



Public Health
England

Non-medical prescribing in the management of substance misuse

NATIONAL
SUBSTANCE MISUSE
NON-MEDICAL PRESCRIBING **FORUM**

July 2014

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1. Introduction to non-medical prescribing

1.1 Non-medical prescribing: an overview

For many years only medical professionals (doctors and dentists) could prescribe medicines for human use. Initial recommendations and support for nurses to take on the role of prescribing were made nearly 30 years ago.^{1 2} By the spring of 2001 approximately 20,000 district nurses and health visitors were qualified to prescribe independently from a limited list of medicines. In 1999 a further review recommended that prescribing authority should be extended to other groups of healthcare professionals.³ Although initially restricted to a limited list of medicines and conditions, legislation was passed in 2006 which enabled nurses to independently prescribe any licensed medicines for any condition within their area of competence and a number of controlled drugs. Independent prescribing for pharmacists was introduced in 2006⁴ and in 2009 further changes in legislation enabled nurse and pharmacist independent prescribers to prescribe unlicensed medicines for their patients and also to mix medicines themselves or direct others to do so.⁵

Forms of non-medical prescribing

There are two distinct forms of NMP: independent prescribing and supplementary prescribing.

Independent prescribing is done by practitioners who are responsible and accountable for assessing patients with undiagnosed or diagnosed conditions and for deciding the clinical management required, including prescribing. Independent prescribers can prescribe licenced or unlicensed medicines within their clinical competence.

Supplementary prescribing is a voluntary partnership between a doctor and a supplementary prescriber (nurse, midwife or pharmacist NMP) to implement an agreed patient-specific clinical management plan (CMP) with the patient's agreement. The doctor makes the initial diagnosis, then both prescribers prepare and agree the individualised CMP. NMPs can then prescribe within the parameters set out in the CMP. NMPs as supplementary prescribers remain responsible and accountable for their prescribing decisions.

Most restrictions around controlled drugs prescribing were lifted in 2012⁶ enabling nurses and pharmacists to prescribe virtually any controlled drug. Training for supplementary prescribing was introduced in 2003 for nurses and pharmacists⁷ and in 2005 for allied health professionals (ie, physiotherapists, podiatrists/chiropractors, and radiographers).⁸ Training for independent prescribing is combined with that for supplementary prescribers in all higher education institutions.

NMP is delivered by specially trained health care professionals who have successfully completed the nationally recognised prescribing course and added this qualification to their entry in the relevant professional register. In the context of the substance misuse field, NMP is only provided by nurses, midwives and pharmacists.

At the time of publication of the original version of this guidance, the National Treatment Agency for Substance Misuse (NTA) estimated that there were approximately 80 nurses and pharmacists working in the treatment of substance misuse who were either active prescribers, in training or contemplating training as non-medical prescribers (NMPs).⁹ A mapping exercise conducted by the National Substance Misuse Non-Medical Prescribing Forum (NSMNMPF) in the summer of 2012 located 316 NMPs in England.¹⁰

1.2 Context of the guidance

Before non-medical prescribing (NMP) was introduced, only medical prescribing was available to drug and alcohol misuse treatment systems. NMP was introduced to improve patients' access to medicines. It makes best use of the skills of experienced and appropriately trained health professionals so increasing the availability, responsiveness and cost effectiveness of prescribing interventions. This guidance applies to nurse and pharmacist prescribers who practise within the context of drug and alcohol misuse treatment.

National guidance on non-medical prescribing, patient group directions and minor ailment schemes in the treatment of drug misusers was published in 2007.⁹ Policy and legislative changes over the last seven years mean that this guidance needs to be updated. This document is intended for NMPs and all those with an interest in NMP including aspiring NMPs, consultants and clinical leads, service managers, NMP leads, colleagues from different professions (eg, doctors, psychologists, and social workers) and service commissioners. The document describes the factors that need to be considered for safely and effectively implementing NMP in substance misuse and addresses some of the specific challenges that the treatment of dependence presents for NMPs and their managers.

The drug and alcohol field presents special issues because the majority of prescribing involves controlled drugs. It also presents special challenges in terms of complexity and risk issues, as people with substance misuse problems often have complex needs. These challenges highlight the importance of ensuring that prescribing interventions are based on sound evidence and are delivered by skilled and supported professionals.

Since the 2012 lifting of restrictions, NMPs have been able to assess, diagnose and independently prescribe for the treatment of drug dependence. Previously, NMPs could only use supplementary prescribing to treat drug dependence – ie, they had to rely on doctors for a diagnosis and to formulate a clinical management plan. Prescribing diamorphine, cocaine and dipipanone for the treatment of addiction continues to be

restricted and is only available to medical practitioners licensed by the Home Office (in England and Wales).

The change in 2012, combined with the shift to a greater recovery focus, has provided NMPs with opportunities to improve treatment programmes.

However, there are potential risks if providers fail to meet their obligations in terms of the governance and clinical support required by NMPs or if NMPs practice beyond their scope of practice or competence. This guidance describes the systems and processes that enable safe and effective delivery of NMP.

1.3 Training as an NMP

To train as an NMP specialising in substance misuse treatment, nurses must meet the prerequisites outlined by the Nursing and Midwifery Council (NMC). These include:

- be a registered first-level nurse
- have three years post-qualification experience in practice (in any area of nursing)
- have practiced in substance misuse for at least one year immediately before applying for training (or for part-time staff a reasonable period to become competent as decided by their employer)
- be able to provide evidence via accreditation of prior and experiential learning (APEL) of being able to study at degree level¹¹

Additionally the applicant must be able to show:

- the support of their employer
- they have been accepted onto the course
- they have a designated medical practitioner (DMP) who has agreed to provide supervised practice during the course (see next section)

Following graduation and a pre-registration year, pharmacists must complete two years of clinical practice experience. Similarly to nurses their employer should assure themselves that the pharmacist is competent to prescribe in their chosen area following training.

NMP training should only to be undertaken if there is a demonstrable need for NMP and if there is the opportunity for the aspiring prescriber to carry out prescribing duties once they are qualified. This has to include access to a budget for prescribing and this must be agreed by their manager prior to embarking on the course.⁴

Some courses and employers require NMP candidates to pass preparatory modules before starting NMP courses. This is at the discretion of the employer and the higher education institution (HEI). However, guidance for nurses sets out certain competencies and prerequisites:

- the applicant must have been assessed as competent to undertake clinical assessment and diagnose before applying
- there must be a clinical need to prescribe within the role
- they must have sufficient knowledge to apply prescribing principles to their own area of practice
- they must have sufficient numeracy skills¹¹

In practice, organisations vary in what pre-qualifications they expect aspiring NMPs to undertake before providing funding and support for NMP training courses. For example, some NHS trusts require nurses to complete psychopharmacology and/or advanced physical health assessment modules at degree level. Other employers require potential candidates to complete their own (internally set and marked) numeracy or medicines management course. Others require candidates to pass the **RCGP certificate**¹² in substance misuse.

As employers become more aware of the benefits of NMP in the substance misuse field it is likely more nurses and pharmacists will be encouraged to train as a non-medical prescribers. However, nobody should be nominated to train for this role if they do not wish to take on the role as a prescriber.¹³

Nurses and pharmacists training to become independent/ supplementary prescribers undergo a minimum of 26 days educational preparation, with an additional 12 days of supervised learning for pharmacists. There are different requirements for distance-learning programmes.^{11 14}

1.4 The role of the designated medical practitioner

In addition to the taught element, the NMP programme has 12 days in practice during which the student applies the knowledge learnt in the classroom to their area of practice. The student's designated medical practitioner (DMP) supervises this period. The DMP is responsible for assessing the student's prescribing competencies. The HEI that runs the prescribing course normally identifies the required outcomes and competencies, and guides and supports the DMP.

The National Prescribing Centre (NPC) published guidance on the DMP role,¹³ including the criteria for the role (checklist A), the necessary competencies for the role (checklist B), and key characteristics of the role (checklist C).

Eligibility criteria for becoming a DMP (*checklist A*)

The DMP must be a registered medical practitioner who:

- has normally had at least three years recent clinical experience with a group of patients/clients in the relevant field of practice
- is in a GP practice and is either vocationally trained or has a certificate of equivalent experience from the Joint Committee for Postgraduate Training in General Practice Certificate or is a specialist registrar, clinical assistant or a consultant within a NHS Trust or other NHS employer
- has the support of the employing organisation or GP practice to act as a DMP who will provide supervision and support to the NMP student and opportunities to develop competence in prescribing practice
- has some experience or training in teaching and/or supervising in practice
- normally works with the trainee prescriber. If this is not possible (such as in nurse-led services or community pharmacy), arrangements can be agreed for another doctor to take on the role of the DMP, provided the above criteria are met and the learning in practice relates to the clinical area in which the trainee prescriber will ultimately be working

Characteristics of a competent DMP (*checklist B*)¹

| | |
|--------------------|---|
| Teaching knowledge | Knowledge about teaching methods (how and when to use them) |
| Teaching skills | Using teaching knowledge, giving feedback, being able to observe, analysing, teaching the trainee to carry responsibility, encouraging reflection, structuring, being able to teach (professional) skills, being able to handle conflict, being able to communicate (including listening), phasing of training |
| Teaching attitude | Giving the trainee latitude, giving the trainee respect, being open to criticism, being open to criticism on his/her teaching, being interested in the trainee, being able to separate private life and teaching, being able to separate the different roles in the teaching-relationship (teacher, colleague), being able to cope with tension resulting from being both a DMP and an NMP trainer, being a role model, offering a safe environment, individualising training, being alert, being critical of the trainee and their learning process, being open to extra training to become a better teacher, enjoying the role of teacher, being available and reachable, making time for teaching, being able to see things in perspective, being stimulating, not profiting from the trainee, being loyal to the department, willing to share patients with the trainee, daring to give feedback, learning from the trainee |
| Personality traits | Enthusiasm, flexibility, self-knowledge, ability to reflect, self-insight, patience, integrity, enjoying their role as a DMP |

¹ Adapted from: Boendermarker PM, Schuling J, Meybroom-de Jong B, Zwierstra RP, Metz JCM (2000) What are the characteristics of the competent general practitioner trainer? *Family Practice*, 17(6), 547-553

Key role and responsibilities of the DMP (*checklist C*)

- establishing a learning contract with the trainee
- planning a learning programme that will provide the opportunity for trainees to meet their learning objectives and gain competency in prescribing
- facilitating learning by encouraging critical thinking and reflection
- providing dedicated time and opportunities for trainees to observe how the DMP conducts a consultation/interview with patients and/or carers and the development of a management plan
- allowing opportunities for trainees to carry out consultations and suggest clinical management and prescribing options that are then discussed with the DMP
- helping to ensure the trainees integrate theory with practice
- taking opportunities to allow in-depth discussion and analysis of clinical management using a random case analysis approach, when patient care and prescribing behaviour can be examined further
- assessing and verifying that by the end of the course the trainee is competent to assume the prescribing role

1.5 Managing external influence

Nurses and pharmacists considering training to become NMPs need to consider the additional responsibilities that come with the qualification. They must be prepared to establish and set new boundaries of practice, balancing the sometimes conflicting demands of safe prescribing and patient choice and preference (eg, where a patient may wish to take home doses of medication before the prescriber is satisfied the person has achieved a stable state). In this context, external pressures can come from the patient, carers and other workers.

Further influence on prescribing practice comes from the pharmaceutical industry and other providers of appliances. Anecdotal reports from NMPs indicate that the industry recognises that NMPs are an increasingly important target group when marketing established and new products. NMPs always need to be mindful of the requirement to carefully consider the evidence for pharmacological products and that persuasive sales presentations are underpinned by vested interests.

Where NMPs feel they are being pressured to provide a certain intervention, they should remember they are responsible and accountable for their actions. Options that should be available to assist NMPs in making an informed and clinically-appropriate decision include clinical supervision with a medical or non-medical prescriber, managerial supervision, and discussion within peer support networks (see section 3.3).

1.6 Personal indemnity insurance and vicarious liability

Following an amendment to EU Directive 2005/36/EC (Recognition of Professional Qualifications),¹⁵ statutorily regulated healthcare professionals will need to have an insurance arrangement or indemnity to cover their practices. This means that NMPs must have an appropriate indemnity arrangement in place when the new requirement becomes law some time in 2014. If they continue to practise without cover after this time they will be breaking the law.

NMPs are professionally and legally accountable for their actions, or failure to act, and must be confident that they maintain the competencies necessary to perform their roles safely, prescribing or otherwise. However, in an employer-employee relationship an employer can be liable for the negligent acts or omissions of its employees, provided it can be shown that they took place in the course of their employment. In this case the employer is “vicariously liable” for the acts or omissions of an employee.

The key question in any case involving vicarious liability is whether the employee was acting in a personal capacity or in the course of their employment. This can often be difficult to determine. Nor does an employer's liability end once the employee leaves the organisation – as the law stands, action can still be taken against an employer even though the person in question no longer works for them.

Determining the level of appropriate cover is the responsibility of individual NMPs, as they are fully aware of the scope and scale of the risks associated with their practices. It is suggested that registered healthcare professionals refer to the guidance published by their professional bodies and regulators for up-to-date information on developments in this area and how they apply to their individual circumstances:

Advice for NMPs on indemnity cover

| | Nursing | Pharmacy |
|------------------------------------|---|--------------------------------|
| Advice from professional regulator | Nursing and Midwifery Council | General Pharmaceutical Council |
| Advice from professional body | Royal College of Nursing Royal College of Midwives | Royal Pharmaceutical Society |
| General advice on indemnity cover | NHS Employers | |

NMP in practice

Jamie and Penny have worked in Torquay as NMPs for four years and during this time have established a new treatment pathway that embeds NMP within the treatment system.

The majority of service users who need a prescribing intervention are automatically booked in for a non-medical assessment, which usually happens within five working days. The NMP completes a thorough assessment of the service user's needs and develops a joint prescribing plan with them.

The NMP discusses the plan with a medical practitioner and a joint decision is made on the appropriateness of non-medical prescribing. If NMP and medic are in agreement, the prescribing intervention can start without delay.

In some cases the NMP considers the prescribing intervention to be too complex and beyond his/her competence and confidence. In these cases, a medical assessment to supplement the NMP assessment is arranged.

This care pathway has significantly reduced the waiting times for prescribing interventions and has ensured that medical staff are able to prioritise working with those users who have more complex needs, and guarantees that the interventions are timely and cost effective.

2. Strategic development of NMP in substance misuse

2.1 Information for commissioners

Promoting independent NMP offers commissioners a powerful mechanism to enhance the flexibility of local care by increasing the availability and responsiveness of prescribing interventions so improving the experience of service users.

Establishing NMP allows responsive, personalised and flexible delivery of care, and enhances the recovery orientation of services, in line with the recent *Medications in Recovery* report.¹⁶ NMP provides faster access to medicines, time savings and improved service efficiency. Incorporating NMPs alongside experienced medical practitioners can facilitate improved access and outcomes for a wide range of users, and an efficient use of resources.

NMP is now well established across many clinical specialties and this includes the independent prescription of controlled drugs for the treatment of dependence.

Commissioners need to appreciate that NMPs are independent prescribers within their identified area of competence, and are obliged not to practice outside that area of competence. It is a requirement of their professional regulators (the NMC and the General Pharmaceutical Council) that NMPs continue to engage in adequate ongoing learning, support and clinical supervision, and to maintain their competencies, including their competence in independent prescribing (typically integrated into the usual continuing professional development (CPD) processes that their employers support).

The careful selection and training process, and the ongoing robust governance framework, enable a flexible and safe system for providing enhanced prescribing. However, this also means NMPs must not be expected to prescribe outside of their areas of competence.

Many people attending drug and alcohol treatment experience unusually severe problems with dependence and/or complex mental and/or physical health disorders. Consequently, services aimed at meeting the core needs of such severely dependent people require suitable qualified medical practitioners to work alongside NMPs as part of the multidisciplinary team. Medical practitioners are trained to diagnose and manage patients with complex medical and psychiatric problems within substance misuse services, so the roles of medical and NMPs are complementary and not interchangeable.

There is currently wide variation across England in the use of independent NMP within substance misuse services. Commissioners will want to carefully consider the opportunities that now exist for promoting NMP within their prescribing services, taking into account the range of needs among users and how services are structured and delivered. Provider services will also want to consider how to develop NMP within their teams and in any proposed service structure when tendering for contracts.

More detail about independent NMP use within the NHS and third sector can be found in [A quick guide for commissioners](#), which the NPC developed to help organisations effectively implement NMP.¹⁷

Professional regulators have published prescribing standards for their own practitioners. These are subject to change and up-to-date standards can be located on regulators' websites. The NPC developed a generic [competency framework for prescribers](#).¹⁸ This can be used as a tool to reflect on practice, and to identify CPD needs. The NPC has also published a guide for NHS managers to help improve their understanding of key issues in medicine use.¹⁹

When NMP is being developed in a service for the first time, commissioners will want to be assured that those planning the service provide enough time for suitable current staff to engage in training and have access to adequate supervision and support arrangements. They should also consider the organisational support arrangements needed for qualified NMPs recruited directly to the service. Provider organisations are advised to have an NMP lead who will be a key resource for advice on training, support, clinical governance, operational frameworks and protocols, and the practical processes for using NMP. This role is described in more detail in section 3.2.

Independent NMPs within substance misuse services offer commissioners a substantial new opportunity to improve quality, effectiveness, cost-effectiveness and the patient experience, by offering more flexible and responsive access to medicines from a wider range of clinicians. This innovation offers an opportunity to integrate independent NMP in to a practitioner's wider therapeutic relationships and to support more flexible working among the wider multidisciplinary team. While NMP clearly complements, and does not replace, the competencies required from suitable medical practitioners, it can help to improve services if taken forward carefully and enthusiastically.

2.2 The scope of prescribing practice for NMPs

Prescribing usually follows a face-to-face consultation between a patient and NMP, and includes an assessment of the patient prior to the NMP making a prescribing decision with that patient. There will be instances where it is in the best interests of a patient, whose prescribing has already been initiated within an established system of care, for an NMP to apply their knowledge, skill and competence, and prescribe for someone they have not personally seen, in order to ensure safe continuity of

prescribing. Such decision to prescribe would be informed by the NMP's knowledge of the nature of the comprehensive assessment(s) and of the clinical review and governance systems that underpin prescribing within their service. The decision to prescribe will follow a discussion with competent colleagues and a review of the clinical record. The NMP can then consider all relevant clinical information, and be in a position to make an appropriate clinical judgement on prescribing in the case in question.

In these circumstances the NMP must satisfy themselves that they:

- have conducted an assessment of all appropriate information in order to prescribe safely
- feel competent and confident to prescribe in this situation, and within the established system of care and clinical governance

2.3 Inducting newly qualified and newly appointed NMPs into services

Organisations using NMP are advised to have a formal governance process to authorise an NMP to start prescribing.

No NMP is expected to, and should not, prescribe from the full range of medicines listed in the BNF. NMPs should only prescribe within their confidence and competence, usually from a list of medicines previously agreed by their employers. Depending on their expertise and competence, NMPs working with substance misusers may be able to treat common infections, and manage conditions such as wounds, withdrawal, constipation, alcohol-related craving, vitamin deficiency, anxiety, depression and a need for emergency contraception. Local decisions will need to be made, and processes agreed, about whether and when NMPs can independently prescribe medicines outside the field of substance misuse.

Newly qualified NMPs may need to spend time developing confidence, starting slowly and gradually increasing their prescribing profile. This will also ensure the NMP is supported through the process of setting up and delivering safe NMP.

Individual employers and NHS trusts may choose to provide additional support to newly qualified NMPs, including direct access to a relevant clinical expert.

During this initial period, the employer and/or NMP may decide that it is appropriate for the newly qualified NMP to work within some constraints, such as restricting caseload numbers and complexity of patients, close working arrangements with a clinical expert ("shadowing") and working within agreed prescribing protocols. This will identify the areas of expertise required of NMPs in a particular setting and ensure training and CPD requirements are fulfilled. At the same time it will build their confidence and experience as independent prescribers. This system will also provide maximum flexibility for an employer so that an agreed formulary of medicines, appropriate to individual NMPs and

their services, are agreed in a systematic and considered way. The length of the initial, transition period should be defined at a local level, but as a guide it is suggested that six months is appropriate for a newly qualified NMP and three months for an NMP newly recruited into the service.

NMP in practice

Rob has worked for four years as a specialist substance misuse NMP in the Liaison Psychiatry Department, Addenbrooke's Hospital, Cambridge. He aims to see every patient who comes into the hospital with a substance misuse problem. While patients are in the acute hospital, Rob and his colleagues provide specialist treatment for their drug or alcohol dependence problems.

Rob is able to provide immediate substitute prescriptions for opiate dependence and can prescribe benzodiazepines to prevent alcohol withdrawal. Typically, he sees people who have injecting injuries, complications from alcohol withdrawal or alcoholic liver disease.

For patients admitted with alcohol dependence, Rob can start alcohol detoxification regimes for those with emergency gastritis, suspected Wernicke's encephalopathy and injuries from falls or fights. When their primary presentation is resolved and the patient is ready for discharge, Rob liaises with the community alcohol nurses who immediately continue the detoxification medication. He also supervises the rest of the detoxification.

Since the change in the law in 2012, Rob can independently prescribe opioid substitution medicines. Previously, he had to arrange for a non-specialist physician to see the patient and prescribe for them or ask the addictions consultant psychiatrist to see the patient first to draw up a clinical management plan so that he could then act as a supplementary prescriber. Having Rob as an independent prescriber has enabled the hospital to provide much faster access to opioid substitution treatment. Many of the opiate-dependent patients are known to their local community drug teams and Rob ensures that their treatment is transferred to the community team or to their GP when they leave Addenbrooke's Hospital.

3. Clinical governance to support NMPs

3.1 Establishing NMP policies and standard operating procedures

Once a provider service has taken the decision to embed NMP into its organisational structure, an NMP lead should be appointed to develop an appropriate policy and standard operating procedures (SOP). These will enable the service to incorporate NMP into its existing and future clinical governance arrangements. It is recommended that lead clinicians are included at every stage of planning and development of the NMP policy and SOP.

The NMP policy and SOP will be tailored to a service's specific needs. However, as a minimum an effective NMP policy will cover the following areas:

- the benefits of NMP and the rationale for introducing NMP into the service.
- the roles and responsibilities of the NMP (this should be understood by all team members) and the level of complexity of patients the NMP will prescribe for
- who will manage and clinically supervise the NMP, and the formal mechanism for supervision (including frequency)
- arrangements for monitoring the NMP's prescribing practice
- provisions to support the NMP's CPD needs. This should include peer supervision/support.
- provision for monitoring the NMP's ongoing competence to prescribe within his/her practice area
- the relevant local and national policies/procedures/guidance the NMP must work within
- the requirement for appropriate professional indemnity arrangements
- the initial period of support for newly qualified or newly appointed NMPs

Note that the lead clinician, service manager and NMP are jointly responsible for guaranteeing that prescribing clinics are effectively organised and that the NMP prescribes in a way that fully complies with high standards of prescribing practice, the legal, professional and ethical requirements, and local policies.

The NMP policy should also reflect that it is good practice to separate the process of prescribing and dispensing/administration whenever possible. Where NMPs are prescribing *and* dispensing (eg, pharmacist NMP) or prescribing *and* administering (eg, nurse NMP) for individual patients, a suitably competent second person should check the accuracy of the dispensed or administered medicine.

3.2 Role of the NMP lead

Organisations using NMP were advised in 2006 guidance⁴ that they should have a lead director who is responsible for implementing their strategic plan for NMP. Since then, the NMP lead role has been widely adopted and the lead has been described as playing a significant part in making effective use of NMPs. However, two studies^{20 21} have found that leads lack dedicated time for their role and there is no standardised list of responsibilities or recruitment procedure for them. The NMP lead is well placed to help reduce the waste of resources caused when professionals take NMP training but then fail to prescribe in practice after qualification.

Functions of the NMP lead

| Strategic influence | Operational management | Clinical governance |
|---|--|--|
| <ul style="list-style-type: none"> • promote NMP in their organisation | <ul style="list-style-type: none"> • provide information to managers liaise with HEIs • select candidates for NMP training • distribute resources, eg, the British National Formulary • support trainee and practising NMPs • arrange internal CPD events | <ul style="list-style-type: none"> • keep a database of prescribers • monitor NMP activity through audit • update the organisation NMP policy • disseminate medicines alerts • collate specimen signatures • report incidents • ensure NMPs receive supervision and appraisal |

Mental health trusts have been slower than acute and primary care to take up NMP.²² Specialist nurses and pharmacists in addictions are likely to be the exception to this with rapid expansion in numbers of NMPs working in substance misuse over the past five years.¹⁰ The NMP lead needs to make sure that the governance arrangements are suitably tailored to the high-volume prescribing practice that is typical of substance misuse community work. Establishing clear prerequisite preparatory training and protocols for prescribing practice before candidates undertake training will reduce drop out from training programmes and ensure NMPs actually prescribe once qualified.

3.3 Assuring competence

Pharmacists and nurses working as independent and supplementary prescribers in the substance misuse field need to work within a multidisciplinary team to ensure they are not working in isolation. They also need access to adequate and appropriate supervision. It is important that all members of the team understand that the NMP

cannot prescribe outside of their area of competence and confidence. This area should be clearly defined, although it will likely grow with experience.

Continuing professional development

Prescribing is part of professional practice, so prescribers are accountable for remaining up to date and competent. Continuing professional development (CPD) appraisal for prescribers should be undertaken annually as part of performance review, preferably using a recognised tool – eg, the NPC generic **competency prescribing framework**.¹⁸ Although prescribers are responsible for their own CPD, employers should support them in meeting these needs.

CPD should suit the individual learning style of practitioners, and meet their learning needs. CPD can take a variety of forms, including peer support (eg, prescribing forums), journals, individual study, work-based learning (including clinical supervision and reflection on prescribing practice), and formal CPD study days. Where possible, CPD should be undertaken within a multi-disciplinary context.

Supervision

Clinical supervision should be provided by a specialist in substance misuse who is easily accessible to the NMP. This can be either a doctor or an experienced NMP. It is suggested that the NMP and clinical supervisor meet formally once a month to discuss prescribing practice, away from distractions and interruptions. These meetings will need to be more frequent initially (eg, weekly) such as when the NMP first joins the team. The clinical supervisor should also be accessible to the NMP on an ad hoc basis to discuss any immediate clinical issues that arise.

Many services also provide management supervision for the NMP by a line manager who may not be a prescriber. Generally, management supervision is provided less frequently than clinical supervision (eg, every three months) although this is service-specific. Where there is separate management supervision, the NMP's clinical supervisor should be involved in developing the NMP's learning and development objectives and have input in the NMP's annual appraisal.

Appraisal

The NPC produced a **single competency assessment framework**¹⁸ for all prescribers that can be used as a tool to assess the competence of newly qualified or appointed NMPs, and as part of the annual appraisal process. The NMP, service's NMP lead and clinical supervisor will together want to assess whether competence can be demonstrated against the framework within the NMP's field of practice. The outcome of this assessment is best documented, and any development objectives identified added to the NMP's development plan.

Peer support networks

NMPs in the same or adjoining areas may find it useful to meet regularly and share best practice and case studies, or to observe and provide feedback on prescribing practice. A number of national and local networks support NMPs in the field of substance misuse.

The National Substance Misuse Non-Medical Prescribing Forum (NSMNMPPF) is for nurse and pharmacist prescribers in substance misuse. This forum holds free meetings three times a year across the country. For details see www.nmpsm.org

SMMGP (Substance Misuse Management in General Practice) runs an online forum freely accessible to NMPs. www.smmgp.org.uk

Regional peer support groups for non-medical prescribers in substance misuse include:

- South West – NMPs across Devon and three treatment agencies meet monthly. This has been an effective environment for sharing prescribing dilemmas, sharing good practice and developing specific local prescribing guidelines and disseminating and addressing concerns relating to process and practice.
- Birmingham – NMPs working with addiction meet monthly to discuss current issues. One of the NMPs will bring a case study for discussion, and another will bring a paper for discussion (a "journal club"). As such, the meetings have quite a strong learning and development focus, as well as being supportive to the group.

NMP in practice

Reuben qualified as an NMP in an inner-city community drug and alcohol team and has a caseload of around 30 patients. The prescribing team has written protocols stating which drugs Reuben can prescribe as an NMP, and has agreed guidance on doses and dose adjustments.

Reuben prescribes methadone and buprenorphine, and uses a patient group direction to issue take-home naloxone. For part of the week he provides a dedicated dose titration and stabilisation clinic where he sees patients who are starting a new treatment episode within the recovery orientated treatment system. He reviews their doses twice a week, or as required, and so stabilises them on prescribed opiates as quickly and safely as possible. During this intensive treatment period Reuben provides overdose training and take-home naloxone, manages blood-borne virus screening and vaccination, and screens all patients for health and nutrition.

As part of his role he audits his prescribing decisions and carries out patient satisfaction surveys at the end of treatment. Patients report high levels of satisfaction, outcomes are good with high levels of engagement and successful onward referral to primary care or other key-workers, and the number of patients leaving treatment prematurely are low. At other times Reuben is a keyworker for his own caseload of patients and prescribes for them while they are under his care.

An advantage for the service in having Reuben working as an NMP is that doctors are able to concentrate their efforts more efficiently on the most complex patients. Reuben benefits by being able to act more autonomously and feels that his relationships with patients are strengthened, and that patients are being reviewed by someone who has known them over an extended period.

4. Appendices

Medicines legislation

The Human Medicines Regulations 2012 (SI 2012/1916) came into force on 14 August 2012.

The regulations are the result of the MHRA's consolidation and review of UK medicines legislation. They replace nearly all UK medicines legislation – most of the Medicines Act 1968 and over 200 statutory instruments

www.legislation.gov.uk/ukxi/2012/1916/contents/made

The regulations set out a comprehensive regime for the authorisation of medicinal products for human use; for the manufacture, import, distribution, sale and supply of those products; for their labeling and advertising; and for pharmacovigilance.

Controlled drugs governance legislation and governance arrangements

The prescription, administration and supply of medicines to substance misusers will, almost invariably, mean working with controlled drugs. Handling of CDs requires additional responsibilities.

All healthcare professionals have an individual responsibility to ensure controlled drugs are managed safely. As part of this, it is essential that they are familiar with the legislation regarding possession, supply and safe storage of these drugs (Misuse of Drugs Act and supporting regulations) and those that relate more specifically to governance arrangements (The Controlled Drugs (Supervision of Management and Use) Regulations 2013). In particular, it is important for non-medical prescribers to be aware that all aspects of a controlled drug's journey within a healthcare setting (including the safe storage of prescriptions) should be set out in a standard operating procedure (SOP) and know to whom they should report controlled drug incidents and concerns, no matter how small the incident might appear to be. This will include an awareness of the role of controlled drugs accountable officers (CDAOs), occurrence reporting, and controlled drugs local intelligence networks (CD LINS).

Non-medical prescribers working within the addictions field are likely to be required to prescribe controlled drugs as part of their practice but must only do so within their sphere of confidence and competence. This should include the necessary knowledge and assessment skills to identify potential risks or complications of prescribing in addiction when patients have complex co-morbid conditions. Since April 2012, pharmacist and nurse independent prescribers have been allowed to prescribe any controlled drug for any medical condition within their competence, with the exception of diamorphine, cocaine and dipipanone for the treatment of addiction.

Controlled drugs legislation

The management of controlled drugs is governed by two key sets of legislation, the Misuse of Drugs Act 1971 and supporting regulations (Home Office legislation) and The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (Department of Health legislation). The main purpose of the Misuse of Drugs Act is to prevent the misuse of controlled drugs by imposing restrictions on their possession, supply, manufacture, import and export. The Department of Health regulations set out strengthened governance arrangements for controlled drugs used as medicines.

Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001

Drugs controlled under the Misuse of Drugs Act 1971 are those that have the potential to be misused and they are classified according to their assessed harmfulness:

www.legislation.gov.uk/ukpga/1971/38/contents

Many controlled drugs are also essential to modern clinical care and their legitimate, clinical use is governed by the Misuse of Drugs Regulations 2001, which categorises them into five schedules based on their therapeutic usefulness and potential harms when misused:

www.legislation.gov.uk/uksi/2001/3998/contents/made

Misuse of Drugs Regulations 2001 amendment for nurse and pharmacist independent prescribers

The Misuse of Drugs Regulations 2001 were amended in 2012 to allow nurse and pharmacist independent prescribers to prescribe any controlled drug listed in schedules 2 to 5 for any medical condition within their competence, with the exception of diamorphine, cocaine and dipipanone for the treatment of addiction. The changes came into effect on 23 April 2012.

The Controlled Drugs (Supervision of Management and Use) Regulations 2013

The Shipman Inquiry was an independent public inquiry set up in 2001 to examine the issues arising from the case of Harold Shipman. The inquiry's fourth report focused on the methods Shipman used to divert large quantities of controlled drugs for his own purposes, and considered how he was able to do it for so long without being detected. It concluded that there were serious shortcomings in the systems for regulating the governance of controlled drugs. In response, the Controlled Drugs (Supervision of Management and Use) Regulations 2006 were introduced and came into force in England on 1 January 2007. They have now been superseded by the new regulations, the Controlled Drugs (Supervision of Management and Use) Regulations 2013, which came into force on 1 April 2013 to reflect the changes in the NHS:

www.legislation.gov.uk/uksi/2013/373/contents/made

The Department of Health has also published information about the regulations to support the changes made in legislation:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/214915/15-02-2013-controlled-drugs-regulation-information.pdf

The regulations require healthcare organisations such as NHS trusts and independent hospitals to appoint a controlled drugs accountable officer (CDAO) who has responsibility for all aspects of controlled drugs management within the organisation. Other organisations, such as substance misuse services, may not be required to appoint a CDAO but may want to consider appointing a lead to ensure controlled drug governance arrangements are in place within their organisation. They must still comply with the Misuse of Drugs Regulations and must have arrangements to ensure the safe and secure management of controlled drugs and the reporting of controlled drug concerns. Each area team of NHS England is also required to appoint a lead CDAO and to designate the controlled drugs local intelligence network(s) (LIN) for their area for the purpose of sharing controlled drug concerns. Each team determines the membership of its LIN and the meeting frequency.

Details of all CDAOs in England are held in the controlled drugs accountable officer register, which is published on the CQC website:

www.cqc.org.uk/content/controlled-drugs-accountable-officers

Clinical guidance

Drug misuse and dependence: UK guidelines on clinical management (commonly referred to as the Orange Book) provides guidance for all clinicians, especially those providing pharmacological interventions for drug misusers. NICE guidelines on drug and alcohol misuse and NICE technology appraisals relevant to non-medical prescribing in substance misuse management are listed below.

- Alcohol-use disorders: Diagnosis and clinical management of alcohol-related physical complications (NICE clinical guideline 100, 2010)
www.nice.org.uk/guidance/CG100
- Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline 115, 2011)
www.nice.org.uk/guidance/CG115
- Drug misuse: Psychosocial interventions (NICE clinical guideline 51, 2007)
www.nice.org.uk/guidance/CG51
- Drug misuse: Opioid detoxification (NICE clinical guideline 52, 2007)
www.nice.org.uk/guidance/CG52
- Methadone and buprenorphine for the management of opioid dependence (NICE technology appraisal 114, 2007) www.nice.org.uk/guidance/TA114
- Naltrexone for the management of opioid dependence (NICE technology appraisal 115, 2007) www.nice.org.uk/guidance/TA115

How this guidance came about

Public Health England recognised the need for updated NMP guidance and asked the National Substance Misuse Non-Medical Prescribing Forum (NSMNMPF) to establish an expert group with the necessary representation to prepare guidance, based on the 2007 NTA publication, that defines clear parameters within which non-medical prescribing can be delivered safely and effectively. Members of the expert group met between July 2013 and February 2014.

Expert group members

Mr Mike Flanagan (Chair), chair, NSMNMPF; consultant nurse, Surrey & Borders Partnership NHS Foundation Trust
Dr Owen Bowden-Jones, addictions faculty chair, Royal College of Psychiatrists
Dr Steve Brinkman, clinical lead, Substance Misuse Management in General Practice
Mr Brian Brown, national pharmacy manager, Care Quality Commission
Dr Carmel Clancy, chair, Association of Nurses in Substance Abuse; head of department, Middlesex University
Professor Molly Courtenay, professor of clinical practice (prescribing and medicines management), University of Surrey
Ms Sarah Dennison, national controlled drugs manager, Care Quality Commission
Professor Matt Griffiths, visiting professor of prescribing and medicines management, Birmingham City University
Mr Kevin Gwilt, standards development officer, Nursing and Midwifery Council
Dr Linda Harris, medical director, substance misuse and associated health, Royal College of General Practitioners
Mr Jamie Holmes, NMP clinical team lead, Shrublands House, Torquay
Ms Joanne Martin, QA manager, General Pharmaceutical Council
Ms Rosie Mundt-Leach, head of nursing, addictions clinical academic group, South London and Maudsley NHS Foundation Trust
Ms Dawn Price, expert representative, Royal Pharmaceutical Society; chief pharmacist, Addaction
Mr Kevin Ratcliffe, consultant pharmacist, Birmingham & Solihull Mental Health NHS Foundation Trust

Policy observers

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