KALEIDOSCOPE Health and Care

HSR UK

Department of Health & Social Care

NHS

Case study 4: Non-medical prescribing

Introduction

Hello. We look forward to you joining us for our digital workshop on Thursday 5 November, 2.30pm–4.00pm. We'll be looking at what we can learn from how nurses and allied health professionals came to prescribe medication.

Please read this short case study before the event. The workshop will be full of interesting discussions, and this background reading will enable you to participate fully in those.

What was the change?

- Government legislation that came into force in 1994 enabled nurses to prescribe medication in the UK.
- Prescribing rights were initially quite limited to specific medication like wound dressing and ointments, but nurses were given much wider powers as independent prescribers from 2006, following successful pilots.
- Prescribing rights were also granted to pharmacists (2003) and allied health professionals in 2005.
- This is in contrast to many countries in Europe and elsewhere, where prescribing is the domain primarily or exclusively of doctors. The UK has the most extended nurse prescribing rights in the world and prescribing rights for allied health professionals like physiotherapists and optometrists are not seen in other countries.
- There are now around 58,000 non-medical prescribers in the UK, the vast majority of whom are nurses.
- This change has given patients better access to medication. For instance palliative care nurses can prescribe opioids for patients at end of life and nurse practitioners can prescribe asthma medication in clinics. This relieves pressure on doctors and is more convenient for patients.
- There is limited research on the effects on quality of prescribing but a recent Cochrane review of 46 studies (Weeks 2016) shows equivalent or better quality, in terms of lower rates of prescribing errors, and greater patient satisfaction.
- Some research shows that prescribing by a range of staff is liked by patients and increases job satisfaction for nurses and others prescribing. It is likely that rates of appropriateness are equivalent between doctors and other professionals, although there are some questions about issues in taking clinical histories and knowledge of drug interactions in some settings (diabetes and dermatology), where nurse prescribing is preferred for longer, more patient-centred consultations.

How was it achieved?

Changing professional boundaries

The NHS Long Term Plan highlights the importance of patient-centred care and the potential for multidisciplinary teams and extending traditional scope of practice to meet rising demand. The rise of primary care networks (PCNs) provides an opportunity for new roles and ways of working.

This is part of a wider debate about changing scope of practice and substitution. Evidence such as a review by Laurant suggests that nurse consultants in primary care can provide equivalent care and potentially higher patient satisfaction rates, but may be more costly (longer consultations, more tests). Recognising high rates of prescribing errors, innovations like ward-based pharmacists in hospitals are seen as a welcome advance to improving patient safety and care.

Patient choice driven modernisation

Patients with complex needs, such as older people with frailty and multiple chronic conditions, are likely to have complex medication needs. Greater access to medication by more members of the multidisciplinary team prevents delays, for instance in prescribing opioids and complex pain relief for those at end of life in the community. This is an important part of making every contact count and can be part of holistic care provided by specialist nurses, district nurses or community pharmacists. Extending prescribing powers provides an opportunity to modernise services, for instance, with nurses or physiotherapists leading clinics for people with chronic pain or long-term conditions.

Incremental change

Changes such as the move from supplementary to independent prescribing were piloted and evaluated. This allowed for gradual acceptance of new roles and powers.

However, some might say change has been too incremental. For instance, a recent survey of pharmacist prescribers in Scotland, cited by Stewart, suggested some were still under-used with other professionals and patients not fully recognising their prescribing role. They also cited the barrier of lack of resources and support networks to underpin individuals' prescribing activities. In terms of theoretical models of change, such as those proposed by Carl May, we may not yet have reached a point where these new ways of working are normalised across the system.

Further reading

- Cope CP, Abuzour AS, Tully MP. Nonmedical prescribing: where are we now? Ther Adv Drug Saf 2016; 7: 165–172.
- Latter S., Blenkinsopp A., Smith A., Chapman S., Tinelli M., Gerrard K., et al. (2010) Evaluation of nurse and pharmacist independent prescribing. London: Department of Health.
- Laurant M, van der Biezen M, Wijers N et al (2018). Nurses as substitutes for doctors in primary care. Cochrane Library
- Stewart D, Jebara T, Cunningham S et al (2017). Future perspectives on nonmedical prescribing. Ther Adv Drug Saf 2017: 8(6); 183-197
- Weeks G, George J, Maclure K et al . Non-medical prescribing versus medical prescribing for acute and chronic disease management in primary and secondary care. Cochrane Database Syst Rev 2016; 11: CD011227