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

Progress Report
August 2010
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Executive Summary

This report provides an overview of progress within the territorial NHS Boards in Scotland, following publication of the strategic framework, *A Safe Prescription* (Scottish Government 2009a).

The main driver for the strategy was that while it was recognised that nurse prescribing was 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 was patchy with significant regional differences and inconsistencies in infrastructure at NHS Board level.

To date, the Scottish Government have spent a total of £4.8m developing non medical prescribing since 2001, with an additional one off payment of £10 000 to each of the participating NHS Boards in December 2009 to support ongoing implementation of the recommendations from ‘A Safe Prescription’.

A national prescribing summit was held in March 2010, involving all territorial Boards and appropriate Special Boards, to identify an approach for prioritising, progressing and reporting local progress.

The summit:

- Reflected the achievements and priorities for Boards following the Programme Officer’s visits over 2008/2009
- Considered how to ensure that NMAHP prescribing remains a Board priority
- Considered how best to align non medical prescribing with local organisation Objectives and the Quality Strategy
- Align the revised non medical prescribing recommendations (which will become standards) with the 6 dimensions of quality (Safe, Effective, Person-centred, Timely, Efficient and Equitable)
- Reviewed and redesigned the existing standards, proposed assessment tool and reporting timeline

‘A safe prescription’ can be accessed on the following link:  
A Safe Prescription Progress Report

Introduction

Building on ‘Non Medical Prescribing in Scotland - Guidance for Nurse Independent Prescribers and for Community Practitioner Nurse Prescribers in Scotland’ (Scottish Executive 2006a), this progress report provides an overview progress within the territorial NHS Boards in Scotland, following publication of the strategic framework, A Safe Prescription (Scottish Government 2009a). The strategy provided NHS Boards with the guidance to ensure development of a strategic infrastructure enabling highly skilled NMAHP prescribers to deliver a safe, effective service for the benefit of the patients and communities they serve.

Background and Policy Context

Non Medical Prescribing originated and has evolved from following the Report of the Advisory Group on Nurse Prescribing (The Crown Report) (DoH, 1989) which concluded that nurse prescribing would lead to better care for patients with faster access to medicines, enhance better use of nurses’ and doctors’ time and foster better communication between health professionals.

UK legislation to allow appropriately trained nurses and pharmacists to independently prescribe any licensed medicine came into effect in Scotland in 2006. Further legislative changes followed which expanded prescribing capacity to include some allied health professionals in 2007.

In 2006, ‘Non Medical Prescribing in Scotland - Guidance for Nurse Independent Prescribers and for Community Practitioner Nurse Prescribers in Scotland’ (Scottish Executive 2006a) was published. The guidance sets out specific, national administrative and procedural steps to enable nurses and midwives to prescribe safely and effectively. This document coincided with the publication of ‘Delivering Care, Enabling Health’ (Scottish Executive, 2006b) which clearly determined the major contribution for nurses, midwives and allied health professions (NMAHPs) in the delivery of future NHS services.

Non medical prescribing is integral to a range of healthcare policy including ‘Delivering Care, Enabling Health’ (Scottish Executive, 2006b); ‘Visible Accessible and Integrated Care’ (Scottish Executive, 2006c); ‘Co-ordinated, Integrated and Fit
Non medical prescribing supports many of the key health care policy drivers in Scotland including:

- The fundamental shift in the NHS from acute hospital-driven services to community-based services
- The challenges of an ageing population and the rising incidence of long-term conditions
- The drive to prevent ill health by focussing on health improvement and ‘wellness’ rather than merely treating illness
- The aim to enable people with long-term conditions to self-manage their care as much as possible
- The drive to treat people faster and closer to home
- The development of services that are proactive, modern, safe and embedded in communities

The ‘Better Health, Better Care: Action Plan’ (Scottish Government, 2007) places patient safety firmly at the top of the agenda, with medicines management, protecting patients from adverse effects of inappropriately prescribed or managed medicines, central to the work of the Scottish Patient Safety Programme.

Patient safety is fundamental to the ‘Standards of Proficiency for Nurse and Midwife Prescribers’ (NMC 2006) which provide Higher Education Institutions’ programmes of preparation for nurses and midwives to prescribe with requirements (standards and proficiency) for prescribing together with standards of conduct; which nurses and midwives are expected to meet in their practice as registered prescribers.

A further driver for the strategy was the development of a Scottish Government improvement framework for Shifting the Balance of Care (Scottish Government, 2009b). Non medical prescribing was identified as one of 20 evidence-based high impact changes to enable a shift in the balance of care from acute to community services.

Although ‘Non Medical Prescribing in Scotland’ (2006a) set out the standards and parameters for safe and effective practice in accordance with the regulatory bodies, there was little in the way of guidance to ensure a strategic infrastructure was in place to support the NHS Boards to develop, manage and monitor NMAHP.
prescribing services. ‘A Safe Prescription’ gives the NHS Boards the guidance they need to develop a strategic infrastructure which compliments the national policy imperatives and helps the NHS Boards to meet their responsibilities to patients and the public.

The findings of the ‘Crown Report’ remain contemporary with the report on the ‘Evaluation and the Extension of Independent Nurse Prescribing in Scotland, commissioned by the Scottish Government and carried out by University of Stirling (Watterson et al, 2009). The research indicated that the public had considerable confidence in prescribing nurses and were regarded as ‘safe’ prescribers by patients and professionals. Findings also supported a belief by Nurse prescribers believed that a prescribing role made them more effective as nurses; and general practitioners found their workloads had been reduced as a direct result of nurse prescribing.
Supporting Implementation of ‘A Safe Prescription’

The Scottish Executive commissioned the University of Stirling, to explore the effectiveness of the expansion of nurse prescribing in Scotland. This extensive study informed the development of *A Safe Prescription (Scottish Government 2009)*, which provides a strategic framework from which NHS Boards can develop local NMAHP prescribing services by setting out the infrastructure needed to take NMAHP prescribing forward in relation to 3 key areas: culture, capability and capacity.

The main driver for the strategy was that while it was recognised that nurse prescribing was 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 was patchy with significant regional differences and inconsistencies in infrastructure at NHS Board level.

A Safe Prescription established a set of recommendations to facilitate the development and management of service that would foster consistency and quality throughout Scotland. A self assessment tool was designed, and included as an appendix to the strategy, to facilitate the implementation of these recommendations which allowed Boards to develop and monitor their progress at local level.

In order to support the implementation of the strategy, a Programme Officer was seconded to Scottish Government to work closely with the NHS Boards and key stakeholders. The Programme Officer has been responsible for assisting Board prescribing leads to identify national and local solutions to some of the challenges posed by the recommendations.

Visits were made to each of the Board areas to facilitate progress. Challenges common to a number of Boards were discussed at the national prescribing leads meetings and this information sharing was extremely valuable to all Boards as a way of finding common solutions. The Project Officer has been the main point of contact with the Scottish Government Pharmacy Department, NHS Education for Scotland, Information Services Division, Practitioner Services Division, the Department of Health and the Home Office; facilitating the dissemination of information to assist the prescribing leads. She has also maintained contact with key stakeholders such as the Association for Nurse Prescribing, the National Higher Education Institution Network and the National Pharmacist Prescribing Group.

Towards the end of 2009 each of the NHS Boards were asked to provide a completed self assessment tool and a summary of their achievements. Areas requiring further work and ongoing consideration are identified in the following
section. Although not all of the recommendations have been met, most are being progressed with clearly defined plans for action.
Summary of Findings from the Self Assessment Tools

Recommendations from ‘A Safe Prescription’ can be found in Annexe 1

Culture

**Governance**

All NHS Boards demonstrated evidence of robust procedures for reporting medication errors and ‘near misses’. These were largely undertaken using both IR1 forms and the Yellow Card scheme.

DATIX incident reporting systems are used in some NHS Boards and are being investigated by others as a useful tool.

Health Boards actively encourage reporting and most adopt a culture of learning from events as opposed to a punitive ideology.

Good practices in some NHS Boards include peer review sessions, to share learning from previous near misses and adverse drug reactions, and local training events.

Mechanisms to ensure rapid access to information are wide ranging:

A number of Health Boards lack clarity in their managerial structure, resulting in poor dissemination of information to NMAHP prescribers.

Lines of responsibility regarding reporting are not entirely clear in some areas, due to some prescribing leads not holding a strategic role with representation at or links to Board level.

A small number of NHS Boards have reported local systems errors leading to difficulty in obtaining prescription pads and BNFs.

Mentoring and supervision following completion of prescribing education appears to be patchy. Some NHS Boards encourage continuation of mentorship provided by a designated medical practitioner and other encourage a ‘buddy’ system where an experienced prescriber works with a newly qualified prescriber for a period of time.

[Management and leadership is discussed further under Capability.]

**Policy**

All NHS Boards have current medicines management policies either ratified or under development. This has been supported by the NMC Standards of Medicines Management which were published in 2007.
Almost all NHS Boards have NMAHP prescribing policies in place. Those whose
policies are not in place are in the process of ratification. NHS Boards with well
developed policies have shared exemplars.

Assessment of local service needs was determined to have been met by only two
NHS Boards.
Most Boards were developing systems to identify service need detailing patient
groups and clinical conditions appropriate for NMAHP prescribing.

**Monitoring**
All NHS Boards gather information on prescribing in primary care through PRISMS
and recent adaptations to the system allow easier access to the data.
Monitoring and quality assurance of prescribing in secondary care remains
problematic as no standard system has been developed. Most NHS Boards used
peer audit to review practice but these have time and resource implications.
Most NHS Boards state they are developing better working relationships with local
pharmacists to support, monitoring of NMAHP prescribing in acute secondary care
settings.

**Resourcing**
There was consensus that the national NMAHP prescribing leads meeting was
determined as a good way of sharing good practice and innovative solutions.
There remain some underlying concerns in most Boards about the impact of NMAHP
prescribing and the issues of securing finance from funds that have been traditionally
procured by medical staff.

**Informing**
Scottish Government must maintain mechanisms to ensure national legislative and
policy information is disseminated timeously to appropriate prescribing leads.
The non medical prescribing pages within the Scottish Government website are to be
updated, together with ‘Non Medical Prescribing in Scotland: Guidance for Nurse
Independent Prescribers and for Community Practitioner Nurse Prescribers in
Scotland’ (Scottish Executive 2006a) to ensure these are current, informative and
inclusive of all NMAHP prescribers.
A patient information leaflet has been designed to reduce any misconceptions and misunderstandings about the role of non medical prescribers and will be published on the prescribing pages of the Scottish Government website in summer 2010.

**Capability**

**Leadership**

A model of leadership was recommended in A Safe Prescription utilising a strategic lead to ensure policy, auditing and quality mechanisms are in place, with an operational lead to provide local leadership and direction.

All NHS Boards have identified a prescribing lead but there is wide variance of responsibility associated with their roles.

Strategic leads included Nurse Board Directors, Directors of Pharmacy and specifically appointed non medical prescribing leads. One NHS Board has separate strategic leads for acute and primary care, allied health professions and pharmacy. In some NHS Boards, one person carries out both strategic and operational lead roles which presents significant workload demands and affects the clarity of reporting lines.

**Information Technology**

All NHS Boards comply with legislation on data protection and information governance and many have a separate local policy in relation to the same. IT systems and electronic prescribing are in use in primary care, although some NHS Boards have highlighted local systems and access issues which require to be addressed.

**Capacity**

**Service Development and service redesign and workforce/succession planning**

Only one NHS Board identified they have met the recommendations for incorporating non medical prescribing into service development and succession planning however little detail is given about how this has been met.

All other NHS Boards identify they have only partially met the recommendations and have no formalised process in place.

Many NHS Boards state that the recommendations have given them an opportunity to review future demands on resources and to work towards systems and processes to ensure this is undertaken.

Where non medical prescribing has been identified as essential to role, job descriptions have been adapted.
Education and Preparation

Most NHS Boards agreed they have strong formal/informal links with higher education providers for non medical prescribing modules.

There is representation from the national HEI prescribing network at the national Prescribing Leads meetings.

Most NHS Boards have a robust selection procedure which is undertaken in partnership with the HEI. One NHS Board has a service level agreement with a HEI but most felt these were not necessary as the flexibility of different modes of delivery is considered to be beneficial to NMAHPs considering modules.

Some constraints to releasing staff from service areas to undertake prescribing education are noted. These mainly involve difficulties with identifying and funding replacement staff for those undertaking a period of study and may be particularly challenging for specialist nurses whose roles are difficult to backfill due to a lack of appropriately trained/qualified staff.

The NMC ‘Standards of proficiency for nurse and midwife prescribers’ (2006) determine clear standards for selection and these are currently in use nationally. Theory and practice are delivered in flexible, innovative ways by most of the HEIs throughout Scotland. The Scottish HEI Prescribing Network considered section 1 of the NMC ‘Standards of proficiency for nurse and midwife prescribers’ and collaborated to ensure assessment across Scotland is adequately benchmarked.

The clinical elements of the programme are considered to have equal standing to the theoretical components.
**Recommendations**

Reflecting the findings of the completed self assessment tools, the following recommendations will be progressed by NHS Boards in partnership with the Scottish Government.

**Culture**

1. The systems for ordering and distributing prescription pads should be robust and consistent within an NHS Board, ensuring;
   - equity of access for staff
   - local systems for efficient ordering of pads
2. Local assessment of efficient ordering and distribution of BNF supplies should be evident, with access for non medical prescribers and students undertaking prescribing programmes
3. Mechanisms for monitoring/auditing prescribing practice in secondary care should be considered locally and nationally in order to share best practice.

**Capability**

4. Leadership models should be reviewed to ensure strong strategic and operational leads, with defined lines of communication.

**Capacity**

5. NHS Boards should identify mechanisms for considering the need for non medical prescribing as part of workforce and succession planning.

**General**

6. NHS Boards should demonstrate evidence of ongoing consideration of prescribing processes with an annual review report of non medical prescribing practice and evidence the impact this has on patient care.
Conclusion

NMAHP prescribing is becoming embedded within Territorial Boards, with activity and progress reflecting local need and priorities. To date the Scottish Government have spent a total of £4.8m developing non medical prescribing since 2001.

The one off payment of £10 000 paid to each of the participating NHS Boards in December 2009 will support ongoing implementation of the recommendations from ‘A Safe Prescription’.

A national prescribing summit was held in March 2010, involving all territorial Boards and appropriate Special Boards, to identify an approach for prioritising, progressing and reporting local progress.

The summit:

• Reflected the achievements and priorities for Boards following the Programme Officer’s visits over 2008/2009
• Considered how to ensure that NMAHP prescribing remains a Board priority
• Considered how best to align non medical prescribing with local organisation Objectives and the Quality Strategy
• Align the revised non medical prescribing recommendations (which will become standards) with the 6 dimensions of quality (Safe, Effective, Person-centred, Timely, Efficient and Equitable)
• Reviewed and redesigned the existing standards, proposed assessment tool and reporting timeline.

The revised standards and self assessment tool are in Annex 3 for information and action.
References


Recommendations from ‘A Safe Prescription’


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. 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:
8.1 ensure effective scrutiny of the NMAHP prescribing service, consequently protecting patients, the public, the prescriber and the Board.
8.2 ensure the system is effectively governed, organised and 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**

18. 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.

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.
NMAHP Prescribing Summit
12 March 2010, Victoria Quay, Edinburgh

The event was arranged with the following aims:
• Reflect the achievements and priorities for Boards following visits in 2008 / 09
• Ensure that Non Medical Prescribing (NMP) remains a Board priority
• Link NMP with local organisations’ objectives and the Quality Strategy
• Align the revised NMP standards with the six dimensions of quality
• ‘Redesign’ the assessment tool and reporting timeline.

NMAHP Prescribing Leads and additional representatives attended from 13 Territorial Boards and one Special Board.

The summit was facilitated by Sheena Williamson (Project Officer NMAHP Prescribing) and Charlie Sinclair (Nursing Officer: Acute Care) using an Appreciative Inquiry approach to consider:

The positive experiences and lessons learned?
• What benefits do NMAHP prescribers bring?
• How has the NMP tool supported the profile of NMP prescribing within Boards?

What will constitute ‘Core’ standards?
• What will NMP ‘look like’ / how will NMP feature on the Board agenda?
• How do we move from ‘snapshot’ to ongoing evaluation and review?
• How will you ensure that NMP aligns with organisations Objectives / Quality Strategy?

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<td>Iain Burns</td>
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<td>Jane Camp</td>
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<td>Caroline McLean</td>
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Annexe 2
Feedback from the event has been positive. There was excellent representation and participation from NMAHP and Pharmacy colleagues.

**Next Steps:**

- Work from the day has been collated and sent to NMP Leads for comment (March 2010)
- The revised standards will be distributed along with the ‘A Safe Prescription’ Progress Report to Nurse Directors, Heads of Pharmacy and NMP Leads (Annex 3).
- Consider future national approach, collaborative working and leadership with Pharmacy Division.
Recommendations and Self Assessment Tool

Over the past 18 months NMAHP and Pharmacy leads within NHS Scotland territorial Boards have used the self assessment tool for implementing the strategy recommendations from ‘Non-medical Prescribing in Scotland’ (Scottish Government, 2006).

NMAHP Prescribing Leads and Pharmacy colleagues have commented on the value that the self assessment tool has brought, valuing ongoing Scottish Government support, as an open and transparent mechanism to consider progress made towards defined goals. Leads have highlighted the value of the ability to benchmark, provide reassurance on progress as well as highlighting areas for improvement. By ensuring that Non Medical Prescribing is embedded in our systems and processes, confidence continues to improve.

The following ‘standards’ are a distillation of the original recommendations which still supports the Scottish Government’s health policy, set out in the Better Health, Better Care: Action Plan (Scottish Government, 2007 and CURAM 2009); Maximising the Potential of Nurses, Midwives and AHPs and Modernising Nursing and AHP Careers. The following ‘standards’ are indicative of the work that Boards should be able to demonstrate in order to evidence their culture, capability and capacity and is reflected under the headings of Governance & Leadership, Policy, Monitoring and Capacity. The ‘standards’ have been mapped to the Institute of Medicine’s Six ‘Dimensions of Quality’ (Berwick, 2002), in order to support alignment with The Healthcare Quality Strategy for NHSScotland (Scottish Government, 2010); and indicative evidence of outcome measures have been added.

There is an ongoing need, and will, for a collaborative approach across NHSScotland to ensure safe, efficient and effective service delivery. The revised ‘tool’ acknowledges the progress made within individual Boards and the reduced number of recommendations to 9 from the original 25 recommendations. The aim is to continue to provide NHS Boards with a point of reference, assuring Boards that risk management and quality standards are being maintained; while enabling the development of a local action plan which can inform the agenda of local groups as part of a Board’s medicines management programme.

It is acknowledged that NHS Boards are at different stages of development in relation to their NMAHP prescribing systems and processes. Some Boards will find it useful to refer to the original self assessment tool contained in the ‘A safe prescription’ publication (2009).
### 1. Governance and Leadership

<table>
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<th>Standard and Dimensions of Quality</th>
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<th>Action required / Lead</th>
<th>Timescale</th>
<th>Review: M = Met, P = Partially met, N = Not met Achieved: Y / N</th>
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<tbody>
<tr>
<td><strong>1.1</strong> NHS Boards should appoint a Strategic Lead for NMAHP Prescribing with clearly defined roles and responsibilities, including defined links with local / operational leads. <strong>Safe, Effective, Efficient</strong></td>
<td>E.g. Identifiable Strategic lead and links with operational practitioners</td>
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<td><strong>1.2</strong> Appropriate mechanisms should be in place to ensure NMAHP prescribers can rapidly access the information they need to prescribe effectively and protect patients’ safety. <strong>Safe, Effective, Efficient</strong></td>
<td>E.g. Critical Incident reviews, Access to live prescriber database, Access to BNF (electronic and hard copy) and IT</td>
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<td><strong>1.3</strong> Appropriate mentoring, supervision and line management structures should be in place for NMAHP prescribers underpinned by PDP processes, to meet mandatory ongoing professional standards and other development needs. <strong>Safe, Effective, Efficient, Patient-Centred, Equity</strong></td>
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## 2. Policy

### 2.1 NMAHP prescribing and associated policies and processes should be integral to the Board’s medicines management programme.

**Safe, Effective, Efficient**

E.g. Evidence of review within existing Board governance structures, Agenda item on Area Drugs and therapeutics Committee, notes from Medicines Management groups / sub groups

## 3. Monitoring

### 3.1 NHS Boards should ensure effective scrutiny of the NMAHP prescribing service, as part of a wider consideration of all prescribing practices.

The system should be properly governed, properly organised and properly reported, and should build on existing resources such as data from NHS NSS, PRISMs, local pharmacy; kardex and peer review.

**Safe, Effective, Efficient, Patient-Centred, Timely, Equity**

E.g. CHP – PRISMs data and prescribing feedback from pharmacy. Operational Divisions (Acute) – peer review of individual practice and pharmacy review of prescribing on ‘kardex’ / prescribing patterns

### 3.2 The lead person for NMAHP prescribing should have in place effective communication mechanisms and strategies with all relevant stakeholders.

**Safe, Effective, Efficient**

E.g. Access to live prescriber database, minutes from meetings, communication organograms and examples of communication e.g. briefs and newsletters.
### 4 Capacity

<table>
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<tr>
<th>4.1 All new service developments and service redesign should include consideration of the most appropriate professional(s) to prescribe medicines for patient groups with specific clinical conditions. Workforce/succession planning for NMAHP prescribing should be an integral part of business plans including current and future training needs.</th>
<th><strong>Safe, Effective, Efficient, Patient-Centred, Timely, Equity</strong></th>
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<tr>
<td>4.2 NHS Boards should have arrangements to ensure ongoing dialogue and partnerships with Higher Education Institutions in relation to NMAHP prescribing education.</td>
<td><strong>Safe, Effective, Efficient, Patient-Centred, Timely, Equity</strong></td>
</tr>
<tr>
<td>4.3 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.</td>
<td><strong>Safe, Effective, Efficient, Patient-Centred, Timely, Equity</strong></td>
</tr>
</tbody>
</table>

*E.g.  Documentation of development of service, Service redesign process and policy, Examples of business plans / cases, 'Service need' documents (local) scoping exercise for NMPs to predict / plan with HEIs*

*E.g. Evidence of mechanisms for communication with HEI, Recruitment processes*

*E.g. Evidence of peer support, PDP processes, Clinical Supervision*