

# **Investigation of Non-Medical Prescribers' Approach to Non-Medical Prescribing Education in the South of England**

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## 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 non-medical prescribers 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 the factors that are important to NMPs regarding NMP education
3. Understand the views of NMPs regarding the new DPP role and identify any barriers to implementation of this.
4. Determine the satisfaction of learners with various aspects of the course
5. Identify the factors that NMPs feel assist with implementing their roles following qualification

## 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. It was also shared on social media.

Participation in the survey was voluntary.

Interview questions are included in Appendix 1.

## 4. Results

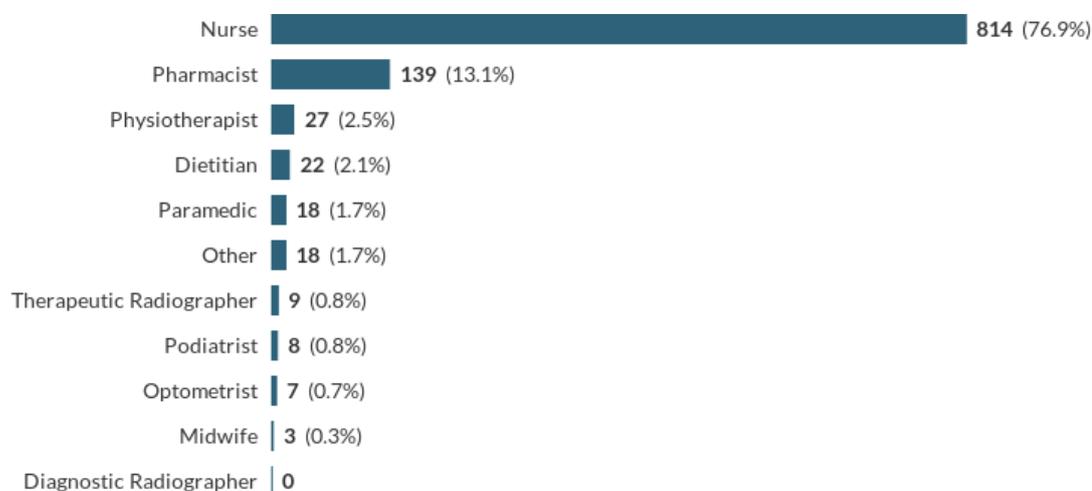
### 4.1 Characteristics of Survey Respondents

A total of 1059 responses were received from a broad range of respondents.

#### 4.1.1 Profession of Respondents

There were representatives from all professions apart from diagnostic radiographers (see Figure 1). The largest proportion of respondents were nurses followed by pharmacists.

**Figure 1. Breakdown of respondents by profession**



Of the 18 who selected “other”, 8 were advanced practitioners, 7 were health visitors or specialist community public health nurses, 2 were community matrons and one was a clinical nurse specialist.

#### 4.1.2 Geographic distribution

The geographic distribution of respondents is shown in Table 1. As can be seen, half of respondents were from the South West and just under a quarter were from KSS.

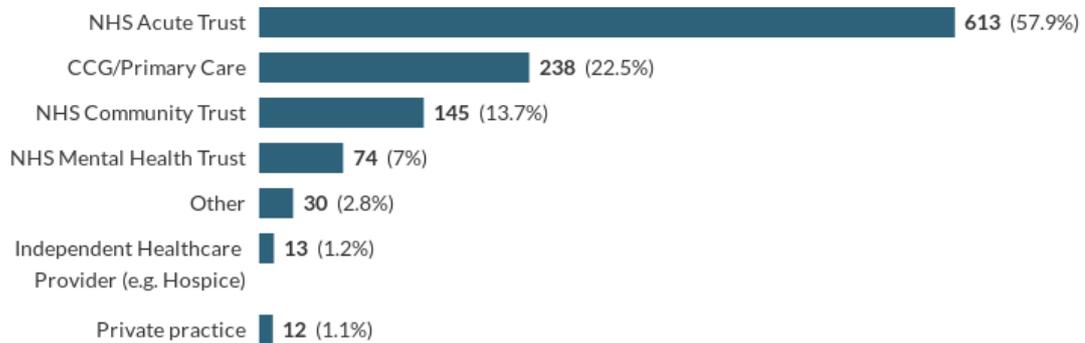
Table 1. Geographic distribution of respondents					
Region	SW	KSS	Wessex	TV	Other
Number of respondents	529	235	132	119	44

Of the 44 who selected “other”, several reported they worked in towns/counties covered by the survey as follows; SW 9, Wessex 7, TV 4, KSS 1. 4 stated they worked in the South East and 1 in the South, although did not clarify which region. 1 respondent worked across both KSS and TV. The remaining 17 all came from outside the area, as follows; London 4, North East 4, North West 3, East 3, Midlands 3.

#### 4.1.3 Employing organisation

The majority of respondents worked in acute NHS trusts, although there was representation from a variety of other sectors (see Figure 2).

**Figure 2. Respondents by type of organisation**

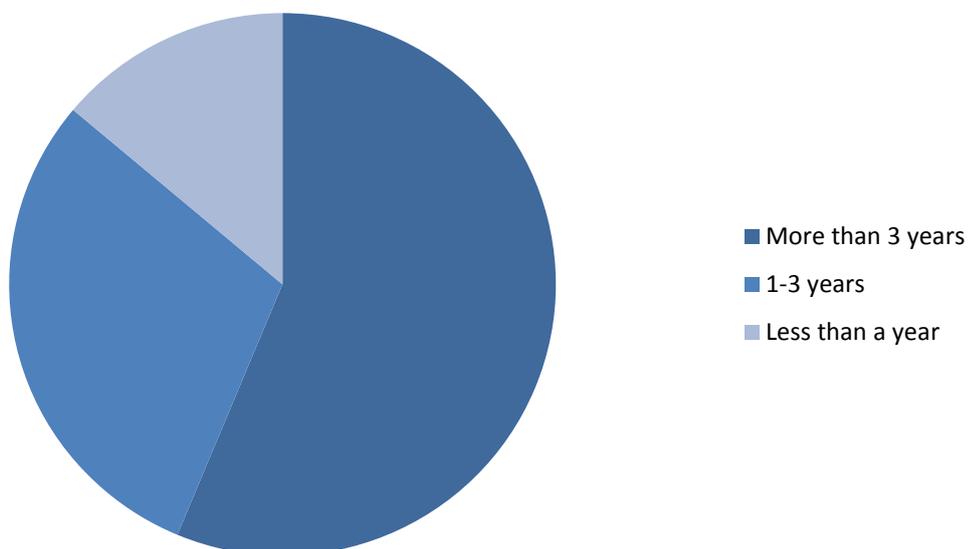


Of the 30 who selected “other”, several fell into the classification system above; 9 worked for independent healthcare providers, 2 for CCG/primary care and 2 for NHS community trusts. 2 respondents stated that they worked in organisations that covered both acute and community care. In addition, 8 respondents worked in community interest companies/social enterprises, 4 respondents worked in HEIs/education and 3 worked for ambulance trusts.

#### 4.1.4 Time since qualification

Respondents were asked how long it had been since they undertook their non-medical prescribing training and the majority reported this was more than three years ago (see Figure 3)

**Figure 3. Time since qualification**



## 4.2 Applying for the NMP Course

### 4.2.1 Selecting where to study

Respondents were asked to rate how important a number of factors were in deciding where to study, on a scale of 1-5, with 5 being the most important. The survey acknowledged that many applicants may have limited choice in deciding where to study, as they may be reliant on funding by their employer who has already purchased or been allocated places at a certain HEI. Where this was the case respondents were asked give their ratings as if they had been given a choice. Table 2 shows the mean average.

<b>Table 2. Importance of NMP course factors to NMPs</b>	
<b>Course Factor</b>	<b>Mean Average</b>
Availability of funding	4.65
Course content	4.25
Where the course was being delivered	4.16
Number of face-to-face study days	3.68
Length of course	3.56
When the course is delivered (e.g. weekends, days of delivery)	3.53
Academic level (either 6 or 7)	3.47
Directed to the University by the organisation	3.46
Availability of online learning	3.15
Number of university credits for the course	3.09
Part of another course (e.g. MSc)	2.61

There were 376 additional comments made by respondents on this topic. A thematic analysis of the comments was completed and identified the following broad themes; availability of funding, reputation of the course, practical considerations and professional issues.

### Availability of funding

Over two thirds of the comments made reference to not having any choice in where to study, but instead having to attend whichever University was used/funded by the organisation. For some this was viewed pragmatically, as in the following statements,

*“Did not get a choice, organisation offering to pay and this was the only option, not necessarily a bad thing- I was happy to be paid to go!”*

*“Needed to wait for funding and a place- all other considerations were essentially irrelevant. In the current financial climate if you are offered a place, you go where your trust has an academic contract.”*

For others there was frustration about the lack of choice, for example

*“I had no choice, the trust 'used' that university to provide the course - as a student I would say the most important factor SHOULD be the level of academic support and quality of tuition provided”*

*“As I was funded and directed by the Trust I had very little influence on the decision. If I was funding it myself I would have chosen a different university”*

### Reputation of the course

Several of the respondents mentioned using recommendations from colleagues as part of their decision-making process when deciding where to study. Reputation was important; if the course run by a particular HEI was viewed as too challenging it put some people off,

*“I was told the course was a lot of work at one University so I decided to do it at another instead”*

Whereas for others a rigorous reputation was a requirement,

*“It was also important to have a highly regarded uni as some courses at lower levels were known to be poor and credibility is very important to flag carrying ANPs”*

Other factors that were taken into consideration included the course pass rate and the quantity of coursework, with reputation influencing at an organisational level as well as an individual level as in the following example,

*“The Trust I was working for had reservations about the local university and would not actively fund their course.”*

### Practical Considerations

Proximity of the course was mentioned by several respondents; although the course run locally may not have been their preferred option they felt that their options were somewhat limited, as in the following examples,

*“it was the only one available at the time within 50 miles of home”*

*“ability to get there easily to ensure family/work commitments were achievable”*

The structure of the course was also important to respondents, who indicated that their decision-making process was influenced both by the number of study days and how these were delivered,

*“study days were in blocks for a majority of them which allowed you to concentrate on this rather than odd study days in between work days”*

*“ability to do weekend course as else could not have been released from work for sufficient number of practice days”*

*“my department only allowed 10 study days a year - the rest of the time needed to come out of annual leave”*

Until recently, there has been a mandatory requirement for all NMP courses to have a minimum number of taught days, although how this is delivered varies enormously from 4-26 face-to-face days across the South (see project report on HEI provision). The majority of HEIs offer online/distance learning or workbooks to supplement face-to-face provision. This was viewed as positive by some but not others,

*“I enjoyed the distance learning as this meant less travelling and enabled me to learn at my own pace in the comfort of my own home”*

*“did not want to undertake distance learning / online-learning. Face to face learning and meeting with other students was a vital part of the learning process..”*

### Professional Issues

For some of the newer prescribing professions, their choices were limited as not all HEIs had made the necessary changes to allow for delivery. For example,

*“Course available to paramedic prescribers as not all confirmed at that time”*

*“Limited by the university courses accredited to train dietitians. no other option available locally”*

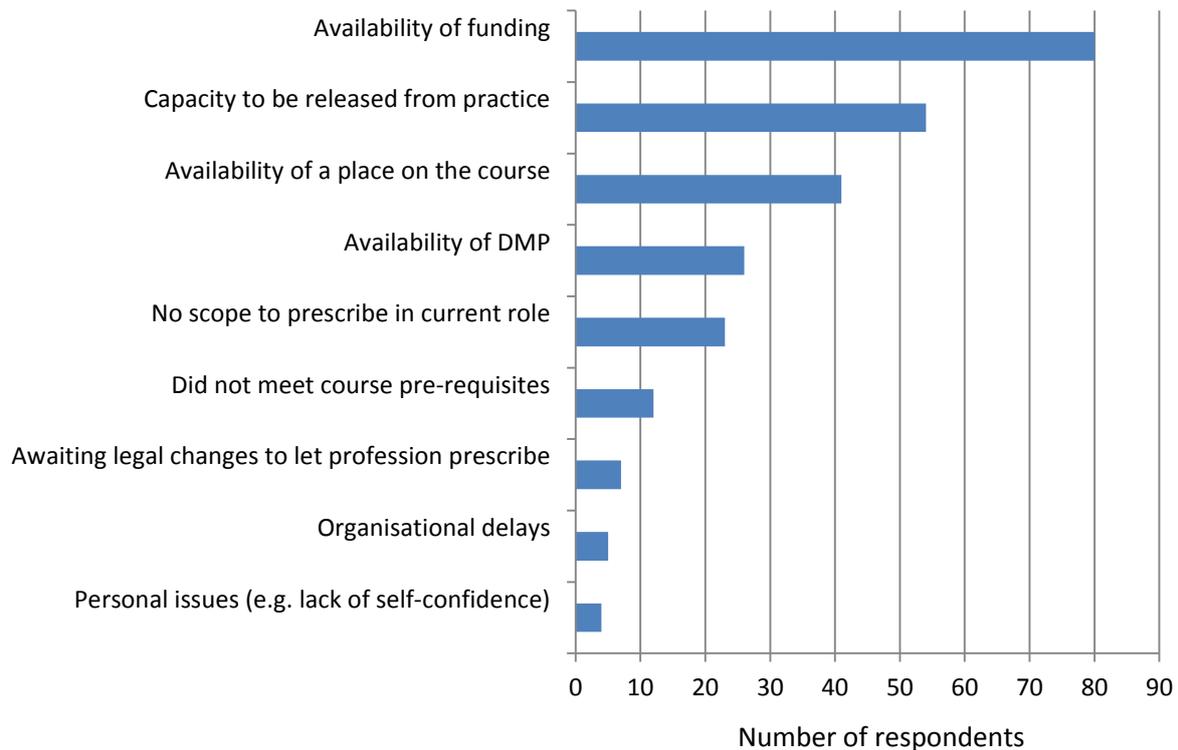
Whilst some respondents valued multi-professional courses, this was not the case for all,

*“Mostly I was interested in a course that was focussed on 1 profession - i.e. the course I did is only for pharmacists so focusses on the skillsets we are lacking in rather than pharmacology that we are familiar with.”*

#### 4.2.2 Barriers to accessing the NMP course

Barriers to accessing the NMP course were reported by 16% of respondents. The most common of these was lack of access to funding followed by lack of capacity to be released from practice (see Figure 4). Respondents were able to select as many different responses to this survey question as were appropriate.

**Figure 4. Barriers to starting the NMP course**



Several respondents gave specific examples of how they felt that their organisation had held them back from undertaking the course because of individual views from line managers as in the following,

*“Manager said she did not think it was required but this was dismissed when challenged”*

*“Initially not supported by my manager, had to change my job to access the training”*

For others, it was the organisational processes which caused the delay, for example,

*“Waiting for head pharmacist to interview and complete maths test. Took almost a year for this to happen”*

*“Ability to meet with Trust NMP Clinical Lead due to her commitments, and progress documentation and pre course requisites”*

Several dietitians and paramedics mentioned having to wait not only until legislative changes were made allowing them to prescribe, but of then needing to explain and justify why their prescribing role would be beneficial to the organisation,

*“There was initially a delay to courses being validated to train Dietitians as prescribers after the legislation changes. Within the trust we had to fight our case as we were the 1st dietitians in trust to undertake the prescribing courses and places had traditionally been prioritised to nurses”*

On occasion, however, the barriers were more to do with the individual, as in the following examples,

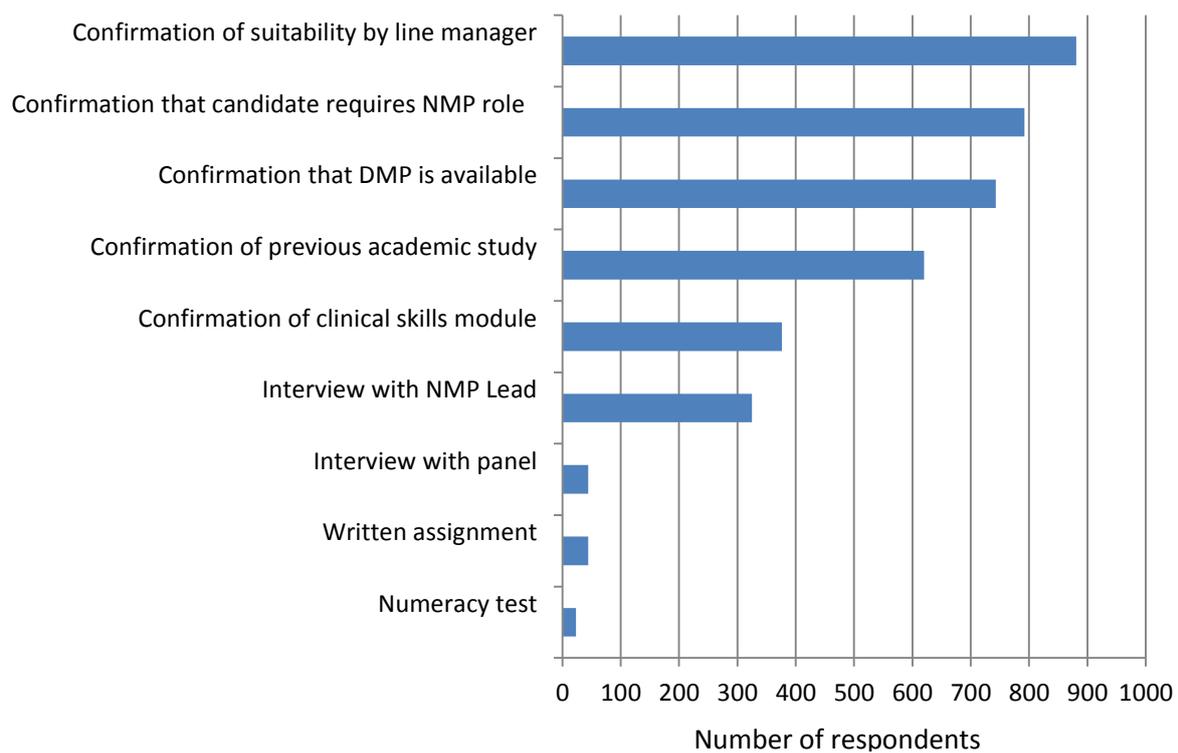
*“procrastination on my behalf”*

*“My own barriers to engaging with the course due to experience of previous people attending the course. I have 3 children so juggling a complex course with my job ( work 30 hrs ) took considerable planning”*

### 4.2.3 Pre-course procedures

Respondents were asked what was required by their organisation before they could apply for the NMP course (see Figure 5). They were permitted to select as many different responses to this question as was appropriate.

**Figure 5. Pre-Course Procedures**



Other pre-course procedures mentioned by respondents included the following,

*“Writing up of proposal as to how the role would benefit the service and confirmation that the role of NMP would be facilitated into my job plan on completion.”*

*“Application form including outline of anticipated role and benefits to the organisation”*

*“application outlining service need and benefit to the service, service users, the team and the Trust, with supporting information on my abilities, competencies, experience, suitability for the course”*

### 4.3 Undertaking the NMP Course

As can be seen from Figure 6, the vast majority of respondents (94.9%) had undertaken an independent prescribing course, with 2.7% stating that they had undertaken a supplementary prescribing course and the remaining 2.5% qualifying as CPNPs.

**Figure 6. Type of NMP qualification undertaken**



#### 4.3.1 HEIs attended by respondents

Respondents were asked to identify which university they attended. As can be seen from Table 3, the majority had undertaken the course in one of the HEIs in the South and the spread of HEIs attended broadly mirrors the spread of survey respondents. It is also worth noting that the University of the West of England have been commissioned by HEE to run the course across the SW over the last 5 years which helps to explain why so many respondents had undertaken training there.

There were a number of respondents who had undertaken the NMP course in other areas. This is probably due to several different factors. Firstly, there were 44 respondents who completed the survey from outside of the area. Secondly, there were 7 optometrist respondents who would have been unable to access a course within the region. Finally, there will always be a certain proportion of people who move to other areas.

Between 5 and 9 respondents stated that they had undertaken the NMP course in the following HEIs: Buckinghamshire New University, University of Birmingham, University of Hertfordshire, University of Winchester. There were 31 other HEIs which had between 1 and 4 respondents who stated that they had undertaken training with them, illustrating the broad spread of course provision across the country.

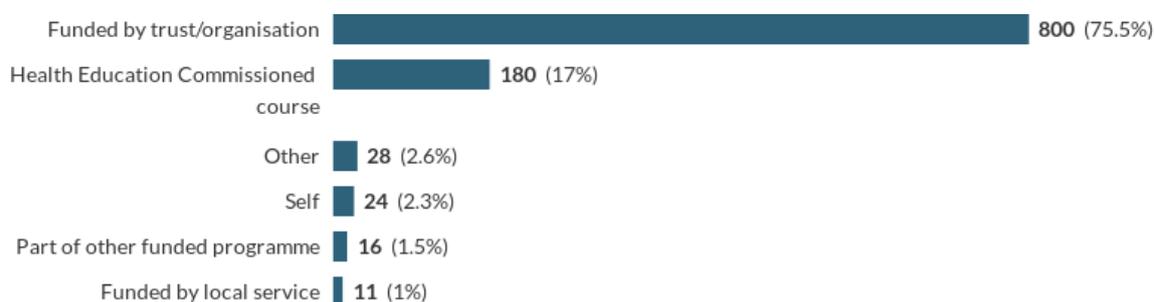
Three respondents clarified that they had undertaken a supplementary prescribing course initially, followed by a conversion to independent prescribing; in each case the courses were at different HEIs.

Table 3. HEIs with 10 or more respondents	
Name of HEI (SW, KSS, TV and Wessex area)	Number of respondents who attended
University of the West of England	290
University of Southampton	106
Oxford Brookes University	75
University of Plymouth	70
Bournemouth University	64
University of Kent (Medway)	60
University of Reading	46
University of Surrey	38
University of Brighton	34
University of Bath	32
University of West London	30
University of Gloucestershire	29
Canterbury Christ Church University	22
University of Nottingham (commissioned by HEE to deliver in KSS area)	21
University of Portsmouth	10
Name of HEI (other areas)	Number of respondents who attended
London Southbank University	18
King's College London	13
University of Northampton	11

### 4.3.2 Funding of the course

The majority of respondents (75.5%) stated that they had received funding for their NMP training through their employer (see Figure 7).

**Figure 7. Source of funding for NMP course**



Those who answered “other” were asked to provide clarification; responses included part-funding from a number of different sources (e.g. employer/self), regional grants, military funding and pharmaceutical company funding.

## 4.3.3 Course satisfaction

Respondents were asked to rate their level of satisfaction with different aspects of the course, on a scale of 1-5, with 5 being very satisfied. Table 4 shows the mean average. The highest rated aspect was the quantity and quality of pharmacology and therapeutics teaching whilst the quantity and quality of physical assessment teaching was one of the lowest.

<b>Table 4. Satisfaction with different aspects of the course</b>	
<b>Aspect of the Course</b>	<b>Mean Average</b>
Quantity and quality of pharmacology and therapeutics teaching	4.12
Overall impression of the course	4.11
Quantity of face to face education delivery	4.05
Preparation for OSCEs and exams	3.94
Preparation for practice as a prescriber	3.88
Relevance for area of practice	3.84
Consultation skills training	3.82
Facilitation of inter-professional learning	3.73
Recognition of prior knowledge	3.72
Support with portfolio development	3.69
Quantity and quality of physical assessment teaching	3.66
Quantity of online learning	3.56

Respondents were invited to make additional comments about their experience of undertaking the course. A thematic analysis of the 664 responses found that the comments they made centred around 4 areas; course content, structure, teaching and assessment.

### Course content

Many of the respondents commented that the content of the course was too broad, too focussed on adult physical health and/or was of little relevance to their particular speciality. Lots of these comments came from paediatric or mental health staff, although other specialist health practitioners also contributed. Examples of some of the comments received included the following,

*“I have a mental health background, they tried to incorporate this but I felt I required a little more support and relevance”*

*“I am a paediatric nurse doing a paediatric masters course and the majority of the drugs were adult based, the exam was only adult based. We had one lecture on prescribing in paediatrics”*

*“Recognise need to be broad but much of content of limited relevance in MSK setting”*

This led one respondent to make the following statement,

*“I understand it is difficult to teach a group of people working in very different areas but I did not feel the course prepared me well for prescribing practice. I think there should be more optional sessions based on experience/previous learning. Probably more bespoke online learning.”*

In contrast, others felt that the broad content led them to learning opportunities which they would not otherwise have experienced, for example,

*“I think the challenge is getting delivery right for all when the field is very broad, but that was also very stimulating.”*

*“it was great for me as a mental health practitioner for updating and improving my physical health knowledge and understanding”*

Undertaking the course alongside those from other professions was seen to have benefits by several of the respondents, such as the following,

*“I loved the mixed groups and feel that a course for only one professional type is limiting and against MDT working.”*

*“The multidisciplinary course was very useful as course participants had good opportunity to gain from each others' knowledge and practice.”*

However for others there was a feeling that courses targeted at a single profession were preferable. Many of these comments were made by pharmacists. For example,

*“The course felt very directed at nurses and did not take into account the prior knowledge/experience of pharmacists or other HCPs (most emphasis placed on learning basic pharmacology, felt not enough support given for pharmacists re physical assessment and medical history taking)”*

*“My course was aimed at pharmacists solely which meant I enjoyed it far more than colleagues who felt very held up by non-pharmacists in their course.”*

The challenges of attending a course traditionally delivered predominantly to nurses was raised by several of the respondents giving examples such as the following,

*“The course tutors were not aware of limitations of paramedic prescribing (e.g. CDs) and also made incorrect statements about paramedic prescribing. As an emergency department ACP, this course did not suit my needs.”*

*“Course was very nurse orientated and it was clear that the course did not have a good understanding of the role of dietitians”*

*“Very nursing orientated with less recognition of clinical background of AHPs”*

*“Lecturers not that aware of the therapeutic radiographer role.”*

### Structure

Online learning was the cause of some contention amongst respondents. There were thirteen respondents who felt that it was useful and should be used more. Comments included,

*“I would have liked more online learning rather than some of the lectures. It would therefore open up the opportunity to do more in your specialist area.”*

*“Not enough online learning”*

In contrast, sixteen respondents reported difficulties with online learning. For example,

*“Online learning package very poor, unable to access for 3 months, then too late to complete”*

*“Online learning was adult focussed on a paediatric course”*

### Teaching

The teaching sessions run by the University were commented on extensively by respondents. There were three sub-themes identified within the comments which respondents gave in this area; teaching of physical/consultation skills, pharmacology teaching and quality of teaching/support.

Several of the respondents felt that the training which they received in physical/consultation skills was not adequate. These included the following examples,

*“Quality of physical assessment teaching was to go into a room with a dummy and try find its pulse or listen to a heart rhythm”*

*“Physical skills were poorly taught, poorly assessed by people who had never practiced the skills that they were teaching.”*

*“Consultation skills assessment or teaching of this to ESP physio's or extended scope nurses was not at a level commensurate to the skills they already brought to the table.”*

This led some respondents to rely on their DMP for this element of the training,

*“As a pharmacist I felt I got the vast majority of my physical assessment and consultation teaching via my DMP rather than the university.”*

Others made complaints about the pharmacology teaching which they had received. Many of the comments in this area focussed on the level of the pharmacology teaching which was often thought to be too high by nurses and too low/not relevant by pharmacists

*“I felt the pharmacology was directed more at the pharmacists on the course. Nurses were not given enough time or attention to subject matter that was not within a comfort zone.”*

*“I felt there was an assumed level of knowledge which was very much the case for the pharmacists but not the nurses. Some of the pharmacology lectures were just over my head at the beginning.”*

*“I think the course was more aimed at nurses rather than pharmacists. The pharmacology was relatively basic in comparison to that which is included as part of a pharmacists undergraduate training.”*

In contrast, many respondents commented positively about the pharmacology training and, in particular, the tutors who were responsible for this element of their NMP course,

*“Very knowledgeable lecturer in pharmacology”*

*“Pharmacology input by pharmacist / tutor was excellent.”*

*“Pharmacology well taught”*

*“The pharmaceutical input and teaching about cell biology was intense and well delivered.”*

Similar comments were made about teaching staff responsible for other areas of the programme, for example,

*“A well delivered course, with good support and excellent teaching sessions”*

*“The course was excellent and well organised. All staff were very approachable and I felt well supported.”*

*“Best course I’ve ever completed. Amazing team.”*

*“My NMP course tutor was the best tutor I have ever experienced”*

Unfortunately, these sentiments were not shared by everyone with several respondents providing examples of times where they felt they had not been adequately supported during the course such as,

*“The course tutors were always rushing to get the train home after sessions. No time for questions and same reply if anyone asked anything “go and look online”.”*

*“I was surprised to be in a cohort of 90 students. We used the conference facilities in a local hotel, and often could not hear what was said by tutors.”*

### Assessment

There were many concerns expressed with regard to assessment. These were split between lack of support for portfolio development and poor preparation for exams/OSCEs.

Respondents indicated that they were not always clear about what was required of them for the practice portfolio, and that they received little support from the HEIs then this was requested. For example,

*“No indication for quantity of prescribing portfolio given, marked down for writing too much even though no word limit was given.”*

*“Absolutely no support with portfolio from the academic team, despite requests by the group as a whole for help.”*

*“Very little time given to support of portfolio, all study days revolve around passing pharmacology exam.”*

Furthermore, there were concerns expressed regarding both the preparation for and the experience of the OSCE and the written exams, with respondents reporting the following,

*“Chest examination was assessed in an OSCE, process was taught but no underpinning knowledge so felt like it was running through the motions with no understanding of what we were listening for!”*

*“The OSCE experience itself was extremely poor, with an unprepared 'actor' who constantly looked at her 'script' or the adjudicator to provide the answers. This threw me completely as I had been expecting to have a conversation with a 'patient' not a monosyllabic person who gave me the answer 'warfarin' to the question 'do you work?, what is your occupation?' Not impressed.”*

*“Exam preparation was poor, as exam was not what was predicted to look like.”*

*“I appreciate that there is an inherent difficulty in making these courses one size fits all due to the vast spread of practice backgrounds, but it is rather baffling to me how during the course you are told NOT to prescribe outside of your scope of practice, and then I had to sit an exam with an 80% pass mark about medications I will never prescribe, similarly with the OSCE where I had to do history taking from a patient and had none that related to my area of practice compared to the majority of other student who were able to choose a patient from their area of practice - it just meant that the course was a bit tougher than it had to be for me.”*

However, there were also several respondents who commented on the support which they received in preparation for the exams, for example

*“Some excellent tutors and the help pre exam was appreciated.”*

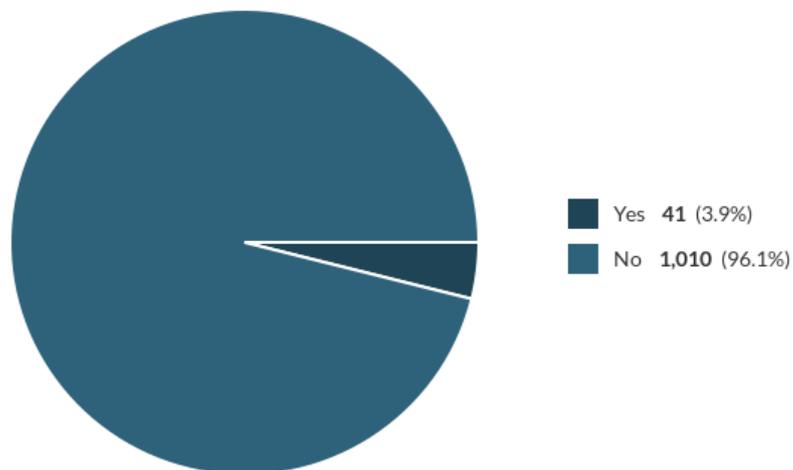
*“Exam preparation was good”*

## 4.4 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.

Respondents were asked whether they were currently undertaking the role of DPP and 41 (3.9%) said this was the case (see Figure 8).

**Figure 8. NMPs currently undertaking the role of DPP**



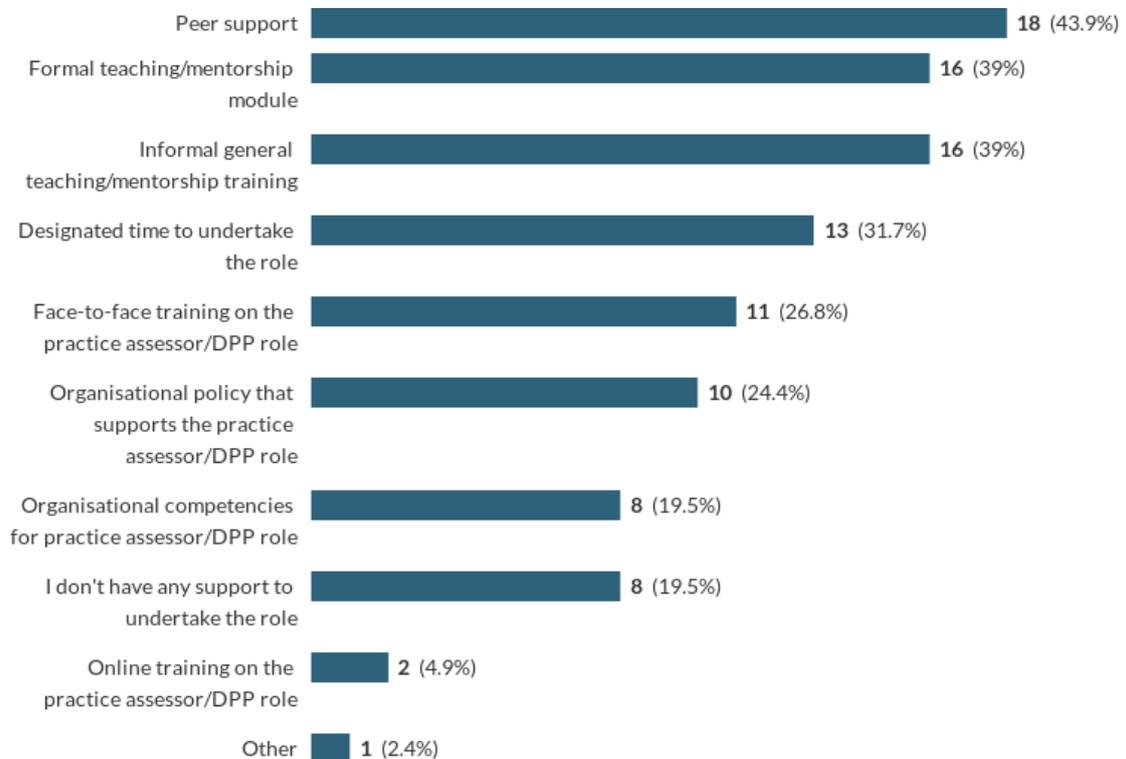
Those who were currently undertaking the role were asked what processes their organisation had put into place to support the role (they were able to select as many responses as they wanted). Figure 9 shows that the most common support was peer support followed by both formal and informal training.

Several respondents indicated that they would like more information about what exactly was required of the role, for example

*“The DPP role seems ill defined even at a national (NMC and Royal College) and organisation level- including the university/ colleges and the NHS Trust- it is hard to find out any information on the role and what the expectations are of the role in practice- I feel I am just muddling through to a certain extent with little support or guidance”*

Of the remaining 96.1% respondents, 583 (57.7%) indicated that they may be interested in undertaking the role in the future whereas the 427 (42.3%) said that they would not. The most common reason given for not wanting to undertake this role in the future was lack of time (58.8%), however other commonly cited reasons included not having the confidence and/or the experience.

**Figure 9. Organisational support for NMPs currently undertaking the role of DPP**



Many respondents expressed their concerns about NMPs taking on this role due to the depth of training and experience which doctors have in comparison to other health professionals, and the way in which this contributes to the learning of students undertaking the NMP course. For example,

*“I don't think it is appropriate for NMPs to take on the role of DPP. Having sat in with a mix of clinicians, there was no replacement for being assessed by my DMP, who after all, has had 30 years of being a 'diagnosing clinician'. I think doctors assess and approach patients in a completely different way to other clinicians and this is invaluable and something I don't think can be offered by an NMP. Part of the reason, why NMPs have been so successful to date is thanks to the rigorous training they have received in part from a DMP, I'm concerned the standards will slip.”*

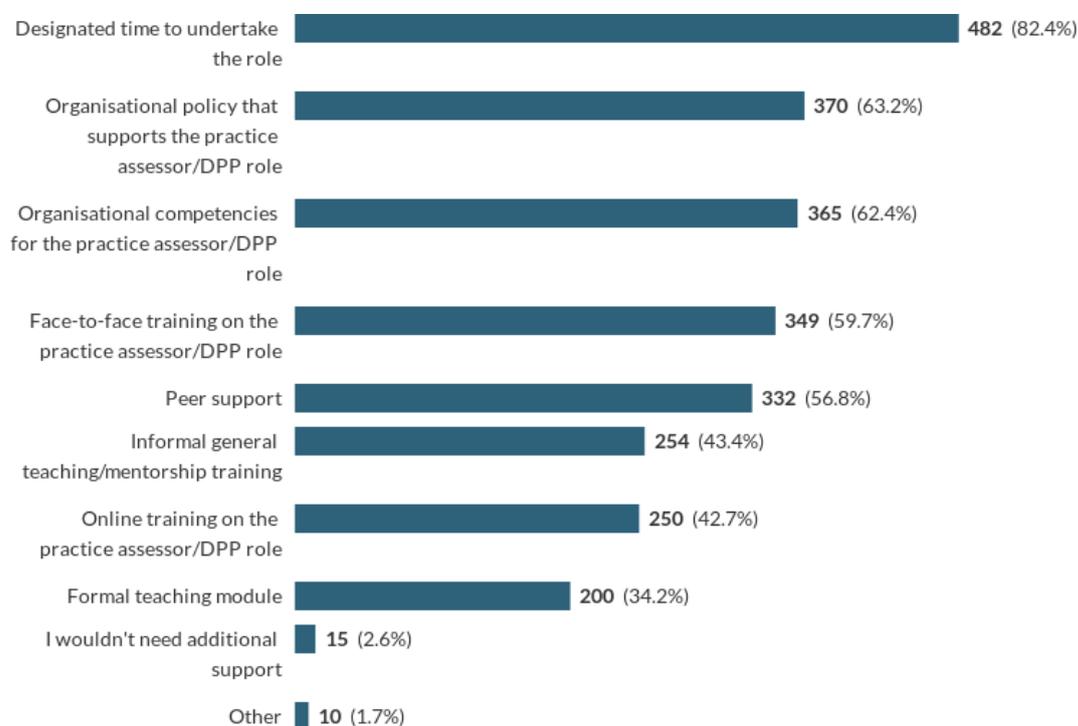
In contrast, several respondents welcomed the development of the new role, feeling that a NMP may bring increased understanding to the role of DPP having undertaken the course themselves in the past,

*“I think it would be much better to have a NMP as a sign off mentor, as they are much more aware of the courses expectations and course content”*

Of the 583 (57.7%) respondents who stated that they would be interested in undertaking the role in the future, it can be seen from Figure 10 that the most commonly required support was designated time to undertake the role, followed by an organisational policy and

competencies. Respondents were able to select as many responses as they wanted to under this survey question.

**Figure 10. Support needed to undertake DPP role in the future**



## 4.4 Implementation of Non-Medical Prescribing

The vast majority of respondents (93.6%) were prescribing within their current role. Of those who were not, 88.2% said they were still using some of the skills they had learnt on the course e.g. consultation skills, despite the fact that they were not prescribing.

There were 441 (37.6%) respondents who reported barriers to the implementation of prescribing within their role. The most common of these were lack of access to peer support and supervision (13.3%) and lack of access to CPD (12.2%), however there were a wide range of other barriers reported, many of which were connected to organisational processes such as,

*“I am about to start prescribing in my role but because I work with chemotherapy patients, I need to undertake a separate module in order to be able to do this. It also has been difficult to get all of the sign offs within my trust that I need prior to prescribing.”*

*“The trust had a ridiculous prescribing process to go through before being recognised as an independent prescriber which was really insulting actually. I feel there could be more useful ways to support new prescribers to feel and be confident in practice.”*

*“Waiting for permission from Hospital Pharmacy department to be able to prescribe in acute Trust”*

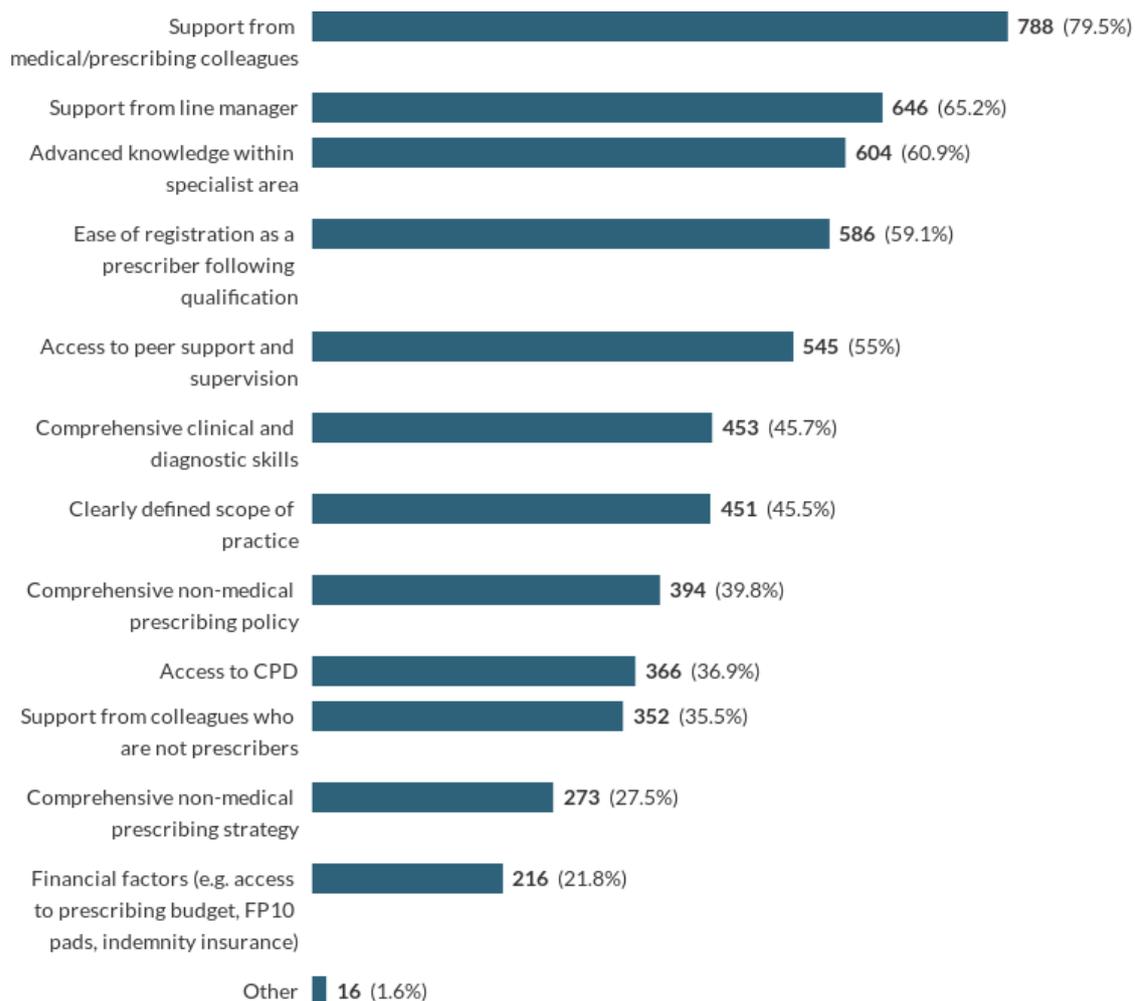
In addition, several respondents mentioned the constraints of prescribing under a clinical management plan as supplementary prescribers,

*“Having supplementary prescribing rights only puts more obstacles in the way. I have to get a signature from a prescriber for each patient before I can prescribe when in fact my knowledge of my prescribing area is greater so it feels rather strange that they have to agree first.”*

*“As supplementary prescribers we need to have a clinical management plan activated before we can prescribe for patients. This makes prescribing more complicated and a barrier for prescribing when needed. I often have to cover patients in clinic and on dialysis and prescriptions are often needed but because i haven’t set up a CMP there is extra work (& stress) involved with activating the CMP alongside my clinical practice.”*

Factors which respondents felt helped with implementation of prescribing included support from medical/prescribing colleagues and the line manager (see Figure 11). Respondents were able to select as many responses as they wanted to under this survey question.

**Figure 11. Factors which assist implementation of non-medical prescribing**



Many of the respondents gave examples of how they were using their role in practice now, and the benefit that this brought to their patients, for example,

*“It is a privilege to help patients manage their medication and in order to reduce the risk of harm due to human factors and competence, I have prided myself in keeping up to date with the latest evidence based practice and management. Being an independent prescriber has also given me the confidence where necessary to challenge medical diagnosis and prescribing practice that is detrimental to an expected level of competence.”*

*“There is rarely a day I do not prescribe and it has a positive impact on my practice and the care my patients receive.”*

## 5. Discussion

There was a good spread of respondents from different professional groups, with the demographics of the professions broadly reflective of the national spread of NMPs by profession. The only exception to this was that the dietitians were over-represented in the results; 22 of them completed the survey out of the 89 registered dietitian NMPs in the UK at the time the survey was undertaken (response by HCPC to FOI request by project lead, 2019). One explanation for this may be that as one of the newer prescribing professions they were more likely to respond as they wanted to make sure their views were heard. In addition, many of the comments from dietitians were in relation to some of the limitations around supplementary prescribing, indicating that they may have been using the survey as a way of expressing their dissatisfaction. There was a good range of NMPs employed by different organisation type with the largest proportion employed by acute trusts.

There was a range of experience, with over half having been qualified as NMPs for over three years. Whilst it is beneficial to have respondents with a range of experience, it also means that there may be an element of recall bias amongst those who undertook the course a long time ago. Additionally, their comments about the experience of undertaking the course may be based on a structure which has changed significantly since that time. However, their views are still important and help to provide a broad insight into the experience of NMPs undertaking the course.

The geographic spread of respondents was weighted towards the South West, with over half of respondents working within this area. One of the reasons for this may be that the project lead works within this area and that there is a functioning NMP Lead network through which the survey was disseminated, meaning that NMPs may have been more likely to hear about the survey. There were, however, significant numbers of NMPs who completed the survey from the KSS area, with fewer from TV and Wessex.

Unsurprisingly, the geographic spread of respondents meant that the most commonly attended HEI was the University of the West of England, who have been commissioned by HEE to provide NMP training across the SW over the last 5 years. Respondents had attended a significant numbers of other HEIs (in total, 53 HEIs were mentioned) including

many from out of the Southern region. There was no provision of NMP courses for Optometrists in the South.

### *Barriers to accessing training*

In terms of delivering HEE's goal that "the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place" (HEE, 2020), it is important to understand the barriers that prevent health professionals from accessing training. It was reassuring that the vast majority of respondents stated that they did not experience any barriers in accessing NMP education. It is of note that 16% of respondents stated that they did experience at least one barrier, the biggest of which was access to funding.

A further barrier cited by many respondents was capacity to be released from practice. This can be addressed by ensuring that HEE only purchase places at HEIs offering within the average number of mandatory face-to-face study days (see recommendation five of the associated HEE HEI report). Some of the barriers are no longer an issue as they have been addressed at a national level (for example, giving some of the newer prescribing professions their prescribing rights and allowing NMPs to undertake the practice assessment role for colleagues undertaking their training).

There are three key contributors to the processes that must be completed prior to an individual undertaking the NMP course. The education commissioner (HEE) may have criteria to satisfy in order to access funding, the employing organisation may have criteria for release from practice and to access allocated funding, and the HEI who will have entry pre-requisites. Pre-course procedures within organisations varied significantly, ranging from confirmation by the line manager to written essays/applications and panel interviews. In order to enable learners to access education the pre-course processes should be streamlined; learners should not have to provide the same information to multiple organisations in different forms and criteria should be equitable.

### *Factors which are important in course selection*

As well as removing barriers it is important that courses are commissioned that meet the requirements and expectations of learners. When the respondents were asked what factors were important to them in the selection of the course, the availability of funding was by far the most important factor. The next most important factors were content and where the course was being delivered. Whilst there was a hierarchy of importance in the factors, it must be borne in mind that the requirements of individuals will differ and that a significant number of individuals rated each of the factors as highly important.

### *Course Satisfaction*

In terms of satisfaction with the course which they attended, respondents were most satisfied with the quantity and quality of pharmacology teaching, and their overall impression of the course. There was little variation in satisfaction with all the listed factors, with the average rating between 3.56 and 4.12 for all aspects. Where there were concerns or

complaints made about an aspect of the course, these were often balanced by contradictory opinions. For example, approximately equal numbers of respondents felt that their tutors were not supportive compared to those who felt that they were. This was also the case for whether or not the course content was too broad.

There was some consistency contained within the comments on course satisfaction within a couple of different areas. Firstly, several people expressed the desire for more online learning which could be accessed according to speciality/profession. The recent COVID-19 pandemic has led to many HEIs changing the way in which their courses are being delivered with a greater emphasis on online delivery. It may be that this facilitates a change which meets the suggestions of respondents wanting more of a “pick and mix” approach to accessing online learning. Secondly, there was concern that some of the courses were focussed on nurses with limited knowledge of other professions on the part of some tutors. It should be acknowledged that paramedics, dietitians and therapeutic radiographers have all only recently joined the prescribing professions and it is anticipated that the understanding of these professions and how they can utilise the prescribing qualification will grow over time.

### *Designated Prescribing Practitioners*

Whilst there were relatively few respondents currently practicing as DPPs, there was a significant amount of interest in undertaking the role in the future. The main requirements that respondents felt needed to be put into place to support them in undertaking the role were designated time followed by organisational policy and competencies. Although the RPS have published the DPP competency framework (RPS, 2020), there is little other national guidance available on this. Without significant support at an organisational level, it is likely that this important change will not be fully implemented.

### *Implementation of Non-Medical Prescribing*

It was reassuring that 93.6% of respondents were using their prescribing qualification in practice, and out of those who were not using their qualification 88.2% reported using some of the skills which they had learnt despite not actively prescribing currently. However, it should be borne in mind that the survey was disseminated via various circulation lists/social media to NMPs, therefore those who were not currently prescribing may not have had the opportunity or the inclination to complete the survey in the first place.

Of concern was the fact that 36.9% of respondents reported barriers to the implementation of prescribing following qualification. The most common of which were lack of access to peer support and supervision (13.3%) and lack of access to CPD (12.2%), although arduous organisational processes also featured strongly in the additional comments which respondents made on this topic. Interestingly, the most common factors reported to assist implementation were slightly different; respondents felt that support from medical/prescribing colleagues and their line manager were the most helpful aspects in this regard. All of the above reinforces the need for organisations to have robust processes which support staff both prior to and following qualification, in order that the money invested by HEE can be used to its full effect

## 6. Conclusion

There was broad representation in respondents both geographically and professionally, although there was some over-representation in the South West and of dietitians. Most respondents did not face barriers in accessing the NMP course, but for those that did the most prevalent barriers were access to funding and the capacity to be released from work. Availability of funding was the most important factor to respondents when it came to deciding where to study, however other important factors included the content of the course and where it was delivered. In general, respondents were satisfied with the courses that they attended. One area for possible development may be the introduction of more online learning content which can be accessed depending on speciality of the learner. Many of the respondents were interested in undertaking the DPP role in the future, although they felt they would need support including designated time to undertake the role and access to organisational policies and competencies. There is a lack of a consistent approach to pre-course procedures and to organisational support following qualification, leading to the potential for inequity. Barriers to implementation reported by NMPs included lack of access to CPD, and lack of access to peer support/supervision.

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## Appendix 1



Survey for NMPs.pdf