REINVESTMENT PROJECT FINAL REPORT

Non Medical Prescribing Coordinator for the South West Strategic Health Authority

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April 2010

‘The non-medical prescribing programme gives patients quicker access to medicines, improves access to services and makes better use of nurses’, pharmacists and other health professionals’ skills ‘ (DH 2006)
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1 Executive Summary

1.1 This one year project has been successful in developing networks, establishing a database and identifying key contacts. Although the previous Non Medical Prescribing (NMP) Regional Coordinator had passed on some of this information, it had been some two years since they had been in post and there had been many changes within Trusts during that time.

1.2 To identify NMP activity in the region and determine next steps a questionnaire was circulated to all NMPs in the region during the last three months of the project. Results and findings from this can be found in appendix 1 whilst some, the most significant, have been incorporated into this report.

1.3 Responses from Non Medical Prescribing (NMP) leads across the region indicated that there was a real need for the role of regional NMP coordinator and it became evident that the South West was the only region that did not have an individual in post and consequently had no representation in various networks primarily the Department of Health’s (DH) bi annual meeting of all the Strategic Health Authority (SHA) NMP leads.

1.4 Meetings across the region have been held during the past year with representation from the National Prescribing Centre (NPC) at two of these. The NPC advisor presented the national picture and prompted more strategic thinking in terms of implementation. Prior to this the NPC had launched a project to collect case studies for a national publication and their web site with the aim being to identify how NMP was being implemented across the country and ways in which it was enhancing service delivery. It was believed that this would enable sharing of best practice and demonstrate to commissioners and Health Trusts how NMP implementation could provide a means to Service Improvements.

1.5 Several NMP leads from the SW region have submitted case studies and two of these are now on the NPC web site with others and are included in the NMP – A Quick Guide for Commissioners (2010). This is a great achievement for the SW and has
promoted NMP activity in the region to a national audience. In addition it has created interest across the region, encouraged sharing of practice and promoted confidence.

1.6 Circulation of ‘latest news’ on NMP including daily browsing of all information sources to determine the most important for dissemination has been a key activity. This has been noted by NMP leads as a really useful activity and they suggest that it helps to keep them up to date. Whilst it is recognised that this activity has been appreciated there may not be the resources to maintain this but NMP leads have been encouraged to access key sites on a regular basis and sign up for alerts.

1.7 Sound links have been established with the NPC and NMP leads have been encouraged to join this and other national networks as these provide daily alerts on medicine management, are a useful resource and provide opportunities for maintaining competence and Continuing Professional Development (CPD) requirements. In a recent survey all NMP leads identified access to these networks and the SHA lead as valuable resources for NMP.

1.8 The role of the NMP lead is now more stable in the Trusts and contact is good but where there has been limited contact due to staff changes and amalgamations of Trusts there are new appointments being introduced and those new to roles are utilising the network. To maintain and sustain the network an identified individual must be identified who has this responsibility.

1.9 Links with the HEIs have been established and they have also attended meetings with the NMP leads. This has been particularly useful in promoting discussion and understanding of the current and future educational needs of the Trusts and the demands of the regulatory bodies.

1.10 The NMP lead in Trusts is usually a nurse but in four Trusts it is a pharmacist this has proven to be of great benefit when we have had the perspective and knowledge base from these two professions both in our meetings and through the email network.
It was evident when coming into post from Prescribing Analysis and Cost (PACT) data and FP10s that in those regions were there had been a greater organisational readiness e.g. the North West that NMP numbers were higher and service improvements greater in comparison to the SW. Having an individual from the SHAs employed as a regional coordinator has made a significant difference.

1.11 As a SHA coordinator I was invited to participate in two events organised by the University of Southampton and Keele University who had been commissioned by the DH to undertake an evaluation of the NMP role. One of these was as a member of a focus group and the other to comment and advise on the findings so far. This proved to be yet another channel for networking and representing the SW region in a national forum. The results from this research are due to be published later in the year.

1.12 Six months into the project all NMP leads were suggesting that the role was appreciated and making a difference in that many Trust NMP leads had felt isolated in their role and having a point of contact and a supportive network promoted confidence and enabled them to develop their ideas.

1.13 Outcomes
1.13.1 On completion of the project a database of NMP leads has been established and strong links with NMP Leads, HEIs, NPC, SHA, NMC and DH. These links have enabled sound relationships to be built and activities identified across the region in terms of the implementation of NMP.

1.13.2 An effective communication system and networking opportunities has been established across the region and nationally. Advice and support has been made available to NMP leads and practitioners and the role has been seen to be a valuable resource.

1.13.3 HEIs have established what the future needs of NMP leads and Trusts might be and have had the opportunity to discuss these with Trust NMP leads. To the best of their
abilities, education and practice are developing practitioners to meet the future health needs of the South West population.
2. Background

2.1 In 2009 the South West Strategic Health Authority (SHA) identified the need for a Non Medical Prescribing (NMP) link between the Higher Education Institutes (HEIs), Health Trusts, the Department of Health (DH), Regulatory Bodies and the SHA.

2.2 The purpose of such a role was to create a mechanism for the exchange of information between the NMP leads in the Health Trusts within the SHA, the HEIs in the SW region and National Bodies.

2.3 An effective communication system between the stakeholders was essential to determine NMP activity across the region, educational demand, and ensure that educational provision and practice met the health needs of the South West population and was in line with government strategy and regulatory requirements.

3. Project aims and scope

3.1 To develop an effective communication system and networking opportunities across the region and nationally

3.2 To determine NMP activity and provide support, advice and resources to practitioners

3.3 To ensure that HEIs were providing the educational programmes to meet the need of service staff and Health Trusts and identify future demand

3.4 To ensure that education and practice were developing practitioners to meet the future health needs of the South West population.

Project team: Susie Ventura Principal Lecturer University of the West of England
Project date: May 2009 – May 2010
4. Project Activity

The Role of the Non Medical Prescribing Lead

4.1 In January 2010 the South West Non Medical Prescribing (NMP) Regional Coordinator sent out 30 questionnaires to the NMP Leads, with 23 responses being received. The aim was to collect information of the Non Medical Prescribers’ role and their activities to determine areas for future action and to gain an insight into the impact and benefits of the role on patients (see appendix).

4.2 Attendance at national conferences, DH and local meetings with NMP leads and participating in discussion with other SHA leads has promoted cross fertilisation of ideas and best practice. Effective communication with these various groups and individuals has enabled discussion of practice issues providing intelligence and identifying areas for attention.

Qualifications

4.3 Of the 23 that responded to the questionnaire 9 are not qualified NMPs the remaining 14 are qualified at either V300 (Independent and Supplementary Nurse Prescribers) or V100 (Community Practitioner Nurse Prescriber integrated with Specialist Practitioner Qualification / Specialist Practitioner Public Health Nurse) but only 8 of these continue to prescribe on a regular basis.

4.4 Of the 14 qualified their qualification had been gained more than 5 years previously with one with a community nursing background achieving their V100 and V300 nine and five years ago, respectively, and continuing to prescribe on a regular basis.

4.5 Nine are currently working in Primary Care Trusts, five in Mental health / Learning disabilities and Partnership Trusts and nine in Hospital Trusts.
4.6 The majority of the NMP leads have senior positions within the organisation and of the 23 who responded to the recent questionnaire nine are not qualified NMPs, of the remaining fourteen who are qualified only eight continue to prescribe on a regular basis due to the demands of the roles that they now hold.

4.7 In the SW region there are at least 900+ V300 prescribers and 600+ V100/ V150 prescribers and the numbers who are undertaking prescribing programmes across the region in this academic year can be seen in table 1 below.

<table>
<thead>
<tr>
<th>HEI</th>
<th>V300</th>
<th>V100</th>
<th>V150</th>
<th>Pharmacists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plymouth</td>
<td>72</td>
<td>13+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gloucestershire</td>
<td>61</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bournemouth</td>
<td>42</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bath</td>
<td></td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>UWE</td>
<td>15</td>
<td>41</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>211</td>
<td>54+</td>
<td>6</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 1 Independent / Supplementary prescribers
Academic Year 2009 – 2010 South West Region

4.8 Nationally it has been noted that numbers for NMP programmes are falling and this appears to be reflected in the SW region. NMP leads have expressed concern that there are high numbers of senior staff who are qualified NMPs and are due to retire within the next ten years. They suggest that the issue of sustainability needs to be addressed.
**The NMP Leads**

4.9 The NMP leads were predominantly at senior level within the organisations and titles varied but in essence are captured under the following.

<table>
<thead>
<tr>
<th>Role within the organisation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist</td>
<td>3</td>
</tr>
<tr>
<td>NMP Lead</td>
<td>5</td>
</tr>
<tr>
<td>Director of Nursing / Professional Head of Nursing / Lead Nurse</td>
<td>3</td>
</tr>
<tr>
<td>Service manager</td>
<td>1</td>
</tr>
<tr>
<td>Practice development</td>
<td>3</td>
</tr>
<tr>
<td>Consultant Nurse / Advanced Practitioner/ Specialist Nurse / Matron</td>
<td>8</td>
</tr>
</tbody>
</table>

4.10 The majority (16) suggested that there were no protected hours for the role of NMP lead but that it was a recognised / expected responsibility for the position they occupied in the organisation. Of the remainder the range spread from one hour per week to a full time post. Whilst five had been in post for more than 5 years, five had been in post for less than 12 months.

4.11 There does not appear to be any significant difference between the effectiveness of those NMP leads who are qualified and those who are not. More importantly it is clear that it is the position that they hold within the Trust that is important and consequently the opportunity to promote an understanding of NMP to groups and individuals who have influence within the organisation. Representation on medicine management groups or at least a channel of communication to this group is important and not all NMP leads have this.

**NMP ACTIVITY**

4.12 When trying to determine the level and nature of the NMPs activity it appears that often this is linked to the number of prescriptions i.e. through FP10s. This is a flawed method on many counts, one being that FP10s only relate to primary and community care and it is extremely challenging within Hospital Trusts to calculate these.
4.13 However more importantly there are a number of activities that NMPs undertake that do not result in prescribing. In fact in many instances particularly in the field of mental health and the older person medication reconciliation activities can reduce the number of drugs, improve patient safety and promote concordance. This activity however cannot be captured by quantitative data alone but it is suggested that it can make a significant difference to patients, reduce the drug budget, in some instances prevent accidents and promote healthier living.

4.14 Areas of activity were principally similar and included:

**Patient safety**
4.15 Healthcare processes, working practices and systemic activities that would prevent or reduce risk of harm to patients were in place and monitored by the NMP leads.

**Clinical and cost effectiveness**
4.16 Healthcare decisions and services help to achieve healthcare benefits to meet patients’ individual needs. Decisions are based on research evidence that demonstrates effective clinical outcomes. However, very few NMP leads are involved in the development of local formularies and guidelines.

4.17 During the last twelve months 7 NMP leads had undertaken audits, with 5 of these attaching the tool used and in some cases the completed tool. These demonstrated a robust approach to audit with action points identified. These were primarily in the Mental Health / Learning Disabilities field.

4.18 PACT / ePACT data was identified by 2 leads as their means of auditing with one Hospital Trust commenting on the challenges for these Trusts in collecting this information but had attached a locally agreed document.

4.19 Two Trusts commented that audit was undertaken by individual NMPs and these were included with their responses. The remainder were in the process of developing a
tool and others had audits in progress. 16 NMP leads had not undertaken a recent clinical audit but had now made this a priority and it has been suggested that they use the London SHA audit tool.

Governance

4.20 Leadership, accountability, systems and working practices to ensure quality assurance and improvement and patient safety. Many of the policies were either being updated or it was recognised that they needed to be updated as soon as possible. Service level agreements were identified as requiring scrutiny as more services were commissioned that were external to the organisation. There have been significant legislation changes during the past year and it is recommended that these be checked to ensure that policies are up to date.

4.21 All recognise and address their areas of accountability and their activities are linked to Governance issues but many suggested that there was limited recognition for the time demanded for this role.

4.22 Commissioning and the legalities of employing NMPs across Trusts and agencies have been raised increasingly by NMPs within the region and by other SHA leads, as have instances of Trusts employing agency staff who are qualified NMPs. The general consensus is that Trust NMP policies and Governance need to address and be aware of these anomalies and it is felt that these could increase as for example from the expected rise in private professionals being commissioned by the Trusts. There are serious implications for patient safety if these issues are not considered and addressed.

4.23 Whilst the majority of NMP leads are undertaking activities, which fall under this remit, it has been suggested that clearer definition and more robust frameworks would be helpful. The London SHA audit tool was recently circulated to all the NMP leads and many are now using this as a checklist for their own Trusts having found it to be a useful framework for audit and Governance. http://www.nelm.nhs.uk/en/NeLM-
4.24 Those areas which they have identified are not adequately covered are being addressed. One of these is to include a greater emphasis on patient involvement in developing patient leaflets / information sheets and an evaluation of the impact and benefit of NMP on patients / service users, an area that only a few NMP Leads have considered.

**Patient Focus**

4.25 Healthcare is provided in partnership with patients, families, carers and other services / agencies and respecting their diversity, preferences and choice is paramount.

4.26 In response to the question on involvement of service users the majority (17) had not. One Hospital Trust unfortunately did not provide any details. Service user involvement had been undertaken in 6 Trusts at various levels. One NMP had a piece of published research, one had designed a patient information leaflet in consultation with service users and two had developed patient information leaflets.

4.27 This is an area for future consideration those that are due to develop patient information leaflets could consider the value of involving patients / service users in their development and it would be well worth developing a tool to determine the impact (if any) of NMP on service users. In other words a more robust evaluation on the impact, particularly in terms of the government's initial aim for service users would be beneficial.

**Accessing the NMP programme**

4.28 When NMP was first introduced to the region there were some individuals who were 'sent' on the programme from Trusts without due consideration of the role or its implications and the supportive infrastructures for their return.
4.29 Consequently many of those who qualified found on returning to practice that there were barriers to them practicing as NMPs. From discussion with other SHA leads this is a familiar experience to many of them. Fortunately there are now more robust mechanisms in place to ensure that the most suitable individuals are chosen to undertake the programme and that the rationale is clearer in terms of service needs, new roles and new ways of working.

4.30 There remains within the mental health field a number of NMPs who on qualification were only allowed to practice as supplementary prescribers and again this is reflected nationally. There appears to be many reasons for this: the nature of the field of practice, professional territories and unclear role expectations. However this is changing and more mental health NMPs are moving into independent prescribing.

Communication
4.31 The majority of NMP Leads cited the two main sources of regular NMP information as being the NPC and the SHA Lead whilst the DH, regulatory and professional bodies, Pharmacists, Journals / literature, websites including NELM, MHRA and the DH were the next most often cited.

4.32 Email was the primary medium used to receive and disseminate material by all respondents.

4.33 Meetings in most instances were held regularly from 3 to 8 times per year. In others these were organised on a regular basis by the NMPs themselves with in some instances the NMP Lead attending twice per year.

Returning to NMP practice
4.34 One area of concern that has been detected is the number of those practitioners holding the V100 and V150 qualification who are not practicing. It is primarily those practitioners with the V100 – Health Visitors that raises concern with one PCT having described their area of practice as limited. There are community nurses with the V150
for whom there appears to be limited information as to the area of practice in which they are practicing. This also raises issues of Trust policy and Governance.

4.35 NMP leads have been in contact for advice on how to manage the situations where NMPs (V100 / V150) have not been practicing and consequently not maintaining competence. Some are looking at developing in house programmes to address this and whilst this is to be encouraged there is an opportunity for HEIs to support Trusts in this endeavour.

**Continuing Professional Development (CPD)**

4.36 Initially I found that there was some confusion amongst practitioners of the CPD requirements for NMPs. During the last six months the NMC have clarified the position, which is now on a par with that recommended by the Royal Pharmaceutical Society of Great Britain (RPSGB) with details to be found on their websites. In essence, practitioners need to be able to demonstrate that they have maintained competence and that they have undertaken activities to promote professional development. Trusts need to articulate their expectations and develop frameworks to demonstrate how this will be achieved and monitored.

4.37 Responses to the questionnaire on CPD activities suggests that Trusts are engaging with this requirement with the majority of the NMP leads commenting that they had responsibility for developing and implementing CPD activities for their NMPs. Many were working with other professions, principally pharmacists, but also with medical staff. In addition many Primary Care Trusts (PCTs), Hospital Trusts and Mental Health / Learning Disabilities Trusts were collaborating in CPD activities with significant success.

4.38 Responsibility for providing in house CPD was identified by 17 NMP leads as their sole or partial responsibility with the remainder suggesting that it was the responsibility for individual NMPs, that it was identified through appraisal / IPR or that the organisations education and training group managed all CPD.
4.39 Twelve NMP Leads suggest to the NMPs in their individual Trusts that CPD may be accessed from a Higher Education Institute (HEI) with all of the Region’s HEI links being identified. Two Leads were in discussion with their local HEI in terms of developing CPD. Others either didn’t suggest HEI or not a specific institution.

4.40 However, it is clear that significant CPD is made available and encouraged to NMPs through their NMP lead and organisation whether in a formal or informal manner. In many cases it is asserted that each individual NMP must take responsibility for their CPD but much is facilitated in house.

4.41 Examples included: various in house sessions including master classes, links with medical teams, pharmacists, and disease specific. Journals, web sites, NPC & NPCi, action learning sets, peer support, Nurse Prescribing Association, regulatory bodies, conferences, reflective practice, Trust intranet, monthly forums and case reviews.

4.42 It was recognised that funding CPD and staff being released to attend CPD events was challenging. It was also suggested that there was a need for reassessment of competence for those who had not been practising.

4.43 Many were clearly conscious of the need for creative thinking, in view of forthcoming financial constraints and suggested closer collaboration with other PCTs and Hospital Trusts.

4.44 I would like to endorse this observation as during my time as SW Regional Coordinator I have been fortunate to have attended four highly successful cross Trusts CPD study days organised by the NMP leads demonstrating effective and efficient use of resources, networking opportunities and a rich learning environment.

4.45 This approach is to be encouraged as having been invited to several of these across the region I found that these events encouraged learning, sharing of practice and
enriched understanding of other professional roles in addition to developing local networks across Trusts.

4.46 NMPs have identified a range of CPD resources that they access and recommend to staff including NPC, NPCi, journals, peer support, and research literature. NMPs organise regular meetings with their NMPs and capitalise on this opportunity to case review, share practice and promote presentations from experts within the Trusts.

4.47 However NMP leads recognised the contribution that HEIs could also make to CPD and recommended Master Classes and other opportunities that regional HEIs were offering.

Making Connections
4.48 In discussion with NMP Leads and NMPs at various meetings it has been useful to remind them of the aims of the DH when NMP was introduced, which was that: ‘The non-medical prescribing programme gives patients quicker access to medicines, improves access to services and makes better use of nurses’, pharmacists and other health professionals’ skills ‘ (DH 2006).

4.49 Reminding practitioners of the aims of NMP has enabled them to reflect on their practice and identify service improvements that have been made. It also reminds them of the purpose and provides a means for them to articulate the value of NMP. I have not been convinced that Trusts fully understand the implications of NMP nor the important role it plays in delivering service improvements, new ways of working or enabling them to meet the Quality Improvement agenda described by Lord Darzi (DH 2008).

4.50 All NMPs have had access to High Quality Care For All: Making Connections, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_109060.pdf which suggests ways that the use of NMP enables a range of healthcare professionals to contribute to service improvement and efficiency. They have found this
to be an interesting and inspiring document and are looking at the ways that NMP in their organisations are helping to meet this agenda.

4.51 From the questionnaire it has been possible to identify that all NMPs have examples of the impact and benefit of NMP that include quicker access to medicines, improved access to services and better use of nurses’, pharmacists and other health professionals’ skills.

**SHA NMP Coordinator role**

4.52 Of the 23 responses 18 suggested that the role should be maintained and provided positive feedback whilst 5 did not comment. Some of the reasons given for continuing with the role were:

‘*That this is a key role much needed in terms of professional development and governance that a central contact is invaluable to disseminate legislation changes, information from SHA & DH, and guidance in addition to providing coordination of NMPs across the region.*’

‘*Networking has been facilitated and collaboration between NMP leads across the region has been promoted thus ensuring the sharing of vision and best practice with resources being used more effectively.*’

‘*Having a central contact point to discuss concerns and have queries answered has reduced the sense of isolation that many NMP leads feel.*’

**5. Key recommendations**

5.1 The SHA, in collaboration with Trusts, should review the numbers of NMPs within Trusts and determine future need, considering the difference NMPs can make in meeting the High Quality Care For All agenda (DH, 2008), and the need for sustainability in view of those practitioners who will be retiring.
5.2 NMP leads within Trusts should identify those practitioners who are not utilising their qualification and develop means to enable them, where appropriate, to update their knowledge and skills either through in house workshops or in collaboration with the local HEI.

5.3 Encourage Trusts to identify where physiotherapists could contribute to service improvements by qualifying as supplementary NMPs.

5.4 HEIs should engage with Trusts to support them in developing study days or materials, for those practitioners returning to NMP practice, with specific requirements being informed by regulatory bodies.

5.5 HEIs should engage with Trusts to develop Master classes / study days / online materials to further meet the CPD needs of NMPs.

5.6 NMP leads to ensure that Trusts have robust governance that addresses the wide range of issues attached to NMP. Trusts need to keep updated in line with the many changes within practice in terms of care provision, for example the importance of addressing NMP issues when commissioning services.

5.7 Encourage patient involvement in NMP through in service training and education, clearer guidelines within governance frameworks, involvement of PALS / patient support groups, an evaluation of the patient experience. Input from a HEI with experience and expertise in this area could be beneficial.

5.8 NMP leads should articulate effectively to Trusts the benefits and impact of NMP on the wider Health Care agendas. Support from academics in gathering and presenting evidence can be helpful here. It is suggested that the potential of NMP to contribute to service improvements is conveyed by NMP leads to medicine management committees.
5.9 The SHA should identify and support an individual who is able to coordinate NMP activity and maintain links with the regional and national networks.

5.10 SHA should develop a mechanism that promotes and supports NMP leads in sharing of good practice.

5.11 Develop a qualitative methodology to identify NMP activity and demonstrate benefits to patients and the Health Service
References:


Royal Pharmaceutical Society - http://www.rpsgb.org.uk/
6. Appendix

Appendix 1

The Trusts that participated were:

**Primary Care Trusts**

- NHS Bath and North East Somerset
- NHS Bournemouth & Poole Teaching
- NHS Bristol
- NHS Cornwall & Isles of Scilly
- NHS Devon
- NHS Gloucestershire
- NHS Plymouth
- NHS Somerset
- Torbay Care Trust

**Hospital Trusts**

- Great Western Hospitals NHS Foundation Trust
- North Bristol NHS Trust (incl NHSP)
- Royal United Hospital NHS Trust Bath
- Salisbury NHS Foundation Trust
- Taunton & Somerset NHS Trust
- University Hospitals Bristol NHS Foundation Trust
- Gloucester Hospitals NHS Foundation Trust
- Royal Bournemouth & Christchurch Hosp NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trust

**MH / LD and Partnership Trusts**

- Avon & Wiltshire Mental Health Partnership NHS Trust
- Cornwall Partnership NHS Trust
- Dorset Healthcare NHS Foundation Trust
- 2gether NHS Foundation Trust
- Somerset Partnership NHS Foundation Trust
Appendix 2

Next steps identified by NMP Leads

- To continue to raise awareness of the potential of NMP in terms of enhancing service improvements and meeting the new ways of working agenda.
- To consider NMP during commissioning of services to ensure budget for prescribing is in built.
- Further development of NMPs in Minor Injures Units and Out of Hours services and to reduce reliance on Patient Group Directions (PGDs)
- Formal re validation for those who have not been practising,
- More use of community prescribing as currently there are a significant number of practitioners who are qualified at V100 and V150 who are not utilising their qualifications fully or developing their prescribing skills.
- Continue to develop prescribers where the professional and service users benefit
- To formalise the role and increase the scope of practice
- Formal pathway for developing competence external to NMPs specialism to enable holistic and safe patient journey
- Pre qualifing education to include an understanding of NMP and in particular PGDs
- Evaluation of services to determine impact and benefit
- To extend NMP to Physician assistants.
- Creation and formalise the role of NMP lead in Trusts.
- Further develop nurse led clinics
To determine the impact and benefits of NMP Making Connections DH framework was used and incorporated the model developed by Alison Sampson at NHS Yorkshire and the Humber.

<table>
<thead>
<tr>
<th>Care Pathway</th>
<th>Impact / Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Ensure patients receive - timely treatment Treatment from a nurse with whom they have a relationship and who spends time with them giving information and monitoring compliance and side effects etc</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Improved service user outcomes / satisfaction Reduction in prescription use, <strong>The following are based on comments from patients.</strong> Patient care has been improved without compromising safety. It is easier for patients to get the medicines that they need. Patients have increased choices in accessing the medicines they need. Nurses discuss other interventions as well as medications</td>
</tr>
<tr>
<td>MH / LD</td>
<td>High impact but sporadically introduced</td>
</tr>
<tr>
<td>Acute</td>
<td>Timely&amp; correct prescribing Expansion of clinics &amp; services Enhance specialist &amp; Nurse practitioner roles</td>
</tr>
<tr>
<td>Acute</td>
<td>Additional quality and safety in pt care/pathway, consistency of care, reduced time pt waiting to have prescription written, freed up junior doctor time,</td>
</tr>
<tr>
<td>Acute</td>
<td>Cost effective care, timely, improved information giving</td>
</tr>
<tr>
<td>Acute</td>
<td>Much more efficient service for patients. Far less frustrating for NMPs as they are no longer waiting around for Dr’s to prescribe.</td>
</tr>
<tr>
<td>Acute</td>
<td>Increased timely access to prescriptions/medicines for patients Safer prescribing in high risk areas (eg neonatal) or drugs (eg anticoagulation) New services run without direct medical support (eg OOH, CNS clinics)</td>
</tr>
<tr>
<td><strong>Acute – various specialities LTD</strong></td>
<td>Autonomous working within specialities, reducing time for patients and carers, reduction in working time directives for junior Dr’s.</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Acute various specialities LTD</strong></td>
<td>In the mainstay, patients have a more streamlined service with staff who know them and can prescribe what they need there and then without having to refer them to someone else. Safer prescribing for specialist conditions, instead of a junior doctor. Some problems though, as some services have developed to rely on NMPs, but as they cannot prescribe outside of their competence, some patients need to be referred outside to another prescriber.</td>
</tr>
<tr>
<td><strong>Acute Palliative care / End of life</strong></td>
<td>Expediting of service delivery. High standard of prescribing practice.</td>
</tr>
<tr>
<td><strong>Acute various specialties LTD</strong></td>
<td>Big impact – has enabled additional nurse-led clinics in various specialties</td>
</tr>
<tr>
<td><strong>PCT Multi disciplinary working</strong></td>
<td>Access to services for patients Multi-disciplinary working Expansion of role</td>
</tr>
<tr>
<td><strong>PCT Co morbidity &amp; poly pharmacy LTD</strong></td>
<td>I think they have had a massive influence on the way patients receive their medicines. Particularly in areas such as chronic disease where the monitoring of the patients is often carried out by NMPs re poly pharmacy Co morbidity etc.</td>
</tr>
<tr>
<td><strong>PCT LTD OOH MIU Complex issues</strong></td>
<td>NMPs have had a very positive impact especially in areas of specialism such as Heart failure, respiratory and diabetes and have allowed nurses to manage complex cases independently and as such reduce admission to the District General Hospital. NMP’s within the Out of Hours Service has ensured that Nurse Practitioners are able to effectively manage the demand within the service. Increasing numbers of NMP’s within the Minor Injury Units has allowed for nurse led units. District nurses are able to manage complex cases and again reduce admissions</td>
</tr>
</tbody>
</table>
and provide care closer to home.

| PCT                                              | Time  
| Access                                         |
| Concordance                                    |
| Use of resources                               |

| PCT     | Reduced number of hand-offs and improved coordination of care and access to medicines for patients. |
| Staying Healthy | Strengthened accountability for prescribing. |
|         | Extended Community Nurse prescribers now the course is in place. |
|         | Consideration of new NMP roles as new professions are able to prescribe |

| PCT     | We have a pharmacist NMP in substance misuse who has had a significant impact. |
| Substance misuse | |

| Substance misuse | |

Staying Healthy | |

Extended Community Nurse prescribers now the course is in place. Consideration of new NMP roles as new professions are able to prescribe.
Appendix 4

Questionnaire
Dear all
As part of my role as SHA NMP coordinator I need to present an annual monitoring report so it would be much appreciated if you could spend some time (max. 45 minutes) in completing the attached questionnaire. The results will provide the necessary data for presentation to the SHA and a summary of the findings will be circulated to you all and discussed at the next regional meetings in April 2010. Please could I have completed questionnaires by Friday 19th February 2010.
Thank you
Susie Ventura

YOUR ROLE

<table>
<thead>
<tr>
<th>What sector do you work in</th>
</tr>
</thead>
<tbody>
<tr>
<td>i.e. PCT, Acute</td>
</tr>
<tr>
<td>What is your main role within the organisation</td>
</tr>
<tr>
<td>How long have you been the NMP lead for the organisation</td>
</tr>
<tr>
<td>Are you a qualified NMP and if so how long have you been qualified</td>
</tr>
<tr>
<td>Do you still prescribe on a regular basis</td>
</tr>
<tr>
<td>What are your key activities as the NMP lead</td>
</tr>
</tbody>
</table>

MANAGEMENT OF THE NMP LEAD ROLE

<table>
<thead>
<tr>
<th>How many hours per week are allocated for your role</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you ensure that you have regular access to information regarding NMP</td>
</tr>
<tr>
<td>What is the primary medium that you use to disseminate / exchange information with the NMPs in your organisation</td>
</tr>
<tr>
<td>How often do you meet with the NMPs</td>
</tr>
<tr>
<td>Do you have a system for ordering and distribution of BNFs and / or the NPFs?</td>
</tr>
</tbody>
</table>
**CPD PROVISION**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you responsible for providing in house CPD for the NMPs in your organisation?</td>
<td></td>
</tr>
<tr>
<td>Do you access CPD from a University for your NMPs? If so which one.</td>
<td></td>
</tr>
<tr>
<td>Please identify any other CPD provision that you suggest to your NMPs.</td>
<td></td>
</tr>
<tr>
<td>Any other comments that you would wish to make regarding CPD provision for the NMPs.</td>
<td></td>
</tr>
</tbody>
</table>

**MONITORING**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you undertaken an audit of NMP practice in the last twelve months?</td>
<td></td>
</tr>
<tr>
<td>If so please attach the tool that you used and a summary of the results.</td>
<td></td>
</tr>
<tr>
<td>Have you involved patients / service users in any capacity?</td>
<td></td>
</tr>
</tbody>
</table>

**OTHER**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the governance arrangements within your Trust for NMP practice?</td>
<td></td>
</tr>
<tr>
<td>What difference (if any) have qualified NMPs had on practice?</td>
<td></td>
</tr>
<tr>
<td>What do you suggest are the next steps for NMP.</td>
<td></td>
</tr>
</tbody>
</table>

Please complete the table below

<table>
<thead>
<tr>
<th>Professional group</th>
<th>Numbers of NMPs</th>
<th>Area/s of competence</th>
<th>Qualification (V100, V150, V300, other)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Visitors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AHPs –please identify</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any other comments
As you may be aware the role of the SHA NMP Coordinator will be reviewed in May 2010 and it would be helpful if you could indicate whether or not you would wish to see this role maintained.

Thank you for your time in completing this questionnaire.
Appendix 5

NMP numbers, qualifications and areas of practice
All Trusts were asked to identify numbers of NMPs, their qualification and there are of competence / practice. Unfortunately whilst numbers of NMPs were supplied there were omissions in terms of the qualification. I suggest that this may be that the terminology is unfamiliar and titles have changed however it is of concern as I had expected that this information would be readily available from their databases. Areas of practice / competence were supplied in many but not all and again this is of concern as prescribing field should be agreed and documented as part of governance arrangements.

Results were as follows:

Mental Health / Learning Disabilities / Partnership Trusts
V300 109 plus 1 midwife V300 not prescribing

Hospital Trusts V300
Nurses - 261
Pharmacists - 20
Physiotherapists – 2 (supplementary prescriber)
Midwives – neonatal - 3
Although 52 Health Visitors were identified by one Hospital Trust there was no qualification identified possibly V100

PCTs this are was the most difficult to unpick as will be noted by the following results.
V300
Nurses in GP practice - 69
Nurses - 247
Health Visitors -3
Pharmacists -24  
Nurses Unspecified - 92

**V300 but only able to practice as supplementary prescribers**

Physiotherapists -1  
Podiatrists-1

**V100** - 401  
**V150** – 68 and 8 in GP practice  
**V200** - 16

110 Community Nurses and Health Visitors were identified as prescribers but no qualification was identified possibly V100.

38 were identified as V300 & V100, 72 were identified as V100 & V150, 45 were identified as V200 & V300 unfortunately it was not possible to determine whether this suggested that the practitioners had two qualifications which is possible or that the NMP leads were unsure as to the numbers for each qualification.