Non-medical prescribing
by nurses, optometrists, pharmacists, physiotherapists, podiatrists and radiographers

A quick guide for commissioners
March 2010
Acknowledgements

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Foreword

As the environment in which NHS services are delivered becomes more challenging and complex there is an ever increasing need for improved productivity without compromising quality. This challenge can only be met by all medical and non-medical healthcare professionals becoming actively involved in service redesign and gaining more efficiency in the deployment of NHS resource usage. Innovation is a key driver to enable this change, and the increase in non-medical prescribers is part of this.

It is not just about the expansion of healthcare professionals’ ability to prescribe, but the increasing role of non-medical prescribers in supporting the clinical commissioning programme for the NHS. Non-medical prescribers can now begin to fulfill a vital role in helping to secure services for patients with an increasing responsibility for NHS resources and quality of patient care.

Prescribing can be regarded as a commissioning activity having assessed a patient’s need, determined a treatment and committed a resource through writing a prescription. As is the challenge for all clinicians, non-medical prescribers will need to make the best use of finite NHS resources.

PCTs and practice based commissioners need to recognise the benefit of integrating non-medical prescribers into commissioning activity and optimise workforce skills within general practice, the acute and community sectors.

Prescribing is therefore part of a much bigger picture, non-medical prescribers are integral to the ongoing reform of the NHS and are at the start of both their extended role in service delivery and commissioning activity.

I wish them every success on that journey!

Dr James P Kingsland

National PBC Clinical Network Lead
President, National Association of Primary Care
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Overview

1. Revised regulations have enabled an expansion of non-medical prescribing (NMP) so that experienced nurses, optometrists, pharmacists, physiotherapists, podiatrists and radiographers can train to prescribe within their clinical competence and complete episodes of care.

2. NMP can give patients quicker access to medicines, improves access to services and makes better use of clinical workforce skills.

3. Non-medical prescribers are a large and growing work-force prescribing millions of items in England annually in acute, community and primary care settings.

4. Across England there is wide variation in the utilisation of NMP to modernise services. NMP should be considered within all service specifications, where medicines are prescribed or supplied to ensure optimal use of the available skill mix.

5. Non-medical prescribing by nurses, optometrists, pharmacists, physiotherapists, podiatrists, and radiographers: A quick guide for commissioners 2010 has been developed by the National Prescribing Centre (NPC) to support organisations in effectively implementing NMP.

6. This guide will help senior healthcare managers, strategic and operational commissioners better understand the scale, scope and range of NMP. They will find this guide assists their understanding of how organisations are using NMP to deliver High quality care for all: NHS Next Stage Review\(^1\) and respond to the QIPP challenge\(^2\) (Quality, Innovation, Prevention and Productivity) by including NMP in care pathway redesign.

7. This guide shows how non-medical prescribers support organisations to:
   - meet referral targets e.g. 18 week targets
   - meet the European Union Working Time Directive
   - provide urgent and out-of-hours care
   - meet quality care standards for adults and children with long-term and specialist conditions
   - overcome unnecessary obstacles to patients receiving appropriate care quickly

8. This guide provides:
   - Practical information and links to key policy documents
   - Answers to frequently asked questions
   - Good practice examples, illustrating the use of NMP in diverse care pathways to: deliver value for money; improve quality; reduce unnecessary hospital admissions; facilitate early discharge; improve access, extend patient choice, reduce health inequalities and provide personalised care closer to home
Aims of the document

This guide will:

• help commissioners understand the nature, role and benefits of prescribing by nurses, optometrists, pharmacists, physiotherapists, podiatrists and radiographers

• provide practical and relevant information supported by case examples. These assist in the wider utilisation of non-medical prescribing in the provision of high quality, cost-effective, safe and accessible patient focused services

Audience for the document

• Senior NHS healthcare managers

• Commissioners of healthcare services including primary care trust commissioners and practice based commissioners

It may also be of interest to healthcare providers, managers, clinical leads, clinicians, professional bodies and higher education institutes.

Please note

Throughout the guide the term ‘nurse’ includes midwife and health visitor and the term ‘allied health professional’ (AHP) includes physiotherapists, podiatrists or radiographers.
Introduction

“The ways the NHS has done things in the past won’t deliver what we need in the future.” David Nicholson, NHS Chief Executive, 2009³

Strategic and operational commissioners should find this guide assists their understanding of how non-medical prescribing may enable them to meet the vision set out by the NHS Next Stage Review for a world class NHS that is fair, personal, effective and safe.¹

Commissioning can be both transformational and transactional.⁴ NMP could be utilised to enable commissioners and clinicians to transform and develop a range of more integrated services, driving improvement and securing better value for money. The extension of prescribing responsibilities gives organisations flexibility to innovate when designing cost-effective quality services that improve patient access and choice.

Key objectives for commissioners are to commission services that deliver enhanced access to quality, individualised care whilst providing value for money and choice in the way patients are treated. These challenges are set in the context of an ageing population with increasing numbers of patients living with long-term conditions and raised patient expectations at a time of great financial pressure.

Across England, non-medical prescribers are working in diverse care settings to:

- provide urgent and out-of-hours care
- meet 18 week referral targets
- meet the European Union Working Time Directive
- meet quality care standards for adults and children with long-term and specialist conditions
- overcome unnecessary obstacles to patients receiving appropriate care quickly
- improve concordance

Revised regulations have led to an expansion of NMP to address the needs of patients and organisations, enabling efficient and flexible use of workforce skills to address national and organisational priorities. Members of the following health professional groups can currently train to prescribe within their clinical competence: nurses, optometrists, pharmacists, physiotherapists, podiatrists and radiographers.
Scale, scope and range of non-medical prescribing

Non-medical prescribers are a large and growing workforce. By October 2009, over 14,000 nurse independent prescribers, 1,700 pharmacist independent and supplementary prescribers, many thousands of community practitioner nurse prescribers and hundreds of allied health professional prescribers had qualified to prescribe within their competence (England, October 2009). Over 1 million items are prescribed each month by non-medical prescribers in primary care on FP10 prescription (England, January - September 2009).

Additionally there are many non-medical prescribers working in acute settings in services transformed to enhance patient care.

Figure 1 illustrates by volume the range of therapeutic areas in which non-medical prescribers prescribe in primary care. Specialist services, such as oncology and palliative care, also utilise NMP.

Figure 1. Proportion of items prescribed on FP10 by non-medical prescribers in England by therapeutic area. November 2008 - October 2009.

Figure 2 compares the number of items prescribed by non-medical prescribers on FP10 prescription across strategic health authorities (SHAs) in England for cardiovascular disease, infection and mental health. This shows that across England there is approximately a six-fold variation in non-medical prescribing in these therapeutic areas. Commissioners play a fundamental role in developing local service competence, capacity and capability informed by clinician skills and knowledge. Whilst the incentive to commission services which use NMP will be determined by a range of factors, the wide variance in NMP use supports the view that opportunities exist for commissioners to share learning across organisations.
Figure 2. Number of items prescribed by non-medical prescribers on FP10 in England for cardiovascular disease, infection and mental health. November 2008 - October 2009. 
Non-medical prescribing delivering organisational and national priorities

This section illustrates how organisations have found that embedding NMP enhances the quality of patient care while also generating income through payment by results (PbR) or reducing costs, increasing efficiency, reducing waste and making more efficient use of professional expertise.

When implemented successfully, NMP can deliver organisational and national priorities, including:

- Value for money
- Patient safety
- European Union Working Time Directive
- 18-week referral to treatment pathway
- Quality Outcome Framework (QOF) and National Service Framework (NSF) targets
- Improved access to treatment
- Delivery on national and local priorities
- Commissioning competencies
- Care closer to home
- Workforce development

For examples of how this has been achieved in local NHS trusts please see the case studies at the end of this guide and on the NPC sharing practice examples online database. Additionally, Making the connections: Using healthcare professionals to deliver organisational improvements maps NHS policy to achieving key organisational benefits using NMP.

NMP could help organisations to deliver the NHS Next Stage Review and respond to the QIPP challenge (Quality, Innovation, Prevention and Productivity). High Quality Care for All: Making the Connections states that NMP offers a strategic, innovative solution to address capacity, quality and efficiency if used more widely within pathway redesign.

NMP should be considered within all service specifications, where medicines are prescribed or supplied to ensure optimal use of available skill mix. Commissioners should actively promote the inclusion of NMP when commissioning services, and providers may wish to respond by considering the inclusion of NMP in service specifications.
Ten questions and answers

1. What is non-medical prescribing?
Non-medical prescribing is prescribing by specially trained nurses, optometrists, pharmacists, physiotherapists, podiatrists and radiographers, working within their clinical competence as either independent or supplementary prescribers.

2. What is independent prescribing?
Independent prescribing is prescribing by a practitioner, who is responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing. In practice, there are TWO distinct forms of non-medical independent prescriber.

i) An independent prescriber may currently be a specially trained nurse, pharmacist or optometrist who can prescribe any licensed medicine within their clinical competence. Nurse and pharmacist independent prescribers can also prescribe unlicensed medicines. There are restrictions on the prescribing of controlled drugs; these are explained in the non-medical prescribing FAQs on the NPC website.

ii) A community practitioner nurse prescriber (CPNP), for example district nurse, health visitor or school nurse, can independently prescribe from a limited formulary called the Nurse Prescribers’ Formulary for Community Practitioners, which can be found in the British National Formulary (BNF).

The following are illustrative examples of how organisations can use independent prescribing from an unlimited formulary to meet NHS and organisational priorities:

**European Union Working Time Directive and quality standards**
Independent non-medical prescribers can provide personalised, timely, flexible access to treatment for patients requiring urgent or critical care, rather than delayed treatment or referral to other services.

- Nurse prescribing reducing A&E admissions and improving access to treatment in an inner city urgent care centre
- Managing and monitoring critical care patients’ medicines by a pharmacist independent prescriber
- Optometrist independent prescribing in a one-stop optometry glaucoma assessment clinic

**Meeting the Quality Outcomes Framework**
Independent non-medical prescribers can optimise the management of long-term conditions, rather than waiting for treatment adjustments requested from the GP.

- Improving patient access and choice with pharmacist independent prescribing in a GP practice
- Pharmacist-led hypertension/CV risk clinics in primary care
Avoiding unnecessary hospital admissions
Independent non-medical prescribers can prescribe timely, effective treatments for patients with specialist health needs without requiring a separate appointment with the doctor, with the associated potential for delay.

- Moving from nurse supplementary to independent prescribing in dementia and other mental health services
- Increasing quality, consistency and access to medicines with nurse independent prescribers in a sexual health service

The following is an illustrative example of how organisations can use restricted formulary prescribing to meet NHS and organisational priorities:

Care closer to home and avoiding hospital admissions
CPNPs can assess patients and use a limited formulary to prescribe timely treatment in locations convenient for patients.

- Community practitioner nurse prescriber increasing access to medicines and providing care closer to home

3. What is supplementary prescribing?
Supplementary prescribing is a voluntary partnership between a doctor or dentist and a supplementary prescriber to implement an agreed patient-specific clinical management plan with the patient’s agreement.

A supplementary prescriber may currently be a specially trained nurse, optometrist, pharmacist, physiotherapist, podiatrist or radiographer who can prescribe any medicine within their clinical competence, according to a patient specific clinical management plan (CMP) agreed with a doctor or dentist and the patient.

The following are illustrative examples of how organisations can use supplementary prescribing to meet NHS and organisational priorities:

Facilitating early discharge
Supplementary prescribers can assess patients and prescribe the necessary medicines along with providing the exercise therapies required for older people requiring rehabilitation after stroke, rather than delayed treatments requested from a doctor.

- Physiotherapist supplementary prescriber reducing hospital stay duration in an intermediate care, therapy-led bed service

Minimising development of antimicrobial resistance
Supplementary prescribers can prescribe the necessary medicines to manage chronic diabetic foot ulcers, rather than delaying treatment with a request to a doctor.

- Podiatrist supplementary prescriber preventing admissions and improving access to treatment for patients with long-term and urgent foot conditions
European Working Time Directive and quality standards
Supplementary prescribers (radiographers) can prescribe the necessary medicines to manage radiotherapy side effects, rather than delaying treatment with a request to a doctor.

- Clinic review therapy, radiographer supplementary prescribing in a cancer centre

4. Why would a commissioner want to know about NMP?

Core tasks for commissioners are to invest locally to achieve the greatest health gains and reductions in health inequalities, at best value for current and future service users. NMP can support commissioners in this. Successful commissioning is a cyclical process whereby clinicians assess the needs of the population; review the use of resources and existing service delivery; identify the need for change and improve practice. NMP will often give patients quicker access to medicines, improves access to services and makes better use of nurses’ and other health professionals’ skills. The scope and range of NMP allows commissioners a range of options to improve patient choice and streamline services. Table 1 shows examples of how NMP can help to achieve organisational targets.

**Table 1. Non-medical prescribing achieving organisation targets**

<table>
<thead>
<tr>
<th>Example</th>
<th>Target</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care centre, Birmingham</td>
<td>Access targets&lt;br&gt;Care closer to home&lt;br&gt;National clinical quality guideline implementation&lt;br&gt;Savings from payment by results</td>
<td>Flexible personalised completion of management of minor injuries by non-medical prescriber</td>
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<td>(See page 23 and NPC website¹)</td>
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<tr>
<td>Rheumatology Department, Northumbria</td>
<td>18 week referral&lt;br&gt;Access targets&lt;br&gt;Savings from payment by results&lt;br&gt;National clinical quality guideline implementation</td>
<td>Clinical treatment review and contribution to continued prescribing by non-medical prescriber</td>
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<tr>
<td>(See page 26 and NPC website¹)</td>
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<tr>
<td>Critical Care, Southampton</td>
<td>Access targets&lt;br&gt;EU Working Time Directive&lt;br&gt;Savings from payment by results&lt;br&gt;National clinical quality guideline implementation</td>
<td>Flexible personalised contribution to emergency care by non-medical prescriber</td>
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<tr>
<td>(See NPC website⁷)</td>
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</tr>
<tr>
<td>GP practice, Stoke on Trent</td>
<td>Care closer to home&lt;br&gt;Extended hours&lt;br&gt;National clinical quality guideline implementation&lt;br&gt;QOF targets</td>
<td>Optimised management of long-term conditions and holistic care by non-medical prescriber</td>
</tr>
<tr>
<td>(See NPC website⁷)</td>
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Appendix A shows how embedding NMP into service design helps achieve world class commissioning competencies.
5. What evidence supports NMP?

National evaluations have been completed which have examined extended formulary nurse prescribing and supplementary prescribing.

- An evaluation of extended formulary independent nurse prescribing: executive summary\textsuperscript{15}
- An evaluation of supplementary prescribing in nursing and pharmacy\textsuperscript{16}

Publication of the national evaluation of nurse and pharmacist independent prescribing (ENPIP) study is anticipated in spring 2010.

Evidence has shown that the benefits of NMP include:

- faster access to medicines\textsuperscript{15-17}
- more flexible patient orientated care\textsuperscript{16-17}
- time-savings\textsuperscript{16-17}
- improved service efficiency\textsuperscript{15-17}

NMP has been found to be:

- safe\textsuperscript{15-18}
- acceptable to patients\textsuperscript{15-17}
- acceptable to other clinicians\textsuperscript{15-16,19}

Professional regulators have developed standards for prescribing practice\textsuperscript{20-25} which should be adhered to by non-medical prescribers who are required to work within competence. The National Prescribing Centre has developed competency frameworks for non-medical prescribers to be used by clinicians as a source of information and as tools to reflect on practice and identify continuing professional development (CPD) needs\textsuperscript{26-30}.

- NPC Competency Frameworks

6. Is commissioning services with NMP cost-effective?

Investing in NMP is an example of invest to save. Services which use NMP will include the employment costs of the non-medical prescriber, costs of training, mentoring and clinical supervision, as well as clinical governance, practical and CPD support once the non-medical prescriber qualifies. If these costs are considered against those for alternative mechanisms of access to personalised prescribing (e.g. the employment costs of using and supporting medical prescribers of equivalent experience, costs in health service inefficiencies from duplication, time or medicines wasted, and lost organisational savings or income from payment by results), it is clear that NMP can represent value for money.

7. At what point in service planning should expert advice be sought?

Supply of a medicine is the most common therapeutic intervention. When considering whether medical, non-medical prescribing or other mechanisms of supply or administration may be appropriate, commissioners must take account of the needs of the patient, safety and how the particular service is being structured and delivered. The National Prescribing Centre has published a guide for all NHS managers to help improve understanding of key issues in medicine use: What you need to know about prescribing, the ‘drugs bill’ and medicines management\textsuperscript{31}

It is essential that those involved in planning services consider the lead in time for training, mentorship and clinical supervision of non-medical prescribers, as with any other new service.
Key organisational contacts include:

- Lead pharmacist
- Professional lead(s)
- Workforce planners
- Non-medical prescribing lead

The organisation’s NMP lead is a key resource for advice on training, support, clinical governance frameworks and the practical processes for utilising NMP.

Organisational NMP leads can be identified by contacting the relevant SHA NMP lead, whose contact details can be found on the Department of Health website.¹⁴

- Non-medical prescribing lead contact details

Clinical supervision and support during and after NMP training ranges from nurse mentors in the case of community practitioner nurse prescribers, to designated medical practitioners (DMPs) in the case of independent and supplementary prescribers. Other professionals who are involved in prescribing also provide essential resources.

8. What should be included in service specifications that utilise NMP?

The Department of Health has produced guidance for organisations on the legal, practical and governance issues relating to implementing non-medical prescribing:

- Improving patients’ access to medicines: A guide to implementing nurse and pharmacist independent prescribing within the NHS in England¹⁰
- Supplementary prescribing by nurses, pharmacists, chiropodists/podiatrists, physiotherapists and radiographers within the NHS in England: a guide for implementation¹²

Professional bodies also offer guidance to organisations and clinicians on the legal, practical and governance issues relating to implementing non-medical prescribing:

- Standards of proficiency for nurse and midwife prescribers. Nursing and Midwifery Council²⁰
- Guidance for optometrist prescribers. College of Optometrists²¹
- Professional standards and guidance for pharmacist prescribers. Royal Pharmaceutical Society²²
- Standards of proficiency – Chiropodists/podiatrists. Health Professions Council²³
- Standards of proficiency – Physiotherapists. Health Professions Council²⁴
- Standards of proficiency – Radiographers. Health Professions Council²⁵

Commissioners should expect all providers using non-medical prescribing to meet the requirements set out in these documents, including robust clinical governance frameworks and mechanisms to support continued professional development and maintaining competence.

9. What is the lead in time for a service using NMP?

Non-medical prescribers are experienced clinicians who must undergo additional degree or masters’ level training, provided by courses validated by the relevant professional bodies at accredited higher education institutes (HEI). Some professions require a minimum length of post-registration experience before application to prescribing courses. Courses are usually delivered over three to six months duration. Advice should be sought from the organisations’ NMP lead regarding timing and duration of local HEI courses. After completion of a prescribing course, several months must be allowed for professional
registration to be amended, implementation of the new service and for the non-medical prescriber to establish their new role.

10. How is NMP monitored?
Organisations which employ non-medical prescribers use a range of mechanisms to monitor the quality, safety and effectiveness of the service. These mechanisms include:

- Prescribing data
- Clinical outcomes data
- Clinical supervision
- Significant event monitoring
- Audit
- Patient satisfaction questionnaires
### Case examples: using non-medical prescribing in Next Stage Review care pathways

<table>
<thead>
<tr>
<th>Care pathway</th>
<th>Service provided</th>
<th>Profession</th>
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<td>Management of urgent care needs</td>
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<td>Urgent care</td>
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<td>Intermediate care</td>
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<td>Planned care</td>
<td>Rheumatoid Arthritis management</td>
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<td>Planned care</td>
<td>Cancer treatment management</td>
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<td>Planned care</td>
<td>Radiotherapy treatment management</td>
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<td>Mount Vernon Cancer Centre, London</td>
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<td>Mental health</td>
<td>Outreach urgent mental health management</td>
<td>Nurse</td>
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<tr>
<td>Mental health</td>
<td>Inpatient urgent mental health management</td>
<td>Nurse</td>
<td>Sheffield Health &amp; Social Care NHS Trust</td>
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</tr>
<tr>
<td>Staying healthy</td>
<td>Smoking cessation service</td>
<td>Nurse</td>
<td>East Lancashire Teaching PCT</td>
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<tr>
<td>Maternity and newborn</td>
<td>Specialist neonatal care</td>
<td>Nurse</td>
<td>Taunton &amp; Somerset NHS Foundation Trust</td>
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<td>Children</td>
<td>Paediatric assessment and treatment</td>
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<td>Calderdale and Huddersfield NHS Foundation Trust</td>
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<td>Children</td>
<td>Paediatric liver and renal impairment management</td>
<td>Pharmacist</td>
<td>Cambridge University Teaching Hospitals NHS Trust (Addenbrookes Hospital)</td>
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<td>End of life</td>
<td>Palliative care in adults</td>
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<tr>
<td>End of life</td>
<td>Palliative care in children</td>
<td>Nurse</td>
<td>Leicester City Community Health Services</td>
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The NPC sharing practice examples online database allows you to search through examples of NMP implementation that have been submitted to the NPC for sharing with the wider NHS.

- **NPC sharing practice examples**  

### Long-term conditions

**NMP improving quality of care in hypertension management of patients with previous poor blood pressure control, evaluated by audit of clinical indicators.** Consultant Pharmacist for Cardiovascular Disease, Southwark Health and Social Care

#### Policy drivers

- **Care closer to home:** Delivered in primary care setting.

- **Value for money:** By focusing on uncontrolled patients only, the skills of the clinical pharmacist in prescribing rationale and cost-effective regimens, identifying and addressing concordance issues and dealing with adverse effects were best utilised to maximize outcomes for the investment made.

- **Improving quality:** Addressing QOF/NSF targets, achievement of which within the clinic populations rose from a baseline of 26% to 57% in clinic one and from 36% to 69% in clinic two over 6 months.

- **Reducing unnecessary hospital admissions:** By improved blood pressure (BP) management.

- **Access:** The service encouraged those patients less engaged with GP services to access healthcare via the pharmacist, longer appointment times than the GPs/practice nurses allowed greater discussion of health beliefs etc. to encourage longer term engagement.

- **Choice:** Patients were given the opportunity to access the pharmacist-led service or see their usual GP/nurse. Uptake of the service was high, with low DNA rates, indicating that the additional service was well received.

- **Reducing health inequalities:** The focus on practices failing to meet QOF targets has enabled the local practices, PBC groups and PCTs to tackle areas of greatest need in the areas of greatest deprivation.

- **Personalisation:** The success of the service in addressing BP management and CV risk reduction has been built around the tailoring of therapy and lifestyle advice to meet the needs of the individual patients.

**Contact:** helen.williams11@nhs.net
**NMP preventing avoidable admissions by improving access to respiratory medicines, evaluated by audit.** Consultant Respiratory Physiotherapist, NHS Medway

### Policy drivers

- **Care closer to home:** Delivered in primary care setting, physiotherapist team facilitates early discharge as patients can be sent home earlier under the care of the specialist team.

- **Value for money:** Treating patients diagnosed with severe chronic lung disease in the community, including prescribing medication, prevents hospital admission. This ensures beds are only used for patients who need hospital care and who cannot be cared for in the community. Specialist physiotherapists ensure that patients only receive medication if it is appropriate, where non-pharmacological management has not been effective. Where medication is given, its effectiveness is monitored, reviewed regularly and discontinued if not effective. Using staff to their full potential by allowing staff to qualify as prescribers ensures value for money from the workforce. It also releases pressure from GPs, freeing up appointments.

- **Improving quality:** Antibiotics are only given when there is a definite proven infection. This prevents unnecessary antibiotic prescriptions which often occur in general practice ‘in case of infection’. It also reduces the need for additional prescriptions when ‘generic’ antibiotics have not worked. This in turn reduces the rate of antibiotic resistance and infections such as *C. difficile*.

- **Delivery on local priority:** Reducing unnecessary hospital admissions and facilitating early discharge of patients from the acute trust.

- **Access:** Referred patients have equal access and can be seen in their home. Prescriptions can be given to the patient at the initial home assessment, meaning that there is no need for patients to visit their GP surgery.

- **Choice:** Patients are fully informed regarding the different ways in which they can receive prescriptions, including using supplementary prescribers within our specialist team or using their GP. The benefits of both options are explained.

- **Health inequalities:** The team actively promotes its services. Public meetings have been held to try and encourage all sectors of the community to engage with our services. We work actively with the public health team to try to identify groups who are most at risk and in need of our services, so that we can focus our attention on meeting the needs of those groups.

- **Personalisation of treatment:** All patients are individually assessed by a specialist clinician. Personal management plans are developed in collaboration with the patient.

### Contact: kath.plumbe@medwaypct.nhs.uk
### Urgent care

**NMP reducing inappropriate A&E attendance by improving access to urgent treatment, evaluated by audit, prescribing data, clinical supervision and patient questionnaire.**  
Nurse practitioner prescriber, Urgent Care Centre, NHS Birmingham East & North

#### Policy drivers

- **Value for money:** The UCC offers an alternative pathway to A&E, thus making a cost saving to the primary care trust via payment by results (PbR) savings. Reduction in avoidable admissions, for example UCC staff work within competence and protocols to initiate treatment for croup in children avoiding admission to the children’s ward. Nurse practitioner staff costs are less than GP locum costs. Cost savings resulting from prescribing autonomy of nurse practitioners, save on multi-disciplinary resource by not requiring PGD development and review.

- **Care closer to home:** UCC is in the centre of the community.

- **Improving access:** Provides extended hours to meet the needs of the patient.

- **Choice:** In a recent audit the majority of new patients stated their referral was through “word of mouth”. The number of repeat attendees suggests satisfaction with the service.

- **Health inequalities:** The UCC is situated in a deprived community serving the needs of the local people who have reduced access to GPs. Due to its success a second UCC is being commissioned to open in an inner city disadvantaged area. All the nurse practitioners are up to date with equality and diversity training and are aware of cultural differences.

- **Personalisation of treatment:** Although the nurse practitioners work to clinical guidelines, as non-medical prescribers, they have the ability to use their clinical discretion when prescribing, allowing them to treat each patient according to their individual needs.

#### Contact: patricia.meally@benpct.nhs.uk
NMP preventing avoidable admissions by providing rapid access foot protection, evaluated by audit. Consultant Podiatrist, NHS Manchester, Manchester Community Health

**Policy drivers**

- **Care closer to home**: The vascular triage service is delivered in the community rather than patients accessing hospital based services. The heel protection service allows patients to be discharged to structured care in the community therefore reducing length of stay in hospital with patient care closer to home.

- **Value for money**: A rapid access foot protection team prevents unnecessary hospital admissions by providing timely care of foot infections in community.

- **Improving quality**: Diabetes patient care is concordant with NICE, QOF and Diabetes NSF.

- **Deliver 18-week referral to treatment pathway**: Patients referred to vascular triage service are seen within 2 weeks of referral from the GP, compared to 8 weeks in the hospital.

- **EU Working Time Directive**: Service provides more than 1200 episodes of care in the community. Traditionally all patients seen in our service would have been initially seen by a GP or physician in secondary care.

- **Improving access**: Patients receive structured timely care in community and NMP allows rapid access to appropriate antibiotics as required. Patients have direct access to one of 6 members of the foot protection team by mobile.

**Contact**: louise.stuart@manchester.nhs.uk
## Intermediate care

**NMP reducing hospital stay duration with physiotherapy-led unit, evaluated by service evaluation of the therapy-led bed service (Ramaswamy 2009), annual prescribing review with lead pharmacist and feedback from patients and staff. Consultant physiotherapist in intermediate care, Derbyshire Community Health Services**

### Policy drivers

- **Value for money:** A statistically significant decrease in the length of hospital stay. No detriment to patient care from reduction in medical cover, with an increased throughput of patients and improved rehabilitation outcomes. Staff costs reduced as medical cover decreased from five 8.00 am – 6.00 pm days to three sessional visits a week from a GP, also with a reduction in the number of call outs to the out-of-hours services. Utilisation of consultant physiotherapists’ combined clinical and medicines management skills means fewer patients require further investigations e.g. X rays etc., saving on costs of unnecessary investigations, staffing escort and transport costs.

- **Improved access:** Patients can be admitted straight to a local community hospital for rehabilitation if medically stable, with no unnecessary utilisation of acute hospital services. The physiotherapist prescriber covers different shifts and weekends, so patients can be admitted out of hours, increasing access to the beds.

- **Choice:** Patient has choice when discussing treatment options in terms of medicines or a physical means of management, for example mobilising or relaxation exercises.

- **Personalisation:** Prescribing practice has ensured that the rehabilitation management is responsive to patient needs with 50 – 75% of prescribing related tasks completed by consultant physiotherapist which were previously undertaken by medical staff at the hospital. As an allied health professional (AHP), the consultant physiotherapist is a supplementary prescriber working to clinical management plans in agreement with an independent prescriber (sessional GP) and the patient.

- **Addressing national and organisational priorities:** Rehabilitation for patients with stroke and palliative care needs. Department of Health (DH) modernisation agenda enables patient-focused care provided by the health professionals most suitable to the needs of the person, which in this case is rehabilitation therapy.

**Contact:** bhanu.ramaswamy@derbyshirecountypct.nhs.uk
**Planned care**

*NMP improving access to quality care and meeting 18 week targets, evaluated by benefits expectations study, patient and staff survey.* Rheumatology Pharmacist Practitioner, Northumbria Healthcare NHS Foundation Trust

**Policy drivers**

- **Value for money:** The service cost is well within the PbR Tariff, and cheaper than consultant costs, whilst maintaining the desired quality of service. It therefore demonstrates good value for money, and provides a return for the investment in NMP.

- **Improving quality:** NICE Rheumatoid Arthritis clinical guideline, aim is for patients diagnosed with RA to commence treatment as early as possible and definitely within 12 weeks of symptom onset. An evaluation was undertaken of 263 patients, the non-medical prescriber scored medians of ‘very good’ achieving the same score as for the consultant, the specialist nurse, and the specialist registrars (results presented at British Society for Rheumatology Annual Meeting in 2009).

- **Improving access:** Improved access as use of the pharmacist prescriber for review appointments frees up capacity for consultant rheumatologist and specialist nurse appointment time to see newly referred patients.

- **Personalisation of treatment:** Patients have opportunity to discuss queries and issues on medicines use with the non-medical prescriber within the context of inflammatory arthritis, and other long-term conditions. A concordant approach to prescribing decisions is developed, outlining the potential benefits and harms of treatment, but giving the choice of treatment approach to the patient.

**Contact:** richard.copeland@nhct.nhs.uk

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*NMP improving access to oncology care, enhancing efficiency and meeting 31 and 62 days treatment targets. Evaluation by audit and patient satisfaction.* Lead Cancer Services Pharmacist, Taunton & Somerset NHS Foundation Trust

**Policy drivers**

- **Value for money:** The service costs are within the PbR Tariff utilising specialist NMP where employment costs are favourable compared to specialist medical costs.

- **Improving quality:** Expert clinical pharmacy advice provided to oncology pre-assessment clinics, so improving the service provided to cancer patients. 24-hour advice is also in place.

- **Improving access:** Improved access as use of the non-medical prescriber for review assessments frees up capacity for consultant to see newly referred patients more quickly.

- **Personalisation of treatment:** Patients have opportunity to discuss queries and issues on medicines use with the non-medical prescriber, with medical advice and help always available if patients need to be referred.

**Contact:** jarrod.dunn@tst.nhs.uk
**NMP improving treatment access and side effect management, making efficient use of radiographer skills to streamline patient pathway. Evaluated by audit of CMP usage and survey of patient, doctor and pharmacy feedback. Radiographer therapy review prescriber, Mount Vernon Cancer Centre, London**

### Policy drivers

- **Value for money:** NMP provides the NHS with an increase in value for money as the costing for a non-medical prescriber to review a patient is less than the cost of a medic reviewing a patient, even though the non-medical prescriber may spend a longer time with the patient. Potential to generate income from PbR tariff.

- **Improving care quality and continuity:** Clinic review radiographer, as a supplementary prescriber reviews the patient for radiotherapy side effects, assesses and prescribes, following an agreed patient specific clinical management plan. An immediate prescribing decision can be made and patient waiting time in the department is reduced considerably. Also the number of healthcare professionals the patient comes into contact with is reduced, streamlining the patient pathway and extending the radiographers role.

- **Access:** NMP provides more timely reviews.

- **Choice:** Patients have a choice of seeing a supplementary prescriber or waiting to see a doctor.

- **Health inequalities:** All patients are treated equally by the supplementary prescriber regardless of their ethnicity, disability or social background state.

- **Personalisation of treatment:** Patients being reviewed by a clinic review radiographer would be seen by the same radiographer, whereas with clinicians it could be anyone from the team. This provides the patient with improved continuity of care to receive the best possible symptom control.

### Contact:

ranjenaverma@nhs.net
### Mental health

**NMP improving access to flexible urgent mental health and clinical care from assertive outreach team, evaluation by audit and survey. Mental health nurse prescribers, Cornwall Partnership NHS Trust**

#### Policy drivers

- **Care closer to home:** Domiciliary setting.
- **Value for money:** The Assertive Outreach Service (AOS) non-medical prescribers are able to take over prescribing for short periods in order to re-establish concordance and adherence which avoids deterioration in patients’ mental health. NMP allows more efficient working, since the nurse prescriber is able to adjust doses; stop and start medicines more rapidly than having to request consultations and/or prescriptions from the GP or consultant. Significant saving in nursing time of up to 4 hours per NMP prescription through removing the need to obtain prescription via the GP surgery.
- **Avoiding unnecessary admissions:** Timely access to medicines for patient avoids escalation and unnecessary admissions.
- **Improved quality:** NMP in AOS means that treatment can be more regularly reviewed and changed in the client’s home, avoiding the stress, delay, risk of DNA and inconvenience of setting up outpatient appointments. The non-medical prescriber works closely with psychiatrists and GPs and makes changes which promote and improve the physical health of users of the service. This includes sharing clinical management plans across primary and secondary care; carrying out blood tests at home if the service user is unable (or unwilling) to attend the GP surgery and initiating other physical health tests.
- **Access:** Quicker access to medicines for the client group. This was noted in an initial local benefits expectations study, and rated as a benefit in the 2009 questionnaire study.
- **Choice:** Service users, who previously rejected written information on medicines, keep their clinical management plan form as an ‘advance statement’ to confirm their choice of medicines.
- **Health inequalities:** Increased focus on physical health monitoring and communication with GP. Sharing clinical management plans, which include section on tests and monitoring, across primary and secondary care; carrying out blood tests at home and initiating other physical health tests.
- **Personalisation:** Non-medical prescribing has contributed to some amazing recoveries through improved medicines adherence. Users of the service, who were repeatedly in crisis, have been stable for longer periods than ever before. Forms part of a more holistic approach to care, allowing alternative treatments and approaches to be initiated. Service users who were unable to undertake psychological therapies have been able to successfully participate and benefit from this, partly as a result of stable medicines adherence.

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**NMP improving access to flexible urgent clinical care, evaluated by audit of treatment plans, non-medical prescribing and case study. Health promotion staff nurse prescriber, Sheffield Health & Social Care NHS Trust**

### Policy drivers

- **Value for money:** NMP avoids unnecessary prescriptions, reduces use of on-call doctors’ service and frees up consultant time.

- **Improved quality:** Clinical outcomes improved due to more responsive and timely prescribing. **Case example:** Client prescribed anti-psychotic and anti-emetic was observed to be increasingly lethargic and unmotivated. After assessment and medication review, the non-medical prescriber was able to reduce the prescribed dose of anti-psychotic by 50% and discontinue the anti-emetic. The client became more alert and was better able to engage.

- **Access:** Ward based practitioners provide clients with exclusive, full-time, access to prescribers (including unsocial hours).

- **Choice:** Clients can choose time, timing, location and prescriber to enhance concordance.

- **Health inequalities:** Providing effective, familiar prescribers to vulnerable clients.

- **Personalisation of treatment:** Allows clients a more complete episode of care and creates a therapeutic alliance that fosters communication for future care.

**Contact:** michael.livingston@shsc.nhs.uk
Staying healthy

**NMP providing flexible extended access to smoking cessation products in order to reduce health inequalities, evaluated by audit and patients satisfaction survey.** Community Practitioner Nurse and Independent Nurse Prescribers, Smoking Cessation Service, East Lancashire Community Services

<table>
<thead>
<tr>
<th>Policy drivers</th>
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<tbody>
<tr>
<td>✓ <strong>Improved quality</strong>: Smoking cessation support is provided by trained counsellors.</td>
</tr>
<tr>
<td>✓ <strong>Access</strong>: Patients can access the smoking cessation service in a variety of settings on a one to one basis or via drop in clinics, with access to prescribers including unsocial hours. Settings include GP surgeries, health centres, children’s centres, libraries, secondary care settings, mosques or other places of worship, pharmacies, leisure centres, the workplace or home.</td>
</tr>
<tr>
<td>✓ <strong>Choice</strong>: Clients can choose time and location to access counselling and support to enhance concordance. Those who find it difficult to access a GP can be offered the most appropriate treatment from the range of smoking cessation products prescribed by CPNP or nurse independent prescriber.</td>
</tr>
<tr>
<td>✓ <strong>Health inequalities</strong>: Increasing the range of settings from which nicotine replacement therapy (NRT) is prescribed enables clients who cannot easily access other services to be supported in smoking cessation, for example clients working shifts, travelling or who have chaotic lifestyles.</td>
</tr>
<tr>
<td>✓ <strong>Personalisation of treatment</strong>: The patient can request their preferred brand or flavour of NRT gum to enhance concordance and the prospect of success.</td>
</tr>
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**Contact**: christine.donnelly@eastlancspct.nhs.uk
### Maternity and newborn

**NMP providing timely access to specialist neonatal care evaluated by audit. Advanced Neonatal Nurse Practitioners at Taunton and Somerset NHS Foundation Trust**

#### Policy drivers

- **Value for money**: Favourable employment costs compared to prescribers of similar experience. Non-medical prescribers are able to use their extensive experience and diagnostic skills to accurately recognise conditions early and initiate appropriate medication. Whilst this may incur initial costs, early treatment often prevents long-term sequelae resulting in more expensive long-term treatments.

- **Quality improvement**: The establishment of the advanced neonatal nurse practitioner NMP role has raised standards of care by providing timely access to medicines for neonates.


- **Personalisation of treatment**: Each baby is assessed individually and a treatment plan created to include medication if required.

**Contact**: gillian.german@tst.nhs.uk and paula.mcgarel@tst.nhs.uk
## Children

**NMP providing acute paediatric care closer to home, evaluated by medicines and patient flow audits and patient satisfaction survey.** 
*Paediatric Nurse Practitioner Prescriber, Calderdale and Huddersfield NHS Foundation Trust*

### Policy drivers

- **Value for money:** Favourable NMP staff remuneration costs.
- **Quality:** Prescribing in accordance with NICE guidance. Improved patient and parent education and health promotion.
- **Care closer to home:** Nurse-led paediatric assessment and observation unit delivered in hospital setting using NMP to deliver paediatric care service locally with access to paediatric service: 24 hours 7 days a week.
- **Improving access:** Early referral from A&E leads to prompt assessment, diagnosis, treatment and timely discharge or prompt transfer to inpatient facility.
- **Personalisation of treatment:** Holistic family care and personalised management plans. Enhanced concordance, for example with personalised treatment plans.
- **Safety:** Accurate prescribing and administration of drugs with relevant information given to parents and children.

**Contact:** [helen.jagger@cht.nhs.uk](mailto:helen.jagger@cht.nhs.uk)

### NMP enhancing the quality of patient care by timely adjustment of paediatric doses in a paediatric intensive care unit, evaluated by clinician feedback.** 
*Lead Pharmacist in Paediatrics, Cambridge University Teaching Hospitals NHS Trust (Addenbrookes Hospital)*

### Policy drivers

- **Value for money:** Favourable employment costs compared to prescribers of similar experience working in paediatric intensive care unit. Significant cost savings are achieved by ensuring appropriate doses of expensive medication are prescribed.
- **Quality improvement:** The pharmacist supplementary prescriber allows for quicker prescription adjustments and reduces inappropriate dose changes. Therapeutic levels are reached sooner and correct monitoring undertaken.
- **Access:** NMP enables improved access to therapeutic drug doses.
- **Personalisation of treatment:** The non-medical prescriber provides immediate adjustments to dosage of medication to suit individual patients.

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### End of life

**NMP enhancing access, expanding capacity and supporting efficient palliative care delivery, evaluated by audit of service delivery and clinical governance.** Palliative Care Clinical Nurse Specialists, Royal Cornwall Hospital’s Trust, Truro

#### Policy drivers

- **Value for money:** NMP expedites symptom control for palliative care patients, minimising calls on other services and generating savings from avoidable admissions via payment by results. Favourable NMP employment costs compared to prescribers of equivalent experience.

- **Improving Quality:** Previously palliative care nurses ‘advised’ their medical and AHP colleagues of the best modes of symptom control care. Despite palliative care nurses’ knowledge base this left the prescribing responsibility with the medical prescriber. Recommendations to change medications could potentially take hours before being implemented, which not only delayed effective symptom control for the suffering patient, but also caused distress to the on-looking relative, loved ones or staff caring for that individual. Care provided in line with Gold Standard Quality Framework.

- **Care closer to home:** To expedite discharges to preferred place of care.

- **Improved access:** More rapid response to the patient’s pain and symptom control by a team of specialist nurses.

- **Expanded capacity:** The improvements in treatments for cancer sufferers means patients are living longer than before, thus needing palliative care input at varying stages of their cancer for their symptom control.

- **Personalisation of treatment:** A seamless approach to care with greater continuity and expediting of service delivery.

**Contact:** mike.thomas@rcht.cornwall.nhs.uk
NMP enhancing the quality of children’s palliative care by timely access to symptom control from Macmillan nurse prescriber. Macmillan Nurse, Children’s Community Team, Leicester City Community Health Services

Policy drivers

- **Value for money:** NMP expedites symptom control for palliative care children, saving GP/hospital consultant time at no extra cost from nursing time as NMP Macmillan nurse was attending child anyway. Savings from reduction in avoidable admissions via payment by results. Favourable NMP employment costs compared to prescribers of equivalent experience.

- **Improving quality:** NMP is used to ease or resolve symptoms and side effects from chemotherapy for children and young people at home. NMP saves visits to GP surgery or a trip to hospital, where they may come into contact with infectious patients.

- **Care closer to home:** Domiciliary setting.

- **Improved access:** Prior to NMP, there were difficulties in quickly accessing prescriptions for children’s palliative care, as hospital prescribers were too busy and GPs reported reluctance to prescribe due to a lack of confidence in skills to prescribe for children who are terminally ill.

- **Choice:** Always have discussions regarding alternatives and can go to GP/hospital for prescription if patient/carer would prefer.

- **Health inequalities:** Equal to all, with access to interpreter if needed.

- **Personalisation of treatment:** Individual to patient with continuity of treatment as prescription provided alongside nursing care.

**Contact:** marie.brereton@leicestercity.nhs.uk
Appendix A

The table below shows how embedding NMP into service design helps achieve world class commissioning competencies.

<table>
<thead>
<tr>
<th>World Class Commissioning Competencies</th>
<th>Embedding NMP into service design linked to commissioning competencies</th>
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<tbody>
<tr>
<td>1. Locally led NHS</td>
<td>Understands the strengths and weaknesses of local NHS organisations and develops their competence and capabilities.</td>
</tr>
<tr>
<td>2. Working with community partners</td>
<td>Uses the skills and knowledge of partners, including clinicians, to inform commissioning intentions in all areas of activity. Full engagement locally through effective and innovative local strategic partnerships and workforce planning processes.</td>
</tr>
<tr>
<td>3. Engage with public and patients</td>
<td>Routinely invites patients and the public to respond to and comment on issues in order to influence commissioning decisions and to ensure that services are convenient and effective.</td>
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<tr>
<td>4. Collaboration with clinicians</td>
<td>Builds and supports broad clinical networks, including across provider boundaries, to facilitate constructive multidisciplinary input into pathway and service design.</td>
</tr>
<tr>
<td>5. Manage knowledge and access needs</td>
<td>Robust ongoing joint strategic needs assessment demonstrating a full working understanding of the current and future local population’s health and well-being needs, especially relating to relative inequalities in health outcomes and experience.</td>
</tr>
<tr>
<td>6. Prioritise investment</td>
<td>Identifies and commissions against key priority outcomes. Uses financial resources in a planned and sustainable manner and invests for the future, including through innovative service design and delivery.</td>
</tr>
<tr>
<td>7. Stimulate the market</td>
<td>Promotes services that encourage early intervention, to avoid unnecessary unplanned admissions.</td>
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<tr>
<td>8. Promote improvement and innovation</td>
<td>Translates research and knowledge into specific clinical and service reconfiguration, improving access, quality and outcomes. Designs and negotiates contracts that encourage provider modernisation, continued efficiency, quality and innovation.</td>
</tr>
<tr>
<td>9. Secure procurement skills</td>
<td>Procures and contracts in line with relevant Department of Health policies, such as patient choice, competition principles and rules, care closer to home and NICE guidelines. Assesses business cases according to financial viability, risk, sustainability and alignment with commissioning strategies.</td>
</tr>
<tr>
<td>10. Manage the local health system</td>
<td>Disseminates relevant information to allow current providers to innovate and develop to meet changing commissioning requirements.</td>
</tr>
<tr>
<td>11. Makes sound financial investments</td>
<td>Analyses costs, such as prescribing, and identifies areas for improvement. Designs and negotiates open and fair contracts that provide value for money and are enforceable, with agreed performance measures and intervention protocols.</td>
</tr>
</tbody>
</table>
## Acknowledgements

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<thead>
<tr>
<th>Name</th>
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</tr>
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<tbody>
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</tbody>
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