

**Clinical Governing Non-Medical Prescribing in an NHS Trust –
Issues for Consideration in Mental Health and Learning Disability**

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Abstract

The Department of Health (2006a) assert that Non-Medical Prescribing (NMP) has provided patients with faster access to medicines, improved access to health services and made better use of health professionals' skills since it's inception over a decade ago. NMP operates from statute, and is required be underpinned by a robust clinical governance framework. This article provides the reader with a summary of the NMP policy and legal context to date, attempting throughout to apply the discussion to the field of mental health and learning disability. It then proceeds to demonstrate the means by which NMP was clinically governed in an acute NHS trust. The aspects of clinical governance to be particularly focused upon comprise the auditing of NMP, implementing independent prescribing, regulating NMP for children and young people as well as producing patient/service user information. To date mental health and learning disability organisations have mostly implemented supplementary prescribing only, and have been slow to implement independent prescribing compared to general or primary care settings (Bradley et al 2008). However given that independent prescribing is now nationally implemented (Department of Health 2006b), it is hoped that the sharing of practice innovations and lessons learned in one acute NHS trust with colleagues in mental health and learning disability, will be timely. The article then concludes by indicating how monitoring and evaluation of the clinical governance established thus far is the necessary next step, as well as signposting some further governance challenges for NMP.

Keywords: Clinical governance, Non-medical prescribing, Independent prescribing for nurses and pharmacists, prescribing for children and young people, patient/ service user information

Introduction

This article provides an overview of the means by which non-medical prescribing (NMP) was clinically governed in an NHS trust. The trust involved was an acute NHS trust, but the author believes that the clinical governance achieved can be applied to any organisation where NMP takes place, particularly in mental health and learning disability settings and this will be further explained.

The article commences with an explanation of the policy and legislative context of NMP, and in doing so seeks to draw out the significant issues for mental health and learning disability NMP. It then proceeds to explain the methodology utilised to ensure that NMP was underpinned by a robust clinical governance framework. This explanation includes initial discussion related to the auditing of NMP before continuing with strategic and policy directions, particularly with respect to nurse and pharmacist independent

prescribing. To conclude further NMP governance priorities will be identified.

Background to Non-Medical Prescribing

The NMP initiative first commenced with nurse prescribing. Humphries and Green (2002) noted that as far back as 1980 the Royal College of Nursing were advocating that nurses should be allowed to prescribe medicines. However nurse prescribing first achieved Government policy status through the Cumberlege report (Department of Health and Social Security 1986). To assist the then Government agenda of increased community care (Department of Health 1989a), Cumberlege was asked to investigate how the role and responsibilities of 'neighbourhood nurses', namely district nurses and health visitors, would need to change to facilitate this initiative. Cumberlege reported that these 'neighbourhood nurses' regularly and independently assessed patients for conditions related to their practice and subsequently made treatment decisions. However, they then had to request prescriptions for their patients from general practitioners (GPs) which resulted in much time wasting for the patients, GPs and the district nurses/health visitors' alike (Luker et al 1997). More significantly Otway (2002) notes that these prescriptions, often rubber stamped by the GPs, compromised the safety of patients and the accountability of the GPs involved, as the prescription decisions were undertaken by those not performing the assessment and examination of the patient concerned.

Following on from the Cumberlege report, the first Crown Report (Department of Health 1989b) supported prescribing by district nurses and health visitors from a limited formulary known then as the Nurse Prescribers Formulary. Brew (1999) reflects on how Crown believed patients would benefit as a result of the implementation of her report.

To make the necessary legislative changes to The Medicines Act 1968, enabling nurses to prescribe prescription only medicines as advocated by Crown (Department of Health 1989b), The Medicinal Products: Prescription by Nurses etc Act (1992) was enacted following a Private Member's Bill that had been commenced the previous year. Nevertheless, Luker et al (1998) notes that it was 1997 before the scheme was implemented nationally, following a pilot exercise at eight sites which commenced in 1994.

To date there are over 34,000 such prescribers registered with the Nursing and Midwifery Council (NMC 2007a). However other groups, who hold a specialist practice qualification, have now been given entitlement to prescribe from the renamed Community Practitioners Formulary for Nurse Prescribers (CPFNP). These groups comprise community learning disability, psychiatric and children nurses as well as school, practice and occupational health nurses (NMC 2006a). The only means of training to prescribe from this formulary currently is within the course of preparation for these community specialist routes (NMC 2006a). However more recently the NMC (2007b) have set standards for educational preparation to enable nurses who do not hold such a specialist practice qualification to be able to prescribe from the CPFNP.

Suitably trained community psychiatric and learning disability nurses are eligible to prescribe from the CPFNP. An example of how this formulary might be relevant is for a community mental health nurse to prescribe a service user with nicotine replacement therapy if assistance with smoking cessation is requested. Equally a learning disability nurse might find it beneficial to prescribe continence or stoma care aids to service users. However mental health/learning disability nurses must ensure knowledge and competence before prescribing in this way (NMC 2006a).

Following a change of Government, who in turn were pursuing a modernisation agenda, the second Crown report (Department of Health 1999) proposed two types of prescriber. The first type of prescriber proposed was the independent prescriber, envisaged to be responsible for assessment, diagnosis and prescribing for patients without reference to another health care professional. Following on from the NHS Plan (Department of Health 2000a) which identified new roles for nurses and allied health professionals, the Government launched in 2001 the Nurse Prescribers' Extended Formulary. This formulary was subsequently expanded at least twice following its inception (Department of Health 2002 & Department of Health 2004a). It allowed suitably trained nurses, midwives and health visitors to prescribe from an extended formulary to that of the earlier nurse prescribers' formulary, for a stipulated list of conditions aimed at addressing minor illness and injury, health promotion and palliative care.

In the field of mental health and learning disability, the National Prescribing Centre (NPC) et al (2005) asserted that most mental health and learning disability nurses would not be clinically competent to prescribe as extended nurse prescribers. However, they did recognise that some specialist services might wish to develop their nursing staff to prescribe from this formulary. An example of this could have been an organisation supporting the training of a nurse in substance misuse to be able to prescribe from the extended nurse prescribers' formulary. Such a nurse could have prescribed to injecting drug misuser's items for minor ailments, again ensuring knowledge and competence to do so (NMC 2006a).

Extended nurse prescribing came to an end when nurse, midwife, health visitor and pharmacist independent prescribing was announced in 2006 (Department of Health 2006a). More recently optometrists have been given approval to independently prescribe for conditions of the eye and surrounding tissue. A suitably trained independent prescriber may prescribe any licensed medicine and some controlled drugs according to their knowledge and competence (Department of Health 2006b). With regards to controlled drugs, the outcome of a consultation is awaited regarding the amendment of The Misuse of Drugs Act (1971) to allow full controlled drug prescribing by nurse and pharmacist independent prescribers (Medicines and Healthcare Products Regulatory Agency et al 2007). To date there are 10,750 independent and supplementary nurse prescribers (NMC 2007a). The NPC et al (2005) noted that in mental health and learning disability, a census in mid 2004 revealed that 128 were undertaking extended independent and supplementary nurse prescribing training with 102 already qualified. Interestingly those involved were located in only four organisations, with one organisation providing 45% of the specified total. Bradley et al (2008) note that in actual fact mental health nurses have been slower than other nursing specialties to take on

the prescribing role. Locally to date 31 nurse prescribers have been trained from mental health, with none in learning disability, out of a total of 369 students. There are no further current national figures available for these specialities.

Moving on, the other type of prescribing proposed by the second Crown Report (Department of Health 1999) was dependent or, as currently referred to, supplementary prescribing. This type of prescribing was subsequently launched in 2003 (Department of Health 2003a) as a result of section 63 of The Health and Social Care Act (2001) being enacted to allow ministers to create new categories of prescriber. The first group of professionals eligible for training for this role were nurses, midwives, health visitors and pharmacists. However in 2005 further classes of health care professionals followed namely physiotherapists, podiatrists, optometrists and radiographers (Department of Health 2005a). Supplementary prescribing takes place following an initial assessment and diagnosis of a patient's condition by a doctor. A clinical management plan (CMP) is then drawn up for the patient. This plan, agreed by the patient, supplementary prescriber and doctor, includes a list of medicines (within the supplementary prescribers area of knowledge and competence) from which the supplementary prescriber is able to prescribe. This type of prescriber is able to prescribe any medicine, but this mode of prescribing is best suited to patients with long-term conditions (Department of Health 2005b).

The NPC et al (2005) particularly welcomed this form of prescribing for those in mental health and learning disability. They recognised the value in supplementary prescribing in this field as it:

1. Allows service user's quicker and more effective access to medicines.
2. Increases service user's choice.
3. Provides service's more efficiently.
4. Makes better use of the skills and knowledge of practitioners.

They also saw the benefits of mental health/learning disability supplementary prescribing in the following sub-specialities:

1. Older peoples in patient and community services.
2. Acute inpatient care.
3. Assertive outreach.
4. Drug and alcohol teams, particularly when relevant controlled drugs can be prescribed.
5. Community mental health teams.

Hemingway (2005) reported how those from these specialities were indeed undergoing nurse prescribing training. He also noted other areas not promoted by the NPC et al (2005) where nurse prescribers were being put forward for training were:

1. Crisis/liaison psychiatry services.
2. Forensic and prison services.
3. Child and adolescent services.

To date there are in excess of 900 pharmacist supplementary prescribers. However, over 350 of these pharmacists have undergone conversion courses to enable them to prescribe as independent prescribers (Department of Health 2008a). The most recent numbers of Allied Health Professional supplementary prescribers are 76 physiotherapists, 43 podiatrists and 12 radiographers (Department of Health 2008a). However, there is unfortunately no evidence of how many such supplementary prescribers are operating in the field of mental health and learning disability.

In summary there are three means of NMP currently available, namely:

1. The community practitioners formulary for nurse prescribers.
2. Independent prescribing for nurses, midwives, health visitors, pharmacists and optometrists.
3. Supplementary prescribing for nurses, midwives, health visitors, pharmacists, optometrists, physiotherapists, podiatrists, radiographers.

To ensure non-medical prescribers are acting within legal and professional requirements, individuals may only practice as non-medical prescribers once they have had their respective prescribing qualification annotated on their entry in the professional register. They must also ensure that they prescribe within the limits of their professional knowledge and competence as well as the formulary they are qualified to use.

Hopefully, the discussion above has revealed that all these three types of NMP are relevant to those practising in the field of mental health and learning disability. The abolition of the extended nurse prescribers' formulary and the creation of independent prescribing for nurses and pharmacists particularly presents new opportunities for those in mental health/learning disability and their service users. The Chief Nursing Officer (Department of Health 2006c) endorsed this view by asserting that during consultation, nurse prescribing:

“was the new role most frequently cited as one that can be of particular benefit to service users” (page 46).

She also recommended the implementation of independent prescribing in mental health and learning disability settings.

The purpose of this article therefore is to share practice innovations and lessons learned from those areas where independent prescribing has been longer established. A particular focus will be upon clinical governance for NMP and specifically independent prescribing. This will hopefully be of relevance to both individuals and organisations, as independent prescribing is implemented in mental health and learning disability.

Clinically Governing Non-Medical Prescribing in an NHS Trust

The Department of Health have produced guidelines for both independent (Department of Health 2006b) and supplementary (Department of Health 2005a) prescribers to follow. Both these guidance documents require that organisations underpin NMP with a robust clinical governance framework. Clinical governance for NMP is also endorsed by the National Prescribing Centre (NPC) et al (2005). Scally and Donaldson (1998) assert that clinical governance is

‘A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.’ (Accessed online)

Clinical governance is an umbrella term incorporating the following components:

- Patient, public and carer involvement.
- Strategic capacity.
- Risk management.
- Staff management and performance.
- Education, training and continuous professional development.
- Clinical effectiveness.
- Information management.
- Communication.
- Leadership.
- Team working.

The NPC et al (2005) recommended a similar clinical governance structure to organisations implementing nurse prescribing in mental health and learning disability.

This article shares the experience of clinically governing NMP in an NHS trust. Scally and Donaldson (1998) umbrella terms, easily applicable to NMP, were pertinent to that process as will be further explained.

Audit

Clinical governance of NMP had been in place in the Trust since the inception of extended independent nurse prescribing in 2002 (Department of Health 2002) and the subsequent launch of supplementary prescribing (Department of Health 2003a). Following a meeting between the Director of Pharmacy, the Trust and University NMP Leads and the non-medical prescribers within the Trust in July 2006, the initial course of action was to undertake an audit of non-medical prescribers within the organisation. This audit had a number of objectives:

1. To determine those prescribing within the Trust and the scope of their current prescribing.
2. To examine non – medical prescribers perceptions of clinical governance arrangements within the Trust with regards to NMP.

3. To identify the continuing professional development (CPD) thus far undertaken by non-medical prescribers and their future needs.
4. To determine non-medical prescribers views on the implications of independent prescribing to their practice following the recent announcement by the Department of Health (Department of Health 2006a).

Undertaking this audit was also thought to be a useful exercise in providing a snapshot on current practice in this area, which in turn could then inform future development of the trust's NMP strategy and policy. Moreover undertaking this audit also enabled the Trust to address a West Yorkshire Workforce Development Confederation (WYWDC now Yorkshire and Humber Strategic Health Authority) (2006) clinical governance priority which requires that:

“Feedback from non-medical prescribers provides a source of information for quality improvement within the trust”. (Page 1)

Finally the audit, and indeed review of clinical governance for NMP, was deemed to be timely considering the recent announcement of independent prescribing for nurses, midwives and pharmacists (Department of Health 2006a) as well as the expansion of supplementary prescribing to allied health professionals (Department of Health 2005a).

The audit used a survey containing open and closed questions which were shaped by available benchmarks, such as the:

- Department of Health (2005a) Supplementary prescribing by nurses, pharmacists, chiropodists/podiatrists, physiotherapists and radiographers within the NHS in England: A guide for implementation - revised edition.
- Department of Health (2006b) Improving patients' access to medicines: A guide to implementing nurse and pharmacist independent prescribing within the NHS in England.
- NMC (2006a) Standards of Proficiency for Nurse and Midwife Prescribers.
- WYWDC (2006) clinical governance priorities for NMP.
- The data was analysed by Excel with the open responses undergoing thematic analysis.

Audit Findings

The NMP audit was distributed in September 2006 to 22 non-medical prescribers, who were all nurses only at that time. Responses were received from 14 nurse prescribers. Some of the findings bore a resemblance to those of Department of Health (2005c), particularly in terms of prescribing rates, confidence and CPD. The respondent's were made up of 7 clinical nurse specialists with the remaining respondents occupying other nursing roles such as specialist sister's and staff nurses.

Their length of service in their current role ranged from 3 to 14 years with the average length of service being 7.6 years. Hemingway (2005) believes that length of service in excess of 6 years prior to commencing prescribing training could be reassuring, as it suggests experiential learning and competence. However, he also notes that it could suggest an ageing workforce which has implications for NMP succession planning.

The year of qualification as nurse prescriber's was 2003 for 5 respondents, 2004 for 2 respondents, 2005 for a further 2 respondents with the remaining 5 qualifying in 2006.

Turning to support received from their medical mentors during and since training, 10 respondents reported receiving excellent support from their medical mentors. Indeed 9 out of these 10 respondents reported that they were continuing to receive and value such support following qualification. The tenth respondent reported that she had left the organisation in which she undertook prescribing training so therefore she had no further contact with her former medical mentor.

Of the 14 respondents, 9 were prescribing between 1 – 20 items per week with the average being 12 items per week. The respondents reported prescribing a range of medicines as either extended independent and/or supplementary nurse prescribers. There were 5 respondents who prescribed as both extended independent and supplementary nurse prescribers with the remaining 4 only using supplementary prescribing arrangements. Some individuals proceeded to identify the medicines they wish to prescribe as independent prescribers.

In terms of confidence in their prescribing, 6 of those prescribing reported feeling very confident in this role with the remaining 3 feeling fairly confident. The responses implied a correlation between length of prescribing practice and confidence, as one prescriber who commenced prescribing in the audit year reported feeling fairly confident in their new role, whilst most of those who have been qualified in excess of a year reported feeling very confident. It is worth noting that of the five respondents feeling very confident as a prescriber, four respondents still believe they were supported by their mentor. Both of those who report to feeling fairly confident were also receiving medical mentor support. This underlines how pivotal medical mentor support is to non-medical prescribers during and following their prescribing training (NPC 2005). Hemingway (2005) agrees noting that this echoes research undertaken in the United States where support from medical staff following qualification was a real determinant in those mental health nurse prescribers who went on to prescribe post qualification (Howard and Greiner, 1997; Kaas et al, 1998; Talley and Richens, 2001).

The following table (Table 1) denotes the respondent's knowledge of clinical governance arrangements for NMP in the trust. The key issues identified were the respondent's perceptions of the lack of:

- Patient information related to NMP; (to be explored later in the context of mental health/learning disability service users).
- Risk management processes to review incidents involving NMP.

- Cross boundary prescribing agreements between organisations. Bradley et al (2008) noted this as a issue for mental health/learning disability non-medical prescribers, a concern highlighted locally by Clibbens et al (2008).

Table 1 – Respondents Knowledge of Clinical Governance Arrangements for NMP

	Yes	No	Don't know/ missing data
A database of all the non-medical prescribers employed by the Trust	9	2	3
An updated job description/person specification to include NMP activity	7	2	5
NMP strategy/policies/procedures	11	1	2
Access to internet/Intranet	14		
A current British National Formulary	13	1	
Clinical governance and/or audit support for NMP	2	3	9
Access to a pharmacist	13		1
Patient information outlining NMP		4	10
Guidance on contacts between trust staff and representatives of the pharmaceutical Industry	9		5
Cross boundary prescribing agreements between organisations		3	11
Information on medicine alerts and other relevant updates.	12		2
Risk management processes are in place to review incidents involving NMP	6	1	7
Support networks with other non-medical prescribers.	8	2	4

The next table (Table 2) indicates the respondent's perceived barriers to NMP. The key barriers identified by respondents were:

- independent prescribing not permitted in the trust.
- time available to attend continuing professional development (CPD).

Again, Clibbens et al (2008) notes similar views from non-medical prescribers in mental health and learning disability settings locally, while the Chief Nursing Officer (Department of Health 2006c) observes the same issues nationally.

Table 2 - Respondents Perceived Barriers to NMP

	Yes	No	Don't know/ Missing data
Lack of job description/personal specification to cover prescribing role	4	7	3
Prescribing budget constraint		7	7
Independent prescribing not permitted in the trust	6	3	5
Time available to write prescriptions		13	1
Time available to access patients notes	1	12	1
Time available to record prescriptions	1	8	5
Time available to attend continuing professional development	6	5	3

Despite one of the perceived barriers to NMP being the time available for CPD, the respondents were clearly engaging in a range of post prescribing qualification learning activities. The CPD being accessed included medical mentor led sessions, the trust NMP support network, NPC, industry and university updates as well as reference to the internet and journals. The CPD needs identified included further NPC, university and industry updates, trust non-medical prescribers meetings and clinical supervision. Finally taught sessions on the law, antimicrobials, drug interactions, adverse drug reactions, and new products were also sought.

Both the CPD activity accessed and required matches the range of CPD opportunities identified by Bramley (2006) and Clibbens et al (2008). One omission in terms of how respondents either accessed CPD activity or identified future needs was the use of NPC competency frameworks (NPC 2001, 2003, 2004 & 2006). This too was noted by Clibbens et al (2008). Linked to CPD, 3 respondents reported receiving clinical supervision related to their prescribing role. Unfortunately however the survey instrument did not identify who was providing clinical supervision and how often such supervision took place. Furthermore no respondents reported receiving appraisal related to their prescribing role, as required by the NMC (2006a). Neither did respondents report undertaking audit related to their prescribing role.

Audit Recommendations

From the findings of the survey the following recommendations were presented to the Trust Medicines Management Committee.

1. Implement independent prescribing within the Trust for suitably qualified nurses and pharmacists. However, before individuals prescribe independently a list of medicines and conditions must be approved by a lead clinician and the Trust Medicines Management Committee.
2. Revise Trust NMP strategy and policy in the light of related Department of Health policy change and statutory body standards.
3. In revising trust NMP strategy and policy, address WYWDC clinical governance priorities.
4. Produce patient information for NMP.
5. Repeat the audit in 2007-8 following the implementation of independent nurse/pharmacist prescribing and supplementary prescribing for allied health professionals.

Addressing these points in the Trust will now form the remainder of the discussion within this article.

Strategic Direction

The Department of Health (2005a & Department of Health 2006b) guidance requires that organisations develop a strategic plan for use with NMP. The Department of Health envisage that producing and approving such a plan would typically involve senior managers, clinicians (doctors, nurses, pharmacists and specified allied health professionals eligible to train as non-medical prescribers), and the drug and therapeutic committee (or equivalent). Within this Trust, the strategy was produced by the NMP network, led by the Trust NMP lead. It was then approved by the Medicines Management Committee and the Clinical Management Committee.

The Department of Health recommends that content for a NMP strategic plan addresses:

1. The benefits to patients of NMP.
2. An initial range of clinical areas where patients could benefit.
3. A way to support and sustain the transition of staff to extended roles and the services they currently provide.
4. A communications plan aimed at informing both patients and all clinical and managerial staff.
5. Timescales for implementation.
6. The identification of a NMP lead.

Likewise this Department of Health guidance requires that NMP operates within a robust clinical governance framework.

Turning to each of the first four of these above-mentioned points particularly, the Department of Health assert that NMP should provide the following benefits to patients:

- Improved patient care without compromising patient safety.
- Easier and quicker access for patients to the medicines they need.
- Increased patient choice in accessing medicines.
- Better use of the skills of health professionals.

These strategic aims are shared with those identified for use in mental health/learning disability by the NPC et al (2005) and discussed above. For the Trust, NMP assisted with the provision of more patient-centred services. It also enabled rapid access to medicines with the use of less health care professionals in the patient journey. This then had the potential to enhance the patient experience, connecting to the intentions of the current NHS review (Department of Health 2007ab).

The Department of Health indicates that NMP contributes to the provision of flexible care delivery. Following the reconfiguration of Trust services, priority clinical areas for NMP emerged. These included:

- Assessment for acute patients.
- Children's assessment.
- Pre-operative assessment.
- The management of long term conditions.

These identified areas translate to similar priority areas for NMP in mental health and learning disability. Such areas have been identified by the NPC et al (2005) and discussed earlier. However to recapitulate, assessment of the service user group across the lifespan is a key component of mental health and learning disability services, endorsed by current Government policy (Department of Health 2008b).

The Trust reconfiguration also relied on changes in practice which both prevented hospital admission and reduced lengths of stay. Therefore the continued selection of clinical areas for NMP sought to enhance the patient's journey from admission to discharge which will assist the achievement of the 18 week target within the Trust (Department of Health 2006d).

To ensure patient safety the Trust prioritised areas for NMP indicated by over reliance on patient group directions (PGDs) and/or the incidence of medication errors. Incrementally, the Trust is seeking to reduce it's provision of medicines using PGDs in line with Department of Health

(2000b) guidance. In mental health and learning disability, NMP may assist in the recommendations from the National Patient Safety Agency (NPSA) (2006) with respect to medication safety for this particular client group.

To maximise the use of skilled health professionals, the Trust encourages those employed in autonomous and specialised roles to become non-medical prescribers. For nurse prescribers, this dovetails neatly with the ambitions laid out for advanced practice in 'Modernising Nursing Careers' (Department of Health 2007b).

Finally, communication for NMP within the Trust was designed to operate at three levels:

1. The first level was with the patient. To comply with statutory body and Department of Health standards non-medical prescribers must ensure that patients are aware that they are being treated by a non-medical prescriber and of the scope and limits of their prescribing. It will be the responsibility of the individual non-medical prescriber to provide this information to patients accordingly. However the Trust produced and approved written information relating to assist with informed consent. More discussion will ensue on this point later in this article.
2. The next level was with the non-medical prescriber. The non-medical prescriber is responsible for communicating their prescribing role within their particular service.
3. The final level rests with the Trust NMP lead: The NMP lead provides strategic communication related to this initiative. This involves promoting NMP where appropriate, as well as acting as a conduit for communication on this initiative both within and without the Trust. The network of non-medical prescribers is also led by the Trust NMP lead.

Policy

The key instrument of NMP clinical governance in the organisation is the Trust policy. It takes reference from the first domain of the Healthcare Commission Standards (Department of Health 2006e) addressing safety. Core standards 4d requires that healthcare organizations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely. Likewise it connects to the National Health Service Litigation Authority (NHSLA) Risk Management Standards (2007). In particular it related to standard 4 dealing with clinical care, and criterion 6 addressing medicines management. Similar standards operate in the field of mental health and learning disability (Healthcare Commission 2007).

The policy document sets a framework to encompass NMP, from the selection of individuals for training through to their practice on qualification. It is governed by the standards set for NMP by the Department of Health (2005a & Department of Health 2006b), but, furthermore, embeds the requirements of the regulators for those who can practice as non-medical prescribers (National Prescribing Centre & Department of Health 2004, Nursing and Midwifery Council 2006, and Royal Pharmaceutical Society of Great Britain 2006). The following discussion will seek to highlight some

key elements of the policy which either linked to national NMP agendas or the audit of NMP undertaken in the Trust. These elements include:

- Implementing and governing independent prescribing for nurses and pharmacists.
- Prescribing for children and young people.
- Patient information.

Implementing Independent Prescribing for Nurses and Pharmacists

As revealed above, clinically governing NMP in the Trust was timely for a number of reasons, but a key driver was the Department of Health (2006b) implementation of independent nurse and pharmacist prescribing. Furthermore, the audit described earlier, identified that current nurse prescribers were keen to be able to prescribe independently any licensed medicine according to their knowledge and competence. Therefore one of the first priorities following the audit, was to develop a means to permit independent prescribing, which was underpinned by robust clinical governance arrangements.

The method adopted was based on work published by the National Electronic Library for Medicines (NELM) (2006). A proforma was developed which captures the intention to practice for non-medical prescribers. The information required on the proforma is contained within three main sections, with additional biographical details included.

The first proforma section involves the non-medical prescriber identifying the disease area to be prescribed for, accompanied by their evidence of competence in this area and related CPD. This section concludes by requiring the non-medical prescriber to stipulate the evidence underpinning this area of therapeutics. Such evidence may include NICE guidelines, National Service Frameworks or Trust protocols.

The second section links to issues identified in the original NMP audit. Within this section, non-medical prescribers must detail both their activity and intentions in NMP appraisal, clinical supervision, audit and CPD.

The final section necessitates signature by the non-medical prescriber's manager and their lead medical clinician before presentation for approval at the Trust Medicines Management Committee. Following approval, independent prescribing may proceed but should the non-medical prescriber seek to add additional items to their prescribing, an 'additions proforma' must first be completed and approved.

This arrangement could assist the implementation of clinically governed independent prescribing in mental health and learning disability settings. So far non-medical prescribers in this arena, through mostly supplementary prescribing arrangements, have operated in prescribing partnerships with doctors. Such prescribing partnerships may have been more longstanding than those of their general or primary care counterparts. Indeed Clibbens et al (2008) noted an individual who had been a

supplementary prescriber in mental health for three years. Therefore using this proforma, doctors are well placed to assess the competence and therapeutic intentions of those supplementary mental health/learning disability nurse prescribers who now wish to expand into independent prescribing. Equally the therapeutic knowledge, CPD and audit activity underlined by Clibbens et al (2008) are all required within the proforma.

NMP for Children and Young People

The second NMP clinical governance priority addressed the NMC (2007c) requirements related to nurse prescribing for children and young people. First the trust policy requires that in terms of all NMP for children and young people, and not just nurse prescribing, a consultant paediatrician only is allowed to provide mentorship to those undergoing training. Furthermore, the proforma described above assisted with the implementation of this requirement. Thus the Trust determined that a consultant paediatrician is the only doctor that can confirm the prescribing intentions of either an independent prescriber, or the clinical management plan utilised in supplementary prescribing with respect to children and young people.

Hemingway (2005) indicates the usefulness of NMP in child and adolescent mental health services. As these services address The Children's Plan (Department for Children, Schools and Families 2007) and standard 9 of the National Service Framework for Children, Young People and Maternity Services (Department of Health 2004b), NMP will inevitably play a part and this model of governance should fit those services. As such, a clinician, who specialises in child and adolescent psychiatry or learning disability, could verify diagnostic and therapeutic competence for a non-medical prescriber wishing to prescribe independently for this service user group.

Patient Information

Finally, the last clinical governance priority for discussion involved the production of a patient information leaflet for NMP. This leaflet is a vital means of ensuring patient consent to NMP. With regard to supplementary prescribing, a clinical management plan is not lawful without patient consent (Department of Health 2005a). For both independent and supplementary prescribing, patients need to provide consent to having medicines provided by a non-medical rather than a medical prescriber specifically (Department of Health 2005a & Department of Health 2006b), in addition to providing consent to examination and treatment in general (Department of Health 2001).

In mental health and learning disability, information for service users with respect to NMP is timely given that the Government has produced recent guidance for this group on medicines management as well as their health care professionals (Department of Health 2008c). Therefore, any service user NMP information needs to be developed to complement this medicines management guidance.

The leaflet developed in the acute NHS trust was designed using the Department of Health (2003b) toolkit for producing patient information but took reference from NMC guidance (2006b). Following proof reading by

patient groups, the leaflet was amended to remove the term controlled drug and clarify the meaning of the term 'optometrist'. This served as a reminder that medical jargon does not easily translate into universal understanding, thus concurring with the opinions of Wolff (2008). The recent implementation of this leaflet requires that evaluation of its usefulness with patients' is the necessary next step.

Conclusion

In conclusion, this article has demonstrated some of the methodology for achieving clinical governance for NMP in an organisation, and as such could be applied to any setting where this initiative takes place. Presented in this article is a means by which independent nurse and pharmacist prescribing can be clinically governed, which is timely as NMP colleagues in mental health and learning disability consider developing this within their organisations. However, a key next step in ensuring the clinical governance arrangements proposed continues to provide a robust framework, is the monitoring and evaluation of the systems and processes developed. Such monitoring and evaluation needs to focus particularly on:

1. The effectiveness of the systems developed for independent prescribing and NMP for children and young people. This could be achieved by undertaking further audit of non-medical prescribers.
2. The usefulness of any patient/service user information leaflet.
3. Patient/service user satisfaction with NMP.

Following implementation of the NMC (2006a) Standards of Proficiency, a further key area for organisation's to address is the determination of diagnostic and therapeutic competence prior to nurse's being put forward for prescribing training. A solution could be to amend the independent proforma so that such determination of competence is undertaken prior to individual's applying for NMP training.

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