A safe prescription

Developing nurse, midwife and allied health profession (NMAHP) prescribing in NHSScotland

September 2009

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Foreword by the Cabinet Secretary for Health and Wellbeing

The Scottish Government’s health policy, set out in Better Health, Better Care: Action Plan, identifies the need for patients to access the services they need quickly and safely as a priority area.

The further development of nursing, midwifery and allied health professional (NMAHP) prescribing in Scotland is another positive move in the direction of increasing patients’ access to vital services in a way that is safe and effective.

While we are stepping up efforts to improve the health of the Scottish population and prevent the occurrence of disease, we recognise that the prescription of medicines to treat illness when it strikes will remain a central plank of NHS services. We are driving forward a range of measures to ensure that patients can get the medicines they need when they need them, spearheaded by the abolition of prescription charges, which will be complete by April 2011.

NMAHP prescribing is about enabling quick, safe and equitable access to medicines for patients, and complements the Scottish Government’s endeavour to increase the kinds of services easily accessible health professionals like NMAHPs can deliver. NMAHP prescribing is therefore not only a quality-of-care issue; it is also about reducing health inequalities and opening access to services for all.

NMAHPs are already extremely important members of the health care team. The prescribing function gives them the opportunity to further influence the quality of care provided, making patients’ experiences of services even better and improving outcomes from the treatments they are prescribed.

A Safe Prescription builds on Non-medical Prescribing in Scotland to provide NHS Boards with strategic guidance on how to set up, manage and drive NMAHP prescribing for the benefit of the communities they serve. NHS Boards will find within its pages a blueprint for a first-class NMAHP prescribing service.

Nicola Sturgeon MSP
Deputy First Minister and
Cabinet Secretary for Health and Wellbeing
Joint foreword by the Chief Medical Officer, Chief Nursing Officer and Chief Pharmaceutical Officer

NMAHP prescribing is based on a very robust body of research evidence. In Scotland, the University of Stirling has carried out an extensive study into nurse prescribing, the results of which can usefully be extended to the wider NMAHP prescribing community.

The study comments on the potential for nurse prescribing to create greater and quicker access to treatments for patients, with additional patient safety benefits. It remarks on the benefits of nurse prescribing in ensuring continuity of patient care. And it emphasises how relations between health professions benefit positively from the implementation of nurse prescribing, especially relationships between nurse prescribers and pharmacists. The medical profession, the study reports, also see readily the benefits of nurse prescribing to patients, in terms of safe and effective treatment, and to themselves, through making their workloads more manageable.

Of equal interest in the Stirling research is its finding that nurses believe their prescribing work makes them more effective as nurses. They feel it enables them to utilise their wide range of skills and that it enhances team working.

NMAHP prescribing presents exciting professional options that individual practitioners have been keen to grasp. But it is important to emphasise that while the development opportunity it offers these practitioners is a very positive consequence of the process, the absolute priority of NMAHP prescribing is about offering patients a service that is safe, accessible and effective.

Patients accrue enormous benefits from prescribed medicines, but every individual prescription presents the opportunity for problems to arise. Safety is therefore the primary concern of any prescribing service.

It is therefore very reassuring to find that NMAHP prescribing is governed by a rigorous process of selection, preparation and evaluation. The rigour involved in recruitment processes, education of potential prescribers, mentoring by experienced colleagues in clinical settings and research into the efficacy of NMAHP prescribing now needs to be matched by the rigour with which NHS Boards develop, manage and monitor NMAHP prescribing services.

Non-medical Prescribing in Scotland, published in 2006, set the standards and parameters for safe and effective practice, in accordance with regulatory body requirements. A Safe Prescription now gives NHS Boards the guidance they need to ensure they can put in place the strategic infrastructure to allow highly skilled NMAHP prescribers to deliver their service safely and effectively for the benefits of patients and communities.

Harry Burns  
Chief Medical Officer

Margaret McGuire  
Acting Chief Nursing Officer

Bill Scott  
Chief Pharmaceutical Officer

Section 1

Introduction
Legislation to introduce Nurse Independent Prescribing in Scotland came into effect on 31 May 2006.

This marked the culmination of a long and at times arduous process that stretched as far back as 1989, when the Report of the Advisory Group on Nurse Prescribing (The Crown Report) (DoH, 1989) claimed that nurse prescribing would lead to better patient care, better use of patients’, nurses’ and GPs’ time, and better communications between team members.

The initiative took off in Scotland in 1996 with a phased introduction that is now complete. A review carried out by the University of Stirling (Watterson et al, 2009) has found that many of the claims made for nurse prescribing in the Crown Report have been borne out. It found that:

- the public had considerable confidence in nurse prescribing;
- nurse prescribers believed their prescribing roles made them more effective nurses;
- GPs’ workloads had been reduced as a result of nurse prescribing;
- nurses were regarded as “safe prescribers” by patients and professionals.

Legislation is now in place to allow some allied health professionals (AHPs), such as radiographers, podiatrists and physiotherapists, to train as supplementary prescribers. Joint undergraduate/postgraduate education courses for nurses, midwives and AHPs (NMAHPs) from a variety of professions commenced in Scotland in autumn 2007.

The Better Health, Better Care: Action Plan (Scottish Government, 2007) places patient safety at the top of the NHS agenda, and protecting patients from the adverse effects of inappropriate prescribing of medicines is a central plank of the work of the Scottish Patient Safety Alliance. NMAHP prescribers’ skills, knowledge and expertise in providing patients with safe, quick and efficient access to medicines will play a big role in supporting the patient safety agenda by improving services, enhancing patients’ experiences and protecting patients from harm.

At around the same time as the NMAHP contribution to delivering NHS services, Delivering Care, Enabling Health (Scottish Executive, 2006), was published, the Guidance for Nurse Independent Prescribers document was produced (Scottish Executive, 2006a). It sets out the parameters and standards for prescribing practice – the “nuts and bolts”, day-by-day operational issues that will ensure safe and effective practice.

What is needed now is a strategic vision to drive NMAHP prescribing over the next decade, a vision that will enable NMAHP prescribing to support and complement national policy imperatives and help NHS Boards to meet their responsibilities to patients and the public across a wide range of clinical and health areas.

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2 “Nurse” encompasses all nurses, including mental health nurses, district nurses, community nurses, health visitors, children’s nurses, general practice nurses and school nurses. It also encompasses midwives.

3 For definitions of independent and supplementary prescribers, see Box 1, page 8.
This document provides that strategic vision. It sets out the infrastructure that will be needed to drive NMAHP prescribing forward in relation to three key areas:

- culture
- capability
- capacity.

The main driver for the strategy is a recognition that while nurse prescribing is bedding down well in certain parts of Scotland, with safe, effective nurse prescribers providing valuable services to patients and the NHS, the overall picture in Scotland is patchy.

There are significant differences between regions and Board areas on how many nurse prescribers are in place, how they operate, how they are managed and how they are resourced. The University of Stirling research referred to earlier found “a lack of coherent, integrated and stable Board-level infrastructure for prescribers and, in some instances, there have been slow responses of Boards to the prescribing agenda”.

Models of excellence in developing nurse prescribing services are emerging, and some of these are referenced in the document. But the main aim of the strategy is to provide NHS Boards with a framework from which they can develop NMAHP prescribing services that are right for patients and the public, right for NMAHPs, and right for fellow health professionals.

While local differences in emphasis will always exist, the strategy also puts in place a set of recommendations on developing and managing an NMAHP prescribing service that will help to create consistency in quality throughout Scotland. In addition, a self-assessment tool designed to facilitate implementation of the strategy recommendations at local level is presented at the end of the document.

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4 As AHP prescribing courses only commenced in autumn 2007, there were no data at the time the University of Stirling research was undertaken on how well AHP prescribing services were being assimilated within NHS Boards.
Section 2

Context – describing NMAHP prescribing
What is NMAHP prescribing?
NMAHP prescribing has one clear aim – to make it easier and quicker for patients to get access to the medicines they need.

Nurses have been able to prescribe dressings and simple painkillers for years, but the legislative changes enacted in May 2006 now allow appropriately trained nurses to prescribe any licensed medicine – products with a UK marketing authorisation (including some controlled medicines) – for any medical condition they are competent to treat. Individual NHS Boards can, however, choose to restrict the items and conditions for which nurse prescribers can prescribe; Boards also have their own medicines formularies to which prescribers must adhere.

This situation hasn’t developed overnight. It has evolved over a long period of time and has involved pilots, trials, education programmes, clinical evaluations and economic appraisals.

But the central issue has always been about ensuring patient safety. This has been enshrined in the Standards of Proficiency for Nurse and Midwife Prescribers (NMC, 2006) developed by the Nursing and Midwifery Council (NMC), which all nurse prescribers must meet.

How does NMAHP prescribing “fit”?
NMAHP prescribing is seen to “fit” nicely with many of the key health care policy drivers in Scotland which call for:

- a fundamental shift in the way the NHS works, from an acute, hospital-driven service to one that is community based;
- a focus on meeting the twin challenges of an ageing population and the rising incidence of long-term conditions;
- a concentration on preventing ill-health by equipping the health service to encourage and secure health improvement and “wellness”, rather than just treating illness;
- an aim to enable people with long-term conditions and their carers to self manage their conditions as much as possible;
- a drive to treat people faster and closer to home;
- a determination to develop services that are proactive, modern, safe and embedded in communities.

“Community-based services”, “meeting older people’s needs and the needs of those with long-term conditions”, “preventing ill-health”, “encouraging self-management”, “treating faster and closer to home”, “embedding safe services in communities” – these policy aspirations effectively describe what NMAHP prescribing was designed to achieve.
NMAHP prescribing also “ticks boxes” across a range of policy initiatives, including:

- *Delivering Care, Enabling Health* (Scottish Executive, 2006), the nursing, midwifery and allied health professions’ action plan;
- *Visible, Accessible and Integrated Care* (Scottish Executive, 2006b), the review of nursing in the community in Scotland;
- *Co-ordinated, Integrated and Fit for Purpose* (Scottish Executive, 2007), the delivery framework for adult rehabilitation in Scotland;
- *Rights, Relationships and Recovery* (Scottish Executive, 2006c), the review of mental health nursing.

Who are NMAHP prescribers?
There are two kinds of nurse/midwife prescriber and one kind of AHP prescriber, as is explained in Box 1.

**Box 1. NMAHP prescribers**

<table>
<thead>
<tr>
<th>Community practitioner nurse prescribers</th>
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<tbody>
<tr>
<td>These are post-registration nurses who hold a Specialist Practitioner Qualification (SPQ), such as qualified district nurses and health visitors, some community children’s nurses, general practice nurses and school nurses. They can prescribe from the Community Practitioner Nurse Prescribers’ Formulary, which includes the majority of dressings and appliances and a limited range of prescription-only medicines, such as some treatments for head lice, thrush and pain relief.</td>
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</table>

A new programme is being developed that will prepare nurses and midwives other than SPQ students to prescribe from the Community Practitioner Nurse Prescribers’ Formulary.

<table>
<thead>
<tr>
<th>Independent/supplementary nurse and midwife prescribers</th>
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<tbody>
<tr>
<td>These are nurses and midwives who are trained to make a diagnosis and prescribe the appropriate treatment (“independent prescribing”). In cases where a doctor has made an initial diagnosis, they may also go on to prescribe or review the medication and change the drug, dosage, timing, frequency or route of administration of the medication as appropriate as part of a clinical management plan (“supplementary prescribing”).</td>
</tr>
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Nurse or midwife independent prescribers can prescribe all prescription-only medicines, including some controlled drugs, and all medication that can be supplied by a pharmacist or bought over the counter. They must only prescribe drugs that are within their area of expertise and level of competence (NMC, 2007).

<table>
<thead>
<tr>
<th>AHP supplementary prescribers</th>
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<tr>
<td>AHP supplementary prescribers can prescribe in partnership with a doctor or dentist (independent prescribers). They are able to prescribe any medicine, including a limited range of controlled drugs and unlicensed medicines listed in an agreed clinical management plan (all supplementary prescribers may prescribe for any medical condition under the terms of a patient-specific clinical management plan). The plan is drawn up with the patient’s agreement after a diagnosis has been reached and following consultation and agreement between the independent prescriber and the supplementary prescriber.</td>
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</table>

NMAHP prescribers must comply with current prescribing legislation and are accountable for their practice.
First and foremost, an NMAHP prescriber has to be a registered practitioner who is deemed competent by his or her employer to work in his or her chosen area of practice.

The NMC Standards of Proficiency for Nurse and Midwife Prescribers document states that a nurse must have been practising for at least three years and must have worked in the clinical area in which he or she wants to prescribe for a minimum of one year.

AHPs who wish to become prescribers must be registered with the Health Professions Council (HPC) and usually have a minimum of three years’ experience as a qualified AHP.

If these standards are met, there is an identified service need and support is forthcoming from the employer, individual NMAHPs can apply to undertake a programme of formal education in prescribing with supervised clinical practice.

**How are they educated?**

Prescribing education programmes are delivered by higher education institutions, with supervision and mentorship offered at the clinical base. The programme has to meet NMC standards and has to have NMC approval, a process carried out on behalf of the NMC in Scotland by an independent agency.

The current programme consists of a minimum of 26 days of theoretical learning at degree level,\(^5\) plus 12 days “learning in practice” facilitated and assessed by a designated medical practitioner.

Successful completion of the programme entitles nurses and midwives to be registered with the NMC as both independent and supplementary prescribers, and AHPs to be registered with the HPC as supplementary prescribers.

A project undertaken by the Scottish NMP Course Leaders’ Network, supported by NHS Education for Scotland (NES) (McAskill, 2007), has demonstrated the excellent progress higher education institutions in Scotland are making in complying with NMC standards and delivering high-quality education programmes for nurse prescribers.

**How are they managed?**

Practice in relation to management varies throughout Scotland. Some NHS Boards favour a traditional line management structure, with the prescriber’s usual line manager taking on management responsibilities. Others have opted to have a designated person responsible for the entire NMAHP prescribing service, with prescribers reporting to him or her on that part of their function. The NHS Board policy on NMAHP prescribing (see Section 3) should describe the management system employed.

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\(^5\) For distance learning programmes, there must be a minimum of eight face-to-face taught days (excluding assessment) plus 10 days protected learning time.
What benefits do NMAHP prescribers bring?
Successive reviews and studies of nurse prescribers have shown that they do bring benefits. Patients and practitioners in several studies have reported the benefits of nurse prescribing (Brooks et al, 2001; Ottaway, 2001, 2002; Luker and McHugh, 2002; Harrison, 2003). Reported benefits included improved timeliness of treatment and better quality of care in relation to issues such as information-giving and health promotion advice.

Prescribing decisions made by nurses in nurse-led services have been reported as safe, effective and acceptable to patients, and nurse-led services have been shown to enable patients to access same-day care (Kinnersley et al, 2000; Venning et al, 2000; Shum et al, 2000).

In pilot studies looking at the impacts of the Direct Supply of Medicines (DSoM) scheme in Scotland, under which community pharmacists are able to prescribe products from an agreed, limited formulary for a range of minor conditions, the scheme was identified as providing an efficient and acceptable alternative to GP prescribing which improved patients' access to medicines (Philips et al, 2001; Schafheutle et al, 2003; Sheehy and Jones, 2003).

Benefits of the service are alluded to in some studies, rather than proven. The University of Stirling research, however, provides a solid evidence base for the benefits of nurse prescribing being realised in Scotland. It found that of 120 patient respondents who had received a prescription from a nurse, 90% were either “satisfied” or “quite satisfied” with the service. Only 1% were “very dissatisfied”. Nurse prescribing was rated “about the same as GP prescribing” by 72%, with 23% feeling it was either “a bit” or “much” better.

When members of the public were asked about benefits of nurse prescribing, they spoke about how it was “able to fulfil their practical needs” and help them “obtain a speedy prescription”. Nurse prescribers were viewed as “saving doctors’ time” and as being able to give the patient more of their time than the GP, which they interpreted as being offered “personal care”.

The University of Stirling research found that nurse prescribing has also had positive benefits on relationships between professions, with the demonstrable competence of the nurse prescriber assuaging any professional concerns. Relationships with pharmacists in both primary and secondary care were very strong, and doctors reported that nurse prescribing was of benefit to patients and themselves in terms of freeing time for other activities; indeed, some hospital doctors and GPs were strong champions of the scheme and energetically supported its future development.

Doctors and nurses were able to recognise the public health contributions nurse prescribers were making, which included control of infections and better treatment of conditions without the use of anti-microbial drugs. There were also some indications that nurse prescribers brought a cautious (and consequently not over-zealous) approach to prescribing which recognised the importance of budgetary restraints.

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6 Most of the research studies carried out to date have focused on nurse prescribers.
Section 3

Culture – defining NMAHP prescribing
Governance

Risk assessment is at the heart of a strong governance culture for NMAHP prescribing.

Robust procedures for allowing health care professionals to report medication “near misses”, errors and adverse drug reactions should be in place, bolstered by a culture of just and fair accountability which seeks primarily to capitalise on the learning arising from adverse events rather than the need to seek out and punish those who were involved. NHS Boards must ensure that current policies encompass the NMAHP prescriber’s role and that appropriate training in reporting procedures has been put in place.

It is an inescapable fact, however, that any health care professional who blatantly disregards policies and procedures at any stage in the prescribing, dispensing and administration of medicines, and in so doing puts patients at risk, will be held accountable for his or her actions (DoH, 2004; Scottish Executive, 2006d).

Equally important to the culture is an efficient system through which NMAHP prescribers can gain rapid access to the information they need to support their practice. This includes access to electronic health records (see Section 4) and effective and timely dissemination of Hazard Notices, Safety Action Notices7 and other alerts; but it also relates to having supervision, mentoring and management lines in place that will ensure NMAHPs can access the right support and ongoing professional development opportunities to function at maximum safety and effectiveness.

Governance of an NMAHP prescribing service is a complex issue. NMAHP prescribers work in different clinical areas with different groups of patients, and prescribe different kinds of drugs. Their needs for ongoing supervision and education are consequently very different, and there is a risk that unless proper governance arrangements are in place, some NMAHP prescribers with high-visibility needs and pressures will prosper at the expense of others. This can lead to a fragmented service characterised by varying degrees of quality and inconsistent delivery – a completely unacceptable situation.

For these reasons, a strong, highly-visible senior member of staff should be in place to manage the NMAHP prescribing service across the NHS Board area. This person would not have day-to-day line management responsibility for the NMAHP prescribers, but would be in a position to monitor quality, assess prescribing practice, provide professional support and advice and develop the service to meet future needs on behalf of the NHS Board (see Section 4).

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7 A Hazard Notice is a high-priority warning requiring immediate action; a Safety Action Notice is a standard-priority notice where action can be planned. For more information on these and other issues related to warnings and reporting adverse incidents, see: [http://www.scotland.gov.uk/Resource/Doc/1095/0024782.pdf](http://www.scotland.gov.uk/Resource/Doc/1095/0024782.pdf)
RECOMMENDATIONS

NHS Boards should have robust systems in place to report and respond to medication “near misses”, errors and adverse drug reactions.

Appropriate mechanisms should be in place to ensure NMAHP prescribers can rapidly access the information they need to prescribe effectively and protect patients’ safety.

Appropriate mentoring, supervision and line management structures should be in place for NMAHP prescribers.

A senior member of management should be identified and prepared at NHS Board level to lead the NMAHP prescribing service across the Board area.

Policy

The University of Stirling research (Watterson et al, 2009) found “a fragmentation of nurse prescribing policy [among NHS Boards]”. It stated that “implementation and management is a cause for concern in some Boards, although it is gradually being addressed”.

An audit of nurse prescribing which reported in July 2006 (Pollock and Dudgeon, 2006) found that only 8 of 13 responding NHS Boards in Scotland had a nurse prescribing policy for their area. The audit report commented that given nurse prescribing’s potential as a driver for change, “it is perhaps surprising that so few Health Boards … have Board-level agreed policies for nurse prescribing”.

Yet it is widely considered that an NMAHP prescribing policy at NHS Board level as part of the general medicines management policy is the necessary starting point for running a safe, effective and efficient NMAHP prescribing service.

Policies can develop to reflect local needs, but as a minimum, a policy should address the following core issues:

• how the NMAHP prescribing service can contribute to meeting patient and service needs;
• governance, line management and resourcing issues;
• articulation of the NMAHP prescribing policy with other Board polices and structures;
• candidate selection, preparation and integration into the service;
• mechanisms for informing patients, unpaid carers, the public and health professionals about the service;
• ongoing support for the service and NMAHP prescribers.

Further advice on content for an NMAHP prescribing policy is given at Appendix 1.

Some NHS Boards have well-developed NMAHP prescribing policies which could be shared as exemplars with NHS Boards currently (or about to embark on) devising their own policies.
RECOMMENDATIONS

NHS Boards should review current medicines management policy and ensure that an NMAHP prescribing policy is either in existence or is being developed.

The NMAHP prescribing policy should be developed by a multi-disciplinary group and should be reviewed regularly.

An assessment of local service needs, detailing the patient groups and clinical conditions for which NMAHP prescribing would be appropriate, should be carried out at regular intervals.

Monitoring

A robust process for auditing and monitoring the quality of the NMAHP prescribing service should be in place. This should be directed towards auditing the safety and effectiveness of services offered to patients and the public and ensuring practitioners are using their prescribing skills to maximum effect. The many existing auditing and quality monitoring systems in NHS Boards, augmented by robust data on NMAHP prescribing being generated by NHS National Services Scotland (NHS NSS),\(^8\) can be used as the foundation for these mechanisms.

But quality monitoring is also necessary in spheres other than clinical prescribing practice. Governance of NMAHP prescribing services, line management, partnerships with the higher education sector, ongoing education and development provision and working in partnerships with patients and the public – all of these areas will need careful monitoring to ensure NMAHP prescribing is being given the support it needs and is providing the service patients expect.

The full implementation of systems described in the national eHealth Programme (see Section 4) will facilitate the audit of NMAHP prescribing services across primary and secondary care settings. In the meantime, NHS Boards should explore innovative ways of auditing services.

RECOMMENDATIONS

NHS Boards should build on their existing systems of auditing and quality monitoring to ensure effective scrutiny of the NMAHP prescribing service, consequently protecting patients, the public, the prescriber and the Board. The system should be properly governed, properly organised and properly reported, and should build on existing resources such as NHS NSS data.

The lead person for NMAHP prescribing should have in place effective communication mechanisms and strategies with all relevant stakeholders, including service agreements with higher education institutions regarding provision of the education programme.

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\(^8\) Due to as-yet limited availability of electronic health records, these data are currently only available for primary care services.
**Resourcing**

General experience of NMAHP prescribing services suggests that resourcing is one of the most challenging issues faced.

Practice differs among Boards, but big challenges tend to be found in defining resourcing responsibilities when patients move between secondary and primary care settings, where their medicines may be prescribed by NMAHPs. A lack of strong collaborative working between primary and secondary care in the past has led to patients’ access to medicines being restricted.

Similarly, infrastructure issues and delays in budget allocation can lead to frustrating hindrances in NMAHPs being able to prescribe effectively, such as lack of prescription pads and inadequate IT facilities.

Innovative and creative approaches to resourcing are necessary. Systems work best when they allow patients who move between secondary and primary care to access medicines when they need them, and not when the system finds it convenient. An approach that makes patients’ needs and safety paramount and which encourages a co-operative ethos among different elements of the service needs to be in place.

In addition, bureaucratic inefficiencies that place barriers in the way of delivering a fast, effective service should be identified and challenged at all levels.

It is important that imaginative solutions to resourcing issues are shared in Scotland. As is the case with NMAHP prescribing policies, some NHS Boards have developed sound systems for managing the resourcing of the service that could be shared with other NHS Boards as exemplars. Sharing can occur through existing structures, such as the Prescribing Leads Network.

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**RECOMMENDATIONS**

Existing mechanisms should be used to share good practice and innovative solutions to resourcing issues within NHSScotland.

Processes should support and facilitate the NMAHP prescribing service, rather than delay and obstruct it.

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**Informing**

While many thousands of patients are now benefiting from nurse prescribing in Scotland, and many more stand to benefit from AHP prescribing, non-medical prescribing in general remains a relatively new service and misconceptions and misunderstandings about its purpose and practice may persist.
Part of the NMAHP prescribing policy at NHS Board level should address how information about the service – its character, its delivery, its impact and its future – is disseminated. The NMC brochure, *What to Expect from a Nurse or Midwife who can Prescribe Drugs* (NMC, 2005), is specifically designed to inform patients, unpaid carers and the public about the service. Exploiting links with the local and national media may also prove beneficial in helping patients and the public understand the benefits – and risks – NMAHP prescribing brings. All internal and external communication systems at the NHS Board’s disposal should be utilised to support this endeavour.

But information is necessary not only for those using the service and their carers, but also for professionals working within the service. Misunderstandings, questions and doubts can be addressed by a planned and sustained campaign to educate professionals about NMAHP prescribing and how it benefits patients and the service.

**RECOMMENDATIONS**

The Scottish Government should develop information materials/resources on NMAHP prescribing that can be used by NHS Board leads to disseminate to patients, carers, the public, managers, professionals and the media.
Section 4

Capability – delivering NMAHP prescribing
Leadership

Leadership is a vital element in the effective implementation, monitoring and evaluation of NMAHP prescribing.

Good examples of strong leadership that has helped to promote NMAHP prescribing can be found in Scotland, but overall, the approach to leadership in NMAHP prescribing has lacked consistency. The audit of nurse prescribing in Scotland (Pollock and Dudgeon, 2006), for instance, reported little direction being given to guide service development in nurse prescribing at strategic level within NHS Boards.

The following is presented as a model of leadership for NMAHP prescribing that NHS Boards can use to identify their own requirements.

At strategic level, a Strategic Lead for NMAHP Prescribing should be identified. This person will have overall strategic responsibility for ensuring policies, auditing and quality mechanisms and support structures are in place within the NHS Board to underpin a safe and effective NMAHP prescribing service. He or she will also: lead on the development of a local strategy and action plan for the contribution NMAHP prescribing can make to service development and redesign; ensure synergy with other service delivery plans in the area; and develop mechanisms to support communication and information sharing with patients, the public, service professionals and other key stakeholders such as higher education institutions, the NMC and HPC, and the media.

At operational level, a Local NMAHP Prescribing Lead should be in place to provide local leadership and direction. This person will also be involved in selection of new trainees, delivery of support to trainees and existing NMAHP prescribers, co-ordination with higher education institutions, designated medical practitioners, mentors, other professionals, local services, patients and the public, and development of an NMAHP prescriber database.

This position could be full or part-time, depending on the demands of the post, but should be embedded at a sufficiently high position within the organisation to give the post-holder authority. The post-holder should have clear reporting lines to the Strategic Lead for NMAHP Prescribing and other senior managers in the NHS Board and should be a member of the Local Drug and Therapeutics Team. Workforce planning and succession planning — ensuring operational issues around backfill, sickness and absence cover and study leave do not impact negatively on continuity of patient services — will be a significant factor in this person’s job description.
RECOMMENDATIONS

NHS Boards should appoint a Strategic Lead for NMAHP Prescribing with clearly defined roles and responsibilities. The Strategic Lead should report to the Board at regular intervals.

NHS Boards should appoint Local NMAHP Prescribing Leads with clearly identified roles, responsibilities and reporting lines.

Information technology
The national eHealth Programme aims to change the way NHSScotland uses information and related technology (IT) to improve patient services. The key objectives from the programme that will impact on NMAHP prescribing are Clinical Portal, the Patient Management System procurement, and the replacement of GP computer systems. The use of the capabilities these systems provide can support clinical governance by providing better information to inform decision making and monitor safe prescribing practice.

Progress has already been made towards delivering on this agenda. The Emergency Care Summary\(^9\) (ECS) has been implemented, allowing practitioners in NHS 24, out-of-hours services and accident and emergency departments to access (with patient consent) information on patients’ current medication regimen and allergy status. This information allows prescribers to make informed decisions on the appropriateness of medicines they might wish to prescribe “out of hours”. There are opportunities to broaden the use of ECS in the future.

There is some evidence supporting the benefits of electronic prescribing (Bates, 2000), and the implementation of an electronic prescribing system could make a contribution to patient safety. Electronic prescribing is widely used in GP surgeries. A Hospital Electronic Prescribing and Medicines Administration (HEPMA) system has been implemented in one hospital in Scotland. HEPMA will be available to NHS Boards as an optional component of the new Patient Management System framework.

It is crucial that steps are taken to ensure all NMAHP prescribers using systems such as these remain compliant with national legislative and policy initiatives relating to protection of patient information and data confidentiality.

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\(^9\) The Emergency Care Summary provides information about patients’ demographics, allergies and current medication to health care professionals who provide urgent care outwith GP practice hours. The information is derived from GP records and stored electronically.
RECOMMENDATION

NHS Boards should ensure that NMAHP prescribers using IT systems in relation to their NMAHP prescribing work comply with legislation on data protection and information governance and with NHS Quality Improvement Scotland standards on handling patient information (NHS QIS, 2005).
Section 5
Capacity – developing NMAHP prescribing
Service development and service redesign
NMAHP prescribers have a potentially very significant role to play in service development and service redesign. It is all about looking at services creatively and identifying who is the most effective person(s) to prescribe to secure the greatest patient benefits in terms of safety, timeliness and ease of access. Each service redesign presents an opportunity for services to think creatively about prescribing for patients, with cost-benefit analyses providing a guide to identification of the most appropriate professional prescriber.

Because of their highly specialised skills, proximity to where patients live, long-established relationships with individual patients, unpaid carers and communities, sound communication skills and strong professional relationships with pharmacists and medical practitioners, NMAHP prescribers can be a catalyst for redesigning services to maximise patient gains.

Senior managers in NHS Boards must constantly be aware of the positive impact NMAHP prescribers are having on the way services are evolving. Keeping an eye on the “middle distance”, assessing impact and likely demand for the future, will ensure that they do not arrive at a succession planning deficit and find themselves with insufficient numbers of NMAHP prescribers to meet need.

RECOMMENDATIONS
All new service developments and service redesign initiatives should include consideration of the most appropriate professional(s) to prescribe medicines for patients affected by the development/redesign.

Workforce/succession planning for NMAHP prescribing should be an integral part of business plans developed for all new service developments and service redesign initiatives.

Education preparation
Key to meeting these future needs is the availability of sufficient places on NMAHP prescribing education programmes to prepare the right number of practitioners. Part of good strategic husbandry and governance of the NMAHP prescribing service is the development of systems to predict future needs and consequent training places required, a function that should be the responsibility of the Strategic Lead for NMAHP Prescribing (see Section 4).

Selection of trainees and the development of the education programme should involve input not only from academic staff, but also from managers, NMAHP prescribers, designated medical practitioners, mentors, patients and the public. The programme must also, of course, take cognisance of new legislative or policy developments and the emergence of guidance and competency frameworks from the NMC, HPC and other organisations.
Innovative and flexible means of delivering the theoretical and practical aspects of the programme, making best use of available information technology, should be considered and developed. This may be particularly beneficial for trainees in remote and rural parts of the country.

Practical elements of the programme are vital to the development of safe and effective NMAHP prescribers, and they must not be considered as secondary to the more theoretical aspects. Proper provision has to be made to ensure trainees can gain maximum education and professional benefits from their practical experience.

More generally, the Higher Education Institutions’ Prescribing Network in Scotland has been doing sterling work in driving up education standards in the NMAHP prescribing programme. The network has produced assessment tools and other resources that are proving very beneficial for trainees. It is creating a consistently high standard of education provision across Scotland.

**RECOMMENDATIONS**

NHS Boards should have strategies and service agreements in place to ensure ongoing dialogue and partnerships with higher education institutions in relation to NMAHP prescribing education.

A system should be in place for predicting future needs for training places.

A robust selection procedure should be in place to ensure the selection of appropriate candidates for the NMAHP prescribing education programme.

Flexible means of delivering the theoretical and practical aspects of the programme should be considered.

The clinical elements of the programme should be considered to have equal standing to the theoretical components.

Health Boards need to review education provision within the workplace to ensure that candidates are adequately prepared to meet the entrance requirements set out by higher education institutions and professional bodies, e.g. NMC Standards of proficiency for nurse and midwife prescribers pp 7-8.

NHS Boards should support and encourage the Higher Education Institutions’ Prescribing Network to continue its excellent work.

**Ongoing professional development and support**

NMAHP prescribers need to maintain and develop their knowledge and skill over their careers. They find themselves having to maintain their competence in two discrete but linked areas – as professional practitioners, and as NMAHP prescribers.
It is reasonable for an employer to expect NMAHP prescribers to accept responsibility for keeping themselves updated. They are accountable professionals answerable to their regulatory body, which has set standards for ongoing fitness for practice that includes the imperative of updating skills and knowledge.

Employers must, however, accept that they, too, have a responsibility in this area. The professional development planning (PDP) mechanism within NHSScotland allows individual NMAHP prescribers to identify their own continuing personal development needs with their line manager, mapping out an agreed course of action that will acquire for them the extra skills and knowledge they need to continue to function safely and effectively.

In addition to the formal PDP process, which may involve only one single meeting each year, NMAHP prescribers have a need for ongoing support, advice and mentorship. They should be encouraged and assisted to identify someone (or a number of people) who can provide this kind of support, which should be considered as an addition to, rather than as a replacement for, traditional managerial supervision and/or clinical supervision.

A range of ways of engaging with supervision has been developed in NMAHP circles over the last decade or so. These offer a variety of solitary activities (critical reflection, journal-keeping), one-to-one processes (mentoring, clinical supervision) and group activities (networks, special interest groups) to help NMAHPs identify and pursue continuing personal development needs.

**RECOMMENDATION**

NHS Boards should be prepared to ensure a range of appropriate sources of support are in place for NMAHP prescribers to enable them to identify and meet ongoing development needs. Central to this is the PDP process, through which NMAHP prescribers can be supported to meet mandatory ongoing professional standards and other development needs.
Section 6

NMAHP prescribing – what next?
This strategy for NMAHP prescribing builds on the vast array of work that has been done in Scotland and the rest of the UK in developing this exciting service.

It offers a way for NHS Boards and their partners – patients, carers, the public and higher education institutions – to take the opportunities NMAHP prescribing presents to look anew at how services are planned, delivered and evaluated. It does so by considering the cultural, capability and capacity issues that underpin NMAHP prescribing.

The strategy’s starting point is that patient safety comes first and foremost. Research on NMAHP prescribing is showing that with the right education, governance, support and regulatory systems in place, NMAHP prescribing can give patients safe, quick and easy access to the medicines they need.

NHS Boards are requested to implement the recommendations set out in this strategy across their services. The Self-assessment Tool in Appendix 2 can be used to facilitate this process.
Section 7

Summary of recommendations
Culture

Governance
1. NHS Boards should have robust systems in place to report and respond to medication “near misses”, errors and adverse drug reactions.

2. Appropriate mechanisms should be in place to ensure NMAHP prescribers can rapidly access the information they need to prescribe effectively and protect patients’ safety.

3. Appropriate mentoring, supervision and line management structures should be in place for NMAHP prescribers.

4. A senior member of management should be identified and prepared at NHS Board level to lead the NMAHP prescribing service across the Board area.

Policy
5. NHS Boards should review current medicines management policy and ensure that an NMAHP prescribing policy is either in existence or is being developed.

6. The NMAHP prescribing policy should be developed by a multi-disciplinary group and should be reviewed regularly.

7. An assessment of local service needs, detailing the patient groups and clinical conditions for which NMAHP prescribing would be appropriate, should be carried out at regular intervals.

Monitoring
8. NHS Boards should build on their existing systems of auditing and quality monitoring to ensure effective scrutiny of the NMAHP prescribing service, consequently protecting patients, the public, the prescriber and the Board. The system should be properly governed, properly organised and properly reported, and should build on existing resources such as NHS NSS data.

9. The lead person for NMAHP prescribing should have in place effective communication mechanisms and strategies with all relevant stakeholders, including service agreements with higher education institutions regarding provision of the education programme.

Resourcing
10. Existing mechanisms should be used to share good practice and innovative solutions to resourcing issues within NHSScotland.

11. Processes should support and facilitate the NMAHP prescribing service, rather than delay and obstruct it.
Informing
12. The Scottish Government should develop information materials/resources on NMAHP prescribing that can be used by NHS Board leads to disseminate to patients, carers, the public, managers, professionals and the media.

Capability
Leadership
13. NHS Boards should appoint a Strategic Lead for NMAHP Prescribing with clearly defined roles and responsibilities. The Strategic Lead should report to the Board at regular intervals.

14. NHS Boards should appoint Local NMAHP Prescribing Leads with clearly identified roles, responsibilities and reporting lines.

Information technology
15. NHS Boards should ensure that NMAHP prescribers using IT systems in relation to their NMAHP prescribing work comply with legislation on data protection and information governance and with NHS Quality In Scotland standards on handling patient information (NHS QIS, 2005).

Capacity
Service development and service redesign
16. All new service developments and service redesign initiatives should include consideration of the most appropriate professional(s) to prescribe medicines for patients affected by the development/redesign.

17. Workforce/succession planning for NMAHP prescribing should be an integral part of business plans developed for all new service developments and service redesign initiatives.

Education preparation
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19. A system should be in place for predicting future needs for training places.

20. A robust selection procedure should be in place to ensure the selection of appropriate candidates for the NMAHP prescribing education programme.

21. Flexible means of delivering the theoretical and practical aspects of the programme should be considered.

22. The clinical elements of the programme should be considered to have equal standing to the theoretical components.
23. Health Boards need to review education provision within the workplace to ensure that candidates are adequately prepared to meet the entrance requirements set out by higher education institutions and professional bodies, e.g. NMC Standards of proficiency for nurse and midwife prescribers pp 7-8.

24. NHS Boards should support and encourage the Higher Education Institutions’ Prescribing Network to continue its excellent work.

**Ongoing professional development and support**

25. NHS Boards should be prepared to ensure a range of appropriate sources of support are in place for NMAHP prescribers to enable them to identify and meet ongoing development needs. Central to this is the PDP process, through which NMAHP prescribers can be supported to meet mandatory ongoing professional standards and other development needs.
References


Nursing and Midwifery Council (2005) What to Expect from a Nurse or Midwife who can Prescribe Drugs. London: NMC.


Appendix 1

NMAHP prescribing policy

An NMAHP prescribing policy at NHS Board level should address the following issues and items.

How the NMAHP prescribing service can contribute to meeting patient and service needs:
• an assessment of local service needs, detailing for which patient groups or conditions NMAHP prescribing will be appropriate.

Governance, line management and resourcing issues:
• a clearly defined line management structure for individual NMAHP prescribers and an identified overall manager for NMAHP prescribing at strategic level;
• the development of a database of registered NMAHP prescribers in the NHS Board; the database should detail not only who they are and where they practice, but also in which particular clinical areas they have specialised; it should also track movement of prescribers within organisations;
• a process for dissemination of Hazard Warnings, Safety Action Notices and other alerts to NMAHP prescribers;
• transparent budgeting and resourcing mechanisms.

Articulation of the NMAHP prescribing policy with other Board policies and structures:
• how the NMAHP prescribing policy dovetails with the local medicines management policy, the Area Drug and Therapeutics Committee and other relevant bodies and policies – a mapping exercise to identify the issues with which the NMAHP prescribing policy must articulate would be a good starting point.

Candidate selection, preparation and integration into the service:
• criteria for selection of candidates for NMAHP prescribing education programmes, taking account of the parameters defined by the NMC and HPC and detailing joint working procedures with higher education institutions (the Guidance for Nurse Independent Prescribers document sets out advice on selection that may also be applicable to AHPs – see pp 9-11);
• procedures to ensure availability of designated medical prescribers and mentors to support trainees through their programmes;
• procedures for initiating the Notification of Practice procedure for trainees successfully exiting the education programme;
• procedures for notifying those who “need to know” about the trainees’ new status as NMAHP prescribers.
Mechanisms for informing patients, the public and health professionals about the service:
• mechanisms for educating the public and fellow professionals about NMAHP prescribing and keeping them informed about developments.

Ongoing support for the service and NMAHP prescribers:
• a robust process for auditing practice, monitoring quality and focusing on near misses and adverse events;
• processes to ensure ongoing support, supervision and education for existing NMAHP prescribers.
### Recommendations

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#### Culture

**Governance**

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2. Appropriate mechanisms should be in place to ensure NMAHP prescribers can rapidly access the information they need to prescribe effectively and protect patients’ safety.

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4. A senior member of management should be identified and prepared at NHS Board level to lead the NMAHP prescribing service across the Board area.

#### Policy

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6. The NMAHP prescribing policy should be developed by a multi-disciplinary group and should be reviewed regularly.

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A safe prescription

Developing nurse, midwife and allied health profession (NMAHP) prescribing in NHSScotland

September 2009