder reported barriers in at least one area. The most commonly reported barriers were lack of capacity to release staff from practice (62.2%) followed by lack of funding (50.0%); see figure 5.

**Figure 5. Barriers to accessing the NMP course**



#### 4.6 Designated Prescribing Practitioners

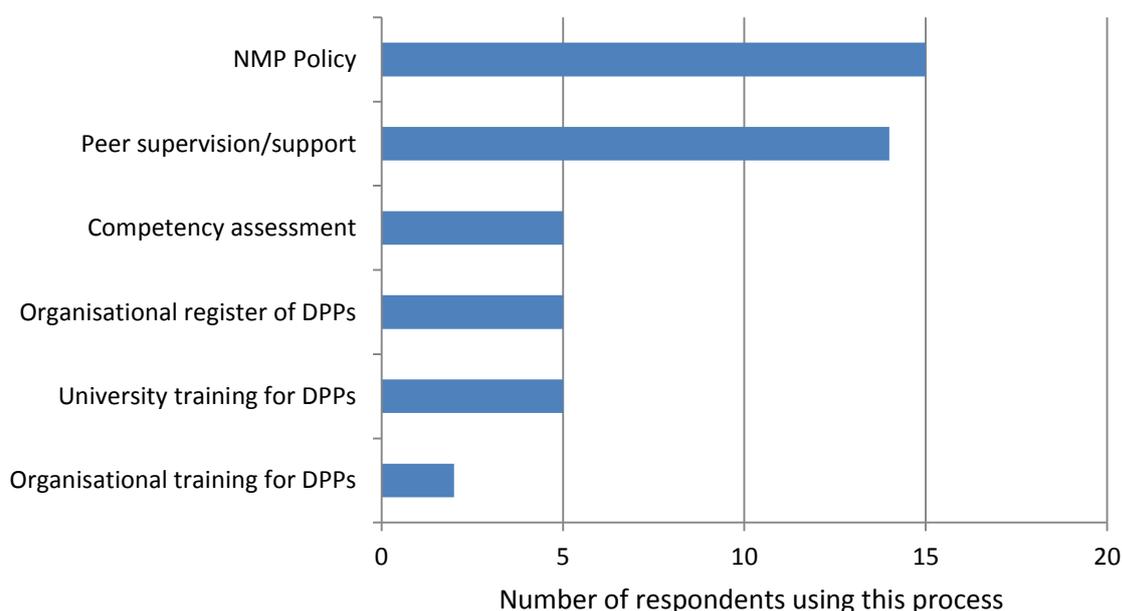
The NMC, GPhC and HCPC have all recently made changes allowing suitably qualified NMPs to undertake the role of practice assessor (NMC 2018a, GPhC 2019, HCPC 2019). Previously the role of practice assessor could only be undertaken by a medical doctor or dentist, known as ‘designated medical practitioner’ (DMP). However, there was significant concern that limited availability of DMPs in some areas was acting as a barrier to those wishing to access training (GPhC 2016) and this, together with a desire to make best use of the skills of a growing workforce of experienced NMPs (NMC, 2018b) led to the regulatory changes outlined above. One of the respondents illustrated some of the issues in the following statement,

*“The need to drive forward non-medical practice assessors is crucial. The link between universities and our medical assessors is poor and therefore the requirement of their role is not clear and relies on the student who is already overloaded with other requirements of the programme. In addition, medics are taught very differently to non-medical professions and their prescribing knowledge is gained over generally a much greater period of time - trying to mix the 2 professions, particularly in an already pressurised GP environment is extremely difficult. Where you have an non-medical assessor who has undertaken the course and is of the same profession as the student , there will be a much more beneficial and successful interaction and outcome for both parties.”*

Each of the regulators names the assessor role differently, however for the sake of simplicity the name used by the GPhC, Designated Prescribing Practitioner (DPP) will be used during this report.

18 (21.9%) of respondents stated that they were already employing DPPs. Of these, 5 stated that they had not experienced any barriers in relation to implementation of the role, although several stated that it was still too early to be able to assess this fully. Of the remaining 13 that were employing DPPs, 8 (44.4%) reported barriers relating to lack of staff capacity/time to undertake training for the role, 7 (38.9%) reported barriers relating to staff capacity/time to undertake the role and 7 (38.9%) reported barriers relating to staff confidence in undertaking the role. Respondents who had already implemented the role were also asked what governance processes they had put into place to support DPPs (see figure 6); the most common process was an updated NMP policy, followed by peer supervision/support.

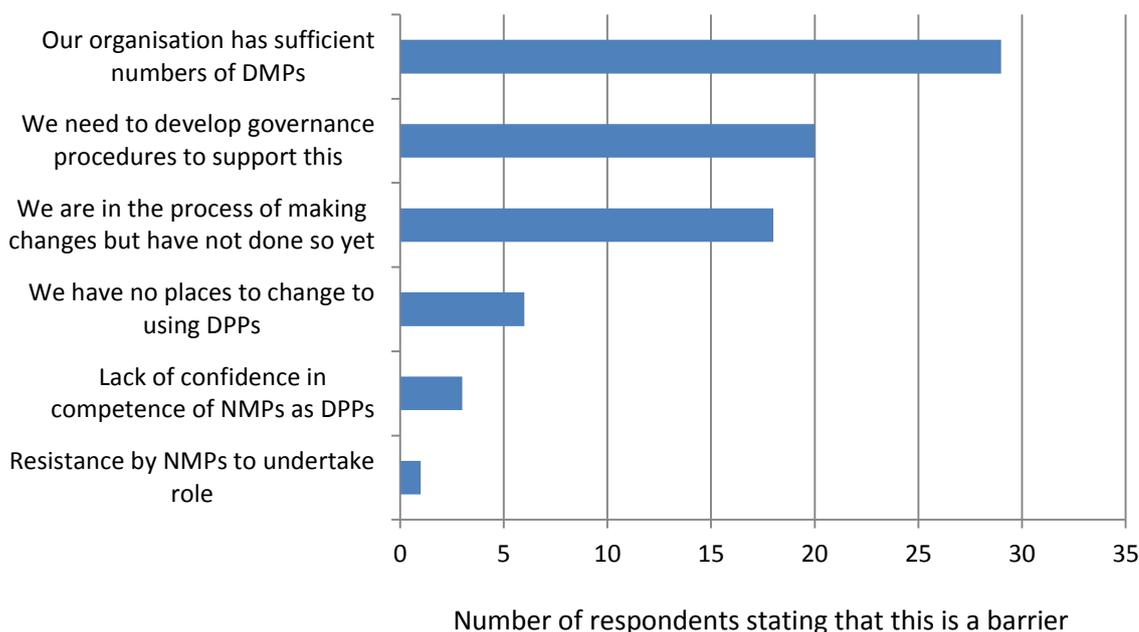
**Figure 6. Governance processes in place for DPPs**



The respondents who were working in organisations not currently employing DPPs (78.0%) were asked what barriers were preventing implementation (see Figure 7). The most common of these was that there were currently sufficient numbers of DMPs able to undertake the role, although in the words of one respondent,

*“The GP practices do charge £2500 for the provision of non-medical prescribing supervision and assessment which may be a challenge going forwards in terms of budgets.”*

**Figure 7. Barriers to implementation of the new DPP role**



Within the free text responses to this section, three respondents stated that they were not aware that the regulatory changes to allow NMPs to undertake this role had been made e.g. *“we were under the impression that a DMP must be a medical professional, although we are aware that the NMC/RPS is reviewing this.”* As the survey was undertaken eight months after the NMC regulatory changes were announced this is of significant concern.

### 4.7 Organisational governance

All organisations should have in place a robust governance framework to support NMPs following qualification (DoH, 2006), however this requirement has been interpreted in a variety of different ways due to lack of specific national guidance. Several respondents questioned whether it was actually necessary to treat NMPs differently from medical prescribers as follows,

*“It is time to move away from the term non-medical prescribing and differentiating from Doctors. We are all prescribers. Time accept them all and not use different terminology.”*

*“Non-Medical Prescribing is now well embedded in the organisation and we are trying to move away from treating them differently to other prescribers. This was needed in the early days but not now. In cases where NMP is well embedded in a team we do not scrutinize applications to the same extent.”*

Respondents were asked about two elements of organisational governance; assessment of competence and access to continuing professional development (CPD). Results are summarised below.

## 4.7.1 Assessment of Competence

The majority of respondents (87.8%) stated that they required NMPs in their organisation to carry out an annual assessment/statement of competence. Of the remainder, 2 (0.02%) required more frequent assessment however the rest either required assessment/statements of competence to be completed every two-three years or not at all. As one respondent put it,

*“We do not set a timeframe. We consider NMPs as professionals who are accountable for their own practice. We do not treat them differently to medical prescribers nor do we treat prescribing any differently to any other clinical competency”.*

The majority of respondents used several different methods to assess the competence of NMPs. Of those with an annual competency requirement, the most commonly used form of assessment was a statement of competence by the NMP themselves (see Figure 8).

The regulators of the NMP professions each have different general revalidation requirements, for example the NMC requires all nurses to submit a revalidation application (including CPD, reflective accounts, practice hours and practice-related feedback) every three years, whereas the HCPC requires registrants to complete a declaration every two years to confirm that they have continued to meet standards of practice (including CPD requirements). 41 (50%) of respondents stated that they had processes in place to monitor completion of these regulatory requirements and 26 (31.7%) of respondents stated that they expected NMPs to meet the requirements but did not officially monitor this.

**Figure 8. Assessment of Competence**



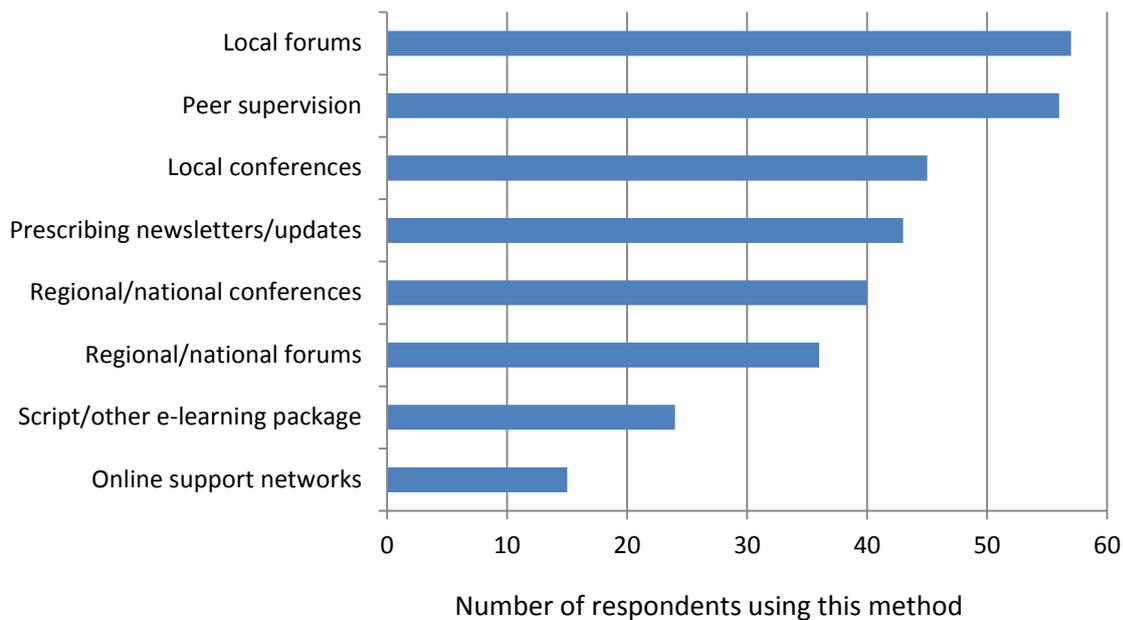
## 4.7.2. Continuing Professional Development

The vast majority of respondents (84.1%) organised or enabled access to at least one form of CPD for NMPs in their organisation. The most common of these were NMP forums (see

Figure 9), although the format of these tended to vary from large multi-service forums to more specialist forums as in the following,

*“Local forums are encouraged due to the diversity of needs of NMPs in different specialities”*

**Figure 9. Continuing Professional Development**



In contrast, one of the respondents made the point that there was no need to organise any CPD centrally, stating

*“NMP is now so well embedded we do less and less specific CPD- most staff identify the CPD they specifically need to do their job as part of appraisal”.*

Some organisations provided updates/conferences that had been funded for NMPs either by HEE or by the organisation themselves, however this was not happening in all areas. Other organisations were providing information about updates/conferences and leaving it to NMPs to arrange for funding, with variable success. For example,

*“Although information about external conferences is shared there is a lack of funding for these odd days”*

*“Conferences are optional and dependant on the GPs supporting funding and allowing time off to attend”*

#### 4.8 Implementation of Non-Medical Prescribing

Nationally, implementation of non-medical prescribing is variable, with 10-40% of NMPs not using their qualification in practice (Courtenay et al, 2012). Respondents were asked to rate how important various factors were in relation to implementation of non-medical prescribing,

using a 5-point Likert scale with 1 being the least important and 5 being the most important (see table 8). When asked for any additional comments, some respondents talked of the need for organisational/strategic support, for example,

*“Supportive and accessible NMP Leadership with a strong clinical focus; facilitates an organisational level of understanding of the needs of NMPs in terms of support and development”*

*“Support at board level for NMPs”*

In addition, legal limitations around the prescribing of some professions impacted on their ability to prescribe,

*“Limitations on controlled drug prescribing by paramedic prescribers is affecting their ability to practice as required in primary care (e.g. analgesia, end of life care).”*

However in general the majority of respondents felt that implementation was influenced primarily by individual factors such as comprehensive clinical and diagnostic skills and advanced knowledge within the NMP’s specialist area, as opposed to organisational/strategic factors.

**Table 8. Implementation of Non-Medical Prescribing**

Course Factor	Mean Average
Advanced knowledge in specialist area	4.68
Support from medical/prescribing colleagues	4.67
Comprehensive clinical and diagnostic skills	4.59
Support from line managers	4.57
Clearly defined scope of practice	4.56
Access to peer support and supervision	4.45
Access to CPD	4.39
Comprehensive NMP policy	4.34
Ease of registration as a NMP following qualification	4.07
Comprehensive NMP strategy	3.95
Financial factors (e.g. access to a prescribing budget, FP10 pads, indemnity insurance)	3.95
Support from colleagues who are not prescribers	3.89

Respondents were asked to give examples of how non-medical prescribing had been used innovatively and/or successfully within their organisation. A thematic analysis conducted on the 60 responses to this question showed a number of areas of commonality, including the positive impact of NMPs on patient care and a broadening in the range, professions and scope of NMPs. Many services were now led by nurses, AHPs and pharmacists, for example,

*“Our organisation is mainly nurse and therapist led so NMPs allow us to deliver a full service to our patients.”*

*“We have nurse led clinics within Cardiology, Diabetes, Upper GI, Hepatic, Pancreatic and Biliary CNSs who see both in and out-patients. These clinics enable the rapid assessment of patients rather than long waits to be seen in Consultant out-patient clinics.”*

NMPs helped to speed up access to treatment for patients, as follows,

*“Improving patient access to medication in a timely fashion, reassuring for patients and families that their specialist nurse has this expertise, reducing anxiety.”*

*“Enables quicker access to new medication or increases in medication for symptom control particularly in last days of life.”*

*“Smooth pathway for the patient reducing waiting times to get prescriptions.”*

The opportunity for patients to be seen by just one practitioner who was able to assess, diagnose and prescribe meant that patients did not have to be seen by multiple staff in order to receive the treatment they needed. As well as being beneficial to patients, this relieved some of the pressure on medical staff as illustrated in the following statements,

*“We now have many nurse, AHP, pharmacy led clinics where patients are seen by one practitioner which improves holistic care, improves the speed at which care can be delivered and releases medical staff to care for patients with more complex needs.”*

*“Our nurse non-medical prescribers find that they can complete a consultation within their field of practice from start to finish rather than relying on the GPs to finalise medication initiations or alterations, having a positive impact on both patient experience and GP time.”*

*“Having an NMP in a workplace can help to improve patients access to healthcare. The lack of GP appointments for example is a nationwide problem. Having other healthcare professional available to attend to patients will relieve the pressures faced in GP practices”.*

There were many different examples provided of speciality areas which were now making use of NMPs within their service. A few of these are given below,

*“Medication review and prescribing safety in key chronic disease pathways.”*

## Health Education England

*“Palliative Care Clinical Nurse Specialists able to make changes to medications and / or prescribe Just in Case medications preventing delays.”*

*“Non-medical prescribing has supported the cardiology at home service enabling patients to be monitored and cared for at home.”*

*“We have prescribers within our adult community services to assess patients within their home. These staff undertake a comprehensive assessment; diagnosis and prescribe to avoid hospital admission.”*

*“NMPs in Children and Young People’s Services prescribe ADHD and ASD medication and monitoring of these children, including supporting other agencies working with the children.”*

*“Enables comprehensive Asthma and COPD review to be carried out and completed by one professional.”*

Following on from the data in 4.2 of this document, respondents gave many examples of how a variety of different prescribing professions were using their NMP qualification to enhance patient care as follows,

*“Therapy radiographer led treatment clinics, where patients receiving radiotherapy are reviewed by radiographers and their symptoms managed in a variety of way including NMP.”*

*“Optometrist led clinics where patients with wet macular degeneration are reviewed and if required anti VEGF injections are prescribed by optometrists to allow a one stop clinic for patients.”*

*“We have supported a paramedic to enable him to prescribe in urgent care centre.”*

*“We have physiotherapist prescribers working in numerous different specialities including MSK, bladder and bowel, frailty and pain management.”*

*“Our pharmacists are now able to complete medicines reconciliation rather than leaving notes for doctors to prescribe patients usual medicines which helps to make sure patients receive their usual medicines correctly during their in-patient stay and have the correct medicines to take home with them.”*

*“A specialist podiatrist to ensure continued prescribing within a diabetes foot clinic.”*

NMPs improved patient flow at all points in the treatment pathway, from admission right the way through to facilitating discharge, examples include

*“Medical/surgical/emergency nurse practitioners at front door and in patient areas.”*

*“The main focus currently within the field of NMP is to assist with patient flow and discharge, prescribing obviously helps significantly with the ability to discharge patients in an effective and efficient manner.”*

*“Currently we have two in training NMP pharmacist who are embedded in the medical teams. This is to facilitate discharges and to improve patient outcomes by having constant pharmacy presence to advise on medicines and support junior docs with prescribing and amending medications. Support from the medics and other ward staff has been overwhelmingly positive.”*

## 5. Discussion

There were responses from a broad cross section of the South in terms of geography as well as type of organisation and role of respondent. The fewest responses came from Thames Valley which may be explained, in part, by the fact that there is no functioning NMP Lead professional network across the locality. However there were relatively few responses from Wessex, despite a functioning NMP Lead professional network. Several respondents commented on the lack of and/or need for national/regional NMP Lead networks. Both the South West and Wessex have a regional NMP Lead professional network, although this is facilitated by enthusiastic individuals rather than through a structured regional approach. Although there is no NMP Lead network in KSS, there is an active ACP leads professional network that meets on a regular basis and many of the individuals that attend are NMP Leads. Whilst there appears to be consistency from NMP Leads in some of the areas covered within the survey (e.g. assessment of NMP competence) this is not the case for other areas (e.g. pre-course application processes). Regional NMP Lead professional networks could provide some assurance of consistency, together with a structure for dissemination of information so that NMP Leads are not in a position, as evidenced in this survey, where they are not aware of important regulatory changes.

In terms of the type of organisation, the greatest number of responses was received from NHS acute trusts and CCGs, reflecting the organisations that traditionally make the greatest use of NMPs. Responses were also received from other organisations including community NHS trusts, mental health NHS trusts and independent sector providers.

The largest proportion of respondents (62.2%) were employed in lead nurse roles (e.g. clinical nurse specialist, consultant nurse, chief nurse) however there were also significant numbers of respondents from other areas including workforce development, pharmacy and clinical governance.

The most commonly employed profession were nurse IPs followed by pharmacist IPs. Interestingly, whilst the third-most common profession were physiotherapist IPs, there were relatively few of them in each organisation (a mean average of 1.27), in comparison to CPNPs where there was a mean average of 6.46.

### *Funding*

Models of funding varied significantly across the South. For example, some regions commissioned NMP places directly from HEIs, some allocated money for NMP places as part of a training budget that was managed by organisations, and some spot-purchased NMP places as required from HEIs. Many organisations reported that they used a number of

different funding models at the same time, such as using HEE commissioned places for the bulk of their requirement and topping up by using internal organisational and charitable funds. Nearly two thirds (61%) of respondents stated that their organisations had sufficient funding to support course fees for NMPs, although there was some regional variation with only 36% of those in Wessex stating that they had enough funding. However, as the number of respondents in Wessex was around half of those in KSS and the South West, it is not possible to draw firm conclusions from this.

Of the organisations who said they required more funding, the vast majority said that they needed funding for Independent Prescribers, with nurses being the most commonly required professional group (required by 84% of organisations who needed more funding). The five-year framework for GP contract reform (NHS, 2019) includes funding for a significant number of new health professionals to work within primary care. These include pharmacists, physiotherapists and paramedics, and it is of note that these were the three professions that organisations in this survey felt required the most additional funding (after nurses). It may be concluded that national developments are having an impact on which professions are being prioritised for training in this instance.

In contrast, only 6% of organisations requiring additional funding stated that they needed this for dietitians; this fell to 3% for diagnostic radiographers. This perhaps reflects some of the limitations inherent to the supplementary prescribing model available to these two professions. Until such time as the legislation is expanded to allow for independent prescribing by dietitians and diagnostic radiographers, it is likely that they will be unable to fulfil their potential as prescribers.

The number of organisations requiring additional places for CPNPs was very low, at just 6%, although the two organisations who responded to this said that they needed 6 and 15 places respectively. The focus of this project was on IP/SP training, as this is where the demand has been for some time now. Where there is a need for nurses to be trained as CPNPs, they tend to do this as part of a broader training pathway such as a health visitor or community nurse qualification. There have been concerns raised over the limitations of the current community nurse formulary (Chater et al, 2019) and the falling number of practicing CPNPs (Jarmain, 2017). Because of this, some HEIs are now moving towards a model where staff undertaking a qualification in community nursing complete the IP course as part of their training, as opposed to the CPNP course.

Respondents stated that the content of the course, supervision requirements and the location of the HEI were the most important factors when it came to deciding where staff should study. Several of them also mentioned other factors which they considered to be significant including the existing relationships which they had with module leaders and previous feedback on the course.

Of less significance was whether the course was provided to multi-professional cohorts or to nurses/AHPs/pharmacists in separate cohorts. This is of particular interest in relation to the discussion on mixed professional cohorts contained in the separate report on HEIs within this project; although HEI Leads had strong and divergent opinions on which model of delivery was better when it came to the training of different professions, this does not appear to have been an issue of concern to the organisational leads.

### *Accessing training*

The vast majority of respondents (87.8%) reported that there were barriers to individuals undertaking the NMP course in their organisation. The most common of these was lack of capacity to release staff from practice (62.2%). This links to the discussion on course structure contained in the separate report on HEIs within this project, where mandated face-to-face days was found to range from 4 to 26 days. Clearly where organisations are struggling to release staff from practice, higher face-to-face study days will cause additional pressures. Recommendations pertaining to this can be found within the project report on HEIs.

There were significant variations in the pre-course application processes used by organisations in the South of England, although 72% of respondents undertook some form of pre-course application process. The most common of these was written confirmation by the line manager (76.3% of respondents who undertook pre-application process), followed by interview with the candidate (50.8% of respondents who undertook pre-application process). Other processes used included written assessments and interviews with the line manager or practice assessor. The lack of consistency is of concern, as it means that access to the course may not be equitable. Respondents largely agreed on the importance of some key factors in the prioritisation of candidates, including local service need and the proposed impact on patient experience. There was less agreement over the importance of other factors however, including the link of the application to national priorities and the proposed impact on organisational targets. In an attempt to address these variations, other areas have introduced a single application process for HEIs (e.g. Doherty et al, 2019) and there are tools that have been developed to provide potential applicants with consistent information about the course (Carey and Stenner, 2020).

There was some variation in how clinical skills should be evidenced prior to undertaking the IP/SP course. All of the professional regulators state that students must have appropriate clinical skills and/or experience prior to undertaking the role, however they do not mandate how this should be evidenced. In some areas such as Wessex, a regional decision has been made that all applicants need to have undertaken a specific clinical skills module prior to undertaking the NMP course. This is not the case in other areas, however, where there is a degree of flexibility in how this is evidenced. Many respondents indicated that they used a number of different ways of ensuring that the requirement for clinical skills was met. For example, 78.0% stated that the applicant needed to have been working in their area for a specific amount of time whilst 75.6% and 69.5% of respondents relied on line manager or applicant certification of clinical skills, respectively. There were 52.4% of respondents who required applicants to have undertaken a specific clinical skills module previously. There were some strong opinions expressed by respondents when asked for additional comments on this topic, with many feeling that although a specific clinical skills module may be useful it should not be mandatory as this could be a barrier to experienced clinicians accessing the course.

### *Designated Prescribing Practitioners*

A small number of organisations (21.9%) had already started using DPPs, with the majority of these putting into place policies and peer support/supervision to assist them in their new

roles. Since this survey was undertaken (in October 2019), the RPS has published a competency framework for DPPs (2019) which will further assist both organisational leads and those undertaking the role of DPP. Of those organisations currently using DPPs, barriers included lack of confidence on the part of DPPs and lack of time both to undertake training for the role and to undertake the role itself.

The majority of organisations had not yet started to use DPPs. Nearly half (45.3%) said that this was because they already had enough medics employed to undertake the practice assessment role currently and a small minority (9.4%) said that they had no plans to changing to DPPs in the future. This is of concern as the move by regulators to open up this role to NMPs can be viewed both as an opportunity to increase access to training (RPS, 2019) and as an opportunity to recognise and develop the skills of NMPs. A further issue is that the NMC has made additional changes to practice-based learning requiring all students to be allocated both a practice assessor (or a DPP) and a practice supervisor from September 2020; if organisations have not implemented the necessary changes to support the role of the DPP, it is questionable whether they have made the necessary changes to support the additional role of practice supervisor.

Reassuringly, a number of organisations have started the process of thinking about how the new role with 32.3% stating that they needed to develop governance procedures around this and 29.0% reporting that they were in the process of making the necessary changes to support the role.

Somewhat surprisingly, there were some organisational leads who stated that they did not know about the changes to regulatory standards allowing both medics and NMPs to undertake the DPP role. This provides further evidence of the need for regional NMP Lead networks suggested in recommendation one, where dissemination of important information can be communicated effectively to all concerned.

### *Post qualification*

Following qualification, there was considerable variation in the governance procedures used by organisations. These included assessment/appraisal by line manager (63.4%), peer review of practice (51.2%) and audit of practice (50.0%). A significant number of respondents said that they either required a declaration of competence only or no additional mechanism over and above revalidation requirements. There was a similar variation when it came to provision of continuing professional development for NMPs; these included local forums (69.5%), peer supervision (68.3%), local conferences (54.9%) and prescribing newsletters (52.4%).

The lack of consistency is probably due in part to the lack of current national guidance on governance requirements for NMPs. When IP was first introduced for nurses and pharmacists, the Department of Health (2006) published an implementation guide to non-medical prescribing, which included clinical governance guidance. The field has moved on significantly since then with larger numbers of IPs from many different professional groups with many years of experience in their roles. There is therefore a need for updated national

guidance on organisational governance procedures pertaining to NMPs. Without this, it is likely that implementation of NMP will be impacted (Graham-Clarke et al, 2018) and this is of course of significant concern to HEE where significant amounts of money are spent on training each year.

Respondents identified several areas that they believed to be of greatest importance in how NMPs were able to use their qualification. These included advanced knowledge, clinical and diagnostic skills in the NMP's speciality, support from line managers and medical/NMP colleagues, and a clearly defined scope of practice. They also gave examples of where NMPs had been used effectively to redesign and develop services, including speeding up access to treatment and flow through treatment pathways, acting as a single point of contact, and developing NMP-led clinics. There is potential for this data to be used to inform prioritisation and/or pre-application processes discussed in recommendation four.

## 6. Conclusion

There are large numbers of NMPs across the South working in a range of organisations, although there are wide variations between organisations when it comes to how applications are managed and organisational governance procedures post-qualification. Nearly two thirds of all organisations felt they had sufficient funding for NMP education.

While pre-application processes are undertaken by most employers before individuals can access funding for prescribing these are not applied uniformly. Local service need and the impact on patient experience are the most important factors in deciding if an individual should be given access to a funded NMP place. The provision of continuing professional development and ongoing assessment of competence is variably managed across organisations. Recommendations have been made in order to provide guidance to HEE on funding of the NMP course, additional support requirements for organisational leads and standardisation in order to reduce variation within organisations.

Recent regulatory changes allowing for non-medics to undertake the role of DPP/practice supervisor will require organisations to review the support offered to individuals taking on this role.

## 7. References

Black, A. (2013) Non-medical prescribing by nurse practitioners in accident & emergency and sexual health: a comparative study. *Journal of Advanced Nursing*, 69(3), pp.535-545.

Carey, N., Stenner, K. and Courtenay, M.,(2014). An exploration of how nurse prescribing is being used for patients with respiratory conditions across the east of England. *BMC health services research*, 14(1), p.27.

Carey N, and Stenner K. (2020) *Preparing to prescribe toolkit*. [Online] Available from: <https://docs.google.com/forms/d/e/1FAIpQLSevXRRWbF6H7sD7MgqPyfKbqF82ps2ssX27XtCOL85qzETOGA/viewform> (accessed 18 March 2020).

Chater, A.M., Williams, J. and Courtenay, M. (2019) The prescribing needs of community practitioner nurse prescribers: a qualitative investigation using the theoretical domains framework and COM-B. *Journal of Advanced Nursing*, 75 (11), pp. 2952-2968.

Cope, L.C., Abuzour, A.S. and Tully, M.P., (2016). Nonmedical prescribing: where are we now?. *Therapeutic advances in drug safety*, 7(4), pp.165-172.

Courtenay M, Carey N, Stenner, K. (2012) *An overview of non medical prescribing across one strategic health authority: a questionnaire survey*. BMC Health Services Research. 12 (138), pp 1-13.

Department of Health (2006). *Improving patients' access to medicines: a guide to implementing nurse and pharmacist prescribing within the NHS in England*. London: HMSO

Doherty S, Jarmain S, Walker S. (2019) *Health Education England independent prescribing review*. Paper presented at: NMP Leads event. Proceedings of the 2nd association for prescribers NMP leads event in Birmingham, UK.

General Pharmaceutical Council (GPhC) (2016). *Discussion paper on supervising pharmacist independent prescribers in training*. London: GPhC.

General Pharmaceutical Council (GPhC) (2019) *Standards for the education and training of pharmacist independent prescribers*. London: GPhC.

Graham-Clarke E, Rushton A, Noblet T, Marriott J. (2018) Facilitators and barriers to non-medical prescribing – A systematic review and thematic synthesis. *PLoS One.*; 13 (4): e0196471.

Health and Care Professions Council (HCPC) (2019) *Standards for Prescribing*. London: HCPC

Jarmain, S. (2017) The Identity of Non-Medical Prescribers. In: Franklin, P.M. (ed.) *Non-Medical Prescribing in the United Kingdom*. Cham: Springer.

National Health Service. (2019) *A five-year framework for GP contract reform to implement the NHS long term plan* [online] Available from: <https://www.england.nhs.uk/publication/gp-contract-five-year-framework/> (accessed 18 March 2020).

Nursing and Midwifery Council (NMC) (2018a) *Standards for Prescribing Programmes*. London: NMC

Nursing and Midwifery Council (2018b) *Education standards consultation response*. London:NMC

Royal Pharmaceutical Society. (2019) A competency framework for designated prescribing practitioners. [Online] Available from: <https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/DPP%20Framework/DPP%20competency%20framework%20Dec%202019.pdf?ver=2019-12-18-150746-160> (accessed 13 March 2020)

Weeks, G., George, J., Maclure, K. and Stewart, D., (2016). Non-medical prescribing versus medical prescribing for acute and chronic disease management in primary and secondary care. *Cochrane Database of Systematic Reviews*, (11).

### Appendix 1



Prescribing Survey  
for Employers.pdf